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Seven 'deadly' assumptions: unravelling the implications of HIV/AIDS among grandmothers in South Africa and beyond

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ABSTRACT
Over the past few years, the pivotal roles older women play in responding to the unprecedented HIV/AIDS epidemic in southern Africa has received increasing recognition by academics, governments, funding agencies, non-governmental organisations, and citizens around the world. Yet, discourses surrounding AIDS and 'grandmotherhood' are laden with a number of ungrounded assumptions that have important implications for researchers, advocates and decision-makers. Drawing on ethnographic and survey data predominantly from South Africa, this paper challenges seven such assumptions. The paper illustrates how certain prevailing 'wisdoms' about grandmothers and AIDS in southern Africa are not entirely accurate and may mask many women's struggles and vulnerabilities, perpetuate stereotypes and misguide well-meaning policies. It also suggests that the societal impacts of AIDS in the region are, at present, not as dramatic as often portrayed, largely because the strength and resilience of many older women have cushioned some of the negative consequences. The paper thus calls for more nuanced and forward-looking analyses and interventions – ones that recognise grandmothers as central to the society's thin safety net and that grapple with older women's complex and diverse vulnerabilities.

KEY WORDS – grandmothers, older women, caretakers, HIV/AIDS, South Africa, households, social networks.

Introduction

We grandmothers need support from the government. What if we die? Who will look after our children and grandchildren? We need to put bread on the table (A grandmother who supports 13 children and grandchildren by selling chickens in Durban, South Africa)

In 2005, 24.5 million people on the African continent were infected with HIV, of whom 13.2 million were women (UNAIDS 2006). In the province

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of KwaZulu-Natal, South Africa, 39.1 per cent of women attending antenatal clinics were HIV-positive (Department of Health 2006). For each person infected, several more are affected. Young adults are dying in the prime of their lives. Communities are losing their breadwinners, parents, teachers and health-care workers (Barnett and Whiteside 2006). Women are disproportionately infected and affected. Popular images convey AIDS-affected Africa as a 'human apocalypse' (Altman 2006). Amidst this apparent calamity, 'grandmothers' are increasingly recognised as 'Africa's heroes' – as the ones looking after the orphans, caring for the sick, and holding families together (Lewis 2005).

This paper takes a critical look at the impacts of AIDS and the roles of grandmothers in South Africa, and develops four provocative and sequential arguments: (1) the effects of the epidemic may not at present be as dramatic as often portrayed in popular and academic discourses (Desmond 2006); (2) this appears to be partly, and ironically, attributable to older women doing what they have always done – caring for their families; (3) while grandmothers may be softening the impacts on others, they are paying a heavy financial, emotional and physical price, and they are ageing; and (4) dominant assumptions around grandmothers and AIDS may be diverting attention away from the disproportionate and long-term vulnerabilities of these women and their families. HelpAge International (2006) estimates that 40 to 60 per cent of orphans in several sub-Saharan countries live in grandmother-headed households. In Namibia, the percentage of orphans cared for by grandparents increased from 44 per cent in 1992 to 61 per cent in 2000 (UNAIDS 2004). A study in Zimbabwe found that older people were the main care-givers of the ill and orphaned in more than 80 per cent of the households that had older people (World Health Organisation (WHO) 1999).

The pivotal roles of grandmothers have increasingly been recognised by the United Nations Organisation (UN), the World Health Organisation (WHO) and the World Bank (*e.g.* WHO 1999; UNAIDS 2004; World Bank 2005). Several international declarations have committed governments to address the needs of older people affected by HIV/AIDS, as with the UN's Declaration of Commitment on HIV/AIDS (2001), the Madrid International Plan of Action on Ageing (2002), and the Valetta Declaration (2005). Most recently, in the lead-up to the 2006 International AIDS Conference in Toronto, the Stephen Lewis Foundation of Canada hosted over 100 grandmothers from southern Africa, as well as hundreds of grandmothers from Canada and the United States. Extensive media coverage showcased the grandmothers' courage, and their hardships captured imaginations across the globe. An unprecedented swell of public emotion led to international mobilisation around the plight of

AIDS-affected grandmothers (Stephen Lewis Foundation 2006). Yet, despite the numbers, the heightened awareness, the international declarations, the momentous mobilisation and the public outrage, older people remain almost invisible when it comes to allocating AIDS resources (Mall 2005). As has been noted:

> While most of the attention is directed at the prospects of those in their care, little of note is being done to meet the material, emotional and social needs of elderly care-givers and fosterers – the 'reverse orphans' who, in the twilight of their lives and in grossly disadvantageous circumstances, are transforming themselves again into mothers and fathers (Marais 2005: 82).

Neither the diversity of the conditions faced by grandmothers in various African settings, nor the complex relationships between older women, their families and social networks are well understood or have been sufficiently researched. Discourses around grandmothers, AIDS, and changing household structures are furthermore laden with several ungrounded assumptions, seven of which are closely examined in this paper. These discourses have been shaped by influential international donors, NGOs, media outlets and academic researchers, and are often deployed to mobilise funding and support. Their common assumptions are that: (1) AIDS is drastically reconfiguring the roles of African grandmothers; (2) it is the primary stress in these women's lives; (3) as a result of AIDS, southern Africa is speckled with 'child-headed' and 'skipped-generation' households; (4) grandmother care-givers are old and frail; (5) in South Africa, where women aged 60 or more years receive state pensions, 'new' grandmother-headed social networks are tied fundamentally to these social grants; (6) grandmothers are bearing the epidemic's burdens in isolated and remote rural conditions; and (7) the worst of the epidemic is manifest now, as parents and breadwinners are dying.[1] Alongside these roughly hewn notions, there has been a failure to look to the long-term implications of present-day impacts. This paper argues that the current assumptions and presuppositions could be 'deadly': they could obscure the diverse struggles among grandmothers, mask many critical issues underlying older women's vulnerabilities, and misguide even the most well-meaning interventions. The purpose of this critique is therefore to challenge current thinking about the effects of AIDS on grandmothers, with a view to enabling more appropriate responses.

