PRINT: ISSN 0970-9274 ONLINE: ISSN 2456-6608
J Hum Ecol, 53(3): 213-221 (2016)
DOI: 10.31901/24566608.2016/53.03.03

The Effects of the Loss of an Adult Child to Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) on the Interaction and Participation of the Elderly in Social Activities in the North West Region of Cameroon

Perpetua Lum Tanyi[1] and Anneline Keet[2]

Department of Social Work, University of the Free State, PO Box / Posbus 339, Bloemfontein, 9300, South Africa
E-mail: [1]<PerpetuaT@ufs.ac.za>, [2]<keetacs@ufs.ac.za>

KEYWORDS HIV/AIDS. African. Traditional Support System. Social Activity. Older Adults. Adult Child. Africa. Children. Believes. HIV/AIDS. Security. System

ABSTRACT The incidence of HIV/AIDS in the North West Region of Cameroon surpasses all other regions. The aim of this paper was to ascertain the effect of the loss of an adult child to HIV/AIDS on the elderly parent's participation in social activities in the North West Region of Cameroon. Using a multistage sampling technique, a sample size of one thousand and sixty (1060) respondents were drawn from three divisions of the Northwest Region of Cameroon. Data was collected from participants using quantitative and qualitative methods, which included questionnaires, in-depth interviews and focus group discussions. The findings of the study showed that there is a reduced level of social participation and interaction because of either caring for grandchildren orphaned by HIV/AIDS or sick children. Participants avoided social activities because they did not have money to pay their contributions. Participants also reported that they stayed away from social gatherings for fear of stigmatization from members of the community. However, evidence from the study output showed that some respondents attended social activities. Some pertinent conclusions were drawn from the findings. The implications of these findings to social policy are discussed.

INTRODUCTION

Literature review on the elderly and HIV/AIDS patients in Africa (Lekalakala-Mokgele 2011) reveals that over the last decade the epidemic has had a devastating impact on older adults, especially in sub-Saharan Africa, with about two million deaths recorded annually and at least 13 million children have lost one or both parents (UNAIDS/WHO 2010; United States Congress 2010; African Union 2012). Studies have shown that HIV and AIDS attack mostly the reproductive and economically active section of the population, changing family composition by creating elderly female-headed and child-headed families (Bohman et al. 2007; AVERT 2009; Schatz and Ogunmefun 2007; Tanga and Tangwe 2014). HIV/AIDS has destabilized the African traditional support system (Schatz 2007; Tanga 2013). The roles of the elderly are seen to be changing to becoming caregivers of their adult children stricken with HIV and AIDS, guardians of their orphaned grandchildren (HelpAge International 2007; Bock and Johnson 2008), which results in an increased burden of caring resting on the elderly.

Literature review on HIV/AIDS and the elderly in the sub-Saharan Africa showed that fifty-nine percent of the elderly people live with children and forty-six percent with a grandchild, and that older adults are more likely to be living with double orphans (Zimba and Tanga 2014). Results from research show that elderly-headed families cannot cope with the increasing number of orphans created by the disease (AVERT 2009). Social networks in regions with high prevalence of HIV/AIDS are reported to have collapsed due to the pressure of having to support orphaned children and children suffering from HIV/AIDS (Tanga 2008).

Literature review reveals that the elderly do not participate in social activities because of frequent and prolonged traveling to cater for sick and orphaned grandchildren by HIV/AIDS (Ssenengozi 2009; Schatz 2007). There is increased social isolation, because the elderly can-

not afford the time or money to take part in social activities (HelpAge International 2008; Help Age International 2012). Another reason for reduced participation in social activities by elderly parents affected by HIV/AIDS is fear of stigmatization as reported by Knodel et al. (2010), and Tanyi and Okoye (2014).

