



Children at Risk: A Study of the Psychosocial Impact of HIV on Orphans and other Vulnerable Children in Benin

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Abstract

This paper describes the effect of parental HIV on the life of children in Benin. A total of 2,043 children aged from 10 to 16 were surveyed on health, diet, violence, school attendance and psychosocial state. The results indicate that, while Beninese children who have had a parent living with HIV are not necessarily subjected to different economic and material conditions than those who have not, they do experience a much greater lack of psychosocial support. In contrast to children whose parents are not known to have HIV, these affected children are less prone to general illness (OR=0.69, 95 per cent CI 0.55-0.86). However, when they *are* sick, HIV-affected children are significantly more likely to undertake self-treatment (OR=1.38; 95 per cent CI 1.04-1.86) and more likely to work (OR=1.65, 95 per cent CI 1.04-2.60). They are also offered fewer meals than unaffected children (OR=1.94; 95 per cent CI 1.52-2.47). With respect to psychosocial factors, the data suggest that children who have had a parent with HIV have significantly higher levels of psychological distress than those who have not. Governments and civil society organisations need to address not only the material deprivation, especially hunger, of children thus affected by HIV, but also their need for social services.

Résumé

Ce document décrit l'effet sur les enfants des parents atteints du VIH au Bénin. L'étude a été faite sur un total de 2 043 enfants âgés de 10 à 16 ans par rapport à leur santé, leur régime alimentaire, la violence, leur présence aux cours et leur

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état psychosocial. Les résultats montrent que même si les enfants Béninois qui vivent avec un ou des parents atteints du VIH ne sont pas nécessairement assujettis à des conditions économiques et matérielles pires que celles des autres enfants, ils sont tout de même sujets à une absence d'assistance psychosociale. Contrairement aux enfants dont les parents ne sont pas reconnus comme étant atteints du VIH, ces enfants sont moins disposés à souffrir des pathologies courantes (OR=0,69, 95 per cent CI 0.55-0.86). Cependant, il a été noté que ces enfants concernés, une fois malades, semblent beaucoup plus disposés à se traiter eux-mêmes (OR=1,38; 95 per cent CI 1.04-1.86). Ils sont aussi plus disposés à travailler (OR=1,65, 95 per cent CI 1,04-2,60). Il a été également constaté qu'on leur offre moins de repas que les enfants non-concernés (OR=1,94; 95 per cent CI 1,52-2,47). En ce qui concerne les facteurs psychosociaux, les données montrent que les enfants avec un ou des parents atteints du VIH ont un niveau de détresse psychosociale beaucoup plus élevé que ceux des autres enfants. Les gouvernements et les organisations de la société civile doivent confronter non seulement la privation matérielle, notamment la faim dont les enfants concernés font l'objet, mais également satisfaire leurs besoins en services sociaux.

Introduction

In the beginning of the HIV epidemic, the international community increasingly responded to HIV as the emergency situation it was. Improved access to effective antiretroviral therapy now makes it possible to look beyond issues of survival, prevention and treatment, and start addressing issues of care and support for people affected by HIV. One group that has come more into focus is children of people living with HIV. The situation of children in the low-income countries that are hardest hit by HIV has been described as a 'rising tide of orphans' (Gosh and Kaplipeni 2004), referring to the fact that the number of children orphaned by HIV will not peak in the foreseeable future. Due to HIV, the overall gains in child survival have fallen, and the total number of orphans due to HIV is estimated to have grown from 11.5 to 15 million between 2001 and 2003 (UNICEF 2004a). If not for the HIV pandemic, the number of orphaned children would have declined globally. Most of the children affected by HIV live in sub-Saharan Africa (UNAIDS 2007), and while there are many other diseases that take a high toll on family well-being there, they are socially more acceptable and do not bear the stigma associated with HIV. Such stigma not only 'infects the infected' but also marks their immediate relatives, including children (Brown 2001; Campbell 2005). From a child's perspective, HIV progresses through several stages – infection, illness and, if untreated, death of one or both parents. When a parent can no longer work or when people start staying away from the home, the child starts to feel the impact of HIV with the growing prospect of sorrow and grief.

