CHAPTER ONE

INTRODUCTION

This chapter provides the background to the study, the problem on which the study was based and its objectives including research questions. The significance of the study and operational definitions of key words used in the study are also highlighted in this chapter.

1.0. BACKGROUND

The HIV and AIDS epidemic has continued to be one of world's dreadful challenges for more than two decades now. It has claimed the lives of 25 million people in the world (Tsegaye 2008). It has become a global concern. By the end of 2007, 39.8 million people worldwide were living with HIV and around half were women. The total deaths worldwide in 2006 alone were 2.9 million (UNAIDS, WHO 2006). Southern Africa remains the epicentre of the global HIV epidemic with 32% of people with HIV globally living in this region and 34% of AIDS deaths globally occurring in this region (UNAIDS, WHO 2006). In 2007, about 22.5 million people were living with the virus in Africa (Tsegaye 2008). In the same year, 1.7 million people were newly infected with HIV, while 2.1 million died of AIDS, 1.6 million of them in Sub-Saharan Africa. Sub-Sahara Africa's epidemics vary significantly from country to country in both scale and scope (Tsegaye 2008). Adult national HIV prevalence is below 2 percent in several countries of west and central Africa but exceeded 15 percent in 7 Southern African countries in 2007. These countries include Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Unlike other regions, the majority of people (61%) living with HIV in Sub- Saharan Africa are girls and women due to their low socio-economic status that compromises their ability to negotiate safe sex (Tsegaye 2008). A study conducted by the Zambia Demographic and Health Survey shows that the overall prevalence rate is 14% between ages 15-49 (ZDHS 2007) and it has not gone below 14% since the 1990s.

Zambia is not an exception to the bias with more women (61%) living with HIV compared to men (12.3%). A study conducted in Zambia in 2004 concluded that Zambia ranks as the worlds 14th poorest country and in Africa, as the 6th highest HIV/AIDS prevalence (International AIDS Conference 2006). This is so because the death toll from AIDS in Zambia has continued to rise from 10,600 persons in 1990, 76,700 in 2000 and it will be about 94,100 in 2010 (NAC 2004). The AIDS impact is very visible. Compared to other diseases, AIDS is not just a medical problem but also a social and economic one.

Zambia has the second highest number of Orphans and Vulnerable Children (OVC) in Africa. 50% of the estimated 1.3 million OVC in Zambia are as a result of HIV and AIDS. Since the first AIDS case reported in Zambia in 1984, the impact the epidemic has had on the lives of children who have lost their parents to it has been bad. Children orphaned by AIDS are vulnerable in almost all aspects of their lives (Haworth et al. 1991). Orphans witness the prolonged illness of parents that later die and because of this, the children may have mental distress. Some of the many challenges faced by orphans resulting from the death include depression, increased malnutrition, lack of schooling, lack of immunisation, early entry into paid labour, loss of inheritance through property grabbing, early marriage, homelessness, exposure to abuse and increased risk of HIV (Hunter and Williamson 1997). Although most OVC rely on a network of support from family and community, it has not been easy for them because the traditional family has been overstretched with the number of children needing assistance. As a result, some children are forced to live in homes where they are resented or unwelcome and may be forced to engage in high risk activities that make them vulnerable to HIV infection. Where OVC do not have a home, they are placed in orphanages or shelters and countrywide, 4,592 children are living in such arrangements (UNICEF 2010). It is estimated that 150,000 children are living without adult supervision (NASF 2011-2015).

The social and economic impact of HIV and AIDS threatens the well-being and security of children affected. As parents become ill, the burden is on children because they take on greater responsibility for income generation, food production and care of family members. Children face decreased access to adequate nutrition, basic health care, housing and clothing. The implications of having AIDS include increased medical costs and expenditure during the funeral (UNAIDS 2006). This means that the money in the household is used to cover medical expenses and in turn reduces on the amount of food and education for the children. In some cases, HIV and AIDS also increase pressure on the care giver because they have to sell assets and borrow from friends and relatives in order to meet the medical expenses (ILO 2003).

In view of the above, this study explored more on how girls and boys cope differently and how they manage to survive after the death of a parent. The concepts of 'coping' and 'coping strategies' are rooted in responses to the famines of the 1970s and 1980s in Africa (De Waal 1989; Devereux 1993). With the onset of HIV and AIDS, the language of 'coping' has become widely used to indicate the extent to which households and communities have the wherewithal to respond to adversities resulting from the epidemic (UNAIDS 1999). However, notions of 'coping' can under-estimate the stark realities for many households and communities affected by HIV and AIDS, who are in fact 'struggling', rather than coping in any positive sense (Rugalema 2000). In addition, the assumption of 'coping' may divert policy makers from the enormity of the emergency that a household or community is facing. Rather than devising a planned sequence of measures, or 'coping strategy', in response to the difficulties faced, households affected by HIV and AIDS often respond to immediate problems in a reactive way, for example by selling off assets to meet their immediate needs (Donahue 1998, National Agricultural Advisory Service of Uganda 2003). Other responses include intra-household labour re-allocation, taking children out of school, making use of fewer crop varieties or less labour-intensive crops, reducing the area of cultivation and/or the size of livestock herds, and reducing the quality of

food and its frequency of consumption (UNAIDS 1999, National Agricultural Advisory Service of Uganda 2003). While traditional community-based support networks enable reciprocal arrangements to alleviate hardship, these are increasingly struggling to respond adequately, given the scale of the epidemic (Family Health International, 2003) and may not always be equitably applied (Baylies 2002). Research now demonstrates that the poorer the household, the more likely it is that the measures adopted will prevent longer-term recovery of the household economy (Skoufias 2003).

Eventually, many households reach a point where they have no further coping mechanisms to employ and are either dissolved or fail to ever regain the quality of livelihoods that they had prior to the death of a prime-age adult (Donahue 1998, Seeley 1993, Yamano et al. 2002). The literature relating to how individuals and in particular children cope in response to the complex and difficult circumstances posed by HIV and AIDS - usually in combination with other adversities - is limited (Mann 2005, FHI 2003, Save the Children 2002). For children affected by HIV and AIDS, coping can be observed at two levels: coping in relation to meeting material needs and basic commodities; and coping on an emotional level, part of what has come to be termed the 'psychosocial' aspects of responding to illness and death (Stein 2003).

Some previous work has explored the notion of resilience and how it can be nurtured in children affected by HIV and AIDS (Mallmann 2002). Resilience has been defined as 'the human capacity to face, overcome and be strengthened by or even transformed by the adversities of life' (Grotberg 1995) or the ability to 'bounce back' after stressful or traumatising events. Building resilience has the potential, therefore, for both protecting children from different forms of vulnerability resulting from the death of parents or relatives, and enhancing their ability to cope.

1.1. STATEMENT OF THE PROBLEM

Although a number of studies have been conducted in Zambia on HIV and AIDS, there is limited information on livelihood and emotional coping strategies employed by children from homes in George and Chazanga compounds of Lusaka District affected by HIV and AIDS deaths. This gap in existing literature led to the formulation of the problem. The main research question for the study therefore, was: what are the livelihood and emotional coping strategies employed by children from homes in George and Chazanga compounds of Lusaka District affected by HIV and AIDS related deaths?

1.2. MAIN OBJECTIVE OF THE STUDY

In line with the statement of the problem, the main objective of the study was to investigate the livelihood and emotional coping strategies employed by children from HIV and AIDS affected households and their experiences with regard to meeting their health and education needs.

1.2.1. Specific Objectives

1. To examine the gender difference in livelihood coping strategies employed by children from HIV and AIDS affected homes
2. To investigate the gender differences in emotional coping strategies employed by children from HIV and AIDS affected homes
3. To investigate the gender experiences of children from HIV and AIDS affected homes with regard to meeting their health and educational needs

1.2.2. Research Questions

In order to achieve the above stated specific objectives, the study collected information in order to provide answers to the following questions:

1. What are the gender differences in livelihood coping strategies employed by children from HIV and AIDS affected households?

2. What are the gender differences in emotional coping strategies employed by children from HIV and AIDS affected households?
3. What are the gender experiences of children from HIV and AIDS affected households with regard to meeting their health and educational needs?

1.3. SIGNIFICANCE OF THE STUDY

The study has added to existing literature currently available in Zambia on livelihood and emotional coping strategies employed by those children from homes affected by HIV and AIDS related deaths.

1.4. OPERATIONAL DEFINITIONS

The following terms were frequently used in this dissertation hence the need to give operational definitions to ensure a common understanding.

AIDS

Acquired Immune Deficiency Syndrome (Mosby's medical dictionary 2009).
In this dissertation, the term AIDS refers to Acquired (must do something to contact) Immune (ability to fight off infections agent) Deficiency (lack of) Syndrome (cluster of symptoms that are characteristic for a disease)

Child

A Child is defined as a young human being below the age of full physical development (Pearsall 2001).
In the context of this study, the term child refers to boys and girls who are between 10- 20 years.

Coping Strategies

Coping strategies refer to thoughts and actions we use to deal with stress (Owen 2010).

In this dissertation, coping strategies refer to ways that are employed as survival skills.

Double Orphan

According to Van Dyk (2005), a double orphan is a child who has lost both parents.
The term double orphan in this investigation refers to a child who has lost both parents.

HIV

Human Immuno – Deficiency Virus (Sepkowitz K. A. 2001).

HIV in this dissertation refers to Human (Isolated to the human species) Immuno-Deficiency (lacking the ability to fight off infections agents) Virus – (a disease causing agent)

Household

People living together in one house collectively (Collins English Dictionary 2003)
A household in this investigation refers to a group of people, who live together in one house, provide for each other and often share meals. Household members also include those who are temporarily absent from the household but have returned at some point.

Livelihood

Livelihood is the way you make your living and pay for the basic things you need in life (your dictionary definitions 2012).
In this dissertation, livelihood refers to the capabilities, assets and resources required in order for one to survive.

Maternal Orphan

Van Dyk (2005) defines a child whose biological mother has died as a maternal orphan.
Maternal orphan in this paper has been defined as a child whose biological mother has died.

Orphan

An orphan can be defined as a child whose parents are dead (Pearsall 2001).
In the context of this research, an orphan is a child between the ages of ten and twenty, who has lost one or both parents through-an AIDS related death. Maternal, paternal and double orphans appear in the research.

Paternal Orphan

A child whose biological father has died is a paternal orphan (Van Dyk 2005).
In this dissertation, paternal orphan refers to a child whose biological father has died.

Single Orphan

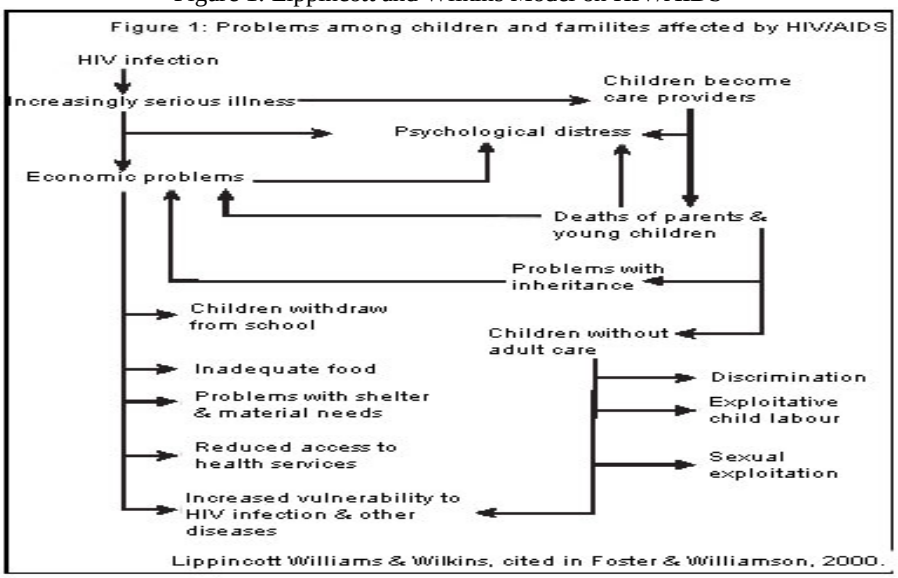
Single orphan refers to a child who has lost just one parent (Van Dyk 2005).
The term single orphan in this dissertation refers to a child who has lost just one parent.

1.5. THEORETICAL MODEL

Although several models have been used to explore the impact of AIDS on children, the model by Lippincott and Wilkins presented in Figure 1 below, was found to be appropriate in guiding this study. Based on this model, the researcher

was able to identify some of the economic and psychological problems experienced by children from homes affected by AIDS.

Figure 1: Lippincott and Wilkins Model on HIV/AIDS



According to the model, children from families affected by AIDS are affected by both economic and psychological problems. Consequences of economic problems include among others, withdraw from school, reduced health care, problems with shelter and inadequate food. On the other hand, consequences of psychological problems are as a result of sexual harassment, exploitative child labour and discrimination. However, the theory did not indicate whether or not boys and girls from families affected by AIDS employ different coping strategies to overcome their economic and psychological challenges.

CHAPTER TWO
LITERATURE REVIEW

2.0. INTRODUCTION

This chapter provides the relevant literature review done by other researchers in connection to the topic under study. It gives the overall situational analysis of HIV and AIDS, situational analysis of orphans, empirical studies on the livelihood and emotional coping strategies employed by children from affected households and finally empirical studies on children's (those from households affected by HIV and AIDS) experiences with regard to education and health.

2.1. OVERALL HIV/AIDS SITUATION

The HIV and AIDS have proved to be an epidemic of concern which affects economic, social and human challenge globally and in particular Sub-Saharan Africa. The epidemic has killed millions of people, impoverished nations, robbed children of their parents and hence has exacerbated the vulnerability of children world over limiting their access to basic services such as food, education, health care and has exposed them to abuse and exploitation. HIV and AIDS have so far claimed the lives of 25 million people globally. By 2006, 39.5 million people were living with HIV and in the same year, 2.9 million people died of HIV and AIDS (UNAIDS, WHO 2006). By the end of 2007, it was estimated that among the 39.8 million adults worldwide living with HIV and AIDS, about half were women (UNAIDS/UNFPA/UNIFEM 2008). In sub-Saharan Africa alone, out of the 23 million adults aged 15-49 and infected with HIV, 13.1 million or 57 percent are women (UNICEF 2008).

Zambia is not an exception to this epidemic; Zambia Demographic and Health Survey shows that the prevalence rate is 14% between ages 15-49 (ZDHS 2007). A study conducted in Zambia in 2004 concluded that Zambia ranks as the worlds 14^{th} poorest country and in Africa as the 6^{th} highest HIV and AIDS prevalence

(International AIDS Conference 2006) and is estimated that currently, around 920,000 people in Zambia are living with the HIV, with about 94,000 deaths as a result of AIDS per year (FHI 2004). A report from the United States Census Bureau noted that the average life expectancy in Zambia in 2006 was 38 years when taking HIV and AIDS into account and 55 years when HIV and AIDS is not taken into consideration (Smith 2009). This shows that HIV and AIDS have contributed highly to the increase in the number of deaths.

2.3. GENDER AND HIV/AIDS

HIV and AIDS have a gender inequality. The 2007 ZDHS indicate that among women, the HIV rate is 16% compared to 12% among men (ZDHS 2007). It affects women more than men because it is imbedded in many cultural traditions that women are the main care givers in a household, therefore, the burden of AIDS care falls on them. Apart from them being more vulnerable to HIV, the responsibility of caring for AIDS patients and orphans is also an issue that has a greater effect on women. The ZDHS 2007 concluded that women below age 40 had a higher prevalence of HIV compared to women above 40 years of age. Women above age 40 also have a lower prevalence compared to men the same age group (NASF 2011-2015). The ZDHS indicated that for women between the ages 40-44 years, the prevalence rate was 18.3 while men of the same age group, the prevalence rate was 24.1. Women between 45-49 years had a prevalence rate of 12.1 while men the same age group were at 18.5. The trend of women especially those below 40 years being infected more has continued as evidenced by the 2009 statistics that an estimated 82,681 adults of newly infected persons with HIV being 59% women and 41% men (NASF 2011-2015). Children are most likely to be affected in countries where women are most affected and this adversely limits educational and economic opportunities for women and girls (UNAIDS 2006).

A review of economic research on AIDS concluded that households belonging to females, the poor, the less educated or unskilled people are the most affected

economically due to AIDS (UNAIDS 2006). In 2004 for example, 75% of all care givers for persons living with HIV and AIDS were women (UNAIDS 2004). This care giving is in addition to the many other tasks performed within the household such as cleaning, cooking, and caring for the children and the elderly. All this work is unpaid and does increase a person's workload by up to a third (UNAIDS/UNFPA/UNIFEM 2004). Women normally find it difficult to bring in an income whilst providing care and therefore many families affected by AIDS suffer from poverty. The rates of infection among women and girls are a cause for deep concern, and when combined with the workload that women take on as well, in caring for AIDS patients, AIDS orphans and their own families, the situation becomes untenable, especially in Southern Africa (UNICEF 2008).

