Chapter -V

DISCUSSION AND CONCLUSIONS

This chapter is presented in three subparts such as Major findings, Hypotheses related discussion and Conclusions.

A. MAJOR FINDINGS

1. Children with HIV/AIDS are found to be having higher adjustment problems than non-HIV/AIDS children.

2. Children with HIV/AIDS are found to be having lower self-esteem than non-HIV/AIDS children.

3. Children with HIV/AIDS are found to be having lower emotional competencies than non-HIV/AIDS children.

4. Girls with HIV/AIDS are found to be having higher adjustment problems than boys.

5. Girls with HIV/AIDS are found to be having lower self-esteem than boys.

6. Girls with HIV/AIDS are found to be having lower emotional competencies than boys.

7. Rural children with HIV/AIDS are found to be having higher adjustment problems than urban children with HIV/AIDS.

8. Rural children with HIV/AIDS are found to be having lower self-esteem than urban children with HIV/AIDS.

9. Rural children with HIV/AIDS are found to be having lower emotional competencies than urban children with HIV/AIDS.
B. HYPOTHESES RELATED DISCUSSION

The results of the study are discussed in the light of earlier literature with reference to the formulated directional hypotheses.

Hypothesis, $H_1$: Children with HIV/AIDS have significantly higher adjustment problems than non-HIV/AIDS children, was accepted. Children with HIV/AIDS have significantly higher social adjustment, higher emotional adjustment, higher educational adjustment and overall higher adjustment problems than non-HIV/AIDS children.

The earlier studies also report similar results. Kashikar et al. (2007) reported that children with HIV/AIDS are at higher risk for psychological adjustment problems than non-HIV/AIDS children. Conte et al. (2003) reported that the higher levels of anxiety and depression and lower level of psychological adjustment compared to normal children. Bachanas et al. (2001) found that approximately 25% of HIV infected children were experiencing significant psychological adjustment problems. Li et al. (2009) pointed out that the children with HIV/AIDS are suffering with psychological adjustment problems in comparison to non HIV/AIDS children. Fielden et al. (2006) said that children with HIV/AIDS has higher suffering of worries, anxieties, psychological adjustment problems, emotional problems compared to normal children. Grover et al. (2007) studied that children with HIV/AIDS compared to non-HIV/AIDS children are at higher risk of psychological adjustment and behaviour problems. Gent and Winkelman (2007) the study reveal that children with HIV/AIDS have significantly more psychological adjustment problems, depression/anxiety, withdrawal and social problems than non-HIV/AIDS. Rao et al. (2007) say that children with HIV/AIDS have been transformed from an acute to a
chronic illness. A number of psychological illnesses including: depression, anxiety, emotional and disruptive disorders, social, emotional and educational adjustment problems and hyperactive disorders have been observed in children with HIV/AIDS. There may be many causes for children with HIV/AIDS to have higher social, emotional and educational adjustment problems than non-HIV/AIDS children.

Taha and Taha (2000) found that HIV-related adjusted recurrent problems of fever, chronic diarrhea, vomiting, ear infection; skin conditions, oral thrush, and cough were significantly higher among children with HIV/AIDS compared with HIV-uninfected children. HIV infected children on clinical examination, otitis media, dermatitis, oral candidiasis, signs of active chest problems, lymphadenopathy, and developmental delay, and cough could be attributed to malaria, malnutrition, and respiratory tract infections, respectively were significantly more frequent in them compared to HIV-uninfected children. According to Conte et al. (2003) childhood chronic illness has significant impact on family functioning, including less family cohesion, parental reported higher levels of anxiety and depression and lower level of psychological adjustment compared to normal children. Howland et al. (2000) pointed out the association of negative stressful life events such as bereavement, hospitalisation of a family member, loss of change in housing for children with HIV/AIDS cannot be ignored, and it can be expected that these children who are facing multiple losses and stressors will experience significant developmental disruptions and ultimately psychological distress and psychiatric disorder.
Gent and Winkelman (2007) reported that children with HIV/AIDS have more traumatic experiences, more problems in social and emotional functioning compared to children without HIV/AIDS. Kashikar et al. (2007) Children with HIV/AIDS are at risk for psychological adjustment problems, chronic illnesses, experiencing emotional, behavioral, and educational difficulties than non-HIV/AIDS. Li et al. (2009) Children with HIV/AIDS were suffering with adjustment problems, anxiety, diarrhea, fever, bacterial pneumonia, recurrent upper respiratory tract infection and oral candidacies in HIV infected children.

