Old AIDS

the impact of AIDS on older people

by Kathleen Okatcha*

HIV/AIDS is the single most devastating issue facing the world today. It has become our 20th century plague. The World Health Organisation (WHO) estimated in July 1997 that of the 30 million people who had been infected with the virus, 90% lived in the developing countries. By the year 2000, the figure will have risen to 95%.

Africa - particularly sub-Saharan Africa - has a gigantic share, with 65% of the world's HIV/AIDS cases. In 1995, the WHO estimated that 16 million Africans had been infected by HIV. East Africa was worst hit, with more than one-third of the world's infections. By November 1998, the figure for Africa had shot up to 21 million.

Demographers estimate that Africa's older population will double in size by 2017. However, AIDS will bedevil improvements in health and living, delaying this expected increase in longevity.

But what about us?

Health professionals, educators, researchers and service planners have neglected the considerable impact of the AIDS epidemic on older people in terms of the risk they face from HIV infection, and as carers of children with AIDS. The economic, health and socio-psychological impact of HIV/AIDS on older persons has thus not been given attention in most prevention and management programmes.

Distorted views are partly to blame for this. For instance, the assumption that HIV/AIDS is a disease of the younger generation has led to the impression that 'older people do not contract the virus'. The evidence, however, shows that although older people make up only a small proportion of HIV/AIDS sufferers in many countries, it is a significant one.

Because HIV/AIDS is seen as a reproductive issue for the 15-49 age group, education programmes are heavily focused on the younger generation.

In the wake of recent data showing that HIV prevalence among adults is growing at an alarming rate, the need to boost awareness has become critical. In Africa, some 90% of all HIV transmission occurs via heterosexual sex. This is almost 100% preventable but in some Kenyan communities sexually-active older people have remarked, 'a real bull dies with grass in the mouth'.

Dr Zewdie, the World Bank's AIDS coordinator, sends out an appropriate message: 'we need to focus on encouraging prevention, specifically among African youth before they become sexually active.'

Information is available in family planning clinics, youth-orientated publications, areas frequented by young people and sex education centres. Older people are not likely to come across them and when they do may well feel embarrassed to be seen showing interest. They thus remain unaware that they too are at risk of contracting the disease and lack information on how to protect themselves.

Older people are at risk because:

- it is thought that they fall within the low risk category.

- it is thought that they are least likely to contract HIV/AIDS, so the symptoms which resemble those of other ailments can at times go undetected or are wrongly diagnosed under the general camouflage of so-called normal old age disease.

- undetected and therefore not appropriately addressed, the onset of the disease and eventual death will be quicker, leaving less time for accurate diagnosis.

- medical treatments may be less accessible to older people, since with limited health resources older people are not likely to be considered a priority and if they have a pension at all, it will probably be inadequate for their needs.

If we continue to refuse to accept that the elderly can be infected by HIV, many older people will not be given adequate medical treatment or care as they suffer the onslaught of opportunistic diseases which hasten the onset of AIDS.

It is a fact that, while most older people are unaware of the risk of contracting HIV/AIDS, many of them are still sexually active.

A study in America found that 51% of older women and 92% of older men had an active sex life. However, none had considered the use of a condom, and this in a developed society! In Africa, where the elderly are the guardians of tradition and culture, there may well be strong resistance to the use of any preventive measures.

Result

Older people with or at risk from HIV/AIDS remain silent sufferers, in an environment in which their plight is not fully understood. The impact of HIV/AIDS on older people is judged on health, economic and socio-psychological criteria.

The HIV virus does not differentiate between ages. Like the rest of the population, older people can contract HIV through sex, through the use of unsterilised medical equipment or through contaminated blood products and fluids.
A case in point

69-year-old Mzee James, sponsored by one of our urban projects in the Rift Valley province of Kenya.

When James’ wife died in 1996, aged about 55 years, he was told that his wife had died of cancer of the liver. Because Mzee James was born to squatter parents of the former white highlands, he owns no piece of land on which he could bury his wife, so she was buried among her people! The Luhya tradition does not allow this, as the spirit of the deceased may not leave James’ family alone. That is why ‘I keep on wondering whether these diseases affecting me should be treated by the district hospital doctors or whether I should go back to my people to help me carry out the required cleansing rites so that I can get better.’

Until January 1999 James was being treated for malaria, coughs and general weakness, opportunistic diseases which passed for diabetes.

The social worker trained by the Catholic Church Social Work Institute and now working for HelpAge expressed her fears but doubted her suspicions because of her cultural values which do not admit that James could have succumbed to what she suspected! She however was adamant that an HIV/AIDS test be carried out and, to her shock, he was found positive.

‘Now I realise that the myths about older people’s sexuality in our society will have to be talked about publicly if they are to be equipped with education to protect themselves’. Until now, society has looked to the elderly for advice and guidance. Whether the old will accept the teaching of the young is another matter.

Economic Impact

HIV is expensive in terms of medical care and lost earning capacity. The most economically-active sector of the population tends to bear the highest infection rate. Older persons are thus unexpectedly forced to resume the role of carer and breadwinner, suffering most from the consequences of the virus. They have to provide medical care, emotional support and income lost when their children, the wage earners, fall sick. This burden can be especially heavy for older people if they themselves have health problems and are economically dependent on their family members.

True Case History

Philomena Omolo (78) of the St. Francis HelpAge Programme, Asumbi.

The late Philomena Omolo would not agree to be admitted into hospital as she was the sole breadwinner for her four orphaned grandchildren (Clare, 12, Atieno, 9, Brian, 6 and Faith, 2). She died in February 1999, leaving Clare to shoulder the responsibility.

In many African countries particularly the Great Lake Region the economic impact of AIDS on older people is clearly evident as lands formerly tilled by the able-bodied lie fallow, and land is sold to meet the huge costs of medical fees in the hope that the sufferers will get better. For those over 75, the economic impact is more critical when they are unable to assume the role of provider and care thrust upon them because of death of their carers.

This situation can be as bad as that of expecting a frail old person to be left in the care of grandchildren after the death of their parents. Young children are unlikely to offer adequate care especially if they have to become the family breadwinners as they are likely to migrate in search of jobs, leaving the elderly impoverished and lonely.

Socio-Psychological impact

Loneliness is one of the main problems of the old, whose families have died of AIDS, leaving them with a tremendous burden of grief and insecurity. The difficult realisation that their child is dying may be coupled with problems of accepting that their child has AIDS. This may entail accepting for the first time that their child has engaged in extra-marital sex. Even if the older person is able to cope with this knowledge, they must still deal with the possibly negative reactions of friends and neighbours. At a time when they most need support, older people may experience a considerable degree of social isolation if they are rejected by friends, or simply if they no longer have as much time to visit and socialise.

Indeed, the prejudice against older people as HIV/AIDS victims or carers is most devastating in cultures where older people are highly respected. Since they are not expected to be sexually active, it may be shocking for relatives and community members to realise that they have been having sexual relations, especially if outside marriage or if the older person has had multiple partners or used commercial sex workers. This leads to loss of face and family honour within the extended family as well as within the community, magnifying the feelings of shame, guilt and depression felt by older people.

Similarly, older people who have HIV/AIDS themselves are often isolated by their families, leaving them destitute and traumatised. These problems are exacerbated where, as happens all too often, there is no support or education for the older persons.

What can be done?

People of all ages are at risk from HIV/AIDS. HIV/AIDS programme strategists should address all groups of people affected included the elderly, otherwise the expected longevity of older persons might turn out to be a fallacy!

Counselling on the socio-psychological impact of HIV/AIDS should be made available within easy reach of the elderly in their own local environments.

The 15-49 age range must be educated about prevention of HIV/AIDS but people of 55+ must also be addressed so that they are made aware that they are at risk. Appropriate information and communication materials should be produced for this.
Strategies to care for HIV/AIDS-positive orphaned children need to be put in place at community level as the skill of care and magnitude of the problem can not be left to older people, who are ill-equipped to cope - emotionally, financially and physically.

Subsidies should be made available for carers of orphaned children and policies and laws and systems put in place to protect their rights, especially for property inheritance of both orphans and widows.

NGOs in collaboration with National Governments should strive to help the economic plight of older persons through development of income-generating activities to help them deal with the economic demands placed on them by their unfamiliar roles.

The HIV/AIDS scourge is the last straw for the crumbling and already overburdened traditional system of care and support for older people. National Governments need to address this issue in all planning programmes. Who will care for the elderly when they cannot care for themselves?

The elderly cannot and must not be seen as an extension of the population pyramid that tapers off to oblivion and is forgotten. They are an integral part of society, with a greater role to play than ever before.

* Chief Executive, HelpAge, Kenya. This is an abridged version of a paper presented at the AGES Conference held in Nairobi on 12-16 April, 1999.

### Facts and Figures

- About 90% of all HIV transmission in Africa occurs via heterosexual sex; this is 100% preventable.
- This underscores the need to spread public awareness, a critical aspect of prevention, to all vulnerable groups.
- An estimated 87% of the world's children infected with the HIV virus live in Africa.
- This places the care givers at risk unless they know how to protect themselves.
- AIDS has lowered average life expectancy by as much as 10-17 years in some African countries. Hardest hit is Zimbabwe where AIDS has reduced life expectancy by more than 20 years.
- The expected increase in life expectancy for older persons due to improved medical services may prove a fallacy if HIV/AIDS programmes on creation awareness do not target all groups at risk.
- AIDS has overtaken malaria and other diseases as the leading cause of death for adults between the ages of 15-49.

**Increased Lifetime Risk of Dying from AIDS.** The World Bank gives the following statistics: Ethiopia (11%), South Africa (24%), Kenya (31%), Uganda (35%), Tanzania (39%), Malawi (43%), Botswana (44%), Zimbabwe (53%), Zambia (68%).

- 95% of Africans infected with HIV/AIDS live in abject poverty.
- With the death of economically-active breadwinners, nothing is left for care givers to fall back on.
Regionally a grim picture exists

Africa has some 10% of the world’s population, and 63% (21 million) of the world’s HIV/AIDS cases.

An average of 3,800 adults in Africa are infected daily. No part of Africa is untouched by the disease.

About 87% of the world’s infected children live in Africa.

AIDS has lowered average life expectancy levels by as much as 17 years in some African countries. Zimbabwe is hardest-hit - life expectancy is reduced by more than 20 years.

AIDS has overtaken malaria and other diseases as the leading cause of death for adults between the ages of 15 - 49.

95% of Africans infected with AIDS live in abject poverty.

Implications

Resources are already overstretched.

Older people are also part of this group. Public awareness is a critical part of prevention and needs a serious boost.

Care givers are at risk unless they know how to protect themselves.

Older people may not benefit from the anticipated life expectancy increase due to improved medical services.

Increased Lifetime Risk of Dying from AIDS. World Bank figures are as follows: Ethiopia 11%; South Africa 24%; Kenya 31%; Uganda 35%; Tanzania 39%; Malawi 43%; Botswana 44%; Zimbabwe 53%; Zambia 68%.

When the breadwinners die, nothing is left for those taking care of orphaned children.

The incidence of HIV/AIDS cases among older people

<table>
<thead>
<tr>
<th>Country</th>
<th>Cases</th>
<th>Age group</th>
<th>Year</th>
<th>% of total recorded HIV cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>over 50</td>
<td>1998</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>“54”</td>
<td>“”</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>U.K.</td>
<td>“50”</td>
<td>1996</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>“50”</td>
<td>1996</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>U.S.A.</td>
<td>“50”</td>
<td>1997</td>
<td>11.0%</td>
<td></td>
</tr>
<tr>
<td>Kenya1</td>
<td>“50”</td>
<td>Jan. 1997</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>Jan. 1997</td>
<td>2.95%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60+</td>
<td>Jan. 1997</td>
<td>0.86%</td>
<td></td>
</tr>
</tbody>
</table>

Sources for all countries except U.S.A. and Kenya adopted from Tansy Evans (1996:2)