

**THE PSYCHOSOCIAL ISSUES OF ORPHANED YOUTH BY HIV/AIDS IN
WESTERN KENYA**

**Submitted by
Lucy Irene Kiyapi, MTS**

**A thesis submitted in partial fulfillment of the requirements of the degree of
Doctor of Philosophy**

**National School of Psychology
Faculty of Art & Sciences**

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March 2007

Statement of Sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

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This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees.

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Abstract

Despite the elaborate intervention strategies and huge emphasis on AIDS and orphanhood, there is a looming danger that might create a lost generation of young people who are growing up without role models, parental guidance, warmth, love and proper care. Young people in these times of AIDS are charged with the responsibility of caring for their infected parents until they die; and thereafter to care for their siblings. Despite playing these important roles coupled with their complex developmental issues young people face as they negotiate their independence towards adulthood, there is generally a lack of concern as far as the psychosocial issues experienced by youth who are orphaned due to AIDS is concerned as evidenced by paucity of published literature. This research therefore, focused on the psychosocial issues of youth orphaned by HIV/AIDS in Western Kenya.

This comparative study compared youth who have lost their parent(s) to AIDS, to those who have lost parent(s) through other causes and youth from intact families. The study explored the daily hassles and uplifts as experienced by these three categories. Their psychological well-being was studied in a bid to understand how this phenomenon has impacted on the orphaned young people emotional well-being. The extent to which self-efficacy (resilience), perceived social support and good coping strategies buffer young people from HIV/AIDS impact were studied.

Data was obtained from 156 students at the Moi University. One way ANOVA test used to test the mean hassles and mean uplifts scores revealed there were not significantly different across the participants' status. Investigations to determine whether the mean scores for anxiety, self esteem, and depression depend on participants' status; a further one way ANOVA was carried out, which revealed based on overall F-test the mean self esteem and

depression scores are significantly different at 5% level of significant. A pair- wise Pearson correlation was performed to investigate whether anxiety, depression and self esteem scores depend on the coping skills, self-efficacy and perceived social support. Results indicate depression significantly associated with social support, while self esteem is significantly associated with self-efficacy. The qualitative data further validated these findings by revealing that orphaned youth by AIDS were depressed and had poor self-esteem.

Dedication

This study is dedicated to all orphaned children and youth by HIV/AIDS in Kenya and the world over.

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Abbreviations

ACU	AIDS control unit
AIDS	Acquired immunodeficiency syndrome
AMPATH	Academic Model for Prevention and Treatment of HIV/AIDS
BSS	Behavioral Surveillance Survey
CACC	Constituency AIDS Control Committees
CBO	Community – based organization
CDC	Centers for Disease Control and Prevention (of USA)
DFID	Department for International Development
DTC	District Technical Committees
FHI	Family Health International
GoK	Government of Kenya
GoUK	Government of United Kingdom
HELB	Higher Education Loans Board
HIV	Human immunodeficiency virus
IPRSP	Interim Poverty Reduction Strategy Paper
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research
MAP	Multi Country AIDS Project
MOH	Ministry of Health
MHA	Ministry of Home Affairs
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program

PEPFAR	US President's Emergency Plan for AIDS Relief
REPSSI	Regional Psychosocial Support Initiative
UN	United Nations
UNAID	Joint United Nations Program for HIV and AIDS
UNICEF	United Nations Children Education Fund
UNGASS	United Nations General Assembly Special Session on AIDS
USAID	United States Agency for International Development
USD	United States dollar
WHO	World Health Organization

TABLE OF CONTENT

**THE PSYCHOSOCIAL ISSUES OF ORPHANED YOUTH BY HIV/AIDS IN
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Statement of Sources	ii
Abstract.....	iii
Dedication	v
Abbreviations	viii
TABLE OF CONTENT	x
List of Tables and Figures.....	xviii
CHAPTER 1: INTRODUCTION	1
Definitions of Key Terms.....	3
The Study Justification.....	10
Background Information on HIV/AIDS	12
Statement of Research Problem	18
Hampered by weak social infra-structures and generally poor economies, developing countries in which HIV/AIDS has reached pandemic proportions, most of which are in Sub-Saharan Africa have often relied on donor funding to deal with the situation. Admittedly, there is a huge influx of funds channeled to respond to HIV/AIDS problems and many countries have established well funded national HIV/AIDS agencies. In Kenya, for example, all HIV/AIDS programs are coordinated by the National AIDS Control Council which receives massive donor support and disburses these funds through an elaborate system of government, non-governmental and local community organizations.....	20
Overall, current HIV/AIDS intervention strategies are largely directed at creating awareness, and for the most part tend to be reactive rather than well designed proactive initiatives showing a clear understanding of the needs of those affected. However what is of greater concern is the rather “scatter-gun approach” to addressing the HIV/AIDS situation in the country, i.e., the simplistic view that if more economic resources are provided the HIV/AIDS affected population – hence the plethora of agencies purporting to do HIV/AIDS work in the country - the issue is being addressed. Although considerable clinical research has been undertaken by the University of Nairobi and Moi University, in collaboration with overseas universities, there is no systematic research available on psychosocial impacts of HIV/AIDS on orphaned young people.	20

