The purpose of this thesis is to examine the impact of AIDS on intergenerational relationships in Nigeria. The study made use of secondary data sources, supplemented by mail survey of a selected group of Nigerians who are engaged in AIDS’ research and relief issues. Findings revealed that AIDS has had a major impact on the relationships between the younger and older populations in the affected areas in Nigeria. It has considerably increased the caregiving responsibilities and challenges faced by the older population at the time when they are supposed to be receiving care. AIDS caregivers face discrimination as a result of the stigma attached to the disease. Governmental policies and programs have not been adequate in addressing the intergenerational challenges that arise as a result of the disease. Recommendations are made as a way to tackle the challenges.
THE IMPACT OF AIDS ON INTERGENERATIONAL RELATIONSHIPS IN NIGERIA: THE POSITION OF THE AGED

A Thesis
Submitted to the
Faculty of Miami University
in partial fulfillment of
the requirements for the degree of
Master of Gerontological Studies
Department of Sociology and Gerontology
By
Bede Ugwuanya Eke
Miami University
Oxford, Ohio
2003

Advisor___________________________
(Dr. Robert Applebaum)

Reader_____________________________
(Dr. Suzanne Kunkel)

Reader_____________________________
(Dr. Lisa Groger)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td>Background of the Study</td>
<td>1</td>
</tr>
<tr>
<td>Research Question</td>
<td>3</td>
</tr>
<tr>
<td>Overview of the Pandemic (Demographic Condition)</td>
<td>4</td>
</tr>
<tr>
<td>Meaning of AIDS and Historical Overview</td>
<td>4</td>
</tr>
<tr>
<td>Composition of the Affected Population</td>
<td>5</td>
</tr>
<tr>
<td>Looking In-depth at Nigeria</td>
<td>7</td>
</tr>
<tr>
<td>Brief History of the Epidemic in Nigeria</td>
<td>7</td>
</tr>
<tr>
<td>Rate of Infection or Disease Prevalence</td>
<td>8</td>
</tr>
<tr>
<td>Potential Effects/Implications</td>
<td>9</td>
</tr>
<tr>
<td>Cultural Background of Intergenerational Relationships in Nigeria</td>
<td>10</td>
</tr>
<tr>
<td>Cultural Pattern of Interactions Between Generations</td>
<td>11</td>
</tr>
<tr>
<td>Caring Among Generations</td>
<td>12</td>
</tr>
<tr>
<td>Changing Profile of Intergenerational Relationships</td>
<td>14</td>
</tr>
<tr>
<td><strong>II. METHODOLOGY</strong></td>
<td>15</td>
</tr>
<tr>
<td>Literature Review</td>
<td>16</td>
</tr>
<tr>
<td>Scope of the Problem</td>
<td>16</td>
</tr>
<tr>
<td>Effects on the Aged</td>
<td>19</td>
</tr>
<tr>
<td>Effects on Children</td>
<td>21</td>
</tr>
<tr>
<td>Survey</td>
<td>21</td>
</tr>
<tr>
<td>Limitations</td>
<td>23</td>
</tr>
<tr>
<td><strong>III. DISCUSSION OF FINDINGS</strong></td>
<td>24</td>
</tr>
<tr>
<td>Cultural Background</td>
<td>24</td>
</tr>
<tr>
<td>Epidemiological Condition</td>
<td>25</td>
</tr>
<tr>
<td>How Does AIDS Affect the Social, Economic, and Emotional Health of Older Population of the Older Population in Nigeria?</td>
<td>26</td>
</tr>
<tr>
<td>Social Implications</td>
<td>26</td>
</tr>
<tr>
<td>Economic Implications</td>
<td>28</td>
</tr>
<tr>
<td>Emotional Implications</td>
<td>31</td>
</tr>
<tr>
<td>To What Extent Has AIDS Affected Intergenerational Relationships?</td>
<td>32</td>
</tr>
<tr>
<td>Impact on Intergenerational Relationships</td>
<td>32</td>
</tr>
<tr>
<td>The New Parental/Grandparental Role</td>
<td>35</td>
</tr>
<tr>
<td>“Orphanhood”—A Challenge to Children</td>
<td>36</td>
</tr>
<tr>
<td>Summary</td>
<td>37</td>
</tr>
<tr>
<td><strong>IV. PROGRAM AND POLICY RECOMMENDATIONS</strong></td>
<td>38</td>
</tr>
<tr>
<td>Steps Taken by Nigeria and Africa to Respond to the Problem</td>
<td>39</td>
</tr>
<tr>
<td>Suggested New Strategies for Nigeria</td>
<td>42</td>
</tr>
<tr>
<td>Improving Intergenerational Relationships</td>
<td>42</td>
</tr>
<tr>
<td>Policy and Program Recommendation</td>
<td>45</td>
</tr>
<tr>
<td>Suggestion for Future Research</td>
<td>47</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The academic program that culminated into this thesis, and the successful completion of the thesis itself would not have been without the numerous assistance—moral, financial and academic, of some people whom I would love to express my gratitude to. First, my gratitude goes to God almighty whose guide and grace has kept me in the process of life and its endeavors. My sincere thanks also go to my academic mentor and a good friend, Dr. Godwin Unanka, whose vision, encouragement and support were crucial in the choice of embarking on this program of study. I owe much to Chief Barnabas Obirieze and Barrister Soronnadi Njoku whose encouragement and financial support made my dream of oversea studies a reality. The moral, financial, and spiritual support of Rev. Dr. Mike Wokomah and family is hereby acknowledged. To others in this category: Rev. Francis Ekeanyanwu, Pastor Hyginus Akamadu, Mr. Saturday Ubi, Mr. Leonard Osuji, Mr. Cletus Onuh and family, Atty. Callistus Anyaeto, Mr. Mercillinus Okoro, Mr. Sabinus Okoro, Mr. Joseph Obirieze, and all my family members, I say thank you.

The faculty and staff of Sociology & Gerontology Department are worthy of my thanks. From the inception of the program to its completion is marked by their constant support and good advice. I wouldn’t have made it without their contribution. In this category, I wish to express my profound gratitude especially to my supervisor, Dr. Robert Applebaum, for his patience in reading and correcting all the drafts, and for his fatherly support and encouragement. When it seemed very tough to continue, his voice of reassurance was a great source of energy. To other members of my thesis committee: Dr. Suzanne Kunkel (who is also my academic adviser) and Dr. Lisa Groger, I owe much
gratitude. It was my independent study which Dr. Kunkel supervised that led to the choice of this thesis topic. She is an “amazon” for me. Dr. Groger proved a good “mother” to me throughout my entire MGS program.

I also thank Dr. Jennifer Kinney, Dr. Chris Wellin, Dr. Shahla Mehdizadeh, Mrs. Kathryn Watson, and Mrs. Arlene Nichol for special assistance. To everyone who assisted me in data collection, and in any other form to make this project a reality, whose name did not appear here, I still express my appreciation.

Bede Eke
August, 2003
To the memory of my late father, Mr. Mark Eke Umunnakwe
THE IMPACT OF AIDS ON INTERGENERATIONAL RELATIONSHIPS IN NIGERIA: THE POSITION OF THE AGED

CHAPTER ONE

INTRODUCTION

Background of the Study

One of the greatest challenges of this century is the AIDS epidemic. Globally, AIDS has claimed over 20 million lives. More than 40 million are estimated to be living with HIV/AIDS worldwide (Kaiser Family Report, July, 2002). The global war on AIDS is still being waged with little or no assurance for success. There is still no cure for AIDS, and prevention strategies are uneven in their effectiveness around the world.

It has been over two decades since AIDS visited Africa with its devastating consequences. A continent with a bedeviled history of colonialism, slave trade, tribal wars, hunger, disease, and suffocating economic woes, Africa is now facing a new “war” with more swift-footed powers than any sanguineous war ever known in its history. Of the global 40 million people estimated to be living with AIDS, Sub-Saharan Africa has 28.5 million, representing 71% of the worldwide total (Kaiser AIDS Report July, 2002). It is one thing to know this figure but another thing to attempt an assessment of the impact of this phenomenon. The impact of HIV/AIDS pandemic is multi-sectoral and multi-dimensional. It is affecting national development, economic growth, community cohesion, households, and individuals. The population profile is changing in Africa and Nigeria in particular as a result of lost of lives (Griffin, 1995). In the words of the U.S. Secretary of State, Colin Powell, “Nations will collapse if we don’t fix these problems” (Online NewsHour, May 11, 2001).
In Nigeria, the AIDS phenomenon and its consequences cannot be overstated—both the young and the old are affected in varied degrees and dimensions. One of the major objectives of the study of gerontology as a discipline is to examine ways in which we can achieve a more healthy, happy and productive long life. Aging does not occur in a vacuum. It is a process that begins at birth and progresses into childhood, adolescence, adulthood and old age. The events and experiences that shape aging start from the earliest stages of life. Even in old age, one does not become an island. To this end, intergenerational interaction and exchange are crucial to the aging experience. As noted by Simic (1993: 10) “One of the most vital elements in successful aging is the ability to achieve a sense of personal integration and continuity as part of a meaningful historical process that not only links the experiences of a single lifetime, but also places the individual in a sequence of intergenerational ties.” The objective of gerontology as mentioned above, cannot be achieved with intergenerational dislocation and disruption, as it exists in today’s Nigeria. My concern in this thesis is to examine how this intergenerational disruption due to AIDS has affected the life of the aged population and what can be done as a solution. The concepts of exchange, cultural values, social role/role change are used in this work having in mind the theoretical frameworks in which they are applied. To this end, the works of Dowd (1975) on the concept of exchange, Goffman (1969), Elder (1985), Uhlenberg (1995), and Uhlenberg & Miner (1996) on social role and cultural value (from the life course perspective), provided guidance. According to Dowd (1975) loss of power due to decline in resources by the older persons lead them to inferior position of compliance. This presumably exists so often in intergenerational
relationships in which the aged, due to decline in resources, feel withdrawn. The
continuation of the actors in the exchange relationship is dependent on benefit or gain
derivable that is greater than the cost incurred. The theory also assumes that exchange is
governed by norms of reciprocity (Gouldner, 1960): When we give something we hope to
receive as much as we have given or even more in return. For the life course perspective,
social role is a set of expected activities and responsibilities that go along with life. It is
essentially that part to be played in life (Goffman, 1969). Aging is seen as a process
involving series of role transition, rather than single event (Elder, 1985). According to
Uhlenberg & Miner (1996), the social contexts under which individuals age affect the
aging experiences. Roles change as individual age; and the nature and type of inter-cohort
connections changes across cohorts. AIDS and its concomitant effects produce a new
social and economic context for the affected areas.

