

HIV and Aging in Rural Cameroon: Experiences of Adults Aged 70 Years and Older Living with HIV in Bafia “For Us Who Are Ill, Old Age Begins At Fifty!”

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ABSTRACT

Background: Rural areas present a unique context for aging. For those living with HIV, aging is a result of unexpected increased life expectancy due to access to antiretroviral treatments. While aging with HIV confronts individuals with multiple vulnerabilities, aging in a rural setting presents an additional challenge. The objective of this study was to analyze the experience of aging with HIV among elderly individuals living in rural Cameroon. **Methodology:** In-depth interviews were conducted with 14 elderly individuals recruited at the HIV Unit Care of the Bafia District Hospital between April 2022 and September 2023. Participants were individuals aged 70 and over living with HIV who consented to participate in the study. Data were collected using interview guides through individual interviews and focus group discussions. **Results:** Data analysis revealed that most older adults living with HIV (OA+) perceived aging with HIV in a rural setting as an immense privilege. Having survived the countless hardships associated with the HIV journey and having access to ART greatly contributed to this positive view. OA+ were well supported and cared for, and social interactions were maintained despite health problems related to physiological aging. However age-related health issues such as debilitating chronic illnesses did affect quality of life. **Conclusion:** Aging with HIV in rural areas was perceived a positive experience, despite some instances of stigmatization and rejection and limited access to healthcare. Therefore, it is incumbent upon public health actors to improve the quality of life of older adults living with HIV and, more broadly, of aging populations throughout Cameroon.

Keywords: Aging; HIV; Lived experience; rural environment; Cameroon.

“When this mandate comes to an end, you will be informed whether I remain here or return to the village.”

— Paul Biya, President of Cameroon

INTRODUCTION

In Cameroon, *returning to the village* is widely understood as the natural continuation of life after retirement. Writing in 1996, Gubry et al. described this movement as fundamentally rooted in economic and social logics, distinguishing between two forms of return migration: one anticipated and planned as part of the life course, the other imposed by circumstances and experienced as a consequence of social or economic failure (Gubry et al., 1996). The first pathway corresponds to a normative stage in the life cycle. Migrants who leave their home communities in search of employment or economic opportunity eventually return to their village of origin at the end of their working lives, having accumulated the necessary resources to fulfill the objectives that motivated their departure. Associated with stability and fulfillment, this vision was echoed by Cameroon's Head of State on 26 July 2022 when he referred to the village as his natural destination following the completion of his political

responsibilities. Several decades earlier, on 20 June 1987, President Paul Biya had already stated: “*Retirement is not a sanction; it is the normal culmination of a career devoted to serving the State. It corresponds to a legitimate aspiration for rest*” (Biya, 1987). Many Cameroonians therefore envision retirement as a period to be spent in their place of origin, surrounded by enduring family ties and embedded in familiar social environment. Returning to the village is often associated with the search for calm after years of urban labor, stress, and social pressures. Rural environments are perceived as offering a slower pace of life conducive to well-being, contemplation, and personal fulfillment. Walking through the countryside and engaging with familiar landscapes are commonly viewed as contributing to quality of life in later years (Gucher et al., 2007). Beyond material considerations, returning to the village carries profound symbolic significance. It represents a reconnection with ancestral lands, kinship networks, and the natural environment, while preparing for a peaceful death.

The second pathway corresponds to an unplanned return associated with social disruption or personal misfortune. Such returns may result from difficulties integrating into urban life or from life events that compromise one's ability to remain in the city, including widowhood, economic hardship, or severe illness—as in the case of HIV/AIDS epidemic.

In 2007, more than 75% of Cameroonians aged 60 years and over lived in rural areas, where they remained active in agricultural and pastoral livelihoods. This population experienced a high prevalence of chronic conditions as well as substantial levels of disability (76.3%) (Central Bureau of the Census and population Studies [CBCS], 2011). Older adults in rural Cameroon faced multiple vulnerabilities, including poverty, declining work capacity, heavy family responsibilities, weakening social support networks, tensions between tradition and modernity, and limited access to social protection and healthcare services (CBCS, 2011).

At the beginning of the 2000s, antiretroviral therapy (ART) was not yet widely available in Cameroon. Therefore, people living with HIV (PLHIV) regarded the diagnosis as a death sentence as HIV infection was often identified at advanced stages due to limited screening options. Many PLHIV with limited financial resources then chose to return to their villages to await death among family members. Yet some survived long enough to witness “miracle” of ART. Access to treatment unexpectedly extended their lives by years, sometimes decades. By decentralizing HIV care and ART distribution throughout the national territory, the Cameroonian health system created an unprecedented social reality: older adults living with HIV in rural settings. In 2001, Monnier and Pennec described this phenomenon as the “*aging of the dying*” (Monnier and Pennec, 2005). Today, however, in light of major therapeutic advances, Foureur and Volery's notion of “*extraordinary aging*” appears more appropriate. This concept refers to individuals who, because of a particular vulnerability, were once denied the opportunity to grow old but have nevertheless reached advanced age (Foureur and Volery, 2025).

