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Editorial

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AIDS: the mad-dog curse of Africa

The AIDS epidemic in sub-Saharan African countries, particularly in the southern African region, is akin to a mad dog – rampant, stealthy, stalking. It ruthlessly and savagely attacks whomever comes in its path. It bites indiscriminately, gnawing at poverty itself. A curse, many say. AIDS is a mad-dog curse, wrested on Africa's people in wrath. A curse that breaks up households, tears families and communities apart, and leaves individuals, mainly older persons, to hold together the remnants. Myths and superstitions abound that AIDS is a product of witchcraft. AIDS is also viewed as a result of a violation of sexual taboos. In Botswana, for example, not following the practice of *boswagadi* in widowhood (ritual cleansing through sexual abstinence for a year) (Tlou, 1998, 1996) is believed to be a cause of AIDS. The grandmothers' curse, or disease, it has been called (Wilson & Adamchak, 2000; Adamchak, 1996), since it is grandmothers who must care for adult children with AIDS, as well as for grandchildren who have AIDS, or who are orphaned after their infected mother, and probably father, die from the disease. It is older women who must carry the heavy burden of care and multiple other responsibilities at a time in their lives when their own strength and capacity are diminishing.

In recent years, *SAJG* has published several research papers on the impact of AIDS on older persons in African countries (e.g. Tlou, 1998, 1996; Myslik, Freeman & Slawski, 1997; Mupedziswa, 1997; Adamchak, 1996). The importance and relevance of the papers and the issues which they highlight are increasing significantly, as the effects and the full impact of the epidemics increase exponentially. This issue of the Journal includes several new research-based papers on AIDS and ageing in sub-Saharan African (SSA) countries.

Far-reaching demographic effects

Since the beginning of the pandemic, more than 50 million people world-wide have been infected with HIV and 16 million have died. (Figures cited here are from a US Bureau of the Census report (1999) on HIV/AIDS in the developing world.) The largest demographic impact of the pandemic of all world regions is in sub-Saharan Africa. It is projected that by 2004 an additional 14 million people infected in SSA will develop AIDS. In twenty-one SSA countries more than 5% of the urban adult population is HIV positive, while urban to rural equalisation of HIV prevalence is increasing. Severely affected countries at present are Namibia, Swaziland, Zambia and Zimbabwe: 19-25% of all adults in these countries are HIV positive. Epidemics continue to develop in the southern African region, most recently and notably in Botswana and South Africa. However, in some SSA countries where epidemics developed earlier, e.g. Uganda, seroprevalence levels have stabilized or have declined.

The most direct impact of the epidemics is an increase in the number of deaths in affected populations, i.e. the number of people per 1000 population who die (the crude death rate (CDR)). The CDR will be considerably higher in countries more severely affected by AIDS epidemics. In Zimbabwe, for example, the CDR in 1998 was over three times as high as it would have been without AIDS and will be four times as high by the year 2010.

The epidemics also affect infant mortality rates (IMR) and are reversing declines in IMRs that have been occurring in many countries during the past two decades. It is estimated that over 30% of children born to HIV-infected mothers in SSA become infected with the virus. In eastern and southern Africa, the regions most severely affected by AIDS, the overall IMR is nearly 70% higher over what it might have been without AIDS. In South Africa the rate is estimated to be 27% higher and will be more than twice as high by 2010. In Zimbabwe, perhaps the most severely affected country of all in SSA, the IMR is now estimated to be 72% higher than it would have been without AIDS and by the year 2010 will be three and a half times as high. In Kenya, the rate is estimated to be 65% higher and will be twice as high by 2010.

The greatest impact of AIDS-related mortality in childhood and early adulthood (where normal mortality is quite low) is on life expectancies. Reduced life expectancies in selected African countries which take AIDS-related mortality into account, as suggested by the US Bureau of the Census, were published in *SAJG*, 1999, vol. 8(1), p. 8. Examples of the projected reductions in life expectancies are declines from 62 to 40 years in Botswana, from 65 to 56 years in South Africa, and from 56 to 37 years in Zambia. At present, only half of all South Africans can expect to live to 60 years because of AIDS, whereas in industrialized countries with low HIV seroprevalence the figure is 90% *(Time Magazine,* 1999: 18).