2.4. SITUATION OF ORPHANS

The situation of orphans in society by AIDS is complex. In a study by UNICEF in 1999, it was established that over 35 percent of all children under the age of 15 were orphans (UNICEF 2002) and 75 percent of orphaned children lived below the poverty line (Fleshman 2001). The UN Secretary General at that time, Koffie Anan, noted that by 2001, the number of AIDS orphans exceeded 13.2 million globally and their numbers where still growing (USAID 2006). Avert in 2010, concluded that the numbers are at an estimated 15 million under 18 orphans and of these, around 11.6 million live in Sub-Saharan Africa.

Zambia has been hit hard by the growing numbers of orphans. USAID found that the number of orphans in Zambia in 2005 was 1.2 million and approximately 750,000 of them as a result of HIV and AIDS. Zambia is reported to have one of the highest mortality rates due to HIV and AIDS, with projected life expectancy currently at age 40. As a result, the number of orphans also continues to increase dramatically. Zambia is also reported to have one of the highest numbers of orphans due to AIDS in sub-Saharan Africa; estimates in 2006 were at 710,000. (UNAIDS 2006). The situation is worrying as more children are left to fend for themselves.

Traditionally, as in many parts of Africa, orphaned children were usually absorbed into the families of their immediate relatives as a matter of fact, when parents died. However, because of the extent and speed of the disease, families are no longer able to cope, as often, multiple members of one family group contract AIDS and die, at about the same time. The result is a growing number of children who end up living on the streets and having to survive on their own. A report published in South Africa indicates that in 2001, there were about 10,000 children living and working on the streets in the country (Gow and Desmond 2002). In several instances these children have to take on the responsibility of head of the house and, depending on their ages, have to look after and provide for younger siblings. As a result of their parents' deaths, children are impacted in several ways including emotional well being, physical security, and mental and overall health (UNICEF 2004).

Available literature seems to support this view. There is an overall negative impact that is experienced by these children, that unfortunately, because of high levels of poverty in this region, only seems to get worse. Direct impact is usually physical with the children themselves becoming ill, and eventually dying. In many cases, poverty and inadequate resources, and support systems to provide nutrition, shelter and required medication exacerbate the high mortality rate among these orphaned children (UNICEF 2003). Even in instances where children have not contracted the HIV virus from their parent, these children are still at a high risk for illness including malnutrition and other childhood illness (UNICEF 2003).

The traumatic effects of parental loss can have further negative psychological effect on the behaviour, emotions and thoughts (Calhoun & Tedeschi 1995). Children are equally prone to psychological distress and shock: first at seeing their parent's physical deterioration and helplessness and, eventually with experiencing their death (Gilborn et al. 2001 & Ndongko 1996). Psychological distress is expressed in varied ways. Some children take to living on the streets as a form of

coping; depression is a common occurrence; various forms of juvenile crimes have been committed, including the abuse of substances (Gow and Desmond 2002a). Children may become exposed to alcohol and drugs and use them as a way of shutting out painful effects (Calhoun & Tedeschi 1995). Fear and anxiety about continuing livelihood and issues around security are common emotional reactions (Calhoun & Tedeschi 1995). Children may continue to carry the effects of trauma long after their parents have died and, even when they have been settled in a new environment (UNAIDS, UNICEF 2003). AIDS still continues to carry a stigma in many parts of Africa and is still associated with shame, fear and rejection. This is yet another psychological effect that these children have to endure. (UNICEF 2003; UNAIDS 2000). There is evidence to suggest that children who lose their fathers due to AIDS become less depressed than those who lose their mothers. This has been attributed to the psychological nurturing that is believed to be provided by the mothers (Basaza & Kaija, 2002).

Issues of economic survival also have an effect on children orphaned by HIV and AIDS. This is felt primarily through the absence of basic amenities, an inability to enjoy past activities and, in many cases, withdrawal from school (Ndongko 1996). In a study on adjustment of orphans, Wild (2001) further states that children in some cases may end up losing their inheritance. In some instances, even those children who are able to continue with schooling do not perform well and eventually drop out. Reasons for this have been attributed to lack of parental guidance, poor nutrition and, absenteeism as a result of having to take care of their ill parents (Basaza & Kaija, 2002).

An increased incidence of children having to become breadwinners or at least significant contributors to the family finances is not unusual. Children find themselves in a position where they have to forfeit books and learning, with entering the job market (Jackson et al. 1999; Phiri & Webb 2002). Because they are unskilled, children end up performing manual tasks that are usually harmful, requiring a lot of effort with minimal wages. The economic impact can also be felt

with respect to the health requirements of orphans. During the continued illness of a child's parents, available resources are normally diverted to obtain what nutritional requirements and medication is needed for the sick parent.

More directly, it has also been found that children living with HIV-infected parents are more likely to contract opportunistic illnesses like Tuberculosis, malnutrition and stunting (Wild 2001). As a result of their parent's illness, children can no longer obtain adequate levels of child care and may not be able to even attend health facilities because their parents are unable to accompany them (Phiri & Webb 2002; Gow and Desmond 2002). Once the parent dies, then even that slim source of funding is no longer available, making access to health care even more unattainable. Children's opportunity to receive adequate nutrition is also affected; the amount and type of food that children receive is greatly compromised /reduced. A study conducted in Uganda in 2001, showed that orphaned children do not receive adequate food to eat, nor do they have a consistent diet. Older children especially were less likely to eat more than a few times in a week (Basaza & Kaija 2002).

2.5. IMPACT OF HIV/AIDS ON EXTENDED FAMILY

It has been established that the extended family takes care of over 90% of the double orphans and that these orphans are 13% less likely to attend school than non orphans and double orphans are more likely to be disadvantaged. One in six households with children is caring for at least one orphan (Manasch et al. 2004). This however, does not mean that because orphans are being taken care of by the extended family then all is alright.

Extended families also face different challenges especially economic ones and children can no longer rely on the support of the traditional extended family system, which in the past provided care and support for the aged, orphans and any vulnerable and disadvantaged family member. This coping mechanism has been over stretched by poverty and by the sheer numbers of children to be cared for,

given the fact that AIDS affects the most productive family members in the prime of their productive and reproductive lives. As a result, children have sometimes gone into homes that are already overstretched and where they are really not welcome (UNICEF 2008).

After the death of a parent, relatives may decide to share out the children so as to reduce the economic burden on any one of them. This however, is often a source of great emotional distress to children who have become attached to one another. The presence of AIDS in most cases means that the household will dissolve because parents die and therefore, children are sent to relatives to be looked after. In some cases, adult relatives may join the household consisting of children to assist. A study by UNAIDS in Zambia revealed that 65% of households in which the mother died, children had been taken by relatives to be taken care of (UNAIDS 2002). It has been observed that many grandparents are left to care for the orphaned children and in most cases, the grandparents have nothing more to offer other than the little shelter they have (MOH/ CBO 1999). This means that there is an increased burden at the community and national level to provide services for these children including health care, school needs and orphanages. Many of these necessities are not met thereby increasing the burden on society in future years. The increasing number of street children in urban areas may be as a result of the impact of AIDS on households (MOH/ CBO 1999).

The role of the extended family and community in coping with orphans is in a state of flux. Where traditional values are maintained such as in rural communities, the extended family safety net is better preserved. Where countries are more urbanized, extended family safety nets are weakened. As the traditional practice of orphan inheritance by uncles and aunts has lessened, it has been replaced by alternate safety nets with care provided by grandparents or other relatives. Children who slip through the safety net may end up in a variety of vulnerable situations such as street and working children and child-headed households. Monitoring the background of such (Lippincott Williams & Wilkins

2000) children can be a valuable source of information about families which have the greatest difficulty caring for children and where efforts to strengthen capacity should be targeted.

In severely affected communities, HIV and AIDS have an impact on children, families and communities which is incremental. The continuous attrition rate of deaths in young adults leads to social and economic impacts which increase with the severity and duration of the epidemic. The impact of HIV and AIDS on children and families is compounded by the fact that many families live in communities which are already disadvantaged by poverty, poor infrastructure and limited access to basic services. Strategies for coping of extended families have negative impacts on children in households indirectly affected by HIV and AIDS, thus enlarging the overall impact and number of children affected. For example, children may experience reduction in their quality of life when their mother goes to provide home care for an HIV and AIDS-affected relative or because of transfers of money to a sick relative's household. Children may see their standard of living deteriorate when cousins come to live with them following the death of an aunt or uncle.

2.6. CHILD HEADED HOUSEHOLDS

All children have a right to survive and develop to their full potential. They also have a right to enjoy a safe, happy and healthy and happy childhood. They have a right to healthy physical and emotional development and to live, learn and be full and respected members of society. Yet, in many poor countries, children face significant hurdles in securing even the most basic standards of survival and development (UNICEF 2009).

In both urban and rural areas, many orphans are struggling to survive on their own in child-headed households. Many others are forced to live on the street and engage in risky sexual behaviours. Some may turn to prostitution and crime as a means of survival. This puts the children at a higher risk of contracting HIV even

when they were born HIV free. It has also been established that the number of child headed households has increased. There may be over 20,000 child headed households in Zambia (Kelly 2006). This has been due to the increased economic burden that extended families continue to face and can hardly accommodate any more children comfortably (Kelly 2006).

In September 2001, Family Health International carried out a qualitative survey to determine the psychosocial and emotional needs of orphans and vulnerable children in Zambia. It was noted that Zambian people have traditionally depended on extended family in terms of difficulties such as looking after orphans. However, HIV and AIDS pandemic have stretched the traditional extended family because of the increasing number of orphans. During the Focus Group Discussions, there was frequently an expressed feeling of frustration that the extended family was not fulfilling their traditional obligations for caring for orphans and vulnerable children. The study concluded that all children live in abject poverty, do irregular piece works and depend on kindness of neighbours. Child headed households have to find work, manage the house and discipline their siblings. All the child headed households earn a living through doing piece work, such as doing the washing for the more affluent people, street vending and small scale trading such as selling small amounts of charcoal. Some of the girls go to the more affluent residential areas in search of work in exchange for a bowl of mealie meal and according to the girls interviewed in the study, such work is hard to come by and when it comes by, an average they earned in a day was K3000 (USAID 2002).

Many of the older girls go to live with their boyfriends or get pregnant, hoping that the boys will look after them and take them away from their current situation (FHI 2002). Some of the girls have been abandoned after falling pregnant by the father of the child and they end up taking care of their babies on their own as well as their siblings. The girls enter into relationships looking for love and to be taken care of, yet, these relationships end up in risky sexual behaviour and it is clear that

the youth do not use protection to prevent HIV infection. These children in particular, are open to severe exploitation which comes in many forms including sexual and this leaves them even more vulnerable (FHI 2002). The existence of Child headed households is a clear illustration of the collapse of the extended family and the high poverty levels.

2.7. CHALLENGES THAT CHILD HEADED HOUSEHOLDS FACE

Child headed households face tremendous emotional and psychological challenges and live with constant memory of their deceased parents and some may even experience depression. They then suffer from stress resulting from adapting to adult roles (Tsegaye 2008). The children experience a decline in the standard of living. They lack food, clothes, money and hence cannot go to school because they have to pay school fees and buy uniforms. It is not easy for the young heads of households to manage everything on very little money since they do not have consistent income. Because of such, some children end up engaging in hazardous child labour activities and most of the child headed households take with them siblings to help with the piece work they do (FHI 2002). Orphans in child headed households are at risk of neglect, violence, sexual assault and other abuses. The children in these households are most likely to experience negative outcomes such as morbidity and mortality at higher rates than their peers do and worse still, the children are more likely to lose their rights to a home through failure to secure inheritance rights or because of stealing by some opportunist relatives. They are also likely to be forced out of their homes by relatives or guardians for fear of contagion or unfounded allegations of witchcraft (USAID 2002).

Overall the impact on a household where the main breadwinner dies due to HIV and AIDS produces a ripple effect. Family income is reduced and that sets off deficiencies in other aspects of the home (FHI, USAID 2002). The amount of disposable income available to be spent is usually not adequate to meet the requirements of the remaining family members. As a result unavoidable sacrifices

are made and far-reaching financial decisions are taken, that ultimately result in the family becoming poorer (Gow and Desmond 2002b).

With Zambia reportedly having one of the highest numbers of orphans in the region, many children have become displaced because of unfavourable family circumstances and hence find themselves on the street. Several of them do not have access to inheritance that is rightfully theirs and see the streets as their only alternative (Phiri & Webb 2002). The phenomenon of "property grabbing" has increased the vulnerability and instability of children, as has homelessness (Gilborn et al. 2001). The streets however present other risks that these orphans have to face. Personal circumstances, such as lack of parental protection, and economic resources make these children particularly vulnerable when they are on the streets. They are at risk for both mental and physical abuse, stigmatisation and perhaps most unfortunately they run the risk of contracting sexual diseases, including HIV. This is especially true when children are exploited for sex, in order to eke out some kind of living. Young girls especially who are in demand by sexual predators invariably get abused more so than boys (Phiri & Webb 2002; UNICEF 2003).

The increased number of children orphaned by HIV and AIDS also represents an increased number of children who are working. The number of children between the ages of five to fourteen who are working in this region is estimated at about 29%. (UNICEF, UNAIDS 2003). At this age, many of these children do not have the physical capacity to perform optimally and invariably this has an effect on their physical development. One other disturbing consequence is that families and siblings often get separated after the death of one or both parents. It is still true in Africa that extended families continue to look after orphans; but unfortunately it is not always possible to absorb all the children from one nuclear family into an existing family. Hence siblings get 'divided' among the extended family and have to be raised in different homes (UNAIDS/UNICEF 2003).

Studies in Uganda indicate that children find this separation particularly stressful as it leaves them feeling isolated. (UNAIDS/UNICEF 2003). Yet, notwithstanding the multiple negative effects that orphans, especially street children, experience as a consequence of HIV and AIDS many of them survive. They have continued to demonstrate resilience in their ability to look after themselves, to source for food and in general to stay alive. It may be assumed that to some extent these children, as with most people, possess an inherent degree of resilience. The social support that they receive from their peers cannot be ignored in this case. Brannon and Feist (2000) speak about the positive link between good health and social support. If this is true then to some degree the same should be available to these children as they pass on and share survival skills; much in the same way that family and friends in society, in general, are seen to provide positive input to well being.

2.8. RELEVANT STUDIES ON LIVELIHOOD COPING STRATEGIES

Although the literature indicates that the study of coping strategies in ordinary situations among children has received less attention than for adults, it has been acknowledged that most of the studies on children focused on specific coping strategies with respect to specific circumstances, such as chronic illness. In general terms, coping strategies have been described as the cognitive and behavioural efforts one makes to try to endure, escape or minimise the effects of stress (Lazarus 1966).

Emergency of child headed households has been one of the ways in which orphans have had to cope with this tragedy. In Rakai studies carried out have indicated that child headed households is real and rampant in the district. Due to its orphan population, Rakai has been recruiting children to go for work in urban centres as house maids (Mwaka and Tumushabe 1996). It has been noted that the economy considerably depends on child labour after the death of the most energetic adult population aged 15-35 years (Mwaka and Tumushabe 1996).

An in-depth study of the coping strategies of orphans and other vulnerable children (OVC) affected by HIV and AIDS which was conducted by UNICEF (2003) across six sites in rural and urban Zimbabwe revealed that a 12 year-old boy in Bulawayo whose father had died talked about the emotional importance to him of the regular visits from his maternal uncle. His paternal uncle also visited regularly and paid his school fees if his mother had not managed to do so. Others described the significance of visits from family members, an indication that they were cared for and not forgotten. There were also several examples of extended family living far away paying someone locally to take care of children, or sending money or clothes whenever they were able to. Others, however, described the presence of extended family that never gave them support. This was often put down to their inability to do so. As a 17 year-old boy heading a household in Rusape commented: "relatives do not help us; they do not have the resources". For the most part, children (like adults) focused on the practical coping mechanisms that they employed and described the day-to-day activities that were carried out in order to sustain themselves and their household, rather than on how they coped psychologically and emotionally. Children of all ages described their roles within their families, although the expectations on younger children varied.

While in some households they took on significant responsibilities to contribute to the household chores and economy, in others they seemed to retain more of their status as children. Children were clearly adapt at drawing on wider resources within the community and those as young as 12 described ways in which they sought assistance from others through asking for vegetable seedlings to grow their own vegetables or borrowing food or money from neighbours when hungry - paying it back when they had surplus or when they were given handouts by NGOs. A 12 year-old boy in Bulawayo talked about how he would mould bricks and sell them, as well as sell vegetables and fruit to get money for food or exchange them for treatment at the local clinic if he was sick. Other strategies adopted by young people were more subtle, such as doing whatever they could to 'please' relatives who had taken them in.

Another 14 year-old boy in Rusape described how he did his allocated tasks without complaint in an effort to "try to make my grandparents happy about keeping me". A wide range of strategies to help secure their basic needs were described by children and young people. These included fishing in the river; selling or exchanging whatever resources were available, such as mangoes and frozen drinks; working in other people's fields; herding others' cattle; washing or looking after cars; moulding and selling bricks; roasting and selling mice; bee-keeping; recycling plastic bottles; and many others. On the whole, these activities were carried out to secure the basic minimum needs of children and their siblings, and in many cases their survival depended on these activities. However, young people felt that they were not always treated fairly by those they worked for. A 14 year-old girl in Chegutu said, "People in the village are very difficult because you weed the whole day and they give you no food and re-negotiate the money that was agreed. When you have done all the work …then they will only give you $8,000 instead of $10, 000" (Zimbabwean dollar). Importantly, boys described a wider range of potential income or resource generating activities than girls. While boys talked of fishing, hunting, brick-making, carpentry, herding others' cattle, and so on, the economic activities described by girls were more confined to working in other people's fields and selling vegetables from gardens, or asking neighbours for help in the form of food or soap or other basic commodities.

