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'Taking Care' in the Age of AIDS: Older Rural South Africans' Strategies for Surviving the HIV Epidemic

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Abstract

Older adults have been largely overlooked in community studies of HIV in highly endemic African countries. In our rural study site in Mpumalanga Province, South Africa, HIV prevalence among those 50 and older is 16.5%, suggesting that older adults are at risk of both acquiring and transmitting HIV. This paper utilises community-based focus group interviews with older rural South African men and women to better understand the normative environment in which they come to understand and make decisions about their health as they age in an HIV endemic setting. We analyse the dimensions of an inductively emerging theme: *ku ti hlayisa* (to take care of yourself). For older adults, 'taking care' in an age of AIDS represented (1) an individualised pathway to achieving old-age respectability through taking up the responsibilities and behaviours that characterise being an older person, (2) a set of gendered norms and strategies for reducing one's HIV risk, and (3) a shared responsibility for attenuating the impact of the HIV epidemic in the community. Findings reflect the individual, interdependent, and communal ways in which older South Africans understand HIV risk and prevention, ways that also map onto current epidemiological thinking for improving HIV-related outcomes in high-prevalence settings.

Keywords

older adults; rural South Africa; HIV prevention; *ubuntu*; community-based focus group interviews

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Introduction

Several decades into the HIV epidemic in sub-Saharan Africa, the images, stories, and research on older Africans have centred largely on their role as caregivers— taking care of the sick and dying and those orphaned by AIDS (e.g., Schatz and Ogunmefun 2007; de Klerk 2012). Only recently has increased attention been paid to HIV infection among older adults (see Freeman and Anglewicz 2012; Negin et al. 2016). This focus is warranted. In our study site in Mpumalanga Province, South Africa, for example, a 2010–2011 household-based representative survey found that a third of the population between the ages of 45 and 60 years old are HIV positive; rates among women are over 10% until their mid-70s, and among men over 15% until their late 60s (Gómez-Olivé et al. 2013). These rates are especially significant considering the social impact of increasing numbers of individuals ageing with HIV. In addition, the rates indicate a likely increase in the exposure of HIV-negative older adults to sexual-partner pools characterised by a high prevalence of HIV, particularly in light of relationship transitions such as divorce, widowhood, separation, cohabitation, and remarriage characteristic of middle and older ages (Zaba et al. 2008). Despite this sobering epidemiological picture, little is known about how older adults understand, navigate, and ultimately ascribe meaning to this context of risk. In this paper, we explore how older men and women living in a highly endemic rural African setting believe they can take care of themselves amid the threat of HIV.

We draw on a set of community-based focus group interviews (FGIs) with older rural South Africans centred on understanding the broader normative environment in which older adults come to understand and make decisions about their health as they age in a high HIV prevalent environment. We analyse the dimensions of an inductively emerging theme from our data—'to take care of yourself' (*ku ti hlayisa* or *ku ti khoma*)[1]. Our analysis of what it means to 'take care' in an age of AIDS reveals three salient features of older rural South Africans' normative environment: the social expectations of gender, the social significance of life course stage, and the import of community. In addition, our analysis highlights the necessity of moving beyond the individual as a focal unit of HIV risk and prevention in addressing the spread of HIV in rural African communities.

Two theoretical concepts guide our analysis and interpretation of the data. First, Elder's (1994) life-course concept of 'linked lives' posits that human lives are inherently embedded in and influenced by social relationships. With respect to HIV, the primary relationships are with one's sexual partner and, beyond that, with one's immediate family and other household members. To date, researchers have rarely applied the notion of linked lives to the African AIDS context (for an exception see Seeley et al. 2009). Yet it has clear implications for understanding not only HIV acquisition—an individual's risk is tied directly to that of an intimate partner—but also the extended family setting in which many Africans live. This includes the web of affected kin — the (grand)children, (grand)parents, siblings, and others — whose lives are linked and interdependent with an HIV-positive person (see de Klerk and

[1] *Ku ti hlayisa* is an expression in the local XiTsonga/Shangaan language that has context-specific meaning. In this paper we analyse it specifically as invoked in relation to HIV.

