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Compassion and Sorrow as Irreducible Minimum for Intergenerational Practice in Sub-Saharan Africa*

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ABSTRACT This paper is intended to fill the gap that has emerged in the scholarship on the changing nature of intergenerational practice in Sub-Saharan Africa. In particular, it addresses the emergence of compassion and sorrow as irreducible minimum in intergenerational practice. The paper attempts to confirm the common assumption among practitioners that in every community, whether in Europe, North America, Latin America, Asia or the Oceania, intergenerational practices notably try to capture the most daunting challenges confronting the people. In the case of sub-Saharan Africa, our own major challenge is HIV/AIDS. To achieve this purpose, the paper begins with a brief explanation of the concept of irreducible minimum, moves through a highlight of the theoretical framework of the discussion, the context of the HIV/AIDS epidemic in the light of how it has changed the demography of intergenerational practice, and concludes with a brief exploration of intergenerational learning exchange programmes that might benefit Sub-Saharan Africa, and, indirectly, the modern world. This might sound over-ambitious but it is our hope that an awareness of the common destiny the human race shares should make our message worth listening to, and matching that with positive action.

INTRODUCTION

Rich in natural resources like mineral oil, diamonds, rubies, gold and natural abundance of flora and fauna, Sub-Saharan Africa is home to about 635.2 million people out of a worldwide population of 6,134.1 billion (The Africa 25 2004, p.1). Unfortunately, the wealth of Sub-Saharan African has not translated into much in terms of development due to the concerted manifestations of forces some of which have almost defiled solutions. This is unfortunately so because rather than take its rightful place among the rapidly developing continents of the world, Sub-Saharan African development is seemingly lagging behind not only because of endless civil wars, border conflicts and weak structures for democratic governance, amongst others, but because of the Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/ AIDS) that is decimating its human capital.

This discussion is not intended to join in the debate as to whether or not the HIV/AIDS epidemic in Sub-Saharan Africa is growing. Paul Benn ell (2005, pp.1-2) has already addressed the issue, noting, in particular, that although it is impossible to generalize about the epidemic across the continent, advocacy is reportedly getting in the way of objective assessments of the levels and trends of the AIDS epidemic. Paul Benn ell (2005, p.2) unequivocally argued that the HIV prevalence rates are not increasing in most Sub-Saharan countries as is usually stated or implied. While that might appear to be "good" news, it is also true that highly accurate statistics on mortality in Sub-Saharan Africa are still lacking and we can only at best rely on estimates of HIV prevalence and sentinel population surveys.

The literature on Sub-Saharan Africa's HIV/ AIDS is building up rapidly over the last decades. Almost all aspects of the pandemic have been addressed. Even at that, not much quality information is available on how HIV/AIDS has negatively influenced intergenerational relationships and practices in the sub-continent. To date, only a handful of information on this dimension has been indicated in the literature. (Oduaran, 2004, p. 1 and Help Age International, 2004, pp. 1-2). This paper is therefore intended to fill the gap in terms of the changing nature of intergenerational practice in Sub-Saharan Africa. In particular, it addresses the emergence of compassion and sorrow as irreducible minimum in intergenerational practice. The paper attempts to confirm the common assumption among

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practitioners that in every community, whether in Europe, North America, Latin America, Asia or the Oceania, intergenerational practices notably try to capture the most daunting challenges confronting the people. In the case of sub-Saharan Africa, our own major challenge is HIV/AIDS. To achieve this purpose, the paper begins with a brief explanation of the concept of irreducible minimum, moves through a highlight of the theoretical framework of the discussion, the context of the HIV/AIDS epidemic in the light of how it has changed the demography of intergenerational practice, and concludes with a brief exploration of intergenerational learning exchange programs that might benefit Sub-Saharan Africa, and, indirectly, the modern world. This might sound over-ambitious but it is our hope that an awareness of the common destiny the human race shares should make our message worth listening to, and matching that with positive action.