In addition, the study in Zimbabwe also reported negative 'coping' strategies from children and young people's narratives such as going to live on the streets; moving from place to place until they found some level of security; leaving home and getting married with the hope of improving their life situations. One young woman in Harare aged 18 had been forced (at the age of 17 years) to leave her job as a domestic worker since she had no identification papers. Left destitute she commented, "my only way out was to get married" and described how she met and married her husband within two months. Other strategies included reducing the number and size of meals eaten, and - in the case of young people living on

the streets - searching for food in rubbish bins, or exchanging sex for food or shelter.

Other studies have also shown that many children in South and Southern Africa already work hard. The Survey of Activities of Young People (SAYP) commissioned in 1999 by the South African Department of Labour found that more than half a million children between five and 14 years of age work for long hours, mainly collecting wood or water. Close to 400,000 children do night work; 183,000 do three or more hours a week of paid domestic work and 137,000 work with or close to dangerous machinery or tools. About 19,000 children (0.1%) beg for money or food in public for three or more hours a week. More than 70% of children work to help their families, either willingly or unwillingly. About 30% of children's work is in contravention of the law. The International Labour Organisation (ILO) estimates that worldwide approximately 120 million children in the five to 14 year age group work on a full-time basis, and this figure rises to around 200 million when those for whom work is a secondary activity are included. Other surveys conducted by the ILO have found that over a 12-month period, the proportion of economically active children in the five to 14 year age group could rise to as high as 40% in developing countries. Such studies conclude that children's labour contributions are an important component of household income, in some cases amounting to as much as one-third of household income.

2.9. RELEVANT STUDIES ON EMOTIONAL COPING STRATEGIES

The emotional impact of parental death on children is overwhelming and this is felt for many years to come. Research that has been done shows that the impacts of watching parents die, watching them being buried even worsens it (UNICEF 2007). This causes devastation on the children. Devastation that comes along with the loss of both parents is even more (ACPF 2008). Studies done in Uganda, Ethiopia, Zambia and Zimbabwe on the impact of HIV and AIDS deaths on children conclude that the children have high levels of anxiety, depression and

unanswered questions as to why it had to be their parents to die. They are not active, they have feelings of hopelessness and at times, thoughts of suicide run through their minds (ACPF 2008).

In the study conducted by FHI / USAID (2002) children who took part indicated several strategies or activities that they employed to deal with the pain of loss of their parents and the negative changes in their lives. Playing football, crying, visiting and playing with friends, praying and talking to someone were some of the strategies identified by the children. Another interesting study to look at is an in-depth study of the coping strategies of orphans and other vulnerable children (OVC) affected by HIV and AIDS which was conducted across six sites in rural and urban Zimbabwe. Qualitative methods including case studies and in-depth interviews were used to examine the daily lives and coping strategies of children and their families. Data were gathered primarily from children and young people, but also from adults in families and communities. The results of the study were as reported below.

Children and young people frequently described the death of more than one parent or relative. The death of a mother was often felt by adults and children alike to be particularly significant because they (mothers) were more likely to provide care and security for a child. Several respondents described how their lives were drastically changed as a result of losing their mothers. A 10 year-old boy in Rusape said, “When I heard that my mother had died, I was out herding cattle. I felt weak and fell unconscious only to gain consciousness when I had been taken home. The thought that I would never see my mother again saddened me and then my father also passed away. Then I was with no parents”. Children reported various ways in which they sought to relieve the strain of the difficulties they faced.

As in other studies (e.g. Mann 2002, FHI 2003), talking to friends rather than to adults was a common support-seeking strategy. For younger children up to the age

of about 12 years, meeting up with friends, playing games and talking to older siblings were strategies they employed. An 11 year-old boy in Chinhoyi described how he told his older sister his problems and asked her to tell him fairy-tales. An 11 year-old girl in Chegutu talked about how her friend "tells me funny stories and releases my stress". Two girls aged 7 and 10 years, interviewed together, talked about the games they played, and the enjoyment they derived from attending school.

For some children in this younger age group, coping also came through a sense of acceptance of their 'lot'. While for some this came across as resignation and low expectations, others demonstrated a great deal of resilience and hope for the future. An 8 year-old girl in Harare who had been subjected to severe physical and sexual abuse, for example, commented that "life will always be like this".

Another 10 year old boy described a situation at home where he was treated badly, shouted at and not given enough to eat; he seemed resigned to the situation. While some older children, particularly girls, employed similar emotional strategies as younger children such as 'sharing problems with friends' or collecting firewood with friends so that they can 'discuss things', others said that they did not tell anyone their problems. As children grew older, it appeared that they could make fewer demands for emotional support and the demands on them to provide emotional support to others increased. A 15 year-old girl in Chegutu commented "I still need to be cared for myself", even though much of her time was spent taking care of her sick mother.

The United Nations report on violence against children, Pinheiro (2006) reported that rejection; isolation, emotional indifference and so forth are perceived as forms of violence that can be harmful to the psychological development and well being of a child. The effects of early childhood vulnerabilities, due to loss of their parents, could have a lasting impact on these children in later life (Raphael &

Dobson 2000), which is already compounded by their lack of academic achievement.

Several young women of 14 years and above described the caring responsibilities they had for sick parents and relatives while simultaneously taking care of younger siblings. The emotional as well as physical demands on them were clearly visible. Children and young people who were heads of households often displayed great resilience, despite being forced to deal with multiple difficulties at once.

A 17 year old young man, head of a household in Rusape, listed numerous strategies he employed to look after himself and his younger sister and sustain the household. He commented, 'I make decisions for the young ones and make sure they go to school – I am taking care [of them]'. When asked about how he coped with the difficulties he faced, he responded 'I always find solutions'. Similarly, an 18 year-old boy in Chegutu who ran his household with sporadic help from his older brother's wife, and who described himself as the breadwinner, described how he grew ground nuts and fruits to sell and worked in other people's fields to get money. When asked how he found his situation, he replied 'I don't have any problems'. The degree of resilience and resourcefulness demonstrated by these young people is important since there is a risk of categorising children in specific circumstances as all being equally vulnerable.

Studies conducted mostly in Southern Africa show that the impact of HIV and AIDS and the coping strategies employed by households are linked. Rural households adapt various coping strategies in order to reduce on the impact of HIV and AIDS on their livelihoods (FOSENET 2007). These are strategies aimed at improving food security which include reducing household consumption, substituting some food items with cheaper commodities, sending children away to live with relatives and begging (SAFAIDS 1999).

AIDS orphans interviewed in Kibera slums described the psychological and emotional problems like lack of love; discrimination and stigmatization affect their personality in everyday life. Some tried to elaborate their experiences by saying that they do miss a lot of things due to their parent(s) loss. They will not forget grief and trauma attached to their minds when they were watching their parents suffering from HIV illness and died turn by turn.

For the orphans, loss of parent/s means loss of everything like love, hope, protection or security, care and support. One of the orphans interviewed in this study described their experience as follows: “we orphans are exposed to different problems that require parental care and protection, it affects our identity and personality, we have no one to hug us that is why we are emotionally jealous when children around us are hugged by their parents”.

Because of social exclusion and stigma, most orphaned children are vulnerable to sexual exploitation and labour abuse, which leads them to live in a very difficult life situation like living on the streets and others, can engage in child prostitution and other undesired activities. Due to stigma and discrimination from some members of the society and some institutions, many orphaned children are denied access to basic social services like health, education and shelter. Because of these, the orphaned children are self stigmatizing themselves to cope with the problem of abuses and stigma.

Some of the orphans interviewed in this study provided their reasons for the causes of stigmatization and discrimination as the negative attitudes and misconceptions about the cause and mechanism of HIV transmission, some people in the society see AIDS orphans as if they are HIV positive children. Some orphans said that other neighbours do not allow their children to play with them while others reject and insult them which are very painful to them. So they do feel scared to integrate with others freely. Also from the author’s observation, the living condition of some orphans and caregivers particularly those who are

managing their life as heads of the household have severe problems of clothing, food, and shelter.

2.10. RELEVANT STUDIES ON EDUCATIONAL EXPERIENCES OF CHILDREN

Not only does AIDS lead children into poverty, it also takes away one of their most important rights-the right to Education and the entire Education Sector is affected. Schools too are affected since AIDS is killing teachers. In Zambia, 1,300 teachers died of AIDS related causes in the first 10 months of 1998, twice as many as during the previous year. Several less developed countries that have seen their HIV prevalence rate increase in the 1990s are at risk of failing to meet the target of basic education for all by 2015 (UNICEF 2001). Poor countries will not meet the health and education needs of their populations. Schools will lose more teachers; health centres more nurses and doctors. Development will stagnate as a generation of children grows up alone, denied care and with little or no education (UNICEF 2001).

A study in Thailand by UNAIDS (2006) shows that 15% of families that experienced poverty had to take their children out of school. Studies in Uganda have also shown that following the death of one or both parents, the chance of children going to school is halved and those who continue with school spend less time there than they did formerly (UNAIDS 2000). A study done in Zimbabwe by the Southern Africa AIDS Training Programme concluded that a child who has a parent or older sibling suffering from AIDS may experience increased responsibility and may experience a drop in school performance because they start providing for themselves as a survival skill so they miss school in search of food (Guidelines for counselling children 2003). When a parent dies, the responsibilities become even more, because the children may have to fend for themselves and they later drop out from school. A related study done in Zambia in 2000 in Mansa District found that 55% of households were unable to meet the costs of children's education as a result of AIDS. An analysis of 49 case studies of

families affected by AIDS in Zambia found that 56 of 215 children had been forced to leave school (African Development Forum 2000) and a survey of 116 AIDS affected families found that 42% of children had stopped attending school (African Development Forum 2000). Since children no longer go to school, they experience increased responsibilities at home.

In Rakai, studies carried out have indicated that child headed households are real and rampant in the district. Only few of the orphans were able to reach higher levels of learning and this is because caretakers did not have the money to further their education. The lucky ones reached senior four and that was it for them. Many of them were forced to go to the teaching profession, which they did not like. This is from one girl who passed well her senior four and wanted to go for "A level"; however, due to the lack of money by her foster parents this was impossible. She spoke this with tears running down her cheeks. Some of the orphans interviewed said that they were often made to work more than the children of foster parents or guardians as if to buy their way for lodge. Many of them emphasized that the work took a lot of their time and thus did not have the time to concentrate on their academics, no wonder the poor grades according to their teachers.

In Uganda, like in many African countries, there exist deep-rooted kinship systems that are expected to provide social safety to the orphaned. These are extended family networks of aunties and uncles, cousins and grandparents. But in most cases you find that the capacity and resources of these relatives are over stretched to breaking point, or are already impoverished, often elderly and have often themselves depended financially and physically on the support of the very son or daughter who has died. The common social problems observed among the orphans include: lack of school fees, lack of scholastic materials lack of love and care, loneliness, lack good clothes, lack of stable homes, discrimination and cannot choose what they want.

According to the 1999 South African October Household Survey, as many as 35% of rural African children between the ages of 6 and 17 years do not attend school. In the sub-Saharan region, an estimated 44 million children, more girls than boys, are not attending school. School dropouts are likely to increase as families become unable to afford the costs of schooling and as children's contribution to care and work is required at home. Experience suggests that the most vulnerable orphans are those in their school years, aged ten years and older. Thus, despite all their shortcomings, schools have significant potential to play a critical role in alleviating the worst effects of the HIV and AIDS epidemic on children. Apart from the accrued personal and social benefits of education for work and national development, schooling provides stability, institutional affiliation and the normalisation of experience for children. It also places children in an environment where adults and older children are potentially available to provide social support.

It is widely believed that the education of children who are most directly affected by the epidemic is adversely affected in a number of ways. The main contention is that given very difficult home situations, both orphans and children in AIDS affected households are often forced to drop out of school altogether with little chances of ever returning to school. 'The growth in the number of orphans is taxing the coping strategies of families and society at large. In many cases, the extended family is finding it extremely difficult to cope economically and psychologically with the numbers it is required to absorb. Few orphans are able to pay their school or training fees. Many others have to care for others in the homes where they live. Many have to work to support themselves or younger siblings dependent on them' (Kelly 2000). In addition, 'because of HIV and AIDS in their families, many children do not want to attend school. For some, the deterrent is the fear of the stigma and scorn that they encounter in school' (Kelly 2000).

However, the school surveys in Botswana, Malawi and Uganda as well as other research studies have found that the relationship between parental status and school attendance is very complex (UNICEF 2003). Moreover, the impact of orphan hood on school attendance is often not as great as is generally believed to be the case.

An in-depth study of the coping strategies of orphans and other vulnerable children (OVC) affected by HIV and AIDS which was conducted across six sites in rural and urban Zimbabwe by UNICEF (2003) revealed that leaving school early has increasingly been documented as a strategy adopted in order to relieve difficulties at home. A significant proportion of children and young people interviewed were not attending school; those living with extended family members rather than their own parents were also less likely to be in school. Although lack of school fees or money for books and uniform were the most commonly cited reasons for withdrawing from school, some children, especially girls, described caring responsibilities that prevented them from attending. One of the unfortunate responses to the death of a parent(s) in poorer households is that of removing the children (especially girls) from schools as school necessities become unaffordable and the girls labour and income generating potential are required in the household (UNAIDS 2002). Children who experience HIV and AIDS death of a parent have lower performance in school than children who have not (Salaam 2005). The preoccupation with the death of their parents, the isolation and stigma due to the loss of a parent to AIDS and the undertaking of additional work that comes with supporting oneself after one's parents have died often make it difficult for orphaned children to concentrate in school (Salaam 2005). Families that are larger and have more people depending on the little income available will send girls to look for some income by selling on the streets or look for piecework. It has been observed that paternal orphans are more likely to live with their mothers than are maternal orphans with their fathers (UNAIDS 2006).

In another study on adjustment of orphans, Wild (2001) further argues that children in some cases may end up losing their inheritance. In some instances, even those children who are able to continue with schooling do not perform well and eventually drop out. Reasons for this have been attributed to lack of parental guidance, poor nutrition and, absenteeism as a result of having to take care of their ill parents (Basaza 2002). An increased incidence of children having to become breadwinners or at least significant contributors to the family finances is not unusual. Children find themselves in a position where they have to forfeit books and learning, with entering the job market (Jackson et al. 2002).

2.11. RELEVANT STUDIES ON EXPERIENCES OF CHILDREN FROM HOMES AFFECTED BY HIV/AIDS WITH REGARD TO MEETING HEALTH NEEDS

In all the affected countries, the AIDS epidemic is bringing additional pressure to the health sector (UNAIDS 2006). As the epidemic matures, the demand for care for those living with HIV rises, as does the toll of AIDS on health workers. In Sub-Saharan Africa, the direct medical costs of AIDS excluding Antiretroviral Therapy have been estimated at about US $ 30 per year for every person infected, at a time when overall public health spending is less than US $ 10 per year for most African countries (Pembrey 2009). As the HIV prevalence of a country rises, the strain placed on its hospitals is likely to increase. In Sub-Saharan Africa, people with HIV related diseases occupy more than half of all hospital beds (Pembrey 2009).

Research in South Africa has suggested that on average, HIV positive patients stay in hospital four times longer than other patients (Pembrey 2009). Hospitals are struggling to cope, especially in poorer African countries where there are often too few beds available. This shortage results in people being admitted only in the later stages of the illness, reducing their chances of recovery (Pembrey 2009). While AIDS is causing an increased demand for health services, large numbers of health care professionals are being directly affected by the epidemic (UNAIDS

2006). Botswana, for example, lost 17% of its healthcare workforce due to AIDS between 1999 and 2005. A study in Zambia found that 40% of midwives were HIV positive (UNAIDS 2006). Healthcare workers are already scarce in most African countries and the HIV and AIDS epidemic is making it worse (Pembrey 2009).

2.12. CONCLUSION

The literature review has attempted to look at some of the livelihood and emotional coping strategies including the challenges orphans face when it comes to meeting their health and educational needs. The literature has shown that children employ both livelihood and emotional coping strategies. The literature also shows that some coping strategies such as taking alcohol and prostitution are negative. The study, furthermore, reveals that children from homes affected by HIV and AIDS have challenges in meeting their educational and health needs. These findings are consistent with the model which has been presented. However, research focusing on the livelihood and emotional coping strategies employed by children from homes where parents have died of HIV and AIDS in Chazanga compound of Lusaka district was nonexistent. This is the void in the body of knowledge that served as the focus for this research.

CHAPTER THREE
METHODOLOGY

3.0. INTRODUCTION

This chapter highlights the research design and approach employed in carrying out this study. It discusses the study design, study site, study population, sample size and sampling procedures, data collection instruments and method of data analysis.

