Grandparents as parents: Skipped-generation households coping with poverty and HIV in rural Zambia

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Questions about children, older people and HIV in Zambia

Introduction

The HIV epidemic has affected Zambian society in all its facets for almost three decades. In particular, the caring capacity of individuals, households, and extended families has been severely taxed by the HIV crisis. The number of new infections was highest in the years 2001, 2002, and 2003 with an estimated 110,000 new cases annually. This has been reduced by over 50% to an estimated 51,000 in 2011 (UNAIDS, 2012). Antiretroviral therapy (ART) is becoming available to more and more people suffering from HIV and AIDS (Ibid.), the impacts on those affected by the epidemic are still dramatic and continue to intensify, as projected by past observers and commentators (Barnett & Whiteside 2006: 48; Gillespie 2006: 1).

The spread of the HIV epidemic in the region, which primarily takes place through heterosexual contact, means that most of those infected are sexually active adults. As a result, children and older people carry much of the burden of the epidemic following the death of (mostly) the middle generation. Furthermore, research on the living arrangements of orphans and vulnerable children (OVCs) in Zambia indicates that many children are not growing up with their parents or other middle-aged adults, but are increasingly living with their grandparents and other older caregivers (Subbarao, Mattimore & Plangemann 2001; Ainsworth & Filmer 2002; Martin & Wiesner 2010; UNICEF 2012). The need for more data on the role of older caregivers looking after OVCs has been noted in the past (see for example CPOP 2006). In part, this call stems from the identification of specific links between old age, poverty, and HIV that are not yet fully understood.
This introductory chapter touches upon the background to the research on which this study is based, providing a brief overview of HIV in Zambia over the past 25 years and a primary analysis of the impacts of HIV on children and older people in the country. The chapter is set up as follows. To begin, the next section introduces the rationale for undertaking this study. The third section contains a brief description of the research I conducted in Zambia in 2001, on the migration of children affected by HIV, some of the outcomes of which led to this current research. This is followed by a section with a declaration of my research affiliation. Then comes a brief overview of the HIV epidemic over the last three decades, both in global terms and as it pertains to Zambia. The section entitled ‘HIV and the changing prospects for children’ describes the changes that have occurred in the nature of orphanhood over the last thirty years, in Africa as a whole and in Zambia in particular. This is followed by a section that examines ageing and the changing position of and pressures on the elderly, in particular in sub-Saharan Africa. The next section then introduces the primary focus of this work, which is skipped-generation households, and in the final section of this chapter the research questions are presented.

Research rationale

Across the developing world, older people are at risk of living in poverty and of experiencing low levels of well-being in material, physical, and emotional terms (Lloyd-Sherlock 2000; Gupta, Pattillo & Wagh 2009). The probability for older people to live in poverty in sub-Saharan Africa is particularly high in comparison to other regions, and the risks associated with poverty are extreme (Collier 2007; Kakwani & Subbarao 2005; Adeyemi, Ijaiya & Raheem 2009). Understanding the determinants of material well-being among older people is therefore an important prerequisite for poverty reduction and for the improvement of overall well-being. In countries and communities severely affected by HIV, the vulnerability of older people to poverty is compounded by the loss of middle-aged adults from the extended family. Adult children are the ones most likely to care for their parents once they reach old age. Indeed, in the region, children are seen as a person’s pension. Since many older people have lost their children, they have thus lost their primary caregivers in their old age.

One living arrangement that has become increasingly prevalent in Zambia as a result of the loss of prime-aged adults and the increasing interdependence of young and old are skipped-generation households. These households consist solely of members of the younger and older generations, and lack a middle generation entirely. Examining the linkages between old age, caring patterns for children affected by HIV, and poverty is especially important in relation to this
type of household. Both the older people and the children living with them face a high probability of living in poverty. Up to now it is unclear how the roles of these two generations who live in skipped-generation households affect the overall well-being, in all its dimensions, of the members. While some empirical findings concerning the needs of OVCs and older people are available (see for example Knodel et al. 2003; Dayton & Ainsworth 2004; Seeley et al. 2009; Ice et al. 2010, Adhvaryu & Beegle 2012), less is known about the specific contexts and needs related to skipped-generation households. The relationships of dependency and reciprocity between the elderly and OVCs, the impact that living together has on the well-being of both generations, and the implications for policy have not yet been analysed.

In Zambia, the precise number of older people caring for OVCs in skipped-generation households is not known. There is some data about the number of children living with grandparents (though this does not exclude the presence of other younger or middle-aged adults). Most estimates suggest that approximately 40% to 60% of all orphans live with grandparents (UNICEF 2006; ORC Macro 2003a & 2009). Data further shows that many older caregivers of OVCs live in rural areas (UNICEF 2006 & 2012). Life in rural areas is tough – services are scarce and work is hard to find – and as a result, poverty rates are much higher than in urban areas (JCTR 2012). The impact of this upon skipped-generation households is particularly heavy since members of such households have little or no access to financial means, nor do they have the human capital to work for money. Thus, understanding the dynamics of skipped-generation households should be an important aspect of any analysis of the linkages between poverty and HIV. Today, the specific risks and opportunities that this living arrangement poses for OVCs, and how these compare to other living arrangements, remain unknown. Living in a skipped-generation household is a forced arrangement in many ways, yet it is possible that the presence of the older generation benefits the younger generation, or vice versa.