One important question for gerontologists is how AIDS affects the older
population of Africa. Because the older population in most communities in Nigeria relies
extensively on their adult children for economic and social support, it seems logical that
what affects the younger generation directly affects the older generation indirectly.

Research Questions

Consequently, the following research questions have been identified:

1. How does the AIDS epidemic affect the social, economic, and emotional health of the
younger and older population in Nigeria?

2. To what extent has AIDS affected intergenerational relationships?
3. What are the policy recommendations for supporting the older population affected by AIDS epidemic.

Traditionally, the aged in Nigeria rely more on their family members and kin for social and economic support than on formal services (Griffin, 1995). Most of these supports come from adult children. With the AIDS epidemic ravaging the middle cohort, the aged face two major challenges—less or no support from adult children and the assumption of new caregiving role. Intergenerational efforts at problem-solving both at family and community levels are collapsing. In the affected areas and families, the older generation is now caring for the younger generation. With advanced age and its potential concomitant frailty, and the new role of caregiving, the aged are facing double problems. Their economic power is diminishing daily with a weakening network of external supports. This represents a negative turning point in the hitherto, known history of the aged population in Nigerian communities. For the aged, a happy, productive, and “successful” aging seems elusive under the present devastation. One wonders what the situation will be in future if there is no intervention.

Overview of the Pandemic (Demographic Conditions)

**Meaning of AIDS and Historical Overview**

Acquired Immune Deficiency Syndrome (AIDS) is an advanced stage of Human Immuno Virus (HIV). This virus attacks and weakens the immune system so that the infected person becomes susceptible to infections of different kinds. This disease has defied solution and the cure for it is still being sought. AIDS is now the leading cause of
death in Sub-Saharan Africa and the fourth biggest global killer (UNAIDS, Untitled Document, 2002).

Since the AIDS pandemic began 20 years ago, the disease has claimed more than 15 million lives in Sub-Saharan Africa. In most of the hardest-hit countries like Lesotho, Zimbabwe, Swaziland, and Botswana, the percentage of adults with HIV/AIDS ranges from 23.6% to 35.8% (UNAIDS, June 2000). Following closely these countries in the rate of infection are, South Africa (19.9%), Namibia (19.5%), Kenya (13.9%), Central African Republic (13.8%), Cote d’Ivoire (10.8%), and Ethiopia (10.6%). The third groups of countries within Sub-Saharan Africa with moderate level of HIV/AIDS infection rates are: Tanzania (8.1%), Cameroon (7.7%), Democratic Republic of Congo (5.1%), Nigeria (5.1%), Gabon (4.16%) and Ghana (3.6%) (UNAIDS, June 2001). The countries mentioned above serve as illustrations designed to show a picture of what AIDS looks like in the region.

**Composition of the Affected Population**

The above percentages represent the infection rates among adults. Children of these nations are also affected almost in similar proportions. For example, in Zambia, 40,000 children under age 15 are believed to be infected (Kaiser NewsHour, May 9, 2002). Adults who die because of AIDS may also have children who are affected as a result. For instance, at the end of 1999, Nigeria had approximately 970,000 orphans because of AIDS; Ethiopia 900,000; Zimbabwe 623,000; Zambia 447,000, and South Africa 371,000. Within Sub-Saharan Africa, Nigeria belongs to the West African Sub-region. This region has a moderate rate of infection compared with central, eastern and
southern Africa, which as a whole make up Sub-Saharan Africa. A summary of
HIV/AIDS epidemiology in West Africa can be represented in table 1.

**TABLE 1**
WEST AFRICA HIV/AIDS EPIDEMIOLOGICAL SUMMARY BY COUNTRIES

<table>
<thead>
<tr>
<th>Estimated number living with HIV/AIDS at the end of 1999</th>
<th>Adult &amp; Children</th>
<th>Adults (15-49)</th>
<th>Adult rate (%)</th>
<th>Women (15-49)</th>
<th>Children (0-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin Republic</td>
<td>70 000</td>
<td>67 000</td>
<td>2.45</td>
<td>37 000</td>
<td>3 000</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>350 000</td>
<td>330 000</td>
<td>6.44</td>
<td>180 000</td>
<td>20 000</td>
</tr>
<tr>
<td>Cameroon</td>
<td>540 000</td>
<td>520 000</td>
<td>7.73</td>
<td>290 000</td>
<td>22 000</td>
</tr>
<tr>
<td>Chad</td>
<td>92 000</td>
<td>88 000</td>
<td>2.69</td>
<td>49 000</td>
<td>4 000</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>760 000</td>
<td>730 000</td>
<td>10.75</td>
<td>400 000</td>
<td>32 000</td>
</tr>
<tr>
<td>Gabon</td>
<td>23 000</td>
<td>22 000</td>
<td>4.16</td>
<td>12 000</td>
<td>780</td>
</tr>
<tr>
<td>Gambia</td>
<td>13 000</td>
<td>12 000</td>
<td>1.95</td>
<td>6 600</td>
<td>520</td>
</tr>
<tr>
<td>Ghana</td>
<td>340 000</td>
<td>330 000</td>
<td>3.60</td>
<td>180 000</td>
<td>14 000</td>
</tr>
<tr>
<td>Guinea</td>
<td>55 000</td>
<td>52 000</td>
<td>1.54</td>
<td>29 000</td>
<td>2 700</td>
</tr>
<tr>
<td>Guinea Bissau</td>
<td>14 000</td>
<td>13 000</td>
<td>2.50</td>
<td>7 300</td>
<td>560</td>
</tr>
<tr>
<td>Liberia</td>
<td>39 000</td>
<td>37 000</td>
<td>2.8</td>
<td>21 000</td>
<td>2 000</td>
</tr>
<tr>
<td>Mauritania</td>
<td>6 600</td>
<td>6 300</td>
<td>0.52</td>
<td>3 500</td>
<td>260</td>
</tr>
<tr>
<td>Mali</td>
<td>100 000</td>
<td>97 000</td>
<td>2.03</td>
<td>53 000</td>
<td>5 000</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2 700 000</td>
<td>2 600 000</td>
<td>5.06</td>
<td>1 400 000</td>
<td>120 000</td>
</tr>
<tr>
<td>Niger</td>
<td>64 000</td>
<td>61 000</td>
<td>1.35</td>
<td>34 000</td>
<td>3 300</td>
</tr>
<tr>
<td>Senegal</td>
<td>79 000</td>
<td>76 000</td>
<td>1.77</td>
<td>40 000</td>
<td>3 300</td>
</tr>
</tbody>
</table>
Table 1 presents the epidemiological picture for West Africa. Adults, women and children are infected in varied degrees. AIDS is ravaging the active cohort of people age 15 to 49, “the creators of the future,” and leaving small children desolate and destitute of parents. Consequently, as noted by Will (2000), this may produce an Africa of old men and women. Average life expectancy has dropped in most of the countries affected by AIDS. The average life expectancy in Sub-Saharan Africa has dropped from 62 to 47 as a result of AIDS. A typical example is Botswana where life expectancy has dropped to a level not seen in that country since 1950. Although Botswana’s case may be more severe, other countries in Sub-Saharan Africa have witnessed a drop in life expectancy as well. Because of the high mortality and morbidity rate associated with HIV/AIDS, there is a reduction in the labor force, an increase in caregiving times, economic drain, and psychological depression. It may be pertinent at this juncture to look at some of the area reports and case studies from some of these countries affected.

