

Aging in the Context of HIV/AIDS: Spaces for Renegotiation and Recomposition of Mutual Solidarity in Burkina Faso

Journal of the International Association of Providers of AIDS Care
Volume 18: 1-8
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DOI: 10.1177/2325958219881402
journals.sagepub.com/home/jia



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Abstract

Purpose: The HIV-infected older people in sub-Saharan Africa are inevitably vulnerable to chronic health-related conditions, yet the needed social support for these people is mostly inadequate. Drawing on the anthropology of disease and health paradigms, this study explores the recomposition of multidimensional and multidirectional nature of mutual familial support for older people living with or affected by HIV/AIDS in Burkina Faso. **Methods:** We conducted multiple in-depth interviews among 147 individuals recruited from nonprofit organizations in Ouagadougou, Bobo-Dioulasso, Ouahigouya, and Yako through 2 projects funded by the National Agency for AIDS Research. Thematic and narrative analytical frameworks were used to analyze the data. **Results:** We found that older people suffered serious socioeconomic and psychological challenges associated with HIV/AIDS. Older people were particularly vulnerable to the double burden of HIV/AIDS and caregiving responsibility for family members infected with the disease. However, the infected older people who received adequate treatment and familial support regained sociocultural positions as agents for cultural transition and material/emotional resources. **Conclusions:** Although HIV/AIDS potentially renegotiated the nature, intensity, and direction of familial support for vulnerable older people, the extrafamily solidarity seems an integral part of the great cycle of reciprocity and intrafamily mutual support. Health and policy interventions targeted at strengthening the interpersonal relationships and support for HIV/AIDS-infected and HIV/AIDS-affected older people are needed to improve their independence and well-being.

Keywords

aging, HIV/AIDS, familial social support, older people, Burkina Faso

Date received: 20 May 2019; revised: 16 September 2019; accepted: 17 September 2019.

Introduction

Recalling the social revealing nature of HIV/AIDS pandemic remains a commonplace in low- and middle-income countries (LMICs). Over the past 30 years, research on HIV, both the infected and affected individuals, has shown serious effects, such as widespread socioeconomic challenges including poverty, stigma, and social isolation.¹ From anthropology of disease, health, and policy (note 1) to the analysis of interpersonal relationships, the understanding of the social situations associated with HIV/AIDS has yielded stimulating insights.²⁻⁶ Further, the HIV/AIDS pandemic reveals patterns of practical kinship.^{7,8}

The effective family ties existing between persons living with HIV (PLHIV) may shed light on mechanisms that are likely to strengthen or weaken a bond between close relatives. Weber⁷ noted that kinship is not only a recognized or claimed

belonging, but it also shows a relationship, social networks, and discontinuous segments which may illustrate an elective link between kin, leading to an “ego-centered kinship.”⁸ This is particularly true in the context of demographic aging and its concomitant multiple health challenges, including HIV/AIDS.^{1,9} Therefore, the analysis of the recomposition of intrafamily solidarity among PLHIV in Burkina Faso may highlight the elective nature of intrafamily solidarity. However, limited

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What Do We Already Know about This Topic?

Clinical and social science research has shown that the prevalence and disparaging effect of HIV/AIDS among the general and older populations are high in sub-Saharan Africa.

How Does Your Research Contribute to the Field?

Although HIV/AIDS potentially changed the direction and intensity of familial support for older adults, the extrafamily solidarity seems to be an integral part of the great cycle of reciprocity and intrafamily mutual support.

What Are Your Research's Implications toward Theory, Practice, or Policy?

We argue for policies and practices to strengthen interpersonal relations and social support for HIV/AIDS-infected and affected older adults to ensure their independence and quality of life.

research has evaluated the nature and direction of familial support for older people living with or affected by HIV/AIDS in LMICs and how this may affect their health outcomes.

In this article, we propose a continuous reflection on the recomposition of family mutual support in an LMIC context, focusing on vulnerable older adults to whom social support networks are critical.¹⁰ Studies have analyzed the elective nature of intrafamily relationships and mutual support from the perspective of generations and population cohorts.¹¹⁻¹⁴ This has lopsided toward refining scholarly and popular insights about the sense of mutual aid within African families.^{15,16} Our main objective is to continue the debate on the ability of contemporary West African societies to generate care for vulnerable older people through mandatory mutual aid mechanisms.