In order to contribute towards remedying this gap in knowledge, this study focuses on the well-being of children and older people living in skipped-generation households in Zambia. The study examines the particular living arrangements of such households and, when relevant, compares them to other living arrangements. By studying the well-being of children, the older people they live with, and the dynamics in their homes, the study will shed some light on the general situation of OVCs, as well as the situation in skipped-generation households in particular. Too often research has been guided by the plight of isolated populations (for example: children or older people or people infected with HIV), while the real impacts of HIV these days can be seen in the dynamics and survival
strategies of (extended) families, in which older people play a pivotal role in the development of children.

Despite the presumed prevalence of poverty and low levels of well-being, especially material well-being, my earlier research among OVCs in Zambia (see the following section) showed that living with older caregivers does offer something positive to children. Many children of all ages explained that they would choose poverty, hard work, and hunger if it meant living with their siblings and grandparents. For them, being with these significant others was more important than meeting basic needs. My findings demonstrate how different dimensions of well-being – in this case material versus emotional well-being – can be weighed up by children, even those who are very young. This is an important finding, and this current study seeks to contribute further towards a better understanding of the implications of the different dimensions of what it means to be well for an overall concept of well-being.

This research was developed to provide better insight into the caring patterns within skipped-generation households, the well-being of the members of these households, and how these households may become better able to fend for themselves. Following from this, the aim of this project is:

To provide a comprehensive understanding of the changing dependency between OVCs and their older caregivers in skipped-generation households in rural Zambia.

The research questions that were developed based on this aim are presented at the end of this chapter. But first, in order to understand and place these questions in context, some background information will be provided below.

Background of this research

In 2001 I conducted research for a non-governmental organisation (NGO) operating a home based care (HBC) programme for people living with HIV (PLHIV) in the Zambian Copperbelt Province. The NGO asked for research about the children of clients enrolled in the programme. At the time there was no ART available to PLHIV, which resulted in the inevitable deaths of all clients suffering from AIDS-related illnesses. During the final stages of these people’s lives, the programme provided financial and food support to them and their families. The children registered with the programme often disappeared from the organisation’s radar, however, following the death of one or both of their parents. The question the organisation formulated was: What happens to children in the
months following the death of their parent(s)? I spent nine months in Zambia conducting research to try to answer this question (see further Reijer 2002).

The first part of the research was a post-mortem survey in two shanty townships, Nkwazi and Chipulukusu, in Ndola. Initially, 616 children of deceased clients of the HBC programme were selected. Of this total, 507 (82.3%) were either traced or information about their new whereabouts was collected. This information came from those children who did not move, and from relatives, neighbours, and HBC volunteers. In total, 26.6% of the 507 children had left town, migrating to the rural villages where their parents’ (in most cases their mothers’) families originated from. Many of the children were reported to be living with their grandparents in these villages.

The second part of the research followed up some of the children in the rural areas to which they had migrated. Two locations where a large number of the children had gone to were selected. The first was Serenje district, which is the home of many Bemba people, who make up the predominant ethnicity in Nkwazi Township. The second was Misangwa, the traditional home of the Lamba people, the predominant ethnicity found in Chipulukusu Township. Household surveys were carried out in both places. Of all the rural children included in the household survey, 8% were orphans who had lost their parent(s) in town. Of the 1646 children included in the two rural household surveys, 624 were found to be orphaned children. Of these 624, 21.1% were orphans who had been living in town and who had migrated to the rural area following the illness or death of their parent(s).

The third part of the research was qualitative. It consisted of numerous in-depth interviews and focus group discussions (FGDs) with children and their parents or guardians. The data showed that in general, orphaned children and young people had very little choice about which relatives they came to live with following their parents’ death. These decisions were made by their adult relatives, usually the older people. Yet many children explained that, if given a choice, they would choose to live with their grandparents. Generally speaking, the socio-economic situation was better in households headed by the children’s aunts, uncles, or older siblings, and the children were aware that food and educational support from grandparents would most likely be less than what other (younger) relatives would be able to provide. Some explained that they knew that they would probably go hungry more often if they lived with their grandparents. Nevertheless, this preference for grandparents as guardians was expressed both by those children living with their grandparents as well as those living with other caregivers.

One of the reasons that I undertook this current research was because it continued to intrigue me how the children and young people that I had researched in
2001 made choices between the provision of basic human needs on the one hand and love and care on the other. The most daunting question I had was regarding the extent to which children and young people can and do actively weigh their choices, and what this means for our understanding of well-being.