Moyer 2016; Kaler et al. 2010). As we show, these wider relational dimensions of social life feature into older rural South Africans' understandings of 'taking care' in an age of AIDS.

The concept *ubuntu* (*vumunhu* in the local XiTsonga/Shangaan language) also guides our analysis. Although *ubuntu* has various meanings (Hailey 2008), we employ it as it emerged in our analysis, namely, to denote a shared humanity that assumes mutual responsibility for the collective good. We show how, in the social imagination of older rural South Africans, taking care goes beyond individual and coupled strategies for HIV prevention; it also connotes protecting the community by keeping others safe from one's own HIV infection, and by helping those infected with HIV take care of themselves. These ideas map onto current epidemiological thinking: increasing the proportion of people on antiretroviral treatment (ART) in a given setting attenuates the community HIV viral load (Das et al. 2010), community support is associated with better treatment outcomes (Zachariah et al. 2007), and the degree to which a community believes they can prevent HIV may reduce HIV risk behaviours (Cain et al. 2013).

Setting, data and methods

We conducted our study throughout villages that comprise the Agincourt Health and Socio-Demographic Surveillance System (AHDSS), located in rural northeast South Africa (Mpumalanga Province), about 500 kilometres north of Johannesburg. Approximately 90,000 people residing in 16,000 households live in the study area, which is governed by both traditional and elected leadership (Kahn et al. 2012). The primary ethnic group is ama-Shangana who speak XiTsonga/Shangaan. The area is a former apartheid 'homeland', to which Black South Africans were forcibly relocated and faced hardships including poor education, high unemployment, and limited infrastructure. The population continues to experience many of these same hardships today (Kahn et al. 2012), which are compounded by a severe HIV epidemic yielding nearly two decades of excess mortality, reversals in which are only now occurring with the wider availability of ART (Kabudula et al. 2017).

Individuals aged 50 years and over constitute 12% of the population. Three-quarters of the population aged 50 and over live in multigenerational households composed of nuclear and extended family, and only 11% live alone or just with their spouse or sibling. Overall, about half the households in the study area have a member who is 50 or older (Schatz et al. 2015).

Following the discovery of high rates of HIV infection among those 40 and older in a 2010–2011 HIV prevalence study conducted in the Agincourt HDSS (Gómez-Olivé et al. 2013), we conducted FGIs in 2013 in the *Izindaba za Badala*[2] study to better understand the normative environment in which older rural South Africans understand and make decisions about their health as they age in a time of AIDS[3]. A total of 77 respondents (36 men, 41 women) participated in nine FGIs, with between 5 and 12 participants in each. We stratified the FGIs by age group (40s, 50s, 60-plus) and gender (men, women, mixed gender[4]) to examine differences in these groups in the transition out of reproductive ages and into older

[2]The local study name is isiZulu for 'the matters of older people', which assumes a topic intended only for 'mature' ears (like sex).
[3]For further details on the larger study, see Mojola et al. 2015.
[4]We included mixed gender FGIs to allow for differences in participant responses by gender composition of the group.

ages. We recruited respondents from locations where the population regularly gather (such as markets and home verandas), and asked them to bring to the FGI two or three people their same age and gender. The FGI instrument included semi structured questions as well as vignettes depicting hypothetical situations and scenarios of similarly aged older men and women (Barter and Renold 1999). Topics focused on community norms and discourses around sexual behaviour and ageing; discourses and dominant expectations around the key social roles, institutions, and life events unique to adults at different points in the transition to older ages; and the collective community experience of social change over the past 20 years (including apartheid and post-apartheid change) to place the HIV epidemic in historical context.

