Perceptions of community leaders about normative understandings of good family care of older people in rural and urban Zambia

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Drawing on qualitative interviews and focus groups with 35 community leaders, this article investigates how community leaders understand norms of care for older people in Zambia. I ask what leads older people in Zambia to receive good care from family. The findings show that across both rural and urban settings, respondents related profoundly powerful norms of reciprocity in both family and community care, with older people viewed as reaping what they have sown in terms of religious and economic contributions throughout their lives. The study raises challenging questions from a rights-based perspective as to who is deserving of care.

Key words family care • older persons • Zambia • family norms

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Introduction

This article investigates how community leaders in rural and urban Zambia understand norms of care in later life. The data presented were collected as part of a wider study exploring elder abuse in Zambia and the role that communities and community leaders play in supporting older people who have been neglected or abused. The article addresses the question: ‘How do Zambian community leaders in positions to formulate norms and to shape understanding in their communities (in both rural and urban contexts) understand what leads to an older person in need receiving good care from their family?’ For the purposes of this study, we understand normative good care to refer to value attachments regarding a willingness to take care of older persons, such that they can grow old in a family setting without mistreatment, with their well-being supported in the later years of their life.

Research gaps exist in global scientific knowledge about normative understandings of good family care of older people in rural and urban Zambia, and indeed across the African continent (Republic of Zambia, 2014; SCAZ, 2013; WHO, 2015; Kabelenga, 2018). Studies have addressed family care of older adults with chronic life-limiting
illnesses, how cultural obligations are contingent on the availability of people and resources, and the role of the church in supporting carers (Lambart et al, 2017; Schatz and Seeley, 2015; Mthembu et al, 2016; Kiisi et al, 2020), but they have not closely investigated the role of family norms in the provision of care.

Where normative prescriptions have been investigated, studies in eastern and southern Africa (Schatz and Seeley, 2015) have established a belief in the reciprocity of care, finding that when older persons care for children, it provides hope that someone will later care for them (Schatz and Ogunmefun, 2007). They have also shown that caring for grandchildren provides hope of receiving support in old age, due to infirmity and for burial (Williams, 2003). The idea that instrumental reciprocity drives receipt of support at times of need in later life has, however, been disputed in studies in other countries in the Global South and North. Vera-Sanso’s (2005) study of filial support in South India, for instance, provided a nuanced picture of filial support and did not assume a positive relationship between old-age support and parental welfare and survival. Reporting the mismatch between evidence on older people’s welfare/survival and the norm that sons provide economic and practical support for their elderly parents, she found that filial relations are much more complex and contingent than is generally acknowledged. She further established that co-residence with a married son, whether within the same household or living adjacently, provided no certainty that parents will receive the level of support that the norm of filial support would imply. This is because a multigenerational perspective on needs, rights and obligations reveals that Indian families are oriented towards the young and away from the old. A man’s first responsibility is to meet the needs of his wife and children; his duty to his parents is secondary. She also established that in terms of the norm of old-age support, many parents were effectively childless, even if their children were alive, as they received negligible (or no) financial and practical support from sons or daughters. Based on these findings, her study concluded that from a theoretical perspective and in relation to filial support in old age, no easy distinction could be made between people who have sons and people who do not.

Despite much sociological writing regarding a sense of ‘obligatedness’ as the cornerstone of kin relationships (with norms of obligation assumed to be readily recognised because they constitute a ‘natural’ part of family life), path-breaking studies on the obligations of kinship in Britain (Finch and Mason, 1991) established, a normative assumption that obligations are stronger for ‘close family’ than for distant kin. Thus, it would be regarded as much more shocking for a parent to refuse help to an adult child than, say, for cousins to disregard each other’s needs. Equally, norms suggest not only that children should support their parents but also that parents should support their adult children. Obligations between generations are thus presumed to operate in both directions. Finch and Mason’s (1991) study established that in 1980s’ Britain, there was no straightforward consensus about a set of normative principles regarding obligations of kinship. That was because people did not carry around with them stable sets of values and meanings about obligations to kin. Thus, obligations and responsibilities between kin can be well understood at the normative level. In a given situation, they found, most people will agree upon and recognise relatively easily ‘the proper thing to do’, even if some try to avoid their responsibilities in practice (Finch and Groves, 1985; Wilson, 1987; Finch, 1989; Harris, 1988). This body of UK literature suggests that normative statements are more likely to be situationally specific than universal, that is, that they depend upon the given circumstances in which the
judgement of appropriateness is made. Thus, for example, a judgment about whether
parents should help their adult children might depend, among other things, upon the
relationship between the parties, the nature and degree of the assistance in question,
notions of relative need and ability to help, the existence of other potential helpers,
and so on. The study also established that people did not always unambiguously assign
normative responsibility for meeting various needs to relatives. It concluded that there
were many unexamined assumptions built into political debate concerning the nature
of family relationships and the responsibilities associated with these.

