EFFECTS OF CHALLENGES FACED BY HIV/AIDS ORPHANS ON THEIR PSYCHO -SOCIAL AND ECONOMIC STATUS IN KAPSARET AND KESSES DIVISIONS OF WARENG DISTRICT.

BY

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DECLARATION

Declaration by the Candidate

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DEDICATION

This thesis is dedicated to those Kenyans who have endured and turned around their lives in spite of the loss of parents and affliction with HIV/AIDS. We remember all young AIDS Ambassadors, especially Nkosi Johnson of South Africa, who lived with the virus for 12 years and worked tirelessly and selflessly to improve the lives of millions of children and adults living with HIV/AIDS.

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ABSTRACT

Background. Orphans occasioned by death of one or both parents through HIV/AIDS are exposed to numerous challenges in life that may affect their psychological status. However, relationships between these challenges and their psychosocial status remain rather unknown for many of these children.

Objectives. This study assessed the effects of various challenges on the psychosocial status of the HIV/AIDS orphans in Wareng District, Eldoret**.** The specific objectives of the study were: to establish the nature and extent of psychosocial problems facing HIV/AIDS orphans; to determine the economic problems among HIV/AIDS orphans and how these affect their psychosocial status; establish the social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status; and finally to determine the social support programs for the HIV/AIDS orphans and how these affect their psychosocial status in Wareng District of Uasin Gishu County.

Study design. This study was conducted through cross-sectional research design. Sample size: Samples were collected from Kapseret and Kesses Division that represent Wareng District. The instruments of data collection were structured questionnaires, interview schedules and document analysis. Collected data were analysed by descriptive statistics, frequency distributions, cross-tabulation, Chi-square (χ^2) tests and bivariate correlation analysis.

Findings. Personal problems experienced by the orphans included depression, trauma, stress, seclusion and grief. Economic problems experienced by the HIV/AIDS orphans ranged from poor living conditions, lack of basic needs such as food, shelter, clothing and education. Social problems among the orphans were found to be high and were mainly associated with changed social behaviour of the children through seclusion causing other vices such as drug and substance abuse. Low levels of social support programmes were available to few orphans.

Recommendation. Consequently, it is recommended that all stakeholders in the society must join hands to provide psychosocial, economic and social support to the orphans through government and private sector led initiatives of compensation for the families that take good care of the orphans including their basic needs and psychosocial needs, proper guidance and counselling, and provision of more social welfare support.

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LIST OF ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMPATH	Academic Model for the Prevention and Treatment of HIV
ART	Antiretroviral Treatment
CGAP	Consultative Group to Assist the Poorest
CNS	Central Nervous Systems
COPE	Community-based Orphan Child Protection and Empowerment Project
GDP	Gross Domestic Product
HH	Household
HIV	Human Immunodeficiency Virus
ILO	International Labor Organization
INAGE	Intervention for AIDS, Gender and Equity
NGO	Nongovernmental Organization
OVC	Orphaned and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	Persons Living with HIV/AIDS
STD	Sexually Transmitted Disease
UNAIDS	United Nations Joint programmes on AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Educational Funds
USAID	United States Agency for International Development
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Affected persons Personal caregivers and family members.

Double Orphan A child who has lost both parents.

Guardian Includes relatives and those not related to the orphan.

HIV/AIDS orphan A child who has lost one or both parents to HIV/AIDS before reaching the age of 18 year.

Infected persons Children living with HIV/AIDS.

Maternal orphan A child whose mother has died.

Paternal orphan A child whose father has died.

Psychological affects Thoughts, feelings, emotions that affect the mental state and well-being of the infected and affected persons.

Relatives Includes aunts, uncles, in-laws and cousins but do not include the siblings such as brother or sisters.

Risky behaviour Behaviours which put the youth in danger without pondering the dangers before indulging in them, such as unprotected sex.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Since it was diagnosed in the 1981, the magnitude of the HIV/AIDS pandemic is clearly immense making HIV/AIDS the most devastating pandemic in modern human history (UNAIDS and WHO, 2005). To date the most comprehensive data on the pandemic has been jointly compiled by the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS, 2010). Although in many countries, systematic HIV/AIDS surveillance remains mostly inadequate, making it hard to obtain reliable data, more than 20 million people have lost their lives to the virus as of December 2010.

Further, UNAIDS estimates that around 42 million people are living with HIV or have AIDS (UNAIDS, 2010) of whom, 38 million are adults (aged 15-49), and 2.2 million are children (under the age of 15). A joint study conducted by the U.S. Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), and the Joint United Nations Program on HIV/AIDS (UNAIDS) found that at the end of 2009, 22 million children under the age of 15 had lost one or both parents to AIDS and were therefore orphans (UNAIDS, UNICEF, and USAID, 2010).

There is great diversity throughout Africa in the levels and trends of HIV infection among children. The world's hardest-hit region, Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 70% of all children living with HIV and more than 85% of all children under 15 living with the disease. That means that eight out of 10 children who have been orphaned by AIDS live in Sub-Saharan Africa. Between 1990 and 2009, Sub-Saharan Africa's population of children

orphaned by AIDS increased from less than 1 million to more than 12 million (UNAIDS, UNICEF, and USAID, 2010). In Kenya, the growing population of children orphaned by HIV/AIDS is a concern, because had it not been for HIV/AIDS, the percentage of orphans would be declining. Data available for Kenya by the year 2003, indicate that there are up to 1.2 million orphaned children without any parent due to HIV/AIDS death (K'Oyugi and Muita, 2002; UNAIDS, 2002, 2004).

The impact of HIV/AIDS on children is just beginning to be explored. Not only are children orphaned by HIV/AIDS affected by the virus, but those who live in homes that have taken in orphans, children with little education and resources, and those living in areas with high HIV rates are also impacted (K'Oyugi and Muita, 2002). So great is the scale now reached by this pandemic on the orphans in Kenya that scholars and policy-makers are beginning to recognize that the longer term impact of HIV/AIDS on the orphans will not be confined to the individual human tragedies suffered by those persons living with the virus but HIV/AIDS will also have a plethora of wider economic and social, ramifications on these children.

However, the economic and social challenges that these children orphaned with HIV/AIDS face may vary from individual to individual depending on a number of intrinsic and extrinsic factors. In intrinsic factors, the orphans assume the ability to predict environmental events and be able to respond to them appropriately. They feel they have no ability to control events and the resultant behaviour and are therefore in control of their own fate. It is this perception of ability to do something that gives rise to concept of perceived control (Melvin and Sherr, 1993). On the contrary, extrinsic factors assume that a person's life is controlled from the external factors e.g. luck, fate and nature (UNICEF, 2004). Such people see themselves as not responsible for what

happens to them and merely accept what happens. They are helpless and at the mercy of the environment. In addition each factor may further be as unique as the children involved. For example, impoverished children living in households with one or more ill parent are also affected, as health care increasingly absorbs household funds, which frequently leads to the depletion of savings and other resources reserved for education, food, and other purposes. However, there is currently very little available study that has documented the economic and social factors that affect the children orphaned by HIV/AIDS in Kenya.

The overlapping of social, individual, family, financial and cultural factors affect the psychosocial status of the children orphaned by HIV/AIDS. Children who have been orphaned by AIDS are forced to leave school, engage in labor or prostitution, suffer from depression and anger or engage in high-risk behavior that makes them vulnerable to psychological problems. It was generally recognized in Kenya that acute and chronic medical conditions in the paediatric population have the potential to bring about a range of psychosocial challenges (Okumu *et al*., 2007). Yet, in Kenya, HIV/AIDS may present perhaps the most complex psychosocial issues of any medical condition among children because children wholly rely on the parent for their social, economic, psychological upbringing without any government inputs (Armstrong *et al*., 2006).

Kenyan Initial interventions in paediatric HIV/AIDS focused on the medical urgency and terminal nature of the disease. Yet, orphaned children are now facing academic, social and emotional issues related to living without parents, which can potentially exacerbate psychosocial problems. The psychological effects of HIV/AIDS reported among these orphans include: fear, loss, grief, guilt, denial, anger, anxiety, low self-

esteem, depression, suicidal behaviour and thinking, and socio-economic issues, the magnitude has never been reported in Kenya. They become withdrawn, aggressive, and rude. The orphans feel (or imagine) being victimized. Infected, and in some cases, affected, children can experience a decrease in self-esteem as they are no longer confident in themselves or what they can achieve.

According to Watstein and Chandler (1998) there are emotional responses that are symptoms of the psychosocial effects that children have when infected or affected with HIV/AIDS. As a result of these problems, the changes in both working and personal relationships, the behaviour of those affected may change. Unfortunately there is very little data in Kenya that has looked at the psychosocial challenges faced by the orphaned children in the face of economic, social and social support among the paediatric HIV/AIDS population in Kenya. This persist even in areas with large numbers of HIV/AIDS orphans. On the basis of the foregoing this study was formulated to determine the influence of economic, social problems and social support programmes on the levels of psychosocial problems in Wareng District.

1.2 Statement of the problem

The support of orphaned children can be managed for the first few days, weeks or even months after death, but this declines with times as the fostering households face day to day realities of life with increased cost of care and daily basic needs. HIV/AIDS orphans have traditionally been relocated within the extended family network, although this number is becoming overwhelmed by the larger number of children needing care. Orphans in developing countries are likely to face many problems which include access to education, inability to get school fees, equipment and clothing, susceptibility to health risk and vulnerability to HIV infection,

psychosocial problems that affect children's development, loss of property due to unclear and cumbersome inheritance procedures, reduction in economic capabilities and risk of violence, exploitation and abuse.

Some of the possible sources of psychosocial problems include: witnessing the slow miserable death of one or both parents, a move to unfamiliar home and pattern of life; with little or even no choice in that matter, often the subsequent loss of sibling, their home and property, friends, school, in fact everything that until then had made up their world. School teachers unsympathetic to their difficulties and often too ready to punish them for being late or ill equipped. Sometimes they may also witness their own sibling ill health deteriorate and the fear for having to fend for themselves in the future. Orphans, who go through such, are prone to psychological problems such as depression, withdrawal and low esteem which have long-term effect on child development and active participation in society. Aggressive behavior may result in response to the teasing and taunting experience from peers. Adopting families often have problems of their own, such as their own large families to care for, and therefore, severe economic strains. Hunter (1990) observed that sometimes the adopting parents are too young or too old to properly care for additional children.

1.3 Justification of the study

The psychological impact of HIV/AIDS on children is often overlooked. Not only do many children who live in heavily affected areas contend with the death of one or both parents, but they also frequently face the death of younger siblings, aunts, uncles and other relatives. While there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members. As

yet, the need to address the long-term psychosocial needs of HIV/AIDS orphans has not been given due attention and therefore there is still little empirical literature regarding the challenges of children orphaned by HIV/AIDS and how it affects their psychosocial status. Therefore, findings from this study will help the stakeholders involved in management of HIV/AIDS orphans to provide practical solutions that will reduce the psychosocial impacts of HIV/AIDS on the children orphaned by HIV/AIDS. Such information will be useful in the long-term to help manage the HIV/AIDS scourge.

1.4 Research questions

1. What are the nature and extent of psychosocial problems facing HIV/AIDS orphans?
2. What are the economic problems faced by the HIV/AIDS?
3. What are the social problems faced by the HIV/AIDS?
4. What are the social support programs for the HIV/AIDS?

1.5 Objectives of the study

1.5.1 Main objective

The main objective of this study was to determine the effects of the psychosocial problems on the HIV/AIDS orphans in Wareng District

1.5.2 Specific objectives

1. To establish the nature and extent of psychosocial problems facing HIV/AIDS orphans
2. To determine the economic problems among HIV/AIDS orphans and how these affect their psychosocial status

3. To establish the social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status
4. To determine the social support programs for the HIV/AIDS orphans and how this affect their psychosocial status

1.6 Scope of the study

The scope of this study was limited geographically to two Divisions namely: Kapsaret and Kesses of Wareng District within Uasin Gishu County, Rift Valley Province of Kenya. The content of the study was limited to determining the challenges faced by HIV/AIDS orphans and their effects on their psychosocial status in the District**.** Based on the availability of resources, this study took three months that were adequate for data collection.

1.7 Limitations of the study

There were a number of challenges during the study especially during sampling. First, since this study used human who have undergone traumatic experience, sampling these groups of people was not easy as finding them proved difficult. The researcher strived to overcome this challenge through the use of snowballing sampling technique.

Secondly, the sampling frame in this study was difficult as some of the rescue homes and relatives in areas where the orphans were staying failed to provide some of the information concerning the children orphaned by HIV/AIDS for fear of the researcher being a government agency. These limitations were partially solved through a permit from the Ministry health and internal security to reduce the bureaucracy in obtaining information from the varied sources.

Thirdly, the use of questionnaire as the only research technique has some limitations. For instance, the answers have to be accepted as final and there's no opportunity to probe beyond the given answer or to clarify ambiguous answers. However, there was also possibility of incorrect responses from some of the respondents especially on the sensitive issues of HIV/AIDS. The researcher carefully analyzed the responses from the field and excluded those that appeared to be inaccurately answered by the respondents. Finally, accessibility was also another major drawback during the study. Poor road network, coupled with unfavourable weather conditions were the major hindrance in reaching some areas where the data were to be collected.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter deals with systematic identification, location, analysis and evaluation of documents containing information that are related to psychosocial status of the HIV/AIDS orphaned children. The chapter is divided into five sections; Psychosocial status of the HIV/AIDS orphaned children; Economic problems facing children orphaned by HIV/AIDS**;** Social problems faced by the HIV/AIDS orphans; Social support programs for the HIV/AIDS orphans and how this affect their psychosocial status and Theoretical framework**.**

2.1 Psychosocial status of the HIV/AIDS orphaned children

Globally HIV/AIDS has resulted into the death of one or both parents. In this regard, it has been estimated that as many as up to 1.2 million children were without any parent by 2002 due to HIV/AIDS death in Kenya and this number might have increased over the last few years (K'Oyugi and Muita, 2002). Children in Sub-Saharan Africa affected by HIV/AIDS are more likely to become psychologically affected and be distressed (Poulter, 1997; Bose *et al*., 2003). Therefore, HIV/AIDS related problems among children have been recognized as a key problem that needs to be addressed in HIV/AIDS intervention (Deacon *et al*., 2005). The literature on children and HIV/AIDS is extensive, as is the literature on HIV/AIDS related stigma, but specific research on HIV/AIDS-related psychosocial problems among orphans are relatively sparse. Contrast this to the estimated 30,000 HIV/AIDS orphans in the United States by the year 2008 (Michaels and Levine, 2008), and the magnitude of problems faced by the orphaned and vulnerable children in Kenya becomes clearer.

Researchers 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. Children of the HIV/AIDS deceased parents may be at risk due to the social isolation associated with HIV resulting in both physical mental, spiritual, economic and psychological effects due to the prevailing conditions (Frank *et al*., 1997; Freedman and Poku, 2005; Hanna and Mintz, 2010).

A number of important researches have outlined the likely scenario for these children in case they are orphaned by the death of the parents. Previously, clinical observation seems to suggest that this population is at risk due to adjustment problems in a number of areas including family issues, isolation, neuropsychological and behavioural concerns (Melvin and Sher, 1993; Mellins and Ehrhardt, 1994; Nagler *et al*., 1995; Lipson, 2008; Armstrong *et al*., 2012).