Looking in-depth at Nigeria

**Brief History of the Epidemic in Nigeria**

It has been almost two decades since the first AIDS case was reported in Nigeria (Igbanugo, 2001). Since then, there has been a steady increase in the number of cases. For instance, in Enugu State, the HIV prevalence had increased from 2.3% of adult
population in 1995 to 16.8% by 1999, an increase of more than 700%. In the same vein, eight other areas in the country had HIV prevalence rates greater than 10% (Akinsete, 2000). At first, it was considered a trivial matter that received little government attention. Perhaps, this lack of seriousness about the disease accounted for the reason that Nigeria programs against AIDS started later than most other countries in Africa. However, with a steady increase in the rate of infection, the Nigerian government launched a war against HIV/AIDS in 1992 (Igbanugo, 2001). Although some successes have been recorded, the wave of AIDS infections is still on the increase. At the current rates, it is projected that 75 million Nigerians will likely be HIV positive or dying of AIDS by the year 2020.

**Rate of Infection or Disease Prevalence**

With a population of about 120 million (representing 1/5 of the total population of Africa), Nigeria, so far, has lost 1.7 million people to AIDS (Akukwe, 2001). According to the results of the November, 2000 Sentinel Survey, 5.4% of the adult population (2.6 million) is already infected with HIV (Akinsete, 2000). Of this number, 1.4 million are women between the ages of 15 and 49, while the number of children infected is 120,000 (UNAIDS/WHO, June 2000). These secondary effects of the infection are substantial. For example, the number of AIDS orphans in Nigeria is placed at 971,472 and is increasing at an alarming rate. In Nigeria’s hardest hit zones, mainly in the urban centers, the prevalence rates range from 15 percent among the adult population to 20 percent of pregnant women. With 17% infection rate among adults (20-39) (Akukwe, 2001), AIDS is claiming the “engine house” of Nigeria’s workforce. This scenario is not without implications especially for intergenerational relationships as it affects the aged population.
Potential Effects/Implications

The potential effects of the above scenario cannot be overestimated. It has both direct and indirect effects. It affects the economic, social, psychological, and cultural lives of the people. For families and communities where the AIDS pandemic has taken its toll, mutual interdependence among generations is now collapsing. Exchange does not thrive well where there is a lack of human and economic resources. The infected adult children are no longer resourceful and have little or nothing to offer in their exchange relation with elders.

The older population in Nigeria is at high risk of losing both financial and social supports they have hitherto derived from their adult children. In addition, they now assume a new caregiving role. Ironically they have become caregivers to their children and grandchildren who are infected with or affected by HIV/AIDS. The level of social support for the younger generation on the other hand is dropping due to much pressure and fewer resources at the disposal of the elders. As reported in “Online NewsHour” of May 9, 2002, “The extended family in the community structure has really broken under the weight of the HIV/AIDS epidemic and poverty, and when the burden becomes too great, families are unable to cope anymore…” As the toll mounts, Zambia’s older generation is struggling to preserve its traditions (Online NewsHour May 9, 2002). This situation may not be different from what is happening in Nigeria given the same cultural pattern. The AIDS epidemic has affected many children and denies them some of the services which orphans traditionally have. In Igboland of Nigeria, it is a popular adage that “children do not belong to their parents; community owns children”. That is to say,
where parents cannot help their children, community can step in and bridge the gap. But with so many orphaned children, it seems the community is getting over-burdened in its efforts to shoulder such responsibility. According to Jonathan Silvers (Online NewsHour May 9, 2002), “… But as millions of children are discovering, AIDS and economic turmoil are destroying social traditions, leading relatives and neighbors to reject them when they’re at their most vulnerable.”

There is a wave of change in intergenerational relationships occasioned by the effects of AIDS. The younger generation is becoming more of a burden to the older generation without adequate reciprocal services and support to them. Additionally, there is a changing role of the elders—either as parents or grandparents. This scenario is not without adverse implications for the socio-economic, physical, and psychological well-being of the older population who are likely to suffer social alienation, economic depletion, physical exhaustion, and depression.

**Cultural Background of Intergenerational Relationships in Nigeria**

Intergenerational relationships exist where the younger and older generations live in sustained mutual cooperation and coordination that benefit members of each of these generations (Newman, et al., 1997). These relationships do not necessarily have to be familial. They cut across families and communities. However, organic human family and community structures can be a springboard for growth of intergenerational relationships. Largely governed by exchange and norms of reciprocity (Goulder, 1960), traditional intergenerational relationships are challenged in Nigeria as a result of the AIDS epidemic.
Cultural Pattern of Interactions Between Generations

In Nigeria, especially the southeastern part, there exists a hierarchical age grading system which accords great respect to old age. That is why in some part of Igboland, elders are not addressed by their first name by younger ones. There must be a prefix expressing respect before the name is mentioned. According to a report on family life in Nigeria, “Family relationships are guided by a strict system of seniority. The freedom to use first names is given only to seniors and superiors. It is an insult to call an elder sibling by his or her first name” (http://cwr.utoronto.ca/cultural/english/nigeria/family.html). As in most parts of Africa (especially West Africa), elders are respected, adored and revered in Nigeria (Appiah-Kubi, 1982). They are regarded as sacred and thus deserving of honor (Brown, 1992 as cited in Unanka, 1999:6).

Similarly, children are highly valued in Nigerian families. Children are considered not only belonging to their parents but also to the community and society at large. The importance of children in the family underscores the reason for giving birth to as many children as possible, and the elaborate naming ceremonies that follow the birth of a child. It is perceived traditionally as unacceptable for couples to live without producing children. Parents believe that their children are a source of glory to them and will provide support in their old age (Cattel, 1990). Children help their parents in economic activities and household chores and assist the family in carrying out farming activities.

The position of women in Nigerian families is such that they are traditionally household keepers. They perform household chores with the help of their children and other relatives. Traditionally, men do not carry out household duties. They go out in
search of money through some of the designated men’s jobs like building of houses, working in factories, and farming. In other words, tasks are shared between men, women, and children but every person’s duty is supportive of the family’s well-being.

Elders function as agents of socialization for the children who are to follow in their footsteps. Children are taught the values and cultural norms of the community, and are looked upon to uphold moral decorum. It is common to find children who are under apprenticeship with elders in order to learn one trade or another.

**Caring Among Generations**

The living arrangements among families in Nigeria promote a sense of caring that characterizes the traditional life of the people. Extended families, in which children, their spouses, grandchildren and other relatives live under one roof, are common in rural areas (Nigeria- Family Life: [http://cwr.utoronto.ca/cultural/english/nigeria/family.html](http://cwr.utoronto.ca/cultural/english/nigeria/family.html); Peil, Bamisaiye, & Ekpenyong, 1989). Caring among generations is seen as part of daily obligation. Parents care for their children and see it as their responsibility to raise them. Children in turn, see it as an obligation and a reciprocal norm to serve as caregivers to their parents and other elders around them. In rural areas the traditional practice of caring for the elders by their children, grandchildren, spouses, siblings or even ex-spouses is strong, but in the urban areas, under conditions of hardship, this tradition is beginning to change (Nigeria-FamilyLife: [http://cwr.utoronto.ca/cultural/english/nigeria/family.html](http://cwr.utoronto.ca/cultural/english/nigeria/family.html)).

As noted by Unanka (1999:5) “… caregiving to the elderly is a reciprocal activity involving children and adult children, their spouses, mothers and the elderly parents.”

Roles are most times divided according to abilities and capabilities. According Togonu-
Bickersteth (1989: 36-37), “While the females (wives) performed their caregiving functions, their mothers-in-law relieved them by babysitting their children, serving as their pediatricians and mentors to the wives. It is essentially an informal (family) caregiving system where the various layers of the young and the old served one another.”

Caregiving is seen as a family responsibility based on family ties and bonds (Brown, 1984; Cattel, 1990; Baiyewu et al., 1997). One can look at the system of caring among generations in Nigeria from Caldwell’s (1982) “Life-Time Intergenerational Exchange/Wealth Flow” model, and Cain’s (1985) “old age security” motive for fertility. Caldwell’s model explains that in the exchanges of wealth between generations, wealth or economic benefits flow upward from children to parents throughout the lifetime and beyond as an exchange for the care they received from parents (Unanka, 1999).

According to Cain’s “old age security” as motive for fertility, people tend to have children because of the expectation of being cared for in old age. Explaining this phenomenon, Cattel, (1990: 377) says “children in developing countries are the best security assets in an environment where there are no extra-familial welfare institutions such as exist in Europe and America.”

In a setting such as the above, mutual cooperation, assistance, and interdependency are cardinal to the survival of the family exchange “system.” Any dysfunction of a “sub-system” (children, mother or father in this case) causes disequilibrium in the entire system. In Nigeria, this long-serving system is changing due to some factors among which AIDS is one.
Changing Profile of Intergenerational Relationships

The traditional intergenerational relationships in Nigeria are changing as family structure is being affected by many factors. As noted by Unanka, (1999: 6) “The caregiving system in Africa began to change with the advent of colonialism by the late 19th century, the spread of Christianity, formal education, and subsequent rural-urban migration.” With the wave of modernization that created new conditions (job opportunities in cities, migration, etc) caregiving to elders in Africa in general and Nigeria in particular started changing its reciprocal nature (Togonu-Bickersteth, 1989). Role reversal is often seen in some cases in which elders are forced by circumstances to care for their children or grandchildren. The eventual arrival of AIDS in the mid 1980s with its astronomical spread, is envisaged to worsen the already changed pattern of intergenerational relationships, and mutual support. Things seem no longer the way they used to be in the relationships among and between generations both at family and community levels. The dimensions and magnitude of this anticipated change occasioned particularly by AIDS, and its impart on the aging population are the primary concern of this thesis. We shall see this more clearly in subsequent chapters.
CHAPTER TWO

METHODOLOGY

This chapter describes the data collection methods (literature review and interviews), and the study limitations. The data for this thesis were primarily collected from secondary sources. A mailed survey was used to supplement the published studies.