The Concept of Irreducible Minimum

The concept of irreducible minimum, as used in this discussion, derives from Nummelin's extrapolation of the theory of Markov's chains with values in a countable set of discrete data (Nummelin, 1984, pp. iv-ix). Used nowadays as part of classical probability theory, the concept of irreducible minimum generally involves the use of simple probabilistic arguments by taking values in an arbitrary measurable space defined as valued random element in a so-called stochastic process defined mathematically as:

Eni n e" 0 (i.e. Xn; n e" 0)

The E – valued stochastic process implies that at every n, next state Xnt i depends only on the present state Xn of the process (Nummelin, 1984, p. ix).

What this means in this discussion is that whilst the data on HIV/AIDS in sub-Saharan Africa ought to be available as countable discrete set, the prevailing inability of many countries to avail accurately recorded prevalence rates can only lead one into probabilistic arguments. In such arguments, one can say for example that whenever the incidence of HIV/AIDS occur in a given African community, it is possible to predict with deterministic certainty that the older persons, either as parent or grandparent caregiver, would be moved with compassion and, inadvertently, embrace sorrow as both generations of sufferers and carers contend with death. In addition, that whenever HIV/AIDS incidence occurs in the Africa community, compassion and sorrow becomes the vital expectation that typifies intergenerational community cohesion. For Sub-Saharan African countries, the concept of irreducible minimum in relation to the HIV/AIDS epidemic has translated into a theoretical framework that has guided this brief discussion.

The Theoretical Framework

Compassion and sorrow are now identifiable general properties that have come to provide a basis for theories on HIV/AIDS in Africa. For as Giddens (1997, p.586) said a theory is an attempt to identify general properties which explain regularly observed events. This discussion is therefore relying on two main sets of theories; namely, the practice theory and the theory of symbiotic relationship.

The Practice Theory

Intergenerational relationship s and practices, from our own perspectives, have move beyond what Kuhn (1962) described as a "pre-scientific stage". The field has arrived at the early phase of a scientific stage. This is the stage of empiricism where we must begin to rely on quantitative and qualitative research data for the explanation of phenomenon such as the one we are examining in this discourse. Unfortunately, the literature on explaining the scientific theories used in intergenerational relationships and practices in Africa are now just developing. Nevertheless, an exploration of Western literature on the subject has been useful to us in identifying and using the practice theory as espoused by Schwartz (1961 and 1962) and expanded by Shulman (1999). Schwartz (1962, p.270) has defined a practice theory as:

"…a system of concepts integrating three conceptual subsystems; one which organizes the appropriate aspects of social reality, as drawn from the findings of science; one which defines and conceptualizes specific values and goals, which one might call the problems of policy; and one which deals with the formulation of interrelated principles of action."

Applied in this discussion and to Africa, we can attempt to describe what we know about human behaviour and social organizations. The

basic assumption here is that most Africans are passionately attached to the African value of compassion as it operates in our extended family systems. The African extended family systems have been very resilience in terms of refusing to surrender completely to the strong impacts of modernity.

Emerging from the present value attached to compassion in Africa is the deliberate pursuit of the specific goal of helping members of our families who are dying from HIV/AIDS. The value of compassion is so strong that many who seek to help their sick relatives have inadvertently lost their lives in the process, even with all the caring education programmes that our governments have "slowly" tried to make available.

The major consequences of the manifestations of compassion have been the unending circle of sorrows that compass our people all about. So then if one were to look at how Africans behave when it comes to being compassionate, it would be clear that very few people will be "scared" by the reality of death as more and more people are dying rather untimely because of poverty and HIV/AIDS. This is the case because Africa is still far from being plagued by the possibility of what Shulman (1999, p. 15) has described as symbiotic diffusion as implying the loss of a clear sense of symbiotic striving. This is especially so in Africa's "theatres" of poverty and death arising from HIV/AIDS.