Considering the perspective of older people requires us to determine when it is possible to qualify and categorize a person as "older" in contemporary West African societies. We define older person in this study as those aged to be in an effective or symbolic position as a grandfather or grandmother but also persons aged 50 years and older who have become inactive and/or dependent for various reasons, such as retirement and difficulties in performing activities of daily living.¹⁷ It is critical to highlight the increased vulnerability of older people who live with HIV/AIDS¹⁸ and those dwelling in a skipped generation households caring for orphans of HIV-related deaths.¹⁹ However, it cannot be assumed that older people are more vulnerable and require support from others.¹⁹

Further, it is also important to ascertain gendered dimensions in growing older, particularly among PLHIV. Moreover, it seems that marital status, specifically conjugal relationships, largely determines the relative fragility of both men and

women in terms of social and medical management of the disease. It is, therefore, important to understand gender dimensions in HIV/AIDS. The specifics of our methods contextualized the modalities of data collection and allow a discussion on the evolution of the epidemiological context and the changes in case management that we have witnessed during fieldwork, and to date. The situations described provide elucidation in changes in mutual support, which are closely linked to the status granted to older people. Differences in harm based on the gender and socioeconomic situations may shed light on what it means to grow older in the context of PLHIV or offering care for an infected relative.

Methods

A Collective Research: An Interpersonal Approach

Multiple qualitative interviews were conducted between 2006 and 2010 as part of two National Agency for AIDS Research (ANRS) projects (note 2). The study involved 147 people in Ouagadougou, Bobo-Dioulasso, Ouahigouya, and Yako. The participants included 111 women and 36 men living with HIV/AIDS in seven support and health-care nonprofit organization (note 3). Seven of them were close relatives of people with HIV and eight couples. Indeed, the inclusion of different categories of participants in our analysis provided the opportunity to capture a comprehensive and nuanced picture of the lived experiences and the support trajectories for people living with HIV/AIDS. We did not predetermine the number of women; the respondents were interviewed until reaching saturation. For the men, given that those living with HIV/AIDS in most cases feel reluctant and fail to attend health facilities for support and care compared with their female counterparts,^{9,20,21} we were able to interview only those present in the facilities who consented to participate during the study period. This justifies the highly biased gender distribution against men. The relatives of PLHIV who consented that we meet their parents, brother, sister, aunt, and so on were also interviewed.

The Bobo-Dioulasso site became one of our survey sites only in 2008 as part of the second ANRS program, while we continued to visit Ouahigouya and Yako regularly for 4 years and also carried out surveys on Ouagadougou in parallel. Both men (aged 25-59) and women (aged 16-68) were interviewed in the nonprofit organizations. Among the participants recruited at the nonprofit organizations of Ouahigouya, Yako and in a district hospital in Bobo-Dioulasso, hail from villages that are often several kilometers away. Trusted relationships were established, with a dozen of interviewees and the meetings took place multiple times at their homes. By sharing interesting daily moments, we were able to capture their family environment. The data were, therefore, mainly from recorded interviews but also from multiple observations and informal discussions. Two-thirds of the interviews were conducted in local languages Moore or Dioula and one-third in French. Four-fifths of the interviewees were Mossi and the others were in Gourmantche, Samo, or from the West (mainly Bobo). The

interviews were transcribed and back-translated to English to ensure consistency. All our interviewees were anonymized with pseudonyms names in order to ensure strict confidentiality of information.