The survey was conducted via mailed questionnaires with some Nigerian health officials and AIDS relief workers. Five of the eight questionnaires sent were completed and returned. In choosing respondents, I was guided by the principle that every respondent must have good knowledge about HIV/AIDS issues, and the impact of the disease. In other words, the respondents should be individuals who are working in health care settings or carrying out researches on AIDS or are involved in AIDS relief operations for victims. I had a contact person in Nigeria who was able to network for me to get in contact with the type of respondents I wanted. A brief profile of the respondents is contained in appendix I. The responses from the questionnaires form part of the data presented in this study. To be able to address study research questions covering AIDS and intergenerational relationships, information was accessed from historic documents, public health publications, epidemiological case studies, demographic documents, ethnographic record, pilot studies, medical research, and intergenerational publications.

AIDS is a phenomenon that is very complex. Through historical records, information about the existing relationships between the younger and older population; the traditional role expectations for the children, young adults, and the elders was accessed. Through health and epidemiological documents, information on the spread of the disease in Nigeria was gathered. Some case study documents helped in the knowledge
about the extent of the impact of AIDS on intergenerational relationships in some countries in Africa, and various communities in Nigeria.

**Literature Review**

The literature review can be categorized into three sub-headings: 1) the scope of the problem 2) impact of AIDS on the aged, and 3) effects on children.

**Scope of the Problem**

The literature to be discussed here examines the cultural background and the tradition of the Nigerian people and its emphasis on filial responsibility. Aspects of the epidemiological and demographic information relevant to this study are mentioned and discussed briefly in this section. The concept of intergenerational relationships is also discussed. General studies on AIDS are discussed in this section as well.

Studies on the culture and customs of Nigeria were examined. The works of Falola (2001), Olaniyan (1985), Bickersteth, (1989), Brown (1984) Cattel, (1990), and Unanka, (1999) afforded insight into the cultural practices and customs of the Nigerian people. Togonu-Bickerseth and Funmi (1989) also provided helpful insight into the present status of caregiving to older adults in Nigeria. The study explained the crisis in the role expectations in the relationships between the younger and older generations. Their findings validated the assumption that traditionally, working adults take care of their aged parents. However, meeting filial obligations not only entails a high financial and emotional cost for the child, but also fails to yield the desirable level of care for the parents as a result of new changes.
The AIDS epidemiological study and publication (Onwujekwe, 2001; Kaslow & Francis, 1989) provided a general insight into the origin of the infection, rate of infection, surveillance, and mode of its transmission. Its description of the epidemic is both revealing and thought provoking as regards the solution of this deadly disease. This publication provided background knowledge into the AIDS phenomenon which is essential to this thesis. Other works on the prevalence of AIDS in Nigeria, which were used in this study are Akukwe (2001), Akinsete (2000), and UNAIDS/WHO (2000).

A 1994 demographic research on aging in developing countries (Martin, Linder, Kinsella, and Kevins, 1994) documented aspects of population characteristics and dynamics of the aged in most developing countries including Nigeria. This study created an insight into the increase in the aging population with its concomitant problems such as increase in caregiving and decrease in resources. The information from this research is helpful in understanding the aging population profile essential for this thesis. Also, Kaiser AIDS reports (2002) and Online Newshour (May, 2001) were good sources of demographic information. In addition to this, documents from the Nigerian National Population Commission (1994) provided additional information about the youth and older population profile in Nigeria.

To understand more about the meaning of “intergenerational relationship” the works of Newman et al., (1997), and Simic (1993) were helpful. Their explanations of the meaning and description of intergenerational relationship and program created the basis for evaluating this aspect of AIDS damage.

Although there is a scarcity of publications on AIDS and intergenerational relationships which is the thrust of this inquiry, some works have addressed aspects of the
impact that are relevant here. Worthy of mention here are the works of Ankrah (1994), Preble (1994), and Levine (1994) among others. Ankrah’s work focuses on the impact of AIDS on the family and other significant relationships in Africa. He identified several impacts of the disease ranging from socio-economic to psychological. The work highlights aspects of African extended family tradition (clan system) as a neglected potential institution that could help in mitigating the impacts of AIDS. It suggests that kinship structure should be activated to complement nuclear family efforts in addressing the various impacts of AIDS. The work of Palloni, Ju Lee, and Lamas (2000) which explored how family cohesion has been affected by AIDS corroborates with Ankrah’s in its findings. Levine’s (1994) study reveals the crisis into which AIDS has thrown families. She noted that traditional families that have developed ways of coping with the crisis may be totally unprepared for the stress created by external pressures such as stigma.

In addition to these, different case studies and projects dealing with AIDS and social relationships in Nigeria were examined as part of the literature review. These studies reveal issues of stigma, weakening social support, caregiving efforts, and other impacts. For instance, a study on “The care of HIV/AIDS patients: A taboo among the slum communities” (Obi, 2001) acknowledges that despite the fact that AIDS is not a moral issue but a health problem, persons infected with HIV and those suffering from AIDS are still being stigmatized, isolated and left to die in utter rejection. Obi’s paper which is based on his personal experiences as HIV/AIDS volunteer worker over seven years among the slum/riverine communities in Lagos, South West Nigeria, explores “various dehumanizing and humiliating ways in which the HIV and AIDS patients are
being treated in these poverty-stricken communities” (Obi, 2001: 5). Obi noted that people suffering from AIDS are believed to be receiving punishment from “God” for their heinous crimes and thus, their situation does not call for any sympathy. The paper however, recommends the use of series of grassroots educational programs on care, support, treatment and human rights of HIV and AIDS patients as a way to reduce significantly the communities’ withdrawal from the HIV/AIDS patients. The works of Iwuagwu (2001), and Dada (2000) corroborated Obi’s findings.

Onyenechere (1999) in her study assessed the impact on the persons living with AIDS and their families through an economic analysis of community home-based care. The study also was aimed at determining to what extent such care is affordable to those with AIDS and their families, and to carry out a geographical analysis to help identify programs, their specific activities, and their geographical distribution. The findings of this study reveal that a community home-based care project exists in each of the three broad geographical regions of Nigeria. The result of the interviews with caregivers shows tendency for those with AIDS to be highly dependent on government programs instead of families and community members for assistance. This is attributed to the stigma of AIDS that makes family and community members to isolate persons living with AIDS. For persons living with AIDS and their families, extra cost of care and support will be a major burden in a depressed economy like Nigeria’s.

**Effects on the Aged**

A work published in the Journal of Cross-Cultural Gerontology (Peil, Bamusaiye and Ekpenyong, 1989) examined the health and physical support for elders in Nigeria.
They found that children and grandchildren are the most important source of services to the older population. However, increasing levels of migration and the present AIDS mortality rate may deprive old people of their children’s services (Griffin, 1995).

A 1995 study “The effects of AIDS mortality on the elders of Sub-Saharan Africa” described societal changes due to AIDS and how informal support network for the elders in Sub-Saharan Africa have been affected (Griffin, 1995). The central focus of the study is that the elderly population has been adversely affected by AIDS. Griffin suggested solutions to the problem that will look at and improve the social insurance program of countries in Sub-Saharan Africa. This approach, she argues, will assure more economic security for older people. Although she mentioned the breakdown in the younger generation’s support to the older population, intergenerational relationship issues were not addressed.

In 2002, the World Health Organization issued a publication on “The impact of AIDS on older people in Africa.” This publication used Zimbabwe as a case study. The focus of this study is on the role of caregiving which the elders in the affected areas in Zimbabwe are assuming; the older persons attitude about caregiving and its impact on their resources, capacity and well-being. The study exposed in detail most of the trauma older people are facing as caregivers to their AIDS infected or affected children and grandchildren. However, this study does not assess the intergenerational relationship status as a result of the AIDS epidemic. To the extent that the study documented the impact of AIDS on the elders’ physical, financial, and psychological well-being, it is relevant to this study.
Effects on Children

Preble’s article centers on the impact of AIDS on African children. Preble estimates the major direct impact of HIV/AIDS—related illness on children, mortality effects as well as the major indirect impact—orphanhood. The work projects the impact of AIDS on the mortality rate of orphans and children under the age of five in ten African countries. It predicted a great increase in the rate of child morbidity and mortality, and orphanhood as a result of AIDS. It suggested the adoption of an integrated policy and program approach to AIDS orphans which involves all relevant governmental agencies. According to this suggestion, “no single sector can independently identify children in need or adequately address their multi-sectoral problems” (Preble, 1994: 166). In addition, the article suggests, among other things, that government and non-governmental organizations should focus on developing community-based, culturally acceptable solutions to the problems of AIDS orphans, and these should reflect family structure and child care practices in each country.

Survey

To amplify the evidence from the secondary data sources, mail survey with some health workers and researchers in Nigeria who have had opportunity of direct contact with caregivers and victims of the disease were completed. With the research questions in mind, the following sub-questions were prepared and administered to respondents:
1. What is your description of the position of the older population who are affected by the disease? For instance, the older population who have lost their children to AIDS, and consequently are taking care of their grandchildren?