The Theory of Symbiotic Relationship

The second theory that is germane to our understanding of the phenomenon being described in this discourse is the theory of symbiotic relationship. In our context, this theory illuminates the symbiotic relationships among peoples in their family systems on the one hand and the close relationships that have developed among family systems found in African environments. Properly understood, this theory has emphasized the value of building African community mutual interest and interdependence in these days of chronic poverty and HIV/AIDS epidemic. The reality of our times demands that we do not castigate what some might call "over-dependence" when faced with the reality of death. Africa is in a quiet struggle to uphold what seemed to have worked well in our traditional communities but that is now being challenged by modernity and individualism. We are yet to accept whole-heartedly what others might promote as the values of individualism.

The consequence of upholding both theories is that Africa is at the threshold of confronting poverty and HIV/AIDS using what had worked for it in times past, and that is compassion, which unfortunately has now brought alongside sorrows. The way out is the application of intergenerational education programs in the area of effective and safe caring principles that are contextual and relevant.

The Context of Sub-Saharan Africa HIV/AIDS pandemic

UNAIDS (2003) indicated that by the end of 2000 data relating to the HIV/AIDS epidemic in Sub-Saharan Africa did not give much signs for comfort as the magnitude of the crisis remained substantially significant for many generations.

From Table 1, it would be observed that Botswana (33.8%), Zimbabwe (33.73%), Swaziland (33.44%) and Lesotho (31%) had the highest HIV/AIDS adult prevalence rates. On the contrary, Gabon, (4.16%), Congo Democratic Republic (4.90%), Uganda (5.00%) had the least HIV/AIDS adult prevalence rates in the selected Sub-Saharan African countries by 2002. However, by the year 2003 sub-Saharan Africa's HIV/AIDS epidemic had assumed such a grim picture that the BBC News of 04th March 2004 tagged the situation as "grim" when viewed against the background of the global spread and effects of HIV/AIDS.

In Table 2, you would observe that in 2003, between 25 and 28.2 million people were living with HIV in sub-Saharan Africa alone as against the figure of 1.3 million recorded for Latin America, 350,000-590,000 for the Caribbean, 1.2-1.8 million for Eastern Europe and Central Asia, 0.7-1.3 million for East Asia and Pacific and 4.6-8.2 million for South and South East Asia as indicated in the BBC News 2003 HIV/AIDS global report. In effect, whilst Sub-Saharan Africa harbored 61% of the world HIV cases with 2.2 -2.4 million deaths as at 2003, Latin America accounted for 4.1% of the total global HIV cases. Comparatively put, Australia and New Zealand accounted for 0.04% with less than 100 AIDS death in 2003.

Although the BBC News report was quite revealing, the 2003 Human Development Report has provided a close-up description of the situation of people living with HIV/AIDS in the

Table 1: Selected sub-Saharan African countries with > 4% HIV/AIDS adult prevalence

Country	*Adult Rate (%)*	*Adults & children*	*Adults(15-19)*	*Orphanscumulated*
1. Botswana	33.80	330,000	300,000	69,000
2. Zimbabwe	33.73	2,300,000	2,000,000	780,000
3. Swaziland	33.44	170,000	150,000	35,000
4. Lesotho	31.00	360,000	330,000	73,000
5. Namibia	22.50	230,000	200,000	47,000
6. South Africa	20.10	5,000,000	4,700,000	660,000
7. Kenya	15.01	2,500,000	2,300,000	890,000
8. Malawi	15.00	850,000	780,000	470,000
9. Mozambique	13.00	1,100,000	1,000,000	110,000
10. Central African Republic	12.90	250,000	220,000	110,000
11. Cameroon	11.83	920,000	860,000	210,000
12. Djibouti*	11.75	37,000	35,000	N/A
13. Cote d'Voire	9.65	770,000	690,000	420,000
14. Rwanda	8.88	500,000	430,000	260,000
15. Burundi	8.30	390,000	330,000	240,000
16. United Republic of Tanzania	7.83	1,500,000	1,300,000	810,000
17. Congo	7.15	110,000	99,000	78,000
18. Sierra Leone	7.00	170,000	150,000	42,000
19. Burkina Faso	6.50	440,000	380,000	270,000
20. Ethiopia	6.41	2,100,000	1,900,000	990.000
21. Togo	6.00	150,000	130,000	63,000
22. Nigeria	5.80	3,500,000	3,200,000	1,000,000
23. Angola	5.50	350,000	320,000	100,000
24. Uganda	5.00	600,000	510,000	880,000
25. Congo Democratic Republic	4.90	1,300,000	1,100,000	930,000
26. Gabon*	4.16	23,000	22,000	N/A
27. Haiti	6.10	250,000	240,000	200,00