The introduction of ART triple therapy in Cameroon—and its subsequent provision free of charge—dramatically reduced HIV-related mortality. For nearly two decades, more than one-quarter of people living with HIV in the country have been aged 50 years and older (National Aids Control Committee [NACC], 2023). Nevertheless, their health trajectories continue to require careful attention. Alongside HIV-related challenges, aging individuals experience age-associated comorbidities, geriatric syndromes such as falls, incontinence and cognitive impairment, long-term polypharmacy, and the psychosocial burden of living with HIV over time. Aging is accompanied by increasing physical, cognitive, and sensory limitations, as well as growing dependency in everyday activities. These challenges are often compounded by HIV-related stigma, ageism, social isolation, family abandonment, and the absence of comprehensive social protection. In rural settings, the hardships associated with aging are further intensified by limited infrastructure and restricted access to services, affecting mental, social, and physical well-being (Kohli et al., 2006; Iwuji et al., 2013).

While some HIV survivors eventually returned to urban areas to reclaim access to urban amenities and opportunities, others chose to remain in rural communities. For these individuals, extended survival required a profound reorganization of life projects and aspirations. They continued the existential work initiated by the HIV diagnosis experience while simultaneously constructing new futures. But what kind of life becomes possible after one has already prepared for death? This question lay at the heart of the Sidaction-funded research program *Advanced Age and HIV: An Anthropology of Aging and Illness in Cameroon and Senegal*. The project sought to examine how adults aged 70 years and older living with HIV in rural settings perceived their quality of life and

their experience of aging. The present article explores these experiences and analyses how older adults living with HIV understand and negotiate aging in rural Cameroon.

METHODOLOGY

Study Design and Setting

This exploratory anthropological study was conducted at the HIV Care Unit of the District Hospital of Bafia. Bafia is a French-speaking semi-rural town located in Cameroon's Centre Region, at approximately 127 kilometers from Yaounde, the national capital. It is the third largest township in the Centre Region (most populous region) and encompasses the urban area and the surrounding villages that are administratively dependent on the township. In 2005, its population was estimated at 72,717 inhabitants (CBCS, 2011). It is a cosmopolitan population made up of rural and urban dwellers. The HIV prevalence rate is between 4.6 and 5.3% (NAAC, 2026). Data collection took place between April 2022 and September 2023.

Participant Recruitment

The study focused on older adults living with HIV aged 70 years and above who were receiving HIV care at the facility. 14 participants attended in-depth interviews and 13 participated to focus group discussions (FGD). Detailed characteristics are presented in Table 1. Participants were required to be fluent French speakers, be physically fit to undergo the interview and willing to participate in the research. All participants were on ART and compliant.

Table 1. In-depth interview participants characteristics.

Participant ID	Sex	Age (years)	Marital status	Highest education level	Employment status
EIA-01	Female	70	Widow	Primary school	Active/Farmer
EIA-02	Female	72	Widow	Secondary school	Retired
EIA-03	Female	70	Divorced	Secondary school	Retired
EIA-04	Female	71	Widow	Secondary school	Active/Farmer
EIA-05	Male	72	Polygamous marriage	Secondary school	Active/Farmer
EIA-06	Female	70	Widow	Primary school	Retired
EIA-07	Male	80	Divorced	Primary school	Retired
EIA-08	Female	79	Widow	Secondary school	Retired
EIA-09	Male	70	Married	Primary school	Retired
EIA-10	Female	71	Divorced	Primary school	Retired
EIA-11	Female	72	Widow	Primary school	Retired
EIA-12	Male	73	Married	Secondary school	Retired
EIA-13	Female	71	Married	Secondary school	Active/Farmer
EIA-14	Female	72	Married	Secondary school	Retired

Informants were recruited through convenience sampling during routine clinical visits for HIV follow-up and ART refills. Given the low daily attendance at the HIV Care Unit, individuals meeting the inclusion criteria were underrepresented and accounted for a small proportion of patients in care. To facilitate group discussions and achieve thematic saturation, appointments were negotiated by the psychosocial counsellor of the *VIHeillir* Project via phone call to inform patients about the study and ask if they would be interested in participating. In case of a positive answer, appointments were scheduled. This strategy enabled the research team to engage a sufficient number of participants and to capture a diversity of experiences among older adults living with HIV.

Data Collection

The entire investigation team was female (two investigators: one senior anthropologist (author #1) and one physician (author #2), 2 research assistants (author #2 and author #3) who are public health physicians), all trained in qualitative research methods. To ensure study's credibility, trustworthiness and ethical rigor, the entire research and writing (author #1, author #2, author #4, author #3) team was involved in the reflection throughout the data collection and analysis processes by keeping reflexive journals. There was no prior interaction between the team and the informants before the start of the study.

Individual interviews were conducted by authors #2, #3 and #5, and the focus group discussions (FGD) by author #1. The average duration of individual interviews was 30 minutes, while that of FGD was 63 minutes.