The incidence of HIV/AIDS in Cameroon is high. Since the first case of HIV/AIDS was diagnosed in Cameroon in 1985, the disease has systematically spread across the entire Cameroonian society, affecting mostly the young men and women between the ages of 15 and 45 years in urban and rural areas. In Cameroon, it was estimated that by 2013 over one million five hundred children would have lost one or both parents to HIV/AIDS (UNAIDS/WHO 2010; United States Congress 2010; African Union 2012). More children live in households with sick and dying family members. Although not yet orphaned, these children also suffer from the effects of HIV/AIDS. In Cameroon, HIV/AIDS is generating orphans so quickly that the family efforts may no longer cope with the needs of these children (UNAIDS 2010).

Extensive amount of research has been carried out in Cameroon on various issues relating to HIV/AIDS (Mbanya et al. 2008; Boyer et al. 2009; Musoko et al. 2007). However, very little has been done on the impact of HIV/AIDS on the social life of elderly parents and their children who are infected by HIV/AIDS. The limited focus of research to date in Cameroon detracts from a fuller understanding of the social context of the epidemic in the country. The major objective of the study was to examine the effect of the loss of an adult child to HIV/AIDS on the participation in social activities of elderly people in the North West Region of Cameroon. This study, however, has yielded important findings showing that there is need for the government to take more interest in aging issues especially when it comes to those concerning HIV/AIDS and its impact on the elderly people. These findings have clear implications for social policy.

Objectives of Study

The aim of this paper was to ascertain the effect of the loss of an adult child to HIV/AIDS on the elderly parent's participation in social activities in the North West Region of Cameroon.

METHODOLOGY

Study Setting

The study was conducted in the North West Region of Cameroon. Three divisions, namely Mezam, Menchum, and Donga/Mantung Divisions were purposively selected for the study. The North West Region comprises seven Divisions, of which Mezam, Donga/Mantung and Menchum are inclusive. West and South West Regions bound the Region. The choice of the North West Region is significant and based on prior empirical findings. WHO/UNAIDS (2010) identified the North West Region as an HIV/AIDS prevalence Region in Cameroon.

Sample and Procedure

The study adopted a cross-sectional survey design using multistage sampling methods to achieve the required sample size of one thousand and sixty (1060) respondents. The data for this paper was extracted from a larger study that examined the burden of HIV/AIDS in 2011 on the elderly parents 60 years and above who have lost an adult child to HIV/AIDS or were currently HIV positive and receiving Antiretroviral Therapy (ART) in the three Divisions (Mezam, Donga/Mantung and Menchum) in the North West Region of Cameroon. All the interviews were administered on a face-to-face basis, ensuring a one hundred percent completion of the copies of the questionnaires. A multistage sampling procedure was adopted in selecting streets, households and individuals for the study. First, three Divisions, namely Mezam, Donga-Mantung and Menchum were purposively selected out of the seven Divisions that constitute the Northwest Region of Cameroon. Their selection was based on the reported rate of HIV prevalence, which showed a high prevalence in these Divisions. One community was randomly selected from each of these Divisions.

Qualitative information for the present study came from focus group discussions and in-depth interviews conducted in 2011 with parents of adults who died of either AIDS (20 cases) or were currently HIV positive and receiving ART (20 cases). Four FGDs and four IDIs sessions were conducted with parents who are 60 years and above, and who have lost an adult child to HIV/AIDS or were currently HIV positive and receiving ART. The FGDs and IDI were conduct-

ed in the three Divisions (Mezam, Donga/Mantung and Menchum) in the North West Region of Cameroon, with the help of local contact persons who were health workers. Eligible parents were selected from different communities for the focus group discussion (FGD). The criteria used in selecting the respondents in the different communities, included availability on the date set aside for the discussion, willingness to participate, being a parent who is 60 years and above and who have lost an adult child to HIV/AIDS or whose child was currently HIV positive and receiving ART and ability to express oneself. The researcher with the help of five research assistants conducted the FGDs and IDIs, which averaged one hour and were typically conducted in the homes of one of the participants that was most convenient for all of them. Informed oral consent was obtained from all study respondents. Respondents were assured of confidentiality, anonymity and right of refusal. Also, oral permission was sought from the respondents to audiotape the sessions. Five thousand and four hundred CFA Franc (Eight dollars) honorarium was given to each respondent.