*Data refer to end of 1999
NA = Not available
Source: UNAIDS, 2002

Table 2: Global Spread of HIV& AIDS

Regions	*People living with HIV*	*% of World's HIV cases**	*New Cases in 2003*	*AIDS Death in 2003*
Sub-Saharan Africa	25-28.2 million	61	3-3.4 million	2.2.-2.4 million
North Africa and Middle East	470,000-730,000	1.6	43,000-67,000	35,000-50,000
Latin America	1.3 million	4.1	120,000-180,000	49,000-70,000
Caribbean	350,000-590,000	1.3	45,000-80,000	30,000-50,000
North America	0.79-1.2 million	2.6	36,000-54,000	12,000-18,000
West Europe	520,000-680,000	1.5	30,000-40,000	2,600-37,000
Eastern Europe & Central Asia	1.2-1.8 million	3.9	180,000-280,000	23,000-37,000
East Asia & Pacific	0.7-1.3 million	2.8	150,000-270,000	32,000-58,000
South and South East Asia	4.6-8.2 million	17.8	0.61-1.1 million	330,000-590,000
Australia and New Zealand	12,000-18, 000	0.04	700-1,000	Less than 100

Source: Adapted from BBC News, http://news.bbc.co.uk/shared/sphl/hi/africa/03/aidsdebate/html,04/03/2004
*Approximately

High Human Development, Medium Human Development and Low Human Development ranks. Table 3 summarizes the situation.

In Table 3, it would be observed that whereas in 2001 just about 0.07% of adults aged between 15-49 were living with HIV/AIDS in Australia and 0.61 (United States), 0.31% (Canada), 0.10% (United Kingdom), 0.10% (Germany), 0.06% (New Zealand) and 0.20% (Singapore), the figure was 0.35% for Malaysia, 0.90% (Russian Federation), 0.65% (Brazil), 1.79% (Thailand), 0.10% (Sri-Lanka), 20.10% (South Africa), and 38.80%

Table 3: People Living with HIV/AIDS in selected high, medium and low human development countries

HDI Rank	*Adults (% age 15-49) 2001*[c]	*Women (age 15-49) 2001*[c]	*Children (age 0-14) 2001*[c]
High Human Development			
1. Australia	0.07	800	140
2. United States	0.61	180,000	10,000
3. Canada	0.31	14,000	<500
4. United Kingdom	0.10	7,400	550
5. Germany	0.10	8,100	550
6. New Zealand	0.06	180	<100
7. Singapore	0.20	860	<100
Medium Human Development			
1 Malaysia	0.35	11,000	770
2. Russian Federation	0.90	180,000	——
3. Brazil	0.65	220,000	13,000
4. Thailand	1.79	220,000	21,000
5. Sri Lanka	0.10	1,400	<100
6. South Africa	20.10	2,700,000	250,000
7. Botswana	38.80	170,000	28,000
Low Human Development			
1. Cameroon	11.83	500,000	69,000
2. Zimbabwe	33.73	1,200,000	240,000
3. Haiti	6.10	120,000	12,000
4. Nigeria	5.80	1,700,000	270,000
5. Tanzania	7.83	750,000	170,000
6. Zambia	21.52	590,000	150,000
7. Ethiopia	6.41	1,100,000	230,000

(Botswana). This latter group of nations comes under the Medium Human Development countries.