3.1. STUDY DESIGN

This research used a descriptive study design. Both qualitative and quantitative research approaches were employed. The qualitative approach was ideal because it established people's feelings; it was humanistic and delved into their opinions on the research topic. This approach also allowed for in-depth, flexible and broad coverage since it was dealing with human beings who are able to express their feelings and it was used in an effort to obtain a deeper understanding of various gender differences in coping strategies of children. On the other hand, the use of quantitative approach involved some numbers as it is statistical in nature. The use of this approach gave way to the calculation of numbers in numerical terms.

3.2. STUDY SITE

The study was conducted in George and Chazanga compounds in Lusaka. George compound has Home based Care (HBC) and Chazanga compound has the Orphans and Vulnerable Children Group (COVC) that are both involved with people infected or affected by HIV and AIDS. They had the necessary records on households that experienced HIV and AIDS related deaths and therefore, they were able to assist in identifying appropriate study participants. In addition, George HBC works hand in hand with the Health Clinic in the respective area and the COVC works directly with the community. Both groups had records of house numbers/location of the deceased and affected children; therefore, it is these

records that helped the researcher to locate households that have been affected with HIV and AIDS related deaths.

The study was centred in the mentioned compounds because they are high density areas where most people of low economic and social class live and also because of the high increase in the number of orphans and the prevailing socio- economic conditions of the areas puts the children in vulnerable circumstances.

3.3. POPULATION

This study collected information from children that have experienced HIV and AIDS related deaths of a parent or parents. Information was collected from children aged 10-20 with consent from their adult keepers. This age was arrived at because the children are able to understand the questions and are also able to express themselves clearly when they speak on the issue at hand. Since the orphans are registered, it was not very difficult to locate them.

3.4. SAMPLING PROCEDURE

The study used random sampling where a list of all affected children was obtained and systematically selected. The sample size was calculated using the sample size formula available in Renckly et al. (1996) as follows:

$$n = \frac{N x Z^2 x .25}{[d^2 x (N-1)] + [Z^2 x .25]}$$

Where:
n = sample size required
N =total population
d = precision level (p-value) usually 0.05 or .10
Z = number of standard deviation units of the sampling distribution corresponding to the confidence level.

Since the total population N from George and Chazanga compounds is 603 and to achieve a 95% confidence level and + precision level (p-value) (d=.05, Z = 1.96) then:

$$n = \frac{603 \times 1.96^2 \times .25}{[.05^2 \times 602] + [1.96^2 \times .25]}$$

$$n = \frac{603 \times 3.8416 \times .25}{[(0.0025 \times 602) + 0.9604]}$$

$$n = \frac{579.1212}{1.505 + 0.9604}$$

$$n = \frac{579.1212}{2.4654} = 234.89948$$

n=235

The maximum sample size that can be obtained is 235 for survey questionnaires. The respondents were randomly selected from the Home Based Care list in George compound with the help of the HBC co-ordinator within the area and in Chazanga compound the sample was randomly selected using the Chazanga Orphans and Vulnerable Children (COVC) group who have a list of all affected children around the area. Samples were drawn according to the total number of children bearing in mind that the names of females and males were separated and probability proportional sampling (PPS) was applied. The children were selected using the following frequency statistical procedure as shown in Cohen et al. (2002).

George compound has 339 children on the list and of these, 207 are females and 132 are males. Chazanga compound has 264 children on the list and of these, 154 are females and 110 are males, therefore, to find the frequency, it will be:

$$\text{Frequency interval} = \frac{\text{Total number of population}}{\text{The required number of sample}}$$

$$\text{Which is } F = \frac{N}{SN}$$

Since the total sample size required is 235, 59 Females and 59 Males from each compound were selected using the above formula.

$$\text{Females in George Compound} = \frac{207}{59} = 4$$

This means that every 4th female on the list available from George compound was selected.

$$\text{Males in George compound} = \frac{132}{59} = 2.2 = 2$$

Every 2nd male child was selected from the George compound list.

$$\text{Females in Chazanga compound} = \frac{154}{59} = 2.6 = 3$$

Every 3rd female was selected from the Chazanga compound list.

$$\text{Males in Chazanga compound} = \frac{110}{59} = 1.8 = 2$$

Every 2nd male was selected from the Chazanga list.

3.5. FIELD DATA COLLECTION

3.5.1. Questionnaire

In this study, structured questionnaires were used to obtain a cross section perspective of the problem. The questionnaires were based on the type of questions used in similar programs done in Zambia and other countries. The researcher trained two assistants on how to ask questions because the questionnaires were translated from English to Nyanja and Bemba with people who are very much conversant with the language. The questionnaires were administered by the researcher and the assistants because some of the children were younger and some illiterate.

3.5.2. Focus group discussion

Apart from the structured questionnaire, the research also based its data collection from 4 focus group discussion (FGD). The recruitment of participants was done from children who did not answer the questionnaire.

20 children constituted the focus group discussion (10 girls and 10 boys). 5 girls and 5 boys from each compound were interviewed using a guide for the focus

group discussion. Two people, the researcher and one assistant conducted the FGD and covered the following themes: livelihood coping strategies, emotional coping strategies education and health experiences.

3.6. Data management

The statistical package for social science was used to analyse both the qualitative and quantitative data from the questionnaires**.** All questions were coded prior to entry.

3.7. ETHICAL CONSIDERATIONS

Strydom in De Vos et al. (2002) clarifies the concept "ethics" as follows: "Ethics is a set of moral principles suggested by an individual or group, and subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students." The researcher conducted the research with, at the back of the mind, knowledge of what is generally appropriate and proper in scientific research. As a result, some ethical issues that were identified by De Vos et al. (2002) which were taken into consideration when conducting this research were:

Harm to research respondents: the researcher exercised the utmost consideration of the AIDS-orphaned childrens' circumstances to ensure that they were protected from any psychological or physiological harm. The researcher was prepared at any time during the study to terminate the study, as well as an interview, if there was any reason to suspect that continuation would result in undue stress to the participants or if the participants appeared uncomfortable. Participants were reassured that they could withdraw at any time from the study if it was too emotionally distressing for them to continue.

Informed consent: the researcher gave potential participants adequate information on the study so that they would fully comprehend the study and consequently could make informed, voluntary decisions about their participation. The researcher, verbally and in writing, thoroughly explained the study in Nyanja and Bemba, languages they clearly understand. Moreover, the researcher phrased the questions in an age-appropriate manner. It was thus necessary for the researcher to inform the adolescents fully about the study in the language and terms that the adolescents could understand. Also, consent was obtained from the Home Based Care Group and the Chazanga Orphans and Vulnerable Children and the Parents.

Deception of participants: the researcher did not withhold any information or offer incorrect information in order to ensure participation of the AIDS orphaned adolescents when they would otherwise have refused it.

Violation of privacy/anonymity/confidentiality: the researcher safeguarded the privacy and identity of all the respondents. Participants' personal characteristics were not made known. Anonymity was maintained by providing each participant with a code name, keeping the master list of the participants and matching code names to separate locations, destroying the list of actual names on completion of the study. In addition, code names were used when discussing the data. Participants generated their own code names if preferred. Furthermore, audio-tapes were kept at a safe place during the study and destroyed after completion of the research. Also, participants were told before they consented to participate in the study that the researcher wished to publish the findings of the study.

Actions and competence of the researcher: the researcher, who had done a course in research methods, was under adequate supervision to ensure that the study ran in an ethically correct manner. The researcher only conducted the study upon receipt of the approved research Topic from the Department in charge.

3.8. STUDY LIMITATIONS

Some respondents that were randomly picked were not interviewed because they had shifted houses. It was not easy to find some respondents the location because the compounds have no road names hence they were not interviewed. This affected the original number of 235 for the questionnaires to 200.

Some children interviewed expected to be provided with help in terms of school requirements support like school uniforms and school books right there.

Some guardians refused to interview the children thinking that it was the human rights commission and still, some guardians refused to give consent to interview the children unless they were paid so those children were not interviewed because the researcher did not budget for respondents or the guardians to be paid. Organizing both focus group discussions and conducting interviews was difficult because guardians of the children were either at work or the market. The emotional state of some of the children also meant that participation was further limited because some of them kept sobbing during the interviews or focus group discussion and some of them in the discussion did not respond to some questions. The researcher and the assistants were disturbed by the rains.

CHAPTER FOUR
PRESENTATION OF RESULTS

4.0. INTRODUCTION

This Chapter presents the results under the following headings: i) background characteristics of respondents ii) gender differences in livelihood coping strategies employed by children from homes affected by HIV and AIDS; iii) emotional coping strategies employed by children from homes affected by HIV and AIDS; and iv) challenges in meeting both educational and health needs experienced by children from homes affected by HIV and AIDS.

4.1. SAMPLE DESCRIPTION

4.1.1. Sex of Respondents

The respondents were asked to indicate their sex whether female or male. As shown in Table 1, the majority of the respondents represented by fifty point five percent (50.5%) were males where as the minority represented by forty percent (49.5%) were females.

Table 1: Ditribution of Respondents by Sex

Sex	Frequency	Percent (%)
Male	101	50.5
Female	99	49.5
Total	**200**	**100**

Source: Survey data

4.1.2. Age of Orphans

The respondents were asked to state their age in years at the last birthday. The survey findings of the study revealed that the average age of the participants of the survey was 15 years. These findings are similar to other findings in developing nations. In other words the age of orphans is fairly consistent across developing

countries. According to an analysis of national surveys from 40 sub Saharan African countries on orphan hood and childcare patterns, the results of these surveys showed that overall, about 15% of orphans are between 0-4 years old, 35% are 5-9 years old, and 50% are 10 years and older (Monasch et al. 2004).

4.1.3. Educatioanl Attainment

Respondents in this study were asked to state whether or not they have attended school before. Table 2 shows that the majority among the male and female respondents, 100 (99.0%) and 96 (97.0%) said that they had been to school before while one male and three female respondents indicated that they had never been to school.

Table 2: Distribution of Respondents stating whether or not they have attended School

Educational Attainment	**Sex**		**Total**
	Male	**Female**	
Not attended school before	1 (.5%)	3 (1.5%)	4 (2.0%)
Attended school before	100 (50.0%)	96 (48.0%)	196 (98.0%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100%)**

Source: Survey data

The survey results of the present study show that the majority of the respondents have been to school. Out of a sample size of 200, 196 respondents (100 males and 96 females) have been to school as compared to only 4 (1 male and 3 females) who have never been. These results are also consistent with other surveys on orphans in developing nations.

4.1.4. Type of Deceased Guardian

Respondents were asked to state which one of their parent is deceased.
Table 3 below shows that children who lost both parents accounted for the highest number of Orphans. Among the male and female respondents, 82 (81.2%) and 65

(65.7%) said that they had lost both parents respectively. The table also shows that among the male and female respondents, 15 (14.9%) and 30 (30.3%) said that they lost their father. The rest of the respondents, 4 males and 4 females indicated that they had lost their mother.

Table 3: Distribution of Respondent's Opinion on Which Parent/Guardian is Deceased

Type of Parent/Guardian	Sex		Total
	Male	Female	
Mother	4 (2.0%)	4 (2.0%)	8 (4.0%)
Father	15 (7.5%)	30 (15.0%)	45 (22.5%)
Both Mother and Father	82 (41.0%)	65 (32.5%)	147 (73.5%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Survey data

4.1.5. Present Parent /Guardian

Respondents in this study were asked to indicate which type of parent or gaurdian was presently taking care of them. Table 4 shows that the majority among the males and females, 30 (29.7%) and 38 (38.4%) said that they were being cared for by their mother respectively. The Table also shows that among the male and female respondents, 30 (29.7%) and 36 (36.4%) said that they were being taken care of by their grandparent. Among other male and female respondents, 18 (17.9%) and 10 (10.1%) said that they were being cared for by their father. The Table further shows that among the male and female respondents, 12 (11.9%) and 10 (10.1%) said that they were being cared for by their Aunties. The rest of the respondents 11 (10.9%) and 5 (5.05%) indicated that they were being taken care of by their Uncle.

Table 4: Distribution of Respondent's Opinion on Which Parent/Guardian is Taking Care of them

Present Parent/Guardian	Sex		Total
	Male	Female	
Mother	30 (15.0%)	38 (19.0%)	68 (34.0%)
Father	18 (9.0%)	10 (5.0%)	28 (14.0%)
Grandparent	30 (15.0%)	36 (18.0%)	66 (33.0%)
Aunt	12 (6.0%)	10 (5.0%)	22 (11.0%)
Uncle	11 (5.5%)	5 (2.5%)	16 (8.0%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Survey data

4.2. GENDER DIFFERENCES IN LIVELIHOOD COPING STRATEGIES

One of the specific objectives of the study was to determine whether or not children from homes affected by HIV and AIDS employ any livelihood coping strategies. In order to achieve this objective, respondent were asked to state whether or not they are involved in any income generating activity and to state whether or not they look for ways to earn income.

4.2.1. Involvement in Income Generating Activities

Respondents were asked if they were involved in income generating activities. Table 5 below shows that the majority among male and female respondents, 55 (54.5%) and 90 (91%) said that they were involved in income generating activities while 46 (45.5%) males and 9 (9%) females said that they were not involved in income generating activities.

Table 5: Distribution of Respondent's Opinion on Involvement in any Income Generating Activity

Are you Involved in any Income Generating Activity?	Sex		Total
	Male	Female	
Yes	55 (27.5%)	90 (45.0%)	145 (72.5%)
No	46 (23.0%)	9 (4.5%)	55 (27.5%)
Total	**101(50.5%)**	**99 (49.5%)**	**200 (100%)**

Source: Survey data

The research established that both girls and boys involved themselves in different income generating activities listed below. It is evidenced from the results that girls are much more involved in these activities. However, more information on the type of income generation activities the respondents were involved in were revealed from the focus group discussions. From the discussions, the common type income generating activities included prostitution, selling, piecework and street begging emerged. The results on each of the income generating activities are presented below under approparite themes.

4.2.1. Prostitution

As mentioned ealier, one of the income generating activities was prostitution. One of the girls informed that:

> "I go to look for money in a lot of ways. At times, I go to the yards to wash clothes and they pay me even K5, 000 which I use to buy small quantities of mealie meal commonly known as 'Pameela' for the family. Sometimes, I go to bars and wait for a man to get me to sleep with me and they usually give me between K5, 000 and K10, 000 for one round. They don't give me much because I insist on using condoms. They say that they can give me K15,000 without a condom but I refuse I tell them that I don't want I want with a condom because I can die of AIDS like my parents and I don't want because my parents suffered a lot. Sometimes I make K20, 000 to K30, 000 in an evening which I use to buy food for my grandmother and my brothers and sisters. At least this business gives me

some money but I don't like it now what can I do." (George compound : 17 years girl).

For the girls who involved themselves in prostitution, it was the last alternative due to the many challenges they faced. They confessed to not liking what they did and had the view that given a chance, they would find a permanent job to just earn some money instead of prostitution. For the girls, their main concern is the welfare of their families and they feel responsible for their families hence the justification for their actions.

> "Yes, I have to work so that I can buy some food so I go to crash stones but sometimes, some men give me some money when they like me. They sleep with me and they pay me. There are three that come when they need my services. My aunt just suspects but she does not know how I get money to help at home. " (George compound: 18 years girl).

4.2.2. Selling

At times, the orphans have to go out to look for money for school, for food and rentals in order to help their guardians. This certainly cannot be easy for them hence the drop outs from school. One girl added that:

> "I go to sell groundnuts and sometimes sweet potatoes at the market so that I can help my mother with food and books for my school. I go to school in the morning and when I knock off, I go to sell so am thinking of stopping school so that I can just do something that will give me money to survive because there is no point in continuing with school when am just dull in class. When I stop school, I can make more money."(Chazanga compound: 15 years girl).

Another girl said:

> "if I don't work, then I will not eat so I have to work and I sell vegetables door to door for my neighbour then she pays me according to how much i have sold". (Chazanga compound: 15 years girl). At times, orphans have

to go to extremes of missing school to look for money for home which has a negative impact on their education. For instance one of the girls disclosed that: **"**after school, I go to sell bananas at the market because my mother can't manage to do so. At times if we have no food at home, I don't even go to school because I have to sell bananas to have some food because at the market, they buy a lot in the morning so I miss school." (George compound: 13 years girl).

The boys on the other hand, had also a similar experience of going out to look for ways of generating income for their wellbeing. The ways though differed to some extent from the girls but that is how they also earn their income. This according to them is what is expected of them by their guardians.

Another 15 years old boy from Chazanga compound disclosed that:

> "I use a wheel burrow to do business. My brother and I carry parcels for people at the market or in Freedom Way to the bus stations or to the taxis. It is not easy but at least we help our mother with few things at home."

In addition, another boy further disclosed that:

> "In the rain season, that is when I make a lot of money because I go to K20, 000 a day..... But after the rain season, it is hard but I start selling plastic bags." (Chazanga compound: 19 years boy).

4.2.3. Going on the streets

Respondents were asked whether they go on the streets to beg or not. Their responses are shown in Table 6 below. The Table shows that males who went on the streets accounted for the highest number. Among the male and female respondents, 63 (62.4%) and 38 (38.4%) said that they went on the streets respectively. The rest of the respondents 38 (38.4%) and majority among the female respondents, 61 (61.6%) indicated that they had never been on the streets to beg.