All the FGDs were transcribed, and translated verbatim from Pidgin into English with the help of the research assistant who served as note-takers. In order to achieve 'immersion in the data', the transcribed texts were read by a colleague who understood the variant of Pidgin English spoken in the communities where the discussions took place. This enabled the researchers to make sure that no information was lost during the translation. A final version of the transcript was obtained based on the inputs of the research assistants and the colleague who read the transcribed notes. From the transcribed notes, themes for analysis were developed by the researcher as suggested by Coffey and Atkinson (1996). Grounded theory approach formed the basis of data analysis as the researchers tried to locate the themes in the interview data rather than preexisting hypotheses. The theme was participation in social activities by parents who had lost a child to HIV/AIDS and/or taking care of PLHA. In order to portray the thoughts of the respondents, verbatim quotes were used in some instances.

The analysis of quantitative data involved the use of descriptive statistics such as frequencies, percentages, as well as graphic illustrations to present the characteristics of the study subjects. Correlation analyses such as chi-square (χ^2) were used to establish relationships between certain socio-demographic characteristics of the respondents and their experiences in coping with their roles in view of their HIV/AIDS realities.

FINDINGS

The results of the quantitative and qualitative analyses of the study are presented together. The qualitative data are used to support and elucidate the quantitative data. The findings are presented under different subheadings that included key socio-demographic characteristics of the respondents and participation in social activities by respondents. These subheadings are presented using tables and figures. The last section discusses the findings, implications for social policy and conclusion.

Key Socio-demographic Characteristics of the Respondents

A glance at the socio-demographic characteristics of the respondents in the quantitative data shows that in terms of sex distribution, 55.4 percent were females while 44.6 percent were males. In terms of their ages, the respondents between 60-64 years were highest 42.3 percent, while the lowest ranged 4.2 percent are those from between 70 years and above (Table 1). In terms of marital status more than half the respondents 65.9 percent were married. The widows, separated, single and/or divorced were few, that is, 20.7 percent, 5.1 percent, 3.2 percent and 5.1 percent, respectively. The respondents' level of education indicates that more than half of them, that is, 41.3 percent have primary education and a little above half, that is, 37.3 percent have ordinary level or higher degrees. In terms of occupation, 36.5 percent of the respondents are civil servants. However, the activities with the next highest number of respondents are the business/traders at 28.5 percent. The next categories of respondents were farmers (25.2%). The unemployed and the retired respondents were amongst the least of respondents (9.1% and 1.2%, respectively.) Christianity (91.8%) is the most common religion practiced by the respondents. However, there were Pegans, African Traditional Religion, Atheist and Islam religion respondents as well (1.7%, 2.5% and 3.3% and 0.8%, respectively).