2. In your research/work on AIDS epidemic, did you find any financial or economic impact of the disease on the younger and older population in Nigeria?

3. Did you observe any emotional impact of the disease on affected older and younger people?

4. If yes to questions 2 & 3, what is the extent of the impact? High, moderate or low?

5. Has the AIDS epidemic affected intergenerational relationships in Nigeria by your evidence and assessment?

6. If yes to question No. 5, to what extent is this effect and how can you describe it?

7. Are there some policies by the government to address any or all of the impacts mentioned in question Nos. 2 & 3?

8. What policy recommendations do you think are necessary for supporting the older population that may be at highest risk of losing support, and assuming extra caregiving responsibility?

9. How can we improve intergenerational relationships in the face of this problem?

Before administering these questions, respondents were e-mailed in order to explain to them the purpose of the interview. This was to make sure that they were convinced of the researcher’s intention in order to make free and unbiased responses to my questions. The stigma associated with AIDS sometimes makes it hard to get appropriate responses from affected individuals and researchers. Four of the five respondents are physicians.
who are serving in various healthcare settings that deal with AIDS issues. One of the respondents is the CEO of a non-governmental organization that fights HIV/AIDS.

**Limitations**

The limitations posed by relying on secondary data sources can apply in this study. Questions are not directly asked in this study. Also, there are weaknesses with previous studies because some of them are not very clear in their methodology, which enabled them to arrive at some of the figures and conclusions used in this study.

The data from the mailed survey are limited. The sample is small and non-representative. Although the respondents are professionals who are involved in different aspects of AIDS research, talking to AIDS victims and their aged caregivers directly would have added a critical dimension to this study.
CHAPTER THREE
DISCUSSION OF FINDINGS

This chapter presents a review and summary of previous research surrounding AIDS in Africa, and responses from the mailed questionnaires sent to Nigerian officials involved in AIDS policy and relief work. Discussions will center on the research questions identified in chapter one. Prior to discussing the research questions, an explanation of the discussion about the cultural background of intergenerational relationships in Nigeria and the epidemiological condition will be presented to help contextualize the discussions of the findings.

Cultural Background

Different historical and cultural publications about intergenerational relationships in Nigeria both at the family and community levels attest to the fact that relationships among and between generations are mutually interdependent and beneficial. A sense of responsibility, altruism, mutual respect and love pervade the social system. Individualism and detachment are not elements that are common in people’s interpersonal relationships. Rather, responsibilities are shared and collectively shouldered for individual and community benefits (Brown, 1984; Olaniyan, 1985; Cattel, 1990; Unanka, 1999, and Falola, 2001). In most communities in Nigeria, the younger and older populations cooperate for sustainable economic and social benefits. Children are seen as a valuable
“asset” and good “investment” for tomorrow (Cain, 1985). Caregiving to sick individuals and older people are usually the responsibility of the family members based on family bond (Brown, 1984; Cattel, 1990). Other members of the community or the clan get involved in caregiving responsibility to the sick when there is no family member available or when the family members are incapacitated. As noted in the literature, traditionally, adult children in a family setting take care of their older parents or members. Parents are also expected to nurture and train their children to be responsible adults. This represents the idealized cultural pattern of intergenerational relationships in Nigeria, which was altered to some extent due to demographic changes caused by migration of younger generations to the cities. More distortion of this cultural pattern of relationships is occurring as a result of the AIDS epidemic.

**Epidemiological Condition**

As noted in chapter one, almost two million Nigerians have died as a result of AIDS. The population most likely to be affected by this epidemic ranges from 15 to 49 years of age. A study by Onwujekwe (2001) shows that between 1990 and 1999 the rate of infection increased from 1 million to 5 million people in Nigeria. Other findings reveal the implications of this to be that the youth population profile is altered in the affected areas (Akukwe, 2001; Akinsete, 2000; UNAIDS/WHO, June 2000; Kaslow & Francis, 1989; Will, 2000). Because of the crucial role of the infected population cohorts (as adult children to aged parents and parents to younger children), there is a problem that could affect intergenerational relationships. The loss of caregiving support to the older population by adult children, and the new role reversal of caregiving to the infected and
affected children and grandchildren respectively by the aged population, is now occurring as a result of the AIDS disease. At this juncture, we can present the findings as they address two of the basic research questions. The third research question will be dealt with in the concluding chapter.

How Does AIDS Affect the Social, Economic, and Emotional Health of the Older Population in Nigeria?

This research question was answered through the information contained in the reviewed literature, and from the questionnaires. For the purpose of clarity, each aspect of the effect/implication is presented under a separate sub-heading.

Social Implications

Socially, AIDS is creating isolation and ostracism of the infected and affected people (Obi, 2001; WHO, 2002; Ankrah, 1994; Bor & Elford, 1994). Due to its stigma, in some communities, individuals fear any association with families or individuals suffering from the disease (Obi, 2001; Online Newshour, 2002, Online Newshour, 2001). For example, a report on AIDS in South Africa, quoted Moetlo, a nurse practitioner, as saying, “women risk being thrown out in the street if they reveal their HIV status” (Online NewsHour: December 2, 1998). The same situation exists in Botswana. As reported by Elizabeth Farnsworth, “Nearly all the women in the prenatal ward—who asked us not to show their faces—also refused to be tested. They said if a mother has HIV, a doctor will tell her not to breast-feed. Then families and neighbors will know she tested positive, and because HIV is stigmatized here she could be rejected” (Online
Zambia’s case is not different from that of South Africa and Botswana. As reported by Jonathan Silvers in an interview with Boas Mobela, 14, a victim of AIDS, Boas was abandoned with his two other siblings by their father and forsaken by neighbors because their mother was suspected of dying of AIDS. According to Silvers, “AIDS is often misunderstood in rural areas where victims of the disease and their families are thought to be bewitched, the consorts of evil spirits. So, the death of Boas’ mother effectively severed the children from community” (Online NewsHour, May 9, 2002). The above scenario is typical of what happens in some communities in Nigeria to HIV/AIDS victims. The work of Obi (2001) made vivid this fact of abandonment and isolation of people suspected to have HIV/AIDS. About the meaning of AIDS and how it is viewed among the people, one of the respondents to the mailed questionnaires reported: “It is an abnorma, an aberration, an omen, and an evil wind that must be stopped” (AIDS Relief Mission worker, age 42).

Not only are AIDS victims isolated by the community where they live, findings reveal also that they tend to withdraw and isolate themselves from people in order to maintain their dignity (McGrath et al., 1994). They also fear disclosing their AIDS status because of the negative consequences associated with this information. For instance, a study reported the confessions of two HIV/AIDS victims:

Nobody knows, but I do not know what will happen if they come to know. Please do not let my sister know of it. Because she will let everybody around here know. She is a person who cannot keep a secret. And it may affect my staying here (Ganda female, aged 28) (McGrath et al., 1994).

I am afraid that if they learn that I have AIDS they may decide to send me home to die. They may fear to keep me in their house any longer let alone paying out money for a patient without any hope of permanent recovery (Ankole male, aged 35) (McGrath et al., 1994).
With AIDS claiming thousands of lives of schoolteachers, the educational process is also being disrupted. Some schools are forced to close due to the loss of teachers (World Bank, 2002). As reported by UNAIDS, as many as one million children and young people in Sub-Saharan Africa lost their teachers to AIDS in 2001 (Piot, 2002; World Bank, 2002). Teachers act as mentors to their pupils and students on one hand. On the other hand, pupils and students represent the legacies and products of the teachers. This type of intergenerational relationship within the school environment produces mutual satisfaction for teachers and students. The loss of teachers as a result of the AIDS epidemic hampers intergenerational relationship in this regard. This is equally true for children and young adults who were under apprenticeship and have lost their mentors to AIDS.

**Economic Implications**

Economically, every nation or community where the epidemic has taken its toll suffers from a decrease in productivity. As the productive cohorts of young able-bodied men and women are being claimed, leaving older people and children, there is economic devastation. Cost of medications further drains the meager treasury of these nations. A World Bank report has it that if all AIDS patients in Tanzania were treated in health facilities, and if sufficient drugs were available to treat them adequately, AIDS care would have absorbed approximately US$27.3 million in 1991 which is roughly equivalent to one-half of the country’s entire public health budget for that year (Mann et al., 1992). If applied to Nigeria, this amount would quadruple because the population of infected people in Nigeria is up to four times that of Tanzania.
Given the fact that the elders in Nigeria are mostly farmers who report yearly declines in productivity due to physical weakness, they already have few financial resources. As individuals age, they can farm only progressively smaller areas although elders generally continue working as long as they can (Kendig, et al., 1992). Ironically, these elders need and depend much on their children for financial support but the trend now is for them to lose such support and, at the same time, be expected to make financial contributions. This situation causes financial stress and frustration. Responding to the questionnaire on this, a senior medical officer in Rivers State of Nigeria explained: “The older population are bearing the brunt of the scourge both financially and emotionally, as they pay the hospital bills and eventually pick up abandoned responsibility…”