Orphans

A major effect of the AIDS epidemics in SSA is the ever-growing proportion of children orphaned as a result of AIDS-related deaths (UNAIDS, 1997). In 1997, it was estimated that the cumulative number of children in SSA who had lost their mother or both parents to AIDS when they were under 15 years was 7.8 million (UNAIDS/WHO, 1997). In Kenya, in 1999, 600 000 children were AIDS orphans, which number is estimated to rise to a million by 2005 (Wahome, 2000). With fewer and fewer adults of normal parenting age as a result of AIDS-related illness and deaths, the burden of care of grandchildren and AIDS orphans is increasingly falling on older persons, typically maternal grandmothers. In Zimbabwe, in 1997, 43% of households with AIDS orphans were headed by a grandmother (Foster, 1997). However, in Kenya it is reported that some households are headed by chil-

dren as young as ten or 12 years old, while in other cases entire family structures have fallen apart and homeless orphans live on the streets (Wahome, 2000).

Households with AIDS orphans headed by grandmothers typically suffer abject poverty (Okatcha, 1997) and usually fall below the poverty line (Saoke, Muteni & Blair, 1996). The needs and problems of orphaned children with which grandmothers must cope are multiple; in particular, they are emotional, health and health care related, financial and schooling related.

Older carers

In 1996, Adamchak pointed out that in neither the scientific nor the popular literature are the dynamics of older persons' role as carers to persons with AIDS (PWAs) and their plight with AIDS orphans discussed. The situation has changed little since then. For example, still very little is known about how older women support orphaned grandchildren, what community support there is for the women and affected households, and what the health status of the children and the carers is.

AIDS orphans aside; SSA households are increasingly likely to have at least one person with AIDS. In Africa the role of carer to ill family members traditionally falls on women. But, Mupedziswa (1997) has pointed out, who will care for the older carers in their time of need, when they become frail and can no longer fend for their orphaned grandchildren and themselves? Indeed, who will shepherd them in their dying? Who will give them a decent burial?

And in rural areas, who will till the lands, formerly tilled by able-bodied breadwinners, who have succumbed to the disease, which lands now lie fallow? Who will plant and harvest the crops, and what will there be to eat? How will households survive? Land will be sold to fund expenses incurred by the disease, including payment for consultations with traditional health practitioners in desperate, last attempts to find a cure for a dying family member, as well as burial expenses.

The psychosocial effects of caregiving on older women in households with PWAs or AIDS orphans are numerous. The women suffer loneliness and despair, as they watch their children and grandchildren die. They face a tremendous burden of grief and insecurity with each death. They and their households experience negative reactions of friends and neighbours and non-supportive communities, in the form of prejudice and discrimination as a result of stigmatization of the disease, as well as rejection and social isolation. Worst of all, they are normally trapped in a quagmire of poverty and must struggle to cope with diminished or depleted resources. Clearly, older carers need government resources to assist them in the short term and also NGOs to help them, through support groups which offer material, emotional and practical support, in the medium term.

Knowledge and empowerment

Knowledge of AIDS among vast numbers of Africa's people remains poor. Through a lack of knowledge, perceptions of AIDS as a curse reinforce fatalistic, risky and futile behaviour. Individuals lack information on measures to prevent infection and the spread of the disease. Carers may turn to witchcraft to seek a cure for their stricken relative, or they may heap blame on others for causing the deaths of their progeny. Government AIDS education campaigns have generally marginalized older persons, who are perceived to be at low risk of contracting the disease and thus have consequently not benefitted from public health messages on AIDS. Hence, through a lack of knowledge older carers are not only vulnerable to HIV infection, but also lack skills to contribute fully to the prevention of AIDS and the management of the epidemics.

In Botswana, Tlou (1998, 1996) has pioneered a programme to empower older women by involving them in AIDS-related behavioural change and care intervention. Components and functions of the programme are education on AIDS and the transfer of prevention and care skills, to equip the older women to carry out peer education, to demystify AIDS, and to discourage risky behaviour, outdated traditions and polygamy among people at the village level.

Although the prevalence of AIDS in older African population cohorts is assumed to be relatively low, this situation is set to change. It is erroneous to assume that older persons are not sexually active and therefore not at risk of infection. In addition, a growing phenomenon in Africa is sexual violence against older women, which carries the risk of HIV infection through forced, unprotected sex. AIDS is not easily clinically detected in older persons, as it is not suspected because of the assumption of a low risk of infection, and symptoms of the illness are often ascribed to old age. There is evidence that when older persons develop AIDS, the disease progresses more rapidly than in younger persons and they die more quickly after developing opportunistic illnesses (Wilson & Adamchak, 2000).