It is important to realize that many children have to cope with not only HIV-related issues, but also additional stressors related to living without parents, poverty, violence, and drug abuse (Mellins and Ehrhardt, 1994). There is, therefore, a number of empirical researches in the status of the psychological status of children affected by HIV/AIDS. One such research outside the Sub-Saharan Africa, indicated that 30% of women who contracted HIV between 1990 and 1996 did so through injection drug use and the majority of HIV positive children contracted HIV through vertical transmission, suggesting that a significant subset of these children are affected by the parental drug use and all of the psychosocial ramifications involved in such a situation (Leserman, 2011).

However, in Sub-Saharan Africa, most of the women contracted HIV/AIDS through sexual intercourse with infected "partners" (Ojwang', 2010). These partners are the bone of contention because the parents of these children are seen by the society as having embraced promiscuity, prostitution and other sexual exploits outside their marital homes that got them or their partners infected with HIV/AIDS (Graham-Pole *et al.*, 2009). The society views on these situations are factors likely to cause psychological traumas to the children orphaned by HIV/AIDS.

Other concerns reported by the surviving guardians of the children coping with HIV/AIDS involve interacting with the medical and external environments and addressing medical concerns (Mellins and Ehrhardt, 1994). Families taking care of the orphaned children must negotiate financial and insurance difficulties and learn to communicate effectively and promise to fully take care of the financial, physical and psychological needs of these children (Draimin, 2005). Additionally, they are coping with hospitalizations, clinic visits and important medical decisions. Caregivers are often required to manage their children's medical condition as well as their own, and possibly, that of other family members (Melvin and Sherr. 1993). In resource poor regions of Sub-Saharan Africa, the outcome of such promise, always results in the family taking care of the child while being harsh to the child and further affect the child psychologically (Kristjanson, 2001).

Children orphaned with HIV/AIDS are also faced with concerns of separation and grief from other siblings because of the economic considerations. Children who lose a parent must cope not only with grief over their loss, but possibly with significant disruptions to their home and family life, such as placement in foster care or the home of another relative (Mellins and Ehrhardt, 1994; Draimin, 2005). Social support and

increased age has been associated with improved grief outcomes (Kristjanson, 2001), and pediatric HIV/AIDS patients may be lacking on both counts. In the event of a parent's death, many grandmothers are being called upon to raise their grandchildren. These grandmothers experience grief regarding the loss of their own children, as well as the stress of assuming parenting responsibilities at a late age and may lack the ability to offer the psychological care that are needed by the children (Pollock, 1997).

Anger and neglect are other concerns. The psychosocial impacts of stress, grief, avoidance and teasing by other children, social isolation and discrimination can lead to behavioral disturbances, fatalism, self-stigmatization, and increased opportunities for abuse (Claudia Tjikuua, 2002). Children tend to worry all the time and are also afraid that one day they will find their parents dead when they come home from school. They also worry about who is going to take care of them. This fear results in children often opting to not attend school, or being hyperactive and inattentive while in school. Children may also suffer from economic constraints as the household provider becomes sick, can't work and loses their job. The responsibility of earning money and providing food is left to the children. They often go hungry, become malnourished and become unable to concentrate. Other economic impacts include no money for school fees, uniforms, materials, clothing and other necessities. Hunger is a common cause of poor school performance and dropout (Gillespie, 1989; Deacon *et al*., 2005; Edstrom and Samuels, 2007).

In an event that either or both of the parents dies of HIV/AIDS, they may leave behind not only grieving children, but could subject children to witnessing their siblings die (Graham-Pole *et al*., 2009). The topic of children's reactions to sibling death is one that does not receive widespread attention, but there is evidence that the

sibling relationship is one of the most important social relationships likely to cause psychosocial problems (Pollock, 1997). There is also lack of empirical research in Kenya on the issues of the psychological effects of the siblings' death on the children.

Another unique aspect of HIV/AIDS is the secrecy, stigma, and isolation that accompany it making children to learn at much later stages of their lives what caused the death of their parents (Tasker, 1995). Such events have always exposed children to emotional breakdown when they realize that most people are aware of the cases of their parents' deaths but chose to remain secretive about it. Despite improvements in understanding of HIV/AIDS, the children may continue to face possible fear, rejection, and prejudice if and when the diagnosis of the parents are revealed to the public (Hanna and Mintz, 2010). It is not only friends and community members who are not told of an individual's illness. Adults who are infected may not tell immediate family members, spouses, partners or children (Tasker, 1995).

Most often, children are not told of their own HIV infection or that of parents and siblings. Parents have indicated that they are uncomfortable discussing HIV status with children for a variety of reasons. One of these is the fear that children will be unable to keep the diagnosis a secret from peers and other community or family members resulting in social rejection of the child and the family (Mellins and Ehrhardt, 1994; Tasker, 1995). Parents also report a desire to protect the child from the knowledge that the parent and/or child have the illness. This is especially true if one or more close family members or friends have already died from AIDS. Additionally, parents report that they are uncomfortable and uncertain how to address questions regarding how the virus was transmitted to parent and/or child (Mellins and

Ehrhardt, 1994). Parents may feel guilty or ashamed about the method by which they contracted HIV.

A large body of literature in paediatric psychology addresses the question of disclosing disease status to paediatrics. A great deal of this literature has been conducted in the area of paediatric oncology. In general, it has been well established that children have better emotional adjustment if they are told of the diagnosis of their parents and allowed to discuss their condition openly with their family and medical caregiver (Graham-Pole *et al*., 2009; Slavin *et al*., 2008). Unfortunately, there is little research regarding disclosure of diagnosis specific to paediatric HIV/AIDS. Specifically, research has not been conducted to assess whether concerns about social ostracism and related psychosocial effects outweigh the need to discuss the child's (or other family member's) HIV/AIDS diagnosis (Boivin *et al*., 2005; Bose *et al*., 2007).

Some preliminary evidence show that children with HIV/AIDS who were not told of their diagnosis exhibited increased levels of social isolation as compared to children who knew of their parents' diagnosis (Lipson, 2008). At present, professionals should attempt to provide families with information regarding the benefits and consequences of disclosing HIV/AIDS status to a child (Graham-Pole *et al*., 2009). Open communication about psychosocial status is generally considered optimal, but this must be weighed against a family's concern about social rejection (Lipson, 2008). Additionally, families may request help formulating an explanation that is developmentally appropriate and answering difficult questions about disease process, prognosis and transmission. Situations involving cognitive or developmental delay may not be appropriate for disclosure if a child's ability to keep the diagnosis private or their ability to understand the situation is impaired (Bose *et al*., 2007).

Additionally, disclosure should be undertaken in an environment that is supportive with adults ready to provide appropriate information and reassurance.

Children with HIV/AIDS have been reported to exhibit a number of behavioural and psychosocial difficulties including hyperactivity, attention deficits, social withdrawal and depression. It is oftentimes difficult to ascertain whether symptoms of these disorders are behavioural, emotional or psychosocial in nature (Armstrong *et al*., 2012). Cognitive deficits, learning disabilities and developmental delay related to HIV orphan-hood can directly impact the children in many ways. It is unclear to what extent the psychosocial status of the paediatrics are related to circumstances such as impoverished economic environment, social status of the child, psychological problems and presence of social support programmes among the paediatric populations (Boivin *et al*., 2005; Loveland *et al*., 2006; Hanna and Mintz, 2010). Careful assessments must be used to tease apart the contribution of these problems to the psychosocial contributions among the paediatric populations.

Given that new medical advances are allowing both children and adults to live longer once infected with HIV, it has become increasingly important to study the psychosocial effects of HIV/AIDS. The complexity of psychosocial factors dictates that we look at both individual and family functioning related to HIV infection. Affected siblings have been largely ignored in this area. Similarly, uninfected spouses and caretakers have not received much empirical attention (e.g. Bennett, 1994).

2.2 Economic challenges facing children orphaned by HIV/AIDS

The pathways of poverty and HIV/AIDS are closely connected and create a vicious cycle of illness and impoverishment in low-income and high-risk communities. The HIV/AIDS pandemic poses great threats to the economic welfare of the HIV-affected

and infected children. Over the past two decades, responses to the HIV/AIDS epidemic have largely addressed prevention, behavior change and curative health interventions. However, economic challenges related to HIV/AIDS are coming to the fore, as millions of households deplete their household's limited resources in the struggle to afford treatment and care (Cohen and Lazarus, 1979).

When affected by HIV/AIDS, poor households face financial and social burdens associated with prolonged illness and medical expenses, loss of productive labor, death of family members, funeral expenses and care for extended families and orphans (Daniels *et al*., 1997; de Waal *et al*., 2005). Within households, the impact is shouldered differently by key demographic groups. For example, orphans and vulnerable children face a unique set of struggles such as lack of psychosocial support, access to education, health services and proper nutrition. Vulnerable children may be taken out of school, face stigma, be deprived of basic resources or be forced to join the workforce prematurely – factors that hinder their longer-term cognitive and physical development (Draimin, 2005).

The pandemic can adversely affect household stability, children access to food, shelter and clothing as well as healthcare and schooling (Richter *et al*., 2004). The economic challenges of children affected by HIV/AIDS occur in stages. The first stage often begins when children realize that their parent has AIDS and is likely to die. They begin to fear for their future, wonder who will care for them, and worry about how they will be able to stay in school. It can also increase the extent to which children are placed prematurely in the position of caregivers and heads leading to future economic problems (Stein *et al*., 1999).

The demise of one or both parents have always been found to economically deprive their children of their livelihood as they are still not in a position to tend to themselves financially. Yet, the reality of the HIV/AIDS devastation is that it causes immense deprivation of the children, their caretakers and caregivers (Barbarin, 1999). Some social scientists are concerned that the growing number of children affected by HIV/AIDS could lead to these children being labourers and therefore affect their overall wellbeing. Children whose parents/siblings fall ill might be expected to be caregivers for these sick relatives, at times causing them to miss or drop out of school (Kane, 2004). Children in resource-poor environments are exceedingly vulnerable to a variety of adverse conditions even before the AIDS-related death of a parent or guardian. Basic needs like schooling, food, shelter and health care are jeopardized, while children face an increased risk of abuse, exploitation and social isolation. Psychosocial needs are significant as children deal with the trauma of impending or actual parental loss as well as possible disclosure issues about their parent's or their own HIV status, adjustment to new living and family circumstances, and real or perceived increases in economic and family responsibilities (Friedman and Mulhern, 2002).

A study of adolescents in South Africa shows that household members who had experienced illness in the last three months were associated with a higher likelihood of their children dropping out of school to take up causal labour (Hunter and May, 2002). Without education and skills training, children orphaned and made vulnerable by HIV/AIDS are more likely to fall deeper into the cycle of poverty and engage in high-risk behaviour, which perpetuates the cycle of HIV transmission (Gillespie *et al*., 2007). Ultimately, the affected countries might find it harder to overcome national poverty and become effective members of the international economy. A study of

HIV/AIDS affected families in Kenya show children's reduced chances of completing school from the affected families (UNGASS, 2010).

In case of an ailing family member, children are often pulled out of school; either to care for the sick or due to the meagre family income spent on the sick. School fees, notebooks and pencils become unaffordable and children begin to struggle to provide care and replace lost adult labour and income (Graham-Pole *et al*., 2009). At this stage, the quality of child-rearing is compromised, and many important lessons on life skills and self-sufficiency are not taught, mostly because the parent(s) is too ill to transfer the knowledge (Hunter and May, 2008). After one parent dies, most children continue to live with the surviving parent or a relative, but they often slide more deeply into poverty. For some, the next stage begins when they find themselves the heads of households (Kashani *et al*., 1995). A young adolescent may be responsible for many siblings, some of whom may be infants. Children who are the heads of households are in a difficult position not only because they must now support their siblings with little to no education and/or employable skills, but also because they most likely have limited resources (Leserman, 2011).

In many cases much of the family's possessions may have been sold to care for the sick. Large numbers of orphaned children find themselves in homes that cannot afford to pay school expenses and drop out to work in the household, fields, or on the street. Young children with minimal education or employable skills can be found doing work such as shining shoes, begging for money in the streets, bartending, selling food and most often in the case of girls, becoming domestic workers (Masanjala, 2006). Many observers believe that the desperation of these young children makes them more vulnerable to abuse and exploitation, ultimately making them more susceptible to

contracting HIV (Melvin and Sherr, 1993; Mellins and Ehrhardt, 1994; Masanjala, 2006).

These young ones may serve as the primary caretakers of ailing parents, assume responsibility for younger siblings or assume additional duties in the household (UNICEF, 2006). If the primary wage earner falls ill, children may leave school to find work to help support the family (Michaels and Levine, 2008). Illnesses in the family may also divert funds that were previously available for school fees. Families of people living with HIV and AIDS often encounter stigma and discrimination that may deny children access to education and even health care (Lipson, 2008).

There is an increased risk of exploitation and abuse for children orphaned by HIV/AIDS. Weak or poorly enforced laws can result in orphans being cheated out of their inheritance (Draimin, 2005). Economic demands may force children, girls in particular, into commercial sex work or relationships with older men to obtain food, shelter or money. Without the protection of a parent or loving guardian, children may become victims of trafficking, exploitive labour conditions, or violence (Edstrom and Samuels, 2007). These risky conditions increase the orphaned child's vulnerability to HIV (Stillwaggon, 2006).

2.3 Social challenges faced by the HIV/AIDS orphans

According to UNAIDS, stigma and discrimination continue to accompany the HIV/AIDS epidemic. Children are not immune from stigmatization. In cases of stigma, children begin to be rejected early as their parents fall ill with AIDS. Some children may be teased because their parents have AIDS, while others may lose their friends because it is assumed that proximity can spread the virus. Harsh cases of discrimination have been reported in many countries, including India, Trinidad and

Tobago, particularly for HIV-infected children. A UNAIDS study found that HIV-related stigma is particularly high in India, where 36% of the respondents in a survey felt that HIV-positive people should kill themselves, and the same percentage felt they deserved their fate. Another 34% reported that they would not associate with an HIV-infected person (Draimin, 2005; Michaels and Levine, 2008).

A recent story illustrated how the desire to disassociate from HIV-positive people impacts children. Two HIV-positive children, who lost both of their parents to HIV/AIDS, were repeatedly barred from schools for two years in India. After the children and their grandfather protested in front of government buildings, one school finally accepted them. However, all 100 of their schoolmates were withdrawn by their parents fearing infection by association (Philip, 2003). Ultimately the government decided to pay for a private tutor so that the children could learn at home (Loveland *et al*., 2006). Children were similarly shunned in Trinidad and Tobago when they were refused entry into schools for six months. One school has finally agreed to accept them, but refuses to give their names in order to avoid protests as have happened in the past (Muzvidziwa, 2004)

Even children who are not HIV-positive may find themselves rejected and alone. This only adds to the feelings of anger, sadness and hopelessness that they may feel after witnessing their parents slowly and painfully die (Huihambo, 2004). One study in Kenya found that 77% of the children orphaned by AIDS said that they had no one outside of their families to "tell their troubles to" (Human Right Watch, 2001). The feeling of isolation can be heightened if the orphaned children are separated from their siblings, as often occurs when family members split up the child rearing duties. Another survey conducted in Kenya by the United Nations Development Programme

(UNDP) found that 48% of the households with orphans reported that some of their family members were relocated to other communities (Ayieko, 1998).