Critics argue, however, that existing theories and empirical literature on family care
of older persons is dominated by studies undertaken in the Global North, and that
these studies largely reflect the preferences, as well as environments, of these settings
(Phelan, 2013; Cadmus et al, 2015). However, if family care is context specific and
reflects propelled normative values attached to the older person, theories that may
explain family care of older persons in certain contexts may not adequately explain
family care in others (Phelan, 2013; Kabelenga, 2018). In countries with rapidly
ageing populations but little care infrastructure beyond the family and community,
understanding how norms of caring are shaped, propagated, understood and
implemented is fundamental to understanding the receipt of needed care in later
life. It is thus important that the voices of local people in the Global South should
be prioritised in scientific knowledge about the region (Martinez, 2010; Kaya, 2014).
To date, Zambia lacks such studies, meaning scientific knowledge about normative
understandings of the care of older persons by family members in Zambia is missing.
This article addresses this gap in scientific knowledge.

Zambia and the demography of older people

The Republic of Zambia is a landlocked country in southern Africa, neighbouring
the Democratic Republic of the Congo to the north, Tanzania to the north-east,
Malawi to the east, Mozambique, Zimbabwe, Botswana and Namibia to the south,
and Angola to the west. Its capital city is Lusaka. Zambia is a former British colony.
It was colonised in 1888 and provided a source of minerals for the British South
African company, which were exported. The British government hoped to increase
white settlement as part of a wider strategy to strengthen British influence in southern
Africa. At that time, Zambians were excluded from the governance of their society
and had no freedom to decide on their own development, and Zambia’s mineral
wealth did not benefit the people of Zambia but rather their colonial masters.
This exploitation led to poor infrastructure development and economic and social
inequalities between rural and urban Zambia, which still persist. Rural areas were
especially neglected, with rural Zambia considered merely a source of raw materials
and where mining activities to feed urban industries took place, leading to a lack
of infrastructure and social services. This situation led to the extensive rural–urban
migration of younger people, mainly men, leaving older persons and women in rural
poverty that persists today. By contrast, Zambia’s urban areas face such problems as
congestion, increased illegal settlement, unemployment and extreme pressure on the
few available urban social services. Women who migrated to urban areas often ended
up brewing traditional beers, which they sold to miners, or as sex workers. With no
form of social security for older people in urban or rural Zambia, there remains heavy
dependence on the informal social protection of the family. Zambians fought for their
Perceptions of community leaders about normative understandings of good family

political independence from their colonial masters, gaining this in 1964 (Rodney, 1973; Noyoo, 2000; Phiri, 2004; Cliggett, 2005; Mapoma and Masaiti, 2012; Chirwa and Kalinda, 2016), with the result that most people aged 60 or older in Zambia’s rural and urban areas were born during the colonial period.

According to the Zambia National Ageing Policy (Republic of Zambia, 2014), illiteracy among older persons in Zambia stood at 58 per cent for older men and 91 per cent for older women. However, knoema (2022) found that elderly female literacy in 2018 stood at 81.2 per cent. These high levels of illiteracy are described as an outcome of the colonial deprivation of formal education to Zambians (Kamwengo, 2004), which left many unable to communicate in English, Zambia’s official language. Without education, many remained unemployed. Those who found jobs often worked in low-paying jobs as cleaners, gardeners, cooks, security officers, primary school teachers and nurses. Many of those employed in the formal sector lost their jobs in the 1990s when, under pressure from the International Monetary Fund (IMF) and World Bank to restructure the Zambian economy through a structural adjustment programme (SAP), the government of Zambia embarked on privatisation, resulting in massive job losses. Workers who lost jobs, now Zambia’s older persons, received no terminal benefits and entered old age without any social security. Due to high levels of unemployment among youths and adults in Zambia, they rarely receive remittances from their children and grandchildren. Thus, income poverty is common among households for older persons (Phiri, 2004; Kamwengo, 2004; Cliggett, 2005; Mapoma and Masaiti, 2012; Republic of Zambia, 2014; Chirwa and Kalinda, 2016).

In 2021, Zambia had a total population of just over 19 million people. Life expectancy at birth was 52 years (Zambia Statistics Agency, 2022), an aggregate figure that is potentially misleading, as many older persons in Zambia live longer than their biological children who, in African culture, are supposed to provide informal security to their older relatives. This situation has developed because many children die before attaining the status of older persons due to HIV/AIDS and other health problems (Kabelenga, 2017). Consequently, some older persons in Zambia grow old in local and national contexts in which they receive no form of informal care from ‘middle-generation’ children. They have to either fend for themselves in old age or, if they cannot do this themselves, depend on other people outside of family settings to take care of them (Phiri, 2004; Cliggett, 2005; Mapoma and Masaiti, 2012; Republic of Zambia, 2014; Chirwa and Kalinda, 2016; Kabelenga, 2017).