Among the selected Low Human Development nations, 11.83% adults aged between 15 and 49 years in Cameroon were living with HIV/AIDS in year 2001. The figure was 33.73% Zimbabwe, 6.10% (Haiti), 5.80% (Nigeria), 7.83% (Tanzania), 21.52% (Zambia) and 6.41% (Ethiopia). There is something peculiar about the prevalence of HIV/AIDS among African nations. For example, although South Africa and Botswana fall within the Medium Human Development rank, the number of people living with HIV/AIDS in 2001 was quite disturbing. In Table 3 above, as many as 2,700,000 women, aged 15-49 and 250,000 children in South Africa alone were said to be living with HIV/AIDS in 2001. In that same year, Botswana whose total population was just about 1.7 million featured about 38.80% adults aged between 15-49, 170,000 women and 28,000 children aged 0-14 living with HIV/AIDS. Again, among the Low Human Development nations, 33.73% adults, 1,200,000 women (aged 15-49) and 240,000 children (aged 0-14) were said to be living with HIV/AIDS in Zimbabwe. These figures should be quite disturbing considering the fact that medical science has yet to come up with any permanent cure for HIV/AIDS.

The devastating effects of HIV/AIDS in the areas of focus are very much indicated in healthy life expectancy at birth. Globally, the 2003 HDR opined that healthy life expectancy at birth ranged from a low 39 years in sub-Saharan Africa to 66 years in developed countries (UNDP, 2003, p.195). The 2003 HDR indicated that in addition to HIV/AIDS, other communicable diseases like malaria and tuberculosis have caused a significant loss of health and life in developing countries, especially in Africa. As at the year 2000, the healthy life expectancy at birth by region produced data reflected in Table 4.

Table 4: Healthy life expectancy at birth by region, 2000

Region	*Years*
Africa	41.4
Northern Africa	57.3
Sub-Saharan Africa	38.7
Asia[a]	55.5
Eastern Asia	60.9
South-Central	51.8
AsiaWestern Asia	50.8
Latin America & the Caribbean	58.0
Oceania[b]	49.6
Developing countries	53.6
Developed countries	66.1
World	56.0

a = this figure excludes Japan
b = this figure excludes Australia and New Zealand
Source: Adapted from HDR 2003 quoting WHO 2002.

In Table 4, it would be observed that healthy life expectancy at birth in the African region was 41.4 years as against 55.5 years recorded for Asia and 58.0 years for Latin America and the Caribbean and the 66.1 years indicated for developed countries. In fact, a closer look at the table would reveal that in real terms, the healthy life expectancy at birth in the year 2000 was 38.7 in sub-Saharan sub-region as against the global figure of 56.0 in that same year. The 2004 Human Development Report had identified among the root causes of this phenomenon the combined forces of HIV/AIDS and other communicable diseases such as malaria and tuberculosis. Nevertheless, scholars have attempted to delineate a possible link between poverty and HIV/AIDS in the area of focus.

The HIV/AIDS epidemic has taken a heavy toll on development in sub-Saharan Africa to say the least. The epidemic has been described as a unique disease that kills adults in the prime of their lives, thus robbing our nations of its most productive people (Squire, 2004). The HIV/AIDS epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities and rapidly and uncontrollably eroding the capacity of governments to avail Africans essential social services, even at a minimum level (Michiels, 2001, FAO, 2001 and UNDP, 2002). In addition to the other devastating effects of HIV/AIDS in Sub-Saharan Africa, it is of great interest to us to know that the epidemic has almost completely changed the demography and focus of intergenerational practice in the region.

The Changing Demography of Intergenerational Practice in Sub-Saharan Africa

It might be true that improvements in hygiene and water supply and control of infectious diseases during the 20th century have greatly reduced the risk of premature death and increased the number of older people world wide (Help Age International, 1999, p.2). It is also imagined that the so-called improvements in hygiene, water supply and control of infectious diseases would definitely boost the population of older people in sub-Saharan Africa. Indeed, Help Age International (1999, p.1) has constantly re-emphasized UN 2002 projections to the effect that there are about 42 million older people in Africa and that the figure would shoot to 205 million by 2050. That is good news to us, but it is one that must be welcomed with immense trepidation and doubts for obvious reasons.