The paper has two parts. It opens with an overview of recent ethnographic research on grandmothers who work as street traders at Warwick Junction, Durban, in KwaZulu-Natal, South Africa. The project has described their changing household structures and particular vulnerabilities, and has provided glimpses into the lives of one group of grandmothers. It was never the intention to generalise the findings. Indeed,

some might argue that the women in this case study do not represent the majority of AIDS-affected grandmothers in South Africa or the wider region, as they are urban, informally employed, mobile and fairly young. As will become clear, however, the group is by no means exceptional or anomalous – the conditions they face reflect widespread demographic and geographic conditions. The Warwick Junction study provides a foundation for the second part of the paper, which is the critique of the itemised assumptions about grandmothers and AIDS. The critique draws on diverse research on historical trends and current social conditions in southern Africa.

Warwick Junction: a picture of South African grandmotherhood?

It has been estimated that there are half-a-million 'informal' street traders in South Africa and 20,000 in Durban, and that the number is growing throughout the region (Charmes 2003). Warwick Junction is the largest trading hub in Durban: 8,000 vendors sell goods and services to approximately 500,000 daily commuters. It is situated in KwaZulu-Natal, the South African province with the highest prevalence of HIV– approximately 40 per cent of the women who attend antenatal clinics are infected, and the prevalence is rising.[2] Most of the traders moved into the city and began trading after apartheid ended in 1994, from which year unemployment has risen. Many of them shuttle between their rural homes and the city. Most live and work in impoverished urban conditions, have received little education, and 70 per cent are women (Lund 2002).

While there are many ways to examine the assumptions about grandmothers and AIDS, this discussion begins with an overview of how one group of older women, all of whom were grandmothers aged in the forties and fifties and who traded in Warwick Junction, have been affected by the epidemic.[3] It considers what makes these women vulnerable, and how they are responding. The account is based on the findings of an ethnographic study carried out between 2004 and 2006. The initial fieldwork in 2004 involved 65 traders, health-care providers, traditional healers and municipal employees. Repeated in-depth interviews were carried out with 20 of the original participants over the two years. One of the main findings was that, compared to other sub-groups of street traders, older women in the study bore the greatest impacts of AIDS. This paper draws only on the component of the research carried out with these older women (see Chazan and Whiteside 2007 for an age-gender analysis of differential vulnerabilities among the traders and for the full results).[4]

The purpose here is not to provide a comprehensive report of the findings but rather to focus on those most pertinent to the lives of the particular group of grandmothers. Their stories were diverse but had common threads, as presented below. Are these women 'typical' South African grandmothers? While there is no intention here to homogenise or stereotype 'grandmothers', it will become evident that the women traders' stories reflect wider trends in South Africa and the region, and thus may make an important contribution to our understanding of the impact of AIDS on the older age groups. This research will thus provide a platform from which to challenge broader assumptions and to examine the social construction of current trends.

Vulnerabilities and impacts among the Warwick Junction grannies

Careful study of the AIDS/HIV epidemic's effects on the traders and the conditions that have shaped their vulnerabilities points to five overarching struggles in their lives (see Table 1):

1. *Financial burdens*: The grandmothers were supporting growing numbers of children and grandchildren and losing income-earning family members. They were struggling with increasing medical, food and funeral expenses, and the costs of taking time away from paid work to care for the sick.
2. *Emotional stresses*: These women had to cope with the anguish of losing their children and the immense pressures of caring for their families. Many were finding it extremely difficult to talk about sex with younger family members, which compounded their emotional stresses.
3. *High unemployment levels*: In the province of KwaZulu-Natal, unemployment has reached 29.9 per cent (Statistics South Africa 2006). The rising level affected these women in various ways: family members were not working, more and more customers could not pay reasonable prices, and they themselves were forced to work 'informally'. Street trading is a matter of survival, but working long hours hindered them from providing their families with what they regarded as proper care.
4. *Displacement*: Most of the grandmothers migrated between the urban area where they worked and a rural area where they supported and looked after the sick. Taxing emotionally, the stresses of displacement were compounded by their 'informal' work, which attracted little respect. In many ways, they were treated as and felt expendable. The discourse of 'informality', which pervaded their existence, assumes that their insecurity is somehow temporary. It also de-legitimises their urban work and residence, which manifested itself in a number of ways,

TABLE 1. *Impacts and vulnerabilities and collective responses in the grandmothers' words*

Evidence from the Warwick Junction grandmothers	
Impacts and vulnerabilities:	
Financial strains	My niece was sick and died last year … She didn't say that she had AIDS, but I knew and she knew. My sister's other daughter is presenting with it now … and another niece, a third one, is also having it. … I am a guardian to all of them; they come to my house and I take care of them. I will be the one to take care of the orphans. … My main worry is that I won't be able to work. What will happen? I tell my kids that one day we will have a problem: I will die and they need jobs, but they have stopped looking. (Seamstress, aged 52 years)
Emotional effects	We talk about it with our children, but still we have kids who are not listening. It's troublesome … One of my daughters still messes around and makes jokes about it … If they can abstain and not have sex, but young people don't listen to their elders, even when we say use condoms. I don't know what to do. I just don't know what to do. (Chicken seller, aged 50+ years)
Unemployment/ chronic illness	I am not well, you can see. I have high sugar, high blood pressure … but I have to provide for my children and now my grandchildren, who are all students. No one else is working. Whether I'm well or not, I have to come to work. (Chicken seller, aged 50+ years)
Displacement	I don't see my children every day and children can become corrupt. Nobody takes care of them, there's nobody to cook for them. … There are stress-related effects [of being away from home], like I'm worried because I don't know what's happening at home. I phone but I don't know … but this is the only way we survive; if they stop me from selling here, we'll all starve. (Mat seller aged 40+ years)
Collective responses:	
Neighbourhood group	We pray together. We organise the neighbours in Mayville to take care of the people falling sick. (Cardboard collector, aged 40+ years)
Church group	Our church group has a 'helping hand' group. Each month we contribute 20 Rand and if there's a death, the money is used to buy food and help out the family. (Seamstress, aged 52 years)
Warwick Junction group	We have a project here that if one trader has a death at home, we put money together to buy food for them. (Chicken seller aged 50+ years)

including being denied health-care services because they did not have 'proper addresses' in Durban.

