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Rescuers In Distress: How Well Can Grandparent Caregivers To AIDS Orphans Cope And Recover From The Multidimensional Disaster?

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Abstract: **This paper is based on a study whose aim was to assess the resilience of the livelihoods of elderly caregivers to AIDS orphaned children, and the consequent ability (or lack of) to recover from the effects of the AIDS disaster on their households. The study was done in Garissa County of Kenya. The concept of livelihoods and the main elements that comprise it are presented and discussed in relation to how each is important in building resilience in caregivers to AIDS orphaned children, guided by the UNISDR model. The study design was cross sectional, employing both quantitative and qualitative tools and techniques in data collection. Descriptive statistics were used to provide answer the research question. It was found that the caregivers' livelihoods had been made vulnerable by the impact of the AIDS disaster on their individual households, and as a result, recovery was very slow or nonexistent in some cases. This implies that concerted mitigation efforts must be effected in order to prevent the households from plunging into destitution.**

Keywords: **AIDS Elderly Caregivers Orphans Livelihoods Resilience Recovery Mitigation.**

I. INTRODUCTION

One of the hardest hitting disasters to visit upon the human race in recent times is that of the Human Immuno-Deficiency Virus (HIV) that causes the Acquired Immune Deficiency Syndrome (AIDS), a condition that has, arguably, been the greatest killer of humanity across the globe in the last 3 decades. A cure is yet to be found, and meanwhile, scores of children in sub Saharan Africa have been (and are still being) left orphaned in its wake. Many of these children are in the care of their grandparents, a generation of elderly that are vulnerable in their own right. The purpose of this study was to examine the livelihoods status of the elderly caregivers in Garissa County of Kenya, and analyze their ability to cope with the effects of the AIDS disaster. The study is significant in that it addresses one of the top priorities of the former Hyogo Framework for Action, (now replaced by the SENDAI Framework), which is the reduction of underlying risk factors that contribute to disasters happening, namely, a high vulnerability level among people. This research work was informed by UNISDR 's model that draws a link between livelihoods and the ability to recover from a disaster. In the model, where livelihoods are vulnerable, people tend to be unprepared for hazards and disruptions such as the AIDS disaster, and consequently take a very long time to recover, or are plunged into destitution. However, where livelihoods are secure, the people are more prepared to absorb the disruption to their normal functioning, and are therefore able to cope or recover quickly.

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Figure 1: Links between status of livelihoods and ability to recover from disaster. Source: UNISDR (2005) [1]

The concepts of recovery and resilience are related in that one affects the other; the more the resilience, the faster the recovery in the event of a disaster.

The Concept of Resilience

According to contemporary literature, (Klein *et al.*, 2003;[2] Paton & Johnston, 2006[3]), the term resilience derives the notion of "bouncing back" from its Latin root *"resiliere"* which means "to jump back". Resilience is an important feature in the Hyogo Framework for Action 2005-2015 in the form the goal of 'Building the resilience of nations and communities to disasters'. This of necessity precludes building the resilience of the individuals that make up these communities and nations. As Davies (1996)[4] puts it, resilience in the face of stresses and shocks is key to both livelihood adaptation and coping, and those who are unable to cope (temporary adjustments in the face of change) or adapt (longer term shifts in livelihood strategies) are inevitably vulnerable and unlikely to achieve sustainable livelihoods. Practical Action (2008)[5] maintain that the indicators of vulnerable people or livelihoods are identified as being a low level of assets (or capital) on which to base their livelihood strategies, and that the vulnerability is because they have little to fall back on if any shock suddenly reduces one or more of these assets still further. The ability to adapt to changed circumstances and adopt different livelihood strategies is limited. On his part, Mayunga (2007)[6] points out that the main goal of hazard planning and disaster risk reduction has slightly shifted to focusing more on building community resilience rather than only reducing vulnerability. The scholar refers to this as the 'resilience-based' approach that looks to enhancing capital of individuals to make them more prepared to deal with disaster in the event that it occurs. This approach lent itself well to the position of this research which maintained that livelihoods that are strong (or resilient) in their individual capital elements will translate to quicker recovery of the household and individuals affected by the AIDS disaster, and in particular the elderly caregiver to orphans. Hence, secure livelihoods can also be described as resilient livelihoods.

