

Social and economic consequences of HIV and AIDS on children: case study of a high-density community in Harare, Zimbabwe

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Abstract

We present results from a household-based survey that was conducted in Mabvuku, a high-density community in Zimbabwe. The objective of the study was to improve understanding of social and economic consequences of HIV and AIDS on children. Children affected by HIV and AIDS (CABA) formed the treatment group while those not affected by HIV and AIDS (non-CABA) were the control group. We found that many of the differences in the socio-economic indicators that we studied between CABA and non-CABA were not significant. Therefore our results indicate a gloomy scenario for all the children. These results are consistent with existing literature which indicates that the impact of HIV and AIDS is exacerbated by poverty. Based on evidence from this paper, we conclude that programmes and interventions targeted at children should encompass both CABA and non-CABA within a framework of sustained commitment to improving the lives of these children. We hope that our findings will be used in the formulation of interventions and strategies to improve the situation of children affected by HIV and AIDS and/or living in impoverished communities.

Keywords: HIV and AIDS, CABA, non-CABA, poverty, Zimbabwe.

Résumé

Nous présentons les résultats d'une enquête menée auprès de ménages habitant à Mabvuku, un quartier fortement peuplé au Zimbabwe. L'objectif de cette étude était d'améliorer la compréhension des conséquences sociales et économiques du VIH et du SIDA sur les enfants. Les enfants touchés par le VIH et le SIDA (ETVS) étaient le groupe expérimental tandis que ceux qui n'étaient pas affectés par le VIH et le SIDA (non-ETVS) étaient le groupe témoin. Nous avons constaté que la plupart des différences entre ETVS et non-ETVS concernant les indicateurs socio-économiques que nous avons étudiés n'étaient pas significatives. Par conséquent, nos résultats présentent un scénario sombre pour tous les enfants. Ces résultats sont cohérents avec la littérature existante qui indique que l'impact du VIH et du SIDA est exacerbé par la pauvreté. En nous fondant sur les résultats de cet article, nous concluons que les programmes et les interventions ciblant les enfants devraient englober à la fois ETVS et non-ETVS dans le cadre d'un engagement durable ayant pour objectif d'améliorer la vie de ces enfants. Nous espérons que nos résultats seront utilisés lors de l'élaboration d'interventions et de stratégies visant à améliorer la situation des enfants touchés par le VIH et le SIDA et/ou vivant dans des communautés pauvres.

Mots clés: VIH et SIDA, ETVS, non-ETVS, pauvreté, Zimbabwe.

Introduction

Nearly a quarter of a century has passed since the first AIDS case was recorded in Zimbabwe but the effects of the epidemic on children are still difficult to quantify. Zimbabwe, with an HIV prevalence rate of 18.1%, is one of the countries most affected by the HIV and AIDS epidemic in sub-Saharan Africa (Zimbabwe Central Statistical Office/ DHS Macro International Inc. 2007). As elsewhere in southern Africa, where there is a similar burden of HIV/AIDS, the impact of the epidemic on children is significant. There is great commonality in the plight of children, families and communities affected by HIV and AIDS in the southern African region. However, the situation of children affected by HIV and AIDS in Zimbabwe is expected to be worse due to the hardship caused by a decade of deteriorating social, economic and political circumstances in the country. The focus of our paper is to determine the socio-economic consequences of HIV and AIDS

on children by conducting a comparative analysis on the impact of HIV and AIDS on two different categories of children (those affected by HIV and AIDS and those not affected) in a bid to determine whether there are any marked differences or if there are other intervening factors such as poverty and the current socio-economic situation in Zimbabwe that affect children.

It is estimated that there are currently some 8 million children in Africa who have lost one or both parents to HIV-related illness and that by 2010 these numbers would have increased to some 40 million. In many countries the proportion of children who have lost one or both parents will be as high as 20 - 25% by the end of the first decade of the new millennium. These trends have direct implications for intergenerational poverty and impose immense challenges for policy makers (Cohen, 2002).