Lower performance in school has been noted among children orphaned by HIV/AIDS than those who are not. The preoccupation with the illness or death of their parents, the isolation due to the loss of friends and the undertaking of additional work that comes with caring for ill parents or supporting oneself after one's parents have died often make it difficult for orphaned children to concentrate in school (Huihambo, 2004). It is common for teachers to report that they find orphaned children daydreaming, coming to school infrequently, arriving at school unprepared and late, or being non-responsive in the classroom. Some teachers ignorant of the cause of the children's distress are not sympathetic. Orphaned children have reported that unsympathetic teachers yelled at them, made fun of them or put them out of the classroom. However, other orphaned children have reported that their teachers have been their primary support base at school (UNAIDS, 2001).

Orphaned children can also experience discrimination and exploitation within their new households. Reports have emerged of orphaned children receiving less food, denied school fees and forced to do more work. Exploitation remains an issue even in countries like Botswana, where the government offers support to orphans. It has been reported that some caretakers, while offering minimal care, are using children to benefit from the government orphan packages (UN Office for the Coordination of Humanitarian Affairs, 2003). Children, especially girls, have also reported instances of sexual abuse in their new households. However, many may silently accept it because they have nowhere else to turn for shelter or protection (Suffering in Silence Report, 2002).

2.4 Social support programs for the HIV/AIDS orphans and how this affect their psychosocial status

African societies were naturally socialists and helped each other in the times of needs (Okeyo, 2004). It is therefore naturally expected that when parents die leaving behind orphans, the society was expected to take care of these orphaned children. However, the magnitude of HIV/AIDS and its devastation considering that up to 1.2 million orphans have to be provided with social support is utterly overwhelming to the society and therefore the society cannot provide support to these vulnerable children (Huihambo, 2004). Additionally, families are experiencing multiple losses. HIV/AIDS is unique in its ability to strike multiple members of the immediate family as well as the larger community, thus severely compromising traditional social support systems. Better family adjustment following the death of a child was earlier shown in the oncology literature to be related to open communication and social support (Spinetta *et al*., 1981). Cultural issues may impact communication patterns, attitudes toward HIV infection, and willingness to access social and psychological support systems.

Access to experiences which address psychosocial needs such as consistency of care appeared to be unmet for many children (Haihambo, 2004). Many orphans 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 (AIDS brief, 2004).

The massive impacts of HIV/AIDS pandemic on children and their support systems in families and communities has prompted fears that millions of children will not receive proper care and assistance for their proper development (Amon, 2002). While these fears have prompted increased research interest in children affected by HIV/AIDS, a number of researchers now suggest that concerns about threats to state security posed by growing numbers of orphans have been overstated – the main challenges is addressing increased poverty in high-prevalence countries (Nattrass, 2002). Extended family support systems have mitigated or delayed the effects of widespread orphan-hood on society (Gilborn *et al*., 2001).

Social assistance programs are intended to provide a first line of relief for households. They typically consist of asset transfers whereby governments and donors provide a safety net for the most vulnerable. Cash transfer programs are increasingly seen as an effective mechanism to offer basic subsistence for the most destitute households (Foster G, 2002). Targeting and distribution, particularly in rural and remote areas, can be challenging and may require an approach that includes community buy-in and public payment points to ensure the most destitute households are reached (Hunter and May, 2008).

Most of the organizations have attempted specifically to address the need of children in the context of HIV/AIDS. Most concern about assessing and addressing the needs of HIV-affected children initially focused on identifying material needs that would no longer be met and conditions of increasing poverty, absence of parental protection and erosion of existing support and education system in the HIV/AIDS pandemic (Gilborn *et al*., 2001).

The majority of children orphaned or made vulnerable by HIV/AIDS are living with a surviving parent, or within their extended family (often a grandparent) (Soo *et al*., 2009). An estimated 5% of children affected by HIV/AIDS worldwide have no support and are living on the street or in residential institutions (Stillwaggon, 2006). Although most children live with a caretaker, they face a number of challenges, including finding money for school fees, food and clothing (Nattrass, 2000). Experts contend that effective responses must strengthen the capacity of families and communities to continue providing care, protect the children and to assist them in meeting their needs (Taha *et al*., 2012). There are thousands of localized efforts, many of them initiated by faith-based groups to address the needs of children made vulnerable by AIDS. Proponents argue that supporting these "grassroots" efforts can be a highly cost-effective response, although additional mechanisms are needed to channel such resources (Rosen and Simon, 2002; Okumu *et al*., 2007). They further assert that additional resources are needed to expand the limited programs and to support the children who are on the street or in institutional care.

While psychosocial support for orphans and vulnerable children is important, the same type of support is often overlooked for caretakers. Reports of grandmothers caring for a dozen children with little to no income are not uncommon (e.g. Soo *et al*., 2009). The grandmothers are often exhausted and overworked. In many rural areas, senior citizens have no social security or retirement benefits. As a result, children under their care are more likely to be uneducated and malnourished. In response, caretakers and a variety of organizations have begun to develop programs that offer support to the caretakers. Grandmothers are also developing support groups to discuss and find solutions to their problems. Some non-governmental organizations offer

financial support to the caretakers and are training them to talk to the children about their grief.

Although there are complex social, medical and cultural, individual and family factors surrounding paediatric HIV/AIDS, there is a paucity of research examining the psychosocial ramifications of this disease and the necessary support programme to be provided. With a large number of orphans, issues of adherence, substance use, sexuality, secrecy, peer relationships and planning for the future may become increasingly important (Ntozi *et al*., 1999; Nattrass, 2000; Nyamukapa *et al*., 2003). Improved social support in these areas will help us to better understand the psychological effects of HIV/AIDS and position us to more effectively intervene to prevent and address psychosocial problems.

There is little data in Kenya that has looked at the psychosocial challenges faced by HIV/AIDS orphaned children in the face of economic, social and social support. This study aims at addressing these challenges.

2.5 Theoretical framework

Adverse circumstances and locus of control

The concept of 'locus of control' refers to the relationship between the environment and the individual's assessment of his or her ability to deal with it and to adjust behavior accordingly. Locus of control has two dimensions: external and internal. The external locus of control assumes that a person's life is controlled by external factors, such as luck, fate and nature. Externally oriented individuals ('externals') do not see themselves as responsible for what happens to their lives but merely accept what happens. From this perspective, a person is helpless and is at the mercy of the environment. The internal locus of control assumes the ability to predict

environmental events and be able to respond appropriately. Internally oriented individuals (‘internals’) feel they have the ability to control events and the resultant behavior. Therefore, they are in control of their own fate. ‘It is this perception of the ability “to do something” that gives rise to the concept of perceived control’ (Lefcourt 1976).

Locus of control in relation to orphans

As noted above, most orphans are at risk of being confronted by powerful cumulative and often negative social changes in their lives over which they have no personal control. Experiences in continuously adverse circumstances do not make life appear to be subject to control through one’s own efforts (Lefcourt 1976). Perceived lack of control produces a feeling of helplessness and loss of hope, and diminishes an individual’s will power (Richter 1959; Overmier and Seligman 1967; Lefcourt 1976). Death of parents makes children vulnerable and predisposes them to physical and psychological risks over which they have no control. The feeling of helplessness is very costly in terms of psychological well-being and may be reflected in lack of concern, involvement and vitality in social and school activities. Emotionally, it is indicated by sadness and depression. The effects of death and bereavement are not always negative. Positive effects are possible as when a child moves from a poor family to an economically better-off one. Children who are fostered may be motivated to use all their power to prove their worth to their new families and to win their support. Children who are forced to live on their own may behave more responsibly and more maturely out of the sheer need to survive.

Locus of control, adjustment and depression

Locus of control is important for effective coping behavior in the case of stress. When faced with stress, internals tend to adopt a problem-solving strategy while the externals tend to react emotionally, by being angry (Sarason etal 1989). Consequently, internals are able to leave their disappointments behind them and live happily. Externals, on the other hand, continue to carry their burdens into their future and hence are often depressed. Our theoretical expectation is that depression is positively correlated with external locus of control and negatively correlated with internal locus of control. This means that those who scored high on the depression scale also scored high on the locus of control scale. Likewise, those who scored low on depression also scored low on the locus of control scale.

Psychological wellbeing (mental health)

According to Warr (1987), mental health has five major components: affective wellbeing (happiness), competence, internal locus of control, aspiration and integrated functioning or adjustment. These five components are interrelated. Therefore, internal locus of control should positively correlate with adjustment; children who feel in control of their environment would potentially have a better capacity to adjust. Similarly, adjustment should negatively correlate with depression: children who experience increased adjustment to their environment would concomitantly be less depressed.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.0 Overview

This section includes information on the research design, area of study, target population, sample size and sampling technique, data collection, pre-test phase, data analysis and ethical consideration

3.1 Study area

This study was conducted in two Divisions Kapsaret and Kesses of Wareng District within Uasin Gishu County located between 34°50′E to 37°30′ East and 0°03′ to 0°55′S. It is situated about 320 km from Nairobi. It lies at an altitude that ranges between 1850-2085 meters above sea level. The County covers an area of 146 km^2. Administratively the County is bordered by Trans-Nzoia to the North, Marakwet and Keiyo County to the East, Koibatek District County to the South East, Kericho County to the South and Nandi District to the West. The County is further subdivided into six divisions: Ainabkoi, Kesses, Moiben, Kapseret, Soy and Turbo. The study area (Wareng District) was purposively chosen because it has the largest number of HIV/AIDS orphans in the Uasin Gishu County. The two Divisions were chosen on the basis of the large number of HIV/AIDS orphans (>70% of the orphans in the county) based on Uasin Gishu District Development Report (2005). The number of households in the two Divisions is approximately 5,740 according to the 2009 census.

3.2 Study population

Kesses and Kapseret Divisions have a mix of rural, peri-urban and slum populations. By the time of the study, the number of orphaned children in the study area was

approximated to be 4,282, while those orphaned by HIV/AIDS were approximately 3,180.

According to the Wareng District (formally known as Eldoret South Constituency) AIDS committee records (Uasin Gishu District Strategic Plan 2005 -2010), Kapsaret and Kesses divisions have the highest number of children orphaned by HIV/AIDS with each having more than 1,000 HIV/AIDS orphans while the other divisions have less than 800 HIV/AIDS orphans.

3.3 Research design

This study adopted a cross-sectional research design in order to capture quantitative data on orphaned children from varied number of households.

3.4 Sample size

In determining the sample size, the Mugenda and Mugenda (2004) method was used. This method is used to determine how many respondent you need in cases where population is too large or not known at all. It uses the 95% confidence level and sampling error of 5% with the confidence interval of between 46% - 51%. The Mugenda and Mugenda (2004) formula was used as shown below.

$$SS = \frac{Z^2(p)*(1-p)}{c^2}$$

Where,

SS = Sample Size

Z = 1.96 (for 95% level of confidence)

p = 0.5 (probability of ensuring the largest sample size)

c = 0.05 (Confidence interval)

To get the actual sample size for the orphans, the following calculation was used.

$$\text{Samplesize} = \frac{1.96(0.5) * (0.5)}{0.05^2} = 384$$

Sample size was therefore 384

3.5 Sampling procedures

This is the description of the technique, which the researcher used to select representative respondents from the target population.

i) Purposive sampling technique to select the two Divisions because of the high number of HIV/AIDS orphans.

ii) Proportional sampling technique was then used to select the orphans in the two divisions based on the population representation of the locations as shown in Table 3.1.

First the proportion of the 384 respondents was subdivided between Kapseret and Kesses divisions based on the population of the orphaned children in each division. During the calculation, 53.4% (205 respondents) and 46.6% (179 respondents) were selected from Kapseret and Kesses Divisions respectively. Proportional sampling technique was then used to select the number of orphans in each of the location as shown in the Table 3.1. This ensured that 13.1% of the sample relative to the population was sampled in each of the location. During sampling, the researcher identified the homes to be sampled using systematic sampling and numbered them. Simple random sampling technique was then employed to pick the orphans from the each household to be included in this study. The guardians (214) were selected through Snowball sampling technique.

Table 3.1: Summary of the sampling technique for the orphans in Kapseret and Kesses Divisions

Division	Locations	Number of orphans who turned up	Sampled orphans
Kapseret	Kapseret	304	40
	Pioneer	777	102
	Simat	202	26
	Ngeria	281	37
Total		1564	**205**
Kesses	Cheptiret	55	7
	Chuiyat	156	20
	Kapkoi	88	12
	Kipchomo	26	3
	Megun	52	7
	Olenguse	380	50
	Tarakwa	197	26
	Tulwet	164	22
	Kesses	245	32
Total		1363	**179**

The number of sampled orphans from each location was determined by the number of orphans who turned up as shown above.

3.6 Research tools and instruments of data collection

The researcher used questionnaires (guardians) and interviews schedules (orphans) as the main tools for data collection. The selections of these tools were guided by the nature of the data to be collected from the children, guardians as well as the objectives of the study.

3.6.1 Questionnaires

There were two questionnaires used for the purpose of this study. The interview schedule for orphan (Appendix i) and the guardian questionnaires (Appendix ii). The orphan questionnaire was researcher administered and the contents of the questionnaires were explained in the most simplistic way to the orphan. Guardian questionnaires were used to gather information from the guardians or any caretaker of

the children and often involved explanation of the content of the questionnaires to the respondents. The questionnaires were justified on the basis of the fact that they enabled the coverage of wide area and extensive contents within a short period of time. The questionnaires captured information concerning: the types of economic challenges, social problems, psychological problems and any social support programme that the orphans are provided with.

3.6.2 Interview schedule

The researcher used interview schedule for the HIV/AIDS orphans who could answer questions to get detailed information from them. The respondents who could not adequately fill the questionnaires were also interviewed but on the contents of the questionnaires. Interviews were used to compliment the questionnaire in getting first-hand information and reduce ambiguity in responses. The researcher used both structured and semi structured questions. The interviews sought more personalized information in the psychosocial challenges of the children orphaned by HIV/AIDS as well as the problems that these children normally undergo when they lose their parents.

3.7 Pre-testing of the instruments

The researcher undertook a pre-test of the data collection instruments in the two Divisions neighbouring Kapseret and Kesses i.e. in Moiben and Turbo Divisions to standardize the data collection methodologies by anticipating the types of response expected from the field. A total of eight orphans and their guardians were sampled in each of the targeted areas. The pre-pretest was specifically carried out to test the interview schedules and the questionnaires to be used in the actual study.

3.8 Validity and reliability of the instruments

3.8.1 Validity of the instrument

To determine the validity of the questionnaire items, one lecturer in the Department of Public Health, Moi University, one expert on orphaned and vulnerable children from an NGO and one public health official from the Ministry of Health examined the instruments and provided suggestions and comments, which were useful to modify the research items and make them adaptable to the study. Based on the feedback offered by those who examined the questionnaire the content of the questionnaire were modified and some items included or excluded completely.

3.8.2 Reliability of the instrument

Reliability is concerned with the degree of consistency between two independently obtained sets of scores. The scores obtained are expressed in the form of correlation coefficients. In this research study, reliability of the instruments were obtained through split half technique. The questionnaires were administered to respondents as described in the pilot study.