Official data indicate that people aged 60+ comprise 4 per cent of the total population (about 600,000 older people); most live in rural areas, either alone or with orphaned grandchildren or extended family members (Republic of Zambia, 2014). While their living arrangements differ, most are categorised as living in poverty (Republic of Zambia, 2014). The Senior Citizens Association of Zambia (SCAZ) considers the 4 per cent figure an underestimate and puts the number of older persons in Zambia at 700,000 or more (Mapoma and Masaiti, 2012; SCAZ, 2013; Chirwa and Kalinda, 2016).

Rural areas in Zambia remain inclined to what most local people believe in, such as interdependence among rural dwellers. Those with needs that cannot be met through self- or family care expect other local community members to come to their aid. Thus, informal measures are still used to address rural community problems. Rural areas in Zambia can also be characterised by cultural homogeneity. Although there is much ethnic diversity across the country, most people living within a specific area
are of the same ethnicity, using the same local languages (Cliggett, 2005; Mapoma and Masaiti, 2012; Chirwa and Kalinda, 2016). Urban areas, by contrast, are characterised by cultural heterogeneity in terms of class, ethnicity, language, traditions, religion, sense of place and other cultural aspects. People in urban Zambia are less dependent on other community members for their everyday economic survival. Thus, people are expected, economically, to fend for themselves or to rely on family, not local community, members. Those who lack the economic means of survival end up either destitute and begging on the streets or dependent on government and charitable organisations for their survival. The implications of these rural–urban set-ups are that in rural areas, older persons who are not able to fend for themselves due to, among other factors, old age, childlessness, the death of biological children, sickness or material poverty depend more on kin networks for their care than in urban areas (Cliggett, 2005; Mapoma and Masaiti, 2012; Chirwa and Kalinda, 2016). This is because in urban areas, such kin networks are minimal, as there are usually fewer extended family members in urban areas (Republic of Zambia, 2014). Despite these differences, previous studies by Phiri (2004), Mapoma and Masaiti (2012) and Chirwa and Kalinda (2016) have established high levels of social isolation and discrimination against older people by family and local community members. These problems are attributed to popular perceptions of older people, who are perceived by some people to be practising witchcraft.

Long-term care of older persons in Zambia

The idea of an older person varies both conceptually and in official understanding. In this study, local community leaders were asked: ‘Who is an older person in this community?’ For many, this started at age 50 years but for others 60, some 65 and yet others 70 or 80. These differing views were expressed by leaders in the same community, sometimes in the same focus-group discussion (FGD). Informants also considered the functional and visible attributes used by local people to construct an older person: ‘looking old’, having grey hair and walking in frail ways.

Although those aged 60+ make up only a small proportion of Zambia’s population, most lack adequate long-term (informal or formal) care (Phiri, 2004; Mapoma and Masaiti, 2012; Changala, 2016; Chirwa and Kalinda, 2016; SCAZ, 2021). Analysis of data collected in the present study revealed three main mechanisms of current long-term care provision for older persons, who all, whether in rural or urban Zambia, face numerous challenges that compromise the quality of the care older persons receive. These are set out in the following.

Institutional homes and medical healthcare systems for older persons

Zambia has just nine institutional homes for older persons. Despite most older persons living in rural areas, most institutional homes are located in urban and peri-urban areas. The government runs two older persons homes, while the remaining seven homes are run by faith-based organisations (FBOs). These homes face many challenges, for example, inadequate shelter, food, funding, transport, essential drugs and resident nurses (Republic of Zambia, 2014; Changala, 2016; Kabelenga, 2018), which the government of Zambia acknowledges, offering two reasons for the small number of institutional homes for older people: (1) ‘Government wants to promote
and sustain the extended family system through taking care of the aged. This is because extended family is the best organ to take care of the aged; and (2) ‘Government does not have resources/capacity to manage and sustain the homes if they are many’ (Republic of Zambia, 2014: 10).

Family

Although the government of Zambia sees the family as offering the best informal support system for its members (Republic of Zambia, 2014), data indicate that traditional patterns of care and support, which include the use of the extended family and village customs, have weakened, with villages becoming smaller (Phiri, 2004; Cliggett, 2005; Mapoma and Masaiti, 2012; Chirwa and Kalinda, 2016). This is attributed to the death of family members, family divisions (due to accusations of practising witchcraft, causing some to leave their villages and live alone) and the refusal of most retirees to return to their villages of origin after ceasing formal employment. Some families are consequently unable to care for their vulnerable older members (Kabelenga, 2018).