The elders in this situation oftentimes compromise their own nutrition in order to accommodate the food needs of their sick children and orphaned grandchildren. According to Griffin (1995: 17), “The nutritional sacrifices made by elders who are attempting to support orphaned grandchildren in a situation of decreased productivity and decreased financial support may cause increased health problems and, ultimately may decrease the life expectancy of those elders.” Again, due to an increase in the death rate, more funerals are organized. For many families where the younger generation is dying, the burden of financing burials now falls on the elders. In the words of Griffin (1995: 18), “Funerals in these areas can become very expensive. The bereaved family must feed the attending guests, provide a casket, and a clean sheet and transport the casket and other guests to the burial site. The average cost of a funeral in Zaire in 1991 was the equivalent of US$320.00, almost the amount of the average annual income of Zairians.” The children who are victims are concerned about the economic burden to their parents or
elders in the community. The flow of intergenerational relationships is disrupted because such relationships are now more of a burden than a source of joy and satisfaction. For example, adults who are free from the infection face severe financial pressures from the infected and affected children around them and the adults who, perhaps, have lost their supportive adult children. Some of these uninfected adults may adopt a distant posture in their relationships with the young and old as a way to shield themselves from severe financial depletion. According to one of the respondents, “The older population suffer the impact of changes in house/family structure, loss of income, impoverishment, grief, psychosocial distress, increased malnutrition, and reduced ability to care for children” (Consultant Physician, aged 40). A study by Onyenechere (1999) reveals a large financial impact on people living with AIDS and their families in Nigeria. Her findings show the financial burden of caring for AIDS patients and their children is very heavy. This situation is aggravated by the fact that most people living with AIDS who are productive have an average income of less than N2, 000 (US$22) per month (Onyenechere, 1999). Describing the nature of the economic impact of AIDS on the younger and older population, four of the respondents maintain that the impact of AIDS is high on the older and younger generations, but the older population ‘especially’ bears the brunt. Younger children with no income are not expected to provide finances to take care of adults who are victims of AIDS although they suffer deprivation when the adult victim is their parent. But older persons in the family see it as a responsibility to preserve the family name, and to stand in the gap where there is problem. Given their meager financial resources which go down in most cases as they age, caring for an AIDS victim in the family increases this burden.
Emotional Implications

Emotional stress is often recorded as one of the problems caregivers face. But this type of stress may assume a unique dimension for an elder who finds him or herself facing a double dilemma. One is the emotional stress of observing one’s own children deteriorate in health; the other is the loss of support from such children, and at the same time having to take care of them. It is emotionally stressful to observe one’s children die and now assume a new role of parenting their children who also may be very sick and emotionally unstable. Elders, as noted by Griffin (1995: 17), “may be experiencing extreme emotional stress from witnessing the death of successive children while at the same time, caring for the orphans who are undergoing the serious psychological effects of watching parents die.” Griffin (1995:18) explained: “Between June 1989 and March 1990, there were 73 funerals in Twanda village, Uganda, a community of only about 1,000 people.” The feeling of uncertainty and a sense of insecurity about the future result in high-level stress for elders. It has always been the prayer of older people in Africa for their children to live after them and give them a befitting burial. But for elders to turn around and be involved in burying their children is heartbreaking. There is also the added worry of elders that they will not be given an adequate funeral because they have lost their children to AIDS. The words of a questionnaire respondent epitomizes the emotional condition of the older population affected by AIDS when she said, “Such older population are subjected to greater emotional and financial stress” (Permanent Secretary, Ministry of Health, aged 50).
On the other hand, children whose parents are infected with the disease face the challenge of caring for them. All the problems associated with “orphanhood” (Preble, 1994) are faced by these AIDS orphans. At the time they need their parental support, they turn (very early in life) to being supporters and caregivers to their young dying parents. In addition, they face the trauma of stigmatization. This situation clearly does not promote happy intergenerational relationships which are supposed to be mutually supportive and benefiting.

Four of the five respondents to the mailed questionnaire described the extent of the emotional impact of AIDS on the younger and older generations as “high.” One respondent describes the extent of this impact as “moderate.” One responded with the following statement: “The older population are bearing the brunt… and are emotionally stressed.”

To What Extent has AIDS Affected Intergenerational Relationships?

**Impact on Intergenerational Relationships**

Intergenerational relationships exist where the younger and older generations live in sustained mutual cooperation and coordination that benefits members of each of these generations (Newman et al., 1997). These relationships do not necessarily have to be familial. They cut across families and communities. However, organic human family and community structures can be a springboard for growth of intergenerational relationships. Largely governed by exchange and norms of reciprocity (Goulder, 1960), traditional intergenerational relationships are challenged in Nigeria as a result of the AIDS epidemic. At this juncture, it is pertinent to note that as a social tradition in Nigeria,
children do not necessarily belong to their biological parents. Children are also for the community and society at large. To this end, community can step in to assist individuals, especially children and older people, who are less privileged. At the family level, it is a social tradition that children are the investments of their parents for economic and social security at old age (Cain, 1985). Parents do their best to raise their children as a social obligation. In return, children see it as their own responsibility to care for their parents in old age. There is mutual support and interdependence across generations both at the family and community levels. Having this background knowledge about the African setting will help us to understand this section better.

As noted by Simic (1993: 10) “One of the most vital elements in successful aging is the ability to achieve a sense of personal integration and continuity as part of a meaningful historical process that not only links the experience of a single lifetime, but also places the individual in a sequence of intergenerational ties.” For families and communities where the AIDS pandemic has taken its toll, mutual interdependence among generations is now collapsing. Exchange does not thrive where there is lack of resources. The infected adult children are no longer resourceful and have little or nothing to offer in the exchange relation.

The older population in Nigeria is at high risk of losing both financial and social supports they had hitherto derived from their adult children. In addition, they now assume a new caregiving role. Ironically they have become caregivers to their children and grandchildren who are infected or affected by HIV/AIDS on the other hand the level of social support for the younger generation is dropping due to much pressure and fewer resources at the disposal of the elders (Dowd, 1975). As reported in the “Online
“NewsHour” of May 9, 2002 about the effects of AIDS on families and communities in Zambia, “The extended family in the community structure has really broken under the weight of the HIV/AIDS epidemic and poverty, and when the burden becomes too great, families are unable to cope anymore…”

On the side of the younger generation, the story is also painful. The AIDS epidemic has affected many children and denies them some of the services that orphans traditionally have. As noted by one of the questionnaire respondents, “It is a hopeless position as the children are at risks. Survival here (in Nigeria) is hard, it is extra burden for them” (CEO, Sabaoth Mission—an AIDS rescue mission, aged 42). According to Jonathan Silvers (NewsHour May 9, 2002), “… But as millions of children are discovering, AIDS and economic turmoil are destroying social traditions, leading relatives and neighbors to reject them when they’re at their most vulnerable.” There is a wave of change in intergenerational relationships occasioned by the effects of AIDS. The younger generation is becoming more of a burden to the older generation without adequate reciprocal services and support to them. Additionally too, there is a changing role of the elders—either as parents or grandparents.

Responding to the question of whether the AIDS epidemic has affected intergenerational relationships in Nigeria, four of the respondents answered “yes.” This level of affirmative response corroborates literature findings that AIDS has affected intergenerational relationships. A respondent to the questionnaire observed: “There is the fear of non-successions and generational gaps in families and organizations” (CEO Sabaoth Rescue Mission, a non-governmental organization that fights AIDS, aged 42). In addition to confirming the effect of AIDS on intergenerational relationships, three of the
five respondents describe the extent of this impact as “strong.” Most times, older persons who are caregivers to their orphaned grandchildren find it very difficult to cope with this challenge. The level of understanding, and communication between a grand parent and a grandchild is weak because of the generation gap. The grandparents would like to raise these kids just the way they raised their immediate children without realizing the generational differences. This may lead to misunderstandings. Oftentimes, grandparent caregivers complain that their grandchildren are stubborn and rebellious while the grandchildren on the other hand, accuse their grandparent caregivers as not understanding their needs. Consequently, the intergenerational relationship in this regard becomes weak, and less cordial.

The New Parental/Grandparental Role

Compared with the traditional roles, parents and grandparents are now assuming a caregiver role instead of a care recipient role. Traditionally, it was common for parents and grandparents to receive both economic and social support from their children and grandchildren respectively. In return, parents and grandparents acted as agents of socialization and cultural transmission to their children and grandchildren. The younger generation generally learns from the older generation in an informal setting. It was noble for parents and grandparents to pride themselves in the supports they received from their children and grandchildren. But today, these intergenerational roles are changing.

The parental and grandparental role is assuming a dimension in which the elders are no longer finding it easy to cope with the demand of caregiving from either their own children or their grandchildren. Studies have shown that in areas with high rates of AIDS
infection and mortality, old men and women are assuming both financial and emotional responsibility of caring for two or three grandchildren orphaned by AIDS (Fleming et al., 1988, WHO, 2002). In most cases, these old people themselves need care because they are very old and frail. A case study from Uganda described a family with nine orphaned grandchildren (all under the age of 15) with an 80 year-old grandfather and 64 year-old grandmother as caregivers (Barnett et al., 1992). According to a projection made by UNICEF for 10 countries in central and east Africa, AIDS had resulted in 11% of the children of those countries becoming orphans (Mann et al., 1992). The financial and emotional implications of elders taking care of many children and grandchildren cannot be overrated. Sometimes, when AIDS infected and affected orphans are isolated by their grandparents or family members, it is not because of the stigma per se but because of the additional financial burden their illness creates. As noted in a WHO Publication, “Reasons outlined for such reticence include the fact that the family members in question were mostly unemployed and therefore unable and/or reluctant to deal with additional burden of ‘adopting’ the orphans” (WHO, 2002:13).