Table 1: Socio-demographic (Background) characteristics of respondents

Socio-demographic characteristics	*Any child died of HIV/AIDS*		*Total*
	Yes	*No*	
Divisions			
Mezam	199 (43.0)	295 (49.4)	494 (46.6)
Donga/Mantung	109 (23.5)	174 (29.1)	283 (26.7)
Menchum	155 (33.5)	128 (21.4)	283 (26.7)
Age			
60-64 years	200 (43.2)	248 (41.5)	448 (42.3)
65-69	157 (33.9)	222 (37.2)	379 (35.8)
70-74	48 (10.4)	55 (9.2)	103 (9.7)
75-79	11 (2.4)	17 (2.8)	28 (2.6)
80-84	25 (5.4)	32 (5.4)	57 (5.4)
85+	22 (4.8)	23 (3.9)	45 (4.2)
Sex			
Male	224 (47.4)	249 (41.7)	473 (44.6)
Female	239 (51.6)	348 (58.3)	587 (55.4)
Marital Status			
Married	309 (66.7)	390 (66.7)	699 (65.9)
Single	16 (3.5)	38 (6.4)	54 (5.1)
Divorced	15 (3.2)	19 (3.2)	34 (3.2)
Widowed	106 (22.9)	113 (18.9)	219 (20.7)
Separated	17 (3.7)	37 (6.2)	54 (5.1)
Religious Affiliation			
Christianity	423 (43.5)	550 (56.5)	973 (91.8)
Islam	7 (38.9)	11 (61.1)	18 (1.7)
African Trad. Rel.	9 (33.3)	18 (66.7)	27 (2.5)
Atheist	6 (66.7)	3 (33.3)	9 (.8)
Pagan	18 (54.5)	15 (45.5)	33 (3.1)
Occupation			
Civil servants	169 (36.5)	215 (36.0)	384 (36.2)
Business/Traders	132 (28.5)	170 (28.5)	302 (28.5)
Farmers	95 (20.5)	172 (28.8)	267 (25.2)
Unemployed	57 (12.3)	39 (6.4)	96 (9.1)
Others/Retired	10 (2.2)	1 (.2)	11 (1.0)
Educational Status			
No formal Education	25 (5.4)	23 (3.9)	48 (4.5)
Primary Education	201 (43.4)	237 (39.7)	438 (41.3)
GCE 'O' level	70 (15.1)	102 (17.1)	172 (16)
GCE 'A' level	89 (19.2)	95 (15.9)	184 (17.4)
OND/NCE	4 (.9)	9 (1.5)	13 (1.2)
B.Sc/HND	60 (13.0)	95 (15.9)	155 (14.6)
M.Sc and above	14 (3.0)	36 (6.0)	50 (4.7)

The socio-demographic characteristics of the respondents in the FGDs and IDIs show that seventy-three percent of them are females, sixty percent are between 60-69 years, sixty-three percent of them earn less than USD 100 dollars in a month, about three percent of them do not have any living child again, about forty percent have lost a child to HIV/AIDS, while eighty percent have at least one child who is currently suffering from HIV/AIDS.

The death of an adult child to HIV/AIDS can negatively affect the social interaction and activities of elderly parents with members of the community where they reside. Most parents spend considerable time either taking care of their sick child or taking care of the children orphaned by HIV/AIDS. This affects their social interaction, for example, not attending weddings, going to church, participating in group meetings and visiting friends.

Taking care of the victims of HIV/AIDS require parents to divert their attention away from social activities. The results reveal respondents' perception between the loss of a child to HIV/AIDS and participation in social activities. Out of the respondents who had lost a child to HIV/AIDS, 20.3 percent participated in social activities while 79.7 percent did not participate in social activities. Of all the respondents who had not lost a child to HIV/AIDS, 79.7 percent participated in social

activities while 20.3 percent did not participate in social activities. The implication is that the loss of a child to HIV/AIDS seems to cause the withdrawal of elderly parents from social activities, and this brings about social isolation, depression and some form of burden on the elderly people.

Social Interaction and Participation in Social Activities

Majority of the study participants reported that they have reduced their level of social interaction because of either caring for grandchildren left behind by their dead children or caring for a sick child. While some reported that they reduced their social interaction because they do not want people to gossip about them, if they participated, others said they did not participate mainly because they spent time to search for food or money. Their ability to visit friends, important places such as the church or market, and attend other important social activities such as weddings, baby naming ceremonies and other ceremonies is restricted because they cannot afford to be away from home for a long period of time. Staying in the house all the time and not going out as they wished brought feelings of depression and isolation.