The consequences of HIV are often unevenly distributed and can have a strong gender bias; for instance, a girl will often be removed from school to care for an ailing parent while her brother continues with his studies. Although there are only few empirical studies on the psychological impact of HIV on children in the developing world, a study of children's reactions to bereavement and their adjustment difficulties in rural Uganda has shown that losing a parent to HIV leads to higher levels of permanent psychological distress, as expressed through anxiety and depression, than losing a parent to other causes (Atwine *et al.* 2005). These findings are consistent with those from similar studies in sub-Saharan Africa (Adato *et al.* 2005; Nyambedha *et al.* 2003; Guest 2003; Foster and Williamson 2000).

In addition to the social and psychological consequences of becoming an orphan, a recent study of female adolescent orphans in urban Zimbabwe indicates a possible association between orphan status and increased risk of, for example, HIV or unwanted pregnancy (Birdthistle *et al.* 2008). It has increasingly become clear that African governments and the international community have failed to protect orphans and provide them with decent opportunities. To do so, however, it is important to understand the living conditions and coping mechanisms of children affected by HIV.

While there is a growing focus on the impact of HIV on children in the eastern and southern parts of sub-Saharan Africa, the situation of affected children in West Africa is poorly represented in the academic literature. Furthermore, research on children affected by HIV in countries with concentrated epidemics has been limited. Existing research on affected children has largely emphasised economic deprivation, rather than possible psychosocial consequences (Birdthistle 2004; Stein 2003). The main objective of the present study has been to assess whether children affected by HIV are experiencing more psychosocial distress than other children, and whether they are subject to negative differential treatment in terms of self-reported health status, diet, exposure to violence, or education.

Methodology

Context, Study Area and Selection of Participants

This study was carried out in Benin over a period of six months in 2005 in all 12 administrative departments.¹ Benin has a population of approximately 6.6 million people and a rich diversity of ethnic and linguistic groups, with the Fon, the Adja and the Yoruba as the most dominant. Approximately 31 per cent of the people call themselves Catholic, 24 per cent Muslim, 19 per cent Protestant and 17 per cent animist, with the rest referring to themselves as

belonging to another or no religion (INSAE 2001). Northern Benin is predominantly Muslim, while the Christian populations are concentrated in the southern and central regions. It should be noted, however, that the majority of the population practises Vodun (voodoo) in combination with another religion, and that Vodun plays an important role in official government discourse as well as in private life (Strandbjerg 2008).

Benin has a rather young population, with an estimated 48 per cent of the people being younger than 15. Although many of these children live a relatively uncomplicated life, a large proportion of them must confront major survival, health, educational and employment challenges. Living in one of the poorest countries in the world – the UNDP ranked Benin 163 out of 177 on its Human Development Index 2007/08 – Beninese children must face many obstacles before they reach adulthood. The child mortality rate is high, at 152 per 1000 live births (UNICEF 2006), and child morbidity is also high, with diarrhoea, acute respiratory infections and malaria as the most severe diseases (INSAE 2002).

Benin has a pluralistic family structure with many polygamous marriages and many children born out of wedlock. While illegitimate children are not necessarily exposed to social stigma, protection of their rights has been regulated by a mix of traditional and colonial law (the *Coutumier du Dahomey* from 1930). It was only in 2002, after more than 10 years of debate and pressure from women's organisations and external donors, that a new family law, *Code de la Famille et des Personnes*, was adopted by Parliament. Among other things, this law guarantees basic inheritance rights and a family name to married women and to children, whether born inside or outside a marriage (Boko Nadjo 2004). If one or both parents die, custody of the children will typically be decided by a family council, the family's elders or a divine authority (a *Fâ*), without involving any legal authorities. Adoption from outside the country is almost nonexistent, and orphans are seldom placed in orphanages (United Nations 1999). Children in Benin have many duties and few officially recognised rights. One fundamental principle is domestic reciprocity, meaning that every child should perform household chores and contribute economically to the household (by working in the fields or engaging in petty trade) in exchange for protection, shelter and food.

