
Role of Elderly people in the Era of HIV/AIDS in Africa

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Introduction:

In the last decade, the HIV/AIDS epidemic has had devastating but under-reported impacts on the lives of older people and those who depend on them. Help Age International (HAI) believes there is now an urgent need to research the effects of HIV/AIDS on older women and men both as an at-risk group and in their critical role as carers, and to support them as key contributors to community survival and coping mechanisms.

Older people in most African societies are a vulnerable group as a result of a lifetime of hardship, malnutrition, poverty and, in older age, high susceptibility to chronic diseases. The AIDS pandemic is now posing an additional burden on them. In their old age, when they may require support and expect to be looked after, they have to take on the role of caring for others, in most cases without even the basic necessary resources. Thus, their health is the most precious asset not only to them, but also to their families and communities. Lack of economic, social and psychological support, combined with poor access to health services, constantly restrict their ability to provide the care expected of them. All efforts must be made to support and address the vulnerability of these older people, not least because it is they who are raising “children orphaned by AIDS” – Africa’s future human capital [adapted from authors]

Older people need to be counted, supported and educated in the fight against HIV/AIDS. The different needs, roles and responsibilities of older men and women need to be acknowledged and included in programs and policies addressing this global epidemic.

Objectives of the Study:

This study seeks mainly to highlight the need to change the role of the elderly people in African household especially with the wide spread of HIV/AIDS infection. This main objective could be realized through the following sub objectives:

- To figure out the demographic impact of HIV/AIDS on the age structure of the African population as a very important determinant of the rapid ageing in the region.
- To discuss how to activate the change of the role of elderly people in the African household as care givers. That will be through better understanding the challenges that may affect their ability to carry on their responsibility of caring. Possible interventions and policies to maximize benefits provided by elderly people.

Organization of the study:

Introduction, objectives, and literature review are presented in section (I), Demographic impact of HIV/AIDS in some African countries will be discussed in section (II), Challenges, interventions and policies suggested to maximize the benefits provided by the elderly people will be discussed in section ((III).

SectionII:Demographic impact of HIV/AIDS and its consequences in some African countries

Our main objective in this section is to discuss the changes in the population age structure due to HIV/AIDS epidemic. 25 years ago the epidemic attacked adults in reproductive age, females are most likely more affected by the epidemic than males. Percentages of infant and child mortality in different countries rose sharply due to mother-to-child transmission. Now and maybe for some more time in the future the lives of old people with good health status will be spared by the epidemic. The demographic impact of HIV/AIDS also has serious effects on the economic status as well as the social lives of populations.

Africa, with an average completed fertility rate exceeding five children per woman, has grown the fastest among the regions. There are almost three times as many Africans alive today, 767 million, as there were in 1960. Africa's share of global population was projected to rise from 9% in 1960 to 20% in 2050. But with the continued spread of HIV/AIDS this 3% annual population growth could reverse and the population could actually reduce over the next 50 years, unless sexual behavior changes.

More than any other disease, HIV/AIDS has proved its ability to disrupt the economic and social fabric of the community. This is because the disease is fatal, mainly affecting adults of working age who have young children and elderly parents to support. It is estimated that up to 25% of people between the ages of 15-49 are infected with the HIV virus. Often AIDS can also strike more than one member of a household or family. That does not mean that older people are not subject to the disease, Best K. (2002), in

his article asserts that older people are not spared by HIV/AIDS despite the impression that AIDS is a younger person's disease. More people have died from HIV/AIDS over the last twenty years than from any other disease in human history. In the United States for instance, the devastation caused by the epidemic poses a clear and direct challenge to long-term U.S. economic and security interests. AIDS is devastating whole societies and economies, depriving countries of the educated and skilled individuals.

As the epidemic devastates a lot of areas all over the world, it is important to undertake aggressive global efforts to mitigate its impact. To meet this challenge, the need to construct and carry out a long-term strategy to defeat AIDS is urgent. To increase funding, accelerate the search for a vaccine, expand access to medicines, and form partnerships with affected governments, businesses, and communities will be critical.

[UNAIDS](#), the global body responsible for coordinating efforts to fight the disease, reported in its December 2000 "[Epidemic Update](#)" that 21.8 million people have died from HIV/AIDS since the beginning of the epidemic. Four-fifths of those deaths have occurred in sub-Saharan Africa—over 2.4 million in the first eleven months of 2000 alone, an average of one death every eight seconds. More than 70 percent of all people living with the disease, or 25.3 million HIV-positive individuals, live in Africa. Over 10 percent of the population is infected in sixteen African nations. Despite these numbers, the epidemic is not limited to Africa. Indeed, the fastest growing front of the epidemic is now in Russia, where the number of new infections exceeded the total from all previous years combined. In 2000, the number of Russians living with HIV/AIDS skyrocketed from 130,000 to 300,000.