Split half technique was used to obtain scores denoted X and Y. The X scores represented the responses from the odd positioned respondents while the Y scores represented the even positional items. Pearson product moment correlations (r) were used to calculate the reliability coefficient. The coefficient obtained was then converted into an appropriate correlation for the entire test using Spearman Brown Prophecy formula (1910). The reliability coefficients of 0.7 and above were accepted as a good measure of reliability (Kothari, 2005). In the current study a reliability of 0.81 was obtained, which was good measures of reliability of the instruments.

3.9 Inclusion and exclusion criteria

During the study, the inclusion criteria used were HIV/AIDS orphans aged between 12 and 25 years. On the other hand, the exclusion criteria were HIV/AIDS orphans who were critically ill.

3.10 Scoring of the instruments

In the questionnaires the marked items were scored to obtain the levels of each variable being studied. The scoring of items determining the levels of psychosocial problems were based on the Likert score of five items for the orphan and the guardians. In the scoring the orphan questionnaire (Appendix i) and guardian questionnaire (Appendix ii), 14 items were used. The items would yield a minimum of 14 if all the questions are marked 1 while a maximum of 70 would be obtained if all the responses are marked 5. Since all the questions were in the negative, the three levels of psychosocial problems were projected (Low, moderate and high), the scores were interpreted as follows: 14 to 39.5 represented low level of psychosocial problem, 39.6 to 44.5 represented moderate and 44.6 to 70 represented high levels of psychosocial problems among the orphans.

In order to obtain the rank scores when computing the nature of psychosocial problems, the following formula was applied. % Rank score = A/B

Where: A = Overall calculated score for all respondents and B = Number of respondents*Maximum possible score (5).

3.11 Actual data collection

The interview schedules were used to collect the data from the orphans with the guidance of research assistants. The questionnaires were administered to guardians. The respondents were asked to fill the questionnaires which were then collected.

3.12 Data processing and analysis

After data collection, data coding of all the responses was done to facilitate easy analysis using computer Statistical Programme for Social Sciences (SPSS version 17.0). All the data were analyzed by descriptive statistical analysis for both the non-numerical and numerical data. Frequency distributions and cross-tabulations were used to analyze the data. All data was analyzed at a level of 95% confidence ($p < 0.05$). The problems of the HIV/AIDS orphans and the psychosocial challenges were summarized using frequency distribution tables. The relationships between the challenges faced by the orphans and psychosocial problems were analyzed using Spearman Rank Correlation. Positive sign meant there is a relationship while negative sign will mean inverse relationships. The results were presented in tables and bar-charts.

3.13 Ethical considerations

The major ethical issues addressed were: informed consent, privacy and confidentiality, anonymity and researcher's responsibility. In this study, the researcher verbally informed the participants on the purpose of the research before providing the questionnaires outlining the purpose of the study. The respondents were assured of the confidentiality of the information given. A written consent was shown to the participants (Appendix iii). All participants remained anonymous. Authorization to conduct the research was granted by the Institute of Research and Ethical Committee (IREC).

CHAPTER FOUR

RESULTS

4.0 Overview

This chapter focused on presentation, analysis and interpretation of the data collected from the field. The data analyzed and presented was based on the responses to the items in the administered questionnaires and interview schedule. Section 4.2 presents and discusses the background information of the orphans including; age, gender, religion, levels of education while the guardians' age, gender, religion, levels of education, marital status and occupation are also highlighted.

Section 4.3 presents and discusses information concerning the psychosocial challenges of the HIV/AIDS orphans in Wareng District. Section 4.4 presents information on the economic problems among HIV/AIDS orphans and how these affect their psychosocial status. Section 4.5 provides information concerning the social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status. Finally section 4.5 gives information concerning the social support programs for the HIV/AIDS orphans and how this affects their psychosocial status. Tables and figures have been used to summarize and illustrate the findings of the study.

4.1 Socio-economic and demographic characteristics of the respondents

The number of orphans and their guardians in Wareng District during the study was 384 and 214 respectively. The overall results showing the demographic data for the orphans and guardians in the current study are shown in Table 4.1.

Table 4.1: Socio-economic and demographic characteristics of the respondents

		Orphaned children (n = 384)		Guardians (n =214)	
Demographic	Characteristics	Frequenc	Percent	Frequenc	Percent
Gender	Male	140	36.5	67	31.3
	Female	244	63.5	147	68.7
Age	< 12	59	15.4	0	0.0
	12-15	156	40.6	0	0.0
	16-18	120	32.3	0	0.0
	19-25	49	12.8	2	0.9
	26-35	0	0.0	15	7.0
	36-50	0	0.0	93	43.5
	>50	0	0.0	104	48.6
Religious	Atheist	52	13.5	44	20.6
	Catholic	184	47.9	94	43.9
	Protestants	134	34.9	68	31.8
	Muslim	14	3.6	8	3.7
Marital status	Single	381	99.2	34	15.9
	Married	3	0.8	156	72.9
	Divorced	0	0.0	11	5.1
	Widows	0	0.0	13	6.1
Highest levels of education	None	7	1.8	0	0.0
	Lower primary	34	8.9	1	0.5
	Upper primary	114	29.7	23	10.7
	Completed	183	47.7	71	33.2
	Secondary	46	12.0	98	45.8
	College	0	0.0	13	6.1
	University	0	0.0	8	3.7
Occupation	Unemployed	366	95.3	16	7.5
	Farmer	5	1.3	85	39.7
	Salaried	0	0.0	79	36.9
	Business	13	3.4	29	13.6
	Banker	0	0.0	5	2.3

Distribution of the respondents by gender indicates that among the orphans, 63.5% were females while the remaining 36.5% were male children. Similarly 68.7% of the

guardians were females while the remaining 31.3% were males. Therefore, the highest proportion of the children orphaned with HIV/AIDS and those who take care of them in Wareng District were found to be dominated by the females. There were no significant gender differences in the proportion of orphans (about 1:2; Male: Female) between Kapseret division and Kesses division ($\chi^2 = 1.334$, df = 1, p = 0.652) as well as the gender proportion of the guardians (also about 1:2, Male: Female) in the two divisions ($\chi^2 = 1.634$, df = 1, p = 0.557), indicating that females orphans and guardians were dominant in both divisions.

Age distribution indicated that more than 71.9% of the orphans were aged between 12 to 18 years. On the contrary up to 92.1% of the guardians were aged over 36 years with 48.6% being aged over 50 years. Like in the gender distribution, there were no significant age distribution of the orphans ($\chi^2 = 2.334$, df = 3, p = 0.531) and guardians ($\chi^2 = 2.334$, df = 2, p = 0.335) between the two areas.

Religious affiliation of 47.9% of the orphans and 43.9% of the guardians was Catholic while close to 34.9% of the orphan and 31.8% of the guardian respondents were protestants respectively. Muslims constituted 3.6% of the orphans and 3.7% of the guardians. There were no significant distribution of the respondents based on religious affiliations among the orphans ($\chi^2 = 1.226$, df = 3, p = 0.322) and guardians ($\chi^2 = 1.955$, df = 3, p = 0.302).

Nearly all orphans (99.2%) were single while 72.9% of the guardians were married. No particular significant differences in marital status was established among the orphans (no statistical comparison made due to near 100% response) and among the guardians ($\chi^2 = 0.334$, df = 3, p = 0.952) between Kapseret and Kesses Divisions in Wareng District.

Among the respondents, 47.7% of the orphans sampled, had managed to complete primary school while about 30% had only reached primary levels of education with only 12% reaching secondary schools (but not necessarily completing). Comparatively, no significant differences in the levels of education was found between Kapseret and Kesses Divisions (χ^2 = 3.119, df = 4, p = 0.458). Among the guardians 45.8% were found to have attained secondary levels of education (followed by those who had completed primary school (33.2%) with few attaining college and university levels of education. Contrary to the orphans, there were significant differences in the highest levels of education among the guardians between Kapseret and Kesses Divisions (χ^2 = 6.334, df = 6, p = 0.652) with higher proportion of the guardians having completed primary in Kesses (39.5%) while most of the guardians in Kapseret had secondary education (48.2%).

Finally 95.3% of the orphans were found to be unemployed with only 1.3% reported cases of farmers and another 3.4% doing business. On the contrary, 36.9% of the sampled guardians were salaried employees while 36.7% were farmers and 13.6% were in business.

4.2 Psychosocial problems faced by the HIV/AIDS orphans

The first objective of this study was to determine the nature and extent of psychosocial problems facing HIV/AIDS orphans in Wareng District. To meet this objective a research question stating "What are the nature and extent of psychosocial problems facing HIV/AIDS orphans?" was formulated.

The nature of psychosocial problems facing the orphans was obtained from the researcher guided questions in the questionnaire for the orphans (Appendix i) and the

guardians' (Appendix ii). Information on the nature of psychosocial problems faced by the orphans as stipulated by the orphans is provided in Table 4.2.

At the initial stages, the rank scores of the orphans psychosocial problems were determined between Kapseret and Kesses (data not displayed) but when they were statistically compared there were no differences in the rank scores between Kapseret and Kesses (Mann-Whitney test; $H = 0.932$, $df = 1$, $p = 0.641$), indicating that the psychosocial problems were similar between the two areas and therefore the data was homogenized (as shown in Table 4.2). The results presented in the table indicate that all the orphans suffered immeasurable psychosocial problems. However, the problems suffered most by the orphans were: trauma, stress, misery and grief which had a rank scored of over 82%. Forms of seclusion, suicide tendency and depression were also suffered by the orphans but they ranked low among the psychosocial problems by the orphans in the study area.

Table 4.2: Nature of psychosocial problems faced by the orphans based on the orphans views

Psychosocial problems by the orphans	All the time	Often	Occasionally	Unknown	Never	% Rank scores	Rank
It is painful to loose the parents (trauma)	321	11	10	9	33	90.1	1
Feeling that the world is coming to an end (stress)	262	56	33	18	15	87.7	2
Not sure about the future (misery)	252	54	21	22	35	84.3	3
Likes to mourn (grief)	211	84	51	18	20	83.3	4
Feeling of deep thought (stress)	183	126	45	14	16	83.2	5
Feeling of loneliness (seclusion)	201	88	61	11	23	82.6	6
Avoid other children (seclusion)	173	124	51	21	15	81.8	7
I am very much annoyed with what killed my parents (misery)	187	102	55	21	19	81.7	8
Fear many people including other children (seclusion)	183	99	67	19	16	81.6	9
You can bring back the parents (hopelessness)	205	87	33	31	28	81.4	10
I encounter a lot of nightmares (trauma)	161	133	51	16	23	80.5	11
Feeling like you don't want to play (seclusion)	134	122	54	53	21	75.4	12
Feeling like I don't want to live (suicide feelings)	89	87	79	109	20	66.0	13
Feeling sad (depression)	101	91	55	27	110	62.4	14

In order to obtain the rank scores when computing the nature of psychosocial problems, the following formula was applied. % Rank score = A/B
Where: A = Overall calculated score for all respondents and B = Number of respondents*Maximum possible score (5)

Among the guardians, the nature of psychosocial problems is provided in Table 4.3. Initially when the rank scores of the orphans psychosocial problems were ranked (based on response of the guardians), and statistically compared (Mann-Whitney test; $H = 1.232$, $df = 1$, $p = 0.411$), there were no differences in the rank scores between Kapseret and Kesses (data not shown in tables) indicating that the psychosocial problems were similar between the two areas, which resulted in homogenization of the data (shown in Table 4.3).

Based on the responses of the guardians, the key psychosocial challenges were found to be diverse. However, the most important among them were found to be trauma, followed by depression, unhappiness associated with grief and finally lack of confidence, which all scored percentage rank scores of over 80%. On the other hand other psychosocial challenges that were prevalent among the orphans as espoused by their guardian but in low proportion were: loss of weight perhaps due to lack of appetite or too many emotional thoughts, traumatic experiences of nightmares and loss of appetite which all scored a rank of below 70%.

Table 4.3: Response on the nature of psychosocial problems faced by the orphans as determined from the guardians

Psychosocial problems by the orphans	All the time	Often	Occasionally	Unknown	Never	% Rank scores	Rank
Trauma	112	76	10	9	7	85.9	1
Depression	133	34	28	11	8	85.5	2
Unhappiness	133	32	22	18	9	84.5	3
Lack of confidence	112	33	51	18	0	82.3	4
Loss of religious faith	112	38	21	22	21	78.5	5
Sense of hopelessness	94	56	22	16	26	76.4	6
Seclusion from others	87	55	18	53	1	76.3	7
Wish to commit suicide	78	71	21	32	12	76.0	8
High tempers	69	56	67	19	3	75.8	9
Self blame	100	26	45	14	29	74.4	10
Emotional drain	75	41	61	11	26	72.0	11
Loss of weight	81	33	55	21	24	69.8	12
Trauma e.g. nightmares	55	35	41	27	56	60.6	13
Loss of appetite	54	26	51	37	46	60.5	14

In order to obtain the rank scores when computing the nature of psychosocial problems, the following formula was applied. % Rank score = A/B

Where: A = Overall calculated score for all respondents and B = Number of respondents*Maximum possible score (5)

The psychosocial problems highlighted by the orphans and guardians were then scored as indicated in chapter 3. The levels of psychosocial problems by the orphans obtained are as presented in Figure 4.1. There were significant differences between the levels of psychosocial problems of the orphans based on ranked scores from the orphans themselves and their guardians (Chi-square; χ^2 = 1.332, df = 2, p = 0.311). The results based on the results of the two respondents indicate that the levels of psychosocial problems among the orphans was high both among most of the orphans (84.1%) and for most of the guardians (81.9%). Few orphans and guardians reported low psychosocial challenges (< 6%)

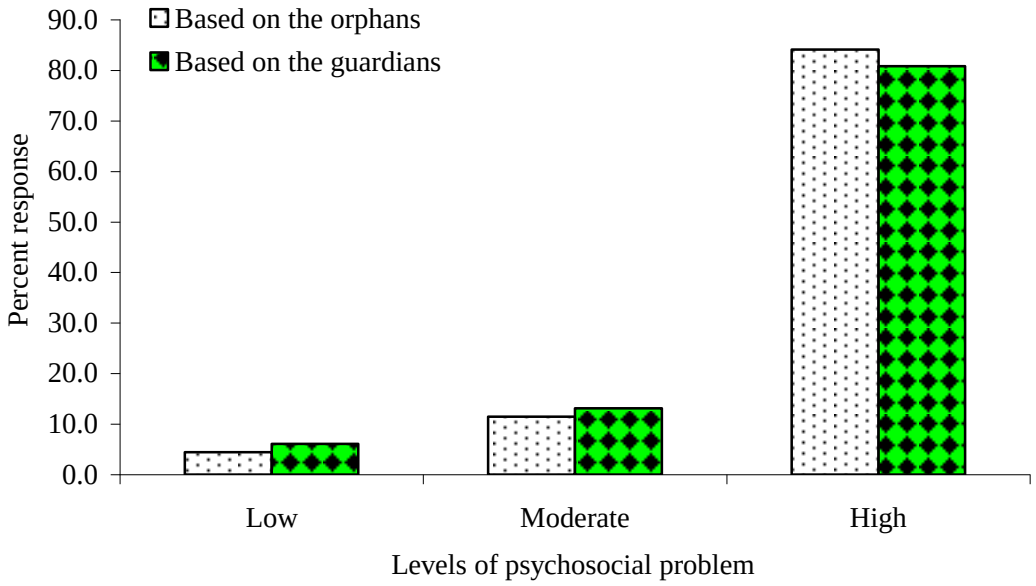


Figure 4.1: Overall status of the psychosocial problems faced by the orphans in Wareng District based on scored responses from the orphans and the guardians

4.3 Economic problems among HIV/AIDS orphans and how these affect their psychosocial status

The second objective of this study was to determine the problems among HIV/AIDS orphans and how these affect their psychosocial status in Wareng District. This was achieved through a formulation of a research question stating "What are the economic

problems faced by the HIV/AIDS orphans and how these affect their psychosocial status?"