The Concept of Recovery

Nigg (1995)[7] asserts that, in all societies, the family is the basic unit of social organization, and that, the majority of the research conducted on disaster recovery has focused on the family, seeking to know the types of families that are most disrupted and those that are likely to recover most quickly. From the literature that Nigg (1995) had studied, it was apparent that family recovery was the outcome of a sequence of activities in which families utilize resources to overcome disaster-induced losses, in a bid to return to some desired or acceptable pre-disaster condition. It has been observed that families not only use their own resources but may also seek assistance from their extended kin group as well as from extra-familial sources, such as governmental programs and non-profit organizations. In this regard, recovery is dependent on capital resources available to the affected family unit. Nigg (1995) maintains that poorer families are not only more vulnerable to disaster-induced losses but also have more difficulty recovering. Nigg (ibid.) argues that despite the fact that poor families often have the greatest needs following a disaster, they have the most trouble acquiring extra-familial aid, and that the social relationships and conditions that exist prior to any disaster will be carried forward into the relief and recovery periods. Hence, those individuals without financial resources, especially those with compound problems such as the poor elderly; will find it even more difficult to meet daily needs.

Similarly, findings by Practical Action (2008) indicate that there is a close connection between poverty and vulnerability,

in that vulnerable people live in circumstances where they are liable to, or live in fear of, a sudden, traumatic loss of their means of livelihoods and of their social or physical environment that they are powerless to prevent. Vulnerable people lack the resilience to cope with and recover from such shocks. The resulting loss is enough to push them into a crisis situation where they are unable to continue with their old means of livelihoods. Practical Action (2008) also asserts that poor people have a low level of assets (physical, social and economic) on which to base their livelihood strategies. They are usually the most vulnerable because they have little to fall back on if any shock suddenly reduces one or more of these assets still further. Their ability to adapt to changed circumstances and adopt different livelihood strategies is limited.

Maharaj (2010)[8] in finding that many older men and women were struggling to meet the demands placed on them and therefore faced huge risks to their own health and economic well-being as a result of their care giving activities, went on to conclude that the burden of providing care in the midst of high levels of poverty becomes too great for many of them who report physical exhaustion and despair at their situation. On their part, Nyabedha *et al*, (2003)[9] found cases where the older persons, upon realizing that they cannot help the orphans meet their costs of medication, are overwhelmed by concern and stress. Makiwane, Schneider and Gopane, (2004)[10] , in their work on the experiences and needs of older persons in Mpumalanga assert that, there is growing evidence of AIDS- induced multiple crises faced by households being headed by the elderly in Africa, implying they are unable to cope with playing the traditional role of absorbing orphans. Schatz and Ogunmefun (2007)[11], HelpAge International (2003) [12], Ssengonzi (2007)[13] , Foud (2004)[14] , and May (2003 [15] all maintain that the care-giving role of the elderly is such that it overwhelms their livelihood, forcing them to contend with various demands in terms of coping with increased health care costs, and meeting the transport and medical costs of ailing children, and paying school fees for orphaned grandchildren. They argue that the elderly caregivers also have to meet the needs of grandchildren who may be HIV positive, and that, as earlier seen, AVERT (2009)[16] and Cohen (1998) [17] contend that elderly-headed families cannot cope with the increasing number of orphans created by the disease. Ssenengozi (2009), HelpAge International (2008), and Schatz (2007) argue that elderly caregivers have increased social responsibility which results in their social isolation, because the elderly cannot afford the time or money to take part in social activities . Alpaslan and Mabutho (2005)[18] further assert that another reason for reducing participation in social activities is fear of stigmatization. The difficulty experienced by elderly caregivers in coping with the responsibility sometimes manifests in orphans being unwilling to accept authority. Another indication of the inability to recover from the disaster is the effect it has on the social life of the caregiver; previous interactions are cut short due to the burden of care, and the stigma associated with AIDS. HelpAge (2003) posit that both children and older people need interaction and acceptance from their local community and peers, yet many older people find themselves so busy with the efforts to provide for their families that they lose touch with their peers and have no one with whom to discuss the difficulties they are facing. Ssengonzi (2007), researching on the plight of older persons as caregivers to people infected/affected by HIV/AIDS, found that the health of older care-givers has deteriorated as a result of the physical and emotional stress of assisting their children. On her part, Ogunmefun, (2009)[19] points to the overall negative impact of HIV/AIDS on elderly caregivers being a deterioration of mental health through stigma, isolation and not knowing how to handle grieving and traumatized orphans. The scholar argues that, in certain instances the elderly reduce participation in social activities, since they fear negative community reactions towards the HIV-positive grandchildren in their foster care. Oburu and Palmrus (2003)[20] maintain that this is compounded by concerns over grieving children who must also cope with the community stigma attached to and often irrational fear surrounding AIDS. In general, worsening psychological health of the elderly has also been reported. Hence, another clear indication of the inability to recover from the disaster is the effect it has on the social life of the caregiver; previous interactions are cut short due to the burden of care, and the stigma associated with AIDS. HelpAge (2003) argue that both children and older people need interaction and acceptance from their local community and peers, yet many older people find themselves so busy with the efforts to provide for their families that they lose touch with their peers and have no one with whom to discuss the difficulties they are facing. Given the foregoing literature, it is evident that recovering from the disaster for households headed by elderly caregivers may be difficult, slow and may sometimes never happen without significant intervention. The literature was useful for the study in that it provided some of the key indicators for measuring the outcome variables, besides revealing a clear gap that needed to be filled.