Table 6: Percentage Distribution of respondent's views on going on the street to beg

Have you ever been on the streets to beg?	Sex		Total
	Male	Female	
Yes	63 (31.5%)	38 (19.0%)	101 (50.5%)
No	38 (19.0%)	61 (30.5%)	99 (49.5%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100%)**

Source: Survey data

From the focus group discussion, the following excerpts were recorded from the participants:

> "Yes I go on the streets to ask for money and food because we do not have a lot of food at home. We just eat once a day so I go to ask for money so that I can help at home." (George compound: 14 years boy). Another one said that: "Once when I was on the streets, I wasn't sleeping. It is a difficulty place to live and I was not sleeping in a good place.....no food, no bath, food was only available if you were able to find some small job, there was no chance to bath when you are on the streets and nowhere to bath from so I rarely bathed and when I bathed, it was very fast because it was outside and very cold so I would beg for money for food and bostik to keep me warm at night." (Chazanga compound: 16 years boy).

Another girl informed that:

> "When we don't have anything to eat, I go on the streets to ask for money or food. Whatever is given to me, I take to my mother and we all share as a family". (George compound: 14 years girl).

Another one disclosed that:

> "I go on the streets everyday to beg along Great North Road on traffic lights. At least some people give me something. They give me K2, 000 or even K3, 000 and I buy food for home to help my mother." (Chazanga compound :15 years girl).

At times, orphans take desperate measures just to earn some income and do strange things to earn some income for their food as one of the boys said:

> "then I take my friend and my friend acts like he is blind so that people can feel pity then I ask for money or food in town so that we can just have something to eat. I am the last born and my step father doesn't care since my mother died so I need to think of a way to survive." (George compound 15: years boy).

Most of the respondents also complained of being told off by the people they ask money from and it hurts them but they have very little or no choice at all and yet they have to swallow all the insults and bad mouthing. A number of orphans on the streets try to earn money there so that they can help themselves and their families. Some of them feel so responsible for their families even as young as they are and worse still, others have to fend for their own school needs because they really want to learn. Below is what one boy recounted about begging and his school:

> "I go on the streets after school to ask for money. That is how I raise money for my school books. When I have collected enough to buy even one book, I buy or I buy anything I need for school. My mother has no money to buy for me since my father died." (Chazanga compound: 15 years boy). Still another boy had this to say with regards to the insults they receive on the streets:

> "I go out to ask for money or food because there is not much at home so whatever is there; I try to leave it for the ones at home and I go on the streets to beg. Sometimes some people give me but some people insult me but I still continue for me to survive." (George compound: 15 years boy)

Still others go on the streets because they are forced to do so by their guardians or else they would not eat at home. In many cases, children will not go to school so as to fulfil what the guardian wants if they do not want to be in trouble like one respondent said:

> "I go on the streets because my aunt tells me to also help bring something at home. I go to beg because I have to bring something at home and if don't, I don't eat anything because I have not contributed". (Chazanga compound: 13 years boy)

Going on the streets for some girls is a bad experience because of what they have to go through. Prostitution is rampant on the streets because the girls need to be supported according to them and they need protection. They end up giving their bodies to the street boys who give them some money for their subsistence whilst on the streets. Some female respondents had this to say:

> "I go on the streets to beg and there, I end up sleeping with some boys from the streets so that they can give me some money if I have not made anything that day." (Chazanga compound: 15years girl)

> "I was on the streets because my aunt was mistreating me. It was better for me than being with her because I really suffered when I was with her.....streets are bad because as a girl, you can't do everything so we used to have boyfriends and we used to sleep with them so that they take care of us and protect us at night. Now, my grandmother got me and I am not on the streets begging." (George compound: 17 years girl).

4.2.4. Piecework

Some orphans involved themselves in different types of piece work for some income as some children interviewed said:

> "I am a boy and my father tells me that I have to help him to look for food for the family since my mother is dead. So, I go to the industries to look for piecework to pack goods or foods. They give me K5, 000 a day. If there is no piecework there I go to crash stones and I make even K10, 000 if I sell something. I also sell cigarettes sometimes if I find enough capital but the money for capital is difficult to find because we need to eat and pay rent at home." (George compound: 17 years boy).

> "Am a guy and I need to help at home somehow, I also need to please my girlfriend because she gives me what I need so i need to work. I sell in a shop in town so like today, am off that's why you have found me so that I can also see how my kantemba (makeshift store) is doing. I have to work hard to survive because my grandmother depends on what I bring..... " (Chazanga compound: 19 years boy).

Generally, both quantitative and qualitative results show both boys and girls are involved in income generating activities. The quantitative data obtained from the survey questionnaire show that more girls than boys engage in income generating activities. On the other hand, the focus group discussion reveals that some income generating activities have been dominated by boys while others by girls. For example, none of the girls interviewed said that they sell cigarettes. It can also be deduced that those income generating activities which demand a lot of physical effort, have been dominated by boys. For example, none of the girls said that they carry people using a wheelbarrow during rainy season as a way of generating income. Further, none of the boys said that they sell food stuffs (groundnuts, potatoes, vegetables to mention but a few).

4.3. EMOTIONAL COPING STRATEGIES

Another specific objective of the study was to determine whether or not children from homes affected by HIV and AIDS employed any emotional strategies to cope with their situation. In order to achieve this objective, the following variables were measured: use of drugs, talking to others, company of friends and imitating habits of their deceased parents.

4.3.1. Taking Drugs and alcohol

Respondents were asked if they take any drugs or alcohol as a way of coping. Table 7 shows the responses. The Table shows that among male respondents, the majority took drugs 87 (86%) compared to female respondents 14 (14.1%) respectively. The rest of the respondents, 14 males and 85 females indicated that they did not take drugs.

Table 7: Percentage Distribution of Respondent's Opinion on Taking Drugs and alcohol

Do you take drugs or alcohol as a way of coping with the loss of your parents?	**Sex**		**Total**
	Male	**Female**	
Yes	87 (43.5%)	14 (7.0%)	101 (50.5%)
No	14 (7.0%)	85 (42.5%)	99 (49.5%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Field data

Most males were of the view that they take some alcohol or drugs to forget some of their problems. In most cases, orphans interviewed thought alcohol or any other substance was the solution to their problems because for a while, they forgot about their problems until they became sober again. They believe this is the way their problems can be solved and they embrace such ideas because of peer pressure as well. Below are some of the views of the respondents who participated in the focus group discussion:

"I drink alcohol to forget about my problems at home. Sometimes I feel like running away and going somewhere I don't know where. I go to drink when I have problems at home. I go with my friends and I feel better but when I am not drunk, I just think about my parents why they died so soon and leave us in all these problems." (George compound: 18 years boy).

"I know alcohol is not nice but my friends tell me that it will make me a strong man and face life's challenges as a man because since my parents died, things have been bad for us." (Chazanga compound: 17 years boy).

"I smoke weed and I feel high when I smoke as if the world is smaller than me that's the way I feel. There is so much poverty at home so I just look for a K200 to buy weed and I feel all my problems are solved." (George compound: 20 years boy).

4.3.2. Talking to Others

Table 8 below shows the distribution of respondent responses on whether they share their feelings with others. Among the male and female respondents, 58 (57.4%) and 44 (44.5%) said that they talked to others as a way of coping with the situation of losing their parents. The table also shows that the majority among the female respondents, 55 (55.6%) did not share their feelings compared to male respondents, 43 (42.6%) with the same view.

Table 8: Distribution of Respondent's Opinion on talking to others about their Orphan status

Survey question: Do you share your feelings with others as a way of coping with the loss of parents?	**Sex**		**Total**
	Male	**Female**	
Yes	58 (29.0%)	44 (22.0%)	102 (51.0%)
No	43 (21.5%)	55 (27.5%)	98 (49.0%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100%)**

Source: Field data

Boys who answered the questionnaire had mostly the view that they felt better when they shared their feelings with other people where as less girls shared the same view. Some of the views expressed by both sexes in the Focus Group Discussion where as follows:

> "I don't do anything to keep me busy because I talk to my mother a lot and I feel good so am just okay." (Chazanga compound: 14 years boy).

> "I tell my mother how bad I feel that's when I feel better. I ask her why dad had to die and she tells me it was his time. Sometimes I just remember the way we used to live with my father and I just want to talk about it but it is very sad". (George compound: 15 years boy).

> "I just sit with my mother at home if I have nothing to do. I sell vegetables with my mother at home. I don't do anything to make me busy". (George compound: 15 years girl).

More girls were of the view that they would rather not share their feelings with other people because it pained them more. However, there were some boys who also said they would rather keep quiet on the death of their parent (s).

> "No one can make you feel like a child if your parents are dead. People just keep you because they have to but inside their hearts, they don't want but because they are your relatives, they just keep you like that so even if you tell them how you feel, they don't care so I don't even tell them how I feel. But it's very painful if you just keep things inside". (Chazanga compound: 14 years boy).

> "I don't want to talk about the death of my parents with anyone because it makes me sad especially when I see my friends who have both parents alive. It just makes me sad. At least if I had even just one parent it was going to be better." (George compound: 16 years girl)

4.3.3. Company of Friends

Respondents were asked to state whether the company of their friends makes them feel better. The Table below shows that among the male and female respondents, 65 (64.4%) and 34 (34.3%) were of the opinion that the company of their friends makes them feel better as one boy said:

> "at least I feel better when I play with my friends because my friends have also lost their dads".

Table 9 further indicates that the rest of the respondents, 36 (35.6%) males and majority of the females 65 (65.7%) said that they did not feel better in the company of their friends.

Table 9: Distribution of Respondent's Opinion on Whether Company of Friends makes them feel better

Do you feel better to be in the company of friends?	Sex		Total
	Male	Female	
Yes	65 (32.5%)	34 (17.0%)	99 (49.5%)
No	36 (18.0%)	65 (32.5%)	101 (50.5%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100%)**

Source: Survey data

Feeling better in the company of friends was a general feeling of the respondents- both boys and girls but boys utilised this strategy more than girls. Both the questionnaire and focus group discussion results revealed the above feeling as can be seen from the table above and some of the responses below.

> "The people around me are very good. They support us a lot even when we don't have anything to eat; some of them help us a lot whenever they can. Even my friends are very good to me. They care a lot and I feel better at least I don't feel very sad that my mother is dead". (George compound: 14 years girl).

> "I like going to play so that I don't remember my parents every time so I keep myself busy. After school I go to play with my friends so that I also go away from my aunt because she tells me that she is tired of keeping me". (Chazanga compound: 13 years girl).

It can be concluded from these results that the company of friends has been found to be a helpful emotional coping strategy by some children. However, there were other views from respondents who thought that the company of friends made them feel bad such as the following:

> "Friends do not make me feel good because some of them laugh at me that my father died of AIDS and that may be I also have it. So, I have stopped

playing with my friends because they just make me very sad". (George compound: 13 years boy).

"People don't care if you've lost a parent or not. They say it is life. So they can't even make you feel stronger instead, they make me feel weak because no one would even want to find out how we the orphans are so they don't make me feel better". (Chazanga compound: 18 years boy).

Table 10 shows the distribution of respondent's opinion on whether imitating the habits of their deceased parent (s) helps them to cope with the situation of losing their parent(s). This question was relevant so as to establish whether this was part of an emotional surviving strategy. Among the male and female respondents, 60 (59.4%) being majority for male respondents and 39 (39.4%) said that they imitate the habits of their deceased parent (s). The Table further shows that the rest of the male respondents 41 (40.1%) and majority of the female respondents 60 (60.6%) said that they did not imitate the habits of deceased parents as a coping strategy.

Table 10: Distribution Of Respondent's Opinion on Whether Imitating Habits of their deceased parents helps them Cope With the Loss

Do you imitate the habits of your deceased parent(s)?	**Sex**		**Total**
	Male	**Female**	
Yes	60 (30.0%)	39 (19.5%)	99 (49.5%)
No	41 (20.5%)	60 (30.0%)	101 (50.5%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Survey data

The results obtained from the boys and girls who participated in the focus group discussion reveal more detailed information on emotional coping strategies. One of the emotional coping strategies employed by respondents is imitating the habits

of the deceased parent(s). One 14 year old boy from George Compound disclosed that:

> "My grandmother tells me that I have to always remember how my late parents lived and be like them, so I remember how they lived and what they did that is how I live as well especially my grandmother what she does is what I do because that is the way I learn and am happy and it helps me cope with my emotions."

Another one informed that:

> "It is important to remember the habits of your late parent (s) if you have to fit in the community. People always compare your parents and you and if you do other things, they say that you are stubborn and that you just want to do things your own way". (Chazanga compound: 16 years girl).

The majority of the female respondents 60 (60.6%) said they did not imitate the habits of others as a way of coping with the situation of losing parents. They believe that one can decide how to live without necessarily imitating others. Another 16 years girl participant was of the view that:

> "You just have to be yourself. I am just myself because I should think on my own whether what I am doing is good or bad. So there is no need for me to start remembering the habits of my late parents". (Chazanga compound)

Another boy disclosed that:

> "I like going to play so that I don't remember my parents every time so I keep myself busy. After school I go to play with my friends so that I also go away from my aunt because she tells me that she is tired of keeping me". (Chazanga compound: 13 years boy**)**

4.4. CHILDREN'S EXPERIENCES WITH REGARD TO MEETING THEIR HEALTH NEEDS

The third objective was to find out challenges experienced by children in meeting their health needs. In order to achieve this objective, variables such as easy access, availability and affordability of medicines were used as indicators to measure children's experiences with regard to health issues.

Table 11: Distribution of Respondent's Opinion on Easy Acess to Health Services

Do you easily access health services when needed?	Sex		Total
	Male	Female	
Yes	40 (20.0%)	29 (14.5%)	69 (34.5%)
No	61 (30.5%)	70 (35.0%)	131 (65.5%)
Total	**101 (50.0%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Survey data

Table 11 shows that the majority among the male and female respondents, 61 (60.4%) and 70 (70.7%) did not easily access health services while the rest of the respondents, 40 males and 29 females said that they had easy access.

The results obtained from the focus group discussion also revealed more information on health challenges faced by children from homes affected by HIV and AIDS. Most children would go to the clinic for attention but end up not getting it due to the many challenges they face. For instance, in one of the focus group discussions, a 15 years girl disclosed that:

> "I do not have access to a clinic because I need to pay and I do not have money to pay for a scheme". (George compound).

Another boy said:

> "I go to the clinic at times, if am lucky, I am given medicine but most of the time, there is no medicine so I have to buy it myself and my father has no money." (Chazanga compound: 11years).

In addition one more girl added that:

> "When I am very sick and visit the clinic, they take me to the lab and while there, I have to pay for laboratory services even if I have paid for the scheme. So I have decided to start buying medicine for myself instead of spending money on the scheme". (George compound: 14years).

Another 16 years boy from George compound informed that:

> "It is wasting money to go to the clinic because my aunt says that clinics have no medicines".

In a similar way a15 year old girl from Chazanga compound disclosed that:

> "I was given a prescription to buy medicine but I didn't have the money so I didn't buy the medicine".

It is not surprising that some people resort to using traditional medicines because they have no money to buy conventional medicine from the chemists like one 13 year old boy from George compound made it very clear that:

> "One time I was sick, then the man at the hospital said I had to pay K2, 500 which I did not have and he told me to go and look for money. So I went back home and my grandmother found traditional medicine for me".

Some parents/guardians have to look for money from sources such as neighbours in order to meet the medical expenses as they cannot afford by themselves. This is what one 12 years old boy from George compound disclosed:

> "I had malaria and I almost died and the clinic told me to buy medicine and I didn't have money. My mother went to our neighbours to ask for any amount of money so that she could buy medicine and most of them

contributed and my mother bought medicine for me from a chemist otherwise if it was not for my neighbours, I would have died".

In general, both quantitative and qualitative results reveal that children experience health challenges. For instance, the results show that medicines are not affordable and available in some health centres. The results further show that health services are not easily accessed by children.

4.5. CHILDREN'S EXPERIENCES WITH REGARD TO MEETING THEIR EDUCATIONAL NEEDS

The fourth specific objective was to find out challenges experienced by children in meeting their health needs. As can be seen from Table 12 below, the majority among the males and female respondents, 70 (69.3%) and 69 (69.7%) said that they faced educational challenges. The Table also shows that among male and female respondents, 30 (29.7%) and 27 (27.3%) did not face any challenges. The rest of the respondents, 1 male and 3 female had stopped school so this did not apply to them.

Table 12: Distribution of Respondent's Opinion on Educational Challenges

Do you face or did you ever face challenges in meeting your educational needs?	**Sex**		**Total**
	Male	**Female**	
Yes	70 (35.0%)	69 (34.5%)	131 (69.5%)
No	30 (15.2%)	27 (13.4%)	61 (30.5%)
N/A	1 (.5%)	3 (1.5%)	4 (2.0%)
Total	**101 (50.5%)**	**99 (49.5%)**	**200 (100.0%)**

Source: Survey data

The results obtained from the focus group participants reveal more information on the challenges experienced by the children. For instance, in one discussion, one 12 years boy from Chazanga compound disclosed that:

> "I am doing grade 5 with no books so I pick papers and stick them in my old book so that I can continue writing in them. Sometimes my teacher used to chase me but now she does not because she has seen that I want to be in class with my friends."