Two interview guides, developed from a common analytical framework, were designed to explore participants' experiences of aging, illness, social relationships, healthcare trajectories, and perceptions of quality of life. Prior to fieldwork, the guides were pre-tested with elderly people aged 70 and over part of the *VIHeillir* cohort receiving care at the Military Hospital of Yaounde and residing in peri-urban areas. This pilot phase allowed the research team to refine the wording, relevance, and sequencing of interview questions.

Participation was conditional upon the prior reading of an information sheet and the provision of formal oral informed consent.

Interviews were conducted within the hospital setting, which participants perceived as a familiar, safe, and confidential environment. Interviews took place in quiet and secluded locations to ensure privacy and facilitate open discussion.

Data Processing and Analysis

Data analysis followed all 5 steps of COREQ (COnsolidated criteria for REporting Qualitative research) guidelines. All interviews were audio-recorded and recordings were transcribed verbatim without selective omission of material by authors #2 and #3. The resulting corpus was preserved in full textual form for analysis. Rurality was not initially a research objective. It emerged through the systematic analysis of the content as a dependent variable in the experience of aging. A hypothesis was then formulated, and this contribution therefore constitutes an analysis of the experience of the rurality experience among older PLHIV in Bafia, Cameroon. Data were analyzed using a thematic approach inspired by interpretive traditions in medical anthropology (authors #1 and #2). The analysis focused on participants' narratives, meanings, and representations of aging with HIV in rural context.

Through iterative reading and transcripts 'coding, recurring themes and patterns were identified and organized into broader analytical categories. Particular attention was paid to participants' experiences of illness, survival, social belonging, and mortality were articulated and understood. At the end, manuscript was then translated from French to English.

Quantitative data were entered and analyzed using SPSS version 20.0. Continuous variables were described using means and standard deviations, while categorical variables were presented as frequencies.

Ethical Considerations

The study has received approval from the National Committee for Human Health Research and administrative authorization have been gathered from the Bafia District Hospital. The protocol adhered to ethical principles governing qualitative health research. Participation was voluntary, informed oral consent was obtained from all participants, and confidentiality was maintained throughout the research process. Interviews were conducted in conditions designed to respect participants' dignity, privacy, and emotional well-being.

FINDINGS

A total of fourteen key informants were included in the study. Participants had a mean age of 72.4 (± 3.1) years, and the sex ratio was 0.52. Most women were living alone (6/10), whereas most men were living with a partner (3/4).

Perception of Aging: Aging with HIV as a Perceived Privilege

Despite visible signs of physical decline, participants described both aging and the prospect of death in positive terms. Their narratives emphasized resilience, adaptation, and the capacity to derive meaning from life after surviving HIV.

A Positive Representation of Advanced Age

Participants frequently portrayed old age as a period of deserved rest following a lifetime of labor and hardship.

"Growing old means first of all advancing in age. When you are not burdened by illness or problems, then you can truly enjoy a well-deserved rest." EIA-09

Participants repeatedly referred to the adversities they had overcome throughout their lives. Surviving these hardships contributed greatly to the positive view they had of aging.

"I used to be afraid. Now I am no longer afraid. I never imagined I would live to this age." EIA-02

For many participants, longevity was not perceived as an entitlement but rather as a gift.

"I believe growing old is an achievement. Seeing your children and grandchildren grow up is an achievement. Aging is not a punishment, nor a sanction. It is a deserved rest. I would even advise young people to organize their lives so that they may grow old." EIA-07

Respect, Authority, and the Social Value of Eldership

The respectful treatment afforded to older adults was unanimously described as one of the most rewarding aspects of aging. Participants associated advanced age with increased social recognition, authority, and symbolic prestige within their families and communities.

"Whenever there is an event in my family, they wait for me to speak first. I still have that role. My mother is gone, my brothers are gone, and now I am the one who remains. Whether it is a celebration or a family gathering, people say: 'Wait for Mama; she will come and open the buffet, or lead the prayer.'" EIA-03

Participants further described aging as a process through which valuable personal qualities emerge. Experience, wisdom, and discernment were frequently cited as benefits of advanced age.

"When you are young, all you have is your youth (...). Aging brings maturity in the way one thinks." EIA-12

Yet even within these positive representations, participants acknowledged that physical decline limited their ability to fully enjoy old age.

"The disadvantage of aging is weakness, nothing but weakness. You simply become weaker and weaker. As I told you, weakness in every sense. I have younger wives, but I myself can no longer stand up easily." EIA-05

Living with Finitude

Respondents consistently associated aging with declining physical capacity and increasing proximity to death.

"For us who are ill, old age begins at fifty! You sit there asking someone to hand you something, and the child says no. You are unable to stand up and get it yourself. You complain, then you remain silent. Nothing to report. That is what we call old age." EIA-01

They confronted the realities of frailty and mortality with striking lucidity. Rather than expressing overwhelming fear, they described approaching death with humility and dignity. Memories of advanced HIV disease before the availability of antiretroviral therapy reinforced their sense of gratitude for the years they had gained. This serenity toward death was closely linked to practical and moral preparations for the end of life.