The succession of these 2 research programs has allowed the monitoring of changes in life trajectories over 4 years. A large part of the interviews took place within the nonprofit organizations, sometimes in pairs or individually. The interview was conducted—as much as possible—to get closer to an informal discussion; we first asked very general questions about the time of the seropositivity diagnosis, the therapeutic pathways, and the different conditions for medical care. Then, the questions focused on family life, relationships with children, spouse(s), parents, and stepparents, but also with uncles and aunts. The key rationale guiding our interviews was to find out who provided support in terms of financial, time, services, labor, emotional, and psychological and what were the impact of the disease's diagnosis on their living conditions, such as inability to work, increased dependence, and increased vulnerability. The material thus collected was rich in the economic (period of inactivity, bankruptcy, change of professional activity, etc), marital (separation, widowhood, etc), and family (birth, death, etc) events that marked the person's life before and after the diagnosis of his or her infection. It provided a broad description of the relationships that participants enjoyed with their relatives.

The analyses in this article are based entirely on this material. In particular, the data collection aimed to highlight the issue of dependency of the vulnerable and to allow us to see under which conditions family ties can provide an insurance function for individuals. The transcripts and field notes were analyzed using thematic analysis approach. We first identified the key themes in the transcripts and fields notes and highlighted crosscutting themes with specific color. We then analyzed these themes and discussed them with related literature.

Ethical Approval and Informed Consent

In line with the Declaration of Helsinki, ethical issues were addressed before the fieldwork. The two research programs received ethics approval from the Burkina Faso Ethics and Health Research Committee, Ouagadougou (reference nos. 2006-035 and 2008-042). Study participants gave written informed consent, which was either signed or thumbprinted (based on the choice of the participant and their literacy levels), after briefing them on the research aims, procedures, and the voluntary nature of their participation.

Results and Discussion

A Differential Vulnerability to HIV/AIDS

There is a clear gendered dimension of HIV infections, on the one hand, and being confronted with the pandemic of a relative during grandparenthood, on the other hand. First, the disease may increase the widowhood propensities among older

women. Historically, although males were first affected by the disease, females are now easily and more likely to be infected due to their unique biological, behavioral, and physiological vulnerabilities to HIV infection risks, as well as their responses to therapeutic interventions.⁹ The transformation occurring in forms of marriage also makes the practices aimed at caring for widows increasingly rare, especially that of the levirate.²² More women are then obliged to be self-supporting, especially if they were not close to their children.

Koudbi was a 68-year-old widow when we meet her in 2007 with her HIV-positive daughter Awa, a 38-year-old widow. Koudbi seemed very old, she could hardly move and had almost lost her sight. We thought she had reached her 80th year before she gave us her age during the interview. She also disclosed how her daughter's infection with the "bad disease" became a major source of her sorrow. Indeed, she believed that the disease resulted from sexual intercourse between females and dogs. Witnessing the signs of illness has been a source of sadness and despair for her and had this to say:

Anytime I go to bed at night, I think deeply about my daughter's sad situation... she's the only one I've. When she started complaining of headaches, I tied her head tightly with loincloth and she kept saying, 'Mom, my head is knocking' and I consoled her that she'll be fine... This persisted and I couldn't sleep for five days... I became despaired and shed tears too as her situation worsened per each day.

The cries and the burden of managing her daughter's illness largely contributed to the pace of her aging and she explains that

Because of the cries, today I'm not able to see properly from afar... I don't see when things are not very close to me.

Koudbi felt that looking at her age, her daughter should have been caring and supporting her, but due to the illness, she had no choice than to continue a role of a mother not only to her daughter but also to her 2 grandchildren with her challenges of growing older.

... but what would I do? Do I abandon my daughter and her kids? I had to be with them, care, comfort and support them... I normally go to the mill, gather the unwanted flour from the ground and prepare *to* (note 4) for them. I also prepare peanut doughnuts for sale and the little money I make is used to buy medicine for my daughter.

Koudbi points out the lack of family support making it difficult for her to seek help, as she is a widow, illiterate, and does not have regular/sustainable sources of income. She does not benefit from a strong extrafamilial social network. Her daughter was also a widow, but they failed to divulge her relationship with her family-in-law. We rather observed that most of the widows whose husbands died of HIV/AIDS received any support from their former parents-in-law, despite the view that they have children. Very often, the deceased's

parents blame the wife of the illness and death of their son. The burden of Koudbi's moral, emotional, and financial responsibilities is such that she felt very exhausted.