Formal and informal income security

Although no data are available on the number of older persons in rural and urban Zambia who have or lack income security, Phiri (2004), Cliggett (2005), Mapoma and Masaiti (2012), Republic of Zambia (2014) and Chirwa and Kalinda (2016) have shown that most older persons in Zambia have inadequate income. Current pension schemes are limited to workers in formal employment schemes who have retired and receive annuities. In most cases, these are insufficient and not linked to economic trends. Notwithstanding that the government of Zambia provides social cash transfers (SCTs) to some of the poorest and most vulnerable older persons in rural and urban areas, in theory on a monthly basis, these are insufficient to lift beneficiaries out of poverty. In 2021, SCTs were just K400 (US$20) per month (Kabelenga, 2021; SASPEN and OSISA, 2021) and inconsistently provided. In 2018 and 2019, beneficiaries went for some months without receiving their SCTs, making SCTs an unreliable source of income for recipients (Kabelenga, 2021; SASPEN and OSISA, 2021). Although older-person households in Zambia have diverse living arrangements (living alone, living with spouse, living with children and grandchildren, and ‘skip generation’), it is evident that the informal social protection supposedly provided by family and local community members is inadequate (Republic of Zambia, 2014). This is attributed both to the weakening of the extended family and village communities, and to the generational gap (Kabelenga, 2018; SCAZ, 2021).

These challenges mean that most older persons in rural and urban Zambia face serious challenges regarding basic needs and experience material poverty. An official report (Republic of Zambia, 2014) showed that some 80 per cent of households headed by older persons were living below the poverty line. Those who are too old to fend for themselves usually depend on others, mostly family members (Mapoma and Masaiti, 2012; Republic of Zambia, 2014; Chirwa and Kalinda, 2016).

Overall, the preceding descriptions of long-term care mechanisms imply that most long-term care is provided by family members, with some older persons receiving good care and others not, even within the same family and local community settings.
This raises the question: ‘In Zambia, what enables some older persons to receive good family care while others do not?’ This question has been tackled through a new empirical exploration of normative prescriptions, as expressed in the rhetoric of community leaders.

Methods

Data and methods

As the phenomenon under investigation is a normative issue with social meanings that are subjective in nature, I draw on qualitative data. These were collected from 35 participants: 22 in a rural and 13 in an urban district. In the urban district, most study participants were national community leaders who spoke about the informal care of older persons, both in their district and throughout Zambia. In total, 35 interviews were conducted. The data comprise 29 individual interviews and six FGDs. These were recorded using audio tapes, with anonymity assured. In the quotations that follow, participants’ names have been anonymised to protect their identity.

Participants

Participants in the study were community leaders who had experience of addressing elder abuse, including: spiritual abuse (family and community members accusing older persons of practising witchcraft); neglect (deliberate refusal by family members to take care of older persons, even if they have the abilities to do so, either because some older people are perceived to be witches or because they did not care about their family members when they had the ability to do so); verbal abuse (use of foul or abusive language to older persons by family and community members as a way to discourage them from practising witchcraft or to remind them of their bad habits when they had the ability to support family members); and physical abuse (beating or killing an older person accused of practising witchcraft or considered a burden to the family and local community) (Kabelenga, 2018). These forms of abuse imply that the care of older persons by family and local community members depends on the perceptions that informal caregivers have towards some older persons. If perceived negatively, the particular older person cannot receive adequate care (Phiri, 2004; Mapoma and Masaiti (2012; Chirwa and Kalinda, 2016; Kabelenga, 2018). With the help of district social welfare officers and older persons organisations that knew older people who had suffered neglect, participants were recruited based on having direct experience of engaging with older persons neglected by family members. Recruitment first involved establishing cases of neglect of older persons by family members in local communities and the community leaders involved in addressing those cases. Individual community leaders were contacted through physical visits and mobile phone calls, and asked to participate in the study as interviewees. This was important because the study sought to understand why some older persons were neglected by family members, while others were not, because in Zambian culture, there is a strong norm that family members should take care of their older parents – if not, this is considered a curse on family members (Kamwengo, 2004; Republic of Zambia, 2014). Only those leaders who accepted were interviewed (that is, no participant was coerced to participate in the study).
In this article, the terms ‘community leaders’ or ‘local leaders’ refer to influential persons in the two districts selected. They were people with the institutional power to influence the affairs of their communities on a daily basis and included traditional leaders: chiefs, village headmen, village court judges, conventional court judges, members of community crime prevention units, leaders of faith and community groups (churches, youth groups, women’s groups, elderly people’s organisations, and area development committees), political party members, senior government workers (ward councillors, head teachers, doctors, nurses, social workers and community development workers) and leaders of civil society organisations. Some participants, especially the civil servants and leaders of civil society organisations, had worked in different parts of Zambia and had experiential knowledge of normative care of older people by family members in not only the selected districts but also other parts of Zambia (Kabelenga, 2018). Collection of data from different categories of participant allowed for the triangulation of data from different types of community leaders in both districts. This revealed both common ground and differences in views about norms of family care of older persons and ideas about how the care of older persons could be enhanced.