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The last population census conducted in Zimbabwe in 2002 provided data on orphanhood status for children aged 15 years and below. We use the data from the population census to show the extent of orphanhood in Mabvuku. A single orphan is taken to be a child with one surviving parent whereas a double orphan is a child with both parents dead (Zimbabwe Central Statistical Office 2005). The Zimbabwe 2002 population census statistics indicated that there were a total of 1 991 (48.0%) single male orphans, 2 161 (52.0%) single female orphans, yielding a total of 4 152 single orphans in Mabvuku. Double orphans constituted 404 (46.8%) males and 460 (53.2%) females, yielding a total of 864 double orphans. The total number of orphans in Mabvuku was therefore 5 016, which translates to 14.1% of the children aged 15 years and below. The population census data further indicated that there were relatively more children with father dead than mother dead (*ibid*). Although the population census data do not show the cause of death for the parents who died, we assume in this paper that the majority of these deaths were caused by HIV and AIDS. It is against this background that we in attempt to provide a comparative analysis of children affected by HIV and AIDS and those not affected. We explain later in the methodology section the operationalisation of the concepts of children affected by HIV and AIDS and those not affected. We will now provide an analysis of related literature on the impact of HIV and AIDS on children.

Kang, Dunbar, Laver and Padian (2008) observed in their study on maternal versus paternal orphans in Zimbabwe that HIV and AIDS had led to a drastic increase in the number of orphans in the country. The authors further observed that orphans (whether orphaned by AIDS or other causes of death) experienced various socioeconomic and reproductive health disadvantages compared with non-orphans.

The SafAIDS News (2005) observed that the impact of HIV and AIDS on children is particularly marked given that children are poorly resourced as they lack the necessary social and economic skills to manage the circumstances of illness and eventual death of their parents from AIDS. Orphaned children are predisposed to economic and sexual exploitation and HIV infection. They also face stigmatisation and discrimination from the extended family (*ibid*).

According to Foster (2006) and Wood, Chase and Aggleton (2006), the AIDS epidemic has had varied adverse effects on children living in communities affected by the epidemic, leading to an unprecedented number of orphans. The epidemic has further greatly affected the capacity of governments in countries affected by AIDS to meet their obligations as contained in the United Nations Convention on the Rights of the Child (CRC).

In their comparative study of Mutare in Zimbabwe and New York in the USA, and in which they focussed on children caring for their ill parents, Bauman, Foster, Silver, Berman and Gambie (2006) observed that children orphaned by HIV and AIDS not only experienced the trauma of losing their parents through death but they experienced the caregiving stress as well. Almost half of the children interviewed in New York and 80% of those from Mutare reported that they had too much responsibility and the majority reported reduced after-school and peer activities. Gilborn, Apicella, Brakarsh, Dube and Jemison (2006) concur that

children affected by HIV and AIDS face adverse events including poverty, the loss of caregivers, having to drop out of school, and even social isolation. According to Wood, Chase and Aggleton (2006) the loss of parents and/or caregivers to the children is likely to be highly complex and dependent on the quality of care and social support networks in place. Richter, Manegold and Pather (2004) observe that since the advent of the HIV and AIDS pandemic there have been frantic efforts by governments, non-governmental organisations and community-based organisations to curb its spread. However, the situation of children and families affected by HIV and AIDS still remains adverse.

Mhloyi (2005) noted that much attention has focused on prevention. Care and support to children in AIDS-affected families and communities has been given little attention. Care for HIV and AIDS orphans often falls on the traditional system of extended families, stretching the capacity of these social safety nets. It has further been observed that these children are less likely to attend school, more likely to be malnourished, less likely to receive health care and are usually very poor (Richter *et al.* 2004). They most often end up on the streets, where they pursue survival strategies that put them at high risk of contracting HIV. According to Mhloyi (2005) addressing the needs of orphans and vulnerable children, their caretakers and communities, has emerged as a major strategy in the fight against HIV and AIDS.