Research affiliation

Throughout the duration of this current project, I was affiliated with the University of Amsterdam in the Netherlands. In total, 14 months of fieldwork were conducted in rural Zambia. While in Zambia, I was affiliated with the Copperbelt University in Kitwe, which provided an office space when needed as well as valuable contacts. The research was conducted in Misangwa, one of the two locations where the 2001 study took place. Funding for this study was provided by the Netherlands Ministry of Foreign Affairs within the IS-Academy cooperation framework for HIV/AIDS. This cooperation between the Ministry and the University meant that I was seconded as a consultant to the Ministry annually. These consultancies consisted of conducting literature reviews and brief research projects, and I was asked to contribute to policy and report documents. Issues that these consultancies focussed on included the Millennium Development Goals (MDGs), social protection interventions, and food security.

Three decades of HIV

The global HIV pandemic\(^1\)

According to UNAIDS, there were 34.2 million (31.8 million to 35.9 million) PLHIV worldwide at the end of 2011. This number is 30% higher than the figure of 26.2 million (24.6 million to 27.8 million) reported for 1999. Furthermore, by the end of 2010, an estimated 6.6 million people in low- and middle-income countries were receiving HIV treatment (ART) – an increase of more than 1.35 million over 2009 and accounting for nearly half of those eligible\(^2\). The number of people dying from AIDS-related causes was 1.8 million in 2010, down from a peak of 2.2 million annually during the mid-2000s. According to new calculations by UNAIDS, thanks to the roll-out of ART 2.5 million AIDS-related deaths have been averted since 1995 (UNAIDS 2012). While this is a major public health achievement, there are still over 10 million people worldwide who are eligible for treatment but who are not receiving the drugs. These numbers serve

\(^1\) Unless explicitly mentioned, data presented in this section is taken from a presentation prepared for the XIX International AIDS Conference in Washington, July 2012, by UNAIDS (see http://www.unaids.org/ under 'Resources' and then 'Epidemiologyslides').

\(^2\) In 2010, all people at stage III or stage IV of the WHO disease staging system for HIV infection and disease were eligible for ART as well as people in stage I and II with a CD4 count below 350 per microliter.
as a reminder that there is much work to be done to help people infected with HIV.

There is less clarity in terms of the agenda for mitigating the effects on people not infected with but directly affected by HIV. In 2006, the then director of UNAIDS, Peter Piot, said that “[t]he first 25 years of action against AIDS and its agent, HIV, can be characterized as a ‘crisis-management’ approach, but it is time for a long-term sustainable response”. In many ways this is still true today. The scale-up of treatment has taken place at the expense of prevention and mitigation activities, and the plight of people who have been affected by, but who are not infected with, HIV is steadily disappearing from the international agenda.

The lack of attention for children affected by HIV in particular was apparent at the most recent International AIDS Conference held in Washington DC in July 2012. At the rapporteur’s session on the final day, only four of the 103 slides that were presented focused on children affected by HIV. The situation in affected countries also shows that their governments largely follow the international agendas and policies. Zambia is no different, and there too mitigation of the impacts of HIV has received less funding and less attention.

A history of HIV in Zambia

The HIV epidemic came to Zambia in the early 1980s (GoZ 2009a). It was generalised and spread throughout the population, mainly transmitted through heterosexual contact (GoZ 2009b). Following the first cases, the National AIDS Surveillance Committee (NASC) and the National AIDS Prevention and Control Programme (NAPCP) were established to coordinate HIV-related activities. Despite this, the response to the epidemic in the early years can be characterised as minimal, and the few activities that did take place were either externally driven or instigated by NGOs. The role of the government during this time was rather dubious, as most of what was known about HIV was kept secret by the authorities, under the directive of President Kaunda. Politicians were very reluctant to speak out about the growing epidemic, and the press, which was state-owned and controlled, did not mention HIV or AIDS.

A turning point came following the death of President Kaunda’s son. When Masuzyo Kaunda died of AIDS in 1987, his father openly discussed HIV and AIDS for the first time. At the time, many in Zambia felt that such openness was coming much too late. History has taught us, however, that it was early compared to other countries in the region. Almost ten years after Dr. Kaunda first mentioned HIV and AIDS, it was estimated that over 15% of Zambians aged 15 to 49 years were HIV positive (see Figure 1.1), and as the prevalence increased the government was again slow to respond to the emerging crisis. Typical of the international community’s evaluation of the government of Zambia was the opin-
ion voiced by Stephen Lewis, then UN Special Envoy for HIV/AIDS in Africa. In 2003, he said that the then current Zambian president, Dr. Chiluba, who had been in power since 2001, “spent his time disavowing the reality of AIDS and throwing obstacles in the way of those keen to confront the disease” (Lewis 2003).

Zambia is one of the most affected countries in the world in terms of HIV infection. Though it does not have the highest adult HIV prevalence rate – this dubious honour is reserved for Swaziland, Lesotho, and Botswana – what makes Zambia one of the most affected countries is the fact that it has had such a high HIV prevalence rate over a long period of time (Figure 1.1). Indeed, for two decades the prevalence rate in Zambia was 20 times higher than the world average.