The Caribbean and Latin America are increasingly affected. Haiti already ranks among the twenty-five most infected countries, with a prevalence rate of over 5 percent. In the Bahamas, adult prevalence rates are 4 percent, and in Honduras, Guatemala, and Panama they top 1.3 percent. The disease is also expanding its reach in Asia—3.7 million people in India are infected, more than in any country other than South Africa. The HIV-positive population in China is estimated at over half a million, and [UNICEF](#) has said that without substantial prevention programs, China could have 10 million HIV/AIDS cases by 2010. The United States is also experiencing a resurgence of HIV/AIDS. In 1999, new infections rose from 40,000 annually to 46,000, according to the [Institute of Medicine](#). [The Centers for Disease Control](#) (CDC) estimates that 800,000 to 900,000 Americans are living with HIV/AIDS.

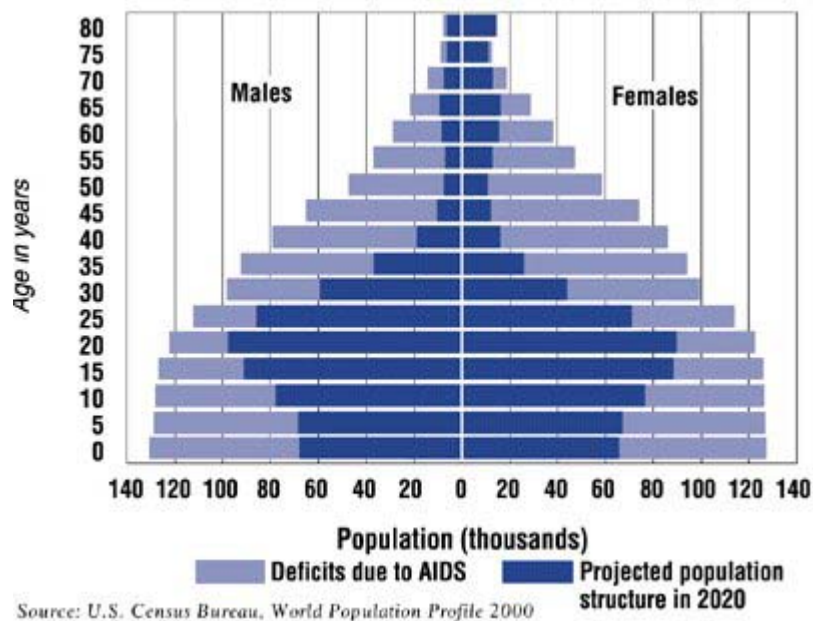
Deaths from AIDS now exceed those from the global influenza pandemic of 1918-19 and the Bubonic Plague. Unlike influenza and plague, HIV/AIDS does not kill its victims for years, and most victims do not know they are infected. UNICEF estimates that only 5 percent of infected Africans are aware of their HIV-positive status, meaning millions of people unwittingly continue to transmit the disease. The effects on individuals,

economies, social systems, and political stability surface slowly, hampering education and prevention efforts.

Globally, the epidemic is accelerating and spreading. According to the (WHO), 5.3 million people were infected with HIV in 2000, bringing the number of people worldwide living with HIV/AIDS to 36.1 million. The WHO estimates that 6 million more will be infected in 2001. Unfortunately, most epidemiologists do not believe an effective vaccine is possible in less than five to ten years, and maybe not even then.

The death toll from AIDS is also mounting. Cumulative deaths from HIV/AIDS almost doubled in 30 months, from 11.7 million deaths in June 1998 to 21.8 million by December 2000. It is now the leading cause of death in Africa. AIDS does not predominately kill the weak and elderly, but rather attacks the most productive adults, leading to distorted demographics in the hardest hit countries. The U.S. Census Bureau calculates that by 2010, average life expectancy will be reduced by 40 years in Zimbabwe and Botswana, and in South Africa by 30 years. The resulting population structures will be unlike anything we have seen before. Instead of pyramids, we will see population "chimneys," where the very young and the very old are supported by only a slim pillar of remaining people in their prime of life (see figure 1).

Figure 1: Projected Change in Demographics Due to AIDS, Botswana



The loss of millions of working adults means not only the loss of the individuals, but the resources invested in them, and their knowledge. Nowhere is this true in the education sector. In the first ten months of 1998, Zambia lost 1,300 teachers, the equivalent of two-thirds of all new teachers trained annually. In the Central African Republic and Cote d'Ivoire, over 70 percent of teacher deaths are linked to AIDS. These losses are a

double tragedy as they deprive the next generation of the education it needs to escape poverty and build stronger economies and institutions.