Richter *et al.* (2004) further show that direct impacts of HIV and AIDS on families and households are discernible as families attempt to adjust to the stresses of economic decline and demoralisation and these include the emergence of child- or adolescent- headed households, separation of siblings, family breakdown, child abandonment and remarriage. Mhloyi (2005) further observe that apart from economic issues, such as the livelihood activities of household members, a number of key demographic dimensions such as gender, ages of affected children and the location of the household mediate the impact of HIV and AIDS on families and communities.

The literature that we have reviewed above is evidence that many studies have been done that only show the plight of children affected by HIV and AIDS. Our present study contributes to existing literature as it aims to show whether the problems associated with HIV and AIDS are only experienced by orphans or children affected by HIV and AIDS (CABA) or other children (non-CABA). We will also show the role that poverty plays in mediating the impact of HIV and AIDS on children. We present our evidence in this paper based on the following indicators: education, health and welfare, living conditions and psychosocial well-being. We expect our findings to corroborate previous research on orphans and vulnerable children in Zimbabwe and to have implications for intervention strategies towards improving the situation of children, particularly those living in impoverished conditions.

Methodology

Study area

The study area was a high-density area (Mabvuku) which lies 20 km east of Harare in Zimbabwe. The choice of Mabvuku for this study was appropriate since the rate of orphanhood is high, namely 14.1% (Zimbabwe Central Statistical Office, 2005).

Research design: household survey

We used a household-based survey to collect data from children in this study. The household survey consisted of children affected by HIV and AIDS (CABA), who comprised the treatment group and those not affected by HIV and AIDS (non-CABA), who made up the control group. It is important to note that one cannot scientifically conclude that children orphaned and affected by HIV and AIDS are worse off if there is no comparative group. Thus children in similar age groups who were not affected by HIV and AIDS were sampled. It is important to note that since the focus of the study was on comparison of CABA and non-CABA, we used equal samples of these two groups of children. We will further elaborate on this in the next section. The age group of children interviewed in the survey was 10 - 18 years.

Sampling

A sample of 236 (5.9%) households was selected by using simple random sampling procedures. This sample constituted about 6% of the total number of households in Mabvuku. We identified a total of 386 children aged between 10 and 18 years in the sampled households. These children comprised of 193 CABA and 193 non-CABA. In the absence of a sampling frame on CABA, we used the following criteria to identify these children: CABA included children aged 10 - 18 years living with AIDS orphans, children 10 - 18 years living with a chronically ill person and AIDS orphans aged 10 - 18 years.

Data collection tools

A semi-structured questionnaire was used in interviews with the children aged 10 - 18 years. In addition, a sub-sample of 12 children was asked to write brief letters to their parents, regardless of their survival status, and tell them about how they felt about their lives. The question was phrased as follows: if you were to write a letter to your parents, what would you tell them about your wishes in life? The story lines will add the children's voice to the analysis that we present in this paper.

Statistical methods

We analysed the survey using the Statistical Package for Social Sciences (SPSS). A simple but detailed descriptive analysis detailing the situation of CABA and non-CABA was provided. We did not differentiate between the age groups of the children in the survey. Hence a similar instrument was administered to all of them. We determined the significance of difference in the various indicators using the independent two-sample *t*-test at $p < 0.05$. This *t*-statistic to test the difference in the indicators between CABA and non-CABA was computed as follows:

$$t = ((\bar{X}_1 - \bar{X}_2) / (S_{x_1x_2} \cdot \sqrt{(2/n)}))$$

where:

$$S_{x_1x_2} = \sqrt{\frac{S_{2x_1} + S_{2x_2}}{2}}$$

$S_{x_1x_2}$ is the pooled standard deviation, 1 = CABA, 2 = non-CABA.

Ethical considerations

Informed consent to interview the children was sought from their parents and/or guardians. The children were also asked for their consent before participating in the study. The children and their parents were assured of confidentiality of their responses. We further informed them that the results of the study would be pooled and analysed without any link to their personal identification.