"I do not know whether I will see tomorrow. Every day that passes feels like a victory. I do not know if I will see the next day. When I wake up in the morning, the first thing I do is pray and thank God for giving me another day." EIA-09

"I had already done my part. When my husband died, there was not much to leave behind. The few houses we owned, I had already divided among my children and told each one what would belong to them. (...) Since I am still alive, people continue to rent the houses. The rent helps me buy my medicines and cover my expenses. When I die, each child will simply take possession of their share." EIA-08

Some informants even expressed a preference for death over a future marked by severe dependency and loss of dignity.

"Aging is something we must accept because we cannot choose when to die, nor can we choose how long we will live. Only God knows that. But living for too long becomes strange. (...) When someone reaches ninety-five or one hundred years old, even they no longer feel useful. It is good to grow old, but not excessively old." EIA-12

Experiencing aging in rural settings: Sociality, Stigma

Informants described village life as the most suitable environment in which to grow old. Their words highlighted the importance of social belonging, sense of familiarity and access to land. At the same time, narratives revealed tensions regarding confidentiality, HIV-related stigma, and the limited health services' accessibility.

The Village as a Space of Belonging

Most participants expressed a strong attachment to their village and viewed it as their rightful place in old age. The village represented not only a geographical location but also a social and moral environment where identity, kinship, and memory were deeply rooted.

"The village is my home. Even if I were given money to leave, I would not go. Everything I know is here." EIA-10

"When you grow old, you need to be among your own people. In the city, people do not even know their neighbors. Here, everyone knows who you are." EIA-12

They frequently contrasted village life with urban life, as it was described as calmer, more relational, and more compatible with the rhythms of old age.

"In town, everyone is running after something. Here, life is quieter. You can sit with people, talk, and rest." EIA-10

Easy access to basic necessities emerged as a central dimension of well-being in rural life. Nearly all respondents cultivated crops or relied on family land for subsistence.

“As long as I can still go to the farm, I know I am alive.” EIA-04

“I’m in my wife’s village. When I came back, I followed her here to Kiki, where she was born. Here, we don’t rent. Even in my village, my father left me a house. It’s better than in the city where you’re forced to rent. And then there’s land, you can grow cassava when you don’t have anything else yet.” EIA-12

Indeed, some informants had chosen to return to their village to improve their circumstances.

“I was in Yaounde. When I lost my husband, I went to stay in Yaounde. I sold small things there. Then, my children died while I was still in Yaounde, and I decided to come back here to Bafia. I’m here in Bafia with the other two.” EIA-06

“When my husband was working, we used to change places. But when he retired, we moved back home because I have a small field here. I don’t buy everything at the market, I get the cassava from the field. It’s easy for me here.” EIA-13

Social Relationships and Family Support

Unmarried informants generally lived alone or with their grandchildren. Children usually lived in the city.

“I am alone in the village. The children come from time to time.” EIA-07

“My husband is dead; I don’t have a husband. I rent out my house with the children. I’m with my grandsons in my house. There are seven of them.” EIA-01

Married individuals, on the other hand, were living with their spouse and sometimes or with unemployed children and grandchildren which could be a financial burden.

“I have children who don’t work at home. There are three of them who don’t work, and the grandsons. They manage, they help me in the fields, they manage.” EIA-13

Some informants were facing a precarious financial situation due to an inability to continue to carry out an income-generating activity.

“I have nothing to do now since I’m sick. I used to sell things. Because with my market there, it still gave me the strength to get up. Since I’ve been sick. I feel awful. My eyes aren’t well.” EIA-06

Others, who had worked in the civil service, were receiving a retirement pension and were less vulnerable.

“I don’t even raise livestock anymore. When I was assigned here, I stopped. Even here in Bafia, I had pigs and chickens, but then I stopped. I don’t do anything anymore. I receive my retirement pension.” EIA-09

Family then constituted a major source of emotional, financial and material support. Children, grandchildren, and community members frequently assisted participants.

“The children give me a little money. Like the other day, my sister’s son, who’s a police commissioner in Bamenda, sent me 5,000. When he sends me money like that, I pay something to get home. To eat.” EIA-06

“My children take care of me. When I have an appointment at the hospital, they make sure I come.” EIA-10

“If I need help, there is always someone nearby. That is one advantage of village life.” EIA-12

Social life was maintained and strongly involved places of worship.

"For example, I'm with the CWA (Christian Women's Association), and I do that. I often take on responsibilities, and I'm often given responsibilities. And then I go to meetings wherever they're held. I attend every meeting." EIA-03

"I was a catechist; I'm the one stepping down because I've gotten older. I was a catechist even here in Bafia, in my parish, I was a catechist, I stopped because I've gotten older." EIA-09

But could sometimes be weak due to precarity, HIV-related stigma, neighborhood conflicts or ageist behaviors.