For each FGI, which lasted two to three hours, there was a facilitator, who posed questions and moderated the discussion, and a notetaker. The local research team audio recorded, translated, and transcribed the interviews from XiTsonga/Shangaan to English; following the interviews, we reviewed the transcripts with the local interviewers. To ease readability in the presentation of the data while preserving a local flavour to voices in our study, we retained the vernacular English from the interviewers' translations but inserted clarifying words in brackets and made minor grammar edits; we also used pseudonyms in lieu of identifying participants generically by age group and gender.

Using NVivo 10 we coded the data deductively for themes drawn from the FGI guide and inductively for emerging themes, utilising elements of grounded theory (Strauss and Corbin 1990; Charmaz 2002). *Ku ti hlayisa* ('to take care of yourself') emerged in our analysis most prominently in relation to our a priori interest in HIV risk and prevention strategies. We refined our understanding of the fuller range of meaning attached to taking care through creating analytic memos and developing related subcodes.

Findings

Our findings show that taking care in a time of AIDS represented (1) an individualised pathway to achieving old-age respectability through taking up the responsibilities and behaviours that characterise being an older person, (2) a set of gendered norms and strategies for reducing one's HIV risk, and (3) a shared responsibility for attenuating the community impact of the epidemic. We explore each of these three themes in turn below and show how they map onto individual aspirations, linked lives, and community responsibilities.

A path to old age and being a respectable older person

The achievement of old age was itself the result of having taken care—it assumes one has avoided the high-risk behaviours that lead to illness, injury, and early death. But taking care was also a continuing obligation of older adults because of responsibilities (both gendered and generational) incumbent upon them.

Ageing as achievement

In a high-mortality context like Agincourt—characterised by deaths from acute and chronic diseases, as well as other factors such as violence (Mayosi et al. 2012)—achieving old age

represents an achievement. In 2005, at the peak of the HIV epidemic in the area, life expectancy at birth was only 57 for women and 52 for men (Kabudula et al. 2017). Gift and Peter, two men aged 60-plus, responded as follows to a vignette about how they imagine the romantic life of a 65-year old man ('Baba Simon'[5]):

> Gift: We must take care of ourselves. If we don't we won't live longer like other older men…. A 65-year-old man is about to be mukhalabye [a very old man], so if he does not take care of himself he won't reach 70 or 80 years.
>
> Peter: If you are a man of 65 years, you have to love your wife even if she is old…. It does not mean that as a man you stop having sex; you don't have to date a 40-year-old woman. Love your wife and forget about young bloods [young women], just stay with your wife [FGI, Men, 60s].

As implied by Gift, taking care is a pathway to reaching old age. Peter qualified that for an older man, this means remaining faithful to one's (older) wife and avoiding the temptation of sex with outside (younger) partners. Despite this seemingly individual nature of self-care to achieve old age, it too is inherently linked and interdependent—in this case, being faithful to one's (older) wife reduces one's own HIV risk.

Participants also expressed that knowing one's HIV status can avert (early) death to AIDS and restore a healthy life. Ida, a woman in her 40s, reasoned, 'I think it is good [to know your HIV status] because I will be able to take care of myself and live many years' [FGI, Mixed Gender, 40s]. Other participants qualified that this meant abiding by requisite therapeutic and lifestyle prescriptions, namely, following ART-dosing regimes, avoiding alcohol, and eating nutritious foods. Taking care is thus not just about averting HIV infection but also about managing HIV infection in a way that promotes successful ageing.

Knowing one's HIV status was not only about the individual returns to health and longevity; it also considered how those very same returns were consequential for others. As Bonginkosi, a man in his 50s, noted, 'It's important to know your HIV status, especially if you have family so you can take care of yourself' [FGI, Men, 50s]. While bodily experiences of ageing with HIV are difficult and daunting, particularly in resource poor settings (de Klerk and Moyer 2016; also see Wright et al. 2012), here the point is simply that taking care is understood as relational. As de Klerk and Moyer (2016) similarly observe, by managing one's HIV infection, an older person can best fulfil their social roles and responsibilities to others, as we elaborate next.