The manifestations of the problem among college students and the approaches used to help them are no different from those of general population. There is still the dominant and naïve view that orphaned young people attending college need mainly to be given financial support in the form of bursaries or scholarships to complete their education so that in turn they can secure employment and be able to financially assist their siblings. The reality, however, is different as many of the affected students have dropped out of college or as in a large number of cases spend many years traumatized through the university education and consequently end up performing only marginally in their academic work. To adequately understand and meet the needs of these young people, it is paramount to view their problems holistically, incorporating the physical, mental, emotional, spiritual and social dimensions (Mukwaya & Kamali, 2002). Viewing orphans' issues strictly in terms of physical and/or economic needs is clearly inadequate and may not be helpful in the end. 20

A psychosocial assessment of orphan issues would identify other needs beyond the physical thus giving a more realistic analysis of their situation in totality (Dane, 1997). The current study sought to document and establishes a psychosocial perspective of HIV/AIDS orphans among college-going young people in Kenya. A comparative study was carried out to compare students that are affected and those that are not. The study of resilience has shown that some people function competently despite noticeable risks and adverse conditions (Masten, Ann, Hubbard, Gest, Tellegen, Garnezy & Ramirez 1999). However, several other studies have uncovered a core set of factors that have consistently been shown to promote competence despite adversity. These factors include self-efficacy, relationships with caring pro-social others, and having good problem solving skills (Masten & Costworth, 1988). This study will explore this link by assessing the role of self-efficacy, social connections and the ability to problem solve in aiding the orphaned student to surmount their challenge..... 21

Study Objectives 21

This study attempted: 21

- 1) To highlight through literature search and review the stressors that affects the young people orphaned by AIDS and their impact on their psychosocial well being..... 22
- 2) To identify the risk factors these young people may be exposed to due to their circumstances. 22
- 3) To analyze and examine the extent to which self-efficacy, perceived social support and coping mechanisms buffer the orphaned students from the negative effects of orphan hood..... 22

Hypotheses	22
It was hypothesized that	22
I. Youth orphaned by HIV/AIDS will have more life hassles than life uplifts.....	22
II. Youth orphaned by HIV/AIDS will exhibit high levels of anxiety, will have poor self-esteem and be depressed.....	22
III. Youth orphaned by HIV/AIDS who have high levels of self-efficacy strong social supports (to family, caregivers, peers, significant others) who have good coping skills, will display few negative symptoms (low depression, low anxiety, high self-esteem.	22
CHAPTER 2: LITERATURE REVIEW	23
The Psychosocial Stressors Experienced by HIV/AIDS Orphans	23
<i>Economic deprivation</i>	<i>23</i>
<i>School attendance and performance</i>	<i>25</i>
<i>Multiple losses.....</i>	<i>28</i>
<i>Stigma and discrimination</i>	<i>31</i>
<i>Psychosocial adjustment of adolescents orphaned by AIDS</i>	<i>37</i>
<i>Risk factors for young people orphaned by HIV/AIDS.....</i>	<i>38</i>
Self-Efficacy, Problem Solving Skills and Perceived Social Support.....	39
<i>Self-efficacy.....</i>	<i>39</i>
<i>Perceived self- efficacy and adaptation</i>	<i>42</i>
<i>Coping strategies</i>	<i>43</i>
<i>Perceived social support</i>	<i>46</i>
<i>Providing psychosocial support to affected youth.....</i>	<i>47</i>
<i>Providing youth orphaned by AIDS with life and survival skills.....</i>	<i>48</i>
<i>Community support</i>	<i>48</i>
<i>Supporting cooperative activities</i>	<i>49</i>
CHAPTER 3: RESEARCH METHOD	51
Sampling Survey: Population of Interest.....	51
<i>Selection and methods</i>	<i>52</i>
The Survey Instruments	53
<i>Hassles and uplift scale (HUS)</i>	<i>53</i>
<i>State-Trait Anxiety Scale(STAI)</i>	<i>53</i>
<i>The Zung self rating depression scale(ZSDS)</i>	<i>53</i>
<i>Rosenberg self-esteem scale (RSE)</i>	<i>54</i>
<i>General self-efficacy scale(GSES)</i>	<i>54</i>
Problem-solving skills were assessed by a modified Ways of Coping Scale (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). This instrument was used to assess the participants' capabilities with regard to problem-solving behaviors and attitudes. The WOC uses 4-point Likert-type items (identifying if the statement is true, moderately true, barely true, and not at all true). Three subscales measure problem-solving confidence style (self-assurance while engaging in problem-solving activities), approach-avoidance style (a general tendency to either approach or avoid problem-solving activities), and personal control (the extent of control one feels they have over emotions and behavior while solving problems).According to research done by DeLongis & Gruen, 1999, among African – American, WOC scale was reported as having an internal reliability ranging from .70 to .90	55
<i>Multidimensional Scale of Perceived Social Support (MSPSS)</i>	<i>55</i>