Results

Introduction

The data are presented thematically as follows: demographic profile, education, socio-economic needs, health and other basic needs, child welfare and psychosocial well-being. As stated earlier, the respondents in the household survey were children and adults. The CABA was the treatment group while the non-CABA was the control group. In order to measure the impact of HIV and AIDS on orphans and other vulnerable children comparison will constantly be drawn between these two groups in the analysis.

Demographic profile

Gender distribution of respondents

Data on the gender distribution of the children surveyed are shown in Table 1. The distribution of CABA and non-CABA by gender followed a fairly similar pattern. The distribution of the children by gender was such that 52.3% of CABA (101) were females and 47.7% (92) were males. Of the non-CABA 50.3% (97) were females while the remaining 49.7% (96) were males.

Household headship

We observed that only 5.2% of CABA had their father as the head of household while 32.5% in the same category reported that their mother was head of household. A fifth of CABA in the same category reported that their maternal grandmother was the head of household. Nearly 8% had either a sister or brother as the head of household. Of the non-CABA, 76.3% had either their mother or father as the head of household. In the same category of children none reported their sister or brother as the head of household.

Table 1. Distribution of children by gender (N=386)

Gender	Type of child				Total	
	CABA		Non-CABA			
	Number	%	Number	%	Number	%
Females	101	52.3	97	50.3	198	51.3
Males	92	47.7	96	49.7	188	48.7
Total	193	100.0	193	100.0	386	100.0

Marital status of head of household

As expected, 50.3% of the CABA reported that the head of household was widowed. Two-fifths of the non-CABA reported that the head of household was married while 15.3% said the head of household was widowed.

Education

Reasons for not being at school

The distribution of surveyed children by reasons for not being at school is shown in Table 2.

Nearly 72% (40) of the CABA were not in school as compared with 28.6% (16) non-CABA ($p=0.0001$). The main reason cited for not being at school was lack of money 65% (26) CABA and 18.8 (3) non-CABA ($p=0.451$). Nearly 13% (5) of the CABA were not in school because they did not have birth certificates (Table 2).

Asked whether they would like to go to school 90.2% (36) of the CABA and 98% (9) of non-CABA said they were willing to go to school ($p=0.322$). An issue that requires further investigation is that 9.8% (4) of CABA not at school said they did not want to go school. One of the reasons cited by one such child was:

'Even if I go to school I would still be hungry since we have no food to eat here at home. It is better for me to roam the streets because eventually I find something to eat from my friends and other well wishers.'

Another child had the following to share:

'First and foremost I wish if my father was alive, he could buy me school stationery, uniform and clothes. He could meet all

my needs and expectations from a parent, like sending me to school. However, my mother is trying her very best, but she is not coping. She only sells vegetables at the market and with that money she is looking after all of us. We are 8 children in the family.'

Food provision

Thirty-three percent (63) of CABA said their relatives supplied them with food compared to 17.3% (9) of non-CABA ($p=0.016$). NGOs supplied food to 7.7% (15) of CABA and 1.9% (1) of non-CABA ($p=0.065$). The school supplied food to 14.0% (27) of CABA and 42.3% (22) of non-CABA ($p=0.000$).

Number of meals per day

The distribution of surveyed children by number of meals they had per day is shown in Table 3.

Only 24.9% (48) and 80.8% (156) of non-CABA said they had at least three meals per day ($p=0.000$). None of the CABA and only 11.9% of the non-CABA said they had at least four meals per day.

'I always think about my late parents. They always made sure that we were well fed. The situation changed for the worst when our parents both died. We no longer have enough food to eat. Sometimes we even go to bed hardly having eaten anything' said one boy, aged 12 years, from Mabvuku.