II. METHODOLOGY

The study adopted a descriptive cross sectional survey design. The study population included the elderly caregivers to the orphans, the County Directors of Health, Education, and Planning respectively; Religious Leaders, Community leaders,

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and the orphans themselves. Non probabilistic sampling techniques was employed in stages, beginning with purposive selection of the study clusters based on the accessibility of the largest population possessing the characteristics of interest; (Garissa Township and Dadaab sub Counties); followed by proportional quota sampling to determine the number of households selected from each cluster, based on their estimated percentage occurrence in the study population, and then a combination of snowballing and a randomizing technique to identify households in each area until the quota was fulfilled. A total of 267 households were surveyed, during which both quantitative and qualitative data were collected using a pre-coded and pre tested structured questionnaire, and qualitative tools.

III. RESULTS

Resilience of Human Capital of Elderly Caregivers

The resilience of the human capital in this study was measured by the ability of the elderly caregiver's health to revert to the stable condition it was in before the AIDS disaster struck the household. The physical and mental health of the elderly caregivers before and after the orphans joined the household was assessed to see if the orphan care had resulted in significant changes for the worse. From the findings displayed in Figure.1, it appears that the health of 86 elderly caregivers (32%) was made worse by the physical and mental strain of caring for orphans whose parents had died of AIDS. In the opinion of the author, this figure may actually be higher, but because of the religious belief in this community that it is desirable and one's duty to care for orphans, it may be that some of the respondents shied away from revealing that the orphan care is, indeed a burden to them.

