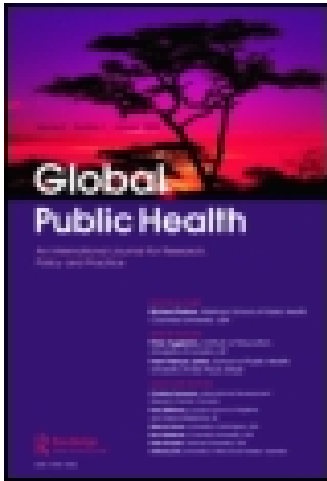


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Publisher: Routledge

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Global Public Health: An International Journal for Research, Policy and Practice

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rgph20>

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Published online: 07 May 2015.

To cite this article: Enid Schatz & Janet Seeley (2015): Gender, ageing and carework in East and Southern Africa: A review, *Global Public Health: An International Journal for Research, Policy and Practice*, DOI: [10.1080/17441692.2015.1035664](https://doi.org/10.1080/17441692.2015.1035664)

To link to this article: <http://dx.doi.org/10.1080/17441692.2015.1035664>

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Gender, ageing and carework in East and Southern Africa: A review

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(Received 31 October 2013; accepted 13 February 2015)

An estimated 58 million persons aged 60-plus live in sub-Saharan Africa; by 2050 that number will rise sharply to 215 million. Older Africans traditionally get care in their old age from the middle generation. But in East and Southern Africa, HIV has hollowed out that generation, leaving many older persons to provide care for their children's children without someone to care for him or herself in old age. Simultaneously, the burden of disease among older persons is changing in this region. The result is a growing care deficit. This article examines the existing literature on care for and by older persons in this region, highlighting understudied aspects of older persons' experiences of ageing and care – including the positive impacts of carework, variation in the region and the role of resilience and pensions. We advance a conceptual framework of gendered identities – for both men and women – and intergenerational social exchange to help focus and understand the complex interdependent relationships around carework, which are paramount in addressing the needs of older persons in the current care deficit in this region, and the Global South more generally.

Keywords: ageing; East and Southern Africa; carework; HIV; gender

Introduction

There are currently about 58 million persons aged 60-plus in sub-Saharan Africa, and their number is growing. By 2050 there will be an estimated 215 million, an increase from 6% to 10% of the population (United Nations Department of Economic and Social Affairs, Population Division, 2011). The growth of this group is significant because they are *receivers* and *providers* of a vast majority of Africa's informal care. First, these older persons will need care. But, particularly in East and Southern Africa where so many younger kin have been lost to HIV and related illnesses, informal care systems are strained.¹ Second, in an HIV-endemic context, the carework older persons provide is critical. Third, there are important shifts and variation in the burden of disease among older persons in this region with an increase in non-communicable disease, as well as variation in the resources available to older persons. In order to continue providing care, older persons will need support as they age (Cancian & Oliker, 2000).

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In East and Southern Africa, few formal systems of care exist; instead, families provide most of the caring for children, the sick and aged (Apt, 2012; Mathambo & Gibbs, 2009; Richter et al., 2009; Thrush & Hyder, 2014). Demographic trends including slowed fertility, a hollowing of the middle generation by HIV/AIDS (WHO, UNAIDS, & UNICEF, 2011), and an ageing population (Cohen & Menken, 2006; Velkoff & Kowal, 2007) have led to a 'care deficit' for the old and the young. As described in other settings, a care deficit exists when the need for informal care exceeds the supply of available caregivers (Ben-Galim, 2009; Ehrenreich & Hochschild, 2004; Zimmerman, Litt, & Bose, 2006). We believe there is evidence that more older persons in this region are lacking care and are being expected to provide informal care for the sick, ageing and young than in the past, at least partially due to HIV/AIDS (Johnson & Climo, 2000; Kautz, Bendavid, Bhattacharya, & Miller, 2010; Mokomane, 2013; Zimmer & Dayton, 2005).