Children affected by HIV are not the only children in Benin experiencing hardship and a higher risk of negative outcomes in life than their peers. One especially vulnerable group is known as 'Vodun children' – twins or children born with certain physical marks, who often, especially in northern Benin, become victims of infanticide or abuse (United Nations 1999). Other groups of vulnerable children include *les Talibés* – boys who are sent to Qur'anic

schools (Amadou *et al.* 2001) – and the ‘Vidomegon’ children who have traditionally been placed as domestic workers in urban households by their families (Kielleand and Tovo 2006). Additionally, Beninese children are at significant risk for trafficking since the country is a main source of child labour to the cocoa plantations of neighbouring countries (UNICEF 2005; Anti-Slavery 2000). *Les Talibés* and the Vidomegon children live away from their biological parents in often-exploitative situations. The difference between them and children affected by HIV is that children in the latter group have lost or can anticipate the likely loss of at least one parent to a heavily stigmatised, often fatal disease.

Benin is not as hard hit by the pandemic as many of the countries in eastern and southern Africa. New data indicate that its HIV prevalence is estimated to be 1.9 per cent of the adult population (age 15–49), or approximately 62,000 people (UNAIDS 2005, PNLs 2005). The number of Beninese children younger than 18 who have become orphans as a result of HIV was estimated to be as many as 28,000 in 2002 and was projected to reach 50,000 in 2008 (PNLS 2005). In principle, access to life-prolonging antiretroviral therapy is free for every child and adult who has tested positive for HIV. However, not all infected people are tested, so their actual status remains unknown. HIV-related stigma and misconceptions about the transmission of HIV are widespread, often in combination with Vodun beliefs. For instance, in northern Benin, HIV infection is referred to as ‘the monkey disease’, and many inhabitants are afraid of HIV-positive people and their children.

Study Design and Sampling Framework

This paper is based upon the results of a survey, which was a part of a larger study that used both qualitative and quantitative approaches. In addition to the survey, the more comprehensive study included 170 focus group discussions with children and 171 with parents and foster parents. These discussions were supplemented by key informant interviews with schoolteachers, NGO representatives, health personnel and other resource people.

The study population was defined as children aged 10–16. The sample included two groups of respondents: a) children with a biological parent who was living with or had died from HIV, and b) children who lived with both their biological parents, neither of whom was known to be infected with HIV.

Children with a parent who is either living with HIV or dead because of HIV are referred to as orphans and vulnerable children (OVCs), and the other children as non-OVCs. This terminology is widely used by international development agencies (UNICEF and Benin 2004; UNICEF 2004b; Banque

Mondiale 2004) because it offers a practical operational definition, but it is not unproblematic. It loses some of its significance in Benin, where many children live separated from one or both of their biological parents for various other reasons, and where a child's vulnerability is associated less with being an orphan than with not having any family members who can defend the child's interests. Another problematic aspect is the fact that an OVC is defined as being younger than 18, an age-specific definition that is not particularly germane in a society where childhood ceases when a person marries or has a child, which often happens well before age 18 in Benin. Moreover, in some Beninese languages, including Batambu and Dendi, the word for *orphan* is also used to designate a child who is simply behaving badly and 'does not respect anybody'. Nevertheless, OVC has been retained as a case definition for this survey because it requires precise definitions to be meaningful, and a concerted effort was made to ensure that the research assistants employed a correct translation of the term in the various local languages used.

The quantitative data were collected using standardised questionnaires with both closed and open-ended questions. Communities were selected from a national list of all registered communities – *arrondissements*, villages and neighbourhoods – using a random sampling approach. In each chosen community, households with at least one OVC were mapped using community-based lists, as well as information from local NGOs working with OVCs or HIV and from other relevant health organisations. To identify OVCs, it was necessary to rely on NGOs that assist children affected by HIV; while the actual serostatus of these children and their parents was not known, each of the children thus identified did have a parent who had HIV symptoms or who had died from a disease most likely resulting from HIV. It should be noted that the OVCs chosen through these organisations are likely to be better off than OVCs who are not receiving assistance from them, and that the OVCs studied may therefore not be representative of all children affected by HIV in Benin. A household was defined as a group of related people living together in the same compound. In each of the chosen communities, several households were then randomly selected. In the vast majority of cases, an OVC was matched with a non-OVC of similar age.