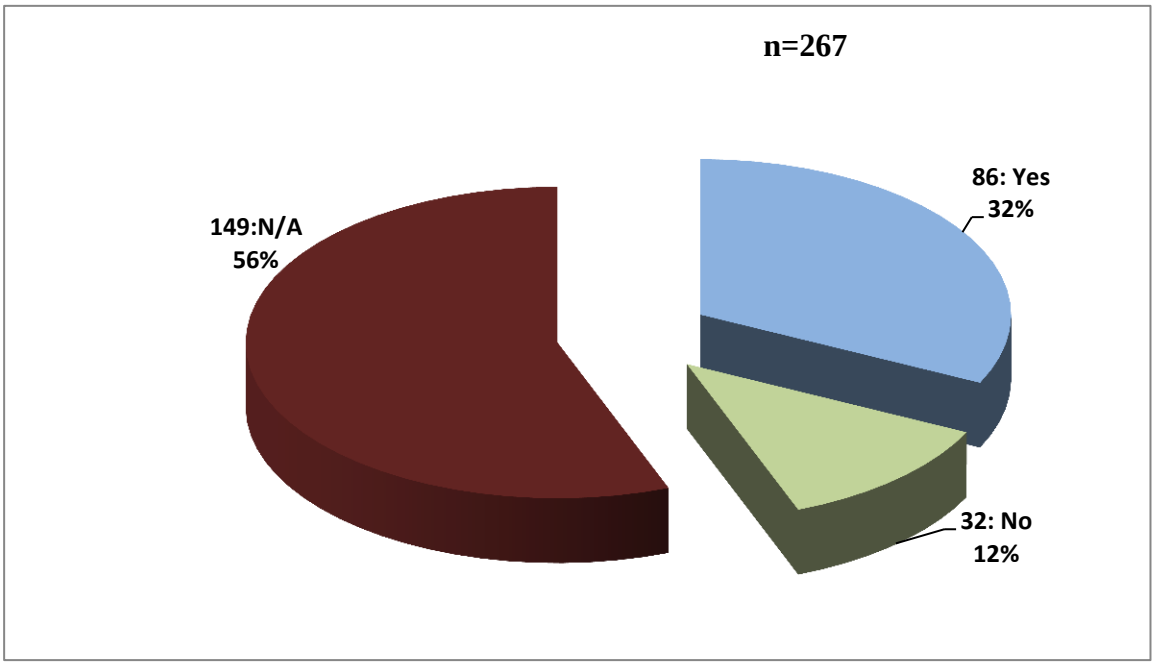

Figure I: Effect of Orphan care on Elderly Caregiver's Mental Health in Garissa County of Kenya

Key Informants concurred with this. One of them stated the following;

"The elderly caregivers looking after orphans are burdened but don't complain alot. They try to meet the needs of the children so they are like others. They are old so they strain. That is why we have the OVCCT program. It helps them somehow" Mr. Rotich, Deputy County Children's Officer

The finding on the human capital's inability to recover is similar to that of HelpAge (2007) when they revealed that, as carers, older people may be physically and emotionally exhausted, lacking time and energy to do anything other than care for their orphaned grandchildren, and that prolonged or frequent illness leads to the older person being unable to work which translates to lack of income that impedes access to health services, aggravating the situation; families sell their assets, borrow money and fall further into poverty. This sums up the situation how the exhaustion of the human capital leads to an erosion of economic capital, and a consequent inability to recover from the effects of the AIDS disaster.

Resilience of the Social Capital of Elderly Caregivers

In this study, the resilience of the social capital was assessed through the elderly caregiver's ability to undertake social activities and enjoy positive socialization as before the disaster. The study sought to measure the ability and opportunity of the elderly caregiver to socialize as before they took on the orphan care giving responsibilities. A total of 175 (66%) of the elderly caregivers admitted that they missed their peers, as they hardly got to see them and more than one third (38%) went on to confess that they saw their peers more often before the orphans came joined their households. For 67 of respondents in the study (25%), the main reason they were not able to attend social events was because they were too busy. It could also be due to fear of being discriminated against, due to the high levels of stigma discussed in earlier chapters of this work. Again, as earlier seen, the HIV/AIDS epidemic not only impacts on people financially but also socially. One major way in which the disease impacts on people socially is through the experience of stigma. Alpaslan and Mabutho (2005) do indeed point out that one reason for reducing participation in social activities is fear of stigmatization. According to Goffman's (1963)[21] classic work, the term stigma denotes an attribute possessed by an individual that not only discredits but also differentiates him or her from others in the society. Thus, an individual with HIV/AIDS can be regarded as someone with a spoiled identity, differentiating him or her from others in the community (Goffman, 1963). As documented in many studies, stigma has been associated with HIV/AIDS since the emergence of the disease (Alonzo and Reynolds, 1995[22]; Green, 1995[23]; Muyinda *et al*., 1997[24]; UNAIDS, 2000[25]; Parker and Aggleton, 2002[26] ; Madru, 2003[27]; Posel, 2004[28] ; Patel and Carter, 2004[29]; Duffy, 2005[30]; Ogden and Nyblade, 2005[31]). In most cases, stigma is targeted at the people infected with HIV/AIDS. Secondary stigma, also known as courtesy stigma, is another level of HIV/AIDS related stigma that is targeted at those who are in close proximity to people infected with HIV/AIDS, that is, people who are caregivers or family members who reside with those who are infected (Patel and Carter, 2004). For another 21 respondents, the reason given for not attending social functions was the prohibitive distance to the social event. The distance carries cost of transport implications. Hence, although not explicitly mentioned here, as literature indicates, the cost of socialization may be beyond what the caregivers can afford; Ssenengozi (2007), HelpAge International (2008), and Schatz (2007)[32] argue that the elderly caregivers have increased social responsibility which results in their social isolation, because the elderly cannot afford the time or money to take part in social activities. In the opinion of this author, the respondents in the study may be, as is asserted in literature regarding elderly caregivers, too physically and emotionally exhausted to engage actively in social activities; elderly caregivers usually lack time and energy to do anything other than care for their orphaned grandchildren. A Chi Square test conducted on the data showed that there was a highly significant ($P<0.01$) variation in the distribution of ability to attend social events like weddings among elderly caregiver household heads $(\chi^2_{1,0.01} = 11.33)$.