Respondents reported that in some cases avoidance of social contact with people with HIV/AIDS and their families, largely because of fears of infection, were visible, although only in few cases did participants explicitly stated that community members clearly stopped visiting them. In many cases, neighbors avoided direct social contact only with the PLWHA. However, some participants mentioned that neighbors were also afraid of being infected by other members who had close contact with the PLWHA, this being the case, they avoided contact with the parents, siblings or children of the PLWHA. Participants also reported that in some cases they deliberately kept away for fear of rejection even when they have not been shown any obvious sign of rejection by community members. One participant summarized it this way:

My son was very sick when he returned from the city. I took him to the hospital and the doctor told me that he has HIV/AIDS. I did not believe that doctor so we went to the general hospital and it was confirmed. When we came back to the village I told my sisters, from that day they stopped coming to my house. Most of my relatives stopped talking to my son, we stopped going out because each time we went out people will be pointing fingers at us. I was so ashamed of what they were doing to us. (60-year-old mother, a rural dweller of the Donga/ Mantung Division)

Another participant who lost a son to HIV/AIDS also had this to say:

Nobody entered my house when they discovered that my son had HIV/AIDS, because they were afraid of the transmission of AIDS. I was not allowed to choose thing whenever I went to the market to buy things. "Do not choose because we are afraid of AIDS." Some villagers said, "Mothers who look after sons with AIDS will get infected with AIDS too." Only I looked after my son and no one helped me to care because they were so afraid of my son. If someone came to visit, they only stood outside the door to talk with him or me and then they returned to their homes. When they managed to bring food and I was not around, they would drop the food at the door. This went on until he died. (60-year-old mother of deceased son, Mezam Division)

Yet another narrated her own story this way:

I have lost two children to HIV/AIDS. Now I am caring for their kids. These kids are being abused each time they go to school or when I send them to the market to buy something for me. Their friends will tell them, "Look at you, your father died of HIV/AIDS. We cannot walk around or talk to you people. (65-year-old rural dweller from the Donga/ Mantung Division)

Several respondents from the FGDs mentioned that avoidance was greater when their son/daughter had visible symptoms or sores.

One of the participants remarked:

*When my daughter was sick, some of my friends were visiting me and my church members were also coming to pray for her but when the sickness became so serious most of them did not come again because my daughter had rashes all over her body and she was coughing endlessly. All my friends stopped coming and even my church members stopped coming. We also stopped going anywhere. It is very difficult for me now, because at times we don't even have food to eat***.**

(67-year-old mother, an urban dweller from the Menchum Division)

Few respondents explained that they enjoyed social contact with other people because there

were no visible symptoms from their care-receivers (for example, after the PWHA had started ART) whom they referred to as being "clean". It was only two respondents that reported that neighbors and relatives came to visit even when the PWHA were visibly ill.

From the discussions it also appears that improved knowledge of the HIV/AIDS and modes of transmission largely instilled fears of infection and improved social interaction among community members. Some of the participants reported that once people understood more about the disease they started interacting with them (the caregivers).

*At the beginning of my girl's AIDS infection, my neighbors discriminated against my family. My friends were even afraid to come to my house. Talking to me was a problem for some of them. However, when some NGO people came and repeatedly talked to us in the community about this disease and how it can be transmitted, many people started relating with me again. Though they still don't come to my house. (*A 67-year-old mother, an urban dweller from the Mezam Division)

Another also remarked as follows:

When my child took ill, people did not eat with us, even when we went somewhere they did not allow us to walk with them. There is no problem now. Everyone has changed their attitude, and they allow us to walk with them and eat with them because they understand that AIDS is not transmitted by walking or eating together with someone taking care of a person with HIV/AIDS. (60-years-old mother, an urban dweller from Mezam Division)

There were also indications from the participants that instances of discrimination had decreased due to improved knowledge, and because high prevalence in some communities meant that people were more familiar with HIV now than before. Some participants however suffered untold hardship and isolation as a result of death of their children to HIV/AIDS.