![Figure 1.1 Estimated adult (15 to 49 years) HIV prevalence rate, Zambia, 1990 to 2011](source)

The new millennium signalled a new and much clearer political attitude and engagement in Zambia. The National HIV/AIDS/STD/TB Council (NAC) became operational in 2002. In that year, the Zambian Parliament passed a national AIDS bill that made the NAC a legally established body able to apply for funding. In 2004, the third president of Zambia, Dr. Mwanawasa, declared HIV and AIDS a national emergency and promised that his government would start providing ART. The efforts of his government paid off, and the response has saved thousands of lives and has resulted in a national programme that boasts one of the highest rates of treatment coverage in Africa. At the end of 2011, ART coverage in Zambia was estimated at 72%, much higher than the average of 48% for low- and middle-income countries (Ford 2012).
The current state of HIV in Zambia

UNAIDS estimated that in 2011, 970,000 people were living with HIV in Zambia, of which 170,000 were children aged 0 to 14 years (UNAIDS 2012: A14). In terms of ART coverage, in 2009 283,863 people were receiving ART in the country (ibid: A67) There is, however, a big difference between the coverage of children and adults; the estimated ART coverage for children in 2011, for instance, was 26%, compared to 84% for adults (WHO 2011, p.163). Regarding mortality figures, it is estimated that in 2009 there were 31,000 deaths in the country due to AIDS-related illnesses compared an estimated 75,000 in 2004 (UNAIDS 2012: A26). While estimates do vary, the number of children younger than 18 who have lost one or both parents is estimated at 1.3 million (MoE 2007; UNICEF 2010)

During the last three decades the epidemic has spread throughout the country and has touched every Zambian’s life. The crisis has impacted households, families, communities, companies, and even the national economy. Indeed, the mortality and morbidity of the epidemic has impacted national progress on many fronts, which include economic growth, improvements in the Human Development Index (HDI), and overall mortality rates.

HIV and the changing prospects for children

The UN resolution “A World Fit for Children” was defined at the Special Session of the UN General Assembly on Children in 2002. One of the core aims encapsulated in the resolution is that in order “To combat HIV/AIDS, children and their families must be protected from the devastating impact of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)”. Nevertheless, today children are still largely ignored in the global response to HIV. The worst shortfalls are in paediatric care, primary prevention, and the protection and support of affected children, notably the 12 million children in Africa who have lost one or both parents to the virus (Horton 2006).

The reality for most children infected with or affected by HIV in Zambia today is bleak. While child mortality was in decline in the decades prior to the emergence of the HIV crisis, progress on key indicators has started to slow down as a result of HIV/AIDS, and child mortality has been on the rise again over the last two decades (ORC Macro 1997, 2003a & 2003b). Many infected children still have no access to paediatric ART services and they are likely to die as a result. Furthermore, for those affected rather than infected, the impacts of HIV on their lives and well-being will linger for decades, even after the epidemic begins to wane (Foster & Williamson 2000). While orphanhood may be the most visible and impacting event in many children’s lives, children whose parents have not
died may also be severely impacted. HIV/AIDS affects children in countless ways. They may become caregivers to the sick or to other children, sometimes even becoming the head of the household. Malnutrition, ill health, and exploitation are common in this group, and they run a higher risk of experiencing abuse, dropping out of school, and contracting HIV themselves.

The demographics of orphans and vulnerable children (OVCs)

In 1995 it was estimated that there were approximately 403,000 single orphans and 49,000 double orphans in Zambia. These children had lost their parents to all causes (MSYCD 2004: Appendix 1, 37). In 2011, according to UNICEF, these figures had increased: 690,000 children had lost one or both of their parents to AIDS-related illnesses, and there was a total of 1.3 million orphans due to all causes (UNICEF 2012). In terms of orphan prevalence, Zambia ranks alongside Zimbabwe and Malawi as having the highest in sub-Saharan Africa. In the region in general there is a high prevalence of orphans and HIV is the largest single factor behind this, responsible for an estimated two out of every three orphan cases (Guarcello, Lyon & Rosati 2004).

In sub-Saharan Africa, the age distribution of orphans is relatively consistent: about 15% of orphans are 0-4 years old, 35% are 5-9 years old, and 50% are 10-14 years old (Monash & Boerma 2004). Since HIV infected adults may live for many years, this results in an increased prevalence of orphans in the higher age cohorts (Bicego, Rutstein & Johnson 2003). Demographic Health Survey (DHS) data for Zambia also shows this trend, as the overall number of children orphaned has increased, but age distribution remains fairly consistent (CSO 1997 & 2003).

In contrast to orphan prevalence, very little data is available on the number of children who are vulnerable as a result of HIV. In 2006 poverty in Zambia was widespread, with 64 percent of the total population living below the poverty line, rising to 80 percent in rural areas (GoZ 2006). As is described in more detail in Chapter Two, there are several indicators – including but not limited to economic factors – that can be used to identify vulnerable children.

