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COMMENTARY

The grandmothers' disease—the impact of AIDS on Africa's older women

Africa's projected proportions of older people in 2000 and 2025 are 4.8 and 6.4%, the lowest for all global regions. However, the percentage change of the over-60s between 2000 and 2025 is the greatest of any region, with the older population increasing from 41 to 102 million, an increase of 149%. During this time period, the percentage increase of the older population of Northern Europe will be about one-quarter of this figure: a modest 38% [1]. Taking the year 2000 as a baseline, Africa's over-60 population will double in only 17 years, and most elders will be women [2].

In contrast, there is a concurrent and sharp decline in regional life expectancies. For example, life expectancies have dropped from 62 to 40 years in Botswana, from 56 to 37 years in Zambia and from 65 to 39 years in Zimbabwe [3]. Life expectancies were, until a few years ago, increasing in relation to fertility decline, allied to improved health and socio-economic conditions [4].

Effects of changing population profiles on older Africans

In countries such as Zimbabwe, Namibia, Swaziland and Zambia, 19–25% of all adults are HIV-positive and the crude death rate has escalated up to three-fold. The increase in crude death rate is exacerbated by a near two-fold increase in infant mortality, as well as the attrition of the 15–49-year-old population group by the HIV/AIDS pandemic. These are the major causes of African regional life expectancy decline [5]. The 15–49-year-old group should make up Africa's productive labour force. Yet from it, 12.2 million females and 10.1 million males are already living with HIV. The HIV seroprevalence in Africa's younger populations ranges widely around a median of 36%. What is not known is the seroprevalence of the over-60s: no data are available (by contrast, around 10 000 Britons are living—although unaware they are infected—with HIV [4]). In Africa it is this productive, working-age cohort which would generate financial and other forms of support such as food and clothing, and then pass these on to their parents and to dependent children.

Older Africans in particular have historically relied on this informal form of support, often augmenting it with small-scale market gardening or trading [6], but African family structure is changing. More young people obtain an education, leave peasant agriculture and rural livelihoods, migrate to urban areas and enter wage economies. This then segregates the elders, who remain behind in rural areas. Informal support declines, as in Zimbabwe where the development process (modernization and urbanization) is changing traditional institutional structures, with older women especially receiving less family support than did previous generations [7].

Less than 10% of the sub-Saharan labour force participate in formal retirement programmes, which could provide reliable financial support in old age [8]. The gap created by loss of informal support is not filled. Pension programmes for older citizens are expensive, and governments preoccupied with development issues may view them as not giving a suitable return on their investment. Investing in capital improvements is seen to yield a favourable return but, more often than not, investing in older people is not.

Older Africans (and in particular the women) are confronted by the prospect of diminished social support at a time when they cannot avoid, but can least afford to take on, an expansion of responsibility. They are called on to care for and support HIV/AIDS-infected ailing and dying children and orphaned grandchildren, who may also be dying from HIV/AIDS. In Zimbabwe, in 1997, 43% of households with AIDS orphans were headed by a grandmother, a significant emerging phenomenon which is described as 'skip-generation parenting' [9]. Meanwhile, HIV/AIDS already places an unprecedented pressure on finite institutional resources throughout the continent. In Kenya, HIV/AIDS substantially enhances the financial burden of the aged, at a time they can least afford it [10].

HIV risks for older people

The consequences to older Africans of the diminished support mechanisms will be enhanced by hitherto unrecognized susceptibility to the health and medical risks of HIV/AIDS. These risks may be direct and indirect. Direct risks include a personal risk of HIV infection through unprotected sexual or other high-risk activities. Despite dogma to the contrary, direct risks can be high for old people of both sexes through

unprotected sexual activity. The risk is especially high in older women; alarming evidence is emerging of elder sexual abuse in South Africa [5]. Traditional healers may in certain circumstances undertake high-risk activities such as unprotected scarification, circumcision, tattooing, and even blood sucking as part of their healing activities. In addition, unprotected manipulation at childbirth may be a risk for traditional midwifery, customarily the role of the older women [11]. Widowhood and divorce are further direct risks for HIV infection of older Zimbabweans [12].

When older people do develop AIDS, they do so more rapidly than younger people, and they die more quickly after developing an AIDS-associated illness [13]. Indirect risks are two-fold. First, and importantly, the conventional thinking that steers health education and community efforts away from older people because they are perceived to be less at risk renders them more vulnerable. Formal health and awareness education is not targeted to older Africans, who are deemed least likely to contact HIV. Secondly, the diminished health and nutritional states of many older Africans result in an overall diminished survival capacity [14].

It could be argued that older Africans are relatively more at risk than their younger compatriots because of prevailing but inaccurate assumptions among governments and donor agencies that they merit less attention as they constitute a low-risk group. Resources are directed away from them and are preferentially channelled towards children, orphans and (young) women's health. Health promotion is oriented towards those considered to be sexually active. Some small, locally-driven initiatives have recognized and responded to this omission with encouraging results. As is often the case in Africa, it is the older women (as in Botswana) who take the lead by recognizing the importance of behaviour modification and responding to it [15].

At a recent inter-sectoral workshop (AFRITA, Nairobi, 1999), delegates emphasized the failure of African governments and major donors to appreciate the challenges, both direct and indirect, posed by HIV/AIDS in older Africans. Attention was drawn to their failure to anticipate, identify, and react to the impending support and health crisis affecting older Africans [16].

All medical and allied professions need to heed this message, and to join their African colleagues in challenging health ministries, non-government organizations and other institutions. An urgent awareness leading to a co-ordinated strategy embodying appropriate intervention to offset this burden on Africa's aged, is required. So far this is only evident in Namibia [17].

It is inevitable that older Africans (especially women, who will outlive their husbands) will shoulder the social, economic and health consequences of HIV/AIDS. As things stand, this will be without concomitant formal or informal mechanisms to enable them to manage. Who will care for the carers in their time of need [18]? It is clear why HIV/AIDS is already referred to as the 'grandmothers' disease' in many villages in rural Africa. Is grandmother going to be left holding the baby?

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Editor's note: with great sadness we report that Donald Adamchak died soon after writing this commentary.

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