When my two children died I was accused of killing them. My husband did not support me. They said I was a witch. They used masquerades to drive me out of the village so I am now staying in my father's house. My other two children visit me once in a while. But I cannot associate with people because they now refer to me as a witch. (72-year-old mother, an urban dweller from the Menchum Division)

The findings show that out of all the respondents who had lost a child to HIV/AIDS, 38.2 percent participated in religious activities while 61.8 percent did not participate in religious activities. Out of all the respondents who had not lost a child to HIV/AIDS, 68.1 percent participate in religious activities while 31.9 percent did not participate in religious activities. This shows that the loss of a child to HIV/AIDS hinders elderly people from participating in religious activities thus dampening their religious life. One would have expected to find more elderly people who had children dead or suffering from HIV/AIDS to participate in religious activities, at least to get some solace by going into the presence of God, but it is not the case. May be they spent much time in taking care of their children so that they did not have time to participate in any religious activities or maybe it was because of their own health situation that they could not participate in religious activities.

In the FGD sessions in all the three Divisions, respondents were asked whether they participated in social activities, for example going to church, attending church meetings, attending weddings, going to the market, visiting friends, or going for child naming ceremonies, and if they did, what was the frequency of their attendance.

…I used to go to church for prayers and do some work in the church but since my child took ill I do not go again. At times, my group members come to pray for us in the house (70-year-old mother, an urban dweller in Menchum Division).

I have so many grandchildren in the house, they will not allow me do anything or go elsewhere. Even though there is someone to help but I still do not have the time to leave them and go elsewhere. I am the only person they have now. I only send my contribution through the house girl. I stay at home to take care of my sick child and my grandchildren (66-year-old mother, an urban dweller in Mezam Division).

I stopped attending functions about three years ago when my two children died, they left six children and I must look after them and see that they eat well and go to school. I didn't go anywhere again (69-year-old mother, an urban dweller in Donga /Mantung Division).

The illness and death of an adult child of HIV/AIDS causes parents to stop participating in social activities. In the three Divisions, re-

spondents said they had no time to attend meetings any longer because they were either taking care of their sick children or children orphaned by their deceased children. In very few cases did respondents say they attended meetings to keep themselves happy and to distract themselves from the existing problems.

DISCUSSION

This study used data from four sets of focus groups and four in-depth interviews to assess participation in social activities of elderly parents affected by HIV/AIDS in the North West Region of Cameroon. Data was collected in 2011 and includes information on participation and interaction in social activities from the perspective of parents who had lost a child to HIV/AIDS and caring for children orphaned by HIV/AIDS and parents who had children on ART. This study's sites include three Divisions (Mezam, Donga/Mantung and Menchum) in the North West Region of Cameroon.

The research on the social participation and interaction of parents affected by HIV/AIDS in Cameroon presented in this study seem to suggest that it is the negative reaction of community members that may have caused some of the participants to withdraw from social activities. The findings indicate a fair degree of variation in community reactions reported by participants. The participants indicated neutral or positive responses towards them by community members. Contrary to the common portrayals that emphasize negative aspects (Moler and Erstad 2007; Li et al. 2008; Tanga 2015), the results reveal that there is a mixture of positive and negative reactions though the positive support from others in the community is more dominant than the negative. However, negative reactions though they still exist appear to be minimal. This finding is supported by that of Tanyi and Okoye (2014) and Knodel et al. (2010) who reported that community reaction towards individuals and families suffering the consequences of AIDS in Thailand, Cambodia and Cameroon appear to be quite positive or neutral for most but not all.

In these findings, respondents reported that there were increased social responsibilities on them, because they spent more time to take care of their ill child or grandchildren. These findings concur with studies carried out by Ssenengozi (2009), Tanga (2008) and Schatz (2007). The participants in this study also reported that they avoided social activities because they did not have money to pay their contributions. These findings also concur with studies carried out by HelpAge International (2008; HelpAge International 2014) on participation in social activities of older adult affected by HIV/AIDS in sub-Saharan Africa. Participants also reported that they stayed away from social gatherings for fear of stigmatization from members of the community and this concurs with studies carried out by Alpaslan and Mabutho (2011).