Projections are not actual figures, and when it comes to sub-Saharan Africa with its well-known problem of prevailing inability to keep highly accurate population data, one has not many reasons to be so confident about the UN expectations. Much more seriously, the elderly persons in Sub-Saharan African, can no longer be said to be entirely protected from contracting HIV with its devastating effect as already pointed out above.

At the moment, research is lacking in the aspect of understanding the full impacts of the HIV/AIDS epidemic on older people. In the absence of such studies, no one can genuinely develop valuable programmes that will benefit older people

It is well known that data collected on HIV/AIDS prevalence in sub-Saharan Africa generally fail to include older persons beyond 49 years as if as soon as you turn 50 you are immured to HIV infection. Yet, the older people are the caregivers in our own case. Yet they are undermined in terms of education about HIV/AIDS, protection and support as if they do not matter.

The reality that faces sub-Saharan Africa is that between now and 2015, the set date for the realization of the Millennium Development Goal, the sub-continent will probably record the highest number of deaths in the middle generation, and this may be due to the high levels of HIV prevalence rates of between 25-30% among the 15-49 year olds (UN, 2000 and Help Age International, 2003). If that incident occurs, we may witness a critical change in intergenerational demography and practice in our region.

For the demographic critical change will definitely see us having a larger proportion of elderly persons and very young people beginning to form the critical mass that is left to embrace the full impacts of HIV/AIDS.

Already, the elderly persons in sub-Saharan Africa who form the important core of compassionate carers are feeling the full strains of the HIV/AIDS in so many ways. Some of these include the fact that the elderly persons:

1. Are left with little or no option but to nurse their children or grandchildren who have been “knocked” down by HIV.
2. Contend with economic hardships, as they

have to provide for themselves and their HIV sick adult children and orphaned children.

3. Have had their meager assets seriously depleted, as they have to fund the purchase of ARV drugs, treatments, funerals, food, shelter, clothing, school uniforms, fees and books for their orphaned grandchildren.
4. Many of them are dying form the process of mismanaging the wastes from their sick children and/or grandchildren.
5. Many of them are also dying from direct contact with HIV through sexual intercourse. It is wrong for anyone to believe that 50-year-old persons are no longer sexually active.
6. Like their adult children and grandchildren, HIV positive elderly persons are equally facing the strains of stigma and exclusion, and this is worsened by the fact that they are made invisible in existing data sets and denied access to information and treatment in some cases.

By far the most disturbing aspects of the changing demography of intergenerational practice in sub-Saharan Africa are the sharp increases in orphanage and then the dramatic dominance of compassion and sorrow in the support system dynamics. Let us examine both occurrences in brief.

Orphanage

Globally, by the end of 2003, the AIDS epidemic left behind an estimated 15 million orphans with 80% living in sub-Saharan Africa alone (AVERT, 2005). AVERT (2005) has made it known that the number of children orphaned by AIDS in sub-Saharan Africa by the end of 2003 stood at 12.3 million with an estimated 1.8 million orphans living in Nigeria, 650,000 in Kenya and 980,000 in Zimbabwe. These numbers will increase as the epidemic develops. This development alone has over-stretched Africa's deep-rooted kinship systems that are built around our traditional extended family networks.

UNAIDS estimated that 120,000 children in Botswana had lost their parent(s) to AIDS by the end of 2003 (AVERT, 2005, p.4). The situation remains so grim that the Botswana Guardian newspaper report of February 11, 2005 featured a headline screamer:

'AIDS bleeds Botswana'

According to the newspaper, HIV/AIDS was said to be hemorrhaging the economy as the epidemic alone is gulping P650 million out of the P1.11 billion appropriated development expenditure assigned to the Ministry of State President. The P650 million appropriated to the HIV/AIDS program represents about 60% of the entire allocation to that ministry and 13.4% of the P4.86 billion development budget. That of course means that other development areas must suffer as government makes good its promise to battle the HIV/AIDS scourge by way of giving a boost to the National Orphan Program that had been established in April 1999 in response to the urgent needs of children orphaned by AIDS.