Ageing and shifting priorities

In Agincourt, ageing-related milestones are reached early in the life course. As elsewhere in sub-Saharan Africa, childbearing is common in one's late teenage years and early 20s (Garenne et al. 2001), making it typical to become a grandparent by one's 40s and a great grandparent by one's late 50s or early 60s. The social expectations accompanying these roles vary, notably by age and gender, and are circumscribed by cultural expectations and

[5]In XiTsonga/Shangaan 'Baba' means 'father' and 'Mhaki' means 'mother'. Their use is common outside the family context to demonstrate respect, similar to the use of 'Mister' or 'Madam' in English.

structural realities. Responding to a vignette about how they imagine the romantic life of a 45-year-old man ('Baba Simon'), Goodwill and Jeremiah, two men in their 40s, reflected on the meaning of fatherhood as men age.

> Goodwill: If a person who takes care of himself has [is] 45 and above, he has grown. He had a mind of behaving like a father.
>
> Jeremiah: If a person has [is] 50, the person start[s] to take care of himself. He didn't [doesn't] focus much on the road [doesn't look for girlfriends] …. He is busy about [with] his family. I should have a future. From 40 downwards we still have minds of looking for love…. Even if I have failed in the past, I want my family, my children to have something to eat [FGI, Men, 40s].

For many African men, long-term economic stability remains elusive in the South African political economy (Morrell 2002), leaving them, following Hunter (2006), 'fathers without *amandla*' ('power' in isiZulu) (as cited in Madhavan and Roy 2012, 803). Having multiple sexual partners thus provided an alternative route to manhood when historical pathways, such as paying bride wealth and providing for a family, were out of reach (Hunter 2006). Goodwill and Jeremiah suggest that as men transition into older ages, when mobility associated with labour-related migration may wane and respectability associated with older age is imminently near, they may be able to regain lost *amandla*. For older men, taking care is thus consistent with masculine ideals promoting fatherhood (Mathur et al. 2016), as expressed here through physical presence and material provision.

By one's 60s, age-related expectations attached to taking care of oneself for the sake of others are even more definitive because men and women become eligible for a state funded, non-contributory pension. A vital source of household income, pensions contribute to family members' health and wellbeing (Lloyd-Sherlock and Agrawal 2014) and confer a coveted status on older adults, who carry increased obligations to provide for others (Schatz and Ogunmefun 2007). Thembi, a woman in her 50s, articulated the connection between pension receipt and behavioural expectations at older ages.

> If a person has [is] 60 years [old] he/she is supposed to stop [having sex]…. If you are an [older] person you have to take care of yourself; now is not time you can have sex. They will not give you a pension if they don't see that you are old [FGI, Mixed Gender, 50s].

For older female pension recipients in particular, crucial financial providers to their households, avoiding sex reduces the likelihood of contracting HIV, dying prematurely, and ultimately becoming unable to provide for the family. Goodness and Ruth, women aged 60-plus, responded to a vignette about how a 65-year-old woman ('Mhaki Lizah') may have become infected with HIV.

> Goodness: Maybe she doesn't take care of herself. There are people who are old having 60 years still having sex. You can see that this old woman was not supposed to have sex. You ask yourself what she feels [whether she gets sexual pleasure].
>
> Ruth: If she is still looking for men she has to get it [HIV] [FGI, Mixed Gender, 60+].

As seen through these remarks, an (unmarried) woman in her 60s having sex was viewed as a moral affront to expectations of diminished sexuality at older ages[6]. Goodness and Ruth's comments also point to gendered differences in injunctive strategies for taking care.

Shifting expectations and responsibilities accompanying the life course are highlighted in a common lament in the FGIs that social boundaries between the young and old are increasingly disregarded. In discussions about how HIV has affected their communities, participants noted that 'young people and old people infect one another' and that 'even old people who are [in their] 60s behave like they are 15 [like teenagers].' They spoke critically of older men spending their pensions on mercenary younger women (Mojola et al. 2015) and of older women practising 'prostitution' (sexually immoral behaviour) by dating younger men (Schatz, Gilbert and McDonald 2013). As reflected in these narratives, older adults appeared fully aware of the epidemiological reality of higher rates of HIV among younger adults and in part deployed age-based injunctions to encourage the selection of safer sexual partners.