To capture the nature of the economic problems likely to be experienced by the orphans, the researcher first determined from the guardians the information related to income levels of the guardians of the orphaned children and the adequacy of the income to meet the child's basic need. Information derived from the guardians on income levels and adequacy of income to the households that the orphans resided is presented in Table 4.4. 40.1% of the guardians earned between Kshs. 5000 to 10000 per month followed by 26.6% who earned between Ksh. 10001 to 20000. Only 2.3% earned salaries above Kshs. 50000. It was further revealed that this income was not enough for 85% of the respondents.

In terms of purchase power of the money, the researcher established that for close to 85.4% of the respondents the income could not purchase enough food, up to 90% of the guardians could not buy clothing while 58.9% of the guardians could not pay shelter using the income they earned. In the midst of the orphan problems with little income to purchase basic needs, up to 91% of the guardians attested that they never inherited any properties from the deceased orphans' parents.

Table 4.4: Income levels and adequacy for the guardians taking care of the orphaned children

Property			Frequency	Percent
Income of guardian		< 5000	64	16.7
		5000-10000	154	40.1
		10001-20000	102	26.6
		20001-50000	55	14.3
		>50000	9	2.3
Income of the guardian enough to support family and orphan		Yes	56	14.6
		No	328	85.4
Income can purchase basic needs				
	Enough food	Yes	87	22.7
		No	297	77.3
	Clothing	Yes	38	9.9
		No	346	90.1
	Pay shelter	Yes	158	41.1
		No	226	58.9
Orphans parents left properties that generate income		Yes	36	9.4
		No	348	90.6

Properties owned by the guardians were determined to establish the extent of economic support that the guardians can provide to the orphans (Table 4.5). Based on the table presented, 67.3% of the guardians had land, which ranged from 1 to 10 acres in each of the divisions. For 70% of the respondents, subsistence farming was practiced in the farms with few cases of mixed subsistence and cash crop farming. Again, few respondents inherited properties such as land, house, money, vehicle and livestock from the orphans' parents. Yet again, among the livestock owned by the

guardians, 53.7% were found to own between 1-3 cattle, 40.7% owned 2-5 goats, 54.7% 3-5 sheep and 98.6% of the guardians kept variable number of poultry.

Table 4.5: Properties owned by the guardian to take care of the orphaned children

Property		Frequency	Percent
Land	Yes	144	67.3
	No	70	32.7
Land sizes	None	70	32.7
	< 1 acre	55	38.2
	1-5 acres	62	43.1
	6-10 acres	21	14.6
	11-20 acres	4	2.8
	> 20 acres	2	1.4
Types of farming	No farming activity	70	32.7
	Subsistence	101	70.1
	Cash crop farming	27	18.8
	Mixed	16	11.1
Inheritance properties from orphaned parents	No inheritance	65	30.3
	Land	44	20.6
	Houses	19	8.9
	Money	22	10.3
	Vehicle	8	3.7
	Livestock	56	26.2
Types of livestock owned livestock[a]	Cattle	115	53.7
	Goats	87	40.7
	Sheep	117	54.7
	Pigs	3	1.4
	Poultry	211	98.6

[a]The total percentage of livestock ownership exceeded 100% because of options for double ownership of different types of livestock.

The researcher further determined living conditions of the orphans in their current homes (Table 4.6). About 90% of the orphans stayed with the guardians who were

mainly grandmothers (44.9%). It was further determined that 91.4% of the orphan respondents had moved from their original home while only 16% of the respondents were found to be satisfied with their current homes.

Table 4.6: Living conditions of the orphans in their current homes

Conditions		Frequency	Percent
Nature of living	Alone/self	5	1.3
	With guardian	345	89.8
	In children home	34	8.9
Nature of the guardian	Not recognized guardian	39	10.2
	Grandparents	155	44.9
	Father only	52	15.1
	Relatives	48	13.9
	Mother only	42	12.2
	Siblings (brother and sister)	48	13.9
Respondents moved away from original home	Yes	351	91.4
	No	33	8.6
Satisfied with the current living condition	Yes	61	15.9
	No	323	84.1

Information on the access to healthcare among the orphans was also determined to establish the ability of the orphans to afford basic health care in their current residents (Table 4.7). Although 47.4% of the orphans were found to fall sick occasionally and another 22.7% often, 50% of the orphans took over the counter medication with another 31.5% lacking any medicine. Only 18.5% went to the hospital. Among those who did not go to the hospital to seek medical treatments, it was established that 63.8% lacked money, a third of the guardians refused to take the orphans to the hospital, while another one fifth lacked fare to the hospital and another one quarter had nobody available to take them to the hospital. When the orphans were asked who paid their medical bills, it was established that the highest proportion of the medical bill was paid by the guardians while the others obtained free medication from

AMPATH at Moi Teaching and Referral Hospital, which takes care of the HIV/AIDS infected and affected.

Table 4.7: Access to healthcare by the orphans in their current residents

Conditions		Frequency	Percent
Orphans have fallen sick	Often	87	22.7
	Occasionally	182	47.4
	Rarely	115	29.9
Source of medication during sickness	Hospital	71	18.5
	Over the counter medication	192	50.0
	Did not take any medicine	121	31.5
Reasons why the orphans did not go the hospital[a]	Lacked money for hospital	245	63.8
	Guardian refused to provide the	138	35.9
	Lacked transport to the hospital	81	21.1
	Nobody took them to hospital	109	28.4
Who pay medical bills[b]	Self	8	2.1
	Get free treatments	65	16.9
	Guardian	103	26.8
	Well wishers	23	6.0
	Organization	19	4.9

[a]The total percentage of responses exceeded 100% because of option to provide more than one answer to the question.
[b]Total percentage responses were less than 100% because only orphans who's medical bills are paid responded to the question.

The schooling status of the orphans was also captured from the orphans and guardians to establish the economic challenges the orphans face during schooling (Table 4.8). Up to 35.7% of the orphans currently attended regular schooling, similar to the proportion that were attending school with high absenteeism while 26.8% had

dropped out of school due to lack of school fees (89.3%), to take care of their siblings (34.0%), to work (10.7%) and by refusal of their guardians to take them to school (14.6%).

Table 4.8: The schooling status of the orphans in Wareng District

Conditions		Frequency	Percent
Current schooling status	Going to school regularly	137	35.7
	Going to school but high absenteeism	144	37.5
	Dropped out of school	103	26.8
Reasons why the orphan are out of school[a]	Lack of school fees	92	89.3
	Lack of fare to school	21	20.4
	Take care of sick siblings	35	34.0
	Go to work to get money	11	10.7
	Refusal by caretaker to take the child to	15	14.6
	Refusal by the orphan to attend school	4	3.9
	Lack food to eat while at school	9	8.7

[a]Responses were based on the 103 orphans who were out of school, the total number of responses exceed 103 due to option for double responses.

Using the responses captured by the guardians, the overall economic status was determined based on the indicators of economic situation (properties owned, food, shelter, clothing, schooling and healthcare) as described in chapter 3. The overall economic status for the orphans determined as presented in Figure 4.2. Based on the figure, highest proportions of the orphans had high economic problems (76.2%) while only 11.3% had low economic problems.

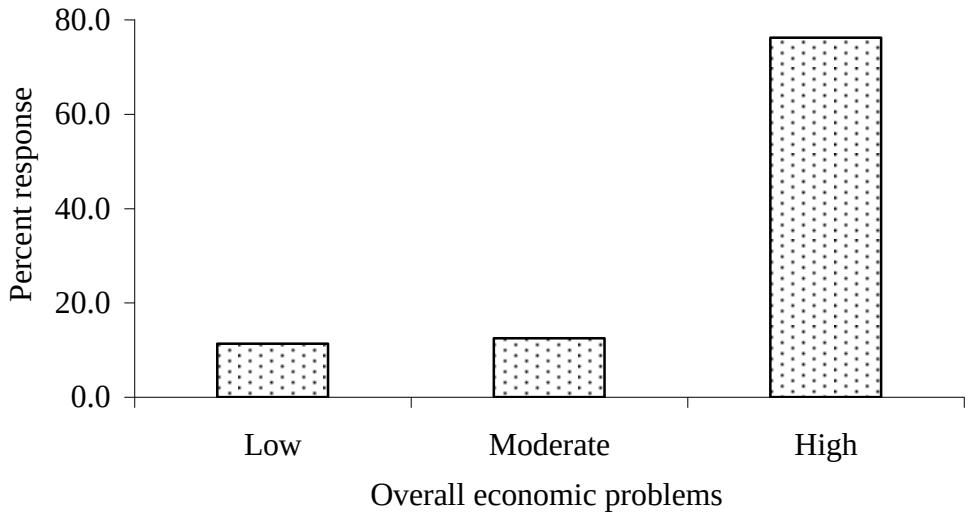


Figure 4.2: Overall economic problems of the orphans in Wareng District

The relationship between economic problems and psychosocial problems of the orphans was then captured as presented in Figure 4.3. There was a significant relationship between economic problem and psychosocial problems among the orphans (Spearman Rank Correlation; $p < 0.001$). From the figure, increased economic problems among the orphans resulted in significant increase in the number of orphans with high levels of psychosocial problems (Spearman Rank Correlation; $r = 0.94$, $p < 0.001$) but a decline in the number of orphans with low levels of psychosocial problems (Spearman Rank Correlation; $r = -0.89$, $p < 0.001$) indicating that psychosocial problems increased with increasing levels of economic problems but reduced with reduced economic problems.

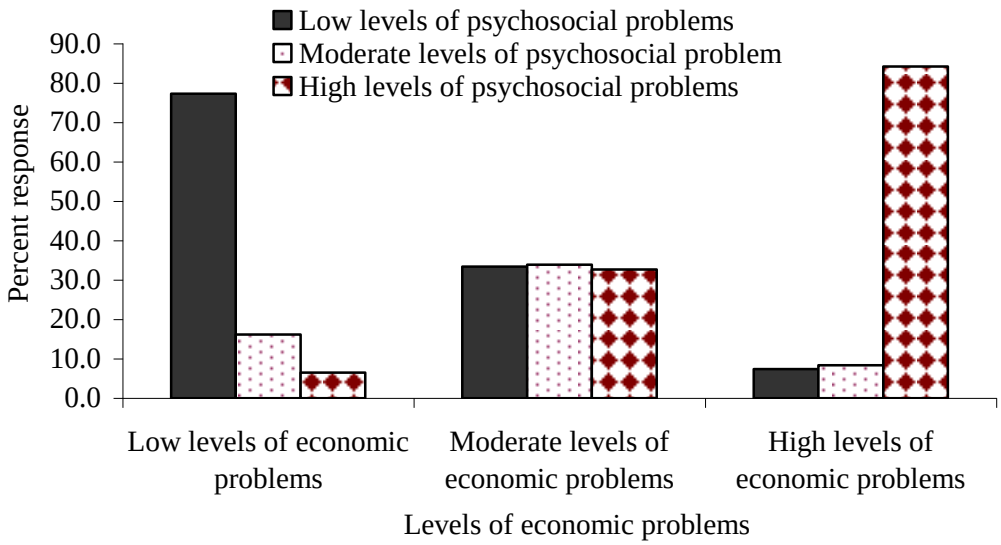


Figure 4.3: Relationship between economic problems and psychosocial status of the orphans in Wareng District

4.4 Social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status

The third objective of this study was to determine the social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status in Wareng District. To meet this objective a research question stating "What are the nature and extent of psychosocial problems facing HIV/AIDS orphans?" was formulated.

The relationships between the orphans and other children were determined as the first measure socialization among the orphans (Table 4.9). From the table, it was deduced that the children high ranks scores were observed as: children running errands alone (82.2%), hating strangers (80.2%), seclusion (79.6%), dislike for neighbours (72.2%), dislike interactions with other children (71.2%) and dislike to watch TV with other children (66.7%).

Table 4.9: Relationships between the orphans and other children in Wareng District

Psychosocial problems by the orphans	All the time	Often	Occasionally	Unknown	Never	% Rank scores	Rank
Likes running errands alone	181	111	55	28	9	82.2	1
Hate strangers	155	133	54	31	11	80.3	2
Like to remains in the house alone	169	102	67	29	17	79.6	3
Rarely visit neighbours	154	87	51	37	55	72.9	4
Does not read with other children	133	88	79	29	55	71.2	5
Does not interact with other children	175	41	61	31	76	70.8	6
Does like watching TV with other children	133	77	28	78	68	66.7	7
Does not play with other children	112	76	59	44	93	63.6	8
Dislike other children	112	87	21	44	120	61.4	9
Don't go to school with other children	112	67	51	29	125	60.6	10
Don't fetch water with other children	100	87	45	28	124	60.6	11

In order to obtain the rank scores when computing the nature of psychosocial problems, the following formula was applied. % Rank score = A/B

Where: A = Overall calculated score for all respondents and B = Number of respondents*Maximum possible score (5)

Information concerning the use and abuse of drugs was also determined from the guardians of the children and information verified from the children on condition of strict anonymity and non-reporting. The results were presented in Figure 4.4. According to the orphans, up to 9% took alcohol, 11% smoked cigarette, 12% took marijuana and 14% occasionally sniffed glue. Interestingly, significantly lower number of the guardians knew about these problems (Chi-square test on each drug; $p < 0.05$)

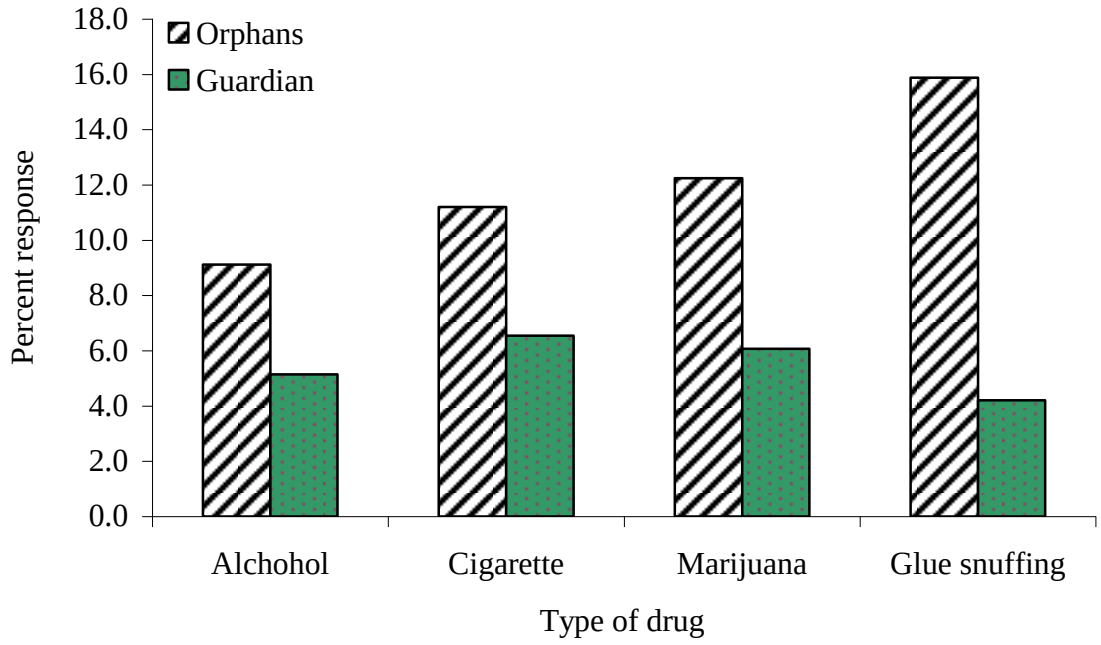


Figure 4.4: Information on the use and abuse of drugs among the orphans in Wareng District

Other information concerning the use and abuse of drugs by the orphans are as shown in Table 4.10. The responses were based only on those who abused drugs. The reasons for smoking and drinking as cited by highest proportion of the orphans was to forget their problems (35.7%), disagreement with the guardian (23.8%0 or was due to deceased parents habits (14.3%). Most of the orphans were also found to smoke and drink occasionally. About 31% of the orphans reported frequent problems when they

drink or smoke. 78.6% of the orphans also reported problems with their guardians when they smoked or drank alcohol.