5. *Untreated personal illnesses*: All the women had chronic, debilitating and largely untreated illnesses, such as hypertension, asthma, diabetes and arthritis, which made it even more difficult for them to care for others. They worried about who would take care of them if they could no longer work, and what would happen to their families when they died.

While research on grandmothers' vulnerabilities has been limited, some studies of AIDS-affected families and communities elsewhere have shown a similar suite of financial and emotional impacts among older women

(*e.g.* Schatz 2005; Oburu and Palmerus 2005); these have been most extensively documented by HelpAge International (Mall 2005; HelpAge International 2006). Less attention has been paid, however, to the compounding and converging factors that shape grandmothers' vulnerabilities (*e.g.* unemployment, displacement and chronic illnesses), which clearly came to light in Warwick Junction.

A worsening situation

The cumulative effects of AIDS, unemployment, displacement and chronic illness were exemplified in the grandmothers' changing household structures. Alongside the repeated in-depth interviews, the traders' 'household maps' were drawn at six monthly intervals (in December 2004, June 2005, December 2005, and June 2006). In December 2004, the traders were also asked to describe their 'households' at Christmas 2002. The term 'household' was referred to by the isiZulu word *umdeni*, meaning a self-defined social network of shared responsibilities and entitlements, not one necessarily confined to one location or limited to kin (Hosegood and Solarsh 2004). The older women defined their 'households' as the people for whom they were responsible. The maps showed a clear trend, of an ever-greater number of people being supported on ever-shrinking incomes – a worsening situation.

One story, of a seamstress who supported 19 people on the equivalent of three US dollars per day illustrated the circumstances of many. The changes over time in her household are depicted in Figures 1 through 3. Over three-and-a-half-years, the woman's household changed from 15 to 19 members; the number of income earners declined from three to one; her income also diminished because of her chronic illness. She was not working in June 2005 or June 2006 because of diabetes and hypertension, which meant that her family had virtually no income. She lost four children, three of whom she suspected had AIDS. She took on responsibility for two orphans and provided personal care for six people, all of whom were seriously ill. It is worth reiterating that her story was by no means exceptional among the traders at Warwick Junction. Indeed, all the household maps revealed a consistent pattern of a growing reliance on grandmothers, a trend that has been shown elsewhere (*e.g.* Ogunmefun and Schatz 2006).

The identified general pattern and trend imply neither a uniformity in people's experiences nor a predictable sequential downward spiral. The household maps of the woman who sold seeds showed new income-earners moving into her network after one six-monthly interval, which meant that fewer people were being supported by more earners,

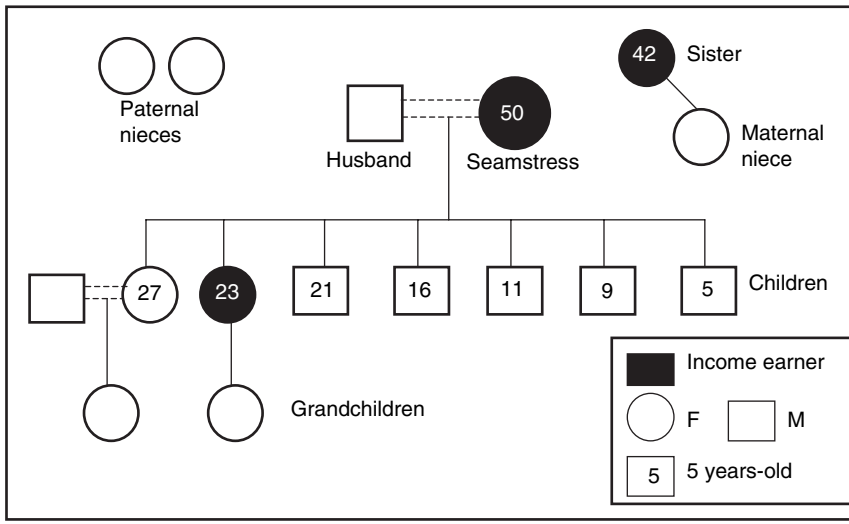

Figure 1. Seamstress household map, December 2002.

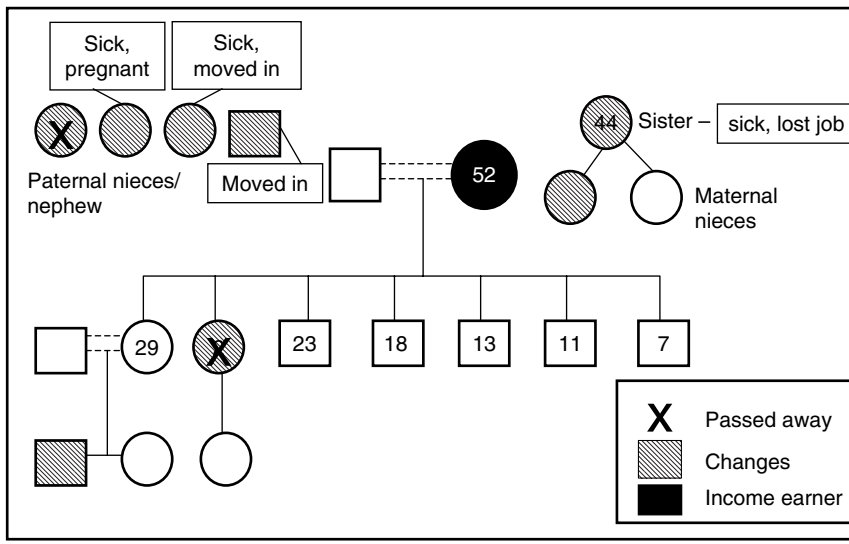

Figure 2. Seamstress household map, December 2004.