"Wandering around! Except for the fact that my older brother's son is over there in the neighborhood. If I hear something's going on, I'll just go see him. That's all. I don't wander around. It's rare. Because here in Bafia, if you start hanging out, people will say you've come begging for food. I'm better off staying home." EIA-06

"I told you that rejection, I didn't feel it in my family. It was the outsiders, yes, who withdrew, who avoided me. They were fingering me. I was being fingered." EIA-04

"I have no friends where I am. Now they call me 'the bad mother,' 'the bad mother there,' when it's them who made me bad." EIA-02

"You know, in the village, once someone reaches a certain age, everyone backs away. They think you're a sorcerer." EIA-07

The Persistence of HIV-Related Stigma

Despite generally positive accounts of rural life, HIV-related stigma remained a significant concern. Participants recalled the intense fear surrounding HIV during the early years of the epidemic and noted that some discriminatory attitudes persisted within communities. Although many believed that HIV had become *"a disease like any other"* disclosure of serostatus remained a highly sensitive issue.

"People say things have changed, but not everyone thinks the same way." EIA-02

"I will be honest with you. My husband's older children help me a lot. If they found out, they might send me away." EIA-13

Many participants restricted disclosure to close family members, particularly children.

"Nobody in my family knows that I am ill except my children. All my children know, but no one else. They are the ones who usually bring me to the hospital. They were there when my husband died. You understand that if my son-in-law knows, he may tell others. For me, it would be the end. Only my children know. Even my brothers and sisters do not know." EIA-11

Rural communities were characterized by dense social networks and intense circulation of information. While these close-knit relationships could foster solidarity, they could also undermine confidentiality. Several participants reported that their HIV status became known without their consent.

"I told only one person, and before long the whole village knew." EIA-11

"I came to the hospital, opened my file, and they started counselling me. When I got home, I called my sister to confide in her, and she told me that the news was already everywhere. (...) I thought, 'How is that possible? There were only two of us who knew!' Young people are often the ones who stigmatize. That is just how it is." EIA-04

For some, secrecy functioned as a protective strategy against potential discrimination and rejection.

"If everyone knew, some people might no longer treat me the same way." EIA-06

Not all participants sought secrecy. Some responded by choosing proactive disclosure and engaged in community awareness activities.

"I give testimony openly. When young people see me, they realize that HIV is not the end of life." EIA-10

Aging with HIV in rural settings: A Life course Redirected

For many participants, the HIV-positive status' discovery represented a profound rupture in their life trajectories. For others, however, despite the initial shock it had little lasting impact on their everyday existence.

HIV Testing and Circumstances of Diagnosis

Pathways to HIV testing differed markedly among participants. Most commonly, diagnosis occurred during episodes of severe illness. Frequently reported symptoms included recurrent fever, malaria-like illnesses, chronic diarrhea and vomiting, persistent fatigue, weight loss, and skin eruptions.

"I was constantly falling ill, every three months. I would treat myself a little and think it was malaria, fever, or something else. I kept getting sick. My health was no longer what it used to be. I was never truly well anymore. Every three months, I was ill." EIA-02

For others, testing was the result of a deliberate and carefully considered decision.

"Nobody sent me for testing. My daughter took me from one hospital to another. When this illness began, I became weak—malaria, heart problems, all sorts of things. They performed scans and examinations, but nobody ever told me to take an HIV test. Then one day, while watching television, I began reflecting. I felt that something was wrong with my body. I told myself that I should look into this matter because I had travelled a great deal in my younger years [alluding to sex work]. [...] At that time, medicine was not as advanced, and people were not routinely tested. I had travelled extensively. So when I started feeling that something was wrong with my body, I went to the hospital myself and asked them to test me for HIV." EIA-10

The illness or death of a spouse also prompted HIV testing for several participants.

"I became infected through the father of my children. He was hospitalized here and died here sixteen years ago. I was the one caring for him. When I realized that he was infected, I simply told myself, 'Go and get tested.' I went for the test, and it came back positive." EIA-04

Reactions to Diagnosis

Although participants had long since moved beyond this difficult stage, retrospective accounts revealed the profound anguish associated with learning one's HIV-positive status. Certain words recurred repeatedly throughout the interviews: *crying, pain, fear, finished, shock, trauma, and a pierced brain*. This vocabulary reflected a pervasive sense of condemnation and imminent death.

"I told my child, 'Before this disease kills me, I will kill myself first.' They tied me to the bed. People started talking to me, but I could not understand anything." EIA-07

For most participants, this initial period of despair was followed by a process of resilience and adaptation that enabled them to continue living with the disease.

"What else could I do? Once something has happened, you endure it. I kept wondering how it would all end. This disease troubled me greatly." EIA-02

Only one respondent explicitly described an experience of denial, a reaction commonly identified in the literature on health-related loss and grief.

"It did not affect me very much because I was not actually sick. It did not trouble me. I went home laughing and told my children: 'How can they say someone is ill when I do not feel anything wrong with me?' I never spent time wondering where it came from or why it happened. I was not afraid." EIA-09

For some, feelings of guilt persisted despite the passage of many years and affected quality of life.