The Deputy County Children's Officer summarized it as follows;

"The social life is predominantly controlled by the Islamic religion. There are no leisure activities as such. What brings them together is weddings or religious celebrations like IDD. Orphans affect the social life of their grandparent caregivers because they use all their time focusing on them." Key Inforant,

The study underscores how social resilience is critical in the recovery process, and agrees with Ogunmefun (2008) who maintains that, although the concept of social capital is sometimes not directly mentioned, studies have shown how individuals and households rely on assistance from their kin and friends in times of crises such as illness and death. She goes on to cite such studies as being those of FAO (2003); UNDP (2005); Wood, Chase and Aggleton (2006); Thomas,(2006); and Gerdner, Tripp-Reimer and Simpson (2007), and emphasizes Muriisa's (2006) position that social capital can help to alleviate the impact of HIV/AIDS on affected people by relieving some of the financial expenses related to care giving through assistance from their kin, friends, and members of their community.

Resilience of Economic Capital of Elderly Caregivers

The ability to meet the basic needs of the household as before, and the restoration of previously sold off assets are the variables being used in this study to measure the economic resilience of the elderly caregiver's household in Garissa County of Kenya. The study measured the relative ability of the elderly caregiver to meet the basic needs of the household before the disaster as compared to after the AIDS event. It also measured the ability of the caregiver to replace assets that had previously been sold off to meet the economic need of the disaster. From the findings, 96 elderly caregivers (36%)

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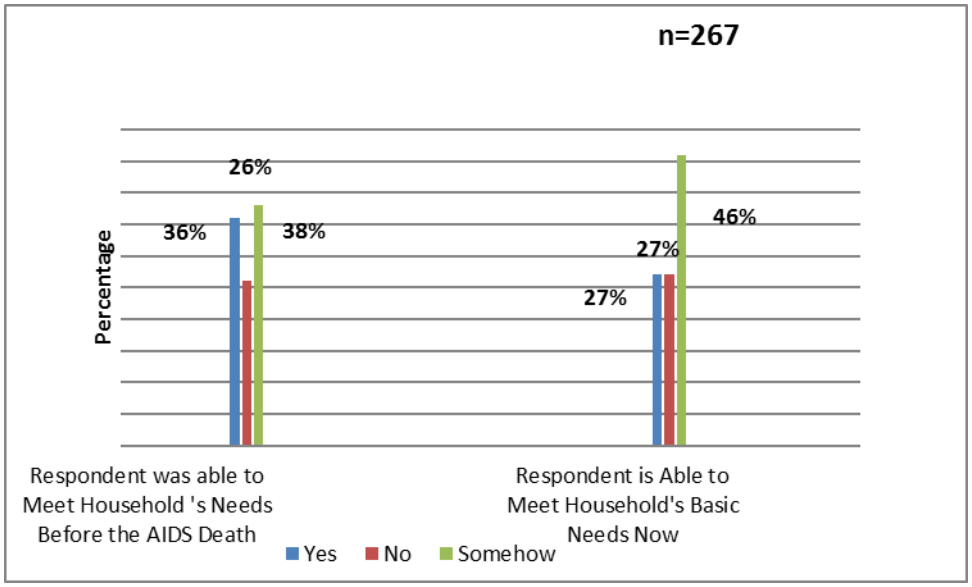
were able to meet the needs of the family before the death, as opposed to the reduced number of 72 who were able to do so after, representing 27% of respondents.