The 35 participants in the study were aged between 27 and 72 years; 27 were men and nine were women, reflecting higher rates of male leadership in Zambia (Republic of Zambia, 2002). Their educational level was high: only one participant had primary school education only, while four had secondary school certificates, 25 had college or degree-level education and five had a master’s degree (see Table 1).

Data analysis

Following transcription (verbatim) of all interviews, data analysis was content oriented, with coding of the accounts in the transcribed material. This involved searching in the data for different social mechanisms that influenced good family care of older persons in rural and urban Zambia to explore how participants thought good family care of older persons could be achieved. Analysis of the data revealed three major explanations about social mechanisms for normative care for older persons: (1) the promotion of good relationships among family and local community members during days of productivity; (2) encouraging all people in Zambia to affiliate to religious institutions throughout their life course; and (3) encouraging people to make economic investments in family and community during days of productivity. By ‘days of productivity’, community leaders meant times when individual older persons were able to fend for themselves and support the well-being of other nuclear and extended family members. Regarding how good care of older persons by family members could be enhanced, two major suggestions emerged: (1) the normative re-education of everyone in Zambia, so they understand the importance of good family and local community relationships and religious affiliations in shaping the care older people receive from their families; and (2) the introduction of a universal social pension for older persons. After reflection on the data, the analytical concepts of ‘relationships’ and ‘reciprocity’ were used to understand the data. All the constructs participants disclosed seemed to revolve around these two theoretical lenses. These conclusions were reached on the grounds that all participants reported that family care was dependent on how the older person had related to family members in their days
Table 1: Summary of the demographic characteristics of the participants

<table>
<thead>
<tr>
<th>No.</th>
<th>Participant</th>
<th>Type of community leader</th>
<th>Age</th>
<th>Sex</th>
<th>Rural/urban</th>
<th>Educational attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Grandmum</td>
<td>National representative of older persons in rural and urban Zambia</td>
<td>72</td>
<td>Female</td>
<td>Urban</td>
<td>Master's degree</td>
</tr>
<tr>
<td>2</td>
<td>Lainess</td>
<td>National representative of older persons in rural and urban Zambia</td>
<td>67</td>
<td>Female</td>
<td>Urban</td>
<td>Master's degree</td>
</tr>
<tr>
<td>3</td>
<td>James</td>
<td>Director of a government hospital</td>
<td>51</td>
<td>Male</td>
<td>Rural</td>
<td>Master's degree</td>
</tr>
<tr>
<td>4</td>
<td>John</td>
<td>Senior nursing officer at a government hospital</td>
<td>53</td>
<td>Male</td>
<td>Rural</td>
<td>Bachelor's degree</td>
</tr>
<tr>
<td>5</td>
<td>Reliable</td>
<td>Hospital chaplain</td>
<td>55</td>
<td>Male</td>
<td>Rural</td>
<td>Pastoral certificate</td>
</tr>
<tr>
<td>6</td>
<td>Trinity</td>
<td>District social welfare officer</td>
<td>49</td>
<td>Male</td>
<td>Rural</td>
<td>Diploma</td>
</tr>
<tr>
<td>7</td>
<td>Theresa</td>
<td>Police officer</td>
<td>40s</td>
<td>Female</td>
<td>Urban</td>
<td>Bachelor's degree</td>
</tr>
<tr>
<td>8</td>
<td>Jane</td>
<td>District social welfare officer</td>
<td>27</td>
<td>Female</td>
<td>Rural</td>
<td>Bachelor's degree</td>
</tr>
<tr>
<td>9</td>
<td>Barbara</td>
<td>District social welfare officer</td>
<td>34</td>
<td>Female</td>
<td>Urban</td>
<td>Master's degree</td>
</tr>
<tr>
<td>10</td>
<td>Stephen</td>
<td>Local community health worker</td>
<td>31</td>
<td>Male</td>
<td>Rural</td>
<td>Diploma</td>
</tr>
<tr>
<td>11</td>
<td>David</td>
<td>Local court judge</td>
<td>50s</td>
<td>Male</td>
<td>Urban</td>
<td>Bachelor's degree</td>
</tr>
<tr>
<td>12</td>
<td>Moffat</td>
<td>National representative of older persons in rural and urban Zambia</td>
<td>64</td>
<td>Male</td>
<td>Urban</td>
<td>Bachelor's degree</td>
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<tr>
<td>13</td>
<td>Enock</td>
<td>National representative of older persons in rural and urban Zambia</td>
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<tr>
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<td>Thelma</td>
<td>Nursing officer at a government hospital</td>
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<td>Bachelor's degree</td>
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<tr>
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<td>Brian</td>
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<td>16</td>
<td>Father Isaiah</td>
<td>National representative of older persons in rural and urban Zambia</td>
<td>64</td>
<td>Male</td>
<td>Urban</td>
<td>Diploma</td>
</tr>
<tr>
<td>17</td>
<td>Headman</td>
<td>Traditional leader/village court judge</td>
<td>50s</td>
<td>Male</td>
<td>Rural</td>
<td>Secondary school certificate</td>
</tr>
<tr>
<td>18</td>
<td>Saul</td>
<td>Traditional leader/village court judge</td>
<td>50s</td>
<td>Male</td>
<td>Rural</td>
<td>Secondary school certificate</td>
</tr>
<tr>
<td>19</td>
<td>Paul</td>
<td>Traditional leader/village court judge</td>
<td>50s</td>
<td>Male</td>
<td>Rural</td>
<td>Secondary school certificate</td>
</tr>
<tr>
<td>20</td>
<td>Chief</td>
<td>Traditional leader/village court judge</td>
<td>55</td>
<td>Male</td>
<td>Rural</td>
<td>Diploma</td>
</tr>
<tr>
<td>21</td>
<td>Sandra</td>
<td>Women's community representative</td>
<td>49</td>
<td>Female</td>
<td>Rural</td>
<td>Primary school certificate</td>
</tr>
<tr>
<td>22</td>
<td>Cephas</td>
<td>Civic leader/political party representative</td>
<td>54</td>
<td>Male</td>
<td>Rural</td>
<td>Secondary school certificate</td>
</tr>
</tbody>
</table>