Informal caregiving refers to 'an unpaid individual (a spouse, partner, family member, friend or neighbour) involved in assisting others with activities of daily living and/or medical tasks' (Family Caregiver Alliance [FCA], 2012). Informal carework for the sick and ageing might include assisting with transportation to medical appointments, getting and giving medicines, feeding, bathing and toileting. Informal carework for children might include feeding, bathing and support with school needs. Completing household chores for self and others, like collecting firewood and water, gardening, cooking and cleaning, are additional activities that are part of informal carework (Bohman, Vasuthevan, van Wyk, & Ekman, 2007; Mugisha et al., 2013; Schatz & Ogunmefun, 2007). Insufficient empirical data focusing on these topics in East and Southern Africa mean that our knowledge about variation in the intensity and diversity of informal carework, and the ways that carework affects and is affected by older persons' health status, their ageing processes and gender roles within the region, is limited.

What we do know is that those who fill the care deficit are often women, and in many cases, older women (Akintola, 2004, 2008; Schatz, 2007). As reported elsewhere, 60% of AIDS orphans in Zimbabwe, South Africa and Namibia live with grandparents (Apt, 2012; Zimmer & Dayton, 2005). The majority of South African HIV caregivers in one study were female (68%); of these, 23% were over age 60 (Steinberg et al., 2002). In a study of Luo grandparents in Kenya, Ice, Yogo, Heh, and Juma (2010) found that about 60% of those classified as caregivers, i.e., caring for at least one orphan, were women. In northern Uganda, Oleke, Blystad, and Rekdal (2005) found that older women headed the majority of households where orphans received care.

HIV has emerged as a central reason for older persons' increasing carework. However, unemployment among working age persons, labour migration, non-marital childbearing and traditions of fostering also contribute to older persons' care burdens (Goody, 1982; Harrison, Short, & Tuoane-Nkhasi, 2013; Madhavan, 2004). While older persons' carework is increasing, growing HIV prevalence and non-communicable disease rates among those aged 50-plus are leaving more caregivers in need of care themselves (Anderson & Phillips, 2006; Kahn, Garenne, Collinson, & Tollman, 2007; Mills, Bärnighausen, & Negin, 2012; Negin, Wariero, Cumming, Mutuo, & Pronyk, 2010). The complexity of the situation in East and Southern Africa demands attention to both care *for* and *by* older persons, with consideration as to how current carework builds on past child fostering and elder care practices, and how these vary by gender, urban-rural residence, region, etc. (Bohman, van Wyk, & Ekman, 2009; Cattell, 1990; Nahemow, 1979; Oppong, 2006; Sagner, 2001).

This paper reviews evidence of the current care deficit, and the benefits and disadvantages of carework in the region, with attention to the ways that age and gender come together to shape the experience of care, the value it is given, and the importance of

care as a relationship between individuals. We then propose a conceptual framework that focuses on gendered identities and the role of social exchange to enhance future carework research in East and Southern Africa. Central to this lens are the importance of interdependence between generations, and the ways that masculinity and femininity shape notions of carework and self. After setting out this conceptual framework, we conclude by using it to suggest directions for future research.

The care deficit

A profound *care deficit* exists in East and Southern Africa because state, family and private markets of care are poorly coordinated (Upton, 2003; Zimmerman et al., 2006). Formal care, where paid providers or governmental agencies provide assistance, include health services, day care, residential and care facilities (FCA, 2012); outside of urban centres, residential care facilities for older persons are rare, and where present they are generally financially accessible only to elites (UNFPA, 2002). While some care may be bought through market services (e.g., childcare, domestic services, hospice care), these paid services usually are not regularly available or financially feasible (Akintola, 2004; Heymann & Kidman, 2009). High levels of poverty among older persons make market services particularly difficult to access (Barrientos, Gorman, & Heslop, 2003); government-provided social protection and assistance are also limited in most countries in this region (Niño-Zarazúa, Barrientos, Hickey, & Hulme, 2012). Thus, families provide most of the care for the children, sick and elderly as they age. However, due to HIV and other factors, this system has become severely strained (Deininger, Garcia, & Subbarao, 2003; Foster, 2000), and that strain is having ramifications across many aspects of social and economic life.

HIV

Table 1 shows East and Southern African countries' 2012 estimated HIV prevalence, which ranged from 2.9% in Rwanda to 26.5% in Swaziland. As prevalence worsened in countries with epidemic levels of HIV/AIDS, some familial care systems were already in

Table 1. HIV prevalence in East and Southern Africa.