However, with the help of community-based organizations, her daughter was being recovered and the mechanism of mutual aid in the family has been restored to a direction considered more usual. Awa, while recovering, became one of the counselors of her association. This job was a source of income and support for the family. It is important to point out the key role of access to treatment in this change. Between 2006 and 2015, the number of people accessing antiretroviral therapies (ARTs) treatment in Burkina Faso increased significantly. Throughout our research from 2006 to 2010, we have already witnessed a double progression. First, an increase in the number of PLHIV receiving treatment, even in rural areas: 12 842 people on ARTs in 2006, 31 543 in 2010, and 65 000 in 2016.²³ Second, a significant decrease in the cost of treatment: from 15 000 CFA francs per month to 5000 CFA and then to free ARTs, but this does not apply to biological tests. As a result, the people we met and whose treatment trajectories and testimonies are described had, in most cases, just been given treatment. Several of them, such as Awa, were dying or in a particularly critical health condition before they were given treatment. Some of them consider themselves to be real miraculous, such as Halimata, 55 years old, met in Yako and living in a village about 10 km away, tells us:

Usually I used to cultivate my farm with my two 7 and 11 year old girls and the season that just ended (rainy season 2007) I couldn't cultivate, I was too weak, my children worked alone on the farm and I told them to save the money they had from part of the groundnuts harvest for my funeral (laughs). And now I'm here, like this even in good condition (Halimata speaks in a collective interview with about fifteen women within the Solvie Association, March 2008).

Indeed, access to care from the organizations significantly improved the conditions of people living with HIV/AIDS.²⁴ For instance, it helped to reduce the economic burden of providing care for the patient for his or her family and friends, such as in the case of Awa.

Oumar situation is quite different. This 65-year-old man holds a position in the National Police in Ouagadougou and was looking for information about efficient HIV/AIDS care. His only daughter, a 21-year-old and youngest of 4 siblings, has just learned of her HIV-positive status. He desperately mobilized his social network, through common French friends, anthropologists who worked in his region of origin, he heard about our work and asked to meet us in order to have information on the most effective routes to get the best possible care. Oumar saw his daughter as a victim of HIV because of the inconsistency of a man older than her and he does not consider her responsible in any way for what she was going through. He was especially distressed by his daughter's infection because he felt that he has not sufficiently protected her from this kind of risk. In this case, mutual aid from outside the family is at its

best. This was possible because his economic and social position allowed him to meet people with a high level of social and intellectual capital.

The third case is that of Sidbenewende, a 59-year-old man and a father of 6 children who lived with HIV infection. Sidbenewende was married and seriously marginalized in his family. This was as a result of his poor health condition and also the loss of his financial power. He lived in Côte d'Ivoire for 20 years where his job allowed him to provide support for his wife and children. His illness obliged him to go back to Burkina Faso and become inactive, and in fact, to depend on his family. Sidbenewende explained that

I was in great shape before and worked very well in Côte d'Ivoire. I asked my wife and children to return to Yako, Burkina Faso due to civil resurgence of war . . .

But weakened by illness, he was forced to return to Burkina Faso to live in a family compound. Too weak to work, Sidbenewende lost his financial autonomy while his wife acquired one by selling cooked meals. During the first moments, he received help from his relatives, especially his wife as he recounted,

When I came back here with my illness, at least at the beginning, my wife really took good care of me because, ah, she too was eating, she was taking advantage of my situation when I was working and since it had become like that, she couldn't let me down.

When his wife saw his condition deteriorating, she encouraged him with heartwarming words to go for an HIV test, which turned out to be positive. Sidbenewende decided to inform his wife and children immediately.

When I went home, I gathered all my children and my wife and disclosed my HIV status. To my surprise, they encouraged me, and pledged their utmost support.

Despite their promise, resentment and bitterness gradually emerged. Sidbenewende's wife accused him of the disease and that she felt betrayed. Sidbenewende denied the accusations of unfaithfulness as he bitterly explained,

I told my wife that I can assure her that I did not contact the disease from another woman, but she didn't believe anything I said . . . that use of razor blades might have caused this mess.