suggesting at least some improvement in economic security. Over the two years, however, the seed seller, the seamstress and every one of the older women in the study reported larger 'households' but a net loss of income-earners. The household maps also revealed some limitations in common research constructs. All the grandmothers defined their 'households' as

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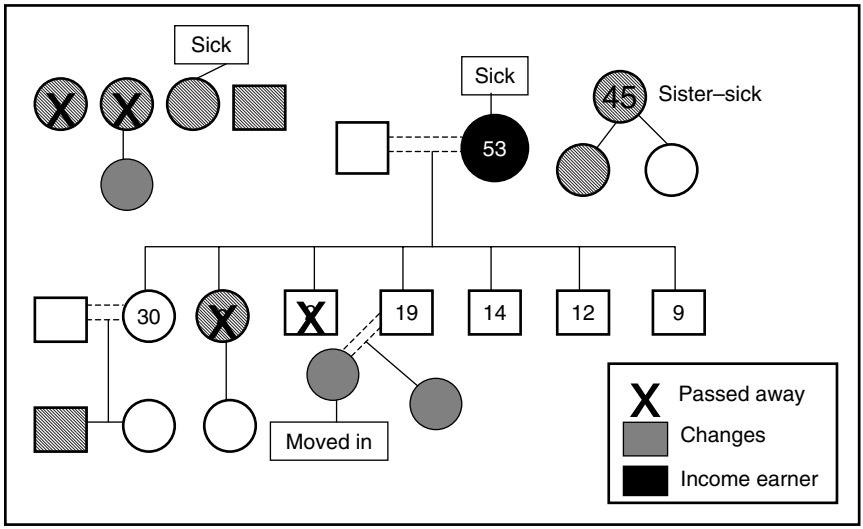

Figure 3. Seamstress household map, December 2005.

large, fluid and multi-locational networks of people for whom they felt responsible. The people in the seamstress's household, for instance, frequently moved between three residences (in the township, in the city and in the rural area). She was affected if any member fell ill or died. To assess how AIDS affected her, one needs to understand the dynamics of her social web. The maps therefore showed not only a worsening situation for grandmothers, but also how conventional conceptions of 'households' as comprising only members that reside at least four nights of a week in the same house (as used in most longitudinal research), are inadequate for tracking the complex effects of AIDS.[5]

Responses and responsibilities beyond the family

Not only were the grandmothers taking on ever more responsibilities in their families, they were also active in their communities, for example by devising collective responses to the epidemic's stresses. Most were involved in group savings schemes that assist AIDS-affected families with food and funeral expenses, or prayer groups that address the emotional and spiritual traumas associated with witnessing so much illness and death (see Table 1). The findings also corroborated research findings from other parts of southern Africa, which has shown grandmothers taking on responsibilities that extend well beyond their families, and playing central roles in AIDS-related home-based care initiatives, income generation projects, support groups and child-care initiatives (Chazan 2006; Mall 2005; Ogunmenfun

and Schatz 2006). Many older women derive support and purpose from such community involvement, but community initiatives like 'home-based care' can also mean that they become engaged in additional, labourious and usually unpaid care-giving (Marais 2005).

Overall, the epidemic had had considerable financial and emotional impacts on the grandmothers in Warwick Junction, which were compounded by myriad other stresses in their lives. Cumulatively, their burdens appear to be worsening, although not in any sequential or single way. As strains built up, they tried to adapt. They assumed ever-greater responsibilities for the growing needs of their families and communities.

Beyond Warwick Junction: extending our thinking on grandmothers and AIDS

The Warwick Junction study did not seek to provide evidence of a general pattern, but the findings raised questions about prevailing beliefs, and challenged and extended taken-for-granted understandings. The remainder of the paper draws additionally from a number of other studies to examine the seven named assumptions. The assumptions are well represented in recent policy, advocacy, media and research documents on grandmothers and HIV/AIDS.[6] Their effect, it is argued, is to mask the diversity of grandmothers and their situations in South Africa, and to sustain certain ungrounded presumptions. It will indeed become evident that embedded rudimentary notions of 'grandmotherhood' obscure the struggles of many vulnerable women, while common assumptions around the exceptionality of AIDS oversimplify the immense pressure on many South African grandmothers, whether or not they are directly dealing with AIDS in their families. Each of the seven assumptions are restated in turn and critically discussed, and each section is closed with an 'extension', a qualifying statement or coda that summarises the critique and conclusion.

Assumption 1: AIDS is fundamentally changing grandmothers' roles in South Africa and beyond. Counter view: The situation is as old as it is new.

As stories of grandmothers affected by AIDS reach national and international audiences, one commonly held assumption is that the epidemic is fundamentally changing their family situations and roles – from women who were once cared for by their adult children, to women who are becoming mothers anew to the next generation. As the narrative goes, if it were not for AIDS, grandmothers in high-prevalence African countries

would be 'enjoying a restful retirement' (Reuters 2006). Grandmothers are viewed as 'Africa's newest mothers' and their roles are understood to be transforming: 'the changing roles of grandparents, or surrogate parenthood, as a result of the epidemics, for example, may result in changed relationships between the oldest and youngest generations' (UN 2004). This is not entirely accurate. The subtlety of the situation was aptly described by one of the Warwick Junction grandmothers:

> Many children have been left behind. It's us grandmothers who are taking care of them. This is nothing new, we have *always* done this. It is our duty. But the cause of death now is HIV/AIDS, even if they [young people] hide the information that they have HIV (Seamstress, emphasis in original).

The historical context and social conditions must be taken into account if we are to understand how AIDS is transforming the lives of grandmothers. South Africa has a long history of labour migration; for many decades, young adults (especially men) have worked away from their homes in factories and mines (Marais 2005). Grandmothers customarily stayed behind to care for their grandchildren, and were dependent on remittances from their adult children. They were in a situation of reciprocal exchanges rather than 'restful retirement': grandmothers raised children, young children assisted with house and farm work, and absent adult children provided income (Madhavan 2004). As Marais (2005) has pointed out, AIDS has undermined the traditional reciprocal care arrangements. Migrant parents who fall ill and die can no longer provide remittances to the grandparents caring for their children, and young adults themselves may move back home to be nursed. Older people, especially poor women, are thus compelled to assume both productive and child-raising duties (Marais 2005). This was shown by the changing household maps in Warwick Junction (see Upton 2005 for similar evidence from Botswana).