In the health care sector, medical staff exposed to HIV are falling sick and dying, constricting already limited access to health care. Resources are also diverted from primary disease prevention and health care to HIV/AIDS patients. In Zimbabwe, HIV/AIDS consumes one quarter of health spending, and in the largest hospitals in Kenya and Burundi, AIDS patients occupy 39 percent and 70 percent of hospital beds, respectively. The loss of skilled and educated citizens will make it harder for struggling countries to build professional, transparent, and accountable governments and institutions. Without strong democratic partners in the developing world, American efforts to form coalitions to build stability, prosperity, and peace will be strained.

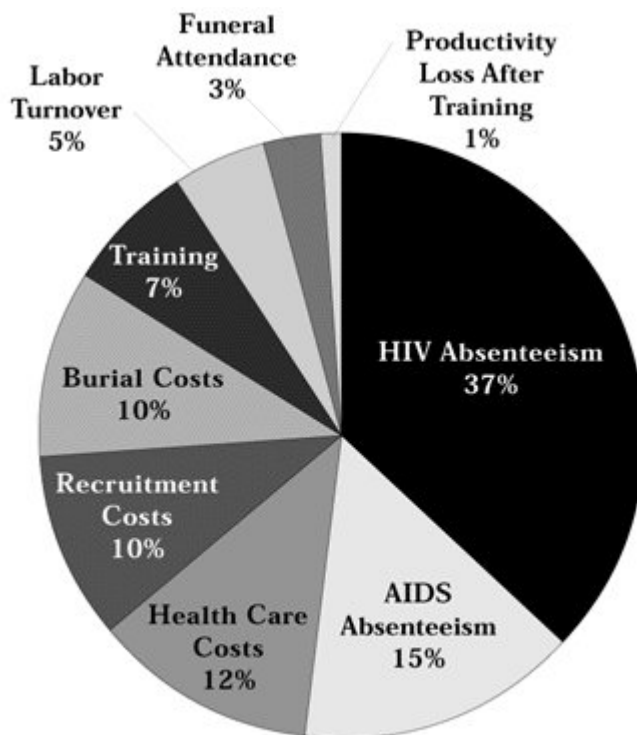
The demographic impact of the HIV/AIDS crisis on African economies is worsening. Rising health care and funeral costs, combined with lost income and savings, are devastating families. Productivity losses, increased absenteeism, and rising insurance and training costs are hurting economies and businesses. Without preventive measures, this pattern could repeat itself in Asia and Latin America.

Very little data is available on the macroeconomic impact of AIDS. However, the [World Bank](#) and others have predicted an annual reduction in per capita income growth of 0.1-0.41 percent in Africa, depending on variables such as productivity and viral incubation periods. An August 2000 study by the World Bank found that South Africa's Gross Domestic Product would be 17 percent lower in 2010 than it would have been without AIDS, costing the economy \$22 billion. A recent Harvard study postulates that these predictions are low because they do not take into account the negative feedback effects of AIDS, including falling worker productivity, declining savings and investment, and rising business costs. More studies are needed on the economic impact on African, Asian, and Caribbean nations.

Although the full brunt of the epidemic has not yet been felt because adults generally take seven to ten years to die from AIDS, the effects on business can be measured. Direct costs to companies include sick leave, health benefits, death and disability benefits, and pension liability. Metropolitan Life, one of the major insurance providers in South Africa, has developed a model to project the scope and effects of the epidemic. The model estimates that the cost of life insurance as a proportion of salary will treble between 1997 and 2007, and pension benefit costs will nearly double. While these costs may be small for individual employees, when multiplied by the number of affected workers, they are significant. Employers will have to either decrease benefits proportionately or increase the price of their product to cover the extra cost. In addition, studies in Kenya and South Africa have shown that indirect costs—absenteeism, time off for care and funerals, lost productivity, and recruitment and training of replacement

employees—comprise more than two-thirds of the total cost to businesses of HIV/AIDS (Figure 2).