Sidbenewende's wife apparently rejected him. Considering the issue of secrecy and confidentiality fosters an understanding of the patient's relationships with those around them.^{5,25} We observed that the announcement of the HIV/AIDS infection can change the scope of the support or its direction, but not necessarily. The responsibility attributed to the sick person, or conversely the fact of considering him a victim, largely determines the help within the couple and in the family. The example, the case of Sidbenewende illustrates that because of the long separation from the children, they were much more

attached to their mother and seemed to support the father's rejection.

They put me aside and provided me separate eating bowls and drinking cups... they never shared same utensils with me...

Sidbenewende started receiving ARTs in 2006, but his exclusion from his family has affected him greatly. We observed the deterioration of his physical condition, such as progressive loss of sight, difficulty in moving around, and social condition during our meetings between 2006 and 2008. The extrafamilial support Sidbenewende can rely upon was extremely limited, because during the past 20 years, he had been living far away from home. The only support available to him was provided by nonprofit organization and various people who benefited from its care. However, Sidbenewende performed his personal chores such as cooking and washing of his clothes because his relatives feared of the possible contraction of the disease. Unfortunately, Sidbenewende's condition deteriorated beyond measure and died in 2009 without being able to find comfort from his wife and children.

Thus, HIV/AIDS can become a factor in aging. Opportunistic infections and moral burden foster the early onset of signs of aging in people older than 50 years who live with and affected by HIV. As seen in Sidbenewende and Koudbi (and also in seven other older people who lived with HIV in our analysis), HIV has contributed to the development of aging signs such as reduced or lost vision, as well as difficulties in moving around. This seriously increased their vulnerability and predicaments. HIV infection can also lead to a reversal of the direction of assistance, as older people may find themselves caring for their children, siblings, or grandchildren who are living with the disease at an age when the mutual aid mechanism would have intended people affected by the disease to be the main supporters of older adults.²⁶

The situations of Koudbi and Sidbenewende reflect a major change, "the conditionality of being." The economic and social status of an individual, and also his or her health status, largely determines all the intrafamily relations that he or she has with the family. The older person infected with HIV may be rejected by relatives, which is often expressed through sharing of support and care particularly in performing household chore. Sometimes, the refusal of mutual support between relatives has serious material consequences. The rejection is such that it undermines the material conditions of existence of the HIV-positive person, as the case of Sidbenewende.

Notwithstanding, we met older people whose HIV status has helped to increase or initiate help. For instance, a 58-year-old woman, Valentine received support from her children when her husband left her for a younger woman about 15 years. She saw this support increase when she became sick and was diagnosis HIV positive. The vulnerability introduced by HIV is gender-specific. For example, men who are sometimes ascertain their HIV-positive status avoid health facilities for fear of shame and stigmatization.^{20,21} Also, women who are often widowed and who are facing rejection by their husband's family; heads of

households are in many cases the only ones who are aware of their children's HIV status, as well as parents with several children being HIV positive. The matrimonial context is crucial for women. This largely determines the level of vulnerability to illness and its medical and social treatment.

The case of Sidbenewende illustrates how power dynamics can be renegotiated or recomposed between seniors and cadets in an HIV situation. Thus, the person holding the financial resources seems to benefit from the roles usually attributed to the social elderly individuals. This is expressed, for instance, in the decision-making process and in the assistance provided to others. These mechanisms lead to high vulnerability, because those who can no longer participate in the reciprocal exchange of donations/services risk being socially marginalized.¹⁵ However, without a relationship, there is no social security, no social recognition, and therefore no symbolic capital.¹⁵

HIV/AIDS as a Catalyst for Changes in the Experience of Being Old and Social Elder