Likewise, another 11 years old girl from George compound informed that:

> "I am in grade 3 but right now I don't go to school because I was chased because I don't have uniforms. I was given 2 weeks at school to buy them but my grandmother has no money up to now so I don't go to school. At first, I was going to school but after 2 weeks, I was told to stop because I didn't buy the uniform and when you buy from somewhere else, they don't allow but the uniform is expensive."

Primary Education according to the Zambian Government is free. However, some citizens still find it is expensive because they have to buy their own books, uniforms and other school necessities. This has caused some orphans to stop school because these same basic necessities are expensive to them and unaffordable. In another separate focus group discussion, a 13 years old boy from George compound revealed that:

> "even if they say that education is free, we have to buy books and uniforms but sometimes it is not easy to buy uniforms."

Equally another 13 years old girl from Chazanga compound further revealed that:

> "I am in grade 5 but I have no uniforms and I was told to only go to school after I have bought uniforms."

Another 16 years old boy from George compound added that:

> "I do not have books and uniforms so I don't go to school I have even become dull now so I will just look for a job or anything to help me find some money for my needs but it is very unfair that the government is saying free education but we are being chased because we don't have uniforms."

In addition, another girl disclosed that:

> "I am in grade 7 and I have nothing for school. No pens, no books, no uniforms. My mother cannot afford to buy all school requirements."

In conclusion, this study has established that children from homes affected by HIV and AIDS employ both emotional and livelihood copying strategies as a way of coping with the loss of their parents. The study has also revealed that children from home affected by HIV and AIDS experience challenges in meeting both educational and health needs.

CHAPTER FIVE
DISCUSSION

5.0. INTRODUCTION

This chapter discusses the results of the present study. The chapter is divided into the following sections: the first section discusses the results on the demographic characteristics of the sample. Section two, discusses the results of each objective of the present study.

The discussions have been supported by similar survey findings on the coping strategies of children affected by HIV and AIDS related deaths of a parent (s) in a household. Reference to such was important because for any scientific research results to be considered reliable, the results should at least be consistent with other research results of a similar nature and context. This principle is referred to as reproducibility. Reproducibility is one of the main principles of the scientific method, and refers to the ability of a test or experiment to be accurately reproduced, or replicated by someone else working independently. The results of an experiment performed by a particular researcher or group of researchers are generally evaluated by other independent researchers who repeat the same experiment themselves, based on the original experimental description. Then they see if their experiment gives similar results to those reported by the original group. The result values are said to commensurate if they are obtained according to the same reproducible experimental description and procedure.

5.1. GENDER DIFFERENCES IN LIVELIHOOD COPING STRATEGIES

Generally the present study revealed that both boys and girls employ livelihood coping strategies. It was discovered that for certain types of livelihood strategies, girls dominated while boys dominated in other types as well. From the survey results, girls were more involved in selling on the streets and prostitution as a livelihood coping strategy while boys were more involved in doing piece jobs outside their homes and going on the streets to beg as a livelihood coping strategy.

It was also clear that for some strategies, both girls and boys employed them though not at equal levels. For instance, both boys and girls went on the streets to sell items such as vegetables and fruits, both involved in piece works, both went out on the streets to beg for money and food. There was only one livelihood coping strategy that was dominated fully by the girls and this is Prostitution. No boy was involved in this one as a livelihood coping strategy. The reasons for becoming sexually active included economic pressure, peer pressure and lack of parental supervision. Boys also dominated completely jobs of carrying parcels or people on their backs in town as a way of an income generating activity in order to survive.

As mentioned earlier, for almost all livelihood coping strategies, both girls and boys were involved and since this study wanted to determine which ones were common amongst girls and which ones were common amongst the boys. The results clearly show that indeed there are gender differences in livelihood coping strategies of children affected by HIV and AIDS related deaths in both George and Chazanga compounds of Lusaka. The results of the focus group discussion also revealed that the majority of the males are involved in piecework and begging to generate income whereas girls are more involved in prostitution and selling.

These findings are consistent with other research results. For instance, a study by Chase on survival strategies of orphans, vulnerable children and young people in Zimbabwe also show similar results. Chase found that a wide range of strategies to help secure their basic needs were described by children and young people. These included fishing in the river; selling or exchanging whatever resources were available, such as mangoes and frozen drinks; working in other people's fields; herding others' cattle; washing or looking after cars; moulding and selling bricks; roasting and selling mice; bee-keeping; recycling plastic bottles; and many others. Importantly, boys described a wider range of potential income or resource generating activities than girls. While boys talked of fishing, hunting, brick-

making, carpentry, herding others' cattle, and so on, the economic activities described by girls were more confined to working in other people's fields and selling vegetables from gardens, or asking neighbours for help in the form of food or soap or other basic commodities and prostitution.

In the same line, UNAIDS survey found out that around two million female sex workers in India, 20% were under the age of 15 and nearly 50% were under 18years old. In addition to the practice of exchanging sex for food, money, and clothing, young girls face a range of challenges that affect their well being. While at school young girls may be raped by their peers or coerced into having sex with their teachers. Young girls are also vulnerable to sexual exploitation as they work, particularly as vendors and domestic servants. A study in Fiji found out that 8 in 10 young domestic workers reported having been sexually abused by their employers. (Worden, J.1996.)

Street children are long-term runaways or homeless children who are able to fend for themselves on the streets. This study shows that there are a lot of children who go on the streets as a livelihood coping strategy because they beg for food and money. There are more males on the streets who beg for money compared to females according to the study. Some of them find comfort on the streets especially the males because they do not want to be a 'burden' to the parent/ guardian keeping them so they would rather spend time on the streets. These boys have been spending some good amount of time on the streets because some of them do not feel part of the homes they live in due to ill treatment by their guardians, while some of them go on the streets because they want food that they do not have at home and they have to fend for themselves. Most of the boys that went on the street did so because they felt the urge to help the surviving parent or their guardian.

The few girls that go on the streets experience a lot of hardships such as sexual harassment from the male street orphans. This is so because girls need protection and food whilst on the streets according to them.

It is clear from this study that boys have dominated the streets though some girls are found there as well as a coping strategy. This is in line with what UNICEF has concluded that Worldwide, it estimates that 30 million children spend most of their time on the streets. Of these, around 10 million are to all intents "abandoned", having lost or severed links with their parental homes. These children are prime targets for STDs and HIV infection. Their life style often places them on the wrong side of the law. Emotionally vulnerable and economically hard-up, such children are easily drawn into selling sexual favours. (UNICEF 2001)

Orphans go around selling food staffs for the same reason of generating some income for survival. Food staffs that are sold especially by girls included vegetables, groundnuts, sweet potatoes and fritters while boys also sold the above though not as much as girls, they also sold crashed stones that they crashed themselves and some sold plastic bags so as to contribute towards the household income. Some of them even have to carry people on their backs in the rain season as work to earn them a living.

5.2. EMOTIONAL COPING STRATEGIES

Results of the survey indicate that children employ different emotional coping strategies. These include taking alcohol, drugs, playing with friends. Drugs in this case according to the study discovered that bostik (glue that is sniffed) was used. The focus group discussion results also reveal that children employ social isolation, imitating deceased parents, being in the company of the family and playing with friends as emotional coping strategies. Research supports the understanding that difficult life circumstances and events are known to bring people with similar experiences together in supportive social networks (Janoff-

Bulman & Berger 2000) notwithstanding whether it is perceived as positive or not.

Similar results were reported by Chase in Zimbabwe in a study to investigate survival strategies of orphans, vulnerable children and young people. In the present study, children reported various ways in which they sought to relieve the strain of the difficulties they faced.

The study revealed that most boys are involved in alcohol and drug abuse as a way of coping with the situation. They were of the view that when they take such substances, they feel better and forget about their problems. They also said this was not a permanent solution because once they sobered up, they still found the problem. This made them drink more and more so as to continue forgetting their problems. This starts causing problems in their lives because they now become drunkards and start involving themselves in other undesirable activities such as theft due to the trickle-down effect of such deaths in a household.

The study also revealed that talking to friends rather than to adults was somehow a relief and it really made them feel better. Most males were of the view that they felt better after talking to their friends about the way they feel compared to the females. Most females were of the view that they would rather not talk about it because they felt hurt even more after talking because their memories where fresh again. For younger children, they found that meeting up with friends; playing different games and talking to their older siblings were strategies they employed for both boys and girls. For instance, a 10 years old boy in Chazanga compound described how he told his older sister his problems and asked her to tell him something nice. An 11 years old girl in George compound talked about how her friends make her feel a lot better when they have funny stories and this makes her forget about some of her problems. Most children did not expect any bright future because of the way they felt at the time of the interview. A 14 years old girl in George compound commented that “life will always be like this because of the death of my mother”. Another 10 years old boy who was badly treated, beaten, shouted at and denied food to eat if he did not contribute seemed resigned to the

situation. While this was the case, some children were of the view that they did not want to share their feelings with anyone because it hurt them even more especially boys.

In a similar study conducted by FHI / USAID (2002) children who took part indicated several strategies or activities that they employed to deal with the pain of the loss of their parents and the negative changes in their lives. Playing football, crying, visiting and playing with friends, praying and talking to someone were some of the strategies identified by the children. The emotional impact of losing a parent affected the children badly especially the girls. They kept shedding tears occasionally during the discussion. It was obvious with boys however, that they were pained and hurt in the way they spoke though they really tried to be stronger than girls.

During the discussion, most participants expressed feeling insecure, isolated and for some of those that lived with their guardians, unloved. The respondents also talked about being sad and still in disbelief over the deaths. While still, others felt stigmatized. Janoff-Bulman and Berger (2000) speak about the loss of invulnerability which the children experience, as being a part of "the aftermath of extreme negative events". The realisation that something so intense could happen to them leaves them feeling defenceless.

More than adults, children begin to rely on what they know; their homes, their families and their social networks, which they see as permanent and reliable. They form attachments which allow them to feel secure and give them the freedom to explore the world beyond from a stable base that they feel anchored to. Most children learn the inevitability of change when they are older and better able to deal with the implications, as they mature. These children however, did not get the chance to learn about how life changes and develops through the cycle that humans have come to accept as normal. This unexpected loss of invulnerability

may account for their extreme feelings. For instance, one of the children disclosed that:

> "Ever since my parents died, I feel no love around me because my uncle does not love me the way he loves his children. I do a lot at home I have even stopped school but my cousins go. At times, I think that it is a dream that my parents have died?"

Some might argue that the child's perception of abandonment and isolation does not necessarily reflect reality, nor does it represent the deliberate actions of the parents. However, some children understand their parent's death and illness as turning away and leaving them to fend for themselves. The expectation is that sick parents will get better; death is not an option. While on some level they can articulate that the death is not in fact deliberate and their parents are not at fault, they still experience it as negative. Notwithstanding the 'facts', it is the child's expressed experience that is critical. Over time, as with most people, these children have learned to master their grief.

Most of the participants spoke about their lack of connectedness to people that loved them, and this appeared to have had an impact on their perception of their own self worth. They said their relatives loved them when their parent/s was alive. In this regard, a number of the children thought that if they did something, their parent/s would not have died. They frequently expressed feelings of helplessness and being without hope. Foster & Williamson (2000) have observed that "Internalised behaviour changes such as depression, anxiety and low self-esteem" are more evident than externalised behaviours in children that are orphaned. This tendency to internalise may be due to their inability to find ways to express their grief adequately like one girl expressed her grief by asking God why she was born to just make her suffer on earth and she did not know what to do about her life because she felt so sad about her parents' death.

It is true that the cycle of life that children expect is that their parents will be available to see them as they grow into adulthood; and in doing so, that they will have guidance through the challenges of life. Additionally they see themselves as belonging to a supportive family unit that provides meaning in their lives. Unfortunately, these children's narratives suggest that the loss of their parents has disrupted the natural flow of their lives, and left them without direction and significance. And so they question their worthiness in a world without parental protection. Some children expressed so much sadness that they even wanted to die because it was not worth living without their parents. Even if this is so, the study indicated that more males tried to remember what their parents used to do at home and they would try to imitate some things and fewer females did the same because most of them did not want to remember the past life with their parents. According to them, it was too emotional. One may think that the children have begun to find ways of coping; however, it is with some difficulty that they are able to engage with their feelings. This is particularly difficult in times of multiple family loses.

The environment they are in, and the well-meaning volunteers who are their current guardians, have done their best to provide the basic needs however, according to some, their efforts still fall short. There is lack of wholeness by some and even though they may have everything provided for, the memories of how the parent/s suffered and died still remains lingering in their minds and just how they will never have that love they had from their parent/s. Some children interviewed acknowledged that their guardians really tried to make them happy but still that was not the mother's love which they still needed so much and no one would ever give it to them again.

Most participants spoke about feeling left out from their familiar social contacts, which once were very close contacts and now thinking that they were alone, without anyone to rely on. A number of children talked about being left in the care of extended family members after their parent's death. In some cases, the experiences reported were difficult; with participants often narrating incidences of

negative treatment received in these homes. Results also indicated that children are facing rejection and being neglected by family members who previously showed them love and concern. Some of the children, who went to live with extended family, reported being subjected to ill-treatment from their guardians. In some instances these children felt that they were regarded differently from the other children in the new household. According to them, unfair treatment and disciplinary measures were employed. On the issue of unfair treatment, one child said:

> "…I have to make sure that after school, I clean the house and cook for my cousins and after that clean the dishes whilst my cousins are playing and after that I go to sell vegetables at the market."

Some children however, indicated that they had continued the good relationships they had with their relatives. In Zambia traditionally, the expectation is that the extended family steps in to care for children that loose a parent/s. This informal adoption in most instances is the norm. However, the ever decreasing number of relatives who are able to fulfill this role has resulted in this support system becoming more difficult to access. According to the ZDHS (2007), in Zambia, the HIV prevalence rate among adults aged between 15-49, is 14%, with the mortality rates estimated at about 96 000 per annum (UNAIDS 2006). Consequently, the number of adults who will be available to look after orphans will remain low and children will continue to have the experience of being neglected and rejected by the very adults that they expect to protect them.

At times, families may make well meaning efforts to make better the lives of the orphans by sharing them in different homes. It has however at times, produced negative effects as one girl said was against this idea which she experienced concluding that staying in different homes made her very unhappy and she was disturbed hence decided to start doing some piecework after school and gave the

money to her surviving mother to expand her business so that the children could go back home. Children would rather stay in one home rather than being shared even if they are suffering.

In the study, children were of the view that the traditional family is not what it was and what it used to represent; most of the children made some reference to the changes experienced when they were no longer part of the connected family unit. The dislocations and deprivations that the children experienced meant that they have lost the family and can no longer access the protection that a family environment provides. As a result, many of these children were left without effective guidance and had to rely on their own limited competencies. Children begin to experience the effects of parental death from AIDS long before the actual death, and also long afterwards. (CARE, FHI, USAID 2003).

Social stigma, gradual impoverishment, and stress related to possible increased responsibility may start and progress during the illness. (UNICEF 2006). While the death of a parent is in itself difficult as it denies the child, among other things, the potential for being nurtured and protected by someone who loves them; it is however the subsequent life changes within the home that seems to have affected the children even more. When both parents die, children are unlikely to remain in their parental homes and may get split up among various relatives, thereby compounding their losses. They may be further denied access to other social networks such as school, friends and community. (Dane 1997, as cited in Wild 2000). The ‘sharing out’ of orphaned children is a strategy employed by extended family members, in order to divide the responsibility of care. (Foster & Williamson 2000).

The absence of parents or a concerned primary caregiver in a child’s early years may impede the development of essential “mental processes and faculties”. (O’Hagan 1993). A child may experience psychological difficulty if they are not able to adequately gain and retain an understanding about the world, acquire

moral standards (Berk 2000) and be able to find a place for themselves within the context of a functioning unit.

Bronfenbrenner's ecological systems theory views the development of a child through a social context of relationships within multi-levels of the environment, on a give-and-take basis. (Berk 2000, Pryor & Rodgers 2001). At the micro- and meso-system levels a child interacts primarily within a nuclear family unit, and then later, within the immediate community of child-care, school, health professionals and community. Thus a child's core well-being is governed by the quality and support provided within these interactions. At the macro-systems level, a child interacts within a wider community with culture, belief systems, attitudes and social policies. (Pryor & Rodgers 2001). At this level, traditional extended family practices should have come into play for the children; unfortunately, they did not, and so the system failed them. The failure of these systems, has thus denied the children of potential social capital, and increased the probability of their suffering harmful negative consequences.

Some of the children in the study, experienced neglect from their own relatives who kept them, with some being made to go without basic necessities such as food. For the male participants specifically, changes in the nuclear family construction such as the introduction of a step-mother (which has been found to sometimes affect family cohesion), may have exerted some social pressure which caused a disruption in the domestic workings of the family that threatened their psychological adjustment, because of their dependency on the family's smooth functioning. (Hauswald 1987).

5.3. IMPACT OF AIDS ON THE HEALTH NEEDS OF CHILDREN

The results of the survey show that most female children have challenges in accessing health services. The survey reveals that the majority of the orphans both male and female face challenges to access health service though it is much more with the girls. However, the results from the focus group discussion reveal more health challenges than simply figures. Most of the participants were of the view

that they have no access to health services because they have to pay. As a result, when they get sick, they can only afford to buy cheap medicines such as panadol. The other participant was of the opinion that it is pointless to visit the clinic because they do not have medicines except pain killers such as panadol. Others were of the view that most clinics have introduced schemes and one has to pay for the scheme. Most children with health challenges gave the above reasons as obstacles to them accessing good health.