Figure 2: Categories of AIDS-Related Costs



Source: AIDSCAP/Family Health International, *AIDS in Kenya: Socioeconomic Impact and Policy Implications*, 1996

Although HIV and AIDS have become a concern for all age groups, to date little has been written about its impact on the older adult population. Society's earlier reluctance to deal with HIV as a problem in the general population has only served to compound problems of addressing HIV as a concern for elderly adults (Linsk, 1994). However, more recent examination of the issues has revealed that older persons are increasingly being affected by HIV/AIDS directly and indirectly, through knowledge of and interaction with HIV positive family and friends. In fact, it has been argued (Whipple & Scura, 1989) that older adults should be considered at risk of HIV/AIDS because they continue to express themselves sexually, may be (or may have been) intravenous drug users, may have received blood transfusions, and may already have a compromised immune system due to other age- and health-related conditions.

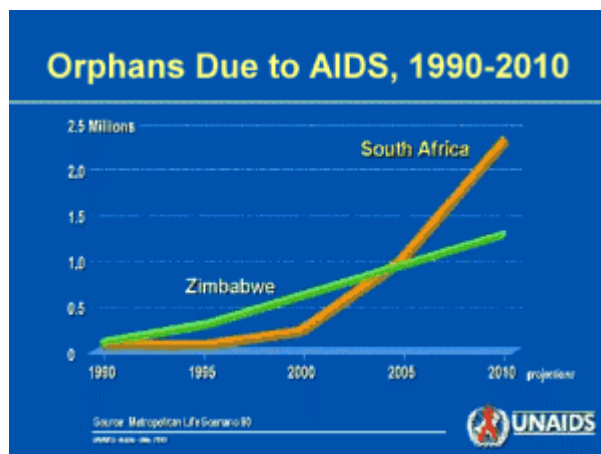
From the social point of view HIV/AIDS places enormous stress on infected individuals and their families who are confronted with the demands of caring for the seriously ill and with the trauma of death. In addition, they also face the economic burdens of health care and funeral costs, as well as the loss of income when the breadwinner becomes ill. All of these factors are worsened by the stigma associated with HIV/AIDS.

This means that people can be victims of prejudice at work, in the community and at home, and invariably lack the support mechanisms that are available for most other fatal diseases.

The death of an adult can have a dramatic impact on family structure and function. Children, the elderly or single parents may be left to run households, with severe implication for those concerned. Women and female-headed households are particularly vulnerable to the impact of HIV/AIDS.

Cultural, social and economic pressures make women more likely to contract HIV infection than men. Susceptibility is increased by factors ranging from rape, economic dependence on men and pressure on teenage girls to have relationships with older men. At the same time, women and girls tend to bear the main burden of caring for sick family members, and often have less care and support when they themselves are infected.

UNAIDS defines an AIDS orphan as a child who has lost his or her mother or both parents to AIDS. More than 13 million children worldwide are AIDS orphans (12 million in Africa alone), and the [U.S. Agency for International Development](#) (USAID) estimates that by the end of the decade there will be more than 40 million AIDS orphans in Africa, equal to the number of all children under 18 living east of the Mississippi. Studies show that orphans are less likely to stay in school and more likely to suffer from malnutrition and be drawn to commercial sex work and other high-risk behaviors in order to survive. Orphans are also vulnerable to recruitment by criminal groups and rebels in conflict areas.



UNAIDS' estimates and projections during the period 1990-2010 for the number of orphans from AIDS in Zimbabwe and South Africa illustrates a very noticeable increase in the expected numbers of orphans in both two countries, more striking increase is expected in South Africa than in Zimbabwe. Figure (3). (Betty Gittens, 2000).

Experiences of some African countries are presented in the State of the future (2001). The book stated that in 1986 Senegal established a national plan and in 1992 declared war against HIV. Since then, there has been a 10 million increase in the production of condoms, and this reflects the public openness to sex. Furthermore it has legalized prostitution, and has thus made it possible to launch education programs in the highly vulnerable segment of the population. As a result, Senegal's infection rate is 1.7% relative to neighboring countries where infection rate goes usually well over 10%. The book also highlights efforts to prevent mother-to-child transmission in 30 African countries. Agreements have already been signed by several countries, including Gabon and Senegal. It also indicates that Zimbabwe passed a law (May 2001), which will sentence those convicted of consciously spreading HIV to as much as 20 years in prison.

Sickness, together with poverty and ignorance are the three corners of the triad of human suffering. No one can imagine achieving a considerable success in resisting spread of infections without ensuring a sustainable potable water supply and sanitary sewage disposal systems. Extreme poverty is the main cause of risky behavior, mainly because people have not been offered alternative honorable ways to earn a living. Because the whole world is sailing in one boat, developed countries are obliged to work on improving the quality of life of people in the developing world, at least for the purpose of protecting the health of people in the developed countries.