Our study demonstrated the contributing factor of HIV/AIDS in changes in the conception and experiences of being old and social elder in Burkina Faso and contemporary societies in general. Old age and the attribute of older persons are socially constructed notions that take into account both external markers related to sociocultural context and internal markers, pertaining to personal experiences.²⁷ Indeed, aging in general is synonymous with new social roles and their conceptions may vary depending on the context of aging. Ellen Corin in the case of Canada has demonstrated that old age is synonymous with a change in roles and expectations of the community but is most often seen in terms of physiological, psychological, and social loss.²⁷ In the context of Burkina Faso and in the broader context of West African societies, the transition to old age, even if it is associated with loss, particularly on the physical and economic level is expected to be combined with social or "gray" power.^{28,29} Indeed, within the relationship between elders and cadets, the former occupy the role of social elders, and as such, they are granted a range of powers and privileges at the social, symbolic, and normally economic level.^{28,30} For men, for instance, seniority, according to Pochet,³¹ "is doubly valued socially through the father/son hierarchy and through the position within the siblings, particularly by the opposition between elders/cadets." Seniority in the family is synonymous with authority, wisdom, and knowledge. Seniors can also have a great deal of decision-making power. They are consulted for decision-making and educational, moral, and even strictly philosophical values are attributed to their words. The advice they are able to provide is generally conceived to contain wisdom because aging is perceived as a reflection of their experience of anteriority.³² With the representation of a potential symbolic power among older people, older persons are generally expect the younger generation to provide for their needs especially when retired from economic activities and also embattled with ill-health including HIV/AIDS.³¹ However, the general living conditions of older people are subject to social transformation

and are therefore likely to change over time.^{31,33-35} It is important to recall that if aging still inspires respect in West African societies, the gerontocratic organization of society is no longer appropriate because the oldest people in these societies experience too disparate social and economic situations as described in this study. In previous research, the analysis of changes in matrimonial choices has shed light on the main changes in seniority and elder relationships from both male and female perspectives.³⁶ Finally, some of the oldest men and women simply have very little authority, both over the younger generations and over their younger siblings because they are in such a situation of economic and sometimes social deprivation that they can only helplessly witness the difficulties their children are facing. This is particularly the case for those among the poorest segments of the population who are battling with HIV/AIDS, such as Sidbenewende.

With socioeconomic transformations, particularly the extreme impoverishment and the emergence of a number of chronic diseases, aging constitutes an increasingly less automatic access to a valued social position. Indeed, in some African socioeconomic and relational contexts, this position of older people may be increasingly synonymous with vulnerability expressed through economic precariousness, exclusion, abuse, and suffering.^{29,34,37} In the context of HIV/AIDS, “being older” implies many realities and can lead to a reversal in the roles and social relationships prior to the disease. The experiences from older men and women living with HIV/AIDS illustrate how the disease intensifies existing disparities between older people. This conforms to the concept of *differential aging* in the context of HIV/AIDS.

Pathways and Recomposition of Mutual Support with HIV/AIDS

This study has also revealed the recomposition of support within family affected by HIV/AIDS. Indeed, at the heart of the issue of HIV/AIDS in terms of experience and care for both young and old, the data show that the former can occupy pivotal positions in social networks because they are more easily, by the simple fact of their seniority and more durably embedded in social ties. This position makes older men and women—the potential captors of the donation and counter-donation systems that govern part of social relations in a relatively conspicuous way in West African societies.

In the sub-Saharan African context, social norms remind everyone of their obligations to provide support and care for close relatives. Assistance, including remittances of monetary and other materials in the view of the actors, takes a clear direction between gender subgroups, generations, and age cohorts. A body of socioanthropological evidence in this context also tends to show that intergenerational relations are marked by the regime of filial piety: the reciprocity of care/debt that children incur toward their parents and grandparents for having been raised by them.^{14,38-40} As a result, it is a child’s social obligation to support their parents when they become older. Roth points out that an “implicit generational contract”

seems to govern exchanges between generations.¹⁵ The payment of this debt is presented by the norm as a social obligation. Marie explains “Debt is therefore the driving force behind sociality and community socialization”. The study participants duly acknowledged these evidences over 20 years later. No one escapes it and everyone maintains the limitless cycle because everyone starts by being a debtor, before being able to claim the status of a creditor. However, when analyzed from this perspective, debt is a social investment, an investment on dependents, which is very rational in societies where people are the main source of wealth and the only guarantee of social protection against the hazards of life, as well as insurance for the future (Marie, 2009). However, the deterioration of economic living conditions challenges this generational contract and sometimes leads to its reversal.^{15,41,42}

Older people occupy a position at the articulation of different social networks, such as village, professional, neighborhood, and confessional networks. They maintain important ties with people in their age group, often have lasting ties with people in the neighborhood and their position as social elders. This potentially allows extended family members to access their social services at least in an advisory role. Their simple age-related prior experience gives them an experience of the social bond, which exists through various social networks. This makes older adults potentially privileged groups in these mutual networks, as illustrated by the case of Omar.