Social support was assessed using the Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet, Dahlem, Zimet, and Farley (1988). This scale assesses participants' beliefs about a set of statements that tap the perceived social support from family, friends and significant others. Responses range from very strongly disagree to very strongly agree. The instrument also assesses the ability of the respondent to reach out for the available support at their disposal and the awareness of the need for such support. This instrument was selected for this study because it is easy to understand and accesses information on support that is central to the study. Researchers have reported this scale as having an internal reliability rating ranging from .81 to .93 (Zimet & Farley (2003).....	55
Procedure	56
<i>The pilot study</i>	56
The in-Depth Inquiry.....	58
<i>Rationale</i>	58
<i>Sub-sampling for in-depth interviews</i>	59
Research assistants utilized in administering the survey instruments were also utilized in this process of identifying and carrying out the interviews. Participants who returned their questionnaires and had indicated their parent(s) had died of AIDS were requested to further participate in the interview if they so wished. However, some declined to take part highlighting fear of stigmatization while others expressed their inability to relive their experiences saying that it was too painful to talk about their dead parent or parents. Even those who participated were reluctant and uneasy sharing freely about their parents' illness and family situation. This situation made it necessary to persuade and at the same time assure them that this information would not be labeled just as the questionnaire was anonymous so as to protect the participants. Due to this data collected from interviews was analyzed separately from that gathered from the survey.	59
Because the matter under investigation was very sensitive and the possibility of the participants becoming distressed was real, referral procedures were put in place to address any such eventualities. Twelve referrals were made to the student counseling clinics for support and follow- up.....	59
<i>The interviews</i>	59
CHAPTER 4: RESULTS.....	62
Quantitative Study.....	62
<i>Demographics and population attributes</i>	62
Table 1: Sample characteristics.....	63
Table 2: T-test results between hassle and uplift.....	64
Fig 1: Average (Hassles and Uplifts) for single and double orphans.....	65
<i>One-way ANOVA results</i>	65
Table 3: One-way analysis of variance results (Hassles vis-à-vis uplifts)	65
Fig 2: Average (Hassles and Uplifts) for various orphan categories	66
Table 4: One way ANOVA results for anxiety, self-esteem and depression....	66
Fig 3: Average anxiety scores against orphan categories	67
Fig 4: Average depression scores against orphan categories	68
<i>Pearson correlation coefficients matrices (hypothesis 3)</i>	68

Table 5: Non-orphans.....	68
Table 6: Single non-AIDS orphans	69
Table 7: Double non-AIDS orphans.....	69
Table 8: Double-AIDS orphans	70
Table 9: Single-AIDS orphans.....	70
Qualitative Study.....	70
Table 10: Economic themes	71
<i>Difficulties in meeting basic needs</i>	<i>72</i>
Table 11: Psychological themes	74
<i>Assumed parental roles</i>	<i>74</i>
<i>Frustrations encountered in securing parents' retirement benefits and inheritance</i>	<i>76</i>
<i>Need for love and Care</i>	<i>78</i>
<i>Negative outcome</i>	<i>79</i>
<i>Positive outcome</i>	<i>81</i>
Table 12: Social support themes.....	83
<i>Extended family support.....</i>	<i>84</i>
<i>Community support</i>	<i>84</i>
CHAPTER 5: DISCUSSION, CONCLUSIONS AND	
RECOMMENDATIONS	87
Discussion	87
<i>Life hassles and life uplifts</i>	<i>90</i>
<i>Self-Esteem.....</i>	<i>92</i>
<i>Depression.....</i>	<i>94</i>
<i>Anxiety.....</i>	<i>96</i>
<i>Coping skills/ self-efficacy/perceived social support</i>	<i>97</i>
Study Conclusions.....	101
<i>Self-efficacy.....</i>	<i>101</i>
<i>Depression and poor self-esteem</i>	<i>102</i>
<i>Social support and coping skills.....</i>	<i>102</i>
Study Limitations	103
Recommendations	104
<i>Practical implications of the study.....</i>	<i>104</i>
Gaps identified in the study	105
REFERENCES.....	106

APPENDIX A: Information Letter To Participants (Interviews).....	112
APPENDIX B: Consent Form - Participant's Copy.....	114
APPENDIX C: Consent Form - Researcher's Copy	115
APPENDIX D: Ethics Approval Letter From Queensland	116
APPENDIX E: Ethics Approval Letter From Moi University	117
APPENDIX F: Questionnaire.....	118
APPENDIX G: Summary of Narrative from the Participants	133
Case 2:	133
Case 3:	134
Mother died 1996-AIDS	134
Case 6:	136

List of Tables and Figures

List Tables

Table 1: Sample characteristics.....	63
Table 2: T-test results between hassle and uplift	64
Table 3: One-way analysis of variance results (Hassles vis-à-vis uplifts).....	65
Table 4: One way ANOVA results for anxiety, self-esteem and depression	66
Table 5: Non-orphans.....	68
Table 6: Single non-AIDS orphans	69
Table 7: Double non-AIDS orphans.....	69
Table 8: Double-AIDS orphans.....	70
Table 9: Single-AIDS orphans	70
Table 10: Economic themes	71
Table 11: Psychological themes	74
Table 12: Social support themes	83