Prior to the survey interviews, informed consent for participation was obtained orally from all the selected children and their respective parents or foster parents. Field assistants interviewed each child in the local language and recorded the answers directly on the questionnaire.

The 50 field assistants who collected data were selected on the basis of their academic records, their experience with data collection and their knowledge of relevant local languages and the country's cultural and social

fabric. A team of senior researchers trained all the field assistants in how to interact with children in an empathetic way that respected each child's right to opt out of the survey at any point, and that arranged follow-up counselling when it was indicated. The field assistants also translated the questionnaires and interview guidelines from French into the local language, giving special consideration to key terms – such as *orphan*, *orphanhood*, *vulnerability*, *rights* and *protection* – that might prove difficult to translate exactly. For example, in Fon, one of the country's dominant languages, /Cyɔvi/ is used to identify a child with a dead parent, while /tɔcyɔvi/ is used for a child whose mother has died and /nɔcyɔvi/ a child whose father has died.

During a pilot phase, the field assistants systematically tested all of the data collection tools. To ensure consistency in administering the questionnaires, the assistants were divided into groups under the supervision of experienced team leaders.

The field assistants surveyed a total of 2,043 children aged 10-16 years old (1,033 OVCs and 1,010 non-OVCs). They also surveyed the adult head of each household to obtain data on household income (size and main source), assets and religion to help provide a general portrait of each household. Finally, the data were transcribed and then translated back into French.

Variables

Fifteen dependent dichotomous variables were included in the analysis, covering self-reported aspects of children's health, diet, violence, psychosocial condition and school attendance. The children were asked to answer questions based on their recollection of the previous two weeks, except for the questions about school attendance and graduation. Health indicators included: the presence or absence of general illness, of malaria, of diarrhoea and of stomach pain; self-treatment for general illness; and whether the respondent worked while being sick. Diet indicators included the number of meals available each day, and whether the respondent had been offered enough food in the last two weeks. Violence indicators were whether the child had been beaten by parents and/or foster parents, or by other children in school. Psychosocial indicators included whether the respondents felt discontented with themselves, whether they had negative feelings about themselves, and whether they felt isolated or rejected in school. School attendance indicators were whether the respondent had ever attended school regularly and whether the respondent had left school before graduating. In addition, the adult informants provided data for the household variables, including household assets, household income and the educational background of the parents or other caregivers. These variables were combined with the child's sex and age as covariables in a logistic regression model.

Data Analysis and Statistics

Research assistants entered the data under the supervision of senior statisticians. Logistic regression was then used to assess the gross and net associations between each dependent variable and OVC status. First, bivariate associations between OVC status and dependent variables were assessed. Subsequently, stepwise backward regression was used to adjust the significant associations obtained in the bivariate analysis for the effect of the two covariables, sex and age. All analyses used the SPSS software package, version 15.0.

Results

A total of 2,043 children were surveyed; see Table 1 for a general demographic and household profile of the study population. All the OVCs studied were living with members of their extended families. The male-female ratio for the sample was 1:1.3 for OVCs and 1:1.4 for non-OVCs. A total of 56.5 per cent of the households were characterised as poor, which was defined as having a monthly income of less than 25,000 CFA francs (• 37), while 39.3 per cent had no more than one type of household asset, such as a radio, telephone or bicycle. Approximately one third of the households surveyed included more than three OVCs.

The results of the bivariate and multivariate analyses are shown in Tables 2 and 3. In general, the overall response rate for questions related to health, diet, psychosocial condition and school attendance was high (79.5–99.8 per cent), but for questions related to violence the response rate was lower (29.5–42.1 per cent). Comparison of the children who answered the violence questions with those who did not answer them did not, however, reveal any marked differences in the age or sex distribution of the two groups.