Policy directions

All SSA countries are having to contend with social and economic effects of large numbers of people affected by the disease. However, in none of these countries does policy on AIDS adequately address the welfare of older persons. Health professionals, educators, researchers and service planners alike have tended to overlook the considerable economic, health and social-psychological impact which the epidemics have on older persons. Political commitment to include older persons in AIDS education campaigns and to support older carers of PWAs and AIDS orphans is needed, and for this commitment to be translated into strong programmes at national and provincial levels. In sum, policy is needed to support households with PWAs, which support specifically benefits older persons (the carers) and young children. When designing and implementing AIDS programmes, policy makers therefore need to consider inter-generational family dynamics in households with PWAs.

Governments must thus be called upon to develop integrated, as opposed to fragmented, multi-sectoral approaches and responses to AIDS epidemics, which recognize and value the role and contribution of older carers, as well as their vulnerability and need for support. The implications of issues pertaining to the effects of AIDS epidemics noted above on both macro and micro levels are considered in the collection of papers in this issue.

This issue

Four of the five articles in this issue either deal explicitly with or refer to the effects of the AIDS epidemics in the authors' countries. The fifth paper deals with late-life chronic diseases of life-style.

In the first paper, **Akinsola** examines effects of the epidemic on older Batswana and evaluates the effectiveness of his country's Community Home-Based Care programme against the programme's objectives, with special reference to the situation of older persons as primary caregivers to PWAs and AIDS orphans. He concludes that the situation of older carers calls for strong and urgent policy action to assist this

highly vulnerable and marginalized group in its critical and valuable role and function as carers.

In her paper on the provision of housing and care for older persons in Zambia, **Sichingabula** considers implications of the anticipated increases in AIDS morbidity and mortality, in the form of an increased demand for formal housing and care by older Zambians in the face of diminished traditional support. Given effects of the country's Structural Adjustment Programme and the Zambian government's inability to expand provision of formal support for the older population, the author makes recommendations for initiatives which NGOs can undertake towards meeting the needs and improving the quality of life of older persons.

Next, **Shaibu** examines the experiences of caregivers to older persons in Botswana within a context of pervasive, abject poverty and multiple, unmet basic needs. The author notes how the HIV/AIDS epidemic, in addition to other social forces, impacts family structures and the capacity of Batswana to care for older relatives.

In their paper, authors **Patel, Steyn, Charlton, Bourne, Laubscher, Fourie** and **Jooste** describe the risk-factor profile for chronic diseases of life-style, such as hypertension, hypercholesterolaemia and obesity, in the older black population of Cape Town and compare it with risk profiles in other South African ethnic groups. The authors note that although the study population is still at low risk of cardiovascular disease – for example, demographic changes, including urbanisation and the adoption of urban life-styles, are likely to lead to an increase in chronic morbidity in future older cohorts in this population.

In a second paper, **Sichingabula** assesses the physical and social environment of Divine Providence Home, a residential care facility for destitute older persons in Lusaka, Zambia. She draws practitioners' attention to the prudence of incorporating design features in facilities built for older persons which enhance the users' mobility, independence and quality of life. She also highlights a lack of social stimulation and the inactivity of the residents at the home. The author makes the point that given an anticipated increased demand for admission to residential care facilities as a result of AIDS-related deaths and loss of traditional support for older persons, living environments in these facilities must be optimized.

In sum, the AIDS-related research papers in this number highlight a need to identify and to strengthen social and care systems which can assist older persons in Africa, as traditional systems are increasingly affected by demographic forces, particularly the effects of the HIV/AIDS epidemics.

Finally, **Møller** reviews a recent, landmark HelpAge International report (1999), which is a compilation of 15 papers on ageing in developing countries and challenges facing research, policy and practice.

Special issue

The October 2000 number of *SAJG* will be a special issue of research papers based on HelpAge International initiatives and projects in several SSA countries, which initiatives aim to generate indigenous knowledge through innovative, participatory-research methodology and to translate research findings into practice.

Readers are reminded that comment on articles published in *SAJG* in the form of letters to the editor is encouraged.

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