Our study revealed that intrafamily assistance is simultaneously elective, multidimensional, and multidirectional due to the view that member of the family across generations provided help to each other in times of need. Also, mutual support that took the form of monetary donations attention and caregiving roles were abound within the social networks. This allowed children and young adults to offer the needed support to their older parents. Héjoaka^{19,43} observed how children contribute in reminding their parents to take medication and help performing a number of domestic tasks including the sales of items in certain cases to support older parents. The provision of emotional, moral, and financial support to parents living with HIV/AIDS was also observed. Mutual aid also appeared multidirectional as it was 2-way affair between the younger and older generations and also between gender subgroups. As demonstrated by extent literature, these circumstances have a practical implications for economic, emotional, relational, and health conditions of the frail older adults battling with HIV/AIDS.^{1,44,45} People living with HIV generally show a phenomenon that is usually not very apparent in the considered societies: the effective multilaterality and nonsystemic of intrafamily solidarities that are usually obscured by normative prescriptions relating to support obligations for older adults and children. It must be emphasized that the various supports, for example, financial depended largely on the density of social network that the person concerned has been embedded during his or her life course. Thus, the life trajectory is essential to understand the type and level of support older persons are likely to receive. This extrafamily assistance is not only subject

to unforeseen circumstances but also punctual, even if it can be very important.

Conclusions

Living with HIV/AIDS in later life has a debilitating effect particularly due to the inevitable vulnerabilities of older people. The intergenerational social support in terms of resources and care are, therefore, important for their well-being. Indeed, intrafamily mutual support and extrafamily solidarity for these older people are perceived as deserving filial piety. However, for those like Sidbenewende whose infirmity deteriorated the socioeconomic and psychological state, nongovernmental organizations were the main recourse. These situations reflect a major change in the motivations for interpersonal action and the development of a supportive relationship. Beyond the existence of a moral and normative frameworks that prescribes mutual intergenerational support, “the conditions of being” largely determine the level of material and emotional assistance that older persons are likely to receive.

Older people with HIV have to manage a double burden of care-seeking and providing caregiving roles. Managing moral and economic burden considerably adds to their daily difficulties. However, those who received required treatment and care regained socio positions as custodians of wisdom, agents of cultural transition, and providers of care for children and material/emotional resources within their households. Social policies and interventional programs that seek to strengthen interpersonal relationships and support for older people with HIV are recommended to improve their independence and well-being.


Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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Notes

1. While anthropology of disease connotes the representations of illness and etiology, anthropology of health explains the organization of the health-care system, provider–patient interactions, and the general therapeutic itineraries. Also, that of policies deals with CBO’s, state responses, global norms, and challenges.
2. National Agency for AIDS Research (ANRS) 12123 and ANRS 12181 programs were implemented in partnership with the GRIL, Groupe de Recherche sur les Initiatives Locales, led by Habibou Fofana of the University of Ouagadougou. The research carried out by the Institut de recherche pour le développement (IRD) team was, during these 4 years, led by Fatoumata Ouattara (IRD). Two components, one dedicated to the health-care system and

caregivers and the other to the reconfiguration of family solidarities with people living with HIV, have been carried out together.

3. The nonprofit organizations we have worked with are in Ouagadougou, the associations AAS and Vie Positive; in Yako, the associations Semus and Solvie; in Ouahigouya, the associations AMMIE and Bonnes Mains; and in Bobo-Dioulasso, a person was met within the association Rev+. We sincerely thank the leaders of these associations and the staff for agreeing to welcome and help us. Without their assistance, this work could not have been carried out.
4. Polenta-style dish made from ground millet, sorghum, or corn. Tô is served with a sauce.

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