It also indicated that Botswana, Kenya, Mozambique, Namibia, Rwanda, South Africa, Zambia, and Zimbabwe all have adult HIV rates over 10 percent (25% for Botswana; 22% for South Africa). According to the UN Population Division, life expectancy has fallen by ten years in the region because of AIDS and is expected to be reduced by 17 years in 2010-2015.

The key reason for the disease's spread is lack of education. For example, some South African men believe that intercourse with a virgin will cure their AIDS. Since some men don't want their virgin daughters to be taken by other men, it is said that some are having intercourse with their own daughters as soon as they are old enough to walk. The World watch Institute stated that without a medical miracle, 20% of the 43 million South Africans would die within five to ten years, which could possibly destabilize the country in unimaginable ways. The UN began its UNAIDS program in early 1996 in order to concentrate funding and international attention on programs for developing countries.

In 1999, AIDS killed about ten times more people in Africa than did armed conflict. At the rate people are dying today, it is bound to adversely affect and frustrate Africa's economic and social transformation.... In the worst hit cities of southern Africa, 40 per cent of pregnant women are HIV-positive. In that same region, more than one child in 10 has lost its mother to AIDS.... Government projections in Zimbabwe indicate that

HIV/AIDS will consume 60 per cent of the nation's health budget by 2005, and even that will be wholly inadequate.

Botswana has the world's highest HIV/AIDS prevalence rates, with one of every four adults infected. By 2025, Botswana's population may be 23 per cent less than it would have been in the absence of AIDS. Nevertheless, because of continuing high fertility, the population is still expected to nearly double between 1995 and 2050. In Zimbabwe, the second-hardest-hit country, one in five adults is infected. Estimated life expectancy at birth is 44 years and will fall to 41 in 2000-2005, 25 years less than what would be expected in the absence of AIDS. The country's population in 2015 is expected to be 19 per cent lower than it would have been without AIDS.

It is stated that 48% of deaths among women in the Tanzanian capital of Dar el Salaam are caused by HIV/AIDS, according to Dr. Stephen Hanson of Tanzania's National AIDS Control Program (NACP), who notes that the statistics a few years old and the numbers could be even higher today. Some 1.5 million Tanzanians have HIV, and more than 520,000 have AIDS. Since 1983, more than 103,000 people have died from the disease. More than 80% of patients are between 20 and 44 years old. "In some parts of Tanzania, AIDS has become the leading cause of death among adult men and women," the NACP says. The NACP also reports that unprotected sex and multiple sexual partners are major factors fueling the AIDS epidemic. Military recruits are at a higher risk because they are sexually active and mobile. Additionally, a crackdown on prostitution in Dar el Salaam appears to have had little effect. Tanzania currently has no official AIDS policy, according to Dr. Bernard Fimbo, head of research and information at the NACP. He says a plan is being prepared and will be implemented in the near future. However, anti-HIV/AIDS campaigns face numerous hurdles. More than 130 NGOs are currently working on HIV programs in Tanzania, but only 4% have more than a regional or district presence. Most are restricted to small communities. And while educational materials are prevalent, the virus continues to spread. (TOMRIC Agency/Africa News Online, 24 April)

According to an International Labor Organization (ILO) report, the AIDS pandemic is killing off the workforce in many African nations, endangering productivity and encouraging companies to turn to child labor. The report goes on to state that in South Africa's mining industry one in five workers is infected with HIV, while in Zimbabwe, HIV/AIDS will cut the labor force by 17.5% 2015. Large companies in Tanzania and Zambia reported that AIDS-related health costs exceeded total annual profits in 1997.

Progress can be made through mass education; making sure that governments assume responsibility, are transparent about prevalence of these diseases, and adopt preventive and curative measures; and improve access of the people to health services. Mainly through their legislative systems, governments can support the family as the only legally and socially acceptable core unit of the society. Blood safety should

be ensured and improve the surveillance system for emerging viruses and infections shall be enhanced through improving the existing local, regional, national and international networks of laboratories and medical centers.

WHO reports that progress has been made in AIDS treatment in Senegal and Uganda with the use of Community based programs instead of simply having a clinic available. In Senegal, educational materials were designed and training sessions organized for religious leaders. The issue of HIV/AIDS became a regular feature of Friday service (Salat-al-Jumah) in mosques throughout Senegal, and religious leaders discussed the issue on TV and radio. Brochures were produced to ensure that AIDS education was incorporated into religious teaching programs. And Christian religious leaders, including those of the Catholic faith, also developed a supportive approach to prevention – providing counseling and psychosocial support and advocating tolerance and care. Although the issue of condom promotion – especially outside marriage – remains an ethical minefield for the country’s religious leaders, they have had the courage to refer people to alternative service providers.