"If I had used condoms, I probably would not have become infected. But sometimes people tell you not to bother, and you listen. You never really know who is who or what someone may do. Then you find yourself in this situation. I still do not know exactly where it came from. I tell myself that I am a victim, and I live with it." EIA-10

Access to Care and Therapeutic Pluralism

As HIV became a chronic condition, regular engagement with healthcare services became an essential component of daily life. Informants reported satisfactory access to the integrated package of HIV-related services available through the HIV Care Unit in Bafia.

"Emilie has been following me here since 2007, right up to today. I attend all my appointments. Whenever tests are needed, I am there. Unless I am not informed, I never miss them." EIA-03

Beyond the quality of care itself, participants repeatedly expressed gratitude for the political commitment that had made ART accessible to all citizens, regardless of place of residence.

"One day I suddenly heard that treatment had become free. Thank God! Thanks to our Head of State!" EIA-11

All participants reported substantial improvements in their quality of life following the introduction and subsequent free provision of ART. Their principal concerns were no longer related to HIV itself but rather to the physical challenges associated with aging.

"At first, when I was diagnosed, it had a huge impact on my life. I felt frustrated, ashamed of myself. So I had to pull myself together, rise above it. Now, it doesn't bother me at all. And I'm doing well! I don't have any minor ailments. Right now, it's the blood pressure that's bothering me." EIA-02

"The last time I came, they told me I was diagnosed with diabetes. I cried so much, I asked what I had done to God; if I had killed Jesus. I have all these illnesses; I come here and take a pill every day for how many years? And I still have to take the other pill for diabetes." EIA-03

"Fatigue, earache, eye strain, body aches. That's what's bothering me today." EIA-01

Participants nevertheless expressed concerns regarding the necessity to bring HIV center treatments and health facilities closer to the population to accommodate their weakened financial capabilities and facilitate access regarding geriatric needs.

"When I left the hospital, I told my child I didn't want to stay in the city anymore, I had to go back to the village. (...) I asked to come here to Bafia. They told me there was a center here in Bafia since there wasn't one in Bokito. So that's why I came here; they welcomed me. I started taking my medication here at UPEC." EIA-07

"Perhaps if specialists came here from time to time to inform us about the illnesses we have, instead of having to go to the hospital in Yaoundé" EIA-04

Indeed, engagement with biomedical services was hampered by geographical and financial obstacles.

"In the village, everything is lacking. In the city, you can find medicine and healthcare more easily than in the village. You have to travel for miles." EIA-12

"When my daughter brought me for three days, It was 150,000 francs CFA (€263\$). My case required 300,000 francs CFA (€266\$) in six days. She told me, "Mama, let's go home, my pocket is already empty. I'm going to run out of money even for the bus to Douala." We found a solution, but I said no, I'm leaving. I'll sign, I'll call, here's my number, I'm working, I'll make money, I'll come." EIA-01

Scarcity of geriatric specialties was also another reason of health facilities' low attendance and of the poor health of the elderly.

"The cardiologist comes twice a month. Every two weeks, that's what we were told here." EIA-02

These difficulties led informants to resort to alternative therapeutic systems.

"When I'm sick, I look for my herbs, I go home, I get it in the pot, I heat it up and, I wash myself." EIA-04

This therapeutic pluralism sometimes extended to HIV treatment itself.

"Western medicine adapts people to the disease, but it does not cure it; it only controls it. Our ancestors left remedies behind. We have to follow those too. These medicines are good and free, but they do not make the disease disappear. Do you understand?" EIA-01

DISCUSSION

Accomplished aging can be understood as a posture of personal fulfilment grounded in a positive vision of later life and the end-of-life course (Fernandez and Toullier, 2010). It rests upon the wisdom accumulated through lived experience and the inner harmony that emerges from self-acceptance, a sense of belonging to a social community, and the perceived duty to transmit acquired knowledge as a final contribution in the work of preparing for death. This notion differs from the more proactive concept of *successful aging*, which refers to the process through which individuals maintain good physical, mental, and social functioning, enabling them to remain autonomous, active, and fulfilled through healthy lifestyles, personal choices, social support, and the prevention of age-related diseases (Rowe and Kahn, 1997).

The older adults living with HIV in Bafia tended to represent their old age through narratives of grace, fulfilment, and wisdom. Although affected by age-related health conditions and constrained by limited access to basic services, their experience of aging was shaped by self-acceptance, the availability of ART, the nutritional and spiritual autonomy afforded by rural life, and the emotional security provided by strong community ties.

The anthropological investigation conducted at Bafia District Hospital revealed an overwhelmingly positive experience of aging in a rural environment. These findings support the long-standing aspiration among many Cameroonian workers to return to their village after retirement, viewing this transition as the natural continuation of life following the first active phase of adulthood. According to the most recent national census conducted in 2005, Cameroon counted 1,067,336 adults aged 60 years and older (5.5% of the population), of whom 77.2% resided in rural areas (CBCS, 2011). Among return migrants, two broad profiles may be distinguished. Some seek what President Paul Biya once described as a "legitimate rest" following years of employment, whereas others return to their native communities to embark upon a second active life, often through political engagement or civic participation. In Cameroon, retirement from formal employment frequently serves as a gateway to local leadership, political involvement, or community service, thereby constituting a meaningful pathway toward accomplished aging by protecting older adults from boredom and social isolation.