The following quotation summarizes the questionnaires respondents’ description of the position of the older population affected by AIDS:

> The older population who have lost their children to AIDS and are caring for their grandchildren are overwhelmed by grief and unexpected economic responsibilities, compounding their dwindling or non-existent finances, and failing health (Medical Officer/Industrial Physician, aged 42).

“Orphanhood”—A Challenge to Children

With AIDS killing young parents and leaving their children as orphans, there is a myriad of challenges these orphans face (Akukwe, 2001; Preble, 1994). Some of them are
left sick (sometimes of AIDS), and may not have anybody to take care of them. Even when they receive care, the quality may be at its barest minimum. These orphans are expected to run errands, and engage in economic activities in order to assist their caregivers (grandparents/relations) to be able to provide their basic needs. Where this is not possible, some end up as “street children.” Some of these children grow up under their own care, and may not have any formal education or trade.

Summary

This chapter discussed the findings from a review of the literature and interviews. It looked into the cultural background and epidemiological condition under which the present AIDS problem is faced. Specifically, the socio-economic, and emotional problems created by the AIDS epidemic were noted and confirmed by findings. Intergenerational relationship challenges were identified from both the literature and interviews.

The next chapter will address the efforts already underway to alleviate the problems, and recommendations necessary for policy and program responses.
CHAPTER FOUR

PROGRAM AND POLICY RECOMMENDATIONS

In this chapter, a presentation of the summary of the major findings is made. Steps taken by Nigeria and some other African countries to respond to the impact of AIDS, and the critique of such steps are presented. This chapter also addresses the new strategies and recommendations for Nigeria to explore in her policy and program efforts in response to the effects of AIDS. Lastly, suggestions for future research are made.

Summary of Major Findings

The AIDS epidemic has claimed many lives of in Nigeria in particular and Africa in general.

- This phenomenon has adversely affected intergenerational relationships, with the older and younger generation at risk of both social isolation and economic deprivation.
- The problem of intergenerational relationships in this regard is aggravated by the stigma attached to AIDS.
- The spread of AIDS places considerable pressure on the older population because their role as caregivers and providers is expanded at a time when it traditionally supposed to shrink.
- There is an urgent need for more intervention by the government and other community organizations.

In response to these issues, Nigeria has made some policy and program efforts which are examined here.
Steps Taken by Nigeria and Africa to Respond to the Problem

Some efforts have been made by Nigeria and some other African countries to prevent the spread of the disease. Policies and programs aimed at educating the public on the reality of AIDS, the emphasis on abstinence, maintenance of a single partner, and the use of condoms have been enunciated. In addition to preventive efforts, some countries like Nigeria have developed programs to support the victims of AIDS through counseling and the provision of training materials. We can look at some of the policy measures adopted by Nigeria.

The rate of AIDS infection among adults in Nigeria is estimated at 5.1%. Over the years, Nigeria has adopted several policy measures to create awareness of the menace of AIDS. Some successes have been recorded since the government launched a war against HIV/AIDS as a policy in 1992 (Igbanugo, 2001). The aim of this policy was to adopt measures ranging from provision of drugs to education of the masses about AIDS in order to lesson the spread of the disease. Consequently, campaign efforts have been carried to schools, public gatherings, youth forums etc. both by local and national radio and television stations, with jingles indicating warning against HIV/AIDS infection are on the air everyday. As part of government’s effort to keep the youth informed, the National Youth Service Corps has incorporated into its orientation programs sessions of HIV/AIDS awareness campaign. In these sessions, different issues about HIV/AIDS are being taught and questions are answered properly. This has significantly reduced the rate of infection among college and university graduates. In addition, the Fellowship of Christian Students (F.C.S.) in its response to the above-mentioned policy of the
government has made some remarkable efforts to stem the tide of the epidemic through the “Aids for AIDS/Design-for-the-Family project (Igbanugo, 2001). This project has helped to support victims of AIDS through counseling and provision of material.

The Nigerian government has also created HIV/AIDS Emergency Action Programme (HEAP). Under this program, a National Committee on AIDS (NACA) was set up. This committee is working out ways to create more result-oriented, impact-alleviation policies. Some of the respondents to the mailed survey identified the following policy measures adopted by the government:

1. Subsidized antiretroviral drugs.
2. Functional social support groups that provide information, counseling and care to victims.
3. Radio/TV adverts asking people not to discriminate against those who are HIV positive.

Some of these policy efforts by the Nigerian government to address the identified impacts of AIDS have been criticized for being ineffective because they mainly target the infected individuals while overlooking those who are affected. As noted by a respondent to the mailed survey, “So far we have not seen a blue print of such impact alleviation policies…” (COE, Sabaoth Rescue Mission, NGO that fights against HIV/AIDS).

The fact remains that even if AIDS is eradicated today or the cure for it is found, the impact it has created especially with regard to intergenerational relationships will last for decades. That is why there is a serious need to address the impact of the disease on intergenerational relationships. So far, not much effort has been made in this direction.
The stigma associated with AIDS has made interactions, and connections difficult for those whose family members are infected, children and older adults alike. The cultural setting in Nigeria makes it much more problematic. In a culture where AIDS infection is seen as a punishment for a sinful life, a disease that might be a result of a curse, many uninformed or ill-informed people feel very reluctant to associate with AIDS carriers or their family members who supposedly share from the curse or may even be the source of the curse. How to lower the stigma associated with AIDS is one of the serious challenges in the campaign to solve intergenerational relationship problems. It is this stigma that has caused some family members to abandon those suffering from the disease and even avoid adoption of AIDS orphans. Communities in some cases avoid getting into closer contact with either the victim or their family members as earlier mentioned. Even when older adults decide to assume caregiving role to their AIDS infected and affected children and grandchildren respectively, they do so ambivalently, not knowing if they also will be infected through closer contact.

Again, since assuming such a caregiving role means an extra financial burden, some decide not to be involved, thereby severing the ties between them and their children, and grandchildren. This scenario is dangerous given its serious emotional implications on the abandoned children and the older adult who feel helpless.

Looking at Nigeria, the policy effort made so far is commendable but not adequate for the magnitude of the problem. The impact of these policy and program measures is yet to be felt by victims. There is no concerted effort at identifying sub-groups like the children and the aged who are indirectly affected, and developing measures to assist them by targeting them in AIDS impact alleviating programs.
Emphasis has been on the direct victims, individuals with HIV/AIDS. Preventive and curative efforts are good as they reduce the rate of spread and help the direct victims to live a better and healthier life, but to add to that, those who bear the indirect impact should also receive needed attention. To this end, the affected older and younger population needs government programs that are aimed at alleviating their pains.

Having seen the efforts by Nigeria and some other African countries to prevent the spread of HIV/AIDS, it is pertinent to examine some of the new strategies and recommendations for Nigeria to explore in order to improve intergenerational relationships where the effects of AIDS are already prevalent. This will help in seeking a solution to the problems faced by older people affected by AIDS.

**Suggested New Strategies for Nigeria**

**Improving Intergenerational Relationships**

To improve intergenerational relationship in the face of AIDS, measures should be taken to remove the stigma of AIDS through grassroots information and education. Local languages should be used to disseminate information regarding AIDS and its implications to life and relationships. Many people are now getting good information about the sources of infection, and its prevention, and this will help in improving relationships between community members and infected and affected people. Most of the older population who become caregivers to their infected and affected children are illiterate and do not understand the nature of AIDS. In the same vein, some community members do no understand the nature of the disease and its spread. This has hindered
some of the connections and interactions necessary at this time between and among generations living in the same community. Using local languages and dialects to explain issues of AIDS to them will reduce the misconceptions that lead to stigma.

The fear of financial burden which also results in some people avoiding responsibility for the affected populations, can be addressed by government policies and programs aimed at subsidizing housing, and creating some funds in form of transport and feeding allowances for children and older adult victims of AIDS. This fund can be disbursed through the local government health and social services so that the service can be provided nationwide.

In addition to the above strategies, there is the need to look beyond the nuclear and extended family components. The aged who are affected can be assisted by the youth in the community who are not necessarily their own children or relations. Elders who are in a better position also can assist other’s children who are victims of AIDS. Healthy and well-to-do youth can form volunteer groups to encourage and support both the older and younger victims. A questionnaire respondent suggesting ways to improve the AIDS situation and intergenerational relationships said, “Formation of family forum for the creation of HIV/AIDS awareness/prevention is needed. UNAIDS should urgently work to safeguard the intergenerational relationship which is breaking apart because of AIDS” (CEO, Saboath Rescue Mission: NGO that fights against HIV/AIDS).