Kinship, for instance, has many consequences for child care and fostering, and thus for the vulnerability of children. It has the potential to impact children through inheritance rules, land rights, social and economic positioning and rights, the nature of support networks, and so on. Across Africa, while most societies are predominantly patrilineal, matrilineal societies are found in parts of Zambia and Malawi, Central Africa, and in Western Africa, especially in Ghana and the Ivory Coast. Across the continent, children traditionally belong to their extended family. In matrilineal societies, children are, if not taken care of by their own mother, cared for by members of her lineage group, and much less so by the
lineage group of their father. The implications of lineage on children’s well-being were found to be far-reaching in Misangwa. Some of the consequences for households and children that emerged will be discussed in the empirical chapters of this study.

Orphanhood: Educational opportunities and labour demands

In terms of access to education in Zambia, net enrolment rates (for both boys and girls) in primary schools were reported to be around 92.4% in 2009, down from 96.8% in 2008 (UNSTATS 2012). Gender inequality is somewhat worrying, however, as in the same year there are only 93 girls for every 100 boys at primary school. In secondary education, the enrolment rates are much lower: the last known net enrolment rates for boys and girls, which dates from 1998, was 16.4% (UNESCO 2011). In terms of tertiary enrolment, Zambia ranked in the bottom five worldwide in 1998 (Legatum Institute 2009). There is no significant effect of orphanhood on children’s opportunities to attend primary school (UNESCO 2011). Differences do exist between orphans and non-orphans as the risk of primary school non-enrolment is higher for double and paternal orphans than for non-orphans (ibid.). However, while no statistics are available, anecdotal evidence suggests that there is a substantial difference between the enrolment of orphans and non-orphans at both secondary school and at the tertiary level.

Educational infrastructure has improved in recent years as the government has invested substantially in primary and secondary enrolment. Primary education is free in Zambia, though there are costs involved for enrolment, and children’s parents or caretakers are required to pay Parent-Teacher Association (PTA) fees, as well as examination and diploma fees. Furthermore, while school uniforms are no longer compulsory, there remains a social obligation for children to wear them, adding to the costs of sending a child to school. Secondary and tertiary education is not free, and the result is that such opportunities are unattainable for many families. Not only is enrolment expensive, but many pupils have no choice but to board at school because the distances to walk are too far. Boarding adds to the financial pressures.

While the available data tells us a fair amount about orphans and educational opportunities, very little is known about vulnerable children. For instance, very little quantitative data is available on the relationship between orphanhood and the demands for labour. It is known that orphanhood, vulnerability, and poverty are often linked, and anecdotal evidence suggests that orphans and fostered children have a higher risk of being forced to work for their households than other children living in the same household. A project conducted as part of the inter-agency research cooperation programme “Understanding Children’s Work” (UCW) (Guarcello, Lyon & Rosati 2004) is one of the few examples of research
that has examined the connection between orphanhood and child vulnerability – in particular labour demands – in Zambia. The project used three indicators of child labour\(^3\) and found that by a relatively small but significant percentage, orphans were more likely to be involved in economic activity than non-orphans. The researchers also found that there was little difference between the three different categories of orphans (maternal orphans, paternal orphans, and double orphans), though on average male maternal orphans were most likely to be engaged in economic activity, while female double orphans were most likely to carry out household chores.

A frequently heard argument among people who advocate against the involvement of children in work for their households is that it may interfere with their education. It is worth noting that this assumption does not hold much weight in present day Zambia, given the situation at most primary schools. Laws on education have limited the number of pupils per classroom, but there is no legislation on the minimum number of hours that pupils are required to be in class. Since teachers’ workloads are very heavy, most pupils at primary level spend no more than two to three hours in the classroom per day. This leaves ample time for children who live close to school to walk there, attend classes, and then walk back and work around their homes and/or in the family fields.

Where are OVCs found?

Fostering within (extended) family networks remains the most common safety net for the care of orphans in Africa. This is not a new phenomenon, and the fostering of orphans by relatives is well fitted to the prevailing African setting (Subbarao, Mattimore & Plangemann 2001). Across the continent we see two types of fostering: voluntary and crisis-led fostering (Foster et al. 1995; Nymukapa et al. 2003; Madhavan 2004). Voluntary fostering pertains to arrangements between the biological and foster caregivers over the raising of a child. The practice is culturally sanctioned in most of sub-Saharan Africa (Bledsoe & Brandon 1992; Caldwell, Caldwell & Orubuloye 1992; Aspaas 1999; Alber 2004) and can have benefits. Crisis-led fostering occurs in response to the death of one or both biological parents or to a major shock.