Uganda has succeeded in lowering its very high infection rates. A new innovative social marketing scheme to promote the use of an STI self-treatment kit (“Clear Seven”) has proved to be successful in treating STIs and preventing IV infection. The Kit, which contains a 14-day course of tablets, condoms, partner referral cards, and an information leaflet, is designed to improve STI treatment. Since 1993, IV infection rates among pregnant women, a key indicator of the progress of the epidemic, have been more than halved in some areas and infection rates among men seeking treatment for sexually transmitted infections have dropped by over a third.

International Plan of Action on Ageing 2002:

State of the world's older people 2002, in its report discusses why global ageing is an urgent issue. From the demographic point of view, the report highlights the revolution in global life expectations and age discrimination as follows:

- A person born in 1950 could expect on average to live for 46 years. By 2050 average global life expectancy will have risen to 76 years
- By 2050, one in five people worldwide will be over 60
- In every region except sub-Saharan Africa, the rate of population increase among the over-65s is higher than that for the under-14s. Even in sub-Saharan Africa the number of older people is growing faster than the number of children
- Older women outnumber older men. In 2000, there were 83 men for every 100 women worldwide. In developing countries, where the gap is lower, the ratio will have increased to 86:100 by 2030.
- All societies discriminate against people on grounds of age. Ageism and stereotyping influence attitudes, which in turn affect the way decisions, are taken and resources are allocated at household, community and national levels.

- Policies that deliberately or by default exclude people from active contributions to society because they are 50, 60, or 80 years old are not only in breach of human rights principles but are a waste of human and social resources.

A change in mindset is needed to welcome older people's contributions and participation, and take a fresh view of relations between the generations. Older people also need to be given opportunities to work, and access to training and credit regardless of age. Experience of providing credit to older people has shown them to be responsible.

In the era of HIV/AIDS the report stated that older people are both affected and infected by HIV/AIDS. They are at risk when they care for those who are infected, and when they are sexually active. Older women, often in severe poverty, nurse their dying children and care for their orphaned grandchildren. The report indicates that:

- No international data is compiled on HIV/AIDS infection in older adults; testing is not carried out on over-49s and they are rarely included in programs to disseminate information and control the spread of the disease
- 8 million children orphaned by AIDS in sub-Saharan Africa are being cared for by older relatives
- In Thailand, two thirds of adults with HIV-related illness are nursed at home by their parents
- In Ethiopia, 68 per cent of those who died from AIDS left orphans in the care of their older parents

The material and psychological strains of coping with AIDS deaths and bringing up orphans. Rosalina Odero, 85, is one of the many older women in Kenya whose life has been devastated by the loss of seven of her children and their spouses to AIDS. She is now the sole carer for her ten grandchildren. 'My grandchildren are too young and cannot even fend for themselves', she explains. 'It is unfortunate, painful, and devastating. Often we have gone without food and the house is falling on us', she said.

The role of older people in caring for AIDS orphans is only slowly being recognized. The poverty of many older people who are faced with the cost of bringing up and educating orphans with meager resources need to be addressed. The fact that they are ignored by HIV/AIDS programs also lays them open to infection, both as carers and as sexually active people.

The report concludes that when older people are included in the design, delivery and monitoring of programs, there are obvious benefits to all generations in areas as diverse as health and legal training, income generation, and local and national advocacy. But barriers to participation include legal constraints, custom and older people's own lack of confidence. A rights-based approach to development places a

high value on networking and support to older people's organizations. Consultations with older people and their organizations have shown how much importance they attach to being involved in civil society monitoring of action on ageing at national and international level. [Ten actions to end age discrimination](#) are proposed in this report.

Section III: Challenges, interventions and policies suggested to maximize the benefits provided by the elderly people

The previous analysis of the demographic impact of the HIV/AIDS highlights and indicates that the elderly people can perfectly play a very important role at least as care givers for their own orphans or adults infected with HIV/AIDS. Challenges facing elderly people in carrying out this role, as well as interventions and policies suggested to maximize the benefits provided by the elderly will be discussed in this section. Experiences of some countries will be presented as well.

In the last decade, the HIV/AIDS epidemic has had devastating but under-reported impacts on the lives of older people and those who depend on them. Help Age International (HAI) believes there is now an urgent need to research the effects of HIV/AIDS on older women and men both as an at-risk group and in their critical role as carers, and to support them as key contributors to community survival and coping mechanisms.