One other child had the following to tell:

'I am a 10-year-old girl. I wish if my father was alive, he would pay me school fees and buying me school uniform. Most of

Table 2. Reasons cited for not being at school (N=386)

Reason	Type of child				Total	
	CABA		Non-CABA		Number	%
	Number	%	Number	%		
Lack of money	26	65.0	3	18.8	29	51.8
Failed school	1	2.5	10	62.5	11	19.6
Does not want to	1	2.5	2	12.5	3	5.4
Completed O-levels	5	12.5	1	6.3	6	10.7
Ill health	1	2.5	2	12.5	3	5.4
No birth certificate	5	12.5	-	-	5	8.9
Suspended	1	2.5	-	-	1	1.8
Total	40	100.0	16	100.0	56	100.0

NB: *The sub-sample of children not reporting at school was 56.

Table 3. Number of meals per day that children had (N=386)

Number of meals	Type of child				Total	
	CABA		Non-CABA		Number	%
	Number	%	Number	%		
One	11	5.7	3	1.6	14	3.6
Two	134	69.4	11	5.7	145	37.6
Three	48	24.9	156	80.8	204	52.8
Four	-	-	23	11.9	23	6.0
Total	193	100.0	193	100.0	386	100.0

the time I do not attend lessons because I would have been sent back home because I do not have a school uniform. My mother is not working and most of my primary classmates are at boarding schools. We also run short of food, sometimes we spend the whole day without food. If there is not enough food provision, we only eat once a day. I go to school without pocket money. I also have a stomach and chest problems, I wish if my father was alive he could have bought medication for me.'

Adequate food all the time

The children in the survey were asked whether they had adequate food all the time. Adequate was taken to imply from the child's perspective whether the child thought the food he/she got was enough. It is important to note that what the survey sought was the child's own subjective perspective and perception on the adequacy of the food. Hence there was no systematic measurement of what was adequate. 'Rarely' was taken to clarify once per week. These data are shown in Table 4. The children in the survey did not experience any difficulties in responding to this question.

Almost 22% (42) of CABA and 82.4% (159) of non-CABA said they always had adequate food ($p=0.000$). Nearly 29% (55) of CABA and only 4.7% (9) of non-CABA said they rarely had adequate food ($p=0.121$). Almost 11% (22) of CABA and 1.6% (3) of non-CABA never had enough food ($p=0.818$).

The following is a story line from one child:

'If my father, was alive I could have been putting on nice clothes. My life could not have changed. I could have been getting

adequate food and all other basic needs like shoes. Now that he is no longer here, I sleep the whole night with one blanket. I have no textbooks and I do not have tennis shoes to put on when I go to school. Sometimes I eat porridge the whole day. I think my life will change when I start working. Right now I need books to read. My mother failed to get the money to buy textbooks.'

Child health and welfare

Child morbidity

Table 5 shows the distribution of surveyed children by disease or illness that they suffered from in the month before the survey.

Nearly a fifth (18.7%) of CABA and non-CABA reported that they had been sick in the month before the survey. The common ailments reported were cough 24.0% CABA and 27.3% non-CABA ($p=0.879$), headache 20.0% CABA and 22.7% non-CABA ($p=0.904$) and diarrhoea 22.0% CABA and 13.6% non-CABA ($p=0.748$).

Person responsible when child is seriously ill

The children were asked whom they thought would be responsible for them in the event that they fell seriously ill. As expected 69.2% of non-CABA said their parents would be responsible for them as compared to 34.4% of CABA ($p=0.000$). This high significant difference is expected given that the majority of CABA are cared for by their guardians and other relatives. Similarly 25.5% of CABA cited their guardian as the responsible person as compared to 17.3% of non-CABA ($p=0.112$).