Children with HIV/AIDS are more likely to experience adverse adjustmental problems outcomes. However, it may be because of chronic illnesses which are at increased risk for experiencing socio-economic status, low income family, psychological functioning, a lack of health facilities, environmental factors, stigma, discrimination, social isolation, illness and complicated regimens, poverty, educational level, inadequate medical services, inadequate medical staffs, and a lack of psychological and social support. All these frequent physical and psychological sufferings along with the family members and their HIV status will have adverse influence on the psychosocial well being of a child and will translate into increased higher social, emotional, educational and overall adjustmental problems in children with HIV/AIDS as compared to those Non-HIV/AIDS children.
Hypothesis, H$_2$: Children with HIV/AIDS have significantly lower self-esteem than non-HIV/AIDS children, was accepted. Children with HIV/AIDS have significantly lower general self-esteem, lower social self-esteem, lower home self-esteem, lower school self-esteem and overall lower self-esteem than non-HIV/AIDS children.

The earlier studies report also supports the above findings. Thanyawee et al. (2010) pointed out the HIV infected children have lower self-esteem than HIV-affected and normal children. Fielden et al. (2006) said that children with HIV/AIDS were low self-esteem, self-confidence and other psychosocial problems compared to normal children. According to Carr (2004) children with HIV/AIDS were low self-esteem and psychological problem than counterparts of non-HIV/AIDS. Bomba et al. (2010) reported that children with HIV/ADS on Antiretroviral Therapy subjects significantly lower physical and psychosocial health functioning, particularly at school, low self-esteem, compared with non-HIV/AIDS children.

There may be so many causes for children with HIV/AIDS to have lower general, social, home, school and overall self-esteem than non-HIV/AIDS children. Kartell and Chabilall (2005) assessed the abandoning school, poverty, lack of parental, educational and social support and social discrimination as inhibiting factors on these children. Carr (2004) reported that children with HIV/AIDS were low self-esteem, however, has been associated with poor psychological adjustment, mental health problems such as anxiety and depression, drug abuse and eating disorders and suicide. This study intense to underline that children with HIV/AIDS were identified with depression, hopelessness and a feeling of loss, as well as confusion, loneliness, fear and suicidal ideation, and psychosocial problems.
Hypothesis, H₃: Children with HIV/AIDS have significantly lower emotional competencies than non-HIV/AIDS children, was accepted. Children with HIV/AIDS have significantly lower in Adequate Depth of Feeling (ADF), Adequate Expression and Control of Emotions (AEC), Ability to Function with Emotions (AFE), Ability to Cope with Problem Emotions (ACPE), Encouragement of Positive Emotions (EPE) and overall Emotional Competencies than non-HIV/AIDS children.

The previous studies also report similar results. Mendoza et al. (2007) studied that children with HIV/AIDS are at risk for anxiety, depression, behavioral problems and low emotional competence than non-HIV/AIDS children. Brown et al. (2001); Pao et al. (2000) studies that developed countries showed behavioral or emotional abnormalities, including depression, anxiety, attention deficits, social problems, low emotional competence and general behavior problems to be among Children with HIV/AIDS. Leslie et al. (2010) pointed out that the children with HIV/AIDS were having higher emotional problems than non-HIV/AIDS children. Fielden et al. (2006) pointed out the children with HIV/AIDS were higher in emotional problems than non-HIV/AIDS children.