East and Southern Africa	Estimated HIV prevalence 2012 ^a
Botswana	23.0
Kenya	6.1
Lesotho	23.1
Malawi	10.8
Mozambique	11.1
Namibia	13.3
Rwanda	2.9
South Africa	17.9
Swaziland	26.5
Tanzania	5.1
Uganda	7.2
Zambia	12.7
Zimbabwe	14.7

^aPrevalence estimates from UNAIDS 2013 Global Report.

place. Grandmothers/grandmothers-in-law, aunts and other female kin were accustomed to providing care (Madhavan, 2004; Nyambedha, Wandibba, & Aagaard-Hansen, 2003; Upton, 2003). However, in many countries HIV has hollowed the middle generation, reducing significantly the care providers for both the old and young (Deininger et al., 2003; Kautz et al., 2010). HIV-related care needs include: (1) young children, including those whose parents are sick and those orphaned by the epidemic; (2) sick adults; and (3) older persons whose caregivers have died of HIV.

Extensive literature from multiple settings documents the tremendous responsibilities older adults have taken on as a result of their adult children's HIV-related morbidity and mortality. This includes financial, emotional and physical work related to their adult children's care and rearing orphans (Bicego, Rutstein, & Johnson, 2003; Bohman et al., 2007; Ssengonzi, 2009; Williams & Tumwekwase, 2001). In doing so, older adults are increasingly living with children, without middle-age adults in the home capable of providing help (Hosegood & Timaes, 2005; Seeley, Wolff, Kabunga, Tumwekwase, & Grosskurth, 2009). In countries with high HIV prevalence, older adults are more likely to be living alone and without someone to provide them with care in their old age, compared to their peers in countries with lower HIV prevalence (Kautz et al., 2010).

It is important to note that due to advances in antiretroviral therapy (ART) HIV/AIDS mortality in many places is stabilising, even if incidence is not necessarily declining (Floyd et al., 2012; WHO et al., 2011). This means there may be fewer sick individuals, fewer deaths of middle-aged caregivers and fewer new orphans. However, it also means that more individuals will need care as they live into old age with HIV (Kuteesa, Seeley, Cumming, & Negin, 2012). Thus, the HIV care deficit is far from stemmed; among high prevalence countries the differential pace and coverage of ART rollout will continue to shape this deficit.

Targeted interventions in areas with high HIV prevalence have meant that older persons in these settings may have access to resources that may offset the burdens of additional HIV/AIDS-related carework. These include unconditional and conditional cash transfer programmes, as well as government-funded social grants, intended for caregivers of orphans and vulnerable children (OVC; Ardington et al., 2010; Miller & Tsoka, 2012; Niño-Zarazúa et al., 2012; Robertson et al., 2013; Twine, Collinson, Polzer, & Kahn, 2007). A number of these programmes have shown improved nutritional and educational outcomes for OVCs in homes that receive cash assistance (Adato & Bassett, 2009; Ayuku et al., 2014; Wakoli, Etyyang, & Lakati, 2012). The expense and staffing needed to implement such programmes at a national level has meant that they often are not scaled up despite their promise. In a number of areas, home-based care non-governmental organisations (NGOs) provide food, supplies, assistance and support to caregivers (Adato & Bassett, 2009; Hansen et al., 1998; Lindsey, Hirschfeld, & Tlou, 2003; Root & Whiteside, 2013). While the potential for home-based care organisations to provide resources and relief are great, more effective partnerships between community members, NGOs and governments are needed to maximise the benefits of these programmes (Campbell & Foulis, 2004; Kalofonos, 2014; Nsutebu, Walley, Mataka, & Simon, 2001). In addition, these programmes are often imperfect in their ability to find and service the most vulnerable populations, and the focus on orphans ignores the fact that they are often not worse off than other poor children in the region (Richter et al., 2009). Thus, programmes are needed that cast a broader net and are more systematic in their reach.

While much of the focus is on older persons caring for the generations below them because of HIV, and increasingly the presence of non-communicable diseases may lead older persons to care for a spouse or to become the person that needs care. Some illnesses

(e.g., stroke and cancer) can be severely debilitating, while others (e.g., hypertension, diabetes, HIV with ART) require attention to diet and medication. In either case, the extent of necessary care can be considerable, and these diseases are increasingly prevalent in this region (Mayosi et al., 2009).