Table 4. Distribution of children by whether they had adequate food all the time (N=386)

Response	Type of child				Total	
	CABA		Non-CABA		Number	%
	Number	%	Number	%		
Always	42	21.8	159	82.4	201	52.1
Sometimes	74	38.3	22	11.4	96	24.9
Rarely	55	28.5	9	4.7	64	16.6
Never	22	11.4	3	1.6	25	6.5
Total	193	100.0	193	100.0	386	100.0

Table 5. Distribution of children by disease/illness suffered from in the previous month (N=386)

Disease/illness	CABA		Non-CABA		Total	
	Number	%	Number	%	Number	%
Cough/cold	12	24.0	6	27.3	18	25.0
Malaria	1	2.0	3	13.6	4	5.6
Headache	10	20.0	5	22.7	15	20.8
Diarrhoea	11	22.0	3	13.6	14	19.4
Bilharzia	2	4.0	3	13.6	5	6.9
Worms	1	2.0	-	-	1	1.4
Cholera	-	-	-	-	-	-
Boils	2	4.0	-	-	2	2.8
Swollen legs	1	2.0	-	-	1	1.4
Other	10	20.0	2	9.1	12	16.7
Total	50	100.0	22	100.0	72	100.0

*The sub-sample of children not reporting at school was 72.

Visiting/checking on children

The children in the survey were asked to state whether anyone visited them or checked on them. Their responses are shown in Fig. 1. This question was necessary to determine the social wellbeing of children. Checking on the children was taken to imply visits by persons such as caregivers.

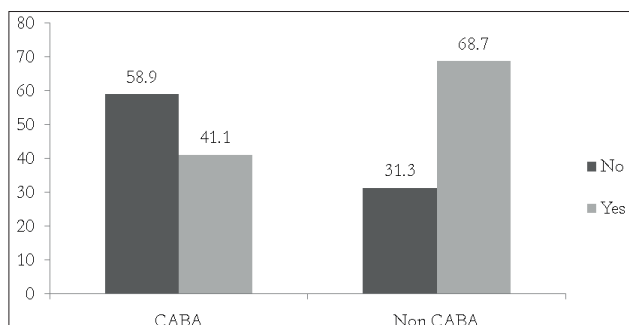


Fig 1. Percentage distribution of children by whether or not anyone visited them or checked on them (N=386)

Fig. 1 illustrates that non-CABA were significantly more likely than their CABA counterparts to be visited or checked on, i.e. 68.7% for non-CABA compared with 41.1% for CABA ($p=0.001$).

Data in Table 6 show that 35.5% (137) of the children were visited or checked on. Of these children, 55.5% were CABA while the remaining 44.5% were non-CABA ($p=0.201$). CABA were more likely to be visited or checked on than non-CABA. The majority of CABA (67.1%) and non-CABA (50.8%) were visited by relatives ($p=0.142$). Non-governmental organisations visited 11.8% of the CABA and 6.6% of the non-CABA ($p=0.046$). This difference was statistically significant.

One child had the following to tell:

'When I think of my mother's death I suddenly feel troubled and painful. Mother, if you were there I could be rejoicing because you are the one who took care of me, buying me clothes and taking me to refreshment areas. Mother you have left me life homework, which is now a heavy luggage for me to carry. Some children still have their own mothers but I am left with father only.'

Relationships with other children

Children were probed on how other children whom they stayed with related with them. It was encouraging to note that children tended to create an enabling healthy environment for their counterparts. Close to 63% and 72.5% of CABA and non-CABA, respectively, responded that other children they stayed with treated them in a friendly manner ($p=0.092$). A third of the CABA said they were treated like a family member. Only 3.7% of CABA and 4.0% of non-CABA said they were either beaten or scolded by other children they stayed with ($p=0.756$).

Treatment of child by parent or guardian

The survey further sought information on how children were treated by their parents or guardians. Seventy-one per cent of CABA and 74.5% of non-CABA said that their parents or guardians regarded them as children ($p=0.284$). It is however worrying to note that there were some children, particularly CABA, who reported ill-treatment from their guardians, 2.1% were overworked, a similar proportion were scolded while 0.5% were denied either food or education.

One child had the following to say:

'My father and mother died. We stay with our elder sister. We do not have school uniforms, clothes and we also run short of food. We need bath soap to wash our bodies before we go to school.'