Table 4.10: Information concerning the use and abuse of drugs

Drug use/abuse		Frequency	Percent
Reasons for smoking	To forget problems	15	35.7
	Disagreement with the guardian	10	23.8
	Was deceased parents habit	6	14.3
	Learned from other children	4	9.5
Reasons for drinking	To forget problems	5	14.3
	Disagreement with the guardian	6	17.1
	Was deceased parents habit	4	11.4
	Learned from other children	4	11.4
Frequency of smoking	Frequently	7	16.7
	Occasionally	14	33.3
	Not sure	10	23.8
	Rarely	11	26.2
Frequency of drinking	Frequently	8	22.9
	Occasionally	10	28.6
	Not sure	6	17.1
	Rarely	11	31.4
Had problems with drinking/smoking	Frequently	13	31.0
	Occasionally	10	23.8
	Not sure	9	21.4
	Rarely	10	23.8
Had problem with the guardian due to smoking	Yes	9	21.4
	No	33	78.6

Based in the overall relationships with other children and on use and abuse of drugs, the overall levels of social problems was determined and presented as shown in

Figure 4.5. Generally, the levels of social problems were found to be high for majority of the orphans (77.5%).

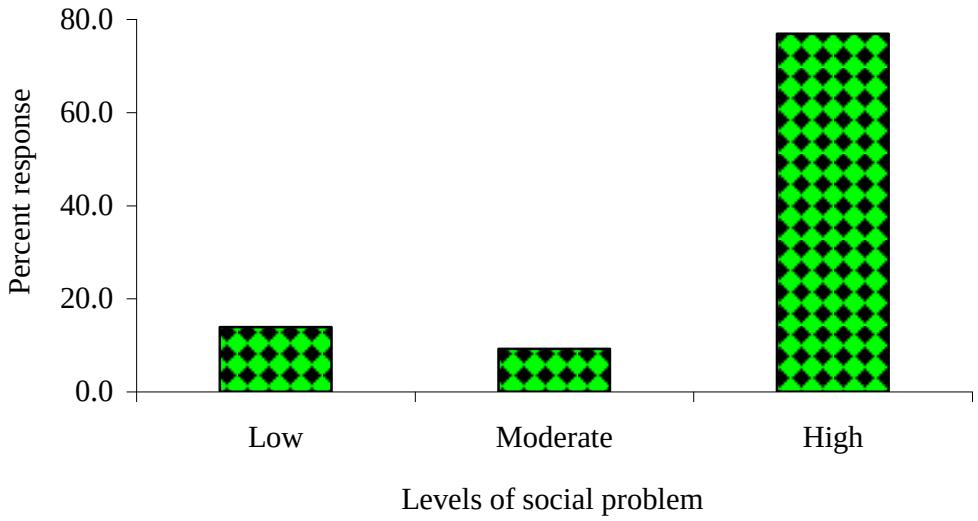


Figure 4.5: Overall levels of social problems among the orphans in Wareng District

The relationship between the extent of social problems and psychosocial status of the orphans was also determined as presented in Figure 4.6. There was a significant relationship between social problem and psychosocial problems among the orphans. From the result presented in Figure 4.6, increased social problems among the orphans resulted in significant increase in the number of orphans with high levels of psychosocial problems (Spearman Rank Correlation; $r = 0.91$, $p < 0.001$) but a decline in the number of orphans with low levels of psychosocial problems (Spearman Rank Correlation; $r = -0.95$, $p < 0.001$) indicating that psychosocial problems increased with increasing levels of social problems.

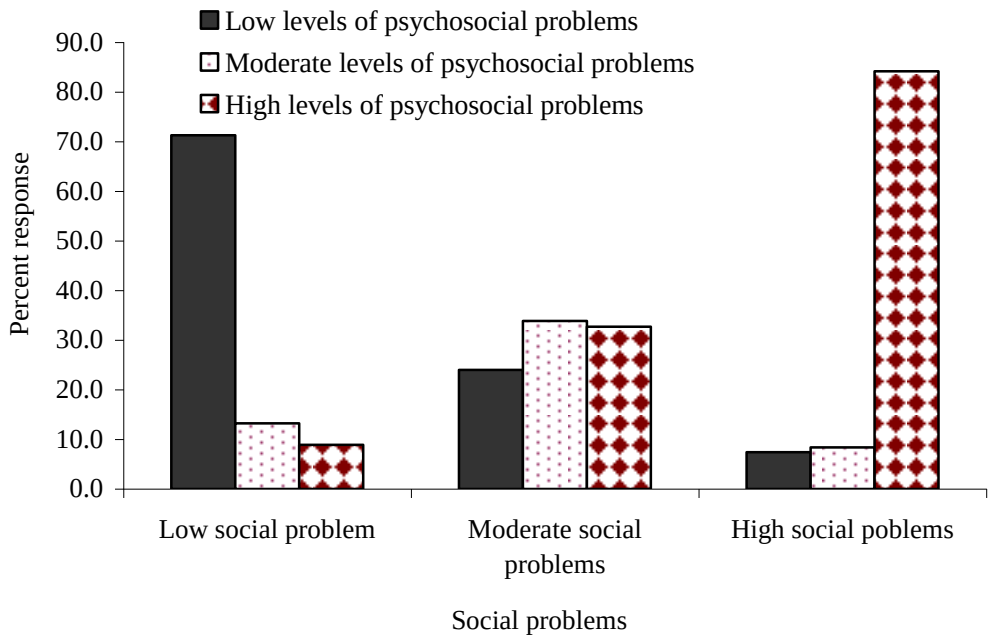


Figure 4.6: Relationship between the extent of social problems and psychosocial status of the orphans

4.5 Social support programs for the HIV/AIDS orphans and how this affect their psychosocial status

The final objective of this study was to determine the social support programs for the HIV/AIDS orphans and how they affect the psychosocial status of the orphans in Wareng District. To achieve this objective, a research question stating "What are the social support programs for the HIV/AIDS orphans and how this affect their psychosocial status?" was formulated

The overall information on the social support programmes among the orphans as determined from the guardians is provided in Table 4.11. Based on the responses of the guardians, only 37.1% of the orphans received social support. These support included mainly support for food (20.6%) and education (21.5%). However, 62.6% of the respondents indicated that these support are not adequate to cover for the needs of the orphans (not to mention the family taking care of the orphans) such as food, rent,

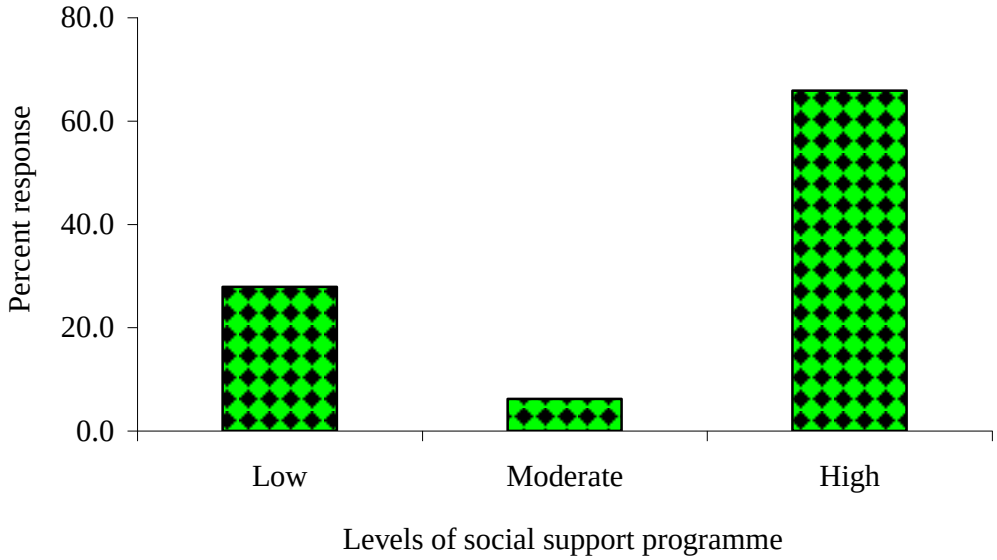
clothing, education and healthcare. Nearly all the orphans (98.6%) relied on the guardians with considerable less than 5% of orphans receiving support for education from government (free primary education) and well-wishers and medicare from NGOs. In all up to 59.8% of the guardians indicated that the social support programme is not enough to take care of the orphans needs.

Table 4.11: Overall information the social support programmes among the orphans based on responses from the guardians

Social support information		Frequency	Percent
Any social support present for orphans	Yes	81	37.9
	No	133	62.1
Sources of support present for basic needs	Food	44	20.6
	Rent	11	5.1
	Clothing	8	3.7
	Education	46	21.5
	Medical care	21	9.8
Adequacy of the social support	Very	8	3.7
	Adequate	16	7.5
	Not sure	56	26.2
	Not adequate	134	62.6
Source of funds for the following:	Working	2	1.4
Food	Guardian	211	98.6
	Relatives	56	26.2
	Well wishers	35	16.4
	NGO	18	8.4
Rent	Working	0	0.0
	Guardian	211	98.6
	Relatives	14	6.5
	Well wishers	9	4.2
Clothing	Working	18	8.4
	Guardian	201	93.9
	Well wishers	8	3.7
Education	Guardian	188	87.9
	Relatives	54	25.2
	Well wishers	13	6.1
	Government	87	40.7
Medical care	Guardian	175	81.8
	NGOs	23	10.7
	Well wishers	12	5.6
Adequacy of the social support	Very	2	0.9
	Adequate	29	13.6
	Not sure	55	25.7
	Not adequate	128	59.8

The researcher also strived to capture the overall levels of social support for the orphans as presented in Figure 4.7. Based on the figure, up to two thirds of the respondents indicated low levels of social support for the orphans while only 27.9% reported high levels of social support.

Figure 4.7: Overall levels of social support for the orphans in Wareng District



Finally the relationship between the levels of social support and psychosocial problems faced by the orphans was also evaluated as shown in Figure 4.8. There was a significant relationship between social support and psychosocial problems among the orphans (Spearman Rank Correlation; $p < 0.001$). From the figure, increased levels of social support among the orphans resulted in significant increase in the number of orphans with low levels of psychosocial problems (Spearman Rank Correlation; $r = 0.97$, $p < 0.001$) but a reduction in the number of orphans with high levels of psychosocial problems (Spearman Rank Correlation; $r = -0.86$, $p < 0.001$) indicating that psychosocial problems increased with reducing levels of social support.

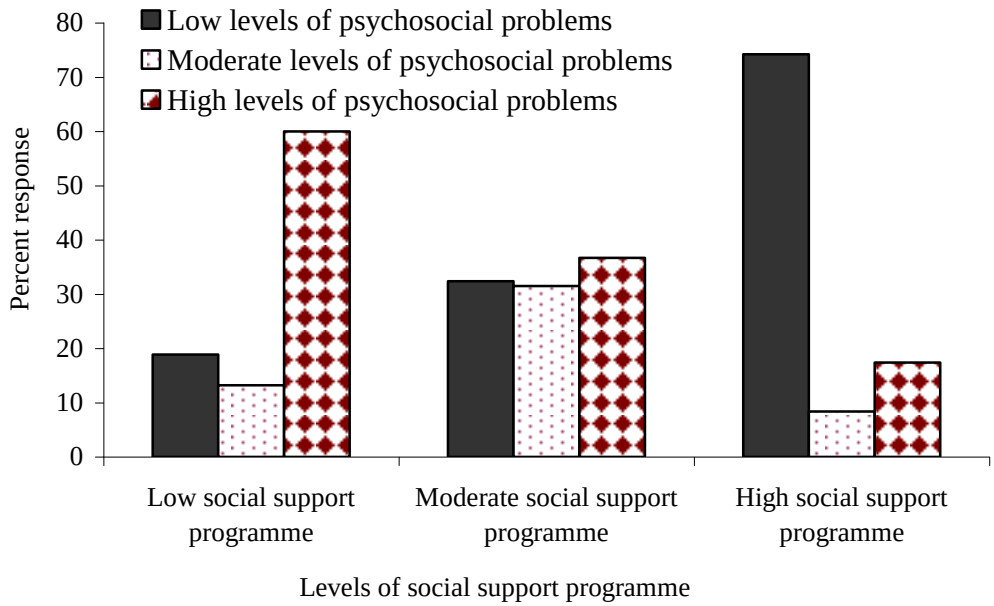


Figure 4.8: Relationship between the levels of social support and psychosocial problems faced by the orphans

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter contains the discussion, conclusions and recommendations of the study. The objectives have been linked to the research questions and conclusions and recommendations made.

5.2 Discussion

5.2.1 Psychosocial problems faced by the HIV/AIDS orphans

In this study, it was established that orphans experienced several psychological problems ranging from trauma, stress, misery, grief, unhappiness, seclusions from others, tendency to commit suicide among other forms of psychosocial problems. These concur with other studies (Kashani *et al*., 1995; UNAIDS, 2001; Friedman and Mulhern, 2002; Bose *et al*., 2007; Hanna and Mintz, 2010; Leserman, 2011). It has been noted that depression, anxiety, stigma, stressful and traumatic life events occur in epidemic proportions in HIV-infected and affected paediatric populations (Daniels *et al*., 1997; Wallander *et al*., 2007), which according to UNAIDS, continue to increase in the HIV/AIDS pediatric population. In cases of stigma, children begin to be rejected early as their parents fall ill with AIDS (Moss *et al*., 1998).