(Continued)
of productivity. Good relationships resulted in good family care and bad relationships resulted in neglect, suggesting reciprocity (Kabelenga, 2018).

### Results and discussion

Analysis of data from both districts suggests that although participants differed in many respects, including in their location and their work, all spoke about the care of older persons in similar ways. This was evident in that all brought out the same three normative factors (already discussed and presented in turn in the following) as influences on good family care of older people in rural and urban Zambia.

#### Good relationships with family and local community members during days of productivity

The data indicate that local community leaders believe good family care of older people in rural and urban Zambia is influenced by the type of lifestyle individual older persons had with their family and local community members when they were still able to fend for themselves. For instance, during the first FGD in rural Zambia, participants summarised factors that determined family care to older persons as follows:

### Table 1: Continued

<table>
<thead>
<tr>
<th>No.</th>
<th>Participant</th>
<th>Type of community leader</th>
<th>Age</th>
<th>Sex</th>
<th>Rural/urban</th>
<th>Educational attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Genesis</td>
<td>Civic leader/political party representative</td>
<td>37</td>
<td>Male</td>
<td>Rural</td>
<td>Diploma</td>
</tr>
<tr>
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‘It was just as he was explaining, to say they were not very generous with their economic resources with family members when they were in employment – some of those who were working, ‘but then you were just busy marrying, divorce, marry and divorce, you don’t care about children’. So, you find that those people, they are the most vulnerable. What helps is what they had done to the community when they were holding on to those positions.’ (Jane, aged 27 [FGD1], district social welfare officer, rural area)

Similar voices were heard in the urban district. Using his own personal experiences of the care he received from extended family members in his old age, attributed to how he treated family members in his earlier days, one national community leader said: “Thanks for what we do in productive days, I have more support from the extended family members. I personally get more help from my extended family members. They are more concerned for me than my biological children” (Enock, aged 65, national representative of older persons in rural and urban Zambia, urban area).

The preceding data can be interpreted using the concept of reciprocity. That is to say, reciprocity is inferred as a process that helps us understand why and how people care for older persons. In this way, providing ‘good’ care is assessed by reflecting not only on how the older person interacted with their family but also on how they interacted with the community at large. This result is consistent with other literature on family care of older persons (Williams, 2003; Schatz and Ogunmefun, 2007; Schatz and Seeley, 2015) which shows that family care was reciprocal, with reference to how older persons treated their family members when they had the ability to take care of them. It is interesting that when these results are compared with Finch and Mason’s (1991) study in the Global North (Britain), they provide a different perspective. In their study on kinship obligations in contemporary Britain, Finch and Mason established that people in Britain did not carry around with them stable sets of values and meanings about obligations to kin. They claimed that this was because people did not always unambiguously assign normative responsibility for meeting their relatives’ various needs. The present Zambian study found, by contrast, that all participants believed that in Zambia (both rural and urban), those who provide care carry stable sets of values and meanings about family members’ obligations to older persons around them. The community leaders were unanimous in believing that if a particular older person in their families and communities was considered by family members to do the ‘proper thing’ for relatives, they would themselves be well taken care of by family members. Conversely, if an older person was thought by family members not to have done the ‘proper thing’ for relatives, they would not get good care from family members. From another lens, it seems the Zambian participants’ views are in line with the view expressed by Wilson (1987) regarding ‘give and take in families’. All Zambian participants in the study felt that most older persons in Zambia ‘reap what they have sown’ when able to fend for themselves. Those who did the ‘proper thing to do’ for relatives, reaped good care from family members; those who did not reap good neglect from family members. Thus, the results agree with studies which argue that the normative care of older persons is context specific and should be understood within its own context (Finch and Groves, 1985; Finch, 1989; Harris, 1988; Vera-Sanso, 2005; Broese et al, 2013; Cadmus et al, 2015).
Participation in religious activities