Source: Field Data, 2013

Figure IV: Relative Ability of Elderly Caregivers of Garissa County in Kenya to Meet Needs of Household

When asked about their economic status prior to the AIDS event, 224 of the respondents (84%) claimed that they had not been poor before the orphans joined the household. A Chi Square test conducted on the data showed that there was a significant (P<0.05) variation in the distribution of ability to meet household's needs before son/daughter died leaving orphans among elderly caregiver household heads $(\chi^2_{2,0.05} = 6.36)$.

In fact, 94 of the elderly caregivers, went on to assert that the AIDS death and the orphans are the reason they were worse off. Another factor that indicated that perhaps the households were not really recovering from the disaster was their relative inability to replace Of those that had sold off assets to offset the economic effects of the disaster 110 (41%) confessed they had not been able to recover the assets, while 40 (15%) claimed they were trying to do so, but very slowly. Only 24 (9%) of those that had sold the assets had been able to replace them. The study went a step further to confirm that for the majority (46%), the reason the elderly caregiver no longer had the previously-owned assets was because of the orphans joining the household. A Chi Square test conducted on the data showed that there was a highly significant (P<0.01) variation in the distribution of ability to replace sold off assets among elderly caregiver household heads $(\chi^2_{3,0.01} = 76.48)$. The orphans also pointed out that the help their grandparent caregivers most need is financial and medical support. The conclusion arrived at concerning the inability of the elderly caregiver to recover economically from the effects of AIDS, thereby demonstrating a low resilience in their economic capital is similar to that which appears in a lot of the literature on this subject. Ogunmefun (2008) maintains that a number of studies (Knodel, Watkins and Vanlandingham, 2002 [33]; WHO, 2002a [34]; Lindsey *et al*., 2003[35]) have shown that HIV/AIDS has a great impact on the economic well-being of elderly people, and their households. The overall findings on the resilience of the elderly caregivers' livelihoods supports the point of Mayunga (2007) about the main goal of hazard planning and disaster risk reduction being to build resilience rather than only reducing vulnerability. Mayunga's 'resilience-based' approach that looks to enhance capital of individuals to make them more prepared to deal with disaster in the event that it occurs is what is required to prevent more households falling into destitution; there is need to intervene, not only in the households headed by the elderly caregivers to orphans, but also in households with AIDS sufferers where the children are likely to be left with elderly persons. The intervention should target the strengthening of resilience. In this way, the path to recovery is made easier. Respondents in the study were asked directly about the ease with which they had been able to recover from the AIDS disaster's impact on their households. A large majority of 187 caregivers (representing 70% of the sample) confessed that they were still trying to recover, but that the process was proceeding quite slowly. Seven percent

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flatly stated that they didn't believe they would ever recover, and that life was actually getting harder. (Figure 8). Only 61 elderly caregivers (23% of the study sample) claimed that they were recovering quite well and quickly.