The results of the bivariate analyses showed that OVC status was significantly associated with 11 of the 15 dependent variables. Of these, 9 remained significant in the multivariate analysis. Contrasted with non-OVCs, OVCs were less prone to general illness (OR=0.69, 95 per cent CI 0.55-0.86) but more prone to stomach pain (OR=1.40, 95 per cent CI 1.04-1.86). The OVCs were significantly more likely to undertake self-treatment (OR=1.38, 95 per cent CI 1.11-1.72) and almost twice as likely to work while sick (OR=1.65, 95 per cent CI 1.04-2.60). OVCs were also offered fewer meals than non-OVCs (OR=1.94; 95 per cent CI 1.52-2.47) and were twice as likely to indicate that they were not being offered enough food (OR=2.42, 95 per cent CI 1.71-3.41). With respect to psychosocial factors, OVCs were four times as likely as non-OVCs to feel discontented (OR=3.94, 95 per cent CI 2.80-5.54), five times as likely to have negative feelings about themselves (OR=5.46, 95 per cent CI 4.27-6.97) and four times as likely to feel isolated or rejected in school (OR=4.35, 95 per cent CI 2.37-8.00).

Table 1: General Characteristics of Respondents and their Households

Characteristics	
Respondents	
Number (males/females)	2,043 (1179/864)
Mean age (years) (range)	12.5(10-16)
Households	
Number of children in urban households (% of total)	716 (35.0%)
Mean number of individuals in household (range)	8.6 (2-70)
Mean number of children in household <18 years (range)	6.1 (1-50)
Mean number of OVCs in household (range)	3.2 (1-15)
Number of households with more than 3 OVCs (% of total)	561 (34.0%)
Mean number of asset types in household (range) ¹	1.98 (0-8)
Number of children living with only 0-1 asset type in household (% of total)	782 (39.3%)
Number of households with low household income ² (% of total)	939 (56.5%)
Number of households with agriculture as primary source of income (% of total)	824 (50.0%)
Primary Religion in Rousehold (% of total)	
Catholicism	481 (29.2%)
Animism	394 (23.9%)
Islam	371 (22.5%)
No religion	135 (8.2%)
Other	221 (13.4%)

1. Household assets were defined as radios, bicycles, televisions, refrigerators, motor-bikes, cars, land-line telephones and mobile telephones. The figure indicates the total number of different types of such assets.
2. Monthly household income < 25 000 CFA.

Table 2: Self-reported Occurrence of Illness and Food Intake among OVCs and Non-OVCs

Variable	Health Status					Food Intake		
	General Illness	Malaria	Diarrhoea	Stomach Pain	Self Treatment for General Illness	Worked While Being Sick	Offered 1-2 Meals/Day ³	Not Offered Sufficient Amount of Food
No. of OVCs who answered the question (percentage reporting the event)	891 (52.0)	808 (20.2)	779 (4.0)	824 (19.5)	975 (61.6)	888 (8.7)	1,025 (38.0)	1,030 (18.1)
No. of non-OVCs who answered the question (percentage reporting the event)	933 (57.8)	850 (20.2)	831 (3.1)	855 (15.3)	961 (52.5)	856 (4.7)	1,002 (21.0)	1,008 (7.2)
OR (95% CI) ¹ for OVCs versus non-OVCs	0.79 (0.66, 0.95)*	1.0 (0.78, 1.27)	1.28 (0.76, 2.18)	1.34 (1.04, 1.73)*	1.45 (1.21, 1.74)***	1.94 (1.31, 2.87)*	2.31 (1.89, 2.81)***	2.82 (2.12, 3.76)***
OR (95% CI) ² for OVCs versus non-OVCs	0.69 (0.55, 0.86)***	ns ⁴	ns	1.40 (1.04, 1.86)*	1.38 (1.11, 1.72)**	1.65 (1.04, 2.60)*	1.94 (1.52, 2.47)***	2.42 (1.71, 3.41)***

1. Results of binary analyses

2. Results of logistic regression analyses; adjusted for sex and age of child, items in household, urban/rural location, household income, and main source of household income

3. Versus 3-5 meals per day

4. Non-significant association

* P < 0.05, ** P < 0.01, *** P < 0.001

Table 3: Self-reported Occurrence of Violence, Psychosocial Problems and School Attendance among OVCs and Non-OVCs