Another had the following to add:

'First of all I would like to talk about my father. If he was alive I might have been going to school. We could have been not running short of food. Mother is ill and he could have rushed with her to the hospital. Some children of my age are going to school whilst I remain at home. We have nothing to eat, father; if you were here you could have helped mother. We have no adequate food; she needs a balanced diet so that she can quickly recover. We do not have food, blankets, soap, cosmetics and many other things. This reminds me the importance of my father's presence.'

Psychosocial wellbeing

The survey had a psychosocial assessment component as an integral component. The output from the analysis from the data is presented in Table 7.

Table 6. Distribution of children by person or organisation who visited or checked on them (N=386)

Person/ organisation	Type of child				Total	
	CABA		Non-CABA			
	Number	%	Number	%	Number	%
Department of Social Welfare	3	3.9	2	3.3	5	3.6
Non- governmental organisation	9	11.8	4	6.6	13	9.5
Church members	6	7.9	3	4.9	9	6.6
School members	2	2.6	5	8.2	7	5.1
Relatives	51	67.1	31	50.8	82	59.9
Siblings	1	1.3	11	18.0	12	8.8
National AIDS Council	4	5.3	5	8.2	9	6.6
Total	76	100.0	61	100.0	137	100.0

Table 7. Distribution of children by rating on psychosocial scale (N=386)

Psychosocial checklist	Type of child		Total %
	CABA %	Non-CABA %	
Often has headaches	39.4	35.3	38.5
Appetite poor	16.6	19.6	17.2
Sleep badly	17.6	11.8	16.4
Easily frightened	18.7	19.6	18.9
Hands shake	9.3	11.8	9.8
Feel tense/nervous/worried	22.3	17.6	21.3
Digestion poor	12.4	15.7	13.1
Trouble thinking clearly	12.4	11.8	12.3
Cry more than usual	17.1	15.7	16.8
Feel more unhappy than usual	28.6	31.4	29.2
Find it difficult to enjoy daily activity	7.8	15.7	9.4
Find it difficult to make decision	19.7	19.6	19.7
Daily work suffering	13.5	7.8	12.3
Unable to play a useful part in life	24.5	11.8	21.8
Have lost interest in things	8.9	23.5	11.9
Feel that you are a worthless person in life	17.2	0.0	13.6
The thought of ending your life been in your mind	4.2	2.0	3.7
Feel tired all the time	9.8	15.7	11.1
Have uncomfortable feelings in your stomach	20.7	19.6	20.5
Easily tired	11.4	24.0	14.0
Total	100.0 (193)	100.0 (193)	100.0 (386)

The psychosocial assessment was meant to provide the benchmark upon which to determine the psychosocial wellbeing of children in the survey. A standard checklist obtained from the Family Support Clinic (FSC) in Harare was adopted for this assessment. CABA were more likely than non-CABA to sleep badly (17.6% v. 11.8%) ($p=0.108$), feel tense and nervous and worried (22.3% v. 17.6%) ($p=0.248$), and feel that one is a worthless person in life (17.2 v. 0.0%) ($p=0.000$). Headaches were predominant among CABA and non-CABA (39.4% and 35.3%, respectively) ($p=0.405$). The non-CABA were more likely to experience the following than CABA: feel more unhappy than usual (31.4% v. 28.6%) ($p=0.548$), have lost interest in things (23.5% v. 8.9%) (0.000), experience poor digestion (15.7% v. 12.4%) (0.351) and feel easily frightened (19.6% v. 18.7%) ($p=0.822$).

Discussion

This study has shown that HIV and AIDS have adverse impacts on children. The consequences of HIV and AIDS on children include depression, reduced wellbeing, increased malnutrition and starvation, loss of health status, loss of educational opportunities, increased street living and exposure to HIV infection. However, what is even more important is that the general wellbeing of all children in the study area is being compromised. This major contribution of our findings to existing literature on HIV and AIDS is that in Zimbabwe the prevailing situation has to a large extent significantly removed the known differences of the CABA and non-CABA. As reflected in our findings, children are experiencing similar difficulties because of the socio-economic situation in the country.