By the end of 2003, UNAIDS estimated that Malawi had as many as 500,000 children orphaned by AIDS just as Zambia was said to be having its own share 630,000 AIDS orphaned children (AVERT, 2005, pp.4-11). So everywhere and anywhere you look, there are millions of people grieving over the deaths of their beloved ones and now the excruciating dilemma of caring for AIDS orphaned children. Either way, there are no quite pools. Compassion and sorrow has become the dominant feature of intergenerational practice in Sub-Saharan Africa.

Before now, our tested and resilient extended family systems and networks wherein aunties, uncles, cousins and grandparents have offered social safety nets for children orphaned by AIDS had stood the test of time. However, the social safety nets are at a breaking point. Things are falling apart and the centre can no longer hold as the famous African novelist, Chinua Achebe, had depicted in his work titled "Things Fall Apart". The United Nations Children's Fund (2003) has put the message much more vividly as follows:

'Almost throughout sub-Saharan Africa, there have been traditional systems in place to take care of children who lose their parents for various reasons. However, the onslaught of HIV slowly but surely erodes this good traditional practice by simply overloading its caring capacity by the sheer number of orphaned children needing support and care. HIV also undermines the caring capacity of families and communities by deepening poverty due to loss of labor and the high cost of medical treatment and funerals.'

That is the truth. However, the overloading of the caring capacity of our elderly has not made them to close their eyes and hearts to the pains being suffered by our children and grandchildren.

In fact, everyday the groaning of our dying children and grandchildren bellow out simply draw our elderly to the fact that they must embrace compassion and sorrow as the irreducible minimum of daily living.

Emerging Intergenerational Compassion and Sorrow

In sub-Saharan Africa, there are many grandparents who would rather take the place of their grandchildren at the "cross" of death by HIV/AIDS. This partly accounts for the love they show for the dying. This partly accounts also for the ignorance with which they manage the last days of their dying children. So then, even though our grandparents may not be counted among the sexually active segments of society in terms of contracting HIV via sexual intercourse, they have been paying the painful price of the failure of their young people to heed the clarion call for protected sexual intercourse. For many young ones, HIV/AIDS remains a myth they have not really comprehended and may yet comprehend because of cultural misunderstanding of the reality of the pervading destructive potentiality of the epidemic. The dimension that we now seek to briefly explore is seriously under studied and reported in academic meetings and journals. It could be that like it is with illiteracy, some pundits may be waiting out there to expound the position that "since the elderly may soon die, why worries about them?" It may sound unreal, but that is the situation thus far.

Out of compassion, our older men and women have become carers for their children and grandchildren who are "marked" down for death by HIV/AIDS. Cohen (2003, p.2) has made it be known that in Africa alone, it is estimated that there were some 8 million children who have lost either one, or both parents to HIV related illnesses. Of course, when that happens, the burden of caring for the orphaned children and grandchildren rests squarely on the elderly. For these elderly people in our societies, the burden of prolonged illnesses attached to HIV and then the consequent death rests squarely on their shoulders.

Culturally, the elderly have no choice in this matter of helping the dying and the orphaned children. They just have to learn to accept the impacts of HIV/AIDS and poverty on their own comfort and lives. The elderly are not just affected. They are sometimes infected, and have had to die out of no fault of theirs. In our context where illiteracy, ignorance and poverty abound in seriously scathing proportions, the multi-dimensional impacts of HIV/AIDS are better imagined.

Whether affected or infected, the realities of compassion and sorrow abound. The expressions on the lips of affected elderly persons bring out vividly their moods. For example, an older woman from Botswana who cares for her adult son suffering from AIDS had this to say:

"I cannot go to funerals or weddings, not even to church because I have to be with him all the time, or most of the time…I can't even go to the fields to plough."