Grandmothers in this region are facing a situation that is both old and new. Moreover, the 'oldness' of the situation is actually shaping the 'new' burdens: powerful and deep-seated gender norms, roles and identities uphold historical care arrangements and underlie the mounting pressures on grandmothers. Participants in the Warwick Junction research, for instance, described their situations as a facet of their 'duties' and 'roles' as women and grandmothers; they view it as 'natural' for them, amidst the escalating epidemic, to assume additional family responsibilities. Likewise, in the Agincourt District in rural South Africa, grandmothers did not perceive their increasing responsibilities as a 'burden', but rather viewed themselves as 'bound' to the wellbeing of their children and grandchildren (Schatz 2005).

Extension 1: South African grandmothers have always played important roles in their families and communities, especially in child-rearing. Over the past decade, AIDS has added a new layer of stress to their lives by altering existing reciprocal relationships of care. The disproportionate load born by grandmothers is probably a result of divisions of responsibility within families that were in place long before HIV/AIDS. It is simplistic to assume that in the absence of AIDS, most African grandmothers would be retired.

Assumption 2: AIDS is an exceptional force in southern Africa; it is the primary stress in grandmothers' lives. Counter view: That AIDS is exceptional is a myth.

The second closely related assumption is that in high-prevalence African communities, AIDS is the primary stress in most families and therefore in most grandmothers' lives. As one well-known advocate remarked, 'all of us who live in privileged western societies experience death from time to time, but in much of Africa that's all people know. Their lives consist of attending funerals … every family in every country … has suffered a loss in the carnage of AIDS' (Lewis 2005: 57). Such 'AIDS exceptionalism' – that is, focusing on HIV/AIDS over and above issues of poverty, migration or food insecurity – may stem from a desire to simplify how practical, feasible (and often medical or technological) responses to human suffering are imagined. It could also be that framing research and interventions in narrow ways is sometimes done to appease institutional expectations; to comply with the narrow AIDS-specific mandates of funders, academic departments or non-governmental organisations (Marais 2005). This too is overly simplistic.

AIDS is a profound stress but not an exceptional force. As discussed earlier, the pressures on the Warwick Junction grandmothers resulted from the cumulative effects of, among other things, AIDS, unemployment, poverty, displacement, stigma and chronic illnesses. They did not see AIDS as the main stress in their lives, but instead pointed to immediate poverty-related threats, like not being able to put food on the table, send their grandchildren to school, or afford transport home. It is true that the household maps showed that these pressures cannot be disentangled: AIDS might not be their most immediate threat, but it compounds pre-existing vulnerabilities (see Schatz and Ogunmefun 2005 for similar findings elsewhere in South Africa). More widely, 'AIDS exceptionalism' could hide the vulnerabilities of many grandmothers – vulnerabilities that probably exist whether or not they are directly dealing with AIDS-related illnesses in their families. If such complexities were embraced, this might lead to more meaningful and comprehensive responses. Certainly,

responding to the multiple stresses in grandmothers' lives would make them better able to deal with the additional burdens posed by the epidemic.

Extension 2: HIV/AIDS profoundly affects families and communities but the epidemic is not spreading its harms in a vacuum. Vulnerabilities are shaped by the cumulative effects of many stresses, such as migration, unemployment, crime, daily struggles to put food on the table, and AIDS.

Assumption 3: As a result of AIDS, South Africa is now speckled with 'skipped generation' households (of only grandparents and grandchildren, and no middle-generation members). Counter view: Skipped-generation households are the exception not the norm.

The third common assumption is that in high-prevalence countries, a wholesale transformation of household composition is occurring, with many families struggling to survive with only elderly and young members (Desmond 2006). According to HelpAge International (2005: 2), 'family structures are changing with "skipped generation households" comprising older people and children … emerging as a new category of household'. The evidence for this change is, however, scarce. The household maps from Warwick Junction did not represent 'skipped generation' living arrangements but rather multi-generational networks. Even where young children had lost their biological parents, middle-generation adults (aunts and uncles) were present in the structure of care. Similar evidence has been forthcoming elsewhere in South Africa (*e.g.* Madhaven and Schatz 2005).[7]

In a recent presentation entitled 'Emotional statistics', Desmond (2006) indicated that despite what is often reported in international campaigns to evoke emotional responses, 'skipped generation' and 'child-headed' households are not yet common in South Africa. His analysis of national data showed that the most common household configurations (defined narrowly) included two (non-elderly) adults or multi-generational members. The data showed that between 1995 and 2005 in South Africa, 'skipped generation' households increased from 1.69 to 2.29 per cent, but that over 83 per cent of households in 2005 were *not* 'skipped', 'child headed', 'young-adult headed' or 'single-adult headed'. Desmond did not discount that even small percentages mean that too many children live in these conditions, but he clearly refuted the prevailing discourse that overstates the prevalence of these arrangements (see also Ford and Hosegood 2005; Hosegood and Timaeus 2005*a*, 2005*b*). The stresses on grandmothers are growing with AIDS, but this does not mean that the

South African countryside is speckled with 'skipped-generation' households; this assumption is not evidence based. The burdens on grandmothers may instead reflect something like we have seen in Warwick Junction: in the face of the growing demands for care, households are joining in grandmother-headed multi-generational social networks. Measuring the growth of such care networks is difficult with existing data.

Extension 3: There is little evidence that 'skipped generation' households are widespread in South Africa. Instead, the burdens on grandmothers in Warwick Junction and elsewhere are encouraging households (in the conventional meaning) to collaborate and form grandmother-headed multi-generational support networks.