Fragmented families

East and Southern Africa have a long history of fragmented families. Rural to urban migration has meant that older persons and children are overrepresented in rural areas (Okojie, 1988). Historically, as men migrated to cities for jobs, mothers and grandmothers were left behind in rural areas to care for children (Madhavan, 2004), with few adults under 50 around. Although some labour streams have recently dried up and slowed migration (Harrison et al., 2013), women have been migrating more frequently (Cross, Gelderblom, Roux, & Mafukidze, 2006). Particularly when children are left behind, this new female migration is further reducing the number of middle-age adults who could provide care, particularly in rural households (Haour-Knipe, 2009; Posel, Fairburn, & Lund, 2006; Upton, 2003). Migration of adult (female) children permanently to urban areas to pursue education, work or life in general also results in older persons losing their carers. Importantly, little is known about gender, ageing and carework in conflict areas; while children are often the focus, rarely are older persons' experiences included (Agadjanian & Prata, 2003; Bird, Higgins, & McKay, 2010; Bundervoet, Verwimp, & Akresh, 2007).

In many East and Southern African settings, children born outside of marriage are raised by grandparents (Harrison et al., 2013; Madhavan, 2004). These children are often regarded as 'belonging' to the grandparents because non-marital childbearing triggers expectations of social mothering (Makoni, 2008; Page, 1989). While not new, fostering is yet another way in which older persons' obligations continue to be extended into the role of caregiver.

Labour migration, displacement and fostering may impact available care providers; high levels of unemployment may alter care relationships (Lam, Leibbrandt, & Ranchhod, 2006). Unemployment and under-employment may mean formerly productive middle-aged members of the household are now dependent on the financial contributions and work of older persons (Schatz & Ogunmefun, 2007; Seeley, Tumwekwase, & Grosskurth, 2009). Further, in settings with pensions or cash transfers for the elderly, older persons who would traditionally be dependents become 'productive' members once more (Case & Deaton, 1998; Case & Menendez, 2007; Schatz, Madhavan, Collinson, Gómez-Olivé, & Ralston, 2014). In fact, old age pensions may affect living arrangements by increasing the likelihood that women/mothers will migrate and leave a child behind (Posel et al., 2006). Household-level analyses, like these, provide important insights into carework, but not all carework will take place within households; carework studies must expand to examine inter-household dynamics.

Benefits and disadvantages of carework

Literature from around the world has evaluated the emotional, financial, physical and psychological impacts of caregiving on both caregivers and care recipients. Quite clearly, caregiving takes a toll, but the effects on individuals are both positive and negative, and change with time (Brown & Brown, 2014). Potential benefits of carework may include reciprocity, a sense of purpose, and fulfilling obligations or perceived traditional roles.

Disadvantages of carework may include worry, depression, lack of control, financial hardship and negative impacts on health. Experiences as a care recipient can also be uneven. Carework may enrich or strain relationships, and in cases where care occurs under duress or not at all, the result may be abandonment and abuse (Oppong, 2006; Sijuwade, 2008). Although research is nascent in East and Southern Africa on the multifaceted aspects of carework, the extant research shows both these positive and negative impacts.

Impacts of carework on caregivers and recipients

Carework is both labour and financially intensive (Heymann & Kidman, 2009; Ogden, Esim, & Grown, 2006). The time burdens of caregiving increase poverty among poor caregivers (Hansen et al., 1998; Lindsey et al., 2003) and the financial burdens may cause caregivers stress (Akintola, 2004; Nnko et al., 2000; Orner, 2006). While most older East and Southern African women are not working in the formal economy, carework still has opportunity costs in the form of foregone subsistence agriculture, informal income-generating activities and self-care (Yajima, van Huis, & Jiggins, 2010). In households already struggling financially, the costs of caregiving can create further financial hardship and social disruption (Seeley, 2008; Seeley, Wolff, et al., 2009; Ssengonzi, 2009). However, given the limited resources of many caregivers, the negative financial impacts may be viewed as modest since they have little income to spend and few assets to sell (Chimwaza & Watkins, 2004). Time-use and income data are limited in these settings, so the full extent of these burdens, whether extensive or modest, remains undocumented.