The results are consistent with observations from other studies conducted in Botswana, Zambia and South Africa. For instance,

Richter *et al.* (2004) concluded that quality and availability of health, welfare and education systems in southern Africa are deteriorating because of demands caused by HIV and AIDS for resources and services because of loss of staff due to AIDS illness and death, and because of a reduced tax base. A study conducted by Foster (2006) also concluded that the AIDS epidemic has worsened the overall situation of children who live in communities affected by the epidemic.

Our findings showed a gloomy scenario for both CABA and non-CABA across all the socioeconomic indicators studied. This is further shown in that while a few of the differences between CABA and non-CABA were significant, many were not significant. This confirms the depressing situation of both CABA and non-CABA in the community studied and is in line with the observation that the problems of HIV-affected children, families and communities overlap considerably with the problems associated with poverty. However, HIV and AIDS exacerbates these problems, partly because of stigmatisation and partly because multiple stressful events are repeated in affected families and communities. The major conclusion to be drawn from this study is that the consequences of HIV and AIDS on children, families and communities are influenced in the main by the broader socioeconomic status of individual families and communities including access to basic services, and the acceptance of HIV and AIDS as a problem that affects everyone.

According to the Jaipur Paradigm developed by Barnet, Whiteside and Decosas (2000), the speed and extent with which the HIV and AIDS epidemic affect communities depend on the overall wealth of the community and the degree of social cohesion that pertains in the society. By social cohesion is meant the strength

of community groups such as parent-teacher associations, faith-based groups, and others who are in a position to act in a united way to mitigate the effects of the epidemic on the children.

In the study area, Mabvuku, the social networks have to a large extent been constrained by persistent poverty, unemployment and political mayhem. The social networks are consequently less supportive. Caregivers are frequently absent as a result of livelihood activities and this leaves children less protected. Kin and neighbours have taken the support of affected families, thus stretching the resources of everyone.

Conclusion

Overall in the findings, we observed high levels of various types of suffering and distress among CABA. Sometimes these levels were very similar to those observed among non- CABA. This could be attributed to the interplay between poverty and the impact of HIV and AIDS in the community that we studied. The findings present a picture of general disadvantage among children in Harare, with a sometimes elevated degree of hardship found among CABA. This was shown by the lack of significance difference in many of the indicators that we studied in this paper. Therefore the focus of policy measures should be on mitigating the suffering of all children which will elevate the quality of life for CABA and non-CABA.

The impact of HIV and AIDS on children was exacerbated by the political turmoil and socioeconomic difficulties being experienced by families in this community. There are no short-cuts or quick solutions. A sustained commitment to protecting and improving the lives of these children needs to link community programmes and actions with those at the global level, so that new interventions can achieve the widest possible impact.

Families need support to deal with the burden of additional children in the household caused by HIV and AIDS morbidity and mortality. Such assistance can be targeted to particular children or households identified to be exhibiting emotional problems or it can be offered on a wide scale in the whole community. Literature concurs on the overlap between problems of HIV-affected children, families and communities and poverty (Mhloyi 2005; Richter *et al.* 2004; Barnet, Whiteside and Decosas 2000; Foster 2006).

It is in order to advocate for the need to address the socioeconomic and political situation in Zimbabwe along with programmes

towards mitigating the suffering of all children and families. It is necessary that further research, preferably on a broad national scale, be carried out to establish the situation of children, families and communities affected by HIV and AIDS in relation to the current difficult social and economic situation in Zimbabwe.

Acknowledgements

We would like to thank the children in the study area who participated in this study. Without them the study would not have been a success. We thank the two anonymous reviewers who diligently gave comments which resulted in the improved manuscript. And, to all those who assisted in various ways, we also say thank you!

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