Assumption 4: The grandmothers that care for AIDS orphans are old and frail.
Counter view: The stereotype is false; not all grandmothers are old and frail.

The fourth common assumption held by many researchers and advocates is that AIDS-affected African grandmothers are old and frail. 'These old and unimaginably frail women often look after five, 10 or 15 kids, enduring every conceivable hardship for the sake of their grandchildren, alongside additional numbers of other abandoned waifs who wander the landscape of the continent' (Lewis 2005: 50). One reason for such descriptions is probably the widespread conflations of 'grandparenthood' with 'old age', and of 'grandmother' with 'elderly woman'. While it is not uncommon to find truly 'elderly' care-givers in South African communities, the images of old-age conjured by speaking about 'grandmothers' may not be entirely accurate. We have seen, for instance, that all the Warwick Junction grandmothers were fairly young, aged in their forties and fifties. But how representative were they? At what age does the 'average' South African woman become a grandmother?

One could argue that the Warwick Junction grandmothers are 'demographic outliers', but the data that suggest that this is not the case. Drawing on the 1998 *Demographic and Health Survey of South Africa*, Moultrie (2006) estimated the ages at which 'African' South African women first become grandmothers. The modal age of entering grandmotherhood was 39 years and the median age was 40 years. Fewer than one per cent of women first become grandmothers after 60 years-of-age. The fact is that there are many women aged from the late thirties to the fifties who are already grandmothers in South Africa, like the traders at Warwick Junction.

The association of grandmotherhood with old age appears to influence how research is carried out and which issues are given prominence. The

scarce literature on the impacts of HIV/AIDS on grandmothers focuses almost exclusively on 'the elderly', often limiting research participants to women aged 60 or more years (*e.g.* Schatz 2005; Oburu and Palmerus 2005). The issues faced by younger grandmothers barely appear in this limited body of research. Moving beyond the stereotypes means understanding that not all South African grannies are old and frail – most are not.[8] It also means not constraining who is included as 'grandmothers'. Younger grandmothers are struggling even though they are not 'elderly'; they may be just as worthy of attention in that several generations depend on them. The exclusive focus on 'elderly' grandmothers in research may be obscuring the vulnerability of younger women in similar positions.

Extension 4: Most South African women become grandmothers when aged in their thirties and forties, and it is unrealistic to equate grandmotherhood and old-age. While there is a need to understand and support 'grandmothers', there is also a need to move beyond essentialist perceptions of frailty. The analytic category of 'grandmother' is defined not by old age, but by the several-fold increase in financial and care-taking responsibilities that comes with having grandchildren.

Assumption 5: In South Africa, grandmother-headed households pivot around old-age pensions. Counter view: The pivots are grandmothers not pensions.[9]

Unlike in most African countries, older people in South Africa can access government old-age pensions – women at 60-years-of-age and men at 65. In this context, it is often assumed that large granny-headed households pivot around these social grants (May 2003; Schatz 2005). While the implications of pension-centred research are critical, it follows from the previous argument that most women become grandmothers long before they are eligible for pensions. There is substantial evidence that pensions, valued at up to 740 Rand per month (approximately US $100), can ease the stresses on older people and their extended families. Amidst poverty and high unemployment, pensions are often the most stable and reliable form of household income (May 2003). Indeed, in one part of Mpumalanga province, where one-in-10 poor older people cared for ill, young adults without basic services, and where older people were the main breadwinners in three-in-four households, the most important source of income was the government old-age pension (Makiwane, Schneider and Gopane 2004).

In AIDS-affected families, older women often use their pensions as substitutes for unemployed children's incomes; they invest them in insurance and credit programmes to cushion AIDS-related shocks, and use

them to cover costs associated with illness and funerals (Schatz and Ogumefun 2005). Channelling subsidies through older people (especially women) also has significant redistributive effects (Duflo 2003). Pensions once aimed at reducing poverty among older people have been transformed into a lifeline for younger household members (Marais 2005; Legido-Quigley 2003). This evidence suggests the potential of state support for reducing vulnerabilities, and the effectiveness of distributing such support through older primary care-givers.[10] Thus, while it is unfounded to assume that granny-headed households necessarily pivot around pensions in South Africa, it is still the case that broader access to social security could mitigate some of the epidemic's impacts.

Extension 5: Pensions are crucial and greatly increase the security and wellbeing of many families, but most grandmothers are too young to be eligible. If state support is going to assist the majority of grandmothers struggling to support large families, it should be based on care responsibilities rather than age.

Assumption 6: Grandmother carers tend to be isolated and live in remote rural areas. Counter view: Grandmothers are extremely diverse. Many have extensive social networks, and some are urbanites who use the latest communications technologies.

In part because mass rural-urban migration established a pattern of grandmothers being 'left behind' in the Bantustans to care for children, and in part because there is a dearth of research in urban areas (especially the 'informal' townships or shanty towns) (Posel and Casale 2003), it is often assumed that to find the African grandmothers most affected by AIDS, one must travel to remote rural areas. Descriptions of 'huts where women are dying in the presence of their children' conjure images of an epidemic taking its toll in the unreachable depths of 'Africa' (Altman 2006). The prevailing picture is that of the rural granny surrounded by squadrons of young children, while their dying mother suffers, isolated in a mud hut. The Warwick Junction evidence presented a very different image – while most of the grannies perceived themselves as 'rural women' and maintained close ties with their rural homes, they were also mobile labour migrants who lived in a large city and kept in touch with their families by cell phones. Many came together to save money, in prayer and to offer mutual support. They may have been stressed by their frequent displacements from home and by the silence around the epidemic, but they were neither geographically nor socially isolated. Again the question arises: are these grandmothers anomalies? The answer must be 'not really'.

In South Africa, an increasing number of grandmothers are urban labour migrants. Since the end of apartheid, cities have been desegregated and laws around informal trading relaxed (Nesvag 2002). More and more women, including older women, move to cities to work, and an increasing number work 'informally' and engage in circular urban-rural migration (Posel and Casale 2003; Hosegood and Solarsh 2004). The number of 'informal' traders in the Central Business District of Durban rose from 200 in 1984, to 800 in 1990 and to 19,800 in 1997; they are predominantly mobile women (Nesvag 2002). In 2002, 58 per cent of the South African population lived in urban areas (World Bank 2005).