There may be many causes for children with HIV/AIDS to have lower emotional competencies than non-HIV/AIDS children. Gelder and Kraa (2006) pointed out that the HIV/AIDS on ART children experience approximately the same psychosocial problems as the control group, in spite of the large difference in traumatic experiences or environments. Leslie et al. (2010) reported that emotional competence cause in HIV infected with higher symptom severity for generalized anxiety, major depression, emotion and dysthymia. This study underscores the
importance of queries concerning pain and emotional stressors in case of HIV infected children and uninfected children exposed to HIV infected children’s individuals. Li et al. (2009) Children with HIV/AIDS were suffering with social isolation, emotional problems, anxiety, diarrhea, fever, bacterial pneumonia, recurrent upper respiratory tract infection and oral candidacies in HIV infected children.

**Hypothesis, H₄: Girls with HIV/AIDS have significantly higher adjustment problems than Boys, was accepted.** Girls with HIV/AIDS have significantly higher social adjustment problems, higher emotional adjustment problems, higher educational adjustment problems and higher overall adjustment problems than boys.

The earlier studies also support our hypothesis. Van and colleagues (2002) in their study showed that female children with HIV/AIDS were having higher adjustmental problems, depression, anxiety, hostility psychosocial problems than male children with HIV/AIDS. Shalu and Audichya (2006) said that girls with HIV/AIDS were having higher psychological adjustment problems than boys. Hampel and Petermann (2006) reported that the female children with HIV/AIDS were having higher psychological adjustment problems than male children. Marcotte et al. (2002) found that gender differences in HIV/AIDS-related psychosocial problems of girls and boys living with chronic illnesses were not distinct. Children with HIV/AIDS and chronic illnesses reported gender differences in psychosocial problems. FAWE (2000) conducted in Uganda and observed that girls with HIV/AIDS have higher adjustment problems compared to boys. Byrne (2000); Corbin (2002); Marcotte et al. (2002) studies reported that there are gender differences in psychosocial problems of children with HIV/AIDS.
There may be many psychological causes for girls with HIV/AIDS to have higher social, emotional, educational and overall adjustment problems than boys. Van et al. (2002) found that female children experienced more psychological problems with emotional responses related to their HIV/AIDS status, such as bad moods and poor role functioning, anxiety, depression. Marcotte et al. (2002) study reveals that girls with HIV/AIDS have higher adjustment problems than boys showing gender difference. The same study also reveals the girl’s social isolation, onset of puberty, methods of coping (Byrne, 2000), less attention in the classroom, feelings of inadequacy at education adjustment, guilt, isolation, learning problems, physical appearance and feelings of competency (Corbin et al. 2002). Some other studies suggest that there are gender differences in psychosocial problems of children with HIV/AIDS.

Girls with HIV/AIDS are more likely to experience adverse outcomes of adjustmental problems. However, it may be because of HIV/AIDS is a chronic illnesses which are at increased risk for experiencing socio-economic status, low income family, psychological functioning, religion, early marriage, male dominated society of India, gender biased violence, socio-cultural and traditional practices, a lack of health facilities, awareness and risk of sexual transmission diseases (STD), environmental factors, stigma, discrimination, social isolation, educational level, inadequate medical services, and a lack of psychological and social support. All these frequent physical and psychological sufferings along with the family members, and their HIV status will have adverse influence on the psychosocial well being of a child and will translate into increased higher social, emotional, educational and overall adjustmental problems in girls with HIV/AIDS as compared to those boys.
Hypothesis, $H_5$: Girls with HIV/AIDS have significantly lower self-esteem than Boys, was accepted. Girls with HIV/AIDS have significantly lower general self-esteem, lower social self-esteem, lower home self-esteem, lower school self-esteem and lower overall self-esteem than boys.

Marcotte et al. (2002) reported that girls with HIV/AIDS have a lower self-esteem than boys. FAWE (2000) reported that boys with HIV/AIDS have better self-confidence and self-esteem compared to girls. Baguma and Muhanguzi (2000) said that girls living with HIV/AIDS have low self-esteem and self-confidence compared to boys. Mann et al. (2004) pointed out that boys with HIV/AIDS have a better self-esteem compared girls. Beck et al. (2001); Muris et al. (2003) Studies indicate that girls with HIV/AIDS possess low self-esteem and are less successful in scholastic activities compared to boys. Donders & Verschueren (2004) reported that girls with HIV/AIDS were low in self-esteem than boys. Westbrook et al. (2002) said that the relationship between gender and self-esteem in children with chronic illness is still not clear. Van et al. (2002) found that, girls with HIV/AIDS were with low self-esteem compared boys.