Religious organizations have been doing a lot of volunteerism in Nigeria. It is time for them in their charitable efforts to target HIV/AIDS victims for emotional, social and economic supports. Within existing traditional organizations/institutions like the Age Grades, the youth organization, married women organization, Elders’ meeting and
organized children services, supports and services can be accessed by those who are now in high need of assistance and supports. As suggested by one of the respondents, “Advocacy programs utilizing the traditional, religious and educational authorities are necessary” (Consultant physician, age 40 years). Most Nigerian communities are “age graded.” In other words, members are hierarchically organized according to their age or cohorts. This has given rise to a number of age-based organizations/institutions like the youth organization (made up of non-married young men and women), married women organization, elder’s meeting and children club. These organizations function more as separate entities with concern centered on their members’ welfare. They are vertically organized, making it somewhat difficult for non-members to benefit from the activities and services of these organizations. However, they can respond to calls occasionally made by non-members if such calls fall within what they consider as their aims and objectives. When community efforts are unified these organizations can prove very strong because they have personal funds and other resources that can assist in times of crisis. Again, as suggested by one of the survey respondents, there should be a “functional support group that provides information, counseling and care to victims” (Consultant physician, age 40 years).

At this time, these organizations can be sensitized to the importance of this challenge and have their impact felt by community members outside their organizational cohorts. This idea of intergenerational relationships as a collective effort in problem solving by different organization of cohorts is yet to be harnessed. In fact, this is the aspect that has not been fully explored in the campaign efforts against the spread and effects of AIDS. Other international agencies that fight AIDS should be more sensitive in
their support for programs that will help build and strengthen intergenerational relationships in the face of AIDS. According to one of the questionnaire respondents, “UNAIDS should urgently work to safeguard the intergenerational relationship which seems to be breaking down because of AIDS.” As we think of AIDS prevention, we should also think about those who are already victims especially the elders and children of the communities in Nigeria where AIDS is taking its toll.

**Policy and Program Recommendation**

Given the above scenario, there is a need to formulate policies and develop programs that can help to improve the quality of life for AIDS victims within an intergenerational context. Governmental policies should aim at joint efforts of the different generations. Program development should involve the participation of different generational cohorts both for preventive measures and for caring for victims. To reduce the stigma, a grassroots policy initiative aimed at educating the people about AIDS with emphasis on removing the assumption that people with AIDS are the worst sinners. According to one survey respondent “Advocacy programmes utilizing the traditional, religious, and educational authorities should be in place” (Consultant physician, aged 40 years). Another respondent said, “Policies on orphan care and support for the aged with food, clothing, school fees, medicare, etc is necessary” (CEO Sabaoth Rescue Mission, age 42 years).

Since the economic burden is becoming too heavy for individual families and even communities to bear, government should come in with some funding that will target caregivers’ and intergenerational volunteer service compensation. This will encourage
family caregivers and support groups in caring for HIV/AIDS victims in their communities. There is need for legislation on the security of jobs for HIV infected persons. This will allow them to maintain a quality of life that will sustain their health for a reasonable period of time. The following policy measures were recommended by a respondent to the mailed survey: a) there should be provision of free medical service for all those older than 65 years, and for children less that 10 years of age, b) there should be regular payment of pensioners, c) there should be provision of less strenuous jobs for older people like minding nursery school children, crèches, picking of litters at public places, etc d) provision of compulsory, free primary and secondary education for all children (Physician, aged 42 years). By doing this, the financial burden on the older persons will be reduced. Government should make provision for more social services like housing for those with AIDS and their caregivers. Because of financial difficulty people with AIDS who live in the cities, oftentimes face housing problems. Their inability to pay house rent exposes them to the danger of homelessness. According to Sunny Chinenye (survey respondent) “Poverty alleviation programme should be one of the policy priorities of the government.”

It is time also for the government to think about establishing centers for affected children whose care burdens are falling on the older population who themselves, need care for their daily survival. This policy measure will reduce the incidence of “street children” and ease the psychological and financial burden from the older caregivers. If centers for children are established, older caregivers can only go from time to time to visit their orphaned grandchildren, and give them a sense of support. This will also
improve the intergenerational relationships. In addition to rehabilitation centers,
Njeribara (a survey respondent) suggested that there should be:

the establishment of peer-assistance groups to which all parents
of HIV/AIDS victims can belong for discussions of their common problems
and find solutions to them. Such association can apply for and receive
targeted donations and assistance from international donors, and other
charitable organizations.

**Suggestion for Future Research**

In an ideal situation, my research questions would have been better answered
through a combination of qualitative and quantitative research designs. Relying on
secondary data sources only will not give the researcher the opportunity to assess the
situation on the ground. A qualitative approach that would make use of in-depth
interviews and focus groups would have been ideal to capture the day-to-day effects of
the disease on intergenerational relationships. That approach would allow the researcher
to interact with those with AIDS and their caregivers. Quantitative approaches would
help to cover more respondents through the use of survey methods with a carefully
structured questionnaire. Because of the stigma associated with AIDS, a questionnaire
that would guarantee anonymity would elicit a more unbiased response. I believe, with
the combination of these two approaches, a more comprehensive result could be
achieved.

Therefore, my suggestion for future research is to collect data directly from
individuals with AIDS and their caregivers in order to assess properly the impact of
AIDS on intergenerational relationships. Because of the nature of AIDS infections and
the diversity in the population and areas affected, a combination of survey and
ethnographic methods will yield a better and more valid result. Future research should also try to look into the reporting approaches used to assess the rate and spread of the infection. It is not yet clear how researchers arrive at some of the figures that are reported, since many cases of AIDS and deaths resulting from them are not reported. Future research should also aim at having an in-depth analysis of the impact of AIDS on children and elders of Nigeria.

One of the important questions we need to address in any future research about AIDS and intergenerational interactions is whether such interactions or relationships are more of a one-sided burden either to the older person or the children. If we hope to improve intergenerational relationships, this question should be a primary one. Intergenerational relationships should be mutually beneficial even though the benefits may not be measured in equal terms. The benefits of reciprocal relationship between generations should be emphasized because if interconnections between generations are weakened, just as we can see with the case of AIDS in Nigeria, society will become dysfunctional. The intergenerational model helps to foster age-integrated ideas for building community and neighborhoods, thus leading to an interconnected society (Grant-Miller, 2003). According to Laszlo (2001), “… the most profound human yearning rooted in our biological evolution is for caring connections.” In fact, people of various ages are lifelines to the world at large. Because to be loved and defended is a need shared by both children and frail elders, what affects these disadvantaged age groups should be the concern of everybody.

For future research, it is pertinent to answer some of these questions: Is the impact of AIDS uniform for elders and children of different socio-economic status
(SES)? Are there variations in this impact? To what extent is the AIDS stigma mitigated when the victim is a rich person from a respected family? Can this stigma limit people from their usual closeness with individuals and families of high socio-economic status? This question is necessary because people’s socio-economic status makes a difference in association and relationships.

Some of the unanswered questions for future research include: Is there a new pattern of relationships and social interaction evolving among the isolated and stigmatized individuals and their families? Since they may now see themselves as experiencing a common challenge, is there a sense of charting a new relationship based on this common experience? Do they develop a sense of solidarity for themselves or are they hostile to one another? How do the affected children see the elders from whom they expected help from but could not get it? Do they look at them with less respect or do they still maintain a sense of respect and love for their elders?

Since many people in Nigeria are religiously minded and belong to different religious organizations, some of the crucial questions for future research in this regard may also include: Do religious organizations play any role in maintaining intergenerational relationships? What is the attitude of religious organizations towards individuals who suffer from AIDS? Can affected individuals find help from religious organizations to which they belong? Does the stigma affect relationships with other members of their religious group? These are possible questions that future research in this area would try to address.

In conclusion, we have seen that the impact of AIDS is overwhelming. It has caused much damage to intergenerational relationships in Nigeria. The younger
generation infected or affected by the epidemic suffer isolation, deprivation of parental/elder’s nurturance, and emotional devastation. Besides, affected elders bear much of the economic and psychological impact of the epidemic.

Hope exists if the trend of AIDS infection is slowed by adopting new preventive strategies. However, slowing the trend of the infection is only one step to redress the impact of the epidemic on intergenerational relationships. To this end, more interpersonal relationships and support transcending family background could serve as a veritable tool for assisting affected individuals who may not have family members to help them. In addition, new dimensions of intergenerational relationships among existing traditional organizations, which encourage unity, coordination, and cooperation would be helpful in redressing the intergenerational effect of AIDS. The time has come for the government to create policies aimed at supporting affected persons and volunteers financially. Reactivating the well-known intergenerational bonds at both the family and community levels will see Nigerians, especially the aged, living more happy and productive lives even in the face of AIDS challenges. The ideal of being “our brothers’ keeper” should be reinforced at this time of challenge.


Legon: Institute of Statistical, Social and Economic Research, University of Ghana.


July 2002.


in Kampala, Uganda. In Robert Bor and Jonathan Elford (eds).


APPENDIX I

Profile of Survey Respondents

<table>
<thead>
<tr>
<th>Position/Organization</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CEO, Sabaoth Rescue Mission-A non-governmental organization that fights HIV/AIDS.</td>
<td>42</td>
</tr>
<tr>
<td>2. Medical officer (Industrial physician).</td>
<td>42</td>
</tr>
<tr>
<td>3. Consultant physician, Rivers State.</td>
<td>40</td>
</tr>
<tr>
<td>4. Permanent secretary, Ministry of Health</td>
<td>50</td>
</tr>
<tr>
<td>5. Senior Medical Officer, Rivers State.</td>
<td>42</td>
</tr>
</tbody>
</table>