Some children may be teased because their parents have AIDS, while others may lose their friends because it is assumed that proximity can spread the virus (Hanna and Mintz, 2010) leading to trauma and depression or seclusion among these children. This can also add to the feelings of anger, sadness, and hopelessness that was observed for some of the children in the study area. One study in Kenya found that most of the children orphaned by AIDS had no one outside of their families to talk to

leading to severe cases of depression and seclusion (Okeyo *et al*., 2002), which might have added more psychological problems to the orphans (Human Rights Watch, 2001).

In this study it was also established that the levels of psychosocial problems among the orphans was high regardless of whether the orphans or their guardians responded to the questions. This indicates that there was a high prevalence of stress, depression, trauma, grief or misery associated with HIV/AIDS orphan-hood, which may aggravate cases of psychological problems. Harsh cases of depression, trauma, stress and discrimination of the children affected by the HIV/AIDS have been reported in many areas of Kenya such as in Kisumu and Siaya (Ayieko, 1997), Nairobi (Horsefield, 1998), and elsewhere in Zimbabwe (Foster, 1997), including in India, Trinidad and Tobago, particularly for HIV-infected children (UNAIDS, 2001). These psychosocial factors (e.g. depression, trauma and coping with stress) have consistent and clinically relevant influences on children development; the effects of psychosocial factors may be mediated biologically through changes in the sympathetic nervous system, "stress hormones" and the immune system, as well as behaviourally through changes in such behaviours as traumatic adjustment syndrome (Drotar *et al*., 1995).

Studies have been conducted that focuses on the psychosocial influences such as stress, depression and trauma among children affected with HIV, although psychological effects of HIV/AIDS loss among children in Kenya is currently not available. In this study, there was also evidence that most of the children remained secluded and avoided other children. This may be because these children are stigmatized and isolated, as ignorance about the virus persist. Not only do many children who live in heavily affected areas contend with the death of one or both

parents, but they also frequently face the rebuke from their peers and from the society due to the stigma attached to the death of ones parents through HIV/AIDS in Kenya (Ayieko, 1998). Such stigma can be properly managed if the children are usually taken to appropriate referrals for psychological and behavioural treatments (Leserman, 2010), which was found to be low in the study area. It therefore appears that these issues have been neglected in biomedical and treatment studies yet they are now known to have significant health impacts.

The feeling of depression, trauma, stress and other psychosocial problems can be heightened if the orphaned children are separated from their siblings, as often occurs when family members split up the child rearing duties – this was established in the current study. Another survey conducted in Kenya by the United Nations Development Programme (UNDP) found that 48% of the households with orphans reported that some of their family members were relocated to other communities (Ayieko, 1998).

The nature and extent of psychological problems were similar in Kapseret and Kesses perhaps because these areas share many similar characteristics and are not widely geographically dispersed, indicating that these orphans share similar predicaments while in their current homes and that geographical, ethnic and environmental similarity between Kapseret and Kesses is not diverse enough to bring about differences in the behaviour changes in the orphans facing similar hardships.

5.2.2 Economic problems among HIV/AIDS orphans and how these affect their psychosocial status

As the HIV/AIDS epidemic continues to advance in Kenya, the individual loss has been enormous. The spread of the disease is increasingly recognized as a serious

concern for economic development. Therefore, the second objective of this study was to determine the economic problems of HIV/AIDS orphans and this impact on their psychosocial status. In this study, the economic challenges among the HIV/AIDS orphans were apparently high. Its impact was seen in family and community structures and relationships and in sectors as varied as education, employment, health care, social welfare and agriculture. The greater risk of being affected with HIV, the extra burden of care brought on by AIDS is falling on the shoulders of millions of guardians, with implications for their health, nutritional wellbeing, psychosocial status and those of their dependent children (Gillespie and Kadiyala 2005, 2007).

Contrary to the popular belief about the rapid disintegration of the extended family due to economic problems, it remained the principle care unit of the orphans. It was believed that in spite of the major economic challenges, the family or relatives would not wish to abandon the orphaned children in an area where no one else would feel responsible for them and in the absence of economic wellbeing, which concurs by studies conducted by Soo *et al* (2009).

It was observed that the guardians did have enough income to support their families and the orphans (Table 4.4). It has been reported in Kenya that the high rate of unemployment render many families especially the ones who take care of the orphans to be destitute and therefore will succumb to very low paying jobs, which are not enough to meet their basic needs and the needs of the children they are taking care of (Ngunjiri and Waihoro, 2004). Reports of grandmothers caring for a dozen children with little to no income are not unusual and were also observed in the study. As a result, children under their care are more likely to be uneducated and malnourished. Orphaned children can also experience discrimination and exploitation within their

new households. Reports have emerged of orphaned children receiving less food, denied school fees, and forced to do more work (Weiser *et al*., 2007).

In this study many of the guardians were found to own very little parcels of land and practiced mainly subsistence farming, which is widely believed to result in low food production to the households. Since the threat that AIDS epidemics pose for food security was recognized in the late 1980s (Gillespie, 1989), many studies in Sub-Saharan Africa have since shown that subsistence poor farmers are vulnerable to the impacts of AIDS because the disease reduces the resources that households can devote to agriculture (recent reviews include Gillespie, 2006 and Edstrom and Samuels, 2007), which is widely believed was also occurring in the study area. Moreover, stories of children going hungry or starving in areas that always had food, because HIV-infected parents who were farmers became too weak to till the fields are increasingly reported across Africa.

The degree and type of vulnerability depend on the characteristics of families, livelihoods and farming systems. In this study, food production appeared to be a challenge as most of the orphans reported less food to eat. Since in many parts of the developing world, people rely on their own plots of land for the majority of their food consumption and income (Rosen and Simon, 2002), the lack of land by the orphans in the current study appeared to limit food production. Many traditional agrarian societies rely on women to produce food, particularly in Africa, where 80% of subsistence farmers are women (World Economic Forum, 2003).

During times of famine these women know which wild grains, roots and berries can be eaten when there are no crops. As significant numbers of women of childbearing age fall ill due to HIV/AIDS, they become unable to transfer these skills to their

children, both in times of famine and without. This is of particular concern in the study area where majority of the women were not available to take care of their children, consistent with other studied on HIV/AIDS in Africa (de Waal, 2009). It's important to stress that impacts of AIDS on agriculture (and indeed other sources of livelihood) are not one-time events – they are processes, often hidden and slow-burning but potentially very destructive.

In the current study, it was found that the orphaned children had high levels of economic challenges; this is because of the long term impacts of HIV/AIDS on the economic prowess of the household. Following a shock to household income, households in Malawi affected by AIDS were found to take up to 18 months to stabilize, with a new equilibrium income that was about half the pre-shock income levels (Masanjala, 2006), which may be inadequate to take care of the orphans. Similar findings had been reported earlier in Kenya (Yamano and Jayne, 2004). Some experts have expressed concern that in the long-run African people will be unable to sustain themselves as they are forced to put off transferring life skills to cope with HIV/AIDS (de Waal, 2009). Such limited resilience is likely to increase vulnerability of the guardians and the orphans not only to economic problems but other psychosocial problems.

It was further established in this study that living conditions of the orphans were not favorable in their current homes. Although few lived along or in children's home, majority stayed with the guardians who were mainly grandmother, which concurs with the findings by Soo *et al* (2009). In the study, Soo *et al*. 2009 found that the extended family remained the principal orphan-care unit with majority of the caretakers being elderly female (78.2%), who had low formal education. There was

also a high percentage of female widowed caretakers (87.3%) and therefore they concluded that the burden of caring from the orphans fall on the female headed households.

The type of living condition and guardian in orphan-hood appears to matter. In Tanzania, Ainsworth and Semali (2000) found maternal orphans to be at significantly greater nutritional risk than paternal orphans (the impact of maternal loss was severe regardless of household assets, while the impact on paternal loss was felt only among poor households). A decade ago, Ntozi *et al.* (1999) found that surviving fathers in Uganda provided more care than mothers because, they suggested, the fathers had greater means and the husband's relatives often denied widows the opportunity to look after the orphans. Paternal orphans tend to live in poorer households than maternal orphans, double orphans or non-orphans, according to analysis of DHS data (Case *et al.*, 2003) and a study in Zimbabwe (Nyamukapa *et al.* 2003). Households containing either maternal or double orphans were not poorer than those of non-orphans.

The increased economic challenges of orphaned and vulnerable children affected by HIV/AIDS were also established to be positively associated with psychosocial problems. This was earlier explained by Stillwaggon (2006), through stages of the development of the orphan-hood. According to the author, the first stage often begins when children realize that their parent has AIDS and is likely to die. They begin to fear for their future, wonder who will care for them and worry about how they will be able to stay in school. Children are often pulled out of school to care for an ailing family member or because meager household income is now spent on the sick. School fees, notebooks and pencils become unaffordable and children begin to struggle to

provide care and replace lost adult labor and income. At this stage, the quality of child-rearing is compromised, and many important lessons on life skills and self-sufficiency are not taught, mostly because the parent(s) is too ill to transfer the knowledge.

After one parent dies, most children continue to live with the surviving parent or a relative, but they often slide more deeply into poverty. For some, the next stage begins when they find themselves the heads of households. A young adolescent may be responsible for many siblings, some of whom may be infants (Piot, 2008). Children who are the heads of households are in a difficult position not only because they must now support their siblings with little to no education and/or employable skills, but also because they most likely have limited resources (Mishra *et al*., 2007). In many cases much of the family's possessions may have been sold to care for the sick. Large numbers of orphaned children find themselves in homes that cannot afford to pay school expenses and drop out to work in the household, fields, or on the street (Hargreaves *et al*., 2007). Many observers believe that the desperation of these young children makes them more vulnerable to abuse and exploitation, ultimately making them to have more psychosocial problems (Rosen and Simon, 2002; Hargreaves *et al*., 2007; Mishra *et al*., 2007; Aggleton *et al*., 2010).

It can be summarized that there was high economic challenges faced by the HIV/AIDS orphans. Without education and skills training, children orphaned and made vulnerable by HIV/AIDS are more likely to fall deeper into the cycle of poverty and engage in high-risk behaviour, which perpetuates the cycle of HIV transmission and increased psychosocial problems.

5.2.3 Social problems faced by the HIV/AIDS orphans and how these affect their psychosocial status

There were a number of social problems faced by orphaned children especially making them to develop antisocial behaviour to other children. The preoccupation with the illness or death of their parents, the isolation due to the loss of friends and the undertaking of additional work that comes with caring for ill parents or supporting oneself after one's parents have died often make it difficult for orphaned children hence develop deep sociological problems (Freedman and Poku, 2005). Such problems may affect the children by causing poor performance and engagement in drugs and substance abuse. It is common for teachers to report that they find orphaned children daydreaming, coming to school infrequently, arriving at school unprepared and late, or being non-responsive in the classroom (Watstein and Chandler, 1998). Moreover, children who are socially affected by the deaths of their parents may be frequently absent or tardy from school, find it hard to concentrate or unable to assume school-related expenses, such as school fees, uniforms, books and other school supplies (Yamano and Jayne, 2004). While teachers may have noticed that AIDS-affected children tend to have lower performance in school, many apparently do not link the behavior with HIV/AIDS.

Increased social challenges of orphaned and vulnerable children affected by HIV/AIDS resulted in increased psychosocial problems. This could also be explained through postulation by de Waal (2005). According to the author, when the children begin to realize that that their parent has AIDS and is likely to die. They begin to fear for their future and try to assume that the whole world is against them and that everybody is laughing at them, which makes these children to avoid almost every other person from neighbours to teacher to other children. However, in situations

where the other children and neighbours begin to realize that the parents of the children are infected with AIDS, they try to avoid the children through stigmatization. At extreme stage and when the parents die, most children continue to live with the surviving parent or a relative, but they often slide more deeply into thoughts that compromise their social lives. Many observers believe that the desperation of these young children makes them more vulnerable to social and psychosocial problems (de Waal *et al*., 2005; Hargreaves *et al*., 2007; Mishra *et al*., 2007; Piot, 2008).

Histories of stress, trauma and discrimination due to the increased social challenges may have contributed to the behavioral adaptation that lead to psychosocial problems (Cohen and Lazarus, 1979), whereas these same contextual factors can contribute to diminished coping capabilities leading to significant psychological distress and behavioral challenges. Interventions to address depression and stress due to sociological problems may help to ameliorate some of the negative health and behavioural effects associated with poor psychological functioning, unfortunately, these are rarely practiced in Kenya and therefore likely to exacerbate the psychosocial problems derived from social challenges.

5.2.4 Social support programs for the HIV/AIDS orphans and how this affect their psychosocial status

When considering the basic needs of a child one is inclined to think in terms of food, shelter, clothing, love and security, a combination of the material and psychological needs. In the current study, there was low levels of social support provided to the HIV/AIDS children. The current finding is in agreement with earlier studies where there is an emergence of orphan households headed by siblings who sometimes has no source of livelihood (Muzvidziwa, 2004; Atekyereza and Kirumira, 2004), which

suggest that the extended family and some of the orphans are under stress. This is because child headed households lack guidance, security, emotional support and material resources for proper socialization. Meeting these needs is important for the growth and ability of a child to succeed through life. According to the United Nations Convention on the Rights of the Child, meeting the psychosocial needs through social support of children is not only a privilege, but also a right of the child.

Organizations in Sub-Saharan Africa have begun to address the rights and needs of children affected by HIV/AIDS; however, many of them deal solely with material aid, such as school fees and food supplies. In this study, the low levels of the support made orphans vulnerable to HIV/AIDS, perhaps because of the magnitude of the orphan problems in Kenya (K'Oyugi and Muita, 2002).

Previously, it was reported that programs that offer social support for orphans and vulnerable children, including peer support groups, recreational activities and counseling are widespread in Africa (http://www.usafriends.org/about.html). Those who offer support to communities affected by HIV/AIDS have found that the early programs, which focused specifically on children whose parents died of AIDS, often missed other vulnerable children, such as those who are at high risk of becoming orphaned by AIDS (because their parents have HIV), those who live in households with children orphaned by AIDS, and those who may have been orphaned from other causes (like war or disease) are equally vulnerable. Additionally, in many communities it is often not known who has HIV/AIDS and who does not, due to struggling health care infrastructures and minimal HIV/AIDS testing. As a result, many of the assistance networks, including UNICEF, UNAIDS and USAID, develop

programs that serve the needs of the most vulnerable children in areas seriously affected by HIV/AIDS, many of whom are children orphaned by AIDS.

In this study most of the social support programmes that were in place were not enough to support the children basic needs such as food, shelter, clothing, education and health care. It has been reported that in contexts of extreme poverty in which basic living needs such as food, shelter and clean water are not guaranteed through adequate social support, psychosocial problems can be seen as secondary to physical health and the other basic physical needs of living (Foster, 2002). However, based on the response of the guardians, the government played a minor role in supporting the HIV/AIDS orphans in Kenya. It has been reported that some caretakers, while offering minimal care, are using children to benefit from the government orphan packages (UN Office for the Coordination of Humanitarian Affairs, 2003).

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The study sought to establish the effects of challenges faced by the by HIV/AIDS orphans on their psychosocial status in Wareng District. The following conclusions were made in this study.

There were several psychosocial problems among the orphans in Wareng District but the most common ones were depression, trauma, stress, seclusion and grief. It was also concluded that the levels of psychosocial problems was high for many of the orphans in Wareng District both in Kapseret and Kesses Divisions.