There may be so many causes for girls with HIV/AIDS to have lower general, social, home, school and overall self-esteem than boys. FAWE (2000) Most of the reasons for female children with low self-esteem were due to family socio-cultural reasons including illness of parents due to HIV/AIDS or orphanhood due to HIV/AIDS or other causes. Other sociocultural reasons included the gender inequality accorded to girls. According to Uganda Bureau of Statistics (2006) Boys were generally provided with the opportunities to continue with their education uninterrupted, while girls were usually requested by their families to stay at home to
continue providing household services in the event of illnesses or demise of their parents. Wahl (2001); Yun (2001) pointed out that childhood due to HIV/AIDS has been one of the greatest effects of HIV/AIDS on girl’s school education in Africa leading to school absenteeism during their parents' illnesses, social status, economic impoverishment and gender role expectations, which accounts for the differences in the psychological self-esteem of between girls and boys with HIV/AIDS.

Van et al. (2002) found that, compared to male, female children had more HIV/AIDS-related symptoms that were associated with poorer physical well-being and greater limits to physical functioning. Therefore, it is possible to infer that with their higher vulnerability to pain and fatigue, HIV infected female children are more likely to suffer HIV-related symptoms than male children. Consequently, female children were having economical problems and emotional stress manifested in inappropriate behavior, stigma and discrimination, social isolation, poorer physical, psychological well-being is associated with their lower self-esteem.
Hypothesis, $H_6$: Girls with HIV/AIDS have significantly lower emotional competencies than boys, was accepted. Girls with HIV/AIDS have significantly lower in Adequate Depth of Feeling (ADF), Adequate Expression and Control of Emotions (AEC), Ability to Function with Emotions (AFE), Ability to Cope with Problem Emotions (ACPE), Encouragement of Positive Emotions (EPE) and overall Emotional Competencies than boys.

The earlier studies also report similar results. Bennett, Cordes, Westmoreland, Castro, and Donnelly (2000) found that female children with HIV/AIDS were with low emotional competence than male children with HIV/AIDS. Breitbart and colleagues (1998) said that female children with HIV/AIDS have suffered higher fatigue and emotion related symptoms than male children with HIV/AIDS. Sheffer and colleagues (2002) found that female children with HIV/AIDS have more emotion, depression and pain disorders than male children. Van et al. (2002) reported that female children with HIV/AIDS disease are more vulnerable to depression, social and emotional problems than male children with HIV/AIDS.

There may be several causes for girls with HIV/AIDS to have lower emotional competencies than boys. Bennett et al. (2000) found that female and male children differ in terms of their emotional competence. For female, emotional expression by crying appeared to be the way to release their tension when confronted with stressful life events; however, this reaction was rarely used by male children. Van et al. (2002) found that female children with HIV/AIDS have greater number of psychological and HIV-related symptoms, Lower emotional competencies, poorer physical functioning, and greater disruptions in physical wellbeing than male children.
Hypothesis, $H_7$: Rural Children with HIV/AIDS have significantly higher adjustment problems than Urban Children with HIV/AIDS, was accepted. Rural children with HIV/AIDS have significantly higher social adjustment problems, higher emotional adjustment problems, higher educational adjustment problems and higher overall adjustment problems than urban children with HIV/AIDS.

The earlier studies also report similar results. Heckman (2003) said that rural children with HIV/AIDS were having more psychological adjustment problems than urban counterparts. Kimani et al. (2012) studied that rural children with HIV/AIDS were having higher adjustmental problems than urban children with HIV/AIDS. UNAIDS (2006) report shows that urban children with HIV/AIDS aware of improved knowledge of good health services, psychological adjustment, social support compared to rural children with HIV/AIDS. Reif et al. (2005) reported that rural children with HIV/AIDS were having more psychological adjustment problems than urban children. Ullrich, Lutgendorf & Stapleton (2002) said that rural children with HIV/AIDS were having negative attitude and higher psychosocial adjustment problems than urban children.