CONCLUSION

HIV and AIDS affect older persons as parents and/or relatives of persons infected by HIV and as caregivers. These indirect effects can manifest in a set of interrelated social, economic and psychological dimensions that could ultimately impact the well-being of the elderly. The social impact of HIV and AIDS has in some cases led to loneliness, isolation and stigma in the lives of the elderly. In many instances the elderly, who are close relatives of HIV-infected persons, are depressed because of the looming death of a loved one in their midst. In the case of the elderly relatives, especially when they are the parents, this emotional toll could influence their ageing process, coming as it does at a stage in their lives when they are progressing to frailty.

Many elderly persons are shouldering vital caring responsibilities for loved ones living with HIV and grandchildren orphaned by AIDS, which is a common practice in most African communities. Child fosterage is not a new phenomenon in Africa, as grandparents and other elderly relatives have traditionally played a key role here, albeit in different forms across the continent. However, child fostering as a result of HIV and AIDS is crisis-led, since the older person has to meet the daily costs of living as well as funding their grandchildren's education without support from the government or their own children since most have been decimated by AIDS.

RECOMMENDATIONS FOR SOCIAL POLICY

Findings from the present study have shown that campaigns about modes of transmission of HIV/AIDS are paying off, and efforts should be intensified to empowerment the elderly so that

they can address their own needs without fear of stigmatization. Empowerment should start with educating the elderly about HIV, its mode of transmission, strategies to prevent infection, and to make them aware of their rights as citizens. HIV and AIDS prevention programs should be user friendly, appealing to the level of maturity of the elderly. The program should adopt cultural aspects that promote social and health issues, which the elderly have used throughout their lives. The elderly in most parts of Cameroon are seen as the pillar of morality, and this should be used as a foundation of developing programs for them. Age appropriate advertising should be considered to increase acceptability of HIV and AIDS prevention programs by the elderly.

Income-generating projects for the elderly should be organized to make up for the deficit caused by caring, such as needlework, baking, beading and selling of products. Finally, governments should formalize the system of foster care placements of orphans and support the elderly financially in their caring for these orphans.

Evidence from this study remains limited to Mezam, Menchum, and Donga/Mantung Divisions in the North West Region of Cameroon. Participation and interaction in social activities by HIV/AIDS affected parents may probably be greater elsewhere, although this requires confirmation through studies in other areas. Caution should therefore be exercised, however, when drawing conclusions from these findings since other regions were left out in this study.

REFERENCES

AVERT 2009. AIDS Orphans. From <http://www.Avert.Org/Aidsorphans.Html.> (Retrieved on 20 February 2012).

Bock J, Johnson S 2008. Grandmothers' productivity and the HIV/AIDS pandemic in sub-Sahara Africa. *Journal of Cross-Cultural Gerontology*, 23(1): 1-25.

Boyer S, Eboko F, Camara M, Abe C, Nguini ME, Koulla-Shiro S, Moattia J 2010. Scaling up access to antiretroviral treatment for HIV infection: The impact of decentralization of healthcare delivery in Cameroon. *AIDS*, 24(suppl 1): S5–S15.

Bohman DM, Vauthevan S, Van Wyk NC, Ekman S 2007. We clean our houses, prepare for weddings and go to funerals: Daily lives of elderly Africans in Majaneng, South Africa. *Journal of Cross Cultural Gerontology*, 22: 323-337.

HelpAge International 2012. *Stronger Together*. London: HelpAge International.

HelpAge International 2008. Older People Invisible in International AIDS Response. From <http://www.helpage.org> (Retrieved on 25 July 2012).

Knodel J, Kespichayawattana J, Saengtienchia C, Wiwatwanich S 2010. *Older-age Parents and the AIDS Epidemic in Thailand: Changing Impacts in the Era of Anti-Retroviral Therapy*. Bangkok: UN ESCAP.

Knodel J, Kespichayawattana J, Saengtienchai C, Wiwatwanich S 2010. The role of parents and family members in art treatment adherence: Evidence from Thailand. *Research on Aging*, 32(1): 19-39.