Variable	Psychosocial factors					Dropped out of School
	Violence Beaten by Parents ³	Beaten by Children at School	Feeling Discontented with Oneself	Having Negative Feelings about Oneself	School attendance Feeling Isolated and/or rejected at school	
No. of OVCs who answered the question (percentage reporting the event)	441 (80.3)	289 (8.7)	936 (22.1)	988 (55.5)	1,023 (7.9)	916 (14.2)
No. of non-OVCs who answered the question (percentage reporting the event)	509 (85.6)	314 (7.0)	941 (8.7)	968 (20.7)	1,002 (1.7)	924 (10.8)
OR (95% CI) ¹ for OVCs versus non-OVCs	0.67 (0.48-0.94)*	1.26 (0.69, 2.28)	2.98 (2.26, 3.91)***	4.78 (3.92, 5.84)***	4.98 (2.93, 8.47)***	1.34 (0.98, 1.83)
OR (95% CI) ² for OVCs versus non-OVCs	ns ⁴	ns	3.94 (2.80, 5.54)***	5.46 (4.27, 6.97)***	4.35 (2.37, 8.00)***	ns

1. Results of binary analyses.
 2. Results of logistic regression analyses; adjusted for sex and age of child, items in household, urban/rural location, household income, and main source of household income.
 3. Beaten by foster parents and/or biological parents.
 4. Non-significant association.
 * P < 0.05, ** P < 0.01, *** P < 0.001

Discussion

Negative Differential Treatment within a Household

The findings from this study suggest that, in some respects, orphans and vulnerable children receive less care and attention from their caregivers than other children in the same household. At the same time, however, the results show that the effects of being an OVC are less pronounced than initially expected. For example, OVC school attendance is almost identical to non-OVC attendance, while somewhat surprisingly, OVC status can even predict slightly more positive outcomes, as in the case of general illness and caregiver violence. Nonetheless, OVCs were more likely to eat only one or two meals per day, and they also reported higher levels of dissatisfaction with the amount of food offered. In Benin, children are typically given a small amount of money to buy breakfast on the way to school, and it may be that OVCs are not always given this money and therefore eat less throughout the day. Access to regular meals is associated with intellectual performance and physical development; since the OVCs in this survey reported not receiving sufficient food, their learning abilities and general development have likely been compromised.

Another area where the data indicate strong disadvantages for OVCs is disease status. Considering that OVCs are at much higher risk for being infected with HIV perinatally and therefore for suffering from HIV-related illnesses later in life, it is surprising to find that OVCs are actually less likely to report general illness. It may be that many of the infected children die before the age of ten and therefore are not widely represented in the OVC sample. The data show that when OVCs are feeling sick they are more likely to engage in self-treatment, for example buying drugs at a local market or pharmacy. This finding suggests that OVCs are less likely to be taken to a health clinic or a traditional healer for treatment than non-OVCs. As the study did not specifically investigate levels of morbidity in the two groups, the health consequences of this relative failure to access available services are difficult to assess. However, it does suggest that OVCs are subjected to greater hardship, a conclusion supported by the fact that the OVC cohort was twice as likely to work while sick.

Levels of Psychological Distress Among Orphans and Vulnerable Children

One of the objectives of this study was to assess the psychosocial impact of HIV on children. The findings suggest that OVCs have significantly higher levels of psychological distress than non-OVCs, in accordance with findings from previous quantitative and qualitative studies employing other assessment methods (Birdthistle 2004; Atwine *et al.* 2005; Stein 2003). As indicated by the high proportions of both OVCs and non-OVCs who reported

being beaten by their caregivers in the previous two weeks, violence against children is endemic in Benin (Kielland and Tovo 2005). Although the data indicates that OVCs are less exposed to violence from their caregivers than non-OVCs, the association does not remain statistically significant after adjusting for the covariables.

The study also showed that Beninese OVCs are more likely to feel discontented with themselves than their peers are, and that they are as much as five times as likely to report that they have a negative perception of themselves, rather than a positive or neutral one. These feelings were just as pronounced when it came to self-perception in a specific social setting, for example school, where OVCs were again five times as likely to feel isolated or rejected. Other studies have found that OVC status is a significant predictor for feeling isolated in school, for example in South Africa, where 97 per cent of children orphaned by HIV reported that they had no close friends (Cluver 2003, as cited in Stein 2003). Thus, although the OVCs in the present study had almost the same school enrolment rates as non-OVCs, their learning opportunities may already have been compromised when they entered school, given that they have eaten less and are less likely to receive treatment when ill than their schoolmates. Psychological distress compounds these initial disadvantages.