HIV/AIDS is changing the age profile in regions with high rates of infection, putting severe pressures on older survivors and placing multiple burdens upon them at a time of ever decreasing resources. Older people have become primary carers for their children who are sick with AIDS, and this responsibility falls primarily on older women. In Thailand, for example, two-thirds of all those affected with HIV-related illness are nursed at home by parents in their 60s and 70s. In a study of older carers in Zimbabwe, conducted by Help Age Zimbabwe with the World Health Organization, 74 per cent of the older carers in the sample were women.

Older people are also left with the responsibility of supporting their orphaned grandchildren. Yet older people are not recognized or supported in current policy and intervention on HIV/AIDS.

One outcome in countries with high HIV/AIDS prevalence is an increase in the number of chronically poor households headed by older women, with a large number of dependents. Older women generally suffer most from chronic poverty and lack of resources. They are often in need of care themselves, but face, sometimes unaided, the costs and emotional stress of nursing terminally ill relatives, paying for burials and the financial and practical difficulties of bringing up orphans - including payment of school fees. Older people need to be supported through community care and support programs to carry out their critical role as carers, for their own wellbeing and that of the children. A key issue here is fighting to overcome the shame and stigma still attached

to the disease which inhibits many people including older people from accessing the right services and advice.

Older people are both affected and infected by HIV/AIDS, as outlined in the draft International Strategy for Action on Ageing. In Thailand, national figures for 2000 show nearly five per cent of HIV infected cases were over 60 years old. Yet most efforts to control the spread of the disease and disseminate information concentrate on under-49s.

International data on AIDS infection is not being compiled for older adults. It is rarely acknowledged that older people remain sexually active and thus at risk of infection. In particular, many older men take younger partners and may become infected. Unprotected sex in polygamous marriages makes this situation difficult for women of all ages. Lack of information about HIV/AIDS and its consequences also exposes older women in particular to infection through their role as carers. The exclusive focus on younger people in educational campaigns ignores the need to educate older men and women on HIV/AIDS and the continuing role older people play in the socialization of children.

Older people need to be counted, supported and educated in the fight against HIV/AIDS. The different needs, roles and responsibilities of older men and women need to be acknowledged and included in programs and policies addressing this global epidemic.

Zimmer Z., Dayton J. (2003) on the detrimental consequences of the AIDS epidemic for older adults in sub-Saharan Africa suggest the need to investigate their characteristics, living situations, and well-being. They examined the living arrangements of persons aged 60 and older in 16 countries, and the tendency of the elderly to live with children and grandchildren, as well as distributions and determinants. Results show that older adults in sub-Saharan Africa live in a variety of household arrangements. Older men are more likely to be living in a nuclear household, while women are more likely to be living in extended families. Regressions show that determinants of living with children and grandchildren differ by sex. Taking advantage of survey items on the survival and whereabouts of parents of children, the study also examined whether older adults living with grandchildren are involved in fostering or orphaning situations. Those living in countries characterized by high levels of AIDS-related mortality are more likely to be living with grandchildren, with but no children in the household, and with orphaned grandchildren. The percent living with one or more double-orphaned grandchildren is strongly associated with AIDS-related mortality, suggesting that the epidemic may be having adverse influences on the living situations of older adults. Knowing about the types of households in which older people live is a first step to understanding their needs in a part of the world with limited resources.

In one study, Dayton J; Ainsworth M, in 2002 stated that the elderly are often especially likely to be adversely affected by the death of prime-aged adults from AIDS. The authors use a longitudinal survey of households from northwestern Tanzania in 1991-94 to compare the activities and well-being of the elderly in households before and after the death of a prime-aged adult with those of the elderly in households that did not experience the death of an adult. A significant proportion of adults suffering from AIDS return to their parents' home shortly before death. Time spent by the elderly performing household chores rises following an adult's death, and their participation in wage employment falls; no evidence is found of increased participation in farm work among the elderly. Evidence shows that the physical well-being of the elderly as measured by body mass index is reduced before the death of an adult relative but recovers thereafter. These results suggest that interventions to prevent a decline in well-being should be focused on the elderly in households with an AIDS patient during the period of illness. Finally, the physical well-being of the elderly in poor and better-off households prior to an adult's death is compared with that of the elderly in the poorest households that did not experience the death of an adult. The comparison indicates clearly that the poor have the lowest body mass index. Thus, deaths of adults from AIDS are likely to have the largest adverse impacts on the elderly in poor households. A broader group of elderly poor people with pervasive low health status should also be the focus of public policy designed to improve the welfare of the elderly.