The community leaders also believed that an older person’s active participation in religious activities earlier in life shaped the type of care they later received from family members. Here, family care included care by a church/religious family. This finding speaks to ideas around the social reputation of being ‘good’ people, exemplified by regular engagement in religious activities. Thus, family members consider family care to be for those who belong to the religious family and not for non-family members. In rural Zambia, for instance, this was summarised by one participant, a district officer in charge of care for older persons neglected by family members, himself of Christian faith:

‘Those people who could have been pastors before, could have been [Catholic] fathers before, once they get old, in most cases, we have seen churches taking up the responsibility of looking after them, up to the point of their death. Even when they are accused of practising witchcraft by the community, we have seen such kind of people taking refuge in churches, and they have been embraced by the church itself.’ (Trinity, aged 49, rural area)

Participants in urban Zambia agreed with their counterparts in rural Zambia. Thus, a participant working as a national representative of older persons in Zambia summarised good family care of older persons with the following words:

‘The church takes care of needy people. However, the care is usually restricted to its own members. I think that the environment in town, family and community care for the needy elder people is no longer there. If it’s there, it is just very few people who are practising that. Only the churches, because if that older person has affiliated herself or himself to the church, then the church would come in.’ (Lainess, aged 67, national representative of older persons in rural and urban Zambia, urban area)

These statements suggest that the concept of reciprocity is central in understanding the informal care of older persons in their religious family. It is clear here that ‘good care’ for older persons is linked to their interaction and engagement in religious activities. If an older person has good standing in the larger religious family, when they are unable to take care of themselves, other family members in the religious family take responsibility for their care. This resonates with Kiisi et al.’s (2020) study, which found that the informal care of older persons with chronic illness in Africa was relieved by connection with the church. That is to say, older persons connected to the church in earlier days may receive support from the church when they are chronically ill, in contrast to those who did not belong to any church. The result also resonates with Wilson’s (1987) research in Give and Take in Families. Participants in the Zambian study held the view that the church, as a religious family, was biased towards taking care of older persons ‘who gave something good’ to the church (when they had time to do so), rather than to older persons who ‘did not give anything’ to the church in such circumstances.

Having economic investments

The data collected in Zambia also suggest that having economic investments is another normative factor that influences family care of older persons. Community leaders in both
the rural and urban localities reported that older persons with financial means usually received good care from their family members because the latter benefitted economically from the older persons. Thus, while providing care for a particular older person, they used some of the older person’s economic resources for their own livelihoods. If the older person died, family members who had cared for them inherited the older person’s wealth. However, older persons with no economic investments, it was stated, are usually neglected by family members. Participants felt that this was because they came to be seen as an economic burden. Referring to the potentially drastic consequences of not being thought of as a person worth supporting, a national representative of older persons in Zambia, based in urban Zambia, explained: “One thing found in our work is if financially empowered and liv[ing] independently, older people are respected in their communities and by their own children. This makes them live independently” (Lainess, aged 67, national representative of older persons in rural and urban Zambia, urban area). A similar point was made by a participant in rural Zambia: “They should empower them financially; they should be on a salary, a monthly salary, whether he was working or not working, The government should at least budget for them and give them a salary so that the poverty is reduced” (Royd, aged in his 40s, head teacher, rural area).

These extracts from the data can be seen as expressing the role of economic power. Participants felt that older persons with more material resources were able to entice or appeal to family members to care for them with a material ‘reward’, both in the present and in the future. On the other hand, if an older person has poor economic power, family members may be unwilling to take care of them (or worse), as such care could be deemed economically stressful and less beneficial for care. Such reasoning normatively supports the South African government’s policies on improving the informal care of people who are unable to care for themselves by introducing Grant-in-Aid for people who need full-time care. Such aid, for persons unable to care for themselves (to the point where they need full-time care from someone else) is offered to older persons, those with disability and war veterans as an additional monthly payment from the government (South African Government, 2020). This is similar to the situation in other African countries, where the informal care of older adults with chronic life-limiting illness has been shown to be contingent on the availability of resources (Kiisi et al, 2020). The result is also similar to policy suggestions made by other researchers in Zambia, such as Phiri (2004), Cliggett (2005), Mapoma and Masaiti (2012) and Chirwa and Kalinda (2016).