Furthermore, the phenomenon of grandmothers being at the centre of community responses is not unique to Warwick Junction: such involvement has been seen throughout the region (Mall 2005; Chazan 2006). A clear example of social and political organisation among South African grandmothers is the Cape Town group, *Grandmothers Against Poverty and AIDS* (Broderick 2006). So not all grandmothers match the image of isolated, old women. Making this clear is not to deny that there are many AIDS-affected grandmothers in highly-impoverished and constrained conditions in rural South Africa, nor that it can be extremely lonely caring for those affected by HIV/AIDS, nor that city life can be alienating and can increase exposure to crime and environmental pollution (especially in trading hubs like Warwick Junction), nor that involvement in community projects offers social support but also means additional, strenuous and usually unpaid work. Rather, there is a need to recognise the diversity of situations in which grandmothers live and work, to document what is happening in rural *and* urban areas, and to analyse critically the effects of 'community mobilisations'. Such critiques require moving beyond hegemonic images of grandmothers stranded in rural huts – these images only obscure the struggles of large and growing groups of women (Mohanty, Russo and Torres 1991).

Extension 6: A growing number of grandmothers live and work in urban areas; many are highly mobile and are involved in community projects in several locations.

Assumption 7: The worst of the epidemic's impacts in South Africa are evident now, as young adults are dying and leaving behind orphans. Counter view: This is short-sighted. We must consider what happens when today's grandmothers die.

At this point, it may seem that the consequences of AIDS are not as dramatic as frequently described. The prevalence of skipped-generation and child-headed households tends to be exaggerated; AIDS is not

drastically transforming family dynamics; it is not the primary stress in the lives of many grandmothers; and not all AIDS-affected grandmothers are elderly, frail women living in rural isolation. The doomsday images of rogue, orphaned children, susceptible to lives of criminality, have not transpired (Marais 2005). In South Africa, AIDS is not a 'human apocalypse' (Altman 2006), or anyway not yet. The irony, of course, is that this 'good news' could be precisely *because* grandmothers are doing what they have always done, and doing it well. The Warwick Junction household maps suggest that grandmothers have mitigated many of the epidemic's negative consequences by caring for growing networks of dependants on shrinking incomes. They are also supporting other families in their communities. Cushioning the epidemic's impacts has come at a high personal cost, however, for many women are in survivalist positions, physically unwell, emotionally distraught, and struggling to make ends meet.

The question arises, 'what do these growing struggles among grandmothers mean for the future?' Or, as the chicken seller asked, 'What will happen when we die? Who will look after our children and grandchildren?' These questions have not been adequately considered by researchers, policy makers or the advocates of AIDS care. The final question addressed in this paper is whether the current assessment of the main negative impacts of AIDS/HIV is short sighted? Is the assumption that the worst of the epidemic's impacts are taking place now, as young adults die, blind to the intergenerational implications of AIDS?

The epidemic in South Africa is new: in 1990 national HIV prevalence was less than one per cent and it has been rising ever since. The intervals between when people become infected, fall ill and die indicate that the epidemic's impacts will unfold for decades. Some suggest that it will be at least another five years before prevalence peaks, and another 10 before mortality rates and orphan numbers stop rising (Whiteside 2004). Figure 4 shows female mortality rates by age in South Africa from 1997 to 2004. The rising peak shows the remarkable increase in mortality among women aged 20–49 years; that is, more and more women have been dying in their twenties, thirties and forties. The trend is likely to continue.

A prospective view of the impacts of AIDS suggests that grandmothers are shouldering today's burdens, while the 'next generation' of grandmothers is disappearing. This raises a series of important but rarely asked questions. With the next cohort of grandmothers decreasing in size, what will happen when today's grandmothers die? Will family structures and gender roles transform or adapt? Do the worst impacts lie ahead? There is much uncertainty, but it is clear that we should be looking to the future and where there are obvious vulnerabilities today, responding vigorously: providing financial assistance, counselling and health-care to keep ageing

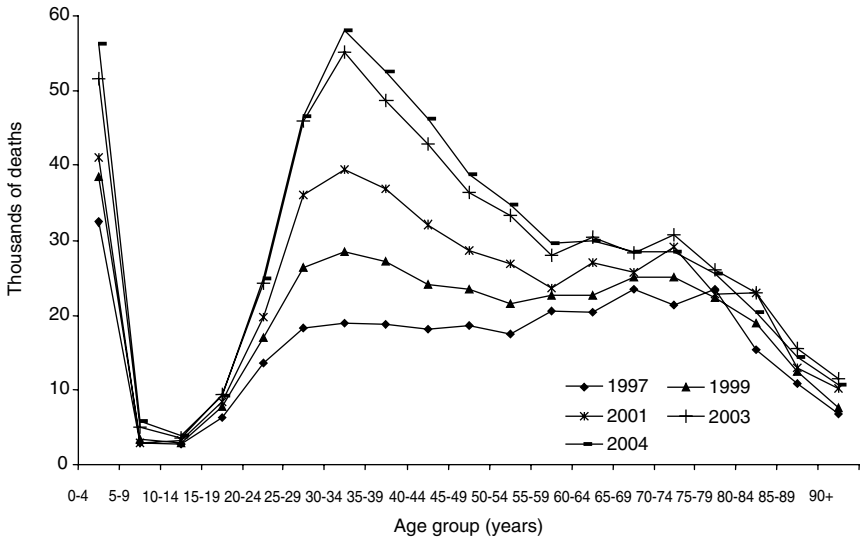

Figure 4. Female mortality in South Africa, 1997–2004. *Source:* Statistics South Africa 2006. *Mortality and Causes of Death in South Africa, 2003 and 2004*. Statistics South Africa, Pretoria, South Africa.

women healthy as long as possible. This requires keen foresight – a commitment to replace the current short-sightedness and to intervene in preventive rather than reactive ways.