Knodel J, Williams N, Kim SK, Puch S, Saengtienchai C 2010. Community reaction to older-aged parental AIDS caregivers and their families: Evidence from Cambodia. *Research on Aging*, 32(1): 122-151.

Lekalakala-Mokgele E 2011. A literature review of the impact of HIV and AIDS on the role of the elderly in the sub-Saharan African Community. *Health SA Gesondheid* 16(1): 6 pages.

Li L, Wu Z, Wu S, Jia M, Lieber E, Lu Y 2008. Impacts of HIV/AIDS Stigma on Family Identity and Interactions in China. *Family Systems and Health*, 26(4): 431-442.

Mbanya D, Sama M, Tchounwou P 2008. Current status of HIV/AIDS in Cameroon: How effective are control strategies? *International Journal of Environmental Research and Public Health*, 5(5): 378-383.

Moler V, Erstad I 2007. Stigma associated with tuberculosis in a time of HIV/AIDS: Narratives from the Eastern Cape, South Africa. *South African Review of Sociology*, 38: 103-119.

Musoko JJ, Macauley IB, Zoungkanyi AB, Bella A, Koulla-Shiro S 2007. Human Immunodeficiency Virus infection and associated factors among specific population sub-groups in Cameroon. *AIDS Behaviour*, 10.1007/s10461-007, 9294-9298.

Schatz EJ 2007. Taking care of my own blood: Older women's relationships with their households in rural South Africa. *Scandinavian Journal of Public Health*, 35(Suppl 69): 147-154.

Schatz E, Ogunmefun C 2007. Caring and contributing: The role of the older women in rural South African multigenerational households in the HIV/AIDS era. *World Development*, 35(8): 1390-1403.

Ssengozi R 2009. The impact of HIV/AIDS on the living arrangements and well-being of the elderly caregivers in Uganda. *AIDS CARE*, 21(3): 309-314.

Ssengonzi R 2007. The plight of older persons as caregivers to people infected/affected by HIV/AIDS: Evidence from Uganda. *Journal of Cross Cultural Gerontology*, 22: 339-358.

Tanga PT 2008. The impact of old age pension on households and social relationships in Lesotho. *Review of Southern African Studies*, 12(1 and 2): 184-215.

Tanga PT 2013. The impact of declining extended family support system on the education of orphans in Lesotho. *African Journal of AIDS Research*, 12(3): 173-183.

Tanga PT 2015. Growing old gracefully: The role of old age pension in Lesotho. *Perspectives of Global Development and Technology*, 14(5): 567-583. doi 10.1163/15691497-12341361.

Tanga PT, Tangwe MN 2014**.** The interplay between economic empowerment and HIV and AIDS amongst migrant workers in the textile industry in Lesotho. *SAHARA-J: Journal of Social Aspects of HIV/AIDS: An Open Access Journal*, 11(1): 187-201. DOI: 10.1080/17290376.2014.976250.

Tanyi LP, Okoye UO 2014. Community reaction towards older adults HIVAIDS caregivers. Qualitative evidence from North West Region of Cameroon. *Asian Journal of Research in Social Sciences and Humanities*, iv(5): 6-13.

UNAIDS, AIDS Epidemic Update 2010. Global Report: UNAIDS Report on the Global AIDS Epidemic. From <http://www.unaids.org/documents/20101123_globalreport_em.pdf.> (Retrieved on 12 October 2010).

WHO/UNAIDS 2010. *UNAIDS Report on the Global Aids Epidemic*. Geneva: UNAIDS.

Zimba ZF, Tanga PT 2014. Challenges faced by traditional healers when treating people living with HIV and AIDS: The case of Intsika Municipality in the Eastern Cape Province. *Studies on Ethno-Medicine*, 8(3): 269-275.

Paper received for publication in October 2015
Paper accepted for publication on March 2016