Gendered norms and strategies for avoiding HIV

Participants shared a general moral belief that taking care embodies and encourages monogamy. These expectations, however, were decidedly gendered. For older women, taking care included fidelity or abstinence[7]. On the other hand, safer sexual practices through condom use and prudent (extramarital) partner choice applied uniquely to older men, for whom the expectation of fidelity (particularly for those in their 40s and 50s) did not extend.

Taking care for men—Men are assumed to have enduring sexual desire and to continue sexual activity into older ages, though their virility may wane over time (Mojola et al. 2015; Freeman and Coast 2014). Men's taking-care strategies thus focused on minimising the risk associated with extramarital or multiple concurrent sexual relationships. Choosing sexual partners carefully was one strategy (Watkins 2004)—not having sex with women they encounter at 'jazz' (clubs/bars) or, as discussed earlier, respecting age-based norms by sticking to same-age partners. As Sipho, a man aged 60-plus, put it, 'If you take care of yourself not sleeping with young women, you won't get infected by HIV' [FGI, Men, 60+].

The repertoire of taking-care strategies for men pursuing extramarital or multiple partners also included condoms. Alfred, a man in his 40s, explained the responsibilities of a man traveling to the city, where sex (and implied below, HIV) is understood as readily available.

> The one who doesn't take care of himself is the one who doesn't have something to protect himself. If I know that I am going where they sell [sex], I go with a condom in my pocket. [In] a person's mind now death is too much [we are concerned about dying]. I don't want to get myself in trouble [and have to] buy a coffin [FGI, Men, 40s].

[6]See Sennott and Mojola (2016) for standards of respectability in the transition to adulthood for women in the same setting.
[7]For older women, taking care also included wearing hand gloves to avoid exposure to infected bodily fluids when caring for sick loved ones. We do not discuss this at length; care-taking risk (as observed in healthcare settings) is rare (https://www.cdc.gov/hai/organisms/hiv/hiv.html).

Despite Alfred's assertion that condoms can prevent death to AIDS, participants also discussed men's (and even women's) aversion to using them. The following banter ensued among Charles, Audrey, and Grace, a man and two women aged 60-plus, who discussed how adults their age can avoid HIV.

> Charles: [It] is two things—to use hand gloves [for women] and not have desire for sex. If you want sex you have to use condoms.
>
> Audrey & Grace: You will not use a condom. [All laugh]
>
> Grace: There is no power [erection]. You will not be able to use a condom.
>
> Charles: You have to take care of yourself [FGI, Mixed Gender, 60+].

Ambivalence toward using condoms as a taking-care strategy reveals the gap between the knowledge of a preventive behaviour and the undesirability of practising that behaviour. Since condoms are also generally used with partners deemed risky or ephemeral, they are seen as unsuited for married couples or those in sexual relationships that assume trust and intimacy, as has now been well-documented by others (e.g., Maharaj and Cleland 2004; Mojola 2014).

Taking care for women—For older women, taking-care strategies emphasised abstinence and fidelity. These injunctions differed, however, depending on a woman's marital status. Married women were expected to stay faithful to their spouses; unmarried women were expected to abstain from sex or, if still desiring it, to choose a partner one's own age and avoid 'prostitution', which for participants meant dating younger men or pursuing men for mercenary reasons. Taking care was also seen as easier for single women, who could more effortlessly refuse sex, as Delani, Linda, and Minah, three women in their 50s, explained.