Ways Forward: Areas for Future Research and Support

The results of the present study clearly support the presumption that children affected by HIV are at higher risk for various negative experiences, including not being able to eat when hungry, not being cared for when sick and not feeling social and emotional connections to others. The vulnerability of Beninese OVCs appears to be rooted in the dynamics of stigmatisation and poverty. They suffer a double stigma of being children who are associated as orphans with both bad behaviour (as noted above) and HIV; a widely feared infection. Yet there remains a dearth of comparative research into the similarities and differences between HIV orphans and other orphans. Most existing studies – this one included – compare children orphaned by HIV with non-orphans. It would be useful for future research to assess different kinds of vulnerability among different kinds of orphans.

The findings from this study may reflect the fact that many of the households surveyed were already constrained economically, and that parents who have taken an average of more than three OVCs into their household are already stretching meagre resources and merely choose to prioritise their own children. However, poverty and closeness of blood ties cannot explain all the negative differential treatment these children are subjected to both inside and outside their households. Stigmatisation and prejudice directed

against people living with HIV also affects their children and places these children in a difficult situation. It cannot be stressed enough that improving the lives of OVCs requires broad-based HIV educational efforts, as well as advocating for the rights of children in affected communities.

Though the OVCs studied have urgent physical needs, particularly for sufficient food, very few of these children receive any government help. Instead, they have all been unsystematically connected to various faith-based organisations and other NGOs. From these NGOs, they typically receive a small amount of food or other allowances, but it is very rare that they are given any kind of psychosocial support addressing the emotional neglect and other negative changes they have experienced during their parents' illnesses.

It seems obvious that Benin requires a new type of OVC support project, one that provides not only material support but psychosocial support as well. Such projects should assess each child's well-being and check up regularly on how they are handling their situations emotionally and psychologically as they grow up. One entry point for this kind of intervention could be schools, which are at present far from being a safe place that can support the passage of OVCs from childhood to adulthood. Another entry point could be the foster families, where regular visits from social workers would support caregivers in providing OVCs with appropriate care and development opportunities. Such interventions should not, however, exclude other categories of vulnerable children, as there are, as mentioned above, several other significant groups of children who live in Benin as *de facto* social orphans. The importance of inclusiveness is especially important in a low HIV-prevalence country like Benin, where singling out the relatively few children who are orphans as a result of HIV may only contribute to their social isolation.

Study Limitations

The present study has some overall limitations that chiefly relate to selection bias generated by the sampling procedures, and these potential biases should be considered before generalising the result to apply to Benin as a whole. As previously mentioned, the OVCs surveyed were identified by health sector and NGO staff and may differ from the overall population of OVCs. In addition, the non-OVCs surveyed were selected because they shared a household with an OVC, and they may therefore differ from the population of non-OVCs who live in families without OVCs. Finally, as mentioned above, less than half of the children studied answered the questions on parental and peer violence. This low coverage probably reflects the sensitive nature of the questions, which may have influenced the responses. Questions on sensitive matters such as these can often result in over or underreporting of the phenomena being investigated.

Conclusion

Even though access to antiretroviral therapy for both adults and children in Africa has progressed considerably over the past few years, the social impact of the epidemic there is far from over. Many more children in low-income countries will find their parents becoming sick or dying from HIV in the years to come, and their needs urgently need to be addressed. Although anthropological research has shown that the circulation of children in and out of different households and their residing away from their biological parents is a widespread and well-functioning phenomenon throughout the continent, the situation of OVCs there calls for special attention. This study shows that the current focus on providing these children with financial assistance has left some critical gaps. The children that HIV has made vulnerable do require material help, especially food, but they also require psychosocial support to help them thrive and grow. Governments and NGOs alike have key roles to play in ensuring that these children receive it.

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Note

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