There may be so many causes for rural children with HIV/AIDS to have higher social, emotional, educational and overall adjustment problems than urban children with HIV/AIDS. Heckman (2003) said that rural children living with HIV/AIDS disease, compared to their urban counterparts, assigned higher problem severity ratings to the following psychological and social barriers: adjustment problems, emotional and behaviour problems, the need to travel long distances to receive medical facilities. In addition to this there is a shortage of adequately trained medical and mental health professionals; lack of personal or public transportation; and
community residents stigma discriminations toward children living with HIV. Added to this the HIV infected children who live in rural areas would suffer with poverty, malnutrition, lack of care and support, social services, lack of awareness and health services, and limited availability of mass transportation which prevent rural children living with HIV from accessing health care services than their urban counterparts. Kimani et al. (2012); Reif et al. (2005) studied that to understand critical barriers to seeking HIV-related care for children in rural South Africa.

Rural children with HIV/AIDS are more likely to experience adverse outcomes of adjustmental problems. However, it may be because of chronic illnesses which are at increased risk for experiencing socio-economic status, low income family, poverty, migration, psychological functioning, health care, social support and systems barriers, all influences the children with HIV/AIDS. Our concern is the expressed need to maintain secrecy regarding a child's HIV status to avoid stigma and discrimination, and misconceptions regarding the course of HIV disease in children; this led to a delay in seeking appropriate care. These barriers need to be addressed, including through focused awareness campaigns, improved access to health care and interventions to address rural poverty and development at both household and community levels. In addition, training of health care professionals to improve their attitudes and practice are necessary.
Hypothesis, $H_0$: Rural Children with HIV/AIDS have significantly lower self-esteem than Urban Children with HIV/AIDS, was accepted. Rural children with HIV/AIDS have significantly lower general self-esteem, social self-esteem, school self-esteem and overall self-esteem than urban children with HIV/AIDS.


There may be so many causes for rural children with HIV/AIDS to have significantly lower general, social, school and overall self-esteem than urban children. Sowell et al. (1997) reported that many rural areas children with HIV/AIDS have weak economies, characterized by high unemployment lower income and poverty rates, lower self-confidence and self-esteem, which render children with fewer personal resources and health treatment opportunities needed to successfully manage their HIV/AIDS disease. These disadvantages often hinder efforts to obtain
appropriate health care and support, awareness services in rural areas, thus resulting in a more rapid progression of their HIV/AIDS disease and psychosocial problems. Heckman (2003) found that HIV infected rural children report greater barriers to obtaining health-care services, poverty, economical problems, caregiver more maladaptive coping strategies, orphan hood life, higher levels of loneliness, lower level of self-esteem and quality of life.

**Hypothesis, H₉: Rural Children with HIV/AIDS have significantly lower Emotional Competencies than Urban Children with HIV/AIDS, was accepted.**

Rural children with HIV/AIDS have lower Adequate Depth of Feeling (ADF), Adequate Expression and Control of Emotions (AEC), Ability to Function with Emotions (AFE), Ability to Cope with Problem Emotions (ACPE), Encouragement of Positive Emotions (EPE) and overall Emotional Competencies than urban children with HIV/AIDS.

The Previous studies also report similar results. Heckman et al. (1998) found that rural children with HIV/AIDS have lower emotional competence than urban children. Sahn and Stifel, (2003) says that urban children with HIV/AIDS have better overall emotional competencies than their rural counterparts.

There may be many causes for rural children with HIV/AIDS to have significantly lower emotional competencies than urban children. Sahn and Stifel, (2003) says that access to health services, knowledge, economic statues and awareness, poverty and child mortality present a clear picture that suggests urban populations are better than their rural counterparts. Heckman et al. (1998) reported that rural children with HIV/AIDS were lower emotional competence, because
emotional and behavioral problems, educational difficulties, poverty, inadequate medical staffs, economical problems and a lack of psychological and social support.