List Figures

Fig 1: Average (Hassles and Uplifts) for single and double orphans.....	65
Fig 2: Average (Hassles and Uplifts) for various orphan categories	66
Fig 3: Average anxiety scores against orphan categories	67
Fig 4: Average depression scores against orphan categories	68

CHAPTER 1: INTRODUCTION

Scholars and international agencies interested with the well fair of orphaned children by AIDS have identified five key action areas and provided operational guidance to governments and other stakeholders as they respond to the needs of orphans. These actions included a) strengthening the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support, b) mobilizing and support community – based responses, c) ensuring that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities, and finally d) raising awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS (UNAIDS/UNICEF, 2004). However, one observes with concern that youth of ages (18-24) have been left out by such strategies yet youth in this times of AIDS bear the largest burden of providing care and support to their affected family members. These strategies are excellent initiatives and will in no doubt provide excellent results if and when they embrace all stakeholders involved in providing care for the infected and affected by HIV/AIDS.

Young people who have lost one or both parents have multifaceted needs and particularly in this era of AIDS. Youth orphaned require different kinds of support different from that given to children because their needs are more complex due to the physical and psychological development as they move towards independence and adulthood. Also, during this time of AIDS, youth who have lost their parents to AIDS are charged with the responsibilities of caring for their sibling thus assuming the parental role early before they have matured enough to handle such a responsibility meaningfully. This experience is traumatizing and stressful as reported by Rotheram, Stein and Lin (2001) in their study on the impact of parent's death and an intervention on the adjustment of

adolescent whose parents have HIV/AIDS which utilized the Harvard Trauma Questionnaire. Though this study was carried out in America among the African – American and the Hispania; literature from the African thresh hood though limited those specific to children orphaned by HIV/AIDS have similarly highlighted traumatic experiences which include separation from family members, lack of food and shelter, loss of property to extended family members, sexual abuse and forced labor (Sengendo & Nambi 1997; Stein 2003). These experiences has been found to impact on the youth's psychological well being negatively. Further, this experience hinders the affected young people from exploiting their full potential as far as their careers are concerned and denies them the opportunity to associate with other young people because of the burden placed on their shoulders. Those who remain in school end up performing poorly due to psychological stresses arising from the uncertainty of raising siblings without secure resources coupled with the academic rigor (Human Rights Watch, 2001).

Further, 55% of the world's population is estimated to be young people between the age of 14 -20 yrs (UNAIDS, 2000a). In Kenya the population of young people age 14 - 20 yrs is estimated at 40% of the total population (MHA, 2003); with the majority of these living with the impact of HIV/AIDS (MHA, 2003) it is therefore necessary that government and agencies understand the impact of AIDS in youths in order to formulate strategies and mechanisms that will best address the needs of the young people who are orphaned and made vulnerable by AIDS.

This study reports on the finding of the research carried out in Moi University in Western Kenya between the months of September 2005 and May 2006. The participants of the study were undergraduate youth (students) enrolled in the academic year 2005/2006. This comparative study was aimed at assisting in discovering the psychosocial issues of youth orphaned by HIV/AIDS in comparison to youth orphaned due to other causes and non-orphans.

This study examined the construct of anxiety, depression, self esteem of youth orphaned by AIDS and the role of self efficacy, social support and coping strategies.

Definitions of Key Terms

Orphan

The focus group in this study was youth between ages 18 to 24, which is generally the age bracket for students attending university (undergraduate) in Kenya. Due to the stigma associated with usage of the word ‘AIDS orphans’ this study will avoid such usage and will use instead ‘youth orphaned by AIDS’. Orphans infected with HIV/AIDS will not be included in this study because of their unique challenges and needs which should be addressed separately. For purposes of this study, “youth” is used to refer more generally to “teenage years -young adults range, and specifically to age bracket defined above i.e. 18-24 years.

The term “orphan” is used more liberally to include young people bereft of one or parents or care givers and/or any person bereft of protection and economic advantage because of lose of the parent or guardian. Although the age of becoming an adult in Kenya is legally set at age 18 years, “young people” remain dependent on their parents/guardians through college education and in some cases beyond because of weak national social security and economic infrastructure.

Hence, to a large extent, college students are still as dependent on their parents as those at primary or high school level education. In this study “child or children” may refer both to conventional biological age as well as age of economic dependence on the parent or caregiver and therefore literature on the subject under investigation will not necessarily be confined to an exclusive age bracket and will draw from available empirical evidence. Double orphan is used to mean youth who have lost both parents while single orphan is used to refer to orphans that have lost one parent.

Stress

Stressful life experiences constitute a potential threat to the well – being and healthy development of children and youth. Increasing large numbers of young people are faced with stressful experiences that include acute traumatic events, adversity such as the death of a loved one or both parents and the accumulation of stressful life events and daily hassles (Garnezy & Rutter, 1994).

Examples of traumatic experiences that threaten the well – being of children and youth include natural and human disasters (Azarian & Skriptchenko – Gregorian, 1998), victimization through sexual and physical abuse, exposure to neighborhood violence and chronic stress in children's lives that include poverty and economic hardship (Mcloyd & Wilson, 1998); personal or parental chronic illness, maltreatment or neglect and cumulative life events and daily hassles both normative(e.g. caught in a traffic jam) and non normative events(e.g. death of a family member) Manly, Cicchetti & Brnett, 1997).