What actually happens to children in Zambia immediately after the death of one or both parents remains under-studied. One of the few studies conducted in the country (aside from my own study that was described in the background to this research) found that 56% of orphans were likely to be separated from their

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\(^3\) The indicators used in the project were based on the 1999 Child Labour Survey executed in Zambia (CSO 1999). They are (1) Economic activity only, (2) household chores, and (3) a composite index that includes as child labourers children performing economic activity (excluding light work) and children performing household chores for more than 28 hours a week (Guarcello, Lyon & Rosati: 2004: 6).
siblings. Of these, 26% never see each other at all and 20% see each other only once a year (USAID/SCOPE/FHI 2002). Such separation has implications for the well-being of children and for their systems of support (Gillespie, Norman & Finley 2005). There are also variations in fostering patterns between urban and rural areas. The Child Labour Survey of 1999 conducted in Zambia showed that orphan prevalence rates were slightly higher in urban than in rural areas, for all three types of orphan categories (CSO 1999).

Living arrangements play a critical role in the well-being of OVCs. Research has shown that across 28 sub-Saharan African countries, the degree of relatedness between orphans and caregivers is highly predictive of children’s developmental outcomes (Case, Hosegood & Lund 2003). These researchers also showed that most single orphans live with the surviving parent. A broader analysis covering 28 countries found that paternal orphans in most of East Africa were much more likely to live with their mother compared to those in West Africa (Ainsworth & Filmer 2002). Furthermore, across the whole sample of country very few orphans who lose their mother remain with their father (ibid.).

Research has shown that in Zambia specifically, only 40% of maternal orphans live with their fathers (Case, Hosegood & Lund 2003). In a different study conducted in Zambia, results revealed that among maternal orphans, 63% do not live with their surviving father, while 32% of paternal orphans do not live with their surviving mother (UNAIDS/USAID/SIDA 1999). Furthermore, across the Southern African region double orphans are much more likely than other children to be living in households headed by a grandparent (Bicego, Rutstein & Johnson 2003). According to DHS data for Zambia covering 2001/2, 33% of all orphans at that time lived in households headed by a grandparent (ORC Macro 2003a).

Over the last decade, there has been growing concern that the increasing number of HIV-related orphans is beginning to overwhelm the traditionally strong extended family structures in highly affected communities and countries (Foster 2002). The cumulative impact of the orphan crisis can be seen in the increasing proportion of households that foster orphans. In 1992, 12% of all households in Zambia contained one or more orphaned children (0 to 14 years), but in 1996 this figure had risen to 18%, and the 2001/2 DHS survey estimated that 21% of all households at the time contained orphans (CSO 2003). According to the 2007/8 DHS, this figure had risen further still, with 24.9% of all households fostering one or more orphans (ORC Macro 2009).

These figures indicate that the proportion of households with orphans in Zambia has increased and that more and more of these households are headed by women (mothers and grandmothers). From the various household surveys conducted in the country in the last decade, it is clear that households with orphans tend to have older household heads than those without orphans. The role of the
older generations, and developments relating to ageing and HIV, are discussed below.

Growing old in HIV affected families

In the following sections, background information on ageing in Africa and the role of grandparents and other older caregivers is provided.

Ageing worldwide and in sub-Saharan Africa

There are notable trends in terms of ageing across the world. For one, the ageing of populations in industrialised countries has occurred to a greater extent than in developing nations. In the Western world, the average age has risen steadily over the last decade. This can be seen in part as a consequence of the baby boom that occurred after World War II (Anderson & Hussey 2000). Two other demographic trends have occurred that have contributed to increases in the average age. The first is that fertility rates have declined sharply, and some countries even have sub-replacement fertility. The second is that average life expectancy at birth has continued to rise. This has led to a situation where, according to the UN, for most OECD member states fertility rates will remain below the replacement rate until at least 2020 (UNDESA 2011).

In another notable trend, the number of people aged 50 years and older worldwide is expected to triple between 2010 and 2050 (UNDESA 2011). The fastest growth within the proportion of people aged 60 years and over is expected to occur in countries in sub-Saharan Africa. Indeed, the situation in Africa and sub-Saharan Africa specifically mirrors global trends. In 1980, 3.1% of Africans were aged 65 years and over, in 2010 this had increased to 3.5% (ibid.).

This change is part of a continuing demographic transition that is being driven by several factors. The first is increasing life expectancy, especially among those people who have already passed their sexually active age. In Africa, life expectancy has been increasing steadily every year, and rose from 53 years in 1990 to 56 years in 2010 (UNDESA 2011). This trend, however, is limited by the declining life expectancy at birth in countries heavily affected by HIV, most of which are located in Southern Africa. In the countries hardest hit by the epidemic, life expectancy at birth has decreased over the past three decades. This is not because older people are dying earlier (they are in fact growing older), but because the mortality rate among young adults has increased. A second factor is the sharp decline in the fertility rate across the continent. In 1990, the total fertility rate

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4 Sub-replacement fertility is a total fertility rate (TFR) that leads to each new generation being less populous than the previous one in a given area. In 2003, the TFR required to sustain the global population was 2.3 (Espenshade, Guzman & Westoff 2003).
(TFR), or the expected births per woman in her child bearing years, in Africa was 5.3. This dropped to 4.4 in 2010 (AfDB 2011). The third factor is the HIV epidemic. As AIDS-related deaths have increased, the proportion of the adult population in highly affected countries has accordingly decreased substantially.