It may appear that government clinics are cheap but according to the study, the little money they have to pay is difficult to find and even when they find it, they at times need to buy medicines for themselves. Due to this challenge, some of them would rather not go to the clinic but instead opt for other methods such as traditional medicines that are cheaper or even free according to the respondents like one 14 year old boy from Chazanga compound said:

> "I take herbs to heal when am sick because she has no money to pay at the clinic since we are a lot at home so she can't manage to pay for everyone."

Some respondents made it clear that they would rather buy food than go to the clinic because it was pointless to go there and pay money and be given panadol. It is just the same as buying the medicine from the counter in a shop and save the rest for food. It was also evident that respondents just did not find it necessary to go to the clinic because they do not often get sick.

> "...it is wasting money to go to the clinic because I don't get sick every day for me to buy a scheme so my aunt says that she will just buy medicine for me when I get sick so when I get sick, then I go to the clinic, they tell me to pay for a scheme and my aunt says that when she buys the scheme, she also has to buy medicine so she says she will just buy medicine for me."(15 years boy: George compound)

There were some respondents, though few, who confirmed that they had free access to the clinic because they are HIV positive and therefore, they experience no challenges when it comes to accessing health facilities. For instance, one of the respondents informed that:

> "I have free access to the clinic because I am HIV+ so I don't have to pay for anything because the ART clinic is free."(11 years girl: Chazanga compound)

Emphasis in clinics has been placed on children living with HIV and not those who have been affected. According to a report presented by Williamson, Children affected by HIV and AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet demonstrated increased morbidity and mortality among broadly affected children compared to unaffected control groups. In this regard, it has been suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic (Williamson 2000) or alternatively, that orphans may not be worse off than peers living in extreme poverty.

Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV and AIDS. One may conclude that it is important to spend money on one's health but this is not the case for such orphans. This may be the least on the list because they have to think about where they will get food from.

5.4. Impact of AIDS on the Education Needs of Children Experiences

The results show that both males and females experience or have experienced educational challenges. Those that stopped school confessed that they were doing very little in school and found it much better to stop and help the family. They mostly stopped school so that they sell on the streets, do piece works or just any

other income generating activities in order to earn some money for their families and for themselves as a coping strategy. The respondents both male and female also attributed their stopping school to lack of money whereas some could not continue with their studies due to lack of interest. Most girls admitted to being overloaded with helping at home financially and house chores after school hours and this became a challenge to them because they could not afford and hence had to choose one thing. Most of such children opted to go out and look for money for food and other basic necessities for home like one 14 year old girl from Chazanga said: “I stopped school because I need to bring some money at home. I have to help mother.”

Most of the girls that stopped school did so after their fathers died because they where the bread winners of the family. The children then end up engaging in income generating activities so as to sustain their lives and those of their elderly guardians and younger siblings. Some of them just lost interest in attending school and equally ventured out in money generating activities.

These results are similar to other findings. For instance a study by Nandago (2007) on coping strategies of orphans and vulnerable children in Uganda revealed that children drop out of school or fail to go to school because their parents cannot afford to pay the fees and other expenses, or when their parents or one of the parents dies and have nobody to take over. From the research findings, a total of 53(88%) orphans go to schools, 7(11.7%) are in primary schools, 37(61.7%) in secondary schools, 8 in tertiary institutions and 1(1.7%) in university 88% of the orphans were going to school but most of them are from primary and secondary, few being able to attain university education.

In households affected by HIV and AIDS, the school attendance of children drops off because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities such as food and shelter. Even where children are not withdrawn from school, education often begins to compete with

the many other duties that affected children have to assume. In addition, stigmatisation may prompt affected children to stay away from school, rather than endure exclusion or ridicule by teachers and peers. A research by UNICEF in 2000 in Zambia, for example, showed that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children. At a national level, a World Bank study in Tanzania suggested that HIV and AIDS may reduce the number of primary school children by as much as 22% and secondary school children by 14% as a result of increased child mortality, and decreased attendance and dropping out (Williamson 2000).

There are so many things children need for school. It is not just material things which most of them already cannot afford. It is also about them having a peace of mind, emotional support, a sense of wellbeing and a sense of belonging. The orphans in the homes affected by HIV and AIDS death of a parent(s) as seen from the results have many challenges concerning their education. Some of them have to stop school for different reasons especially that they have to look for money for school, home and other necessities for their survival.

CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

6.0. INTRODUCTION

This chapter highlights the main results of the study and recommendations.The overall picture from the findings of the survey was that there were gender differences in livelihood coping strategies of children affected by HIV and AIDS and children employed emotional coping strategies. It was also clear that children experienced health and educational challenges in their lives after the death of parent/parents.

It is also clear that girls are much more affected when it comes to employing the coping strategies. They have the highest number of being involved in income generating activities, when they go on the streets, they are sexually harassed by the males and emotionally they find it much more difficult to come to terms with the death of their deceased parent and they would rather not talk about it. When it comes to health, results show that they do not easily have access to health facilities; therefore, they resort to other means such as using traditional medicines or just not go to the clinic.

With education, both girls and boys experienced challenges such as dropping out, lack of school uniforms and books. Girls, though, expressed many other challenges such as house chores such as cooking, cleaning, drawing water and taking care of their younger siblings which boys did not talk about apart from the works that both sexes do.

The issues raised in this study are in line with those identified in the literature review. Children whose lives are affected by HIV and AIDS through the death of their parents suffer the consequences at livelihood, emotional, educational and health levels.

Previous studies have focused on the socioeconomic impact of HIV and AIDS on children, and there is evidence to suggest that efforts have been made to begin to address the immediate basic needs of a number of orphans and vulnerable children in Zambia. However, there has been a gap on how these children cope in terms of livelihood, emotional, educational and health needs. Emotional needs cannot be left unattended, as they can have adverse long-term effects on children's behaviour, well-being and eventual entry into the world as adults.

This study brought out clearly the differences in livelihood coping strategies of boys and girls. Whereas boys are more involved in doing piece works and going on the streets to beg, girls are more involved in selling on the streets and prostitution as livelihood coping strategies.

Children also employ emotional coping strategies both positive and negative ones. To them, whether something is good or bad does not matter as long as it makes them feel better emotionally. Some positive ones include playing with friends and being in the company of friends whereas negative ones include taking alcohol and drugs.

With regard to education, most children had stopped school due to lack of sponsorship and for some, lack of learning materials such as uniforms and books. Some of them indicated that they stopped school because they had to generate income after the death of their parent/parents.

It is clear also those children in homes that have experienced HIV and AIDS related deaths struggle when it comes to health. Most of them may have access to the health facilities but do not have money to pay for the prescribed medicines which puts them at a risk of ill health.

6.1. RECOMMENDATIONS

HIV and AIDS have got severe implications on the lives of AIDS orphans, caregivers and the community at large. With the best interest of orphans and other children made vulnerable by HIV and AIDS in mind, the author believes in the importance of support services and care in supporting the needs of orphans, families and communities to enable them build up their capacity to confront the disease. Children affected by HIV and AIDS have a right to basic needs, education, health care, family care and protection.

Based on the study findings, the author recommends the following support services and care, in supporting the needs of orphans and children made vulnerable by HIV and AIDS:

1. Girls should be considered in making school programmes because they have other social obligations at their homes.
2. There should be counselling for orphans in clinics so as to reduce the effects of parental deaths.
3. The government should have a deliberate policy of making sure that there are no street children especially girls because they are in danger on the streets. This can be done by creating space for them by the ministry of Community Development and Social Services where they can be kept and monitored by the government.
4. Special attention and urgent support should be given to single parent households. Because the traditional role of the extended family in caring for orphans is threatened and weakened by HIV and AIDS, Orphans are likely to live in poor conditions and have little chance of escaping poverty without external support. So their attempt to survive and continue as a family unit needs to be supported.
5. Legal and human rights advocacy. An advocacy is required to give protection and support for orphans and other vulnerable children. It is

basically needed to ensure that these children are recognized by the Government and addressed in national constitutions, legislation and social welfare systems.

6. State support for orphans and vulnerable children in education, health, food security are very important. Support from the state can be in many forms like exemption of school fees not only at primary level but secondary level too and award bursary to all such orphans at tertiary level and free health care services.
7. The Government should promote social and economic support to improve incomes of the surviving spouse and guardians through income generation activities.
8. Institutions working with AIDS orphans and local community organizations like NGOs must review their bylaws and regulations so as to make the orphans self supportive and protect them from further risks and vulnerability.
9. Churches in particular should preach more on the goodness of extended families and how they should extend their hand in accommodating orphans. Although the economy is pushing even nuclear families to breaking points, yet also people are misplacing values. People are valuing more accumulation and consumption of wealth than accommodating orphans. For example, a nuclear family may decide to buy a car than accommodate an orphan. If people lessened on greed and became more generous and selfless, Zambia does not deserve to have street kids. Street kids in reality are a sign of the greediness of this society and a breakdown of the values and moral fibre of the society.
10. Households that have less privileged grandparents taking care o their grand children should have assistance. Thus, government should work out a social welfare system to help such families so that orphans do not turn out to be the bread winners and in that case, they can concentrate on their education.

National Strategies and Policies

Ministry of education and other education institutions should act together and not in isolation. Supporting these affected children is everyone's responsibility and not only the community. The impact of the HIV and AIDS epidemic on the education sector will, to a large extent, depend on the overall level and effectiveness of the assistance given to these children and their careers outside of school. This highlights the importance of governments developing comprehensive national policy frameworks in order to tackle the AIDS crisis.

REFERENCES

A costing analysis of community based programmes from children affected by HIV/AIDS-results from Zambia and Rwanda. UNAIDS, UNICEF, USAID (2004).

Accelerating Action against AIDS in Africa. (2003) UNAIDS Geneva.

African Child Policy Forum (2008). *Reversed Roles and Stressed Souls: Child Headed Households in Ethiopia*.

AIDS in Africa. Country by country (2000).UNAIDS.

AIDS Orphans (2010). Avert

Ainsworth, M., &Filmer, D. (2002). *Poverty, AIDS and children's schooling: A targeting dilemma:* World Bank Policy Research Working Paper 2885; World Bank.

Ainsworth, M., &Semali, I. (2000). *The Impact of Adult Deaths on Children's Health in Northwestern Tanzania.*Washington DC: World Bank.Becca Smith, (2009). News blog

Banda. A. & Tembo. S. (2001). *Preliminary results of orphans and vulnerable children household baseline:* Zambia, Lusaka: SCOPE- OVC/FHI/USAID.

Barnett, T. 2002b, *Progress report: HIV/AIDS impact studies II - some progress evident*, Forthcoming in Progress in Development Studies.

Basaza, R. &Kaija, D. (2002).*AIDS public policy and child-well being: The impact of HIV/AIDS on children: Lights and shadows in the "successful case" of Uganda.* Florence:UNICEF. Available http://www.unicef-icdc.org/research/

Baylies, C. 2002, "The impact of AIDS on rural households in Africa: a shock like any other?", *Development and Change 33 (4)* no. 33 (4), pp. 611-632

Brannon, L. &Feist, J. (2000). *Health psychology: An introduction to behaviour and health*. 4th Edition. USA: Wadsworth

Berk, L.E. (2000). *Child development*.5th Ed. USA: Allyn& Bacon.

Calhoun, R.G., Tedeschi, L.G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. USA: Sage Publications

Caring with confidence. (1997). *Practical information for health workers who prevent and treat HIV infection in children.* Russel Press. Nottingham.

Children on the Brink. (2002). *A joint report on orphan estimates and programme strategies.* UNICEF.

Cohen, L. and Manion, L. (1992). *Research methods in Education.* London: Routledge.

Collins English Dictionary (2003). Complete and unabridged. Harper Collins publisher.

Cornia, G.A. (2002). "*AIDS, Public Policy and Child Wellbeing*". Chapter - I: Overview of the Impact and Best Practice Responses in Favour of children in a World Affected by HIV/AIDS. UNICEF.

Descombe, M (2007) *The Good Research Guide for small-scale Research projects.* Buckingham: Philadelphia. Open university.

Devereux, S. (1993). *Goats before ploughs: Dilemmas of household response sequencing during food shortages. IDS Bulletin* 24(4):52-59.

De Waal, A. (1989) *Famine That Kills.* Oxford: Clarendon Press.

Donahue, J. (1998) *'Community-based Economic Support for Households affected by HIV/AIDS'*: Discussion Paper on HIV/AIDS. *Care and Support,* No. 6, Arlington, VA: Health Technical Services (HTS) Project for USAID.

De Vos, A., Strydom, H., Fouche, B. and Delport, C. 2002. *Research at Grass Roots for the Social Sciences and Human Service Professions*. Pretoria: Van Schaik Publishers.

De Vos, A., Strydom, H., Fouchē, B and Poggenpoel, M and Schurink, E. 1998. *Research at Grass Roots, A Primer for Caring Professionals.* Pretoria: Van Schaik Publishers.

Epidemiological projections for the period 1985 to 2010. CSO.

Fleshman Michael (2001) Africa renewal vol. 15. 3.

Folkman, S., and Lazarus, R.S. (1980). *An analysis of coping in a middle- aged community sample.* Journal of health and social behaviour.21, 219- 239.

Food Security Network: *impact of HIV and AIDS on Rural Agricultural Production and Food Security in Chivi and Makoni Districts.*

Foster. G., & Williamson, J. (2000). *A review of current literature of the impact of HIV/AIDS on Children in sub-Sahara Africa*.AIDS 2000. Retrieved 15 August, 2007 from World Wide Web

Ghoshi B.N, 1982. *Scientific method and social research*. New Delhi.

Gilborn, L. (2000). *Outreach for AIDS Affected Children and Families in Uganda*, paper presented to the International Conference in AIDS, Durban

Global Summary of the Aids Epidemic (2006). UNAIDS, WHO.

Gow J and Desmond C (2002). *Impacts and interventions- the HIV/AIDS epidemic and the children of South Africa.* Durban. University of Natal Press.

Grotberg, E. (1995) *A Guide to Promoting Resilience in Children: Strengthening the Human Spirit.* Early Childhood Development: Practice and Reflections series.

Guidelines for Counselling Children who are infected with HIV or affected by HIV and AIDS (2003). Harare ,Zimbabwe.

Haworth,A. Et al. *"Social consequences of AIDS in 49 Zambian families: A descriptive study".* paper presented at the VII International conference on AIDS, Florence Italy.

Hauswald, E. (1987). External pressure/internal change: Child neglect on the Navajo reservation. In Scheper-Hughes, N. (Ed).*Child survival: Anthropological perspectives on the treatment and maltreatment of children.* Holland: D. Riedel Publishing.

Haworth A. (1991). A *Study of the Effects of AIDS upon Children in 116 Zambian Families.*Lusaka: University of Zambia.

HIV/AIDS in Zambia: background, Projections, impacts and interventions.(1999) MOH/ CBH.

HIV and AIDS in Zambia. 2008. Avert.

Hunter, Susan and John Williamson (2000). *Children on the brink executive summary: updated estimates and recommendations for intervention*. Washington: USAID.

Holahan. C. J., and Moss. R.H. (1987). *Risk, resistance and psychological stress: a longitudinal Analysis with adults and children.* Journal of abnormal psychology, 96,3-13.

Ishikawa et al. (2010): *Breaking down the wall of silence around children affected by AIDS in Thailand to support their psychosocial health.* AIDS CARE, 22:3, 308-313.

Janoff-Bulman, R., & Berger, A.R. (2000). The other side of trauma: Towards a psychology of appreciation. In J.H. Harvey & E.R. Miller (Eds), *Loss and Trauma: General and close relationship perspectives* (pp. 29-44).Philadelphia: Brunner-Routledge

Kelly, M. (2000). *Planning for education in the context of HIV/AIDS, IIEP Fundamentals of Educational Planning* No. 66, UNESCO, Paris.

Kelly, M. J. (2000). *The encounter between HIV/AIDS and education.* UNESCO, Harare.

Kelly M.J. (2006). *HIV and AIDS: A justice perspective.* JCTR.

Lazarus, R.S., &Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Living Conditions Monitoring Surveys. (2006). *Preliminary report. Central statistical office. Lusaka.*

Mallmann S. (2002) *Building Resilience Among Children Affected by HIV/AIDS.*

Mann, G (2002) *Family matters: the care and protection of children affected by HIV/AIDS in Malawi.* Research commissioned by the Save the Children Alliance as part of the Care and Protection of Separated Children in Emergencies Project (CPSC).

Monasch. R. & Boerma, J. (2004). *Orphan hood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries. AIDS 18* (Suppl 2), S5565.

Mosby's medical dictionary. 8th edition (2009). Elsevier.

Moser C (1998). *The Asset Vulnerability Framework: Reassessing Poverty Reduction Strategies*, World Bank.

Mutangadura G, and Webb (1999). *Mortality and Morbidity on Households in Kafue District*, Zambia. SAFAIDS, Harare.

Mutangadura, G., Mukurazita, D., & Jackson, H. 1999, *A review of household and community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa*, UNAIDS Best Practice Collection.Kafue District, Zambia. SAFAIDS, Harare.

