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Abstracts

AIDS: The 'Grandmothers' Disease' in Southern Africa

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In Africa, AIDS is called the grandmothers' disease because the burden of caring for the sick and the survivors falls on older women. The two abstracts which follow report an overview of research on the social and economic effects of the HIV/AIDS epidemic in Southern Africa and a case study of an intervention among older women in a Botswanan village.

Rene Loewenson and Alan Whiteside, *Social and Economic Issues of HIV/AIDS in Southern Africa*. Southern African AIDS Information and Dissemination Service, Harare, Zimbabwe, 1997.

Dr Loewenson, Technical Co-ordinator of a health, safety and environment programme in Harare, Zimbabwe, and Professor Whiteside, of the Economic Research Unit at the University of Natal in South Africa, overview the regional impact of HIV/AIDS in terms of public health and development. The bulk of the report, which was compiled for the Southern African AIDS Information and Dissemination Service (SAFAIDS), summarises current research in each country in the region. The authors synthesise the research themes and outline a research agenda.

The authors stress the distinctiveness of the HIV/AIDS epidemic and argue that it requires a different and much broader response. The important points are that AIDS is a new epidemic and the disorder has a long incubation period (estimated as 5–10 years in sub-Saharan Africa); persons who are infected by the HIV virus may have many years of productive life, although they can infect others during this period; and the current prognosis for people infected is bleak. The disease is found mainly in adults aged 20–40 years and infants. Slightly more women than men are infected. In Southern Africa about 80 per cent of HIV infection is transmitted through heterosexual intercourse. Babies infected by mothers (prior and during birth or via breast milk) account for about 15 per cent of all cases. There are links between HIV and other diseases; tuberculosis incidence has increased and is directly related to HIV. In some Southern African countries the epidemic may have peaked in urban centres but it continues to spread in rural areas. The latest data indicate that in some urban settings more than 30 per cent of ante-natal clinic attendees are HIV-infected. The World Bank projects that life expectancy in sub-Saharan Africa by 2020 will be 43 years (and without AIDS would have been 62 years). In addition the dependency ratio will change, with a projection for the region of about 5 million orphans by 2020. Contrary to popular opinion, AIDS is not

a solution to the population problem of Africa. The most productive people in society are affected by the disease. The main effect of AIDS will be to reverse hard won development gains and make people and nations worse off.

Many of the studies reviewed by Loewenson and Whiteside inquire into home-care alternatives. The health care system in sub-Saharan countries is unable to provide either tertiary care or expensive home-based care: the common result is home-based neglect. Researchers in Zimbabwe, one of the countries most affected by AIDS, recommend a model which seeks to empower communities and especially women who are the primary care-givers. The continuing stigma of HIV/AIDS presents a barrier to the effective development of community home-based care programmes, as does the poverty of care-givers. Loewenson and Whiteside argue that a twofold response to the epidemic is required. The transmission of HIV must be prevented to contain the social and economic costs, and the epidemic needs to be managed in a socially sustainable manner. Prevention should remain a priority, for even if 40 per cent of ante-natal clinic attendees are infected, 60 per cent are not and there are new cohorts of people entering the sexually active ages who need protection. The challenge for the next phase of research will be to link current information on susceptibility and vulnerability with intervention strategies and to evaluate these.

A pronounced feature of AIDS research in sub-Saharan Africa is the predominance of work by external agencies and the way in which they dictate the research agenda. A key recommendation is that for research to effect change, there must be local participation in its development and agenda. The need for participatory and action research is perhaps best illustrated by a well-funded longitudinal study of over 800 households in Tanzania. Progress has been hampered by research fatigue: people in the area say they are tired of researchers who collect information and offer no assistance.

COMMENT

Given the fragmented research efforts in the region, the report prepared by Loewenson and Whiteside for the SAFAIDS is an important first step in assessing the social and economic impact of the AIDS epidemic. In many sub-Saharan countries, AIDS has been treated only as a public health issue; these authors approach the epidemic from a broader development perspective. A welcome addition to the stock of knowledge is the information being generated by research in the private sector which normally does not enter the public domain. Models of the AIDS epidemic are rare, but the report cites a World Wide Web site where readers can access a working model for South Africa. Lastly, it is clear that Loewenson and Whiteside would like to see more regional co-operation and co-ordination of research efforts aimed at assisting society to cope with the long-term effects of the AIDS epidemic. Their plea for participatory research has not fallen on deaf ears, as the next abstract shows.

Sheila Tlou. 1996. Empowering older women in AIDS prevention: the case of Botswana. *Southern African Journal of Gerontology*, **5** (2), 27–32.

Dr Sheila Tlou reports a culturally sensitive peer education and support programme for AIDS prevention among older women in Botswana. Pregnant women in both the urban and rural areas of the country have HIV prevalence rates of 19–39 per cent. AIDS has slowly spread from its sub-Saharan epicentre in Uganda southwards to Zimbabwe, Zambia and Tanzania. In the last few years, there has been a rapid increase of the infection in Botswana and South Africa, both of which were formerly relatively free of the disease. Tlou's reasons for choosing older women aged 50–60 years for her AIDS prevention programme are threefold. Contrary to a widespread stereotype, older women in Botswana are sexually active; they are important sources of advice and information for the younger generation concerning proper manners and sexual behaviour; and the burden of care will be on middle-aged and older women, most of whom missed out on HIV/AIDS educational messages and have limited knowledge about the provision of care in the home. The AIDS prevention programme for older women followed a successful precursor which reached some 2,000 women of reproductive age.

The intervention programme was introduced in a village close to Gaborone, the capital city of Botswana, to empower older women with knowledge about HIV/AIDS which they could communicate to daughters and granddaughters. A pilot study of the older women's existing knowledge and beliefs about AIDS, and of their sexual practices and experience in caring for people with HIV/AIDS was carried out. It found that the older women believed that AIDS is not a new disease but an epidemic of *boswagadi*, the Tswana term for 'a state of widowhood whereby … the surviving spouse has to undergo ritual cleansing and observe several taboos, the principal being sexual abstinence for one year'. After the year, a traditional doctor can perform the purification rituals and declare that the widow(er) may live as a single person. It is believed that failure to observe these rituals can result in disease and ultimately the death of the widow(er) or any person with whom they have sex. The term *boswagadi* is also applied to disease resulting from failure to observe the prescribed rituals.

These observations from the pilot study richly informed the design of the main study's intervention, to increase knowledge and concern about HIV/AIDS among older women and their offspring. An education programme emphasised that AIDS is different from *boswagadi*, not least because the belief is that the latter can be cured, and it gave the basic facts of HIV virus transmission and its prevention through safe sex. Individuals were encouraged to develop a personal safety plan to protect themselves from AIDS and other sexually transmitted diseases. The women were also expected to participate in at least one formal or informal activity to help prevent HIV/AIDS among younger men and women. Six peer leaders were trained for three days and engaged 67 people aged from 48 to 62 years. The training sessions were designed for two hours but lasted longer because the participants

were eager to meet other women, to relax, laugh, talk about sex and act silly, as in the days when they did not have to care for aged parents and their grandchildren.

The post-intervention evaluation indicated that the programme was a success in terms of AIDS prevention and the empowerment of the women. They were able both to apply the new knowledge to prevent their own infection and to mobilise and support other women in AIDS prevention. The women and their peer group leaders continued to engage in community activities after the completion of their sessions and initiated some AIDS prevention activities. They volunteered to teach on HIV/AIDS related issues, to serve on village health committees, to talk at village meetings on the prevention of AIDS and the care of the affected, and they joined the newly-formed Botswana chapter of the *Society for Women and AIDS in Africa*. The author concludes that older women in Botswana are strongly motivated to prevent HIV/AIDS transmission among themselves, their families and their communities. AIDS prevention programmes led by older women can help to reduce the impact of HIV/AIDS on the country and do empower women in their daily lives.

COMMENT

The Botswanan peer-education programme is a practical example of an HIV/AIDS intervention which is likely to be sustainable: it builds on the roles older women play in African society and also meets their personal development needs. The research design from pilot study to post-intervention evaluation is exemplary. At the same time the research has been intrinsically African rather than imported, as shown by the careful design of the sessions and the use of evaluation criteria which are relevant to the local setting.

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Depression Among Older People: A Need for Greater Awareness

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During the past year depression has remained an important theme of debate in Britain because of its continued high prevalence and association with suicide. Nonetheless patients are often inadequately assessed, the diagnosis is frequently missed, and treatment is commonly inadequate. Depression also has a complex aetiology and physical causes including several medical conditions are often causally related. The condition has a devastating effect on an individual's life and without adequate treatment can be disabling. The following papers examine some of these issues in detail.

I. Hickie, C. Mason, G. Parker and H. Brodaty. 1996. Prediction of ECT response; validation of a refined sign-based (CORE) system for defining melancholia. *British Journal of Psychiatry*, **169**, 68–74.

There has been considerable media interest in electroconvulsive therapy (ECT) over the past year but most commentary has been very negative. In the past, ECT was often given inappropriately without an anaesthetic and muscle relaxants. Although modern ECT is a safe and effective treatment, it is still perceived by many as a barbaric procedure. There is now good evidence that when given to patients with severe depression it is very effective. The study attempts to make the use of ECT more appropriate. Patients with depression may present in different ways: some require psychological and or pharmacological management whereas others may need ECT. This study involved 81 patients with a primary affective disorder who received ECT. The authors concluded that psychomotor change is a robust independent *predictor* of response to ECT, and that depressed patients with psychotic features and marked psychomotor change (agitation or retardation) have the best response.

S. Banerjee, K. Shamash, A. J. D. Macdonald and A. H. Mann. 1996. Randomised controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home. *British Medical Journal*, **313**, 1058–1061.

The majority of older mentally ill people live at home either alone or supported by their families. In hospital settings, depression in older people is often not diagnosed or appropriately treated: among community-based subjects, it is likely that depression is missed and not treated on an even greater scale. This study examines the treatment of depression in older disabled people who also received home care from their local authority. Sixty-nine people suffering from depression were randomly allocated to an *intervention* and a *control* group. The subjects in the intervention group received an individual package of care formulated by the psychogeriatric team (from the local hospital), whereas the control group received 'normal' general practitioner care. The main outcome measure was recovery from depression. 58 per cent in the intervention group made a full recovery compared with 25 per cent in the control group, a statistically significant difference. This demonstrates several important points. Firstly, depression in older disabled individuals can be treated: although people may be disabled and often socially isolated, this is no reason for 'therapeutic nihilism'. In addition, the assessment and treatment of depression in older community-based patients should be thorough and of a high standard.

P. F. Boston, S. M. Dursun and M. A. Reveley. 1996. Cholesterol and mental disorder. *British Journal of Psychiatry*, **169**, 682–689.

Cholesterol plays a vital part in cellular structure and function and changes in serum levels may affect neurotransmission in the central nervous system. It is also vital in the synthesis of a number of essential hormones. As the bulk of the cholesterol in the bodies of those eating an average diet comes from the liver, it is interesting that there is so much pressure, particularly from the media, to diet and to take other measures to reduce one's cholesterol level. This paper reviews the relevant literature during the period 1990–1995. It confirms previous reports that lowering the serum cholesterol level may reduce the risk of heart disease but is associated with an increase in violent deaths and may precipitate, or be associated with, a variety of psychiatric disorders, including depression and suicidal ideation/behaviour. Although the reasons for this are undoubtedly multi-factorial, there is now substantial evidence that serum cholesterol levels may be associated with variations in mental state. Older people may be at greater risk of heart disease since they have many of the known risk factors. They may also be more often advised to reduce their cholesterol intake. Several other factors may incline older people towards depression, including multiple losses and changes of role, to name but two. Doctors should be mindful of the risk of advising older people about cholesterol and a balance clearly needs to be struck between the risks and benefits of such a policy.

M. S. Hunter. 1996. Depression and the menopause. *British Medical Journal*, **313**, 1217–1218.

A prevailing view is that the menopause is linked with depression. While there is no doubt that the menopause is a time of important change and it is said to be 'understandable' that women should become depressed at this time, there is also evidence that depression and other psychiatric disorders are more likely after the menopause, after child birth and at certain times of the menstrual cycle when oestrogen and progesterone levels are reduced, often dramatically. Conversely, many other psychiatric conditions may improve during pregnancy, further supporting the hypothesis of a link between sex steroids and psychiatric morbidity. Hunter's editorial explores these issues in detail and shows that there is not a simple relationship between sex steroids and psychiatric illness. Rather there is a complex interaction between predisposing, precipitating and perpetuating physical, psychological and social factors, not simply a change in hormone levels. To attribute depression in a middle-aged woman automatically to the menopause is 'overtly simplistic and usually unjustified'. This approach is possibly symptomatic of the medical profession's desire for quick answers and simple solutions to complex problems. If people become depressed around the time of the menopause, simply equating this to hormonal changes would result in it being seen as a normal and understandable reaction and, under such circumstances, appropriate treatment (medical, psychological and social) is unlikely to be forthcoming.

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