At the outset of this study, we hypothesized that aging with HIV in a rural setting would largely reflect an economically constrained return migration resulting from a disrupted life trajectory (Gubry et al., 1996). Existing literature suggested that the hardships of rural living, coupled with HIV-related stigma and agism, would negatively affect the quality of life of older adults living with HIV. Their return to the village was initially conceptualized as the consequence of a failed urban trajectory and the loss of their primary form of capital: health. In this perspective, rural aging with HIV was expected to be characterized by anxiety surrounding impending death, severe community stigma, and limited access to essential services. The findings, however,

challenged these assumptions. Rather than a narrative of decline and despair, participants described a stage of life marked by serenity, awareness, and acceptance, despite the physical challenges associated with advanced age.

To have grown old with HIV in Cameroon is to have lived through three distinct historical moments: first, the experience of HIV as a virtual death sentence; second, the introduction of subsidized antiretroviral treatment in major urban centers beginning in 2004; and third, the decentralization and free provision of ART across the national territory from 2007 onwards. These successive transformations profoundly shaped participants' perceptions of both illness and aging. Having once anticipated an imminent death, participants felt they had received years of life that they never expected to experience. The nationwide decentralization of HIV care, extending services to peripheral health facilities, dramatically improved access to treatment. Between 2018 and 2023, the number of HIV treatment units increased from 848 to 2,870 facilities nationwide, contributing substantially to universal ART coverage (NACC, 2023). Because they had personally experienced advanced HIV disease and the expectation of death, participants expressed a remarkable degree of gratitude toward the Cameroonian healthcare system. Such expressions of appreciation are noteworthy, particularly in a context where policies of free healthcare are often met with suspicion and conspiracy narratives that can undermine public trust and reduce policy effectiveness (Ridde and Queuille, 2016; Meessen et al., 2011). The testimonies collected in Bafia suggest that such skepticism is less likely to emerge among populations who have directly experienced the life-saving impact of these interventions.

Participants remained acutely aware of the relationship between public health policy and their own survival. Having endured the anxiety of anticipated death, opportunistic infections, physical suffering, social exclusion, and the burden placed upon family caregivers, they embraced ART as a tangible and meaningful intervention. While free access to ART has now become normalized after nearly two decades of implementation, participants continued to view it as an extraordinary political achievement rather than a self-evident entitlement. Their narratives serve as an important reminder that universal access to treatment is not an inevitable reality but the result of deliberate political choices. Participants vividly remembered the early years of treatment, the availability of drugs such as AZT and d4T, the introduction of combination therapies, and more recently the widespread deployment of Dolutegravir-based regimens. For them, these developments represented successive moments of hope that transformed HIV from a fatal condition into a manageable chronic disease. This positive perception was reinforced by the expansion of HIV care units and the integration of psychosocial support services. Although participants acknowledged that further improvements remain necessary to ensure equitable and comfortable access to care in rural settings, they consistently described HIV services as a profound source of relief following years of uncertainty and fear. Their accounts illustrate how aging with HIV has evolved from an experience of extraordinary survival to one of accomplished aging, characterized by gratitude, wisdom, and the reinvention of self after confronting mortality.

Contrary to our initial expectations, most participants expressed a highly positive perception of growing old with HIV in the village. Across much of Africa, and particularly in Cameroon, the village remains associated with tradition, family solidarity, and strong social cohesion (Dubiez, 2006). It is therefore often imagined as a secure and fulfilling environment for later life, in contrast to urban settings characterized by constant movement, social fragmentation, and increasing incompatibility with the rhythms of old age (Jaillet et al.; 1997). The prevalence of return migration at the end of professional life can thus be understood as a return to one's origins and social foundations (Nkoma, 2021). Participants consistently described the village as a place of rest, familiarity, and belonging. Previous research on migration in southern Cameroon similarly demonstrated that rural return migration rarely reflects a desire for permanent relocation elsewhere; rather, migrants maintain emotional, social, and economic ties to their home communities throughout their lives (Dubiez, 2006). The village therefore fulfils a fundamental need for identity and belonging that appears central to aging well. This observation resonates with Bertrand Quentin's conception of accomplished aging, which emphasizes the acceptance and accompaniment of life's vulnerabilities rather than their denial (Quentin, 2025).

Following Quentin's perspective, aging with HIV in rural Cameroon may be interpreted as a transition from *extraordinary aging* to *accomplished aging*. This perspective rejects ableist assumptions that equate human worth with autonomy and performance. Rather than seeking to erase vulnerability through technical solutions

alone, accomplished ageing invites individuals and communities to inhabit vulnerability and recognize it as a shared human condition. According to Quentin, accomplished aging is not the absence of frailty but the presence of supportive relationships that enable individuals to live meaningfully despite it. Vulnerability becomes a mirror reflecting our common humanity, while dignity remains intact regardless of functional dependence (Quentin, 2025).