Mwaka V. and Tumushabe J (1996). *The state of child labour in uganda.* Unpublished report, ministry of labour and social affairs/ UNICEF

Nandango L. (2007). *A case study of Entebbe Municipality.African population conference.* Arusha Tanzania.

Ndongko, T. (1996). *A preliminary study of the socio-economic impact of HIV/AIDS in Africa*. Africa Development Vol. XXI, No.1, 1996.

O'Hagan, K. (1993). *Emotional and psychological abuse of children.* Buckingham: Open University

Owen Kelly. (2009). *Obsessive- compulsive Disorder guide.* Medical review board.

Pearsall, J. (2001). *The Concise Oxford Dictionary.*10th Edition. New York: Oxford University Press Inc.

Pembrey Graham (2009). Avert.

Phiri, S. & Webb, D. (2002). *AIDS public policy and child-well being: The impact of HIV/AIDS on orphans and programme and policy responses*. Florence:

UNICEF. Retrieved November 21, 2005 from http://www.unicef icdc.org/research/

Pinheiro, P.S., (2006). *World report on violence against children: United Nation's secretary generals study on violence against children.* Geneva: UN

Poverty and children: lessons of the 90s for least developed countries. UNICEF (2001).

Prevalence, Abuse and exploitation of street children.

Pryor, J., & Rodgers, B (2001). *Children in changing families: Life after parental separation.* UK: Oxford Blackwell publishers

Raphael, B., & Dobson, M. (2000). Bereavement. In J.H. Harvey & E.R. Miller (Eds), Loss and Trauma: *General and close relationship perspectives* (pp. 45-58).Philadelphia: Taylor &Francis

Rapid Assessment of street children in Lusaka (2002).UNICEF.

Renckly .R (2002) *guidelines for planning, organising and conducting surveys.* Air university. United States of America.

Renckly T.R (1996). *Air university sampling and surveying handbook.* Air university. United States of America.

Report on global HIV/AIDS Epidemic (2002). UNAIDS.

Report on global HIV/AIDS Epidemic (2004). UNAIDS.

Report on global HIV/AIDS Epidemic (2008). UNAIDS.

Rugalema, G. (2000) *"Coping or struggling?" a journey into the impact of HIV/AIDS in Southern Africa*. *Review of African Political Economy*. 86, 537-545.

Salaam, T. (2005). *AIDS Orphans and Vulnerable Children (OVC): Problems, Responses, and Issues for Congress. Congressional Research Service. The Library of Congress.*

Segens Medical Dictionary (2012). Farlex incorporation.

Skoufias, E. (2003) *Economic crises and natural disasters: coping strategies and policy implications. World Development* 31, 7, 1087-1102.

Stein J. (2003) *Sorrow makes children of us all: a literature review on the psychosocial impact of HIV/AIDS on children.* Centre for Social Science Research, University of Cape Town. Working paper no. 47.

SumaleePitayanon, SukhonthaKongsin and Wattana S. Janjareon. *The economic impact of HIV/AIDS mortality on households in Thailand.*

The HIV/AIDS. Epidemic in Zambia. National HIV/AIDS/STD/TB Council. (2004).

The HIV/AIDS epidemic in Zambia. 2007 WHO.

The National Agricultural Advisory Service of Uganda (NAADS) (2003) *The impact of HIV/AIDS on the agricultural Sector and rural livelihoods in Uganda*. Uganda:

The State of the World's Children: child survival. (2008). UNICEF.

Togom David K. (2009). *Challenges facing AIDS Orphans in Nairobi Kibera Slums.Turun Ammattikorkeakoulu.* Turku University of Applied Sciences.

Tsegaye, Shimelis (2008). *Short Lives and Limited Life Chances: An overview of child wellbeing in Africa.* Vol. 8, no 1

The African Child Policy Forum. Waking up to devastation (2000). Report on the

global HIV/AIDS Epidemics. UNAIDS.

UNICEF, (2000) *Childworkers in the shadow of AIDS: Listening to the children*, UNICEF Eastern and Southern Africa Regional Office.

Van Dyk, A. (2001). *HIV/AIDS Care &Counselling: A Multidisciplinary Approach.*Cape Town: Pearson Education South Africa.

Sepkowitz K.A (2001). *Wikipedia – the free encyclopaedia*. Wikipedia foundation incorporation.

Wild L. (2001). *The psychosocial adjustment of children orphaned by AIDS: a review. Southern African Journal of Child and Adolescent Mental Health* 13(1): 3-21.

Williamson J, (2000). *Finding a way forward: Principles and strategies to reduce the impacts of AIDS on children and families, in C Levine & G Foster (eds), The orphan generation: The global legacy of the AIDS epidemic*, Cambridge University Press, Cambridge.

Women and HIV/AIDS-confronting the crisis. UNAIDS/UNFPA/UNIFEM (2004).

Worden J (1996) *Children and grief: when a parent dies.* New York: Guilford Press.

Yamano, T. & Jayne, T. (2002). *Measuring the impacts of prime-age adult death on rural households in Kenya*, Department of Agricultural Economics, Michigan State University, East Lansing, Michigan.

Yih, R (1994) *Case Study Research.* Newbury Park CA: Sage publications.

Your dictionary definitions (2012). Love to know corporation.

Zambia Demographic and Health Survey, 2001-2002. Central Statistical Office. Lusaka.

Zambia Demographic and Health Survey (2007) preliminary report. Central Statistical Office. Lusaka.

APPENDIX A
INFORMATION SHEET TO THE PARTICIPANTS

INTRODUCTION

My name is Rita Taonga Nacidze, a student at the University of Zambia in the school of Humanities and Social Sciences. I am currently pursuing a Master of Arts Degree in Gender Studies and I am conducting a research on Gender differences in coping and livelihood strategies of children affected by HIV and AIDS related deaths in a household.

This research is being carried out in fulfilment of my Masters Degree. The study is purely for academic purposes and the information given will be important because it will help the policy makers and implementers of programs know the extent of the problem so as to find long lasting solutions.

You are being requested to take part in the research study mentioned above. The information given will be highly confidential. Before you decide whether or not to take part in this study, I would like to assure you that there are no risks involved in this study. You will be asked questions on the research topic. If you agree to take part, you will then be asked to sign this consent form or make thumb print in the presence of someone. Your participation in this study is voluntary and you can withdraw any time during the course of the interview because you are under no obligation to participate.

APPENDIX B

INFORMED CONSENT FOR THE CHILDREN

I hereby declare that I have fully understood the purpose of the study and therefore, I Name……. having been fully informed on what this study is all about, the benefits, discomforts, risks and confidentiality, agree to participate willingly.

Sign/Thumbprint

……

Date:

……

Witness

Sign…….....

Date.....

APPENDIX C

PARTICIPANT CONSENT FORM

LEGAL GUARDIAN

I have read and understand the information provided above about the study and the process involved. I, being the parent / legal guardian, hereby give my consent for the child named below to be included in the study. I understand that the child will also be given the choice as to whether to take part in the study or not.

Signature: Parent / Legal Guardian _____

Date: _____

Name of child _____

R.T Nacidze_____

Date: _____

APPENDIX D

CONSENT FORM FOR USE OF AUDIO TAPE

LEGAL GUARDIAN

I have read and understand the information provided about the study and the process involved. I, being the parent / legal guardian, of the child named below, hereby give my consent to have the focus group discussion audio tape recorded. I understand that the information on the audio tape will be kept confidential and will be used by Ms. Nacidze only for the purposes of this study. I understand that the recordings will be kept in a safe place and will be destroyed once Ms. Nacidze has completed her studies in the next two to three years.

Signature: Parent / Legal Guardian _____

Date: _____

Name of child _____

R.T Nacidze_____

Date: _____

APPENDIX E

CONSENT FORM FOR USE OF AUDIO TAPE

PARTICIPANT

I have read and understand the information provided above about the study and the process involved. I, being the child named below, hereby give my consent to have focus group discussion audio tape recorded. I understand that the information on the audio tape will be kept confidential and will be used by Ms. Nacidze only for the purposes of this study. I understand that the recordings will be kept in a safe place and will be destroyed once Ms. Nacidze has completed her studies in the next two to three years.

Name _____

Signature: _____

Date: _____

R.T Nacidze_____

Date: _____

APPENDIX F

FOCUS GROUP QUESTIONS

1. Please tell us about the changes that have occurred in your life since your parent (s) died
2. Do you go to school? If no, why?
3. What are some of the difficulties you face in your educational needs?
4. How do you feel losing a parent?
5. Do you involve yourselves in jobs that you are paid for?
6. Do you take desperate measures to survive?
7. Do you find ways to generate income?
8. Have you ever been on the streets begging for food or money?
9. Have you involved yourself with drugs or alcohol?
10. Do you ever talk to anyone about how you feel?
    -Whom do you talk to?

    if you do not talk to anyone, why?

11. Do you feel better in the company of relatives and friends better?

    -give reason for your answer

12. Do you ever recall parental advice?

13. Do you imitate other people's habits as a way of coping?

    -do you distract yourself as a coping strategy?

14. Do you have access to the clinic?

    -if not, why?

    -what are the health experiences and challenges you face?

15. What do you do if there is no money?

APPENDIX G

QUESTIONNAIRE

	QUESTIONS AND INSTRUCTIONS	RESPONSES	GO TO
SECTION A: BACK GROUND CHARECTERISTICS			
Q1	Sex of respondent	Male 1 Female 2	
Q2	Age of respondent	10 – 15 1 16- 20 2	
Q3	Marital status	Single 1 Married 2 Separated 3 Divorced 4 Widowed	

		5	
Q4	Have you ever attended school?	Yes 1 No 0	
Q5	How many years of schooling have you completed altogether?	Highest grade attained _____	
Q6	Who is dead between your mother and father?	Father 1 Mother 2 Both 3	
Q7	Do you have any brothers and sisters?	Yes 1 No 0	→ Q8
Q8	Where are they and who looks after them?	_____	

Q9	Are you in touch with your family e.g. extended family?	Yes 1 No 0	
Q10	Where and who did you live with after your parent(s) passed away?	_____	
SECTION B: SOCIAL ECONOMIC CHARACTERISTICS			
Q11	Have your living conditions changed since the death of your parent(s)?	Yes 1 No 0	
Q12	If yes, in what ways?	specify _____	
Q13	How many rooms is your house?	No of rooms in the house hold _____	
Q14	Whom do you entirely depend on?	Specify _____	
Q15	If you go to school, do you have the basic needs such as uniforms	Yes 1 No	

	and books for school?	0	
Q16	If you do not go to school, why?	_____ _____	
Q17	If you do not go to school, what do you do at home when your friends are at school?	_____	
SECTION C: LIVELIHOOD STRATEGIES			
Q18	Do you take desperate measures in order to survive?	Yes 1 No 0	
Q19	If yes, what kind?	Specify _____	
Q20	Does the company of friends and community make you feel stronger?	Yes 1 No 0	

Q21	Do you recall parental advice and values?	Yes 1 No 0	
Q22	Do you imitate the habits of your deceased parents as a way of survival?	Yes 1 No 0	
Q23	Do you ever distract yourself as a way of moving on?	Yes 1 No 0	
Q24	How many meals do you have in a day?	1 1 2 2 3 3 Above 3 4	
Q25	Did you eat anything yesterday?	Yes 1	

		No 0 Do not know/not sure 8	
Q26	If yes, which food did you eat yesterday?	breakfast only 1 lunch only 2 supper only 3 breakfast + lunch only 4 breakfast + super only 5 lunch + super only 6 breakfast + lunch + super 7 other (specify) ————————	
Q27	How likely is it that you will have enough food to eat tomorrow?	Unlikely 1 Somewhat unlikely 2	

		Likely 3 very likely 4	
Q28	How likely is it that you will have enough food to eat next week?	Unlikely 1 somewhat unlikely 2 likely 3 very likely 4	

Q29	Has the household living standard since the death improved, remained the same or deteriorated?	Improved 1 Remained the same 2 Deteriorated 3 Do not know 4	
Q30	Do you fend for yourself or for your siblings?	Yes 1 No 0	
Q31	Do you look for ways to generate some income for the household?	Yes 1 No 0	
Q32	D o you engage in any work that you are paid for?	Yes 1 No 0	
Q33	How much do you earn a day on average?	_____	

Q34	Have you ever sold any assets in order to survive?	Yes 1 No 0	
Q35	Have you ever been on the streets to beg for money or food?	Yes 1 No 0	→ Q36
Q36	If yes, why?	_____	
SECTION D: SOCIAL COPING STRATEGIES			
Q37	Do you ever have happy family activities such as birth day celebrations?	Yes 1 No 0	
Q38	If no, why?	_____	
Q39	Do you miss family time?	Yes 1 No	

		0	
Q40	Do you ever feel that the family peace has been disturbed?	Yes 1 No 0	
Q41	If yes, how?	_____	
Q42	Can you depend on your extended family for anything?	Yes 1 No 0	
Q43	Is your family still intact?	Yes 1 No 0	
Q44	If no, why?	specify _____	
Q45	Do you feel loved by the people around you?	Yes 1 No 0	
Q46	If no, why?	specify _____	
Q47	Do you ever experience unwantedness from people who once	Yes 1 No 0	

	loved you?		
Q48	Do you feel protected by your family?	Yes 1 No 0	
Q49	Do you have parental advice from around?	Yes 1 No 0	
Q50	Do some people remind you of your parents?	Yes 1 No 0	
Q51	Do you have any family memories?	Yes 1 No 0	
Q52	If yes, what kind?	specify _____	
Q53	Have you taken any adult roles since your parent(s) died?	Yes 1 No 0	
Q54	If yes, what kind?	specify _____	

Q55	Do you ever receive peer pressure from any one?	Yes 1 No 0	
Q56	If yes, what type and why?	specify _____	
Q57	Do you or have you ever involved yourself in the use of drug or alcohol abuse?	Yes 1 No 0	
Q58	If yes, why and what type of abuse?	specify _____	
Q59	Do you have any friends around?	Yes 1 No 0	→ Q60
Q60	If no, why	_____	
Q61	How do your friends respond to you?	Very good 1 Good 2 Bad	

		3 Very bad 4	
Q62	Have you ever gone to stay with other relatives because your parent could not afford to take care of you?	Yes 1 No 0	
Q63	How do you relate with other members of the household?	Very good 1 Good 2 Bad 3 Very bad 4	
Q64	How do you relate with your parent/guardian?	Very good 1 Good 2 Bad 3 Very bad	

		4	
SECTION E: EMOTIONAL COPING STRATEGIES			
Q65	Are you treated the same with other children in the house?	Yes 1 No 0	
Q66	If no, how differently are you treated?	specify _____	
Q67	Do you feel neglected?	Yes 1 No 0	
Q68	If yes, by who and why?	specify _____	
Q69	Do you do anything to keep you busy and not think about your parent(s)?	Yes 1 No 0	
Q70	If yes, what do you do?	specify _____	
Q71	Are you or have you been sexually abused?	Yes 1 No	

		0	
Q72	if yes, by who?	Specify _____	
Q73	Do you ever refuse to believe that you lost a parent(s)?	Yes 1 No 0	
Q74	Do you talk about how you feel with your parent/guardian?	Yes 1 No 0	
Q75	Do you have any fears?	Yes 1 No 0	
Q76	If yes, what are they?	specify _____	
Q77	Do you mention your fears and worries with parent/guardian?	Yes 1 No 0	

Q78	If yes, what is the response you get?	specify _____	
Q79	Do you ever feel abandoned?	Yes 1 No 0	
Q80	If yes, how	Specify _____	
Q81	Do you in any way feel disadvantaged because you have lost a parent?	Yes 1 No 0	→ 82
Q82	If yes, how?	_____	
SECTION F: HEALTH			
Q83	Do you have access to a clinic?	Yes 1 No 0	→ Q84
Q84	If no, why?	_____	

Q85	Who takes you to the clinic when you are sick?	Parent /guardian 1 Siblings 2 Neighbor 3 Alone 4 Other (specify)———————	
Q86	Have you ever been denied care from a health facility because you could not pay?	Yes 1 No 0 Do not know/not sure 8	
Q87	Have you ever been prescribed medicine that you could not obtain because you could not pay?	Yes 1 No 0 Do not know/not sure 8	
Q88	Where would you normally go for medical care?	Area Government Clinic——————— Other (specify)———————	

Q89	Who pays your medical bills?	Parent /guardian 1 Siblings 2 Neighbor 3 Alone 4 Other (specify)_____	
Q90	What happens if there is no money?	_____	
Q91	Have there been times when you have been sick and not visited the clinic?	Yes 1 No 0	
Q92	If yes, why?	_____	
Q93	Have you suffered from any disease?	Yes 1	

		No 0	
Q94	If yes, how long?	_____	
Q95	Are you currently suffering from any disease?	Yes 1 No 0	
Q96	Are you taking any medicine?	_____	
Q97	Have you ever been hospitalized?	_____	
EDUCATIONAL CHALLENGES EXPERIENCED AND RECOMMENDATIONS			
Q98	Do you face or did you ever face challenges in meeting your educational needs?	_____	
Q99	What kind?	_____	

Q100	How best can these problems that you face including others in your situation be solved?	_____ _____	

END OF QUESTIONNAIRE

THANK YOU VERY MUCH.