Understanding the role of stressors in the lives of orphaned children and youth by HIV/AIDS has both theoretical and practical significance. At the theoretical level, prevailing models of child and adolescent psychopathology recognize the potential importance of environmental stressors in the etiology and maintenance of both internalizing and externalizing disorders in youth (Grant & Compas, 2003), and at the practical level, numerous conditions pose threats to children and youth.

This is reflected in high levels of poverty, violence and family adversity; as well as in high rates of emotional and behavioral problems in young people (Grant et al., 2003). Children and youth are exposed to a host of stressors due their parents' illness and eventually when they lose the parents interventions to reduce HIV/AIDS orphans exposure to stressors and to enhance the adaptive capacities to manage life stressors should be made a priority.

Two approaches have been proposed as definition of stress which include;

- a) Exposure to environmental events (e.g. loss of a loved one, natural disaster, chronic conditions and poverty) that represent objective measurable changes in or characteristics of individuals' environmental conditions (Grant et al., 2003).
- b) Stress is further defined in the transactional models that view stress as a relationship between environmental events or conditions and individuals' cognitive appraisals of the degree and type of challenge, threat, harm or loss (Lazarus & Folkman, 1984). The transactional perspective states that the occurrences of stress is dependent on the degree to which individuals perceive environmental demands as threatening, challenging or harmful (Grant et al., 2003). One's experience of stress is therefore dependant on the person's interpretation of a given environment as taxing or exceeding his or her resources and endangering his or her well being. This model is limiting in the sense that cognitive appraisal processes are likely to vary greatly with development. For example, researches on stress during infancy indicate there are clear negative effects of maternal separation, abuse and neglect on infants (Field, 1995; Pollard, Blakley, Baker & Vigilante, 1995). The negatives occur presumably, without the cognitive appraisal component that is central to the transactional definition (Grant et al., 2003). Further, preliminary research indicates that cognitive appraisal processes, which play a significant role later in development, do not play the same role for young children exposed to stressors (Turner & Cole, 1994; Holmes & Rahe 1997). Therefore indicating stressors do occur independently of appraisal processes during some periods of childhood and even adolescence.

This study adapts approach (a) where stress is seen in terms of the exposure to environmental events in this case the HIV/AIDS (chronic condition), the death of a

loved one and the resultant poverty. These experiences represent ‘objective’ measurable changes in or characteristics of individuals’ environmental conditions. Further, this study adapts the theoretical models of the etiology of developmental psychopathology where greater emphasis is on mediating and moderating processes that influence or explain the relation between stressors and psychopathology.

This study examines the relationship between the psychological well – being (anxiety, depression, self esteem of youth orphaned by AIDS, and the role of self efficacy, social support and positive coping strategies as moderating the impacts of the AIDS pandemic.

The cumulative stressors that impact the affected youth after a parent(s) or caregiver is diagnosed with HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) the resultant deaths and the psychosocial issues that arise as the orphaned youth adapts to the new circumstances will be explored. The moderating measure of self efficacy, the perceived support and the positive coping strategies were examined.

Depression

Depression is classified as feeling sad, frustrated and hopeless about life, accompanied by loss of pleasure in most activities and disturbances in sleep, appetite and lack of concentration and energy (Polite et al., 2004). Also observed is that internalized stress can cause anxiety, depression and poor self esteem. Further cognitive models of depression emphasize that negative cognition or maladaptive belief system as diatheses in the initiation and continuation of depressive symptoms. In the depression debate, two central theories have received considerable empirical support in both adults and among children and adolescents. Both the hopelessness theory by (Abramson, 2002) and Beck’s

(1967) cognitive theory propose that individuals who attribute negative life events to global and stable causes and who perceive disastrous consequences from such events and who infer negative characteristics about self as vulnerable to depression when confronted with life experiences (Abela & Sarin, 2002). Beck's cognitive theory on the other hand proposes that negative views of the self, the world and the future, the negative cognitive triad serve as a possible cause for depression in the face of negative life events. The multiple stresses and risk factors experienced by youth whose parent(s) or caregiver are affected by HIV/AIDS that include fear, worrying, observing and caring for ill parents in pain, social stigmatization, hospital visitation, shattered hope and eventually the death of a parent(s) or caregiver (Wild, 2001). These effects have the potential to cause anxiety, poor self esteem and depression (Germann, 2001).

Self esteem

Self esteem is defined as a positive or negative orientation towards oneself; an overall evaluation of one's worth or value. Self esteem is one component of self concept, which has been defined as "totality of the individual's thoughts and feelings with reference to himself as an object" (Rosenberg, 1989). The cognitive theories have not only considered thoughts about oneself but also ones' self worth (McCarthy, 2007). This model proposes that persons with depression are likely to have a poor self esteem. Abramson et al., (2002) test on this model with children and youth (age 7-21) reported a strong support for cognitive diathesis for depression among children and adolescents, further suggesting a strong correlation between depression and self esteem not only among adults but also among children and youth. Although this models was formulated for a different cultural setting, children and youth orphaned by HIV/AIDS who have been reported as being depressed have been found to have a poor self – esteem (Sengendo & Nambi, 2004); Germann, 2001).