Participants' narratives strongly support this interpretation. Respect, precedence, and social veneration emerged as some of the most valued aspects of advanced age. Even when dependent upon others, participants felt recognized for their life experience and social contributions. Such forms of recognition protected them against one of the most damaging experiences associated with aging: social invisibility.

By continuing to involve older adults in family decision-making processes, ceremonial activities, and community events, village communities reaffirmed their social significance. This recognition appears particularly important at a time when social isolation among older adults is increasing globally. Indeed, the World Health Organization identified loneliness and social isolation as an urgent public health concern in 2023 (World Health Organization (WHO), 2023).

Participants' acceptance of aging was also shaped by their awareness of human finitude. Having survived numerous hardships and confronted mortality directly, they recognized the limits imposed by time, illness, and human knowledge. Although such limitations can generate anxiety, they also foster humility, wisdom, and reconciliation with oneself (De Leo, 2024).

Many participants appeared to embody what contemporary psychology describes as *mindfulness*: an intentional, non-judgmental awareness of the present moment that cultivates resilience and well-being (Fiocco and Mallya, 2015). Their accounts closely resembled the philosophy of happiness described by Frédéric Lenoir, which emphasizes five interconnected dimensions: living in the present, practicing gratitude, cultivating meaningful relationships, reconnecting through contemplation or nature, and choosing love over fear (Lenoir, 2010).

Indeed, most participants described a peaceful relationship with death, despite occasional concerns regarding divine judgment. Aging confronts individuals with successive losses which inevitably bring awareness of mortality (Abende, 2024). Yet participants generally reported feeling prepared for death rather than fearing it.

Their narratives resonate with classical descriptions of aging in Africa, where elders are often expected to die peacefully and with dignity after having fulfilled their earthly responsibilities (Abende, 2024). This serenity appeared rooted in a sense of life accomplishment, the desire to preserve dignity, and a reluctance to become a burden to relatives. Spirituality, communion with ancestors, connection to the natural environment, and family support further reinforced this sense of peace.

Economic factors also contributed significantly to quality of life. Participants generally lived in their own homes and retained access to agricultural land. Compared with urban environments, rural settings offered greater opportunities to meet basic physiological and security needs at lower cost (Nkoma, 2021). Financial, material, and emotional support from relatives constituted another major source of well-being (Pinghane, 2011).

Nevertheless, the principal obstacle to aging well with HIV in rural Cameroon remained limited access to basic services, particularly healthcare. Participants appreciated the privilege of reaching old age in a country where life expectancy at birth was only 58.4 years in 2005 (CBCS, 2011), yet they lamented declining physical strength and increasing frailty. Previous research conducted in Cameroon reported that older adults living in rural areas frequently face multiple comorbidities, economic vulnerability, family burdens, and weakening support networks (Ouedraogo, 2007). Rural communities are increasingly affected by demographic and social transformations, including youth migration and the diffusion of more individualistic values, both of which may reduce traditional forms of support (Ouedraogo, 2007).

Moreover, dense social networks often leave little room for privacy. Confidential information, including HIV status, may circulate rapidly, exposing individuals to stigma and potentially affecting treatment adherence. Poor

adherence has already been linked in Cameroon to the earlier onset of comorbidities such as hypertension, renal disease, and cognitive impairment (Kohli et al., 2006; High et al., 2012).

In the absence of comprehensive geriatric services, participants frequently combined biomedical care with other therapeutic resources, including traditional medicine and spiritual practices. Similar patterns have been documented in Gabon, where therapeutic pluralism among older adults is motivated by healthcare costs, geographical barriers, and the desire to reconnect with cultural and environmental traditions (Yaba et al., 2013).

Finally, it is important to acknowledge that all participants were enrolled in the VIHeillir Project and therefore benefited from regular follow-up and first-line geriatric support. Their experiences may consequently be more positive than those of other older adults living with HIV in rural Cameroon. Nonetheless, these findings suggest that improving quality of life in later life is fundamentally a matter of political commitment. Just as HIV has been transformed into a manageable chronic condition through sustained public health action, policymakers in Cameroon and across sub-Saharan Africa possess the means to promote accomplished aging through universal access to basic geriatric care and evidence-based social support interventions.

CONCLUSION

The Cameroonian healthcare system has not yet fully adapted to the demographic realities of population aging, and the need for accessible geriatric services emerged clearly from interviews conducted with older adults living with HIV in rural Cameroon.

Nevertheless, participants expressed a positive experience of aging with HIV in a rural environment. Deeply grateful for free and decentralized access to ART, they remained fully aware of the privilege of being alive. Their narratives emphasized the respect accorded to elders within the community, attachment to ancestral land, connection with ancestors, and a form of spirituality that fostered acceptance of human finitude.

Public health actors should therefore continue their efforts to improve the quality of life of older adults living with HIV in Bafia and, more broadly, of aging populations throughout Cameroon. Strengthening geriatric care services, reinforcing social support systems, and promoting inclusive community environments constitute essential steps toward ensuring that longer lives are also lives lived with dignity, meaning, and fulfillment.

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