> Delani: One guy will come and approach you, even if you told yourself that you don't want a partner, they will come and they will give you the [HIV] virus. If you still have feeling [desire sex], something in your blood [sexual desire] will click and you will find yourself doing it [having sex]. (They laughed).
>
> Linda: I won't agree…. I won't even allow you to touch me, because if you touch me, my blood will click. I will stay far from you. (They laughed).
>
> Minah: Another thing is that, I don't have a husband but I have a partner [boyfriend]…. And we had agreement [fell in love] long-time before there was this disease [HIV], and now because there are diseases you won't leave/chase him [away]. Even if you want to stay [without a partner] telling yourself that you want to live longer for your children, he will come and knock [at your door] and because you have agreement with him, you will open the door for him. Even if you can try to close [your] legs he will find a way to enter [penetrate] because he knows you and by that way you will find HIV or you already have it. I only have him as my partner and I'm taking care of myself even if we are not staying together but you will find that he have lots of partners and by that way it's easy to get HIV [FGI, Women, 50s].

As Minah suggests, relationship duration makes it hard to refuse sex with an intimate partner. Indeed, for older adults, many intimate relationships began before the advent of the HIV epidemic in South Africa. HIV thus presented those in long-term relationships with a new set of concerns, which are particularly troubling for married or partnered women, who lament that men pursue extramarital or multiple concurrent partners but (unprotected) sex is expected within a union.

The absence of formal labour-market opportunities (Blalock 2014) exacerbate concerns about infidelity in a context like Agincourt by contributing to labour-related migration[8], which forces couples to endure long periods of separation (Lurie et al. 2003)[9]. While participants blamed both men and women for engaging in sexual affairs in one another's absence, older women in particular expressed what it meant for their own efforts to take care. Doreen, a woman in her 40s, lamented that

> ….. sometimes we don't stay with our husbands at home, they are far away. I'm at home taking care of myself then he come home and infect me. I didn't misbehave at all, then we all get infected in that way [FGI, Women, 40s].

Esther, a woman in her 50s, echoed Doreen's concerns, pointing to another dimension of the sexual economy that is consequential for HIV risk.

> You find that you as a mother you are at home taking care of yourself, then your husband will find a schoolgirl and give her R50 [approx. 5 USD] and she will take that money in exchange of sex. In that way, you will get infected [FGI, Women, 50s].

As Esther alluded, 'transactional' relationships—or exchanges of sex for material support (Stoebenau et al. 2016)—were believed to be alive and well in their community. These relationships were reinvigorated when men became eligible for an old-age pension and thus had disposable income (Mojola et al. 2015). Indeed, participants lamented that 'Hillbrows'[10] are now in rural areas too, alluding to the centrality of money in sexual relationships. As Swidler and Watkins (2007) observe, the exchange of sex for material support is better understood as one of many 'ties of dependence' in African societies; they join together—in 'an ethic of redistribution and reciprocity' (157)—those who have resources to share and those who benefit from them.

In the absence of a spouse taking care, older women discussed self-care strategies such as avoiding sex by invoking their tired/ageing bodies, sleeping in a separate room, or sharing the bed with their (grand)children. Such strategies were not always viable in the long term, however. Many older women thus expressed the futility of taking care on their own—aware of the risk their spouse could bring them but unable to sustain strategies that would mediate that risk. Indeed, taking care would work only as a linked couple strategy.

[8]Labour-related migration and mobility in Agincourt is considerable: approximately 60% of men and 20% of women between the ages of 20-60 are regular circular migrants (Clark et al. 2007).
[9]Lurie et al. (2003) find that it is not only migrant men who infect rural partners with HIV but also women who infect their migrant partners.
[10]Hillbrow is a neighbourhood in Johannesburg reputed for vices like prostitution.

Taking care of the community

In the social imagination of many older adults, the HIV epidemic emerged in tandem with profound changes occurring in South Africa in the decades following democratisation. Despite the horrors of life under apartheid, participants romanticised the past—a time remembered as one when they could eat off the land, when sicknesses were curable and taboos were feared, and when a shared sense of humanity (*vumunhu*) and respect (*nhlonipho*) pervaded their communities. This is epitomised in the words of Jabulani, a man in his 40s, who lamented of the present, 'We no longer have humanity as people' [FGI, Mixed Gender, 40s]. Esther (quoted earlier) explained how life was different 25 years ago for people her age.