Generally speaking, ageing comes with increasing feminisation of the older age categories. While the male to female ratio can be expected to be equal for most other age categories, it becomes skewed for age groups above 64 years. Across Africa today, there are 25% more women aged 64 years and over than there are men (AfDB 2011). This skewed distribution is caused by women outliving men, but given the rates of high maternal mortality and poor access to health care for women, especially in sub-Saharan Africa, this distribution could be more skewed. As deliveries become safer, and women’s access to health care continues to improve, even more women will outlive men in the years to come.

Why should policymakers be concerned about the trends of ageing across Africa? Ageing is correlated with the reduction of physical and mental health and well-being, the remedy of which requires substantial inputs of time and money from families, communities, and governments. Few African countries have formal social security programmes, and social protection programmes have very low coverage. This means that very little support is currently being provided to the elderly, and in order to meet their needs substantial investments are required. Despite this, ageing populations have been ignored in policy dialogues and documents. This is strange given that the elderly and elderly-headed households are among the poorest. The traditional structures that guaranteed that both children and the aged are cared for have eroded in many places. HIV-related morbidity and mortality, increasing individualism, and migration have all contributed to the declining support for the older generation, and have led to a situation where older people are increasingly forced to care for their grandchildren.

**Children with older caregivers**

The HIV epidemic has been, and is, cutting away the middle generation in many sub-Saharan African communities. The middle generation is vital to the organisation of social life and for the care and support of children and the elderly. Grandparents and other older people are often the primary caregivers for OVCs, and given the feminisation of old age it is increasingly grandmothers who assume these caring roles. According to UNICEF, between 40% and 60% of all OVCs in sub-Saharan Africa are cared for by their grandmothers (UNICEF 2012).

In African countries, elderly women are probably the most vulnerable group within society. Poor education, limited access to work, and patrilineal inheritance practices mean that many older women are forced to work up to an old age (UNICEF 2007). The deaths of their husbands add to their poverty and their
dependency on subsistence farming and other forms of informal employment. Many old people have to sell all of their lifetime’s accumulated assets in order to pay for the care of their sick children and the funeral costs of deceased relatives.

**Figure 1.2** The increasing importance of grandparents: Relationships of double orphans and single orphans (not living with surviving parent) to the head of the household, Namibia, 1992 and 2000

It is not traditionally uncommon for grandchildren to live with their grandparents, but HIV has changed traditional patterns of household formation. The lack of support from, or the absence of, children’s parents, the numbers of children living in a single household, and the lack of alternatives are all indicators that the fostering seen today is characteristic of crisis-fostering. In many communities, grandparents have emerged as the ‘new’ parents (Martin & Wiesner 2010), but there are variations between countries. DHS data collected in 2003 in Kenya showed that 40% of all OVCs lived with their grandparents (ORC Macro 2003a). In Tanzania and Zimbabwe, close to 60% of all orphans were reported to be living with their grandparents in 2007 (UNICEF 2007). Figure 1.3 shows how fostering by grandparents changed in Namibia between 1992 and 2000. Not only has the size of the group of orphans increased (this is indicated by the relative size of the two pie charts), but the percentage of children who are the grandchil-
Children of the heads of households has also increased from 44% in 1992 to 61% in 2000 (UNAIDS 2004).

Increasingly, the middle generation within families has either migrated away or disappeared, leaving only the young and the old, the latter of whom are mostly women. Those left behind constitute two dependent generations (the old and the young), who lack the middle generation who would traditionally have performed the caring role. These households are referred to as skipped-generation households. Our understanding of the dynamics and caring structures in such households is limited, as is described in the following section.

**Moving forward together: Skipped-generation households**

A generally accepted definition of a skipped-generation household (or skip-generation household, as they are sometimes called) is one “where an older person, often a grandparent, becomes the primary caretaker for a child who has lost one or both parents, or whose parents are absent for a long period of time” (Samuels and Wells 2009: 1). There is very little published work on skipped-generation households. Some authors have mentioned such households in their studies (Chazan 2008; Samuels & Wells 2009; Evans & Day 2011; Woods 2012) and have commented that their prevalence is likely to increase as the HIV epidemic matures (Jesmin, Amin & Ingman 2011; Zhageni 2011). For children, living with elderly caregivers in skipped-generation households has been associated with numerous negative consequences, including lower nutritional status, lower material well-being, a higher risk of dropping out of school, and higher demands for labour (Schatz et al. 2012). For the older caregivers, the consequences are not positive either, as caring for orphaned children has been related to depression, destitution, and lower well-being in general (McKinnon & Harper 2011; Ice et al. 2012).