There were high levels of economic problems experienced by the HIV/AIDS orphans ranging from poor living conditions and lack of basic needs such as food, shelter, clothing and education. Increased levels of economic problems were also established to significantly increase the levels of psychosocial problems among the HIV/AIDS affected orphans.

The levels of social problems among the orphans were found to be high and were mainly associated with changed social behaviour of the children through seclusion. Secondary effects of social problems were found to be associated with alcohol, smoking of cigarettes and bhang. It was further established that increased levels of social problems significantly increased the levels of psychosocial problems among the orphans.

Finally, this study established presence of social support programmes, which provided low levels of support to the orphans to enable them meet part of the basic needs such

as food, education and medical care. The levels of social support were low but increased levels of social support resulted in significant reduction in the psychosocial problems among the orphans.

6.2 Recommendations of the study

The following recommendations were made by the study:

1. A comprehensive update on the issues that bring psychological trauma, stress and depression such as discrimination of the children should be addressed by HIV/AIDS physicians and other healthcare practitioners working with HIV-infected persons through regular anti-discriminatory campaigns and provide a chance to treat such children to reduce their psychological risks
2. Guidance and counselling of the orphans and children who are not orphans on the needs to associate with each other would be an important step in stemming the social problems. This can be done in special sessions in schools through collaboration between the community members, government leaders and teachers.
3. All stakeholders in the society must now join hands to provide economic support to the orphans. This can be done through government and private sector led actions such as compensation for the families that take good care of the orphans including their basic needs and psychosocial needs.
4. While there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members, therefore there should be deliberate measures for the HIV/AIDS advocates and guardians to educate the public on ways to help these children cope with stressful situation and therefore reduce their psychosocial problems.

6.3 Recommendation for further research

It is recommended that future studies should involve more detailed analysis of the methods of diagnosis and treatments of psychological condition in children to determine the adequacies in treatment methodologies in reducing psychological problems.

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APPENDICES

Appendix i: Orphans interview schedule

Demographic Data of Respondents				
1.1	**Age**	[a] 12	[d] 15	
		[b] 13	[e] 16	
		[c] 14	[f] 17	
1.2	Sex	[a] Female	[b] Male	
1.3	Religion	[a] Protestant	[c] Muslim	
		[b] Catholic	[Other (Specify)	
1.4	What age were you when your parents died?		[a]	
1.5	Category of orphan	[a] Orphans living with fathers only		
		[b] Orphans living with mothers only		
		[c] Orphans living with grandparents		
		[d] Orphans living with other relatives		
		[e] Orphans living on their own (child-headed families)		
1.6	Level of education	[a] None		
		[b] Primary		
		[c] Secondary		
		[d] College		
		[e] Other (Specify)		
1.7	If living on your own how do you meet daily needs.(more than one response acceptable)	[a] Working		
		[b] Relatives		
		[c] Getting from well wishers		
		[d] From neighbours		
		[e] From voluntary organizations		
		[f] AMPATH project		
		[g] Others please specify		
1.8	If working in No. 6 above what type of work do you do?	[a]		
		[b]		
1.9	If working in No. 6 above how much do you earn per month?	[a] KShs.		
1.10	How many brothers and sisters do you have?	[a] Brothers		
		[b] Sisters		
1.11	How many brothers and sisters do you live with in the same house?	[a] Brothers		
		[b] Sisters		
1.12	If not all; where are the others?	[a]		
		[b]		
		[c]		
		[d]		
1.13	What do they do?	Boys	[a] Working	
			[b] Schools	
			[c] At Home	
		Girls	[a] Working	
			[b] Schools	
			[c] At Home	

1.14	Are you going to school	[a] Yes
		[b] No
1.15	If in school who pays for the requirements?	[a] Self
		[b] Relative
		[c] Friend
		[d] Voluntary Organization
		[e] Government
		[f] Others (specify)
1.16	Occupation of guardian (more than one response applicable)	[a] Unemployed
		[b] Farmer
		[c] Salaried Employee
		[d] Business
		[e] Others (specify)
1.17	Who is the head of your household?	[a] Self
		[b] Brother
		[c] Sister
		[d] Others please specify
Psychological problem		
1.18	What difference does it make now that your parents are not alive?	[a]Not able to meet our basic needs
		[b] Dropped out of school
		[c] A lot of responsibilities
		[d] Others please specify
1.19	Do you think you find meaning in live?	[a] Yes
		[b] No
1.20	Do you feel that your life has a meaning?	[a] Yes
		[b] No
1.21	Are you bothered about the future?	[a] Yes
		[b] No
1.22	Do you feel bothered by your attachment to others?	[a] Yes
		[b] No
1.23	What do you like best in your current life?	[a]
		[b]
1.24	What worries you most in your life?	[a]
		[b]
Health care		
1.25	In the last three months did you have a health problem?	[a] Yes
		[b] No
1.26	Did you go to hospital?	[a] Yes
		[b] No
1.27	If not what were the reasons?	[a] Did not feel very bad
		[b] Did not have transport to the hospital
		[c] Did not have somebody to take me to the hospital
		[d] Did not have money for hospital fee
		[e] Others please specify
1.28	If you went to the hospital who took you?	[a] Guardian

		[b] Self
		[c] Other (specify)
1.29	what types of problems have you been experiencing since the death of your parents? *(More than one response acceptable)*	[a] Physical problems
		[b] Psychological problems
		[c] Social-economic problems
		[d] Others please specify
1.30	In the past three weeks how often have been pre occupied with your problems?	[a] All the time
		[b] Often
		[c] Several times
		[d] None of the time
1.31	In the past three weeks have you felt significantly different form everyone and everything around you?	[a] Yes
		[b] No
1.32	In the last three weeks how often have you felt sad and unhappy?	[a] All the time
		[b] Often
		[c] Several times
		[d] None of the time
1.33	Do you feel frustrated about anything in your life?	[a] Yes
		[b] No
1.34	If yes what? Please specify	[a]
		[b]
		[c]
		[d]
1.35	Did you have to move from where you lived with your parents?	[a] Yes
		[b] No
1.36	If yes in above How satisfied are you with your current Home compared to where you were lived with your parents?	[a] Not at all
		[b] A little
		[c] A moderate amount
		[d] Very much
		[e] An extreme amount
1.37	Since your parents died how many different home have you lived in?	[a]
Income		
1.38	Is your guardian able to me*et al*l of your needs?	[a] Yes
		[b] No
1.39	Are you worried that your guardian might not be able to meet your needs in future?	[a] Yes
		[b] No
1.40	Who buys clothes for you and your siblings?	[a] Self
		[b] Relative
		[c] Friend
		[d] Other Voluntary Organization
		[e] AMPATH
		[f] Government
		[g] Others please specify
1.41	In the last three months have you ever been out of school?	[a] Yes
		[b] No

1.42	What were the reasons?	[a] Did not have fair to school	
		[b] Did not feel like attending the class	
		[c] Did not have school fees	
		[d] My siblings were sick	
		[e] Did not have food in the house	
		[f] Others please specify	
1.43	Have you ever gone without food?	[a] Yes	
		[b] No	
1.44	If yes, in the last three weeks how many times did you go without food?	[a]	
1.45	What were the reasons?	[a] No money to buy food	
		[b] No body to prepare food.	
		[c] No fuel to cook food	
		[d] Denied food	
		[e] Others please specify	
1.46	What do you like most about the guardian you stay with?	[a]	
		[b]	
1.47	What do you not like about the guardian you stay with?	[a]	
		[b]	
Relationship problems			
1.48	Do you feel that your guardian understand you	[a] Yes	
		[b] No	
1.49	How easy is it for you to go out and play with others?	[a] Very easy	
		[b] Moderate	
		[c] Not easy	
1.50	Do you feel people avoid you?	[a] Yes	
		[b] No	
1.51	Do you feel people are unkind to you?	[a] Yes	
		[b] No	
1.52	How comfortable are you being around other people?	[a] Not at all	
		[b] A little	
		[c] A moderate amount	
		[d] Very much	
		[e] An extreme amount	
Substance use and abuse			
1.53	Which of the substances below do you take?	Alcohol	[a] Yes
			[b] No
		Cigarette	[a] Yes
			[b] No
		Marijuana	[a] Yes
			[b] No
		Others	[a] Yes
			[b] No
1.54	What are the reasons for smoking?	[a] To forget my problems	
		[b] Disagreement with the guardian	
		[c] Others	

1.55	What are the reasons for drinking/taking drugs?	[a] To forget my problems
		[b] Disagreement with the guardian
		[c] Others
1.56	How often do you drink/take drugs?	[a] Once per week
		[b] Twice per week
		[c] Thrice per week
		[d] More than thrice per week
1.57	If yes in 53 above have you ever had problems due to drunkenness/taking drugs?	[a] Yes
		[b] No
1.58	What problems?	[a]
		[b]
		[c]
		[d]
1.59	Do you have a problem in controlling your drinking habit?	[a] Yes
		[b] No
1.60	Do you feel guilty after drinking?	[a] Yes
		[b] No
1.61	Have you ever had health problems because of you drinking?	[a] Yes
		[b] No
1.62	Have you ever had problem with your guardian because of drinking habit?	[a] Yes
		[b] No

Appendix ii: Guardians questionnaires

Demographic Data of Respondents			
1.1	Age		[a] Years
1.2	What is your relationship with the orphans under your custody?		[a]
1.3	Sex	[a] Female	[b] Male
1.4	Religion	[a] Protestant	[c] Muslim
		[b] Catholic	[Other (Specify)
1.5	Level of education	[a] None	
		[b] Primary	
		[c] Secondary	
		[d] College	
		[e] University	
		[f] Other (Specify)	
1.6	Occupation	[a] Unemployed	
		[b] Farmer	
		[c] Salaried Employee	
		[d] Business	
		e] Others please specify	
1.7	The level of income		[a] KShs.
1.8	Do you receive any other form of income from elsewhere?		[a] Yes
			[b] No
1.9	If Yes, specify the sources	[a]	
		[b]	
Section B: Socioeconomic			
1.10	How many own children do you have?		[a]
1.11	How many own children are you living with?		[a]
1.12	How many orphans are you supporting currently?		[a]
1.13	Do you own land?	[a] Yes	
		[b] No	
1.14	What is the size of your land?	[a] Less than 1 acre	
		[b] Between 1 – 5 acres	
		[c] 5 – 10 acres	
		[d] 15 - 20 acres	
		[e] Over 20 acres	
1.15	Do you own any livestock?	[a] Yes	
		[b] No	
1.16	If yes, which ones and how many?	[a] Cattle	
		[b] Goats	
		[c] Sheep	
		[d] Pigs	
		[e] Birds (chicken, turkey ducks)	
		[f] Others (specify)	

1.17	How do you utilize the farm produce?	[a] Sell
		[b] Food
		[c] Both
1.18	Did orphans parents leave any property behind?	[a] Yes
		[b] No
1.19	If yes, what kind of property?	[a] Land
		[b] House
		[c] Vehicles
		[d] Money
		[e] Animals
		[f] Others (specify)
1.20	Who is responsible for the property at the moment?	[a] Me
		[b] Children
		[c] Others (specify)
1.21	Are you receiving any income from the property?	[a] Yes
		[b] No
1.22	If yes how much?	[a] KShs.
	Are the children aware of the existence of the property?	[a] Yes
		[b] No
Section C: Education Access		
1.23	How many own children are you educating?	[a]
1.24	How many orphaned children are you educating?	[a]
1.25	In the last six months have the children ever missed school?	[a]
1.26	If yes, why?	[a] Lack of money to buy school uniform
		[b] Lack of fare to school
		[c] They remain to take care of home
		[d] They go to work so that they can get money for food
		[e] Others (specify)
Section D: Nutrition		
1.27	Where do you get your food?	[a] Own farm
		[b] Market
		[c] Through Aid
		[d] Others (specify)
1.28	Are the foods from the above mentioned source enough?	[a] Yes
		[b] No
1.29	If No, where do you get the supplement?	[a]
		[b]
		[c]
		[d]
1.30	Is any child on mineral or vitamin supplement?	[a] Yes
		[b] No
1.31	In the last three days has anyone in your family	[a] Yes

	gone without food?		[b] No
1.32	If yes what were the reason?	[a]	
		[b]	
		[c]	
		[d]	
Section E: Medical Care			
1.33	How often does the orphan(s) under your care fall sick?	[a] Rarely	
		[b] At least once every 3 months	
		[c] Once per month	
1.34	What problems do you encounter in accessing medical care?	[a] Financial	
		[b] Distance	
		[c] Health personnel/workers	
		[d] Drugs	
		[d] Others (Specify)	
1.35	When the orphan(s) become sick, who pays for the health care?	[a] They get free treatment from the health facility	
		[b] I pay for them since they are under my care	
		[c] Other (specify)	
1.36	Do you expect the orphans to contribute towards their upkeep?		[a] Yes
			[b] No
Section F. Psychological Care			
1.37	After the death their parent(s), how frequent do you notice the following in the child(ren)?	Unhappiness	[a] Most of the time
			[b] Often
			[c] Sometimes
		Sense of hopelessness	[a] Most of the time
			[b] Often
			[c] Sometimes
		Crying spells	[a] Most of the time
			[b] Often
			[c] Sometimes
		Loss of religious faith	[a] Most of the time
			[b] Often
			[c] Sometimes
		Self-blame	[a] Most of the time
			[b] Often
			[c] Sometimes
		Lack of confidence	[a] Most of the time
			[b] Often
			[c] Sometimes
		Low energy and easily get tired	[a] Most of the time
			[b] Often

			[c] Sometimes
		Loss of appetite	[a] Most of the time
			[b] Often
			[c] Sometimes
		Loss of weight	[a] Most of the time
			[b] Often
			[c] Sometimes
		Insomnia	[a] Most of the time
			[b] Often
			[c] Sometimes
		Temper tantrums	[a] Most of the time
			[b] Often
			[c] Sometimes
		Complains of headache	[a] Most of the time
			[b] Often
			[c] Sometimes
		Doesn't play/associate with the other children	[a] Most of the time
			[b] Often
			[c] Sometimes

Appendix iii: Ethical clearance form for the research

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471/2/3

MOI UNIVERSITY
SCHOOL OF MEDICINE
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

Reference: IREC/2009/63
Approval Number: 000403

1st June, 2009

Mary W. Chege,
Moi University,
School of Public Health,
P.O. Box 4606- 30100,
ELDORET.

Dear Mrs. Chege,

RE: FORMAL APPROVAL

The Institutional Research and Ethics Committee have reviewed your research proposal titled:

"Psycho-Social Challenges Experienced by HIV and AIDS Orphans: A Case Study of Uasin-Gishu District, Kapsaret Division".

Your proposal has been granted a Formal Approval Number: **FAN: IREC 000403** on 1st June, 2009. You are therefore permitted to continue with your study.

Note that this approval is for 1 year; it will thus expire on 30th May, 2010. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to IREC Secretariat two months prior to expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you must notify the Committee of any proposal change (s) or amendment (s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The Committee expects to receive a final report at the end of the study.

Yours Sincerely,

PROF. D. NGARE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
APPROVED
01 JUN 2009
P.O. Box 4606 ELDORET

cc: Director - MTRH
Dean - SOM
Dean - SPH
Dean - SOD