Methodological limitations (sample size, comparison groups, confounding variables) may lead to overstatement of the negative consequences of carework (Brown & Brown, 2014). Despite these potential limitations, there is a fairly large literature documenting the negative impacts of caregiving on health and well-being, particularly for older female caregivers; however, the results differ by country, level of HIV prevalence and types of measures captured. Older caregivers have a high risk for poor physical and mental health, such as stress, fatigue, depression and exhaustion (Oburu & Palmérus, 2005; Orner, 2006). Other studies have found little physical impact of caregiving, but poor mental health outcomes; the loss of possible support in old age led to a pervasive sadness (Ice et al., 2010). Little is known, however, about the effect of losing a future caregiver on older persons' overall health and well-being (Oppong, 2006). HIV caregiving in particular has been found to saddle caregivers with stigma, discrimination, isolation, lack of support and the breakdown of social networks (Howard et al., 2006; Ogunmefun, Gilbert, & Schatz, 2011). Importantly, the experience of carework is not static. A recent study using longitudinal qualitative data found that while despondency was present among caregivers, for many of the reasons mentioned thus far, it waxed and waned over a prolonged period (Wright, Zalwango, Seeley, Mugisha, & Scholten, 2012). The study also showed that carework burdens vary over time in the ways they are experienced and talked about among family members. Consistently capturing mental health measures, longitudinally when possible, in older populations across contexts would further strengthen our knowledge in this area.

While much of the caregiving literature stresses negative impacts, there is growing attention to the positive effects caregiving might have for carers (Brown & Brown, 2014). Many caregivers gain satisfaction from carework; caregiving can also provide respect and emotional and spiritual strength (Abel, 2000). Mugisha et al. (2013) found that about one in six older respondents provided care to someone who was sick, but did not report

poorer health status or quality of life. Yet, these data cannot tell us if the caregivers were in better health to begin with, or caregiving itself had psychological benefits.

To this end, some researchers have begun to examine caregivers' coping strategies. Through carework, caregivers have agency and remain resourceful despite hardships. Casale (2011) shows how caregivers use reciprocity and borrowing and draw on coexisting notions of 'tradition' and 'modernity' to continually expand help-seeking options. Indeed, this reciprocity of care, stemming from social exchange, is an under-researched but potentially important way caregivers receive benefits from their carework. A Ugandan study showed that those with larger caregiving responsibilities more frequently *received* support (Mugisha et al., 2013). Older persons may receive care from young people and adults in their home; while at the same time, they are providing care to children and the ill (Abebe & Skovdal, 2010; Schatz, 2007; Skovdal, Ogutu, Aoro, & Campbell, 2009). The older persons provide childcare, while the children contribute physical labour, e.g., help with collecting water, firewood and other activities that are difficult for older persons to do (Evans, 2010; Foster & Williamson, 2000).

The reciprocity of care may improve emotional well-being. Some caregivers feel that there is joy from having a child in the family (Howard et al., 2006). When older persons care for children, it provides hope that someone will later care for them (Schatz & Ogunmefun, 2007) and caring for grandchildren provides hope of receiving support in old age, infirmity and for burial (Williams, 2003). In return the children for whom they care receive emotional support. Given the prevalence of multi-generational families, this bi-directional carework is probably more extensive than currently documented.

Gendered nature of carework

Gender helps define how care is framed, who provides it and how it is experienced as a giver and recipient (Abel & Nelson, 1990; Cancian & Oliker, 2000; Talley & Crews, 2007). In East and Southern Africa, both men and women live with the impacts of the care deficit. However, the sexual division of labour has meant women predominantly fill the void in care (Kalipeni, Oppong, & Zerai, 2007; Oppong, 2006). Cultural beliefs about 'maternal instinct' and men's 'natural' roles as breadwinners have led to assumptions that women are better suited to daily care of the young and sick, while men are supposed to provide financial assistance (Cancian & Oliker, 2000). Thus, the research focus has been largely on women's experiences (Akintola, 2008; Bohman et al., 2007; Schatz, 2007), but we cannot fully understand the gendered implications of carework without also capturing men's experiences.

Importantly, gender helps determine not only who gives or receives care, but also the classification of carework both by researchers and by those answering survey and interview questions (Oppong, 2006). For example, women (and men) may see care for an ageing or sick husband as a continuation of 'wifely duties'. Likewise, caring for the young or sick may not be reported as carework, as it fulfils routine family expectations and obligations (Makoni, 2008; Schatz, 2007). On the other hand, men's physical and emotional carework is often more visible. Because men's carework is further outside men's normative familial roles, it is more likely to be viewed as carework and reported as such. Thus, adding other data sources, like time-use data, may provide more accurate documentation of gender differences in time spent on carework.