Anxiety

Spielberger (1985), defines state anxiety as the actual emotional responsiveness or anxiety that one individual experiences at the present moment. Trait anxiety is defined as the tendency one perceives in several situations as threatening or dangerous. As noted in the depression and self esteem models that have found a strong relationship between these two constructs, anxiety and depression have been found to have equally a strong correlation. This was established in a test of the tripartite model of anxiety and depression in elementary and high school of boys and girls. This study established there exist a strong relationship between anxiety and depression with correlations between self report measures of anxiety from .50 to .70 and with as many as two thirds of anxious or depressed children having a co morbid diagnosis of depression or anxiety (Heather, 2004). This model views symptoms of anxiety and depression along three broad dimensions. The first general affective distress or negative affective (NA) is associated with both depression and anxiety. The second physiological hyper arousal (PH) is specific to anxiety; and the third, a lack of positive affect (PA), is specifically associated with depression (Clark & Watson, 1991). Nonspecific shared symptoms of negative affect are thought to explain the strong association between measures of anxiety and depression (Watson, 1995). This construct is measured here to establish the where youth orphaned by HIV/AIDS are anxious.

Self- efficacy

The construct of self- efficacy reflects an optimistic self belief, this is the belief that one can perform novel or difficult tasks, or cope with adversity in various domains of human functioning; self- efficacy facilitates goal setting, effort investment, persistence in the face of barriers and recovery from setbacks (Creer & Wigel, 1993). Self-efficacy can

give a person certain beliefs that they can accomplish certain behaviours and that they have control of certain situation in their environment (Bandura, 2001).

Albert Bandura is credited with creating the theory of self-efficacy. Bandura (1993) created self-efficacy theory to see how people perceive their work or obstacles. According to Bandura self-efficacy can influence people in terms of how they feel, what motivates them, and the kind of behaviors they display. The concept of self-efficacy is actually part of our self system. Self-efficacy can regulate behavior in three distinct ways. First it can affect *cognition*, if a person has high self-efficacy they are more likely to have higher aspirations, take on more challenging task and feel confident in completing those tasks. Secondly, self efficacy affects *motivation*. With a moderate to high self-efficacy people can become motivated in believing they can accomplish certain goals. Self-efficacy can directly influence the type of goals that a person sets based on what they believe they can accomplish and the amount of effort they believe they will have to put forth (Bandura, 1997). Third, self-efficacy can have some effect on a person's mood or affect. Self-efficacy can relate to a person's coping ability. When encountered with stress of difficult situations a person with high self-efficacy will be able to handle the risk and the stress by making their environment less threatening. Those with low self-efficacy may have trouble managing the stressful situations because of their lack of belief in their ability to control what is going on around them (Bandura, 2001).

Coping

Conceptualization of coping styles is inconsistent between studies. Some researchers emphasize the empirical methods, such as explanatory factors analysis, to classify coping styles and theoretical approaches. One widely used theoretical model that has been appraised as the measurement of adolescent coping and distinguishes between 'engagement' coping and the 'disengagement' coping. (Daniel, et al., 2007). Engagement coping involves coping responses that acknowledge thought and emotions while

disengagement involves responses which disassociates from thoughts and emotions.

Engagement coping is viewed as a more adaptive behavior. This study has enhanced the engagement coping theoretical approach as the one responsible for the positive outcome described in the result section.

Social support

Social support is the positive and harmonious interpersonal interactions that occur within social relationships (Boyd, 2005). Social support is the process and the social networks within which support occurs. Social support serves three functions:

- i) Emotional support contributes to a personal feeling of being cared for or loved.
- ii) Tangible support provides a person with additional resources for example direct aid such as loans, gifts services such as taking care of someone who is ill, doing a job or chore.
- iii) Information support helps a person view situations in a new light, e.g. providing information or advice and giving feedback about how a person is doing.

University students were chosen for this study for two main reasons. First, they comprise a literate population, more versed with the HIV/AIDS problem and therefore more likely to provide reliable information. Secondly and more importantly, it is possible that some of the current students were orphaned by AIDS some years prior when they were children and this study particularly sought to document such cases to reveal how they coped with the situation in a more detailed way.

The Study Justification

The United Nations (UN) has a basic framework of actions for working with orphans and vulnerable children affected by HIV/AIDS (UNAIDS/UNICEF, 2004). It adopted the framework through a collaborative process with donors, UN agencies,

foundations, NGOs, faith based organizations, academic and research institutions and other civil society organization. This framework was further endorsed by the UNAIDS Committee of Cosponsoring Organizations and included five key strategies (UNAIDS/UNICEF, 2004). However, there is definitely a shortfall in such a framework because youth orphaned by AIDS and who are key players in the role of care providing are left out yet, they are in need of help both physically, emotionally and economically. Youth in these times of HIV/AIDS are bearing the bigger burden of caring for their sick parents, accompanying their parents to hospitals and administering the drugs, spending sleepless nights caring for the sick in their families until the parent(s) die. Orphaned youths are responsible for providing food in their households and as well attending to their schoolwork. There is therefore enormous pressure and demands exerted on these young people that require concerned agencies, and governments to come to their aid. The majority in this predicament are still in school/colleges and end up performing poorly while others drop from school altogether.