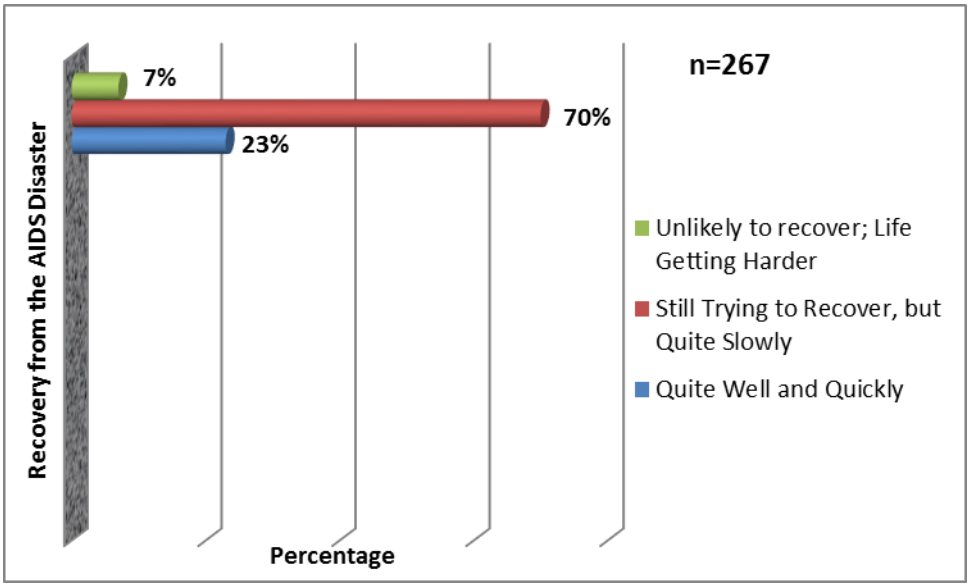

Figure VIII: Ease with Which Elderly Caregivers Recover From the AIDS Disaster in Garissa County of Kenya

Key Informants and Focus Group Discussants were also in agreement that the elderly caregiver households were having difficulty recovering from the AIDS disaster visited upon them. Some of them summarised their opinion as follows;

"My thinking is that they are not recovering very well because the grandparents are not able to support their households without external funding or support. The households are very vulnerable; the children in the custody of these grandparents lack basic needs like education and health. It is sometimes necessary for the community to support the household with food. But it is usually not enough because the community is also poor. So the household affected by HIV and AIDS experiences a lot of difficulties." Deputy County Director of Planning

In agreement with the assertions in literature (Practical Action, 2008), which claim that vulnerable people lack the resilience to cope with and recover from extreme shocks like the AIDS disaster, this study has found that the elderly caregivers in Garissa County are deficient in their ability to cope with and recover from the AIDS disaster, as discussed in the status of their human, social, and economic capital. As Davies (1996) also asserts, the inability to cope becomes a sign of vulnerability in itself. Indeed many works in literature, (Maharaj, 2010; Nyabedha *et al*, 2003;Makiwane *et al*, 2004; Schatz and Ogunmefun,2007); HelpAge International, 2003;, Ssengonzi, 2007; Foud, 2004; and May,2003) one way or another, concur with what this study has established that the weakened livelihoods resilience leads to an inability to recover from the effects of the AIDS disaster; that elderly-headed families cannot cope with the increasing number of orphans created by the disease, and therefore their ability to recover back to a stable condition is severely hampered.

IV. CONCLUSION AND RECOMMENDATIONS

This paper presented and discussed the findings of research work done to evaluate the ability of the elderly caregiver household heads to cope with the AIDS disaster in Garissa County of Kenya. The indicators of coping for this study were identified as the physical and mental health being as good as before; the ability and opportunity to undertake social activities as before, and the ability to meet basic needs of the household as before. The effects of confounding factors by way of other disasters that may have occurred to affect the livelihood of the household were also examined. It can be concluded that, as a result of the overall weakened state of the livelihoods of the elderly caregivers, coping with the AIDS disaster's impact on their household is difficult, slow, and in some cases, not happening at all. Consequently, this impedes the recovery process, and some households have despaired of ever recovering from the effects of the disaster. It is recommended that a minimum package of interventions, constituting an age-appropriate a mitigation model be designed and put in place to help speed up the livelihoods recovery of the AIDS affected households headed by elderly caregivers.

This should be a package that can be readily domesticated and adopted by other countries in sub-Sahara Africa and beyond, which have borne the brunt of this socio-biological disaster.

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