One of the most common causes for psychological problems related to HIV/AIDS is the impact of social stigma on the infected individual. This stigma can lead to feelings of depression, guilt and shame, limited participation within communities, and an increase in behavior that may heighten the risk of further transmission. Phiri (2000) reported that common reactions of children to the death of a parent include: depression, hopelessness, suicidal ideation, loneliness, anger, confusion, helplessness, anxiety and fear of being alone. These feelings are constant, and even terminology (which is more a taggiry) used to describe the effect of HIV/AIDS on children creates feelings of pain, resentfulness and psychosocial problems.

Claudia (2002) study reveals the psychosocial problems of children with HIV/AIDS are suffer from stress, grief, teasing by other children, social isolation and discrimination which can lead to behavioral disturbances, fatalism, self stigmatization, and increased opportunities for abuse. Children may also suffer from economic constraints as the household provider becomes sick, can’t work, and loses their job. Then the responsibility of earning money and providing food to the family is rested and the young shoulder of the child. They often go hungry, become malnourished, and become unable to concentrate. Other economic impacts include no money for school fees, uniforms, study materials, and other necessities. Hunger is a common cause of poor school performance and dropout. Haihambo (2004) studied that author have observed symptoms associated with trauma, depression and lack of bonding and attachment in very young children. This may lead to children feeling deprived of
their childhood, causing misery and sometimes thoughts of suicide. Access to experiences which address psychosocial needs such as consistency of care appeared to be unmet for many children.

AIDS Brief (2004) pointed out that many children are usually incorporated into the extended families that act as a safety net. However the shrinking number of caregivers and the considerable strain on families means that children are much more vulnerable to economic and social hardships such as malnutrition, poverty, child labour, homelessness and reduced access to education and healthcare.

Most of this study shows that, children with HIV/AIDS are more likely to experience adverse psychosocial problems outcomes. However, it may be because of the chronic illnesses are at increased risk for experiencing socio-economic status, low income family, suffering of orphanhood, psychological functioning, socio-cultural factors, religion, early marriage, socio-cultural and traditional practices, gender based violence, a lack of health facilities, awareness and risk of sexual transmission diseases (STD), migration, environmental factors, stigma, discrimination, social isolation, illness and complicated regimens, poverty, educational level, inadequate medical services, the lack of knowledge and awareness of sexual transmission diseases (STD), emotional, social behavioral, self-esteem and educational difficulties, inadequate medical staffs, and the lack of psychological and social support. All these frequent physical and psychological sufferings along with the family members, and their HIV status will have adverse influence on the psychosocial well being of a child and which would translate into increased higher adjustmental problems, lower self-esteem and lower emotional competencies in children living with HIV/AIDS as compared to those Non-HIV/AIDS children.
CONCLUSIONS

1. Children with HIV/AIDS have more adjustment problems than non-HIV/AIDS.
2. Children with HIV/AIDS have lower self-esteem than non-HIV/AIDS.
3. Children with HIV/AIDS have lower Emotional Competencies than Non-HIV/AIDS.
4. Girls with HIV/AIDS have more Adjustment problems, lower self-esteem and lower Emotional Competencies than Boys.
5. Rural Children with HIV/AIDS have more Adjustment problems, lower self-esteem and lower Emotional Competencies than Urban Children.
IMPLICATIONS AND SUGGESTIONS

One of the most noteworthy contributions of this study was the stimulation of questions and ideas for future research. The significant results of this study lead to a number of other avenues for further study such as the use of counseling and exercise as treatment interventions for children living with HIV/AIDS.

1. One of the limitations of this study was the lack of geographic representation. This study should be replicated with other opportunistic diseases of the people with HIV/AIDS across the different parts of the nation, with attention paid to different states.

2. The present study suggests the need for intervention targeting towards girls and rural children living with HIV/AIDS to restore their optimum level of functioning and preventing them from maladjustment, low self-esteem and low emotional competencies.

3. The present study seeks attention of Government and Non-Government Organizations (NGO’s), Educational Institutions, Social Scientists like Psychologists, Educationists, sociologists, etc. and they should focus their attention to the children with HIV/AIDS, they may either by providing special training to the teachers or through guidance and counselling services.