Even as this thesis goes to press, a brief literature study revealed that still very little has been published specifically about skipped-generation households. Most of what is available about such households pertains to contexts that are very different from the setting of this research, as they predominantly focus on Hispanic and African-American families in North America (Goodman 2012; Luo et al. 2012; Shakya et al. 2012). Other available texts are found among the grey literature (UNDESA 2004; UNDESA 2005; Albone & Cain 2008; Samuels & Wells 2009). There is, in addition, some work that touches upon the topic of skipped-generation households but does not focus on them specifically. There are very few, if any, publications that focus explicitly on skipped-generation households in communities affected by HIV and AIDS in sub-Saharan Africa.
Research questions

The research aim, which is stated in the second section of this chapter, was used to formulate the following central research question guiding the study:

How do members of the older and younger generations, who live in skipped-generation households in rural Zambia, care for each other, and how does their interdependence and well-being change over time?

The demographic and social trends highlighted in this chapter suggest that members of both the older and the younger generations face multiple vulnerability risks as a result of HIV and AIDS-related illness and death among the people around them. The deaths of parents and other middle-aged caregivers have orphaned large numbers of children and have left many older people without support. Children who can no longer live with their parents are increasingly found to live with their grandparents, or with other older relatives, in households without a middle generation. In light of this situation, the following sub-questions were formulated:

1. Where do OVCs live and what proportion of OVCs and other children live in skipped-generation households?
2. How does the situation of children living in skipped-generation households compare to the situation of other children?
3. What are the attitudes and caring strategies of the older generation towards the younger generation?
4. What are the attitudes and caring strategies of the younger generation towards the older generation?
5. What are impacts on the well-being and development of the younger generation living in skipped-generation households?
6. What are the recommendations, based on this research, to strengthen the resilience of the younger and the older generations living together in skipped-generation households?

The first sub-question of this study aims to reveal more about the living arrangements of OVCs, and in particular provide insight into the extent to which OVCs live in skipped-generation households, in Misangwa, Zambia. The data collected aims to show the distribution of children and young people in the community of Misangwa, and the proportion of these, OVCs specifically, that live in skipped-generation households. Answering this question will also enable an examination of whether or not evidence exists to support claims that there is a
trend towards a feminisation of the impacts of HIV and of caring patterns in the community studied.

This introductory chapter has also shown that the old are especially at risk of living in extreme poverty. The poverty of older people and of skipped-generation households has a direct influence on the well-being of children. Therefore, the second sub-question aims to compare the situation of children in skipped-generation households to that of children in other types of households. This comparison takes shape mostly in terms of socio-economic well-being, the broad definition of which, as adopted in this study, relates to many characteristics including education, nutrition, housing quality and parenting.

To understand the development and well-being of OVCs, we can consider many factors. One of the most important determinants of the development of children is the role of guardians. What responsibilities do guardians hold, and what attitudes and coping strategies do those people who act as guardians hold towards these responsibilities? This is captured in the third sub-question, which seeks to provide insight into the roles and responsibilities of the older generation who are increasingly acting as guardians for the younger generation. In this chapter, it has been explained how growing old in times of HIV has impacted people extensively, in both material and psychological terms. This question aims to unravel how much the impacts of HIV affect older age guardians. This requires both a subjective understanding of these people’s self-ascribed roles, as well as an objective assessment of what they are able and willing to do for the children in their care.

While the third sub-question above covers one aspect of cohabitation in skipped-generation households – the attitudes and caring strategies of the older generation towards the younger generation – the fourth sub-question aims to examine the question from the reverse perspective: namely the attitudes, roles, and coping strategies of the younger generation towards the older people they live with. The changing and volatile realities of children affected by HIV have been described in this chapter, as has their self-professed preference to live with their grandparents. How do their past experiences and their expectations of living with their grandparents affect the way they feel about growing up in skipped-generation households? What are their attitudes toward their older guardians? Part of this assessment is to see whether their expectations have been met and how they deal with their present day situation and the needs and expectations of their older guardians.

This chapter has shown that in Zambia, the well-being of both the older and the younger generation is under stress as a result of numerous factors, many of which are related to the impacts of more than three decades of HIV. The fifth formulated sub-question thus seeks to find out how the development and well-
being of children are influenced (both positively and negatively) by living in skipped-generation households. It aims to do this by unravelling how the changes in rural Zambia at the levels of the community, the family, and the household, including the impact of HIV, influence the well-being and development of children growing up in such households. Is the context one that causes dysfunctional behaviour or does it help children to excel and deviate from the negative expectations that some people hold for them given the background and context of their development? This analysis includes examination of what it means to live with older guardians as well as other OVCs in skipped-generation households.

The trends and changes illustrated in this chapter are unlikely to end any time soon. At the same time, today’s older generation is ageing and the next older generation (the middle generation of today) has been diluted in many families, while in some families it has disappeared altogether. This means that the problematic situation in many families and skipped-generation households is not likely to improve over the coming years. The sixth and final sub-question of this study is meant to provide, based directly on the findings of this study, recommendations to strengthen the resilience and well-being of those living in skipped-generation households, now and in the future.