There is a lack of empirical literature that highlights the psychosocial adjustment of orphans and other vulnerable youths as a priority for research and intervention (Bray, 2003; Foster, 1997; Geballe & Gruendal, 1995). There is also limited research conducted in sub-Saharan Africa on psychosocial issues of youth and specifically related to HIV/AIDS in particular. The few published studies include some discussion of psychosocial issues as part of a broader investigation of the circumstances and experiences of AIDS orphans, but not devoted to this area of study per se (Stein, 2003; Wild, 2001).

A large proportion of these studies lack a control or a comparison group comparing the adjustment of children or youths affected by AIDS with that of unaffected youth from the same community on psychosocial issues (Germann, 2004; Wild, 2001). The importance of such a group cannot be overemphasized. Any change of behavior observed in youth orphaned by HIV/AIDS can only be verified by investigating a

comparison group from the same community before any conclusions are made. The current study conducted a comparative study of youth (students) who were orphaned due to AIDS and compared the psychosocial impact and resilience to those who were not orphans and those who were orphaned through causes other than AIDS.

Wild observes that despite the methodological limitations of many studies there is nonetheless, sufficient data available to give us a good clear picture of some of the major stressors facing youth affected by HIV/AIDS (Wild, 2001). The primary purpose of the current study is to add to the body of knowledge on the youth orphaned by AIDS' phenomenon to inform policy development and the creation of interventions and mechanisms that effectively address the orphaned youth problem. To this end the study explored the daily hassles and uplifts experienced by the orphaned youths, their psychological and emotional well-being, and the extent to which self-efficacy (resilience) and good coping strategies have aided in coping and in shaping a better future outlook. This study also examined the role played by family and community support in mitigating the negative impact of AIDS on the orphaned youths. The above theoretical framework was used to underscore the importance of resilience as the trait responsible in assisting the orphaned youth manage to negotiate their extremely difficult circumstances as stated by Panter –Brisk, (2003), who argued that a helpful counterpart to the risk discourse is to focus attention on the resilience of those who manage to negotiate such difficulties.

Background Information on HIV/AIDS

The growing crisis of HIV/AIDS in sub-Sahara countries poses many challenges. The epidemic continues to expand affecting adults, children and youth resulting in unique social and economic consequences. World wide, it is estimated that about 18 million people have died of AIDS and roughly 32 million are currently infected with HIV. About 70% are estimated to live in Africa (UNAIDS, 2000a); by the end of 2005, almost 25 million people in this region were living with HIV. Two million adults and children have

died of AIDS (UNICEF, 2006). In sub-Saharan Africa, AIDS is the leading cause of death among adults ages 15-59. Although the total number of orphans from all causes in Asia and in Latin America and Caribbean since 1990 has been decreasing, the number of orphans from all causes has risen by more than 50 % in sub-Saharan Africa, where an estimated 12 million children and youth have lost one or both parents to AIDS. This makes the region home to 80 % of the children and youth in the developing world who have lost a parent to the disease (UNICEF, 2006).

The HIV/AIDS in Kenya

The first case of HIV was diagnosed in Kenya in 1984, but concrete response on the part of the government came only years later (NASCOP, 2003). The Department for International Development (DFID) and the British government aid ministry, noted with concern that Kenya was notoriously slow to admit to its HIV/AIDS problem. These bodies took upon themselves to pressurize the government to demonstrate high-level political commitment (GoUK, 2001). The first national policy statement on AIDS came with the Kenyan parliament's adoption of its Session Paper number 4 in 1997 which made recommendations for program implementation.

In November 1999, President Moi declared HIV/AIDS a national disaster, his first major public statement on the subject (Russell, 1999). By then, an estimated one in every nine sexually active persons in the country was infected. The government quickly established an inter-ministerial NACC to develop strategies for controlling the spread of the disease (GoUK, 2001).

Today Kenya is ranked ninth highest HIV prevalence rate in the world (UNAIDS, 2000a). It was estimated 500 persons died every day from AIDS in 1999, while experts in Kenya now use the figure of 600 deaths or more per day (The Kenya Daily Nation News Paper, May 31, 2001). About 75 % of the deaths from AIDS in Kenya so far have occurred in adults aged 18-49 years though HIV/AIDS remain shrouded in denial and silence in

much of Kenya, which complicates discussions of policy and legal measures to address the problem as well as the delivery of services to those affected (NASCOP, 2001).

HIV/AIDS has ravaged Kenya during a period of increases in the rate of poverty, in 1972, it was estimated that about 3-7 million Kenyans lived in poverty (defined as income level of less than U.S. \$1 per day). By the year 2000, that number had shot to 15 million or about 52 % of the total population as reported by the (IPRSP, 2000-2003).

