

**An Evaluation of Health of Elderly People Involved in  
Care-Giving to People Living Positively With HIV/AIDS  
in Homes:**

**A Case Study of Chimbele Village in Northern Province**

**Conference ID: CFP/915/2018**

Author: Mubanga Emmanuel

[fremubangacmm@yahoo.com](mailto:fremubangacmm@yahoo.com)

School of Business/Humanities

Information Communication University,

Lusaka, Zambia.

Advisor: Mr. Kelvin Chibomba

School of Business/Humanities

Information Communication University,

Lusaka, Zambia

**ABSTRACT**

*Aging is a phenomenon that is found worldwide. In developed countries, the elderly people living conditions are relatively better than their counterparts in developing countries. According to Living Conditions Monitoring Survey (LCMS) for 2015, individuals aged 60 years or older who also fall under poverty datum line head 53 percent of Zambian households. With the increase in poverty levels; particularly in the 1990s, it is likely that the deaths were resulting from the failure of the rural aged people to access medical services in rural areas. What compounds elderly people; particularly the poor is that they are out of pension and the government has no formidable scheme to support the old people in the country. On this issue, the IRIN/Plus News in 2007 commented that despite being a signatory to the International Conventions on the elderly including the Madrid 2002 Plan of Action on the aging which calls on governments to recognize the rights of the aged/older people, Zambia has no*

*legislated policies for the aged. The Social Cash Transfer (SCT) is too general to address specific needs of elderly people. The absence of a social security scheme for the aged people makes them vulnerable to poverty and diseases after retirement. And the government pension is specifically for the people who earlier on worked for the formal sector. Consequently, the aged who have not worked for formal sectors before are left out of economic viability groups. Even though government has introduced a free medical care scheme for people aged 65 and above, this only covers consultations and other medical requirements such as x-rays, treatments, drugs among others; making elderly people bear the rest of medical care costs (European Scientific Journal January 2016 edition).*

*The aim of this paper was to investigate the challenges experienced by the elderly involved in care-giving to people living positively with HIV/AIDS in Zambia. This was a desk study that used both a quantitative and qualitative methods focusing on the analysis of available literature on aging in Zambia. I. Examine health conditions of elderly care-givers in Chimbele village. ii. Investigate government policies and programmes directed at elderly people. iii. Find out interventions by Government and civil society organisations (CSOs) to help ease the care-giver's burden of looking after their sick children. Iv. To investigate the impact of stigma and isolation on elders in Chimbele Village.*

*The results revealed that 53% households with old people; especially those who are not on pension scheme are among the poorest in the country. 25% of elderly people have low and poor access to medical care services due to inability to pay for such services. Government and CSOs have no specific policy or programmes target elderly people: not even for those involved in care-giving for people living positively with HIV/AIDS. 22% of the respondents said other challenges elderly people faced; especially in rural areas was social stigma arising from being suspected of practicing witchcraft; including accusing the same aged people to have bewitched the child who they offer care.*

*Inadequate family support arising from nuclear family approaches. The burden of orphans compounds the economic viability of the elderly as they are too poor to support a crowd of their grandchildren in terms of school, decent shelter, clothing and medical care. Besides, the elderly is also left out of awareness creation on HIV/AIDS management programmes. To understand the factors associated with the caregiving and health of elderly caregivers in homes affected by HIV/AIDS, a study was conducted in Kasama District of Zambia.*

## **ACKNOWLEDGEMENTS**

I would like to take this opportunity to thank those who have supported me throughout my undergraduate school experience. First, I would like to thank my family for always being there for me. Thank you for your belief in my competency and accomplishments that make you always proud of me. My determination to be successful in life comes from you. Thank you for your support throughout the seemingly long journey of academic excellence. Thank you for all the great help with my schoolwork throughout these years.

Finally, I would like to extend my gratitude to my supervisor for being a great advisor and tutor. I am thankful for your support and confidence in me. I will live to remember your guidance and input in this entire enterprise.

## TABLE OF CONTENTS

### CHAPTER 1:

<b>1.0</b>	<b>INTRODUCTION .....</b>	<b>10</b>
1.1	Background to the Research Situation.....	11
1.2	Statement of the Problem.....	14
1.3	Purpose of the study.....	14
1.4	Research Objectives.....	14
1.5	Research questions.....	15
1.6	Significance of Study.....	15
1.7	Theoretical Framework.....	16
1.8	Limitation of the Study.....	17

### CHAPTER 2: LITERATURE REVIEW

2.0	Introduction.....	18
2.1	Global perspective.....	18
2.2	Regional perspective.....	19
2.3	Local perspective.....	20

### CHAPTER 3: METHODOLOGY

3.0	Introduction.....	27
3.1	Research Design.....	27
3.2	Target population.....	28
3.3	Sample size.....	28
3.4	Sampling Techniques.....	28
3.5	Instruments of Data Collection.....	29
3.6	Data analysis Techniques.....	29
3.7	Headman's interview.....	29
3.8	Elderly Men and Women's interview.....	30
3.9	Children's interview.....	30
3.10	Health Practitioners and Community health Workers interview.....	30
3.11	Data Analysis.....	30

## CHAPTER 4

### Presentation, Analysis and Discussion of findings

4.0	Introduction.....	32
4.1	Headman’s Response.....	32
4.2	Elderly Men and Women’s Response.....	33
4.3	Children’s Response.....	34
4.4	Community Health Workers Response.....	35
4.5	Health Workers Response.....	36
4.6	Presentation of Findings.....	37
4.7	Simple Frequency Table.....	40
4.6	Discussion of Findings.....	41

## CHAPTER 5

5.0	Conclusion.....	45
5.1	Recommendations.....	45
5.2	References.....	46
5.3	Appendix.....	47

## **CHAPTER 1.**

### **1.0 INTRODUCTION**

Zambia is among the countries in sub-Saharan Africa most seriously affected by the HIV/AIDS pandemic. An estimated 35,000-85,000 AIDS-related deaths have been recorded per annum. The majority of AIDS-related deaths have dominated the most productive age group of men and women about 20- 45 years. This study of the health of elderly caregivers caring for people living positively with HIV/AIDS at household level investigated risk and protective factors in Chimbele village associated with the impact of premature death of the breadwinner on the livelihood of their surviving spouses, dependent children, as well as wider circle of their extended family.

Worthy nothing is the fact that HIV and AIDS epidemic has many complex social and economic consequences that include declining life expectancy, reduced human productivity, reductions in household investment in education, weakened health systems, reduced agricultural output and limited sustainable human capital development. At the household level, the epidemic is competing for resources, reducing the ability of households to save and invest in addition to increasing household food insecurity. The epidemic threatens to destroy traditional community coping mechanisms and safety nets, making communities even more vulnerable. At the macro level, the epidemic is likely to reduce national and community capacity to absorb and utilize resources earmarked for socio-economic development, hence contributing to deepening poverty and deprivation of basic needs.

Structured interviews were conducted with 25 old women, 5 children and 10 old men in low-income and health practitioners in neighborhoods. The loss of adult labor has forced some families to withdraw older children from school to help maintain current levels of food production. Educational continuity is most severely jeopardized in child headed households. Implications however are discussed for the design of services to reach children and families with the greatest needs. Intervention strategies should be carefully adjusted to respond to the rural ecological, social and economic conditions of each community. HIV and AIDS continues to be a major developmental challenge for Zambia, which still has one of the highest HIV prevalence rates in the world National AIDS Strategic Framework 2011-2015 (NASF 2011-2015). Once again, it is time to assess and reflect upon the efforts that have been made in our multi-sectoral response to this challenge.

## 1.1 BACKGROUND

Chimbele village is located 9km on the western side of Kasama Central Business district (CBD) along Kasama, Luwingu road opposite Kasama airport. Chimbele covers a total of 50 square km and a total population slight over 5,500 people whose main activity is agriculture. The village produces barely enough food stuffs for local consumption hence this pauses a threat to national food security.

According to the Living Conditions Monitoring survey for 2015, about 65 percent of the population are aged between 0 to 25 years of which 44 percent are aged between 0 and 14 years and 21 percent are youths aged between 15 and 24 years and that there is no significant difference in the distribution of the population by age group and between male and female (LCMS 2015). This shows that the majority of Zambians are the youth. And the same survey shows that the population aged above 65 years old only constituted 2 percent of the country's population. Of this percentage, the males are 3 percent while the females are 2 percent. Thus the elderly population as at 2015 was a minority group and this group had males slightly more than the females.

Despite a high population growth rate of 2.8 per cent per annum, both the quality and quantity of human capital in households are diminishing due to deaths, illness or children dropping out of school because they are orphans or need to help in household work. The prospects for attaining the Millennium Development Goals (MDGs) are perceived to have improved although HIV and AIDS remains a significant threat even though the first case of AIDS was diagnosed in 1984. Zambia now has a generalized epidemic, with HIV spreading throughout the population as opposed to being concentrated in specific populations.

Although the level of the epidemic in rural areas is much lower than in urban areas, the population affected is quite high since about 61 per cent of the population lives there. In terms of the gender gap among the aged, the difference is minimal at national level. However, it is important to note that the population sizes for both gender categories are very small to other age groups in the country. The data above suggests that there are very few people who live very long lives in the Zambian society whether male or female of the elderly in both urban and rural areas in Zambia. Besides, there are more elderly females in rural areas than those in urban areas in all age groups. The observed decline in the numbers of the elderly people in the country suggests that there is a problem that has been going on but not fully either addressed or known by the policy makers or it is an indication that the elderly are not a visible

category in the decision making bodies in the country. There are a number of probable problems affecting this group or category of people namely poverty.

Data reveals that households with old people are among the poorest in the country. For instance the Living Conditions Monitoring Survey (LCMS) for 2015 reveals that 53 percent of households headed by individuals aged 60 years or older fell below the poverty line (LCMS 2015). Poverty has its own offshoots such as diseases that could be the leading to the deaths of the people aged 65 years and above. On the deaths it was found out that the rural areas experienced more deaths in the age groups 65 years and above than the urban areas (LCMS 1996). With the increase in poverty particularly in the 1990s, it is highly likely that the deaths were resulting from the failure of the rural aged to access medical services due to high poverty levels in the rural areas. What compounds the elderly particularly the poor is that they are out of pension and the government has no formidable scheme to support the old people in the country. The Social Cash Transfer (SCT) is too general to address specific needs of elderly people. The absence of a social security scheme for the aged people makes them vulnerable to poverty and diseases after retirement. And the government pension is specifically for the people who earlier on worked for the formal sector. Consequently the aged who have not worked for formal sectors before are left out of economic viability groups. Even though government has introduced a free medical care scheme for people aged 65 and above, this only covers consultations and other medical requirements such as x-rays, treatments, drugs among others; making elderly people bear the rest of medical care costs (European Scientific Journal January 2016 edition). On this issue, the IRIN/Plus News in 2007 commented that despite being a signatory to the International Conventions on the elderly including the Madrid 2002 Plan of Action on the ageing which calls on governments to recognize the rights of the aged/older people, Zambia has no legislated policies for the aged.

Moreover, access to proper medical care, which is important for the well-being of the aged, is not fully accessed in Zambia particularly among those who are poor and have no support from the immediate relatives. Isolation from the communities due to social stigma is one of the commonest problems faced by elderly people especially in rural areas arising from being suspected of practicing witchcraft. Not only have they faced this stigma, but also some have been killed because they are the suspects for unexplained deaths in rural communities. According to IRIN/plus news for 2007, Zambia's elderly people are faced with double jeopardy: they are shunned by communities as witchcraft practitioners and they have little understanding of the pandemic HIV/AIDS.

Currently there seems to be no available HIV/AIDS statistics and programmes for the elderly people aged 65 years and above however, many programmes that deal with sexually active groups are predominantly for the youth and formal workers. The aged are only statistics when it comes to their role in taking care of the people living positively with HIV/AIDS and the orphans. The Voluntary counselling and testing (VCT) programmes are oriented and administered by the youths most of the times if not all the time. This is a classic example of how information about the elderly people is not gathered as though this category of the community is not infected with the HIV at all. The aged people though they are a small minority in the entire population are equally affected by the HIV pandemic and some have died of AIDS.

Furthermore, elder people know very little about HIV/AIDS and other diseases particularly if they are illiterate. This is due to the fact that programmes on health are rarely targeted on this population too. As argued above, any focus on the elderly populations is usually confined to their responsibilities as care givers for the infected AIDS youth and orphans. The needs of the aged and their susceptibility to the pandemic are either disregarded in HIV programming or not given priority regardless of the fact that the elderly make 75% of the world's HIV infections (IRIN/Plus news 2007). Given the above situation, there is need to have more information about the elderly in Zambia on several issues which among many include their knowledge of HIV and AIDS, their economic status and its implications on their health, their life styles and how this affects their well-being, among others. Lack of family support and the burden of orphans for many years even today, the elderly people have been relying on their children as a form of social security in future and society equally teaches children to look after their parents in old age. As urbanization and other economic and social changes are taking place in society, the family ties are weakening leaving some sections of the family particularly the aged without support. The impact of HIV/AIDS has reversed this trend as more old people are in charge of supporting the young children especially the AIDS orphans in society. Besides, more and more Zambians are breaking with tradition of taking care of old parents in their homes by putting for them in nursing homes, Seniors World Chronicle reports. Others have succumbed to the HIV and AIDS pandemic leaving young children to the care of their grandparents. With this background in view, this paper investigated Zambia's deliberate policy of care and support of elderly caregivers and planned interventions to arrest the situation.

## **1.2 STATEMENT OF THE PROBLEM**

Despite Zambia being a signatory to the International Conventions on the elderly including the Madrid 2002 Plan of Action on the ageing which calls on governments to recognize the rights of the aged/older people, Zambia no legislated policies to this effect. This is of great concern to non-governmental organizations (NGOs), individuals, stake holder over care and support to elderly people. There is very little information about how elderly caregivers of children living with HIV and AIDS manage the burden of caring for such children especially in the rural areas of Zambia. The nature and the extent of this problem were thoroughly investigated and established solutions have been put forward.

## **1.3 PURPOSE OF THE STUDY**

The main aim of the study was to examine how elderly caregivers manage their socio-economic and health care needs, cope with the pandemic and care of themselves and their sick children in view of contributing to the quality of care and support for elderly caregivers in rural areas of Zambia. This was a desk study that used both qualitative and quantitative methods focusing on the analysis of available literature on aging in Zambia to understand the nature of interventions put by government and civil society organizations (CSOs) to help affected households with elderly care givers who are taking care of people living positively with HIV/AIDS among the poorest in the country.

## **1.4 RESEARCH OBJECTIVES**

The study was guided by these objectives:

- To examine the challenges faced by elderly caregivers in Chimbele Village.
- To evaluate the effect of Stigma and isolation of elderly people in Chimbele Village.
- To assess interventions by government and NGOs to help ease the caregivers' burden of looking after their sick children.

## **1.5 RESEARCH QUESTIONS**

The questions used in the study were as follows:

- What are challenges faced by elderly caregivers in Chimbele village?

- What are the effects of stigma and isolation of elderly people in Chimbele village?
- What are the interventions by government and NGOs to help ease the caregiver's burden to look after their sick children?

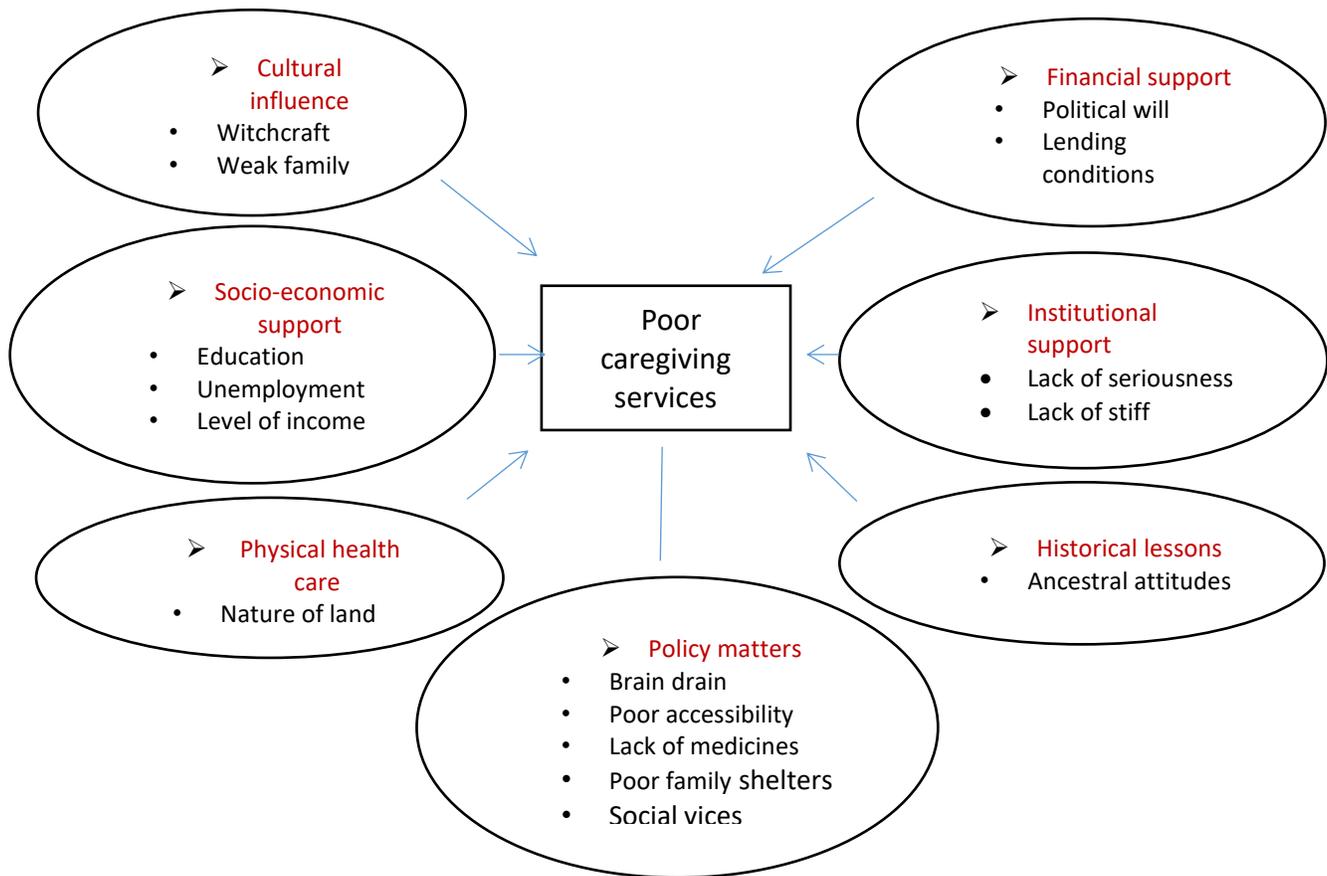
## **1.6 SIGNIFICANCE OF STUDY**

The HIV/AIDS pandemic in Zambia challenges individuals, families, traditional institutions, government and non-governmental organizations to provide support and long term care to patients living with HIV/AIDS, patients dying of AIDS and to their caregivers since it was first identified in Zambia in 1985 (NAC, 2003 and NSO, 2004). In addition to this challenge, there is very little information about how elderly caregivers of people living with HIV/AIDS manage the burden of caring for such people especially in the rural areas of Zambia. Support and care are crucial resources for the sick and their caregivers and yet without documenting personal, specific, culturally sensitive needs of caregivers and the person living with HIV/AIDS and the way they deal with their conditions, resources may be spent inappropriately without benefiting the individual and their caregivers (Popper, et al. 1999). In Zambia to date, very little is known and documented about the caregivers' experiences as they support and care for those children living with HIV and AIDS. Furthermore, the study strives to provide more information to parents and policy makers on the causes of poverty and also how to reduce it.

## **1.7 THEORETICAL FRAMEWORK**

In this project Theoretical conceptual framework was constructed to guide the design of elderly care giver's health in HIV/AIDS-affected homes in Chimbele village exploratory investigation, with a view to identifying predictors that might vary across outcomes. It is hoped that the results will in turn inform the refinement and elaboration of the framework as a basis for more tightly structured research designs in future research. The logic of the framework traces the immediate problems faced the elderly upon the death of bread winners from HIV/AIDS and formed the basis upon which objectives, research questions and variables were defined (see Fig.1).

**Figure 1. Variables contributing to the poor care giving services**



### **1.8 LIMITATION OF THE STUDY**

The study had a number of barriers that made it difficult for some investigations to smoothly be carried out due:

- **Limited time:** it is challenging for the researcher to spare and divide time between daily schedules as a full time employee and conducting a research.
- **Sample size:** due to the vastness of the area and a number of 50 homesteads were limited sources of conclusive information to conduct research.
- **Information concealing:** some participants were not free and open to reveal or divulge the right information especially in case of their survival and the source of the little income. Others were completely illiterate about the subject. This was very unfortunate as some pieces of information were left out.

## **1.9 OPERATIONAL DEFINITIONS**

**ELDERLY CAREGIVERS:** Elderly people who take care of people living positively with HIV/AIDS and orphans.

**QUALITY HEALTH NEEDS:** A situation where elderly caregivers have basic needs not lacking any necessities.

**AIDS:** Acquired Immune Deficiency Syndrome.

**H.I.V:** Human Immunodeficiency Virus.

**SCT:** Social cash Transfer is the money given to needy families especially of members who are 55years and above to boost the income.

**CSOs:** Civil Society Organizations which help the government to deliver projects to the people.

**LIVING POSITIVELY:** Clients living according to the prescribed medication to sustain one's life

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

In the previous chapter, the discussion was centred on the lack of information, programmes and conceptual understanding of the challenges faced by elderly caregivers in keeping up with their health and looking after the sick people living positively with HIV/AIDS in Chimbele village. This chapter reviewed the impact of HIV/ AIDS in a resource poor setting: Sub Saharan Africa. It examined how heavily affected Zambia is in the region besides Malawi, Mozambique and South Africa.

#### **2.1 Global Perspective**

HIV and AIDS have prompted mobilization of political, financial and human resources as never before in many countries in the world including the Sub Saharan countries (UNDP, 2005). In addition HIV and AIDS have ignited many challenges that have led to a strong level of leadership and ownership by

the communities and countries most heavily affected (UNDP, 2005). In 2000, global leaders embraced a series of Millennium Development Goals that reflected newfound energy to make the world safer, healthier, and more equitable (UNDP, 2005; WHO, 2008). Millennium Development Goal 6 states that, by 2015, the world will have slowed and begun to reverse the global HIV epidemic (WHO, 2008). By making the HIV response one of the overriding international priorities for the 21st century, world leaders acknowledged the central role of the HIV response to the future health and well-being of our increasingly interconnected planet (UNDP, 2005; WHO, 2008).

Although world leaders have championed this endeavour, much needs to be done at the implementation level because many developing countries require an enormous amount of resources to achieve this goal (UNDP, 2009a; UNAIDS, 2009). It is therefore not only planning but also implementation that is needed (UNDP, 2009b). For instance, towards the end of the last Century, world leaders developed an agenda to drive forward health issues worldwide and called “Health for all by the year 2000” (UNDP, 2009a). The question is and still remains the same- Did the world achieve this goal? And now with the ambitious “the Millennium goal number 6” is world leaders ready to mobilize resources to achieve this goal among others? Of course there is the global fund set aside to combat HIV and AIDS, malaria and tuberculosis (UNDP, 2009; UNAIDS, 2009). These conditions are all major diseases that require tackling individually and not as a group (UNDP, 2005; WHO, 2008). The danger that may be anticipated is that the resources may be used more on one condition leaving the others aside depending on the magnitude of that condition in a particular region or country (UNDP, 2010). In Sub Saharan African countries for example, the emphasis may be put on HIV and AIDS because it is a major health problem overriding tuberculosis and malaria which have been equally national health problems for many years before the advent of HIV and AIDS (UNDP, 2009a). Besides, Zambia is one of the Sub-Saharan African countries and as a signatory to many United Nations statutes including the Millennium Development Goals, has embarked on the implementation of the Goals including goal number 6 (MDHS, 2010).

## **2.2 Regional Perspective**

HIV and AIDS have caused great economic and social burden in the Sub-Saharan African countries and has reduced life expectancy by more than 20 years, slowed economic growth, and worsened household poverty (UNAIDS, 2009; UNDP, 2008). The natural age distribution in many national

populations in sub-Saharan Africa has been dramatically reduced by HIV, with potentially dangerous consequences for the transfer of knowledge and values from one generation to the next (UNDP, 2005). In addition, the 'cultural safety nets' such as community help for a family faced with a chronic illness have vanished (UNDP, 2005) because all families within the communities are either infected or affected (UNAIDS, 2010). In sub-Saharan Africa alone, the epidemic has left almost 12 million children aged less than 18 years as orphans (UNDP, 2008, UNDP, 2005). This chapter in short, explored global policies on HIV and AIDS, the impact on HIV and AIDS in Southern African countries, underlying the challenges experienced by elderly caregiver in rural Zambia to set the scene for the study.

The effects of HIV and AIDS are reflected in the changes to life expectancy which is the best summary indicator of the effects of HIV and AIDS on countries with high levels of HIV prevalence (UNAIDS, 2009a). This data illustrates the demographic impact of the epidemic on African populations (UNDP, 2008). In many countries in Sub Saharan Africa, adult mortality has doubled and trebled over the past decade and this is directly attributable to HIV and AIDS (UNDP, 2009a and UNDP, 2008). What is now being experienced by these populations are levels of life expectancy, which were typical of Sub-Saharan Africa in the 1950s. This is not confined to those living in poverty but nevertheless, is concentrated on those living in poverty who account absolutely for most of those who die from HIV-related illnesses (UNAIDS, 2009b). Thus there is a correlation between socio-economic status and infection rates, and between socio-economic status and mortality rates.

This situation reflects HIV infections which occurred in the late 1980s and since then, HIV prevalence in many Sub Saharan countries has intensified rather than diminished (WHO, 2006). For example, in Swaziland, average life expectancy fell by half between 1990 and 2007, to 37 years. In 2008, more than 14.1 million children in sub-Saharan Africa were estimated to have lost one or both parents to AIDS (UNAIDS, 2009; WHO, 2009).