(Help Age International, 1999, p.1).

Fleshman (2001) was reported by AVERT (2005, p.11) as having engaged one 70-year-old woman raising her 4 grandchildren in Zambia as having told researchers that:

"…ever since these children were brought to me I have been suffering. I am too old to look after them properly. I cannot cultivate…and the food does not last the whole year."

(AVERT, 2005, p.11).

That was a case where increasing ageing process is not considered an excuse for abandoning your traditional role of caring for your grandchildren.

In Zimbabwe, a 65-year-old man who is a carer for three school-aged children had this to say:

"Looking after orphans are like starting life all over again, because I have to work on the farm, clean the house, feed the children, buy school uniforms…I thought I would no longer do these things again. I am not sure if I have the energy to cope".

(The Namibian (2002) Older AIDS caregivers face stigma, allafrica.com, Dec.16, quoted in AVERT, 2005, p.11).

The substance of the three examples featured in these quotes is that grappling with the HIV/AIDS pandemic in sub-Saharan Africa leaves no one with a choice to make. Both the grannies and their grandchildren have to move beyond the traditional caring programmes built around African mores, customs and values into a practice forum of understanding a phenomenon that is almost over-whelming. That is HIV/AIDS.

Needed Learning Exchange Programmes

Whilst compassion and sorrow remain the

basic irreducible minimum in sub-Saharan Africa's intergenerational practice, practitioners should now begin to help in evolving learning exchange programmes aimed at promoting national and regional understanding. Such programmes might help in minimizing or reversing the impacts of HIV/AIDS on intergenerational relations. For we can only talk about robust intergenerational programmes and practices when people are alive. The learning exchange programmes intended in this context may be itemized as follows:

1. Promoting and funding research that should help us in appreciating the impacts on elderly persons of the HIV/AIDS epidemic in terms of the roles they play in the areas of care giving, economic and social support and violation of their rights as they are denied information and treatment of infected.
2. Requesting that academics become much more interested in including elderly persons when collecting data on HIV/AIDS prevalence in the region.
3. Focusing on elderly persons as a major group at risk, educators and caregivers for their sick and dying children and grandchildren and or orphaned children
4. The inclusion of the elderly and their grandchildren in strategies targeting HIV/AIDS communication development and dissemination.
5. Involving the elderly in generating culturally appropriate HIV/AIDS awareness campaigns for the young and the old.
6. The development of advocacy materials that include in a dominant way the impacts of HIV/AIDS on the elderly and why and how they should be reflected in public policies.
7. International collaboration in the development of culturally relevant and interesting HIV/AIDS prevention and care giving reading material that can be freely distributed in all the different language blocs in Sub-Saharan Africa.
8. The design of appropriate caregivers supports programmes that seek to protect the elderly as well as those that respond directly to their needs.

Those are just a few of the issues that learning exchange programmes must target. The arguments for empowering the elderly are profound but, as citizens, they have their won rights to information, good health care and support of all kinds. To neglect to provide for the elderly in sub-Saharan is to be disdainful of the contributions they make to social stability, economic growth and cultural transmission.

CONCLUSION

We have attempted to demonstrate in this paper the fact that in every society intergenerational relationship theories and practices are palpably influenced by phenomena that appear dominant. In this case, we focused on the HIV/AIDS epidemic that has compassed sub-Saharan Africa on all fronts. We alluded to the point in our context, there has been a change in the demography of intergenerational practices such that the duo of compassion and sorrow has become the irreducible minimum functions that all generations are almost compelled to understand, appreciate and embrace. In doing this, everyone is aware that, if need be, going to the cross of death is becoming inevitable. Everyone is equally aware that going to the cross of death may be delayed or completely averted and the social equilibrium sustained if only we can with stringent determinism promote the strategy of informing, communicating and educating our people with a specific purpose and using all available resources. The point remains: the elderly amongst us, as Africans, remain our most valuable assets and not liabilities. They must thus be so appreciated as agents of change.

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