Nyanza Province which has the highest poverty rate of 29% of its total population also records the highest poverty rate of 63% nationally, whereas in early 1990s Nyanza Province was among the least poor regions in the country (IPRSP, 2000-2003).

HIV/AIDS has contributed to the economic downturn in several ways. Agricultural sector employs about half the labor force in Kenya. In Nyanza Province alone, AIDS has reduced the workforce on agricultural estates by and estimated 30% (NASCOP, 2003). The World Bank estimated that in the year 2003, an average corporation in Kenya paid the equivalent of 8% of its profit for AIDS related costs such as worker absenteeism and funeral compensations (NASCOP, 2003). Further observed by the Policy Project of Future Group International is that average rural smallholder household loses between 58 and 78 % of its income following the death from AIDS of and economically active adult (Bollinger, Stover and Nalo, 2002). The loss suffered in the urban households is in the same range. The death of a second adult results in the loss of an estimated 116 to 117% of household income. This in many cases households end up in debts which in turn forces them to liquidate assets, withdraw children from school or send children away to live with relatives.

Similar to many other counties, there is controversy in Kenya over the number of orphans. In 1999, the UN estimated that there were about 750,000 children under age fifteen in Kenya who had lost their mother or both parents to AIDS since the beginning of

epidemic. Today it is estimated that there about 1.5 million orphaned children (UNICEF, 2005).

Social services, including those on which children rely, are gravely affected by HIV/AIDS. The Teachers Service Commission estimates a national shortage of about 14,000 teachers at the primary and secondary levels, attributed in large part to AIDS deaths among teachers (NASCOP, 2003). According to the Ministry of Education annual reports, a school in Kenya might easily have seven of eighteen teaching positions vacant because of attrition due to AIDS (Johnston & Muita, 2001).

The care and treatment needs of persons with AIDS have overwhelmed health services in some parts of the country, causing reduced access to services generally, including basic child health and survival services (NASCOP, 2003). One study estimated that by 2004 expenditures made to care for AIDS patients in government health facilities would be about the equivalent of the entire 1993-1994 Ministry of Health budget (Bollinger et al., 2002). It is only recently that under pressure from nongovernmental organizations, the government has begun to take measures to improve access to antiretroviral drugs for the vast majority of persons with AIDS in the country for whom these drugs are unaffordable. In June 2001, over stiff opposition by pharmaceutical companies, the Kenya Parliament passed the Industrial Properties Bill, which will allow the country to import and manufacture generic antiretroviral drugs (Reuter, June 12, 2001). In addition, the Minister of Finance that same year announced that tariffs on imported condoms would be removed to accelerate the fight against HIV/AIDS (The Kenya Daily Nation News Paper, June 15, 2001).

Though this research is not looking at gender disparity, it is important however to mention here a very important observation observed not only in Kenya but also in other countries fighting the HIV/AIDS. Girls are especially affected by the HIV/AIDS in Kenya. The rate of HIV infection in girls and young women from fifteen to twenty years old is

about six times as high as that of their male counterparts in the most heavily affected regions (NASCOP, 2003). Although there are biological reasons why HIV transmissions in this age group may be more efficient from male to female than in the opposite direction, biological reasons alone cannot account for a disparity this great. Several observers conclude that girls in this age group are catching the virus from older men, in many cases as a result of sex in which they engage to survive economically (Johnston & Muita, 2001). While one Kenyan girl in five reports that her first sexual experience is coerced or forced (Johnston & Muita, 2001).

Further, girls are more readily pulled out of school when someone in the household is ill with AIDS, as has been at after four years of primary school in heavily AIDS affected Nyanza Province, girls make up only 6 % of those who are promoted to grade five (Human Rights Watch, 2001), while in Eastern Province which has the lowest rate of HIV prevalence of Kenya provinces, 42 % of those passing into grade five are girls. The permanent secretary of the Ministry of Education attributed these disparities to AIDS and also noted that girls and boys passed through to grade five in roughly equal numbers twenty years ago before the epidemic's impact was felt (Human Rights Watch, 2001). Ministry of Education figures show the 72 % children orphaned by AIDS on Rusinga Island in western Kenya, girls from AIDS-affected households were less likely to be in school than boys (Johnston, Ferguson & Akoth, 1999; Williamson, 2004).

Wife inheritance is practiced among some groups in Kenya, particularly the Luo tribe in Nyanza Province. This practice, whereby a widow is taken in marriage by the brother or other relative of her deceased husband, traditionally provided protections to the widow and her children who might otherwise find themselves bereft of the social and economic support of a family (Buckley, 2001). In the era of HIV/AIDS, however, wife inheritance has been criticized by some government and community leaders as a means for spreading HIV/AIDS (Johnston et al., 1999). A study of AIDS-affected families on

Rusinga Island concluded that wife inheritance is losing its former popularity due to risk of AIDS infection but found that 77 % of women widowed by AIDS still remarried, of whom half were inherited by the brothers of their husbands (Buckley, 2001).

The war against HIV/AIDS is long and hard but Kenya has begun to see infections trends go downwards thanks to President Kibaki who declared a total war on AIDS (NASCOP, