Grandmothers caring for their grandchildren orphaned by HIV and AIDS

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ABSTRACT
This exploratory study investigated the psychosocial impact on rural grandmothers in four districts of Gutu, Zimbabwe, caring for their grandchildren orphaned by HIV and AIDS. The participants included 12 grandmother-caregivers, whose ages ranged from 56 to 76 years, with orphans in their care ranging from infants to 18 years. The study made use of Erikson’s psychosocial theory of development on late adulthood. Data was gathered using semi-structured, open-ended interviews and interpretive analysis was used to analyse the audio-taped data. The findings revealed that most grandmothers experience considerable difficulty in dealing with the late adult crisis of integrity versus despair, and also find it difficult to resolve the grief of losing their children while engaging in full time grand parenting in a stigmatising society. Participants reported a need for support and interventions tailored to their unique needs. The findings of the study recommend a need for counselling, social support, financial assistance and teaching skills and knowledge about HIV and AIDS.

Keywords: AIDS orphans; care giving; Erikson’s psychosocial theory of development; grandmother-caregivers; HIV and AIDS

In the past years Zimbabwe has been confronted by four major challenges—increasing poverty, a polarised political environment, serious droughts, and the HIV and AIDS epidemic (UNICEF, 2003). Since the first AIDS case in the country was reported in 1985, the pandemic has continued to spread at an alarming rate. As a result, an estimated 33.7% infection rate amongst adults and a 12% infection rate amongst children were recorded. Family patterns are the worst hit as AIDS is leaving behind
vulnerable age groups, specifically the very young and the very old. As a result, a generation of orphans is left behind as their parents are succumbing to the epidemic in the prime of their lives. According to UNICEF (2003, 2005), Zimbabwe has an orphan rate of 17.6%, with more than three quarters orphaned because of AIDS. Life expectancy is projected to decrease to 35 years or even lower by 2010 (UNAIDS, 2004, 2006). The large number of people dying in the productive age group that is attributable to AIDS has serious consequences on the social fabric of many societies. The extended family’s capacity to care for relatives is being weakened and grandparents, especially grandmothers, are faced with the burden of caring for their grandchildren, in spite of the physical challenges they are encountering as a result of their age.

CULTURAL BACKGROUND

In the past, in most African societies, the sense of duty and responsibility of extended families towards other members was almost without limits (Foster, 2000). This was the basis for the assertion that, ‘traditionally, there was no such thing as an orphan in Africa’ (Foster, 2000, p. 56). Even if the family did not have sufficient resources to care for existing members, orphans were taken in as a group that deserved special attention. Life in traditional societies was characterised by brotherhood, with a sense of belonging to a large family. People lived collectively, and could therefore accommodate orphans.

Foster (2000) argues that marriage was not so much the linking together of two individuals from two families; rather, when marriage was decided upon, the bride price was collectively paid in the form of cattle, which entailed that future children from the union would be the responsibility of the entire family. Among the Shona people of Zimbabwe, according to Bourdillon (1998), one practical outcome of the extended family system was that, should the father be away from home for some time or should he die, one of his brothers or even a paternal cousin could take his place with legal and economic responsibility for his children. The extended family cared for orphans, widows, old people, and even the disabled, and the burden of caring was therefore shared amongst a large group of close relatives.

GRANDPARENTING

According to Erikson (1982), old age should be expected to be a relaxed time and grandparenthood – according to Smolak (1993), age is evidence of the resilience and persistence of people. Their presence gives the family a sense of continuity, rootedness, and the means to survive adversity. Notably, in most African societies,
grand parenting has always been a common phenomenon, though often not on a full time basis. Smolak (1993) found that the actual decision that makes grandparents full time caregivers is out of their control. This is true of the present-day scenario of HIV and AIDS, where the capacity of families is weakened, leaving grandmothers with no option but to care for their orphaned grandchildren.

It is important to acknowledge that most grandparents enjoy the company of their grandchildren (Orb & Davey, 2005). However, there have been indications that grandparents have difficulties and concerns regarding raising their grandchildren, particularly those who take on the primary responsibility for these children. This supports Cook and Oltjenbruns’ (1989) findings that grandparents can view their role differently as they question why their lives are being spared when their offspring are dying young. Orb and Davey (1989) found that full-time grandmothers claim less life satisfaction than other grandmothers who take care of their grandchildren on a part-time basis. This resonates with Erikson’s assertion that old peoples’ lives may be in despair and much of their despair is in fact a continuing sense of stagnation, which prevents successful aging.

Grandmothers become mothers again

The role of a caregiver has traditionally been allocated to women due to deeply entrenched gender and socio-cultural practices. Winston (2006) supports the assertion that even in households where there are two grandparents the grandmother is usually the one to assume the role of a caregiver. Traditionally, grandmothers are the most appropriate caregivers for grandchildren, and are said to be experienced in raising children, and are believed to share in equal measure the parents’ interest and affection for children (Safman, 2004). They are perceived to have fewer obligations to compete with childrearing as they are at home and, consequently, available to provide care. However, Winston (2006) disputes this view and argues that the role of grand parenting is not always freely chosen, but rather adopted because of familial expectations and cultural norms. Winston’s (2006) study found that grandmothers often assumed the role of parenting under compulsion. These grandmothers take on these roles with the belief that families come first and should stay together at all costs.

The majority of grandmothers in Zimbabwe reside in rural areas, which has become home for most patients who are ill with HIV and AIDS. A study by Foster, Levine, and Williamson (2005) in Manicaland, Zimbabwe, found that rural areas experience an influx of ill patients when their situation deteriorates. This is an indication that the going-home-to-die phenomenon still continues in most communities. The same pattern was noted in South Africa where the two most
common scenarios were that an ill mother would return to her parents’ village together with her two children, but would die soon after, or a widower in an urban area would send his children to live with maternal relatives in rural areas (Foster et al., 2005).

Another contributing factor to the influx by ailing patients to rural areas, as noted by Matshalaga (2004) is that, once people become frequently ill, they lose their source of income for sustaining themselves in urban areas, and consequently find their way back to rural areas to ensure that they are being cared for and that their children enjoy security in rural areas. At the same time, hospitals are increasingly unable to cope with patients with HIV and AIDS-related illnesses, and tend to discharge them prematurely. Meursing (1997) notes that ill patients choose to go to rural areas because they can easily access the services of traditional healers, who are perceived to possess powerful African herbs that can ‘cure’ AIDS.

One compelling reason for the influx of Kenyans to rural areas, as cited by Ayieko (2005), is that women would normally go back to their maternal homes when they are at advanced stages of their illness mainly because they are too frustrated by their in-laws to continue living with them. In Kenya, tradition does not allow one to turn down the assignment of absorbing orphans into one’s household. Winston (2006) supports this view by asserting that the maintenance of strong kinship bonds is a vestige of traditional African-American family structure that has made it possible for families to survive from slavery to the present.

**Challenges of care giving for grandmothers**

**Grieving**

According to Kübler-Ross (1975) grieving has five stages, which apply to both the grieving process after the loss of a loved one and the grieving following diagnosis of a chronic illness. The first stage is denial, where, in the present scenario, the grieving grandmother learns that her child is terminally ill, but cannot accept the fact. This is followed by anger, whereby the grandmother will resent the fact that other people’s children are healthy when theirs must die. This anger is often directed at God, as He is seen as imposing the death sentence arbitrarily. The third stage is a process of bargaining where the grandmother bargains with God to give the dying child more time in return for good behaviour. Depression constitutes the fourth stage where the victim of grief is now waiting for the sick person to die. The last stage is acceptance which, according to Kübler-Ross, is neither a happy nor an unhappy stage. It is devoid of feelings but is not resignation; rather, it is victory. In the present scenario, grandmothers finally accept that death is inevitable. However, the proposed stages are not absolute and not everyone goes through every stage in the same sequence or at the same predictable pace (Kübler-Ross, 1975).
Grief, according to UNICEF (2002), is a normal reaction to loss and is usually intertwined with bereavement. Most grandmothers taking care of their children may begin the mourning process during their child’s illness and go through most of the emotions related to anticipated loss and grief. Another type of grief is called delayed grief, which emerges long after the death of the loved one. Anticipatory grief is yet another type of grief, which occurs on the realisation that death is virtually guaranteed to occur (Rybash, Roodin, & Hoyer, 1995). Dane and Miller (1992) argue that some grandparents experience shadow grief, which is a form of grief that does not manifest itself overtly. This type of grief emanates mostly from the desire of mothers to never forget their losses and the general inability to express feelings to others, thus the need to remember becomes pre-eminent, assuming that if they do not remember their children, no one else will.

Cook and Oltjenbruns (1989) claim that researchers have largely ignored the grief process that grandparents go through. These authors argue that grandparents are often more alone, and without the necessary support system in their grief than any other group, yet they are expected to cope well so that they can be of support to other family members and serve as role models.

**Losses in adulthood**

Erikson (1950) argues that a parent who grieves the loss of an adult child is also grieving losses concomitant with life stage transitions, their ability to achieve a sense of continuity and generativity may therefore, be compromised. With grandmother-caregivers, the situation is worse as Winston (2006) found maternal grief to be intense and lengthy given the unique relationship between a mother and her child.

One cannot ignore the contextual background of HIV and AIDS from an African perspective. Death and bereavement take place in a social context and there is always the influence of social and cultural factors governing the mourning process (Newness, 1991). When a parent loses a child to AIDS, the likelihood that the mourning process will be hindered is increased because AIDS is associated with antisocial behaviour, and is also a disease that is often stigmatised. Karim and Karim (2005), in writing about HIV and AIDS in South Africa, cautioned about the circle of violence, stigma, and disenfranchised grief. The authors claim that in South Africa as in elsewhere, stigma goes hand in hand with discrimination based on different perceptions and misconceptions on HIV and AIDS. Communities remain locked in denial, and refer to AIDS-related death in a euphemistic way. This aura of secrecy, stigma, and social ambiguity leaves no pathway for the normal grieving process. Hindmarch (1993) also found that deaths related to HIV and AIDS carry an element of social stigma that presents an added difficulty for families who are trying to come to terms with
their grief as death as a result of HIV and AIDS often leads to a reduction in the level of sympathetic support that is usually forthcoming in other situations.

Dane and Levine (1994) view an AIDS death and the effect it has on the families of the departed from a spiritual perspective, and deduce that death is a spiritual crisis, as it demands answers beyond the realm of immediate experiences. Death due to AIDS is viewed as a divine punishment for moral failures and the victims are presumed to be responsible for their affliction and deserving their fate. For the family members who remain, such mystifications may be spiritually draining and they tend to question why their families fell victim to such a shameful and stigmatised disease.

For most grandmothers, adulthood is associated with stress and distress due to multiple losses. According to Erikson (1982), grandparents who lose spouses seem to mourn for anatomy weakened, initiative lost, and intimacy missed. They lament the loss of a future they had planned for as well as shattered dreams. Harvey (2002) found that older women (in their 60s on average) exhibit severe depression than similarly aged men soon after the loss of a spouse. Surprisingly enough, when older persons exhibit normal responses to bereavement, such as lack of energy, confusion, loneliness, and social withdrawal, these behaviours are sometimes interpreted as problems reflective of old age.

Grandparents may be overwhelmed by the loss of children and the kind of grief that has been described as three-fold. They are grieving for the loss of life their deceased grandchild suffered, for their own children’s grief, and for their own loss of a grandchild (Smith, 2005). Most grandparents, according to Ponzetti (1992), suppress their feelings of sorrow in order to shelter their families from further anguish. Another disturbing loss is that of a child, and it has been reported (when compared to other types of loss), to produce the most intense grief and the widest range of reactions (Sanders, 1980). This is because the death disrupts the anticipated order of the generational cycle, regardless of the child’s age. In the case of the death of an adult child, Jeffreys (2005) claims that it increases fears about their needs to be taken care of not being met in the future. Parents even suffer survival guilt as they question why their lives are being spared at the expense of their children’s. Thus, following an accumulation of losses, grandmothers feel they have lost themselves, their hopes, and their future.

Grandparents are also at the brink of losing their health as they advance in years. They reach a time when they confront the realisation of severe limitations on their bodies creeping in subtly and gradually as they find themselves increasingly unable to attend events outside their homes (Smith, 2005). In a study conducted among grandparents in Botswana, Alpaslan and Mabutho (2005) found that elderly caregivers all reported having health problems either from old age or from the stress
suffered as a result of a child or children having died from AIDS-related illness. Many grandmothers might be mourning the loss of major senses such as sight hearing, and the most common problems are those of back ache, high blood pressure, and chest and side pains. All these, combined with other multiple losses experienced, may hinder the ability to provide care to infected children and affected grandchildren.

Other challenges faced by grandmothers

Raising grandchildren on a full time basis is not expected by most grandparents as they might not be afforded the time to adjust to this transition and to deal with their own emotions prior to assuming the role of caregiver. This is because they gain grandchildren but lose their own child in the process. Emotional strain resulting from negative community reactions to HIV and AIDS can be worrying. It can also be emotionally draining for most grandmothers who often do not have the capacity to follow up on their deceased children’s rights due to ignorance, advanced age, fear of intimidation, and feelings of helplessness as a consequence of having lost a financial supporter (Ayieko, 2005). Another problem is that of lengthy procedures for recovering personal asserts, which lead many able-bodied relatives to decline requests from elderly caregivers for assistance in recovering asserts. Thus grandparents end up living in emotional turmoil in addition to financial poverty.

Meursing’s (1997) study reports physical constraints as a major challenge by a grandparent who has assumed the role of a caregiver. This is because patient’s decline were long drawn out and, as patients often suffered from several illnesses simultaneously, medical and nursing care become complicated, taxing, and costly. Rural homes were found to be poorly equipped to deal with such needs – health services are not easily accessible (are often far away, poorly staffed and supplied, and difficult to reach because of infrequent transport). Caring for orphans ranging from infants to teenagers can be physically challenging and exhausting. Thus, grandmothers in Orb and Davey’s (2005) study expressed tiredness as an overriding factor in their lives. They embraced the physical, emotional, and spiritual needs of the children as well as providing them with food, clothing, and shelter.

The most challenging hardship in Orb and Davey’s (2005) study was financial hardship. Grandmothers had to go out of their way to source income for the survival of their families, following the depletion of resources during times of illness by the deceased. Safman (2004) found that the dominant concerns of caregivers to orphaned children in Thailand were the costs associated with child rearing in an increasingly market-based society. Ansell and Young (2004) add that grandmothers are sometimes unable to accept children on account of poverty, and when children choose to leave grandparents’ homes, their decision is usually motivated by poverty.
Wilson and Adamchak (2000) also add that diminished resources in the households of grandparents reduce the already overstretched ability of older Zimbabweans to maintain their fitness and nutrition. Foster, Makufa, Drew, Kambeu, and Saurombe (1996) assert that due to economic hardships that these grandmothers are facing, they are unable to take care of their orphaned grandchildren owing to the fact that as the AIDS epidemic spreads, they are robbed of their economic support mechanism, their sons and daughters. Matshalaga (2004) found that grandmothers would provide care for their grandchildren in a situation of severe poverty.

### Available support for grandmother-caregivers

Government and societal responses to the needs of grandmother-caregivers have been desperately inadequate despite the fact that the writing has been on the wall for so many years (Karim & Karim, 2005). Matshalaga (2004) also indicate that when government provides assistance, registration is not comprehensive as only a few households could be assisted, leaving many needy households without assistance. Thus, some grandmothers resorted to selling home made beer or fruits to generate income (Matshalaga, 2004).

The extended family as the traditional social security system in many African countries has been weakened because parents, aunts, and uncles are dying of AIDS. In some instances grandmothers end up caring for children from polygamous marriages. Due to the high mortality rates and the weakening of the extended family, the burden of caring for orphans is left entirely on grandmothers (Matshalaga, 2004).

There are few studies that investigate the experiences of grandmother-caregivers looking after grandchildren orphaned by AIDS, as most studies tend to focus on the experiences of younger generations. Most of the documented research findings in relation to grandparents parenting grandchildren are from the United States, leaving a gap in the literature regarding this phenomenon, especially in Zimbabwe and in Africa as a whole.

### STATEMENT OF THE PROBLEM

As a result of the AIDS epidemic, societies have been severely affected in a negative way as rural grandparents are recruited into full-time care giving. Grandparents have, in the past, temporarily cared for their grandchildren when their parents migrated to urban areas or when they divorced or separated. The situation has changed in recent years, primarily because of the weakened extended family caused by of the migration of labour, the cash economy, demographic changes, and urbanisation.
These have led to a reduction in the frequency of contact among relatives and possessions perceived as personal property, which no longer belong to the extended family (Foster, 2000). For example, as a result of the cash economy, the husband now pays the bride price by himself; instead of the entire family collectively paying the bride price with cattle. This has led to marriage becoming a contract between two individuals; hence the weak linkages between and within extended families. As a result of this children have no one to care for them in cases of death as families are no longer collectively responsible for them.

The goal of this study was to explore the psychosocial impact of AIDS on rural grandmothers caring for their grandchildren orphaned by HIV and AIDS. The study’s theoretical development is derived from the gerontological concept of Erikson’s theory of psychosocial development in late adulthood; namely, that of integrity versus despair. According to Erikson (1982), the sense of integrity reflects an affirmation that one’s life was a meaningful adventure in history. The opposite is a sense of despair, which is an existential sense of meaninglessness and a feeling that one’s life was wasted or should have been different. This study therefore, attempted to contribute to the current knowledge base regarding grandparents and the role of caregiving by exploring their experiences of re-parenting at an old age.

**METHOD**

I, the first author, undertook an exploratory qualitative study by conducting in-depth interviews with 12 grandmothers in rural Zimbabwe. Interpretive methods of analysis were employed, which assume that people’s subjective experiences are real and should be taken seriously; that we can understand others’ experiences by interacting with them and listening to what they tell us; and that qualitative research techniques are best suited to this task (Terre Blanche & Kelly, 1999). A qualitative design was followed as it is typically in-depth in nature and, as proposed by Esterberg (2002), it allows for the telling of detailed stories about a small number of cases. Winston (2003) argues that a qualitative research method further assumes that valid understanding can be gained through accumulated knowledge acquired firsthand by a single researcher.

Data was gathered in the Zimbabwean province of Masvingo, in a rural district of Gutu, among Shona-speaking grandmothers who are permanently living in the villages of Makore, Mukaro, Mukadziwasha, and Utsinda. I chose this setting since I hail from the same province (which made it easy for me to get participants), and also because Masvingo is located in a semi-arid region, where life is difficult for...
most inhabitants who mainly depend on farming. Service delivery is also a problem, owing to the fact that the Gutu district is situated far from major towns.

**Sampling**

Participants were selected using purposive sampling, which emphasises that sampling should be done for information-rich cases. It involves the researcher in handpicking subjects on the basis of traits to give what is felt or believed to be a representative sample (Patton, 1990, cited in Merriam & Associates, 2002). The small sample size was chosen as it allows for the development of contextually-rich narratives that would deepen an understanding of the study’s inquiry. A primary caregiver was identified as one who provides instrumental and expressive care to a grandchild or grandchildren living in the same household on a daily basis for an indefinite period of time (Sands & Goldberg-Glen, 2000). The main advantage of this sampling method is that one can possibly better ensure a cross-section of the population in a small sample (Black, 2002). However, I acknowledge that I may not have identified all contributing variables and characteristics, and that individual bias may have prevailed when carrying out the selection.

Twelve grandmothers (three from each village) whose adult children had succumbed to AIDS, and were permanently living in Gutu, and taking care of orphaned grandchildren of between birth and 18 years, were recruited to participate in the study. The grandmothers’ ages ranged from 56 to 76 years. Seven of the grandmothers were widows, three were married, and two were divorced. Identification and selection were facilitated with the assistance of the Department of Social Welfare, National AIDS Council at district level (District AIDS Council), and some local gatekeepers, including ward councillors and headmen.

The criterion for choosing participants was that they should be caring for children who were orphaned by AIDS. This requirement posed a problem as some grandmothers wanted to be included on the basis that they had cared for orphans. Because of the overwhelming numbers of orphans in the country, most grandmother-caregivers are struggling and are therefore, eager to explore any possible source of assistance. Although I had made it clear that there would be no direct benefit resulting from participation, potential participants nevertheless, hoped that it might somehow help them deal with their caregiving burdens. This posed an additional challenge to me, as keeping the identities of the selected participants confidential became increasingly difficult.
Interviews

The study made use of open-ended semi-structured interviews, which were in-depth in nature and allowed me to explore the topic of interest more openly, while allowing participants to express their opinions and ideas in their own words (see Esterberg, 2002). Interviewing gives one the opportunity to know people quite intimately, so that one can really understand how they think and feel (Terre Blanche & Kelly, 1999). Interviews were carried out in the participants’ homes. Tutty, Rothery, and Grinnell (1996) assert that with qualitative research, the aim is to understand how people live, how they talk, how they behave, and what captivates or distresses them. I kept in mind that in interpretive research, one should not disturb the context unduly, but attempt to become a natural part of the context in which a certain phenomena occurs. I achieved this by entering the setting with the necessary care and engaging with the grandmothers in an open and empathetic manner, given the sensitive nature of the topic. The interviews lasted between 45 minutes and one hour.

Prior to conducting the interviews, I carried out a pilot study with two grandmothers in Mukadziwasha village, and this made me realise that for participants to open up, they need more rapport – to achieve this, I included songs in the actual interviews since in interpretive research a researcher may reformulate research questions as a result of new material they have collected, or change their data collection strategies in response to new findings.

With in-depth interviews, Bryman (2001) suggests that the researcher should have a list of questions or fairly specific topics to be covered, often referred to as an interview schedule, although the interviewee should have a great deal of leeway in how to reply. I therefore developed an interview schedule consisting of a number of questions allowing participants to describe their experiences in their own words and convey their feelings about caregiving. All the interviews were audio taped (with the consent of the participants), and the audio taped data was transcribed and translated from Shona to English before analysis.

Data was analysed using interpretive analysis which, according to Terre Blanche and Kelly (1999), involves reading through the data repeatedly and engaging in activities of breaking the data down (thematising and categorising), and building it up again in novel ways (elaborating and interpreting).

Research ethics

Informed consent was sought prior to the interviews. Once participants had agreed to participate in the study, they signed an informed consent form, which was translated into Shona. Confidentiality was also maintained, which according to Bryman (2001) means that the identities and records of participants should be maintained.
as confidential. No deception was used and counselling services were arranged for with responsible organisations should participants be in need of counselling.

FINDINGS

Three main themes arose from the process of interpretive analysis. These themes are: (1) challenges experienced by rural grandmothers in caring for AIDS orphaned grandchildren, (2) grief responses and coping strategies, and (3) support systems available to assist rural grandmother-caregivers in caring for AIDS orphans.

Challenges

Basic needs

The majority of participants said that being a full time caregiver to grandchildren had far-reaching economic implications for them. They mostly complained about secondary education since it is not affordable for many. Some grandmothers ended up wanting orphans to drop out of school to alleviate their burdens. This can best be described in one grandmother’s lamentation: ‘Since last year, I have been begging her, this one in form three, please drop out of school as you can see this heavy burden I have, but she would cry continuously.’

Food, clothes, soap, and blankets were cited as other scarce commodities in the household of these grandmothers. One grandmother reported that the pair of twins that was amongst the orphans she inherited could not sleep on the floor and could not do without warm clothing. Food was a problem due to a series of droughts that hit the country in the past few years and most grandmother-caregivers expressed mistrust in the government when it comes to relief; they alleged that some government officials practice nepotism and do not follow the correct channels when registering people for food aid. These grandmothers relied on aid from Non-Governmental Organisations (NGOs). Those who are fortunate to be enlisted for governmental aid, however, complained about delays caused by government red tape. Some are told that their files had gone missing without proper explanation, and most grandmothers lacked the legal expertise to challenge such claims.

Obtaining assistance was also hindered by the fact that most often, orphans do not have birth certificates since most grandmothers had lost contact with their sons-in-law – most orphans’ fathers withdrew once their children were in the care of their grandmothers. Obtaining a birth certificate was a hassle as it entailed going to Masvingo town, which is about 100 kilometres or more away from Gutu. Also, close relatives of orphans need to be present to act as witnesses for the authorities to issue birth certificates, and all these add to the accumulation of bus fares as the
orphans had to be present too. One should also bear in mind that the process of obtaining a birth certificate could be very slow because of long queues at the point of registration due to lack of decentralisation.

**Health challenges**

Most grandmothers complained that their health compromised their ability to provide adequate care for their grandchildren. For most of them, care giving exacerbated their feeble health – most of them complained about side pains, backache, painful legs, and tiredness and reported having health problems either from re-parenting at an old age or because of the stress suffered as a result of losing a child or children to AIDS. Two of the grandmothers had hearing problems, two were on treatment for Tuberculosis (TB) one experienced visual problems, while another had been struck by herpes. Most of the health problems were cited as a result of old age as well as hard work since most of the work in the rural areas is manual and routinely done. Due to lack of support, most grandmothers resorted to exchanging labour for cash or food, some brewed beer for sale, while others seasonally sold the few fruits in their orchards. All these entail hard work.

**Acclimatisation of orphans to rural life**

Grandmothers are also faced with the challenge of helping orphans with the transition to rural life as most of these children were brought up in urban areas. The children complained about exhaustion since the schools are usually some kilometres away, and grandmothers have to escort them during the first visits to school. Adjustment to rural diet was another problem for most orphans, as one grandmother pointed out, ‘food, food my daughter, on the fire is a clay pot half-full of dried mushrooms some of the orphans do not like them, yet all of them look up to me, it is painful to see them sitting on that bench with dry mouths’.

Grandmothers are also at risk of infection as they were exposed to direct interaction with infected persons. Most of them had cared for their deceased children and some of the orphans they cared for were infants. One grandmother inherited a week old infant whose mother had died of AIDS, while the child’s father was also left ailing under the care of the grandmother. In such instances, grandmothers faced a greater risk of infection. Gloves are not easily available in the country, let alone in the rural areas. Moreover, wearing gloves when caring for an ill person is usually unacceptable in the African culture.
Psychological distress

Most grandmothers are experiencing psychological distress because of the losses they incurred and the burden of caring for orphans. Most of the participants raised concerns about what the future holds for them, given the young ages of the orphans they cared for in relation to their feeble bodies. They were worried about what would happen to the orphans if they themselves were to die. The stigma associated with HIV and AIDS in their communities had forced them to withdraw socially from most social activities. Grandmothers had to contend with the unique strains imposed by HIV diagnosis and disease progression, which compounded the stress of care giving in later life. As a result, they were isolated from traditional social support systems, and were reluctant to turn to others for assistance for themselves or their families. The distress was worsened by the idea that grandmothers were fighting a lone battle in caring for the orphans. During the interviews, extended family members were never mentioned as contributing in any way. Only immediate family members were said to assist, but only when they could, given the socio-economic hardships in Zimbabwe.

Grandmothers complained about the emotional turmoil they experience caused by depleted resources due to losses incurred in caring for their late children. One grandmother lamented the loss of the little wealth she had acquired, ‘this homestead is now quiet, all my chickens are now gone’. They also had to contend with emotional strains as they had to witness the families breaking because of tension between their families and those of their in-laws. One grandmother complained that they never heard from her son-in-law, and his family did not even come to convey condolences when her daughter passed away.

Some of the grandmothers complained about the psychological pain of being dumped by their husbands, and when they remarry, they are married as second wives in polygamous marriages, and later take care of their husbands’ children as well as their rivals. Grandmothers could not refuse such an assignment as was also found to be the case in Kenya (Ayieko, 2005), but the pain was said to be unbearable. The other emotionally draining aspect was whether to disclose to the orphans that their parents had died of AIDS. Grandmothers wished they had someone to share these problems with, but unfortunately, they had no one to turn to.

Grief responses and coping strategies

Most grandmothers continued to be grief-stricken, even if the deaths had occurred a long time ago because the presence of orphans in their lives remains a constant reminder to their children’s death. One grandmother said, ‘each morning revives sad memories and the reality of your loss and burdens, and to face the poor orphans,
how emotionally draining it is’. Most grandmothers, however, mentioned their religious beliefs as a source of their comfort and strength. They maintained that they prayed more often so as to lighten their burdens. Most of them believed that what they are experiencing is God’s will. For some, however, AIDS was believed to be ‘that incurable disease foretold in the Bible’. Their religion and spiritual life, therefore, serves as their source of strength.

For most grandmothers, prayer, song, and faith are resources that assisted them care for both their dying children and the remaining orphans. They bargained with God to heal their children and when this failed, they went on to pray for strength to care for the orphans. Attending church also helped these grandmothers to cope with the stress of parenting at an old age, while grieving at the same time. These grandmothers sung one common religious song which, appeared, was their way of communicating with God and coping as well. The song acknowledged God’s power since He had given them children and had now taken them away. Grief overwhelmed most of these grandmothers as they wept while singing – I was equally overwhelmed as the atmosphere was becoming emotional.

For some grandmothers, the belief in ancestral spirits shaped their grief responses. They believed that losing several children in succession or after a long illness was a sign of angry ancestral spirits punishing them for wrongdoing. The fact that they did not know who did wrong – they, or their children, worsened their grief? Not all grandmothers found solace in attending church. As one grandmother remarked, ‘it is a lie which they tell us that if you pray using the rosary you will be healed’. For her, drinking beer brought her much comfort than attending church as it helped her forget the loss of her six sons. One grandmother stopped going to church since the death of her daughter-in-law in 2004, as she could not bear the sight of the empty seat that the deceased used to occupy in church. Avoidance, therefore, became a coping mechanism for such grandmothers.

**Support systems available to assist grandmother-caregivers**

Mechanisms devised to assist caregivers include counselling and Home-Based Care (HBC) to bereaved families, especially from the National AIDS Council. This is an important measure as most hospitals have to send patients back home due to lack of medical supplies, the overwhelming numbers of patients, and lack of staff. The Department of Social Welfare assists caregivers with school fees under a programme called Basic Education Assistance Module, as well as access to medication for infected orphans. However, most grandmothers said there are sometimes delays in the payments of the school fees, resulting in their grandchildren being sent home because of outstanding fees. Most rural clinics do not receive constant medical
supplies and are usually understaffed, and this results in very inadequate patient care. As a result, most grandmothers stopped asking for help. Another problem that participants mentioned was nepotism on the part of governmental institutions that are generally unsympathetic to these grandmothers and the latter’s diminished trust, as was also found in Winston’s (2006) investigation. Registration for assistance is not comprehensive as only a few households in a given village could be assisted, leaving numerous households in need of help.

The government offers relief aid in times of drought, but this is often unreliable as distribution is not always regular enough to keep up with families’ need for food reserves. In traditional Shona societies, there used to be a collective field placed under the responsibility of the chief. Members would take turns to work in this common field, with the harvest used to feed the sick, community soldiers, and those coming to be tried at the courts, called zunde ramambo (UNICEF, 1998). The programme is now being resuscitated in the context of orphan care to provide for their needs. However, as noted by Matshalaga (2004), these programmes operate within environments of severe poverty and are only able to support a limited number of needy orphans. In this study, no mention of zunde ramambo assistance was made.

NGOs were reported to be playing a major role in assisting the disadvantaged in Zimbabwe. Of particular important is CARE Zimbabwe, which helps poor people, mostly in rural areas, through the provision of food such as cooking oil, beans, barley, and so forth. One grandmother remarked, ‘if it was not for CARE, many of us would not have made it through to this day’. However, the involvement of community leaders in the operational activities of the NGOs was reported to cause problems, as one grandmother was surprised to find her name struck off the roll with no explanation. Rural Unity for Development Organisation also offers educational assistance through direct payment of school fees and food security both at household and community level mainly to orphans and vulnerable children. Matshalaga however notes that one of the challenges most NGOs in rural areas are facing has been to strike a balance between assisting poor communities, while at the same time encouraging them to be more self-sufficient so that in the event of such NGOs withdrawing, they would still continue with the development projects. Poverty eroded self-sufficiency in most of the communities.

**DISCUSSION**

The findings of this investigation provide new insights into the experiences and challenges of grandmother-caregivers. The main area of concern raised by participants is that of grief caused by losing their children to AIDS, which is further revived by the presence of affected and infected orphans. There is a strong desire to remember
their deceased children, hence they will remember vividly the dates their children passed away. Their lives have been turned inside out as they experience the reversal of roles, which are contrary to their hopes of a relaxed adulthood. Their reliance on families of origin and spirituality points to an important implication, namely that they are not enjoying the benefits of social support. Grandmother-caregivers have no other choice but to keep going and develop resilience in order to raise their grandchildren.

Another finding by the study is that most grandmothers are illiterate and, consequently, confused and overwhelmed by the paper work required when approaching government departments for assistance. Inappropriate and inadequate dissemination of information also makes these grandmothers’ situation difficult, as they rarely possess radios or televisions, given the rural nature of their homes where there is no electricity. Grandmothers described their reactions and feelings about their losses as devastating and catastrophic. The psychological distress, caused by the reversal of roles in a stigmatising society aggravates their situation. Consistent with Winston’s (2003) finding, the study established that most grandmothers suffer because of the stigma that is associated with an AIDS death, which includes shame, guilt, and anger. The orphans are also in turn, stigmatised – there is no doubt that coping in such circumstances can be difficult or even impossible.

Depleted resources and poor health pose serious challenges to the welfare of most grandmothers. Their health is compromised and their ability to parent is in the process, reduced. Their functional independence is also compromised as they continue to age. The despair experienced by most of them emanates from the fact that events in their lives have taken a turn for the worse. While Erikson (1982) notes that late adulthood should be a time of reflection when one relinquishes previous roles and strives to achieve integrity, these grandmothers do not enjoy successful ageing.

The findings of this investigation are consistent with those of previous studies (see for example, Ansell & Young, 2004; Ayieko, 2005; Foster et al., 2005; Foster et al., 1996; Karim & Karim, 2005; Matshalaga, 2004; Meursing, 1997). Some inconsistencies regarding coping strategies were, however, identified, which include avoidance and weakening of spirituality. In previous studies (see Berger, 1994), reliance on spirituality was found to be a strong factor among grandmothers. The findings, therefore, provide important new insights into the experiences of grandmother-caregivers, emphasising their need for social support and the need to be recognised as a group deserving special attention.
IMPLICATIONS AND RECOMMENDATIONS FOR COMMUNITY SERVICE AGENTS

There are several implications for community service agents who render services to this population. Grandmothers’ high levels of stress and grieving can be alleviated if counselling services are more readily available. The findings further demonstrate the need to assist grandmother-caregivers with more insight regarding HIV and AIDS, and in particular, how to handle the problems they are encountering in their roles as caregivers. Skills training, knowledge, and orientation in raising grandchildren, some of whom are infected, are needed. However, it is not enough for grandmothers to get financial assistance only— they also need social support and psychological help to strengthen their capacity to continue as caregivers, and to ensure the optimal functioning for the future of the orphans in their care. It is also important that aid agencies cater for the basic needs of these grandmothers and be consistent with delivery dates for that matter. Agencies should also take greater care to ensure that all rural areas are covered.

If these recommendations were to be implemented, monitoring in terms of performance and potential would be essential. Community partnership such as involving caregivers and orphans in the implementation and development of the programmes is necessary. This would generate better results than simply design programmes in isolation and handing them over to people in need.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

One of the limitations of this study has been the small sample size. These findings may not hold true for other caregivers in the whole of Zimbabwe. A larger sample size selected randomly from more than one village in a similar situation would have allowed for more generalisable results. It is therefore, suggested that a relatively larger sample size, including male caregivers which also covers a wider geographical area, be drawn in future. One can also argue that because there was only one researcher conducting the study, the findings might not have been analysed objectively.

Despite its limitations, the study has assisted in identifying a number of issues that are pertinent to grandmother-caregivers that have not been recognised previously, which include the need for social support and recognition in order to help them achieve continuity and generativity necessary for successful aging, rather than to become mired in despair. The study also have shed some understanding on how grandmothers have become a potentially health risk population, a fact which needs attention in most policy interventions.
The study has afforded members of a hidden and traumatised population a chance to tell their stories, and the open-ended nature made it possible for the researcher to gather data that is illustrative and rich. Most of the research done has focused on the young people and ignored caregivers. Understanding how caregivers are able to move on with their roles without external support is a vital avenue of inquiry for future research and studies should examine a variety of demographic and ethnic characteristics of both male and female elderly caregivers.

CONCLUSION

As the AIDS epidemic continues to spread, there is a need to support elderly caregivers. They provide care when age-related issues already place a heavy burden on them, and yet they have to act as safety nets for families. The least that we can do is support them as they assume re-parenting in late adulthood. This study supports other studies on grandmother-caregivers that report that it is essential to support grandmother-caregivers, and that this group not only contributes to the well-being of the orphans but also to the community at large, given the weakening of the extended family.

ENDNOTE

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