A double burden of care

In the East and Southern African context, an important, though largely invisible, emerging issue is older women's experience of a double burden of care. In the Global North, an extensive literature reveals the 'sandwiched generation' (i.e., middle-aged women raising their own children and simultaneously caring for their sickly parents) and the psychological and emotional stressors of that position (Brody, 1985, 1990; Ingersoll-Dayton, Neal, & Hammer, 2001). While not sandwiched, older East and Southern African women may be simultaneously or sequentially caring for both their children and their children's children. Most articles on caregiving in HIV-endemic contexts focus either on caregiving for orphans or caregiving for HIV-positive individuals and are not sensitive to the possibility of a double care burden. We need new data and fresh analyses of existing data to understand the magnitude of this double burden.

Developing a conceptual framework

Documenting the types, extent, expense, duties and impacts of carework is an important first step to understanding carework in East and Southern Africa. However, in order to truly understand the growing care deficit, we have to understand how carework is bound up with gendered identities and individuals' sense of self. Expectations about care and the complexity of relationships involved are gendered and affected by the age and life stage of both the carer and cared for (Oppong, 2006; Razavi, 2007). If ageing is viewed through a life course perspective as a career (Cattell, 1990), we see old age as an accumulation of experiences, life events and relationships that help define one's sense of self and how to relate to others (Bowling & Dieppe, 2005).

The social, cultural and political environment shapes both the individual (i.e., identity) and the constraints and opportunities available for living out that career (Myerhoff & Simić, 1979). Thus, it is possible that, as Makoni (2008) argues, independence in old age is valued in the Global North, but *interdependence* with kin is a more valued and potentially successful ageing strategy in East and Southern Africa.

Gender plays an important role in older age careers and kin relationships (Calasanti, 2010). Indeed, given the patriarchal systems in place in much of East and Southern Africa, in each context we must account for how gender tropes shape older persons' experiences of carework, how gender impacts their notions of self and how gendered norms help elucidate anomalous behaviour (Oppong, 2006; Zimmerman et al., 2006). Gender identity, built over a lifetime and shaped by local norms and values, affects how older persons understand themselves and what roles they believe they can and should play as they age. Learned gender norms (masculinities and femininities) shape older persons' perceptions and definitions of carework, their likelihood of engaging in specific types of carework and the impacts of carework on their well-being (Calasanti, 2008, 2010).

In many East and Southern African settings, men are expected to be financial providers and women providers of emotional labour and physical carework (Oppong, 2006). But as the care deficit worsens, men and women are increasingly faced with conflict between their families' needs and their own sense of self. For example, when men must provide physical care for the sick or young, they often have difficulty aligning this role with societal norms of masculinity (Morrell & Jewkes, 2011; Mudege & Ezeh, 2009; Munthree & Maharaj, 2010). Common narratives of masculinity give primacy to time, money and energy spent on leisure activities in old age rather than on care (Mudege & Ezeh, 2009; Munthree & Maharaj, 2010; Whitehead, 2000). Thus, normative masculinity and a lifetime of providing financially but not emotionally or

physically may make some carework more difficult for men, at least psychologically (Connell, 2005).

On the other side, women's decision to care for dependents aligns with narratives about older women being altruistic and selfless caregivers. However, gender norms may make it difficult for women to refuse to provide emotional or physical labour, or challenging to ask for or accept assistance, particularly financial assistance, if one's husband has died or is not capable of providing help.

We argue that carework depends on interdependence in these settings. And because older persons are both caregivers and care recipients (sometimes simultaneously), it helps to see carework through the theory of social exchange (Cain, 1983; Cattell, 1990; Hendricks, 1984; Moore, 1979). Social exchange draws our attention to the specific actors taking part. While past research has focused on the relationships between parents and children (Cain, 1983), the focus must now shift to exchange and expectations between grandparents and grandchildren. Although interdependence in old age may be desired and valued, it is a social exchange that individuals are having to reinterpret as actors change, but also as older persons age and have different, likely fewer, resources to offer, while their needs simultaneously increase.