### **2.3 Local Perspective**

It is estimated that 920,000 people in Zambia are infected with HIV out of a total population of approximately 12.3 million (UNAIDS, 2009). Sixteen percent of Zambian adults are HIV+ (women - 18%, men - 13%) (UNAIDS, 2009) and in urban areas, two in five women aged 25-39 are infected (UNAIDS, 2009). In addition to those infected, many others feel the impact and usually, family members are either infected or affected by HIV and AIDS (UNAIDS 2009). The number of people

dying as a result of AIDS in Zambia is estimated at 89,000 per year, leaving behind a growing number of AIDS orphans, currently estimated at 801,000 (UNAIDS, 2009). Nevertheless, new cases appear to be declining as high-risk sexual behaviours become less common (UNAIDS, 2009). Despite declining incidence, mortality is likely to continue climbing for at least a few more years (WHO, 2009; WHO, 2003).

Knowledge of HIV/AIDS is fairly high in Zambia (WHO 2003, UNCEF, 2008). The Demographic Health Surveys (DHS) conducted in Zambia in 1996 and 2002 reported that the proportion of men and women having ever heard of AIDS remained at 99% (WHO 2003, UNCEF, 2008). By 2002, the survey showed that 77.9% of women and 85.5% of men knew of two or more ways of avoiding HIV/AIDS (WHO 2003, UNCEF, 2008). Recognizing the undeniable link between human rights and public health in the context of HIV/AIDS the Zambian government has developed policies as a tool for promoting a non-discriminatory environment in which the success of HIV prevention, care and support strategies can be optimized by declaring compulsory tests for HIV tests on every out patient.

However, little attention has seemingly been paid in policies and programmes to address the generational effects of the epidemics holistically. Much clamour is heard though about the increasing numbers of so-called AIDS orphans, both realized and expected numbers, and a growing need is frequently mooted for the establishment of more orphanages. Although the role and contribution of grandparents, particularly grandmothers, as caregivers are acknowledged, it is doubtful that if any policies provide specifically for affected or infected grandchildren and indeed adult children with AIDS or dying as a result of AIDS. Then, if such policies do exist, questions pertain to how effectively they are being implemented in practice. Besides, though in terms of medical care, government has introduced a free medical scheme for the people aged 65 and above, this only covers consultations and other medical requirements such as x-rays, treatments, drugs among others have to be borne by the old people themselves. Consequently access to proper medical care, which is important for the wellbeing of the aged, is not fully accessed in Zambia particularly among those who are poor living below poverty datum line and have no support from the immediate relatives.

One of the commonest problems faced by elderly people especially in rural areas is social stigma arising from being suspected of practicing witchcraft. Not only have they faced this stigma, but also some have been killed because they are the suspects for unexplained deaths in rural communities. Zambia's elderly caregivers are faced with double jeopardy: they are shunned by communities as witchcraft practitioners and they have little understanding the pandemic HIV/AIDS. Interestingly,

social workers and police have already sounded the alarm over increasing violence against the elderly. Older women and men are often branded as wizards and witches blamed for the deaths of young people, poverty and other misfortunes. Surprising enough even though such violations are going on in society against the aged, there seems to be no programmes that are aimed at educating the rural communities on the importance of respecting the rights of the elderly in the communities. Left out of the HIV/AIDS statistics and programmes: Currently there seems to be no available HIV/AIDS statistics and programmes for the elderly people aged 65 years and above. The available statistics and programmes target the populations aged between 15 and 49 years of age. This implies that at the policy making level in the health sector, the elderly people are assumed not to be sexually active.

In Zambia today there are many programmes that deal with the youth and workers who are assumed to be sexually active but there are no programmes to deal with the elderly people. The aged are only statistics when it comes to their role in taking care of the AIDS orphans. The VCT programmes are oriented and administered by the youths most of the times if not all the time. The elderly are not given priority on Voluntary Counseling and Testing (VCT): The VCT programmes are very common and usually target the young population who are in schools, colleges, and universities and other popular places. The VCT services are rarely available to the aged or elderly population who are perceived to be sexually inactive both in rural and urban areas. IRIN news reported that the Senior Citizens Organisation is calling on government to introduce more elderly friendly VCT services which are generally youth friendly and are administered by the young people in the majority of cases (IRIN news 2007). There are no open discriminatory practices against the elderly population when it comes to provision of services, which are usually found in clinics, health centres, and hospitals. The argument is that these services are not culturally sensitive to people of different age groups. While the youth find it easy to seek VCT services from fellow youth running VCT programmes, elderly people do not find it easy to divulge information about their private lives to young people. There are generally very few elderly people involved in the running of VCT services in different communities. The administration of VCT services is predominantly in the hands of the youth and this makes it difficult for the elderly people to access VCT services. If the elderly were a priority in the provision of VCT services, efforts would have been made to involve a good number of elderly people in the provision of these services to their peers.

Furthermore, the Global Age Watch for 2015 ranks Zambia as number 90 out of 96 countries where the welfare of the aged was assessed. The report states that Zambia ranks low in the Index, at 90 overall. It

ranks highest in the capability domain (67). This fall from last year's ranking (57) is due to a change of indicator from labour force participation rate to employment rate. The country also ranks low in the enabling environment domain (84) due to older people's low satisfaction with safety (34%). It ranks at 89 in the income security domain, with low pension coverage (7.7%), the highest old age poverty rate in the region (22.9%) and the lowest rate of relative welfare (78%) among older people in its region. Zambia ranks lowest in the health domain (91), with values below the regional averages on all indicators (Global Age Watch 2015).

Isolation to information: There is no policy in Zambia that aims at improving the welfare of the elderly people in terms of information sharing and other educative programmes for the aged about their health and care-giving thus older people know very little about HIV/AIDS and other diseases particularly if they are illiterate. This is due to the fact that programmes on health are rarely targeted on this population too. As argued above, any focus on the elderly populations is usually confined to their cultural responsibilities as care givers for the infected AIDS orphans. The needs of the aged and their susceptibility to the pandemic are either disregarded in HIV programming or not given priority regardless of the fact that the elderly make 75 of the world's HIV infections (IRIN/Plus news 2007). Given the above situation, there is need to have more information about the elderly in Zambia on several issues which among many include their knowledge of HIV and AIDS, their economic status and its implications on their health, their life styles and how this affects their well-being, among others.

Lack of family support and the burden of orphans: Nowadays family bonds have broken loose to the extent that most families have left the burden of taking care of the orphans and other needy members to the elderly people. For many years even today, the elderly people have been relying on their children as a form of social security in future and society equally teaches children to look after their parents in old age. As urbanization and other economic and social changes are taking place in society, the family ties are weakening leaving some sections of the family particularly the aged without support. The impact of HIV/AIDS and individualism has reversed this trend as more old people are in charge of supporting the young children especially the AIDS people living positively in society. Seniors World Chronicle reports that more Zambians especially in rural areas are breaking with tradition and abandoning or neglecting their elderly parents to the help of well-wishers and government with its meager resources. Others have succumbed to the HIV and AIDS pandemic leaving young children to the care of their grandparents. Most of the elderly people are poor and cannot manage to support their grandchildren in terms of school, decent shelter, clothing and medical care. Lack of social support and the burden of

looking after people living positively with HIV/AIDS and orphans are the current realities of old age in Zambia particularly among the poor elderly people. The Zambia Human development report pointed out that the elderly are themselves over burdened by the incidence of orphaned children due to HIV/AIDS, reducing their own source of livelihoods (UNDP, 2003). On the same scenario, the United Nations Development Programme in 2007 observed the devastating effects of HIV and AIDS on the family social support systems and reported that even as family units are being destroyed, the social security system continues to be extremely weak. Community social structures and support systems, which existed to support households during illnesses and bereavements, are breaking down as they fail to cope with the numbers of sick people and deaths. In grandparent-headed households, many children drop out of school. The nutrition of children is affected; children have poor access to health services and are usually very poor. Grandparents may be too old to walk long distances to health institutions, work or produce for the family (UNDP 2007) HIV risk practices among the elderly: There are some serious risk practices among the elderly caregivers that make them vulnerable to HIV infections in communities but have not been given attention by the policy makers and anti-AIDS activists. There are traditional birth attendants in rural areas that do not have any information on how HIV is transmitted and on how to prevent contracting the virus. Yet these women who are usually elderly are exposed to blood during their work that may be infected with the virus. Secondly elderly people in communities usually prefer to seek or consult traditional healers for the ailments, which they usually have and if they have their HIV infected children this means that they delay their treatment so much that by the time they are diagnosed, the bodies are weak, and cannot take strong ARVs nor fight opportunistic infections.