Agyarko R.D. *et al.*,(2002), carried out a project titled "Impact of AIDS on older people in Africa", which was designed to develop a methodology to examine the impact of HIV/AIDS on older caregivers preliminary in four countries in Africa, Zimbabwe, Ghana, South Africa and Tanzania. Starting with a pilot project in Zimbabwe, a mix of qualitative and quantitative research methods was designed, tested and applied to provide statistical and qualitative information on the role of older people in HIV/AIDS-related care, and on the burden they bear. This pilot study was carried out in six provinces selected to represent the diversity of the Zimbabwean population. Working in close collaboration with governmental departments, non-governmental organizations (NGOs), and academic institutions, the WHO Ageing and Life Course team (ALC) aimed to provide baseline data which would facilitate efforts to improve institutional and community understanding of the plight of older people in the context of the AIDS epidemic in Africa. It is expected that the data will be useful for policy and program initiatives that can potentially strengthen the capacity of older people to act as care providers to their HIV/ AIDS-affected families.

Knodel J.,VanLandingham M. (2000), in their article focus on the impact of the HIV/AIDS epidemic on infected family members who are affected emotionally, economically, socially, and physically by the illness and death of a person with AIDS. In terms of the impact of parental AIDS on the children, it has been noted in the study of Schuster *et al.* that 28% of persons with AIDS in the US have children younger than 18 years of age. Although the study does not provide evidence about the nature of the

impact of parental AIDS on these children, it is assumed that most of them are or will be affected by their parent's illness in profound and lasting ways. For parents of AIDS-infected adult children, its effects are manifested in the caring for AIDS orphans, financial demands, physical and health impacts, economic and social opportunity costs, and emotional impacts. The research conducted in Thailand revealed an extensive parental involvement in living and care-taking arrangements of adult children with AIDS, especially in a developing country. This article suggests that more attention should be given in assessing the ways and extent to which the AIDS epidemic affects the older population in a developing world, as well as the public health implications for older persons who are affected.

Mukoyogo MC; Williams G, 1991, state that 70% of children born to HIV- seropositive mothers are uninfected with HIV. Facing the present spectra of eventual premature death, these infected mothers will nonetheless leave many children orphaned. UNICEF estimates that 3.1-5.5 million youths under age 15 will be orphaned in 10 countries of central and East Africa by the turn of the century, while WHO estimates 10 million newly made orphans under age 10 worldwide over the same period. 9 million of WHO's estimated 10 million will be in sub-Saharan Africa. While commenting on AIDS in the global context, this paper largely focuses upon AIDS in Tanzania at the national and regional levels. Input for regional-level conditions was gained during a 10-day visit to the Kagera region of Tanzania in November 1990. Regional families are suffering heavily from AIDS. Traditional coping mechanisms offered by extended families are frequently overwhelmed, leaving both orphans and care-providers in great need of assistance. Specifically, orphans need physical, emotional, and psychological support, educational and vocational skills, health care, and assistance in coping with and/or avoiding stigmatization, exploitation, and socialization. On the other hand, care-givers need child care, labor and agricultural inputs, vocational skills, legal advice and assistance, health care, psychosocial support, and HIV testing. Immediate and significant investment is needed at all levels to help communities and families cope with the AIDS pandemic. The roles of employers, nongovernmental organizations, families, orphanages, foster care, and new community initiatives are discussed. Synopses of 13 cases are presented.

The role played by older people in caring for orphans infected with HIV/AIDS, is also discussed in Kenya conference 2003, the conference states that "The number of AIDS orphans is raising drastically as the pandemic continues to claim millions of young adults all over Africa," Help Age International (HI), "Most of these children end up under the care of grandparents living under extreme poverty that compromises their ability to provide adequately for them and this burden will increase as the (numbers of) orphans increase," it added. The charity said the meeting would try to identify ways to increase support to elderly people and others caring for HIV/AIDS sufferers, and was set to launch a report on the issue, entitled "Forgotten families".

"The report highlights that older people caring for orphans and vulnerable children in countries severely affected by AIDS face hardship and isolation and are themselves in urgent need of support," said the organization, a global network of charities that support the elderly. Recent World Bank figures show that in Africa and Latin America, more than one in five orphaned children is living with their grandparents.

The Declaration of Commitment on HIV/AIDS adopted by the General Assembly titled "Global Crisis - Global Action" United Nations, from 25 to 27 June 2001, at the twenty-sixth special session of the General Assembly convened in accordance with resolution 55/13, as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner. The HIV/AIDS challenge cannot be met without new, additional and sustained resources.

In addition signatories of the Declaration decided that:

68. By 2003, [they would] evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to: address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society especially on women and the elderly, particularly in their role as caregivers and in families affected by HIV/AIDS and address their special needs; adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labor productivity, government revenues, and deficit-creating pressures on public resources;

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