> In the past, we were living good life. Most of the things that we are seeing it was not around. We didn't know that there is HIV. In the past, we knew the illness called drop [an STI] and it was curable…. But nowadays illnesses are uncured. Nowadays illnesses don't come to an end. There is a problem. You find that I am HIV positive and there is a man proposing [sex with] me, I will not tell him that I'm sick. We will have sex and when he receives that HIV he spread it because he is not dating you alone. When he finishes having sex with you he will go to another woman he is dating and she will be infected. And you find that woman is dating another men [man] and the HIV become spread in that way. That is why I don't think this illness will come to an end, because it's spreading a lot [FGI, Women, 50s].

In her comparison of the past with the present, Esther invoked the sexual practices identified in the previous section and alluded to a third dimension of taking care—that HIV not only affects individuals and those with whom they are linked but also connects individuals through sexual networks in the community. In Esther's (epidemiologically accurate) analysis, widespread HIV transmission begins as nondisclosure within couples, which is then exacerbated by (presumably unprotected) multiple concurrent sexual partnering. Soloman, a man in his 50s, corroborated Esther's concerns.

> If a person has this disease, he/she hides. Some of them we know them, you will find that person is going to Bhubezi [local health centre known in the community as an HIV clinic] for treatment two times or three times and [then] stops collecting the treatment. You will find a person going to him/her [having sexual relationships], it will be difficult for this disease to end…. When you have it [HIV] you don't talk about it.… Even us, the men, you will find that we have it, the women will not believe you. I will keep quiet with it [HIV]. It is okay for me to give it [HIV] to [them], and I will die with many people. This thing is cruel that people have it [HIV] put the country and our children in trouble.… This disease will not stop; we have to take care of ourselves [FGI, Men, 50s].

In addition to echoing Esther, Soloman adds erratic adherence to treatment as another factor fuelling the spread of HIV, one that begins by not wanting to advertise one's HIV status to others in the community by making frequent trips to the clinic (also see Angotti et al. 2009) to refill medication. He further implies that a community lives and dies together. Soloman thus aligns taking care of oneself with taking care of a community comprised of others.

In light of these shared concerns, participants in several instances discussed potential community measures to check the spread and impact of the epidemic. Bongani, for example, a man in his 40s, was defiant in support of strict institutional measures.

> I think if the government or municipality can intervene in the community…. In every household, there should be a book where the HIV status of every member is recorded. Two young energetic people should visit the households every three months to check their HIV status. So, whoever have an unprotected sex, it will be easily seen within three months that this one has been infected with HIV…. As a community, you should request from the government to start this…. After 3 years, they could stop it and everyone would know why he was on treatment and we would live better [FGI, Mixed Gender, 40s].

In Bongani's assessment, regular (and non-confidential) HIV testing would allay community concerns about the invisibility of HIV: for those who are HIV negative, it would make it easier to avoid unknowingly having (unprotected) sex with someone who is HIV positive (Angotti 2012); for those who are HIV positive, it would enable them to access life-saving medication[11]. Following Bongani's logic, it would thus make it easier for everyone in the community to take care.

In another example, participants discussed how best to provide support to HIV-positive friends and neighbours. Responding to a vignette examining the life circumstances of an older HIV-positive man ('Baba Mishek'), Stella, a woman in her 50s, noted that

> when he is sick we must support [look after] him because we can see that this person is sick. Like me I'm selling alcohol in my house[12], when they are there I must remind them to go home for treatment or I give them food so that they can take their treatment [FGI, Women, 50s].

By reminding one another how to take care—illustrated here by offering food and encouragement to follow therapeutic regimes—individuals are acting in the interest of the greater good. These gestures reproduce the collectivism and shared sense of *vumunhu* that characterised the past (Chasi and Omarjee 2014). Indeed, from a public health standpoint, these actions would also result in a reduced community viral load and a lower likelihood of an HIV-positive person (like Baba Mishek) being infectious to a sexual partner.