Moreover, elderly caregivers in Zambia are also exposed to high levels of stress due to a number of factors. For instance, Zambia's sharp economic decline has seriously eroded the country's traditional support system for the old people (Noyoo 2008). The continuing economic decline in the country has exacerbated the lives of the aged people some of whom have completely no sources of income for food, health care, and decent accommodation among others. Poverty levels are high among the aged despite the fact that some of them worked before but their resources have been depleted over years because of lack of a social security system that would have invested their earned resources during working years (for those who are retirees). Sickness is very common among a lot of the aged with serious complication that may require expert health care but resources to access quality health care are not available).

The elderly people in most situations are left alone to battle it out for themselves and are denied a chance of living with their grand sons or daughters since there are no quality schools in villages hence loneliness among the elderly people whether women or men is a common phenomenon. This results from weak social ties with family members or lack of children to act as a social security and support mechanism in old age. There are some families who perceive the elderly as an extra burden and usually leave them on their own if they live with family members or assign some poor lowly educated family member to live with them in rural areas and infrequently visit them. This is the case where the elderly person does not have financial and material resources. On Loneliness, Mapoma (2013) reported that there are some cases where old people do not have anybody to look after them and the lonely elderly people are in most cases very poor and have very weak social ties with their relatives. UNDP stressed that the weak social security system in Zambia exacerbates the situation of the elderly (UNDP 2003). This scenario compounds the situation of loneliness among the elderly people in different communities. As indicated earlier, the poor old men and women who have information about hospices resort to find their way to hospices or old age home

Many studies have been undertaken in Zambia that included participatory HIV/AIDS prevention services, whereby the elderly have been able to express their own challenges of poverty and how it could be addressed. One of the biggest obstacles is that of human resources. There is a shortage of trained staff in some of the departments and units of the health delivery system. The capacity of existing trained staff is limited by the available numbers. HIV/AIDS has increased workload exposing the health sector to systemic weaknesses. One solution is to accelerate community mobilization, which is a key element of the investment framework and has been recognized as a cornerstone of HIV/AIDS programmes. However, the Zambian national response, interventions that attempt to address structural factors have been weak. For example there are limited sustainable livelihood strategies targeting vulnerable groups such as the elderly people and young people. Enabling environments for vulnerable groups who are found HIV positive to access continuum of care services are not conducive.

The Legal and Policy environment has not been conducive for implementing HIV prevention programmes for some vulnerable and key populations in rural Zambia. It is hoped that more evidence will be available in subsequent reporting periods to enhance programming and reporting as two major studies on key populations are in progress. No study has been undertaken to determine the root causes of selective attention on elderly caregivers in rural areas of Zambia a focus study of Chimbele Village in Kasama District.

## **CHAPTER THREE: METHODOLOGY**

### **3.0 Introduction**

This chapter dealt with research design, data collection, and population of study, choice of sample, data analysis and sampling procedure. Both quantitative and qualitative research approaches were used for this study because: Questionnaires were used to collect quantitative data while in-depth interviews were used to collect qualitative data. The shared application of both qualitative and quantitative research perspectives, within a single study provided a richer and deeper understanding of the area under investigation than would otherwise be possible and increases validity (Corner, 1991).

This kind of research emphasizes on objectivity and systematic procedures to measure human behaviour by using formal primary data collection such as structured instruments, interviewed schedule and questionnaires. Secondary data collection was used like scientific journals, statistics and articles when collected data from respondents. Qualitative indeed make participant's to express themselves freely and the researcher draws closer to them. In this study thus an attempt was made to obtain information from old people aged 60 and above living below poverty datum line, old people under National Pension Scheme Authority and those under Social Cash Transfer in Chimbele village.

The researcher used structured interview to gathering more information about the phenomenon studied and to obtain relevant information and to describe and identify factors that have contributed to poor health conditions for elderly care givers involved in caring for people living positively with HIV/AIDS in rural areas.

### **3.1 RESEARCH DESIGN**

The study used longitudinal descriptive qualitative research design. Data collection involved in-depth interviews with men and women elderly caregivers (n=30), medical practitioners and community health caregivers (15), 5 children and direct observations of the environment where care was taking place and of a local Rural Hospital to explore primary care and support for this particular type of clientele (patient) population. Data collection took place within Lualuo Police Camp Health Care Clinic catchment area. Thematic data analysis was carried out to represent the experiences of caregivers and detailed narrative analysis of one caregiver was also carried out to better understand how women constructed their stories in their own particular cultural context.

In view of this, the study was focused on households in Chimbele village of Northern Province in Zambia Kasama District. The survey was designed to investigate the challenges of elderly caregivers in Chimbele village face in maintaining their health and care giving to people living positively with HIV/AIDS in homes to bring out possible interventions by government and other non-government organizations.

### **3.2 TARGET POPULATION**

Basha and Harter (1980 cited in Djan, 2013) “a population is any set of persons or objects that possesses at least one common characteristic.” The term population“ should not be taken in its normal sense when sampling rather it represents the full set of cases from which the sample is chosen (Saunders et al., 2012). Thus, the population from which sample for the study will be chosen is randomly selected 50 households and members of the general public in Chimbele Village in Kasama district.

### **3.3 SAMPLE SIZE**

The sample for this study was drawn from the 50 randomly selected households in the area and members of the general public in Chimbele Village. From the above population, fifty (50) participants were targeted and reached that is the headman, old women, old men, health practitioners and affected children.

### **3.4 SAMPLING TECHNIQUES**

The researcher used purposive sampling procedure for choosing the participants from affected households in Chimbele Village. That is the headman, fifteen (14) old women, fifteen (15) old men, fifteen (15) health practitioners and community health workers and five (5) of the affected children. These people were randomly selected and interviewed.

### **3.5 INSTRUMENTS OF DATA COLLECTION**

The study employed two methods of collecting data and those were primary and secondary because these were sources of all the types of data information. A Patoo (1971) state that primary data collection involves collecting of data through field work and this is the first hand information from respondents. In this method, the researcher employed administered questionnaires, interviewed schedules and focus discussion. In secondary, data was collected by the use of a variety of published information such as text books, statistics and articles.

### **3.6 DATA ANALYSIS TECHNIQUES**

Personally managed questionnaire and structured interviews were used to collect the data in order to decrease misinformation biases. The respondents were informed of the purpose of the research. The data from the questionnaires were cleaned, coded, collated using SPSS.

The interviews and structured questionnaires were preferred for various reasons; one of them is that data collection was simple because respondents were able to express themselves freely and interviews also involve social interaction. Furthermore, focus group was intended for deeper and broader insight from participants. In this regard, if other methods were used, for example unstructured interviews, there could have been problems of giving concrete answers as most of the respondents were illiterate and it could have led to collect information which was not complete. This means that interviewer bias is unavoidable. To some extent the interviewer will affect the responses of the interviewee. Allah (1981) claims that the greater the status difference between the interviewer and the respondents; the less likely respondents are to express their true feelings.

### **3.7 Headman interview**

The researcher decided to interview the Headman because of the task he has to manage people's affairs in the village and being preview to most of the challenges of his subjects that includes the men and women, children, the community health workers and health practitioners including resources. The headman safe guards tradition practices and guides the subjects live an authentic life detached from different kinds of vices that will endanger their life style and cultural values. He exercises his authority to control his people so as not to be blamed for not doing much to prevent social ills such as stigma and isolation in families the headman was interviewed as shown by appendix A.

### **3.8 Elderly Men and Women interview**

The elderly people are the ones who spend most of the time planning on how to sustain the homes where the people living positively are living. They take care of their own health and the health of the people living positively by providing the basic needs the living. They look up to the government and the civil society for lasting solution to lighten the burden of not only material and financial support but cure to free the infected in order to live again as responsible citizens. Appendix **B** has more information.

### **3.9 Children's interview**

Children especially orphans were interviewed because they are the victims of the effects pandemic. The researcher wanted to find out what experience they have of losing parental care and support. This is the reason why they were included in the research as appendix **C** is showing below.

### **3.10 Health practitioners and community health worker's interview**

Health practitioners were interviewed because they are responsible for the health of their clientele. They have the task to train the elderly care givers and the people living positively on pre-cautionary measures of how to maintain good hygiene and good health. They were involved in order to find out from them the reasons why elderly care givers have been left out in HIV/AIDS educative programmes. The researcher further wanted to inquire from the practitioners what steps to take as a general public to facilitate for a prompt response to interventions that will lessen the burden of poor health care services to elderly people and the sick at household level as shown in appendix **D** below.

### **3.11 Data analysis**

The researcher analyzed data in three stages. Firstly, it was transcribed from interviews and questionnaires manually. Secondly, data were put into emerging themes and subthemes in order to create categories that come first. Thirdly, the researcher compared data with literature available. By so doing, a centre idea emerged and the data were put into more specific subthemes. Vessewel (1998:7) 'terms this process axial coding'. In addition, the researcher analyzed data using the bar graph pie chart and table to present the findings from the research.