Conclusion

Because the need for carework in East and Southern Africa is increasing and it is unlikely the public sphere will ease the burden for families anytime soon, as Talley and Crews (2007) pointedly summarise 'priority must be given to determining the services and interventions that are most useful to caregivers' (p. 227). Using gendered identities and social exchange as a framework, we can see carework as a vehicle that transmits gendered social and cultural values across generations. Recognising and capturing the interdependent and reciprocal nature of carework by and for older persons will bring into focus the 'goods' and values exchanged (Ben-Galim, 2009). Uncovering these dynamics could help highlight the type of assistance older persons want, from whom, and how complex relationships mediate those desires. Accounting for how gender, identity and social exchange shape older persons' experiences of care will point to sound interventions. Perhaps these will include interventions that address emotional well-being and participation in civil society, as a means of reducing social isolation and providing support and care to carers (Ben-Galim, 2009; Richter et al., 2009).

With a focus on sense of self, we may be able to more concretely capture the positive effects of carework on older persons. Using and adapting tools that measure resilience and successful ageing might expand our understanding of the positive effects of carework and ageing in East and Southern Africa more generally (Åstedt-Kurki & Heikkinen, 1994; Nygren, Norberg, & Lundman, 2007; Rowe & Kahn, 1997). If older caregivers gain hope, self-esteem and general well-being from the care they provide for others, whether it be because this care ensures their own care later on, a proper burial or simply the knowledge that they have helped their kin, this may mean that intervention programmes that support older persons' ability to provide this care, through social and economic resources, would be beneficial both to older carers and to those for whom they provide care.

For example, a promising area of intervention, which needs further study, is the ways in which cash assistance to older persons' homes shapes their carework, living arrangements and own health and well-being. Social pension programmes targeting older persons exist in Botswana, Kenya, Lesotho, Mozambique, Namibia, South Africa and

Swaziland, and in limited or pilot form in Uganda and other countries in the region (Barrientos, Niño-Zarazúa, & Maitrot, 2010). In the past, humanitarian aid often took the form of donor-funded food aid and emergency assistance; a move towards cash transfers as part of more regular and reliable long-term social protection, particularly government-funded programmes, is necessary to reduce endemic poverty (Adato & Bassett, 2009; Mokomane, 2013; Niño-Zarazúa et al., 2012). The benefits of social protection programmes directed towards older persons (most programmes target those aged 60-plus) reach not only older persons but also indirect beneficiaries – their children and grandchildren (Ardington et al., 2010; Case & Deaton, 1998; Duflo, 2003; Schatz & Ogunmefun, 2007). Importantly, access to these financial resources provides older persons with the chance to diversify their livelihoods, the means to provide various types of care to the ageing, sick and children, and the possibility to purchase goods and services (Adato & Bassett, 2009). Yet much more research is needed to understand how these programmes affect the care deficit, older persons' health and well-being and gendered identities, as well as how inter- and intra-family transfers (both to and from older persons) impact older persons' health and well-being (Kohler, Kohler, Anglewicz, & Behrman, 2012). In addition, this research may help governments to justify this expense in an environment of competing interests, a reduction in funder investment in HIV/AIDS and other areas, as well as questions of financial sustainability of social protection programmes (Moyer & Igonya, 2014; Niño-Zarazúa et al., 2012).

Increasing the number of studies, the diversity of research designs and types of tools used to understand ageing in these settings will provide insight into the diversity and trends related to ageing and carework in East and Southern Africa. Further, making use of a gendered identities and social exchange lens will help to elucidate not only the present reality, but also the services and interventions that older persons, who provide and need care in this region, need. Finally, increasing research on gender, ageing and carework, whether focused on social support, health or financial resources, will provide governments with evidence of programme effectiveness needed to scale up to improve the health and well-being of a wider swath of older Africans.

Acknowledgements

Earlier versions of this paper were presented at the Gerontological Society of America meeting and the American Sociological Association Meeting. The authors would like to thank Feinian Chen, Gillian Ice, Micki Iris, Paul Kowal, Susan Short and anonymous reviewers for constructive feedback that improved the paper. The content is solely the responsibility of the author and does not necessarily represent the official views of NIH or NICHD.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This research has also benefited from the NICHD-funded University of Colorado Population Center [grant number R21 HD51146] through administrative and computing support. Additional support came from the University of Missouri Research Board.

Note

1. We focus on the geopolitical region of East and Southern Africa as designated by the World Health Organization, UNESCO, UNAIDS, IOM and other international organisations.

The countries included in this region vary depending upon the organisation or project, but generally include the following: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. While not all countries in the region have been equally affected by HIV/AIDS (see Table 1), the majority has contended with an HIV/AIDS epidemic.

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