Extension 7: At present, grandmothers are absorbing many of the devastating effects of AIDS at high cost to themselves. The next cohort of grandmothers is diminishing. The question arises, what happens when today's grandmothers die? Worse impacts may lie ahead.

Conclusions

This paper has sought to challenge a series of assumptions around grandmothers and AIDS in South Africa and to elucidate some of the complexities inherent in older women's vulnerabilities. It opened by describing a group of grandmothers much affected by the epidemic who work as street traders in the inner-city transport hub of Warwick Junction, Durban. Displaced, impoverished and chronically ill, these women have assumed ever-greater financial and care-taking responsibilities for their families and communities. The Warwick Junction study provided a foundation for a critical discussion of the broad premises that surround AIDS, household change and grandmothers in southern Africa. What emerged

was that certain prevailing 'wisdoms' about the epidemic's impact and about 'African' grandmotherhood are not all accurate and may mask the struggles and vulnerabilities of many women. The presuppositions could perpetuate stereotypes, reify identity categories, homogenise diversity, decontextualise the epidemic's impacts, and misguide policy and intervention. Examining these assumptions also made evident that the *societal impacts* of AIDS are, at present, not as dramatic as frequently portrayed. South Africa does not appear to be experiencing 'calamity' or 'apocalypse'. Instead, it seems that the strength and resilience of grandmothers are cushioning the negative consequences of the epidemic.

The effects *on the grandmothers*, however, are not being cushioned. While they are doing what they have always done – caring – they have become increasingly stretched. They are supporting growing numbers on shrinking incomes. Many are not yet eligible for pensions and have had to resort to taxing work in order to feed their families. Their wellbeing is at stake, both emotionally and physically. They are, in many ways, the invisible, unpaid and unrecognised, and yet they are the pillars of their families and communities. Meanwhile, the 'disease of youth' continues to spread and is endangering the 'next generation' of grandmothers. This is especially distressing in South Africa, where the epidemic is young and impacts will evolve for decades.

Extending and improving the lives of today's grandmothers means, among other things, seriously grappling with the drivers of poverty, unemployment and migration; providing ageing women with wider access to social grants, health-care and psychosocial support; and paying salaries to those working in arduous community initiatives such as 'home-based care'. If we are to move beyond short-sighted analyses, there is a need to consider critically what will happen when today's grandmothers die. Moving beyond short-term interventions, there is a need to act now to keep future doomsday predictions as the stuff of 'emotional statistics' and media hyperbole.

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NOTES

1 Two additional unfounded assumptions bear mentioning but will not be dealt with here: (1) that older women are not sexually active and thus not susceptible to HIV infection (except though contact with bodily fluids when caring for others); (2) that older women's activities are apolitical.

2 There are no available disaggregated data for Warwick Junction – this provincial estimate is the most reliable source for HIV prevalence levels.

3 The category of 'older woman' in this research is not based on age but on life circumstance, though all were aged in the forties and fifties. 'Older' women are defined as those with children *and* grandchildren, whereas 'younger' women had only young children. 'Older women' are thus by definition 'grandmothers'; the two terms are used interchangeably. Moreover, the category of 'grandmother' in this research is defined by the presence of grandchildren in these women's lives – the grandmothers in the study do not identify primarily as 'grandmothers', but when asked about their family responsibilities, they all discuss their care-taking roles in relation to their children *and* grandchildren.

4 This paper will not discuss the grandfathers: the men in the study were not fully abreast of happenings at home; did not speak of burdens around HIV/AIDS in the same way as the older women; and tended to be younger than the older women, with fewer grandchildren. This reflects the fact that men tend to stop trading (or 'retire') younger than women (Skinner 2004). Others have indicated that even when women fall ill and die, men are generally not taking on caretaking roles (Marais 2005). More research is needed to explore the role of grandfathers in AIDS related social responses.

5 The narrow household concept used in most studies makes it difficult to verify whether trends identified by this research mirror broader patterns. With a narrow household definition, even a finding that household sizes are shrinking could reflect a loss of adults, which could result in more 'household units' merging into larger networks with fewer carers. The findings in Warwick Junction, however, are supported by evidence from rural KwaZulu-Natal (Hosegood and Solarsh 2004), from one of the few longitudinal data sets that uses similar a household definition.

6 These include documents compiled by HelpAge International (available at http://www.helpage.org/Researchandpolicy/HIVAIDS); media coverage for the AIDS 2006 Grandmothers Gathering in Toronto (available at http://www.stephenlewisfoundation.org/grandmothersmedia.htm); UN documents (*e.g.* UN 2004; UNAIDS 2004, 2006); the international declarations noted in the introduction; and various South African research reports, papers and presentations (*e.g.* Marais 2005; Posel and Casale 2003; Desmond 2006). Some specific examples are cited throughout.

7 These findings are not easily comparable against most longitudinal data. They could be seen as a result of defining 'households' fluidly; it could be argued that middle-generation adults may be part of the network but not present in the house and thus these could still be, by definition, skipped-generation structures. However, even researchers drawing upon studies that use narrower household definitions are questioning the extent to which families are operating entirely without middle-generation members (*e.g.* Desmond 2006).

8 Clearly, further attention to the various factors that link and divide the category of 'grandmother', including age, is required. This paper does not aim to compare 'young' and 'old' grandmothers, but rather to point to the fact that many are quite 'young', which has implications for their mobility, income-generating capacity, and access to social grants. Moreover, there is need to investigate the differential risk of HIV infection among various grannies, but this is beyond the scope of this paper.

9 Note that this assumption applies specifically to the South African context and in many ways is an extension of the previous argument.

10 Foster grants also exist for some older people caring for grandchildren, but awareness about them is low. Problems with identity papers and eligibility requirements deter many people from applying (HelpAge International 2005). The grandmothers in Warwick Junction reported difficulties accessing any form of social grant, including child grants, foster grants and disability grants.

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