## CHAPTER 4

### PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

#### 4.0 Introduction

Application of the conceptual framework to the empirical data set generated a number of specific hypotheses on risk and protective factors with respect to economic, educational, health, nutritional outcomes. The study revealed that some of the risk factors for AIDS-affected families and their children were different from what had been anticipated in the theoretical framework. Data gathered from the respondents revealed that, there are a number of factors that have acted to the disadvantage of good health care delivery, according to the objectives set by the researcher, the following are some of the findings of the study and are categorized as follows: Headman, elderly men, elderly women, children and health practitioners.

#### 4.1 Headman's response

The headman expressed anxiety over the alarming rates of the poverty that elderly caregivers experience resulting from being over loaded with different responsibilities. Sadly enough most of the productive generation in Chimbele village have taken to heavy beer drinking causing additional distress on elderly people taking care of the people living positively with HIV and AIDS. The headman of Chimbele village sited lack of employment as one of the problems resulting to beer drinking even though the main occupation of the youth and the general public is farming, molding of bricks and formal employment in town. He attributed lack of material and financial support to declining family ties and lack of formidable policies by government and civil society to support the health and care giving to affected homes.

Moreover, these families have experienced a sharp drop in income, and in most cases have been forced to move out of their original home in towns. A few families had been protected against the most extreme forms of economic hardship by one or more of the following factors:

- The family owned their home and rented out part of it to earn some supplementary income
- No “property grabbing” by relatives had occurred.
- The mother was educated and employed in the formal sector before.
- The orphans were taken in by wealthier relations.

## 4.2 Elderly men and women's response

Elderly people, who were interviewed, attributed the problem of poor health and care-giving of Chimbele village to a number of factors:

- Distance from health institutions.
- Lack of educative health programmes for the elderly people.
- Discriminatory voluntary counselling and testing facilities run by the youth.
- Politicized government and civil society programmes.
- Lack of education.

The elder people pointed out lack of education as a big problem with causes any progressive programme to be mistaken for political mileage. The elder people in Chimbele have missed out on a number of social programmes because of mistaking the for political campaigns leaving the needy out of programmes such as Social Cash Transfer (SCT) Education is key to a number of social economic factors because it enhances development and better health living. They said socio-economic status of the health and caregiving in a family was a significant protective factor: the frequency of dropping out of school following parental death was much lower for orphans in economically better-off families than for orphans in poorer households.

The educational outcomes for orphans in the Chimbele village was affected by age of the orphans not by socio-economic status, or gender; where some of the caregivers expressed willingness to withdraw older children from school upon parental death to help take care of their younger siblings and to work in the fields (plowing, weeding, harvesting, etc.). A similar scenario was reported in studies conducted in Thailand cited in the World Bank (1997) report, where the authors found that about 13% of older school age children in families where someone was ill and dying of AIDS were withdrawn from school to help support the family.

The elderly people complained of distance to health institutions which make a number of elderly people resort to self-administered medication most of the time for inadequate energy to reach the health institutions. It becomes even worse to take the people living positively in homes to hospitals just relying on the care and support from elderly care givers. They felt left out in most of the educative

programmes of HIV/AIDS on prevention and most of the techniques of how to handle patients of different health standards.

Moreover, they recommended that they need counselling programmes which into consideration their plight by training their peers to handle specific places for them instead of the youth who are in most cases inexperienced.

### **4.3 Children's response**

When some of the children were interviewed, one of the girls responded the parents force them either out of school or into early marriages in order to free themselves from the burden of taking care of their needs and school fees. The children expressed their displeasure not only of dropping out of school but also being used as house maids for very little money to earn their living. This affects the socioeconomic growth of the Chimbele village whose skills remain trapped in domestic works. The impact of HIV/AIDS on the health status of infected adults and children and the resulting reduced life expectancy due to AIDS related deaths is the most obvious health outcome and has received the most attention worldwide since the epidemic broke out in the early 80s.

The interviewed children were worried about their future after seeing many of the friends and parents die from HIV/AIDS. Measuring and predicting the impact of AIDS on the health status of uninfected but AIDS affected family members is much more difficult, not only because of lack of quality data on this category of families and their children, but also because the relative severity of the effect of AIDS on health depends on many other factors, including the success of the health care system in addressing health problems affecting the whole population especially children, such as malnutrition, diarrhea and infectious diseases such as measles, whooping cough, and malaria.

The children said that in most cases food was not so much of the problem in their homes as the live as one family in the village and are able to share meals with other families to survive. Besides, data regarding the health status of children during the past two weeks prior to the interview indicate that Chimbele village, as predicted, availability of at least sufficient wealth to guarantee basic nutrition is protective. However, the age of the orphans had an effect on their health status, whereas, socioeconomic status of the caregiving family did not have any effect. Data collected on the other health indicators, such as the number of times the children were taken to the hospital, number of times

they were hospitalized, and number of times they saw a doctor yielded no statistically significant correlations. The conclusion was that reports on these variables may reflect more the health seeking behavior of the caregivers than the true health status of the children. The various risk and protective factors identified in this study are relevant to the design of policies and services to mitigate the impact of AIDS on the various outcomes reviewed above for AIDS-affected families and their children.

#### **4.4 Community health worker's response**

The Community health workers that were interviewed concerning the challenge of health and care-giving by elderly people keeping those living positively with HIV/AIDS in homes responded that meager resources to support the little effort made by elderly people to run their homes make it difficult to have much of a balanced diet. In some situations the people living positively become selective with the food they eat and mostly need good food not vegetables hence this is a burden to the elderly care givers. The community health workers said that with the coming up of medicines to boost the immune system families have great relief on patients with good compliance. The challenge remains with the patients who always want to play sick and hide games and remain stubborn to start taking medication or worse still become defaulters.

They said that a number of infected people in the affected families seek traditional help to respond to treatment and most of the times take long to be on medicine. This behavior has seen many to the grave before the right time for departure. Both the patients and elderly care-givers suffer from stigma and isolation because the village mates shun them and pass a lot of comments that discourages the sick person to be open to members of the public and community health workers. The community health workers expressed dissatisfaction in the services they give to the community as voluntary workers who not only need food on the table but also basic needs to run their homes hence mostly abandon their work.

The community health workers said that that government and civic social organizations should come up with policies that have a holistic approach to take care of all key players in care-giving and support for affected households. They regretted the lack of deliberate government policies to take care of the elderly people regardless of previous status in the community to serve the elderly people. They commented on the social cash transfer to be too general to be effective in terms of health care and support.

Furthermore, they appealed to the sexually active groups to practice safe sex or totally abstain. The methods of sexuality education in Africa have substantially weakened in the sense because urbanization and death of adults because of HIV/AIDS. This has really resulted in void of information about reproduction and the relations with the opposite sex. This has not been replaced by formal education or by systematic instruction from reliable adults such as parents, elder's teachers and others. It has been believed that peers have filled this void as the most relevant source of knowledge and influences on sexuality (Bloom, 2001). Unfortunately, peer knowledge has believed to be misguided and inaccurate.

In addition, community health workers have blames on the alcohol consumption policy in the country which lacks discipline and control. The productive age that should be aggressive in taking care of the living positively with HIV/AIDS in homes have become useless forcing the elderly care-givers to have an extra burden. They feel that the government should put stiff laws to regulate the abuse and make especially Chimbele village sober again.

#### **4.5 Health practitioner's response**

The health practitioner's expressed relief in the type of cases being handled now than before because to the use of Antiretroviral medicines in combating the HIV/AIDS. However, they were worried about the health of the elderly care givers who out of hard work overload themselves of stress. The common hypertension in the elderly is mostly out of the pressure of taking care of the dependents and people living with HIV in homes. To lessen this burden the government must come up with a social scheme that targets the elderly people in health management and socioeconomic development by making them self-supportive.

#### **4.6 Presentation of Findings**

Data presentation is a method of summarizing, organizing and communicating information using a variety of tools like diagrams distribution charts, histograms and tables

From the research I undertook, 25 participants talked much on lack of knowledge and poor health care programmes, 2 of them said that broken homes have caused the problems in health care delivery services, 13 respondents mentioned stigma and 10 of them talked about inadequate support. The results were calculated in percentages and then presented in a pie chart, for instance

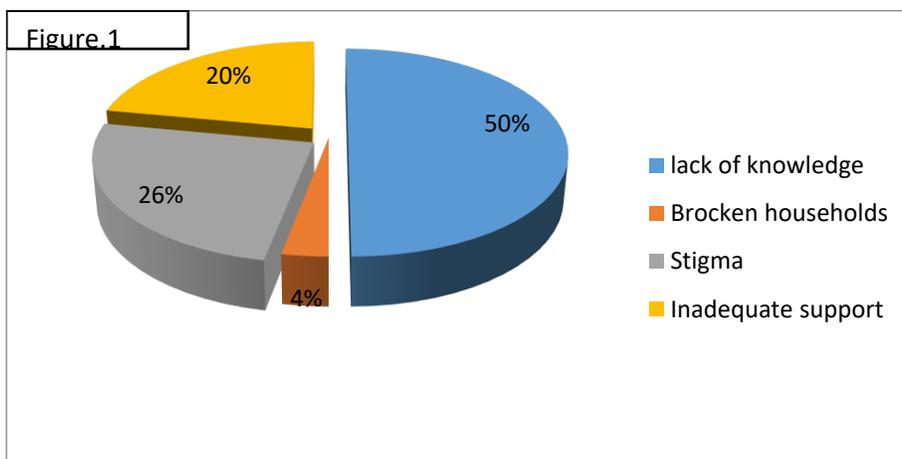
1.  $\frac{25}{50} \times 100 = 50\%$  Lack of education and knowledge

2.  $\frac{10}{50} \times 100 = 20\%$  Inadequate support

3.  $\frac{13}{50} \times 100 = 26\%$  Stigma

4.  $\frac{2}{50} \times 100 = 4\%$  Broken homes

**A Pie chart showing the responses form 50 respondents in Chimbele village.**



**Source: Field work in villages.**

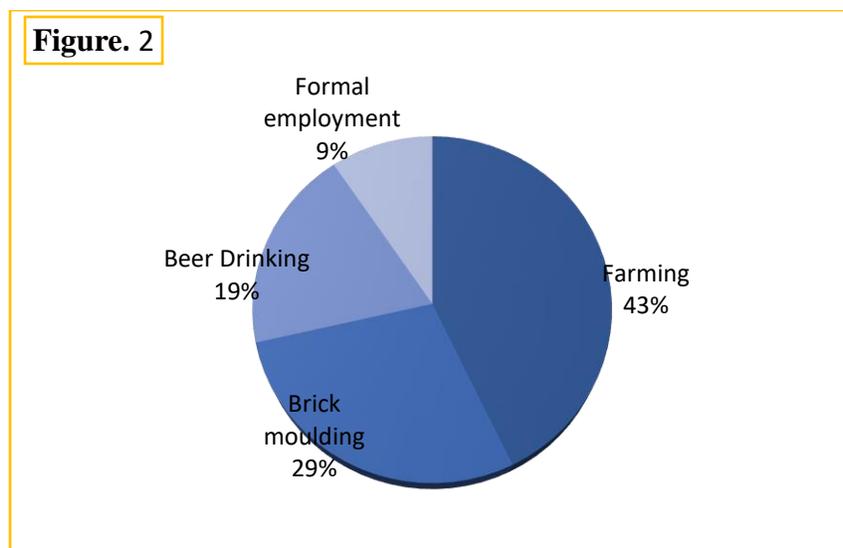
The pie chart above indicates various levels of experience of life in affect households in Chimbele village. It is clearly shown that a lot of elderly people have no knowledge of the effects of the pandemic because of scant information on the health and care-giving to people living positively. Worth noting is the vastness of the problem looking at the 50% percentage of respondents who expressed ignorance on the topic. Uninformed community is difficult to develop due to the battle involved in making the community understand the development being implemented in their midst. Mostly much of the developmental issued are mistakenly taken for political mileage and cadres take over as implementers. The elderly always leave the powers to the implementers to work using their discretion hence it is difficult to know the difference between government and civil society organization projects even after thorough explanation. Most of the respondents talked to think that any help that comes to them from the government is a favour rendered to them and not an entitlement.

Moreover, some elderly people were still in a state shock on what behavior exhibited by some family members after the demise of the bread winner. Twenty two percent (4%) of Families fail to re-unity because of the treatment received by those entrusted with the care of orphans, the remaining spouses or family members to the deceased. Households disintegrate never to have anything in common but are united only through the blood they share.

Besides, 26% respondents cited stigma as a slow but sure way of promotion of poor care giving and health of elderly care givers. The elderly people once there is suspicion fail to be at peace for they are accused of being witches and wizards to the extent of destabilizing the unity and love of the family members and the neighborhood. Now days even having children that are well to do is a big issue in some communities because riches are highly associated with black magic.

Furthermore, 20% respondents felt that poor health and care giving is exacerbated by lack of support to elderly people by close relations. Some elderly people are left by themselves to fend and take care of their own affairs. Sometimes it happens like that even when one has wealth children worse if the children all struggle to make ends meet. In this case people look up to the government to rescue the situation but due to lack of formidable policies that support the elderly peoples' health and wellbeing of the people living positively. The experience of Social Cash Transfer has been too general to be specific to issues that affect families.

**Pie chart showing types of occupation of people in Chimbele village**



Above is a pie chart showing the types of occupation of people in Chimbele Village. As shown in the diagram, 43% of people that is men and women depend on farming, 29% both women and men do business, 19% are involved in beer drinking and finally 9 % are employed formally.

Source: field work in forty five households in Chimbele village. The pie chart above comprises of four occupation categories of, farming, beer drinking, brick making and formal employment. The percentages presented in the pie chart therefore, were the responses from them on the causes of poor health and care-giving in affected homes.

Data of ages of 35 elderly care-givers who take care of people living positively with HIV/AIDS in homes conducted in Chimbele village.

60, 60, 65, 66, 67, 64, 69, 64, 66, 66.

65, 69, 65, 64, 70, 65, 67, 65, 64, 67.

70, 70, 72, 75, 72, 71, 69, 70, 64, 71.

71, 75, 66, 65, 72

#### 4.7 Simple Frequency table showing ages of interviewed elderly caregivers

AGE	FREQUENCY
60	2
64	5
65	6
66	4
67	3
69	3
70	4
71	3
72	3
75	2

The age that occurs most frequently is 6 therefore, the age of 65 has the highest frequency of 6 this means that the age which is mostly affected by poor health care is 65 and then followed by 64 which has 5. It was reviewed that, the elderly people at the age of 65 have little knowledge on the consequences of having HIV/AIDS at a tender age.

#### **4.8 Discussion of Findings**

The 2015 LCMS observations on the health status of all persons in Zambia; the health status of a household member directly affects the welfare of the household. From the findings of the study, several factors are strongly associated with and contribute to the increased risk of poor health for the elderly and care giving to people living with HIV/AIDS in households. These factors include: lack of knowledge about HIV/AIDS treatment and support, lack of resources, family break ups, stigma and isolation. The observed decline in the numbers of the elderly people in the country suggests that there is a problem that has been going on but not fully either addressed or known by the policy makers or it is an indication that the elderly are not a visible category in the decision making bodies in the country.

Poverty levels revealed that households with old people in Chimbele village are among the poorest in the country. Poverty has its own offshoots such as diseases that could be the leading to the deaths of the people aged 65 years and above. In Lusaka, Moser and Holland found out that the poorest are the very young, sick, disabled and the elderly (Moser and Holland 1992). Besides, most elderly people quality health care becomes a problem because they have no Capacity to afford good services. What compounds the elderly particularly the poor is that they are out of pension and the government has no scheme to support the old people in the country. The absence of a socioeconomic scheme for the aged people makes them vulnerable to poverty and diseases after retirement. Moreover, there is no policy that supports the poor whether they have worked before or not. And the government pension is specifically for the people who earlier on worked for the formal sector the recent introduced social cash transfer is too general to attend to the plight of senior citizens.

Consequently the aged are left out of the development programmes and policies. Even though in terms of medical care, government has introduced a free medical scheme for the people aged 65 and above, this only covers consultations and other medical requirements such as x-rays, treatments, drugs among others have to be borne by the old people themselves. Consequently access to proper medical care,

which is important for the wellbeing of the aged, is not fully accessed in Zambia particularly among those who are poor and have no support from the immediate relatives.

The researcher observed that the elderly were by themselves Isolated from the communities due to stigma which is the commonest problem in rural areas. Suspicion of elderly people to be practicing witchcraft has left most communities divided. In Chimbele village the elderly are scared of the unknown out of stigma they faced day by day and of killings experienced in other communities of suspected elderly people. For instance, the Karavinas in Northwestern and Western provinces have been killing a lot of old people who they suspect to practice witchcraft.

The collected data show that there is scant information of the HIV/AIDS statistics and programmes for the health of elderly people and care-giving. This implies that at the policy making level in the health sector, the elderly people are assumed not to be sexually active and only statistics when it comes to their role in taking care of the AIDS orphans. On the contrary, the elderly especially the men are sexually active and some have continued to marry young women and even abuse or defile young girls in their quest to look for an AIDS cure (belief in the virgin cure). This finding calls for policy interventions to save the older generation from the pandemic.

Traditionally families have been thriving on the care and support from immediate relatives as a form social security; society equally teaches children to look after their parents in old age however, as urbanization and other economic and social changes are taking place in society, the family ties are weakening leaving some sections of the family particularly the aged without support. The impact of HIV/AIDS has reversed this trend as more old people are in charge of supporting the young children especially the AIDS orphans in the community. Seniors World Chronicle reports that more Zambians are breaking with tradition and putting their elderly parents in nursing homes. Others have succumbed to the HIV and AIDS pandemic leaving young children to the care of their grandparents. On the same scenario, the United Nations Development Programme in 2007 observed the devastating effects of HIV and AIDS on the family social support systems and reported that even as family units are being destroyed, the social security system continues to be extremely weak. Community social structures and support systems, which existed to support households during illnesses and bereavements, are breaking down as they fail to cope with the numbers of sick people and deaths. In grandparent-headed households, many children drop out of school. The nutrition of children is affected; children have poor access to health services and are usually very poor. Grandparents may be too old to walk long distances to health institutions, work or produce for the family (UNDP 2007). Most of the elderly are poor and

cannot manage to support their grandchildren in terms of school, decent shelter, clothing and medical care. Lack of social support and the burden of looking after orphans are the current realities of old age in Zambia particularly among the poor elderly people. The Zambia Human development report pointed out that the elderly are themselves over burdened by the incidence of orphaned children due to HIV /AIDS, reducing their own source of livelihoods (UNDP, 2003).

There are some serious risk practices among the elderly as observed by the researcher that make them vulnerable to HIV infections in communities but have not been given attention by the policy makers and anti-AIDS activists. There are traditional birth attendants in rural areas that do not have any information on how HIV is transmitted and on how to prevent contracting the virus. Yet these women who are usually elderly are exposed to blood during their work that may be infected with the virus. Secondly elderly people in communities usually prefer to seek or consult traditional healers for the ailments, which they usually have and if they have HIV infection this means that they delay their treatment so much that by the time they are diagnosed, the bodies are weak, and cannot take strong ARVs nor fight opportunistic infections.

Sickness is very common among a lot of the aged with serious complication that may require expert health care but resources to access quality health care are not available. Besides, loneliness torments most of the elderly people whether women or men to the extent that they feel the impact of weak social ties with family members or lack of children to act as a social security and support mechanism in old age. On Loneliness, Mapoma (2013) reported that there are some cases where old people do not have anybody to look after them and the lonely elderly people are in most cases very poor and have very weak social ties with their relatives. UNDP stressed that the weak social security system in Zambia exacerbates the situation of the elderly (UNDP 2003). This scenario compounds the situation of loneliness among the elderly people in different communities. As indicated earlier, the poor old men and women who have information about hospices resort to find their way to hospices or old people's homes to be cared for. Research recommended that although the family or community was the ideal caring system for the aged, there were those who could not trace families due to urbanization. There were attempts at the level of government to retain services for the old for old people who did not have families to look after them. It is because of this and other situations that the researcher still feels the need for further studies and through investigations in rural areas in different parts of the country, as well as community to guide the delivery of health and care-giving services.

## CHAPTER 5

### CONCLUSION AND RECOMMENDATION

#### 5.0 Conclusion

Household level studies on the health of elderly people and care giving of people living positively with HIV/AIDS are very limited not only in Zambia but in most parts of sub-Saharan Africa. Further research is needed to verify whether the impact of AIDS is differentiated depending on whether the families are rural or urban based. Moreover, rural populations vary greatly in their ecological, economic, social and service access characteristics even within Zambia. Hence, the need for further studies that investigate the situation in rural areas in different parts of the country, as well as community needs assessment studies to guide the delivery of services.

This study revealed the health condition of the aged who are also involved in care-giving with people living positively with HIV/AIDS. Low and poor access to medical care services compounds the poor health conditions of the aged. It has unearthed challenges such people face from absence or inadequate government and other organization's support. Stigma against the aged especially those involved in care-giving for people living positively with HIV/AIDS erode enough family support for the aged.

#### 5.1 Recommendations.

The following are the recommendations to improve on the health conditions for the elderly involved in care-giving to people living positively with HIV/AIDS in homes:

1. Government should introduce economic empowerment policies and programmes for the aged 65 and above
2. More efforts are put in place to reduce on elderly poor health conditions.
3. Improved health medical care services for the elderly should be introduced.
4. The aged involved in care-giving to people living positively with HIV/AIDS should be included in HIV/AIDS management awareness programmes.

## APPENDIX A

### INTERVIEW GUIDE FOR THE HEADMAN

1. What is the name for your village?
2. How many HIV/AIDS orphans do you have in this village?
3. Do you have any people living positively with HIV/AIDS in your homesteads?  
Yes  No
4. If your answer is yes for question 3, who then are taking care of them?
5. What challenges do you face in taking care of the infected people and orphans?
6. What do you know about HIV/AIDS and care-giving?
7. Why do the infected and affected families shun the community?
8. How do you look at those living positively in your community?
9. Why do people living positively with HIV/AIDS face stigma?
10. What interventions are put forward by government and NGOs in your community?



APPENDIX C

INTERVIEW GUIDE FOR CHILDREN

1. What is your name?

.....  
.....

2. How old are you?.....

3. Do you go to school?.....

4. Who pays for your school fees?.....

5. What do your parents do for their living?.....

6. How many friends do you have?.....

7. Do they all go to school? Yes  No

8. If No why?

9. What do you think about your friends who do not go to school?

10. What do you know about HIV/AIDS?

**APPENDIX D**

**QUESTIONNAIRE FOR NURSES AND CARE GIVERS**

1. What is the name of the clinic you work from .....

2. Which department are you saving from.....

3. For how long have you been a nurse/community health worker.....

4. Is it true that elderly care givers have a challenge of taking care of the sick in homes?

Yes

No

5. What do you think are the major causes of these challenges?

.....  
.....  
.....

6. How has the problem HIV/AIDS affected the homes of elderly people with people living positively

.....  
.....  
.....

7. Having identified the causes in questions 5, what can be the solution to these problems?

.....  
.....  
.....

8. From your experience, how is the adherence to living Positively on ARVs?

.....  
.....

## **REFERENCES**

- [1] Ainsworth, M., G. Koda, G. Lwihula, P. Mujinja, M. Over, I. Semali. (1990). Measuring the impact of Fatal Adult Illness in Sub-Saharan Africa: An annotated Household Questionnaire. Living Standards Measurement Study (LSMS), Working paper No. 90. Washington D.C.: World Bank.
- [2] Ainsworth, M., G. Koda, G. Lwihula, P. Mujinja, M. Over, I. Semali. (1990). The Economic Impact of Fatal Adult Illness from AIDS and other causes in Sub-Saharan Africa: A research proposal. Washington D.C.: World Bank.
- [3] Ainsworth, M. and M. Over. (1994b). The economic impact of AIDS: Shocks, Responses and Outcomes. Technical Paper No.1, Population, Health and Nutrition Division, Africa Technical Department: Washington D.C.: World Bank.
- [4] Armstrong, J., Eduard Bos. (1992). The Demographic, Economic, and Social Impact of AIDS. In J. Mann, D. J. M. Tarantola & T.W. Netter (Eds.), (1992). AIDS in the World: A Global Report. Cambridge: Harvard University Press.
- [5] Bailey, K. D. (1987). Methods of Social Research. New York: The Free Press, Division of Macmillan, Inc.
- [6] Bailey, M. (1992). Children and AIDS. In J. Mann, D. J. M. Tarantola and T. Netter (Eds.) AIDS in the World: A Global Report. Cambridge: Harvard University Press.
- [7] Barnett, T., (1994). The effects of HIV/AIDS on farming systems and rural livelihoods in Uganda, Tanzania and Zambia. FAO project TSS/1 RAF/92/TO/A.
- [8] Central Statistical Office (Zambia), Ministry of Health (Zambia), Macro International NC. (USA): Zambia Demographic and Health Survey 1996, Calverton, Maryland, USA, September 1997.
- [9] Central Statistics Office, Poverty Manual Zambia 2010, CSO Printers, Lusaka. 8.
- [10] Deaton, A. et al (2002): Guidelines for Constructing Consumption Aggregates for Welfare Analysis. Living Standards Measurement Study, Working Paper No. 135, Washington D.C. The World Bank. Volume 56, Harwood Press, Chur, Switzerland.
- [11] Deaton, A. et al (2002): Guidelines for Constructing Consumption Aggregates for International Labour Organization: International Standard Classification of Occupations (ISCO), Revised Edition, Geneva (ILO), Switzerland.
- [12] Kakwani, N. (2002): Measurements of Poverty, ADB. Washington press, Washington.
- [13] Kalton, G. (1987): Introduction to Survey Sampling, SAGE Publications Inc., Beverley Hills, USA.
- [14] Kish, L. (1965): Survey Sampling, John Wiley & Sons, New York, USA.
- [15] Ministry of Finance (Zambia), Economic Report (2015). Monitoring Survey Report (1996), Lusaka, Zambia.
- [16] Sixth National Development Plan (SNDP 2011 -2015)