Conclusions

The concept of reciprocity in the care of older persons by family members emerged as a powerful norm in the results of this study of community leaders’ perspectives in Zambia. It differs from the evidence presented in studies undertaken in Britain and Germany (Finch and Mason, 1991; Hahmann, 2017), which showed that in those countries, reciprocity was not the main driver in mutual family support. From the views of the community leaders who participated in this study, it seems that norms of reciprocity are real in Zambia; they were prevalent in their rhetoric and understanding. While the intention of this article was not to test the applicability of concepts about family care that have dominated scientific knowledge, as a sociological phenomenon, it is important to note that concepts about family care of older people developed and written about in other national contexts cannot necessarily be applied to what community leaders reported in this study.
Based on the study reported here, we can conclude that the participants, all community leaders in rural and urban Zambia, socially constructed good family care for older persons in similar ways, despite the very different contexts of urban and rural living they experienced (outlined earlier). Analysis of the interview and focus-group data revealed that participants shared overarching views: having good relationships with family and local community members, and being active in religious and economic activities, were critical to shaping the quality of care that older people in Zambia can expect to receive from informal carers.

It is of interest that the three normative issues identified revolved around older people’s previous lifestyles prior to needing support and the particular relations older persons had with family, local community, religious institutions and economic activities. These findings point to a strong sociological norm of reciprocity, that is, the idea of ‘give and take over time’, and suggest that these shape the quality of care provided to persons in old age.

The consensus in participants’ responses is unlikely to be coincidental. Rather, it seems to have emerged from their first-hand information and experiences as individuals and within institutions, which included exposure to the narratives of local, national and international non-government and government organisations about the informal care of older persons. Participants offered concrete examples of older persons who received good family care and those who did not, and reflected on the explanations of these in the communities they lived in and serviced, leading to their understandings of the importance of reciprocity over the life course.

Thus, from the data used in this article, there is some evidence of a relationship between what people do to family members who had the ability, when younger, to do what is considered the ‘proper thing to do’ and what they can expect in return from family members when they need care in later life (Finch and Mason, 1991). Notwithstanding this, there are thorny issues of interpretation raised in this article. How, for example, should we interpret the normative consensus provided by the participants, especially from a human rights perspective? Given that every human being needs proper care when in need of it, can we deny them care just because they are constructed by society not to have done what is considered ‘proper to do to relatives’? What happens if one could not provide because of material poverty or other circumstances, such as sickness? What happens if one is not religious or if one could not believe in God? Finding answers to these questions is important to break the social norms of reciprocity in the care of older persons by family members. The questions are also important for generating data that can inform policy and practice on what should be done to provide holistic care to every human needing care.

This study has reported local ways of knowing and doing in understanding the care of older persons in rural and urban Zambia from the perspectives of community leaders participating in the study, broadening global scientific knowledge about normative understandings of good family care in these settings. As some participants were national leaders who had participated in national programmes aimed at improving the care of older persons throughout Zambia, their responses also reflect the national landscape about family care of older persons. However, normative beliefs may not always accord with what obtains on the ground. For instance, some indigenous ways of living, such as being a traditional healer, may make a person respected in the family and society (Kamwengo, 2004; Chiggett, 2005). The findings of this study must thus be interpreted with caution. By bringing Zambia into mainstream global scientific debates about normative care of
older persons, it is hoped that this article will generate fresh debates about the care of older persons, adding to knowledge of this important contemporary issue.

Notwithstanding its contribution to scientific knowledge, the article has the following limitations: first, it relied on the views of a specific group of people in Zambia (community leaders, the large majority of whom were men). This means that there is an absence of perspectives of other Zambian people, including older people in different circumstances and younger Zambians, whose views cannot be assumed to be the same as those of community leaders. Therefore, the findings cannot be generalised to all categories of Zambian people. Second, the study was qualitative in nature; the quantitative aspect is missing. Thus, the article has not established the extent to which the normative perspectives of community leaders are held widely in other sections of Zambian society, such as by older women and young people, who are the majority of informal carers (Republic of Zambia, 2014). To draw broader conclusions about good family care, future studies should include different segments of Zambian society, so that the perspectives of different Zambians can be established.

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Conflict of interest
There is no conflict of interest in this manuscript. However, some of the materials used were part of my PhD dissertation, which I publicly defended at the University of Lapland in Finland in 2018 in the Faculty of Social Sciences.

References
Perceptions of community leaders about normative understandings of good family