Discussion

In this paper, we explored older rural South Africans' normative understandings of what it means to take care of yourself in an age of AIDS. We found that for older adults, taking care to avert HIV risk or live into one's older age with HIV has life-course, gendered, and community dimensions. Our findings also reflect the individual, interdependent, and communal ways in which older rural South African men and women make sense of HIV prevention and the norms and strategies they reason will help themselves and their community survive the epidemic.

[11]ART is also understood as veiling one's HIV status by restoring a healthy bodily appearance, thus contributing to community perceptions that it creates an unsafe sexual environment (Kaler, Angotti, and Ramaiya 2016).
[12]'Shebeens'—private homes that sell alcohol—are a form of entrepreneurship in South Africa.

Our analysis of this inductively emerging discursive theme makes three important contributions to studies of HIV in highly endemic African contexts. First, we investigate a setting at the front lines of the epidemic to come, one characterised by large numbers of adults ageing with HIV and at risk of becoming infected with HIV at older ages. Indeed, typical relationship transitions characteristic of middle age and older adulthood—widowhood, divorce, separation, cohabitation, and remarriage—are now occurring in a context of high HIV prevalence (Zaba et al. 2008). As two recent studies from the same area have found, older adults are at continued risk of acquiring and transmitting HIV, risks associated with extramarital sex, cross-generational sex, low condom use, and unknown HIV status (Houle et al. 2017; Rosenberg et al. 2017). This paper thus provides timely information to inform future prevention campaigns.

Second, our analysis of emic strategies for HIV prevention through *ku ti hlayisa* contributes to a body of literature that has examined locally formulated ideas for reducing HIV risk in rural African contexts (e.g., Watkins 2004; Schatz 2005). We advance the literature by situating these strategies at multiple levels—individual, couple/familial, and community; as well as theoretically by using life course ('linked lives') and *ubuntu* as frameworks. We find that reaching old age was evidence of an individual taking care, but this was expected to be sustained by adhering both to age-appropriate norms of caring for others and to age-appropriate sexual partnerships. Taking care was also gendered: strategies for older men included careful partner choice and condom use, whereas the predominant strategy for older women was to (creatively) avoid sex. Both men and women were aware that their HIV risk was linked to their partners and that taking care could not work as a merely individual endeavour. Individual and coupled strategies alone, however, do not suffice for taking care. Care for one another and a sense of community monitoring and responsibility reframe the individualistic imperative and reflect a collective obligation attendant to the shared humanity within a community. Importantly, these local strategies map onto epidemiologically sound methods for reducing HIV, including ART adherence to reduce community viral load and choosing lower-risk sexual partners.

Third, by focusing on older South Africans' normative environment, we can begin to think about prevention efforts that would most strongly resonate with them. Our findings suggest that HIV prevention initiatives for older South Africans would gain from first investigating existing local norms and strategies for HIV prevention and incorporating the concurrent individual, interdependent, and communal dimensions of taking care unique to a particular study setting. In this site, social marketing and prevention initiatives that target older people might explicitly invoke *ku ti hlayisa*. Our data show that such efforts should be attentive to the gendered and generational social roles that older people embrace and value—for example, by appealing to the respectability of mothers and fathers to look after their families or of pensioners providing for grandchildren, or by cultivating the need for community members to be mindful of and look out for one another in the HIV and AIDS-mitigation effort. Just as HIV-prevention efforts encourage pregnant women to be routinely tested (and treated) for HIV for the sake of their (unborn) children's health, so too messages for older adults might draw on the latter's concern for and involvement with the kin and community with whom their lives, livelihoods, and future prospects are intertwined.

Community members take part not only in sense making around issues that disrupt the fabric of their communities but also in formulating emic responses that can be invested in and developed for the greater good. We should thus utilise older adults' own mandate and ask them to take care to ensure that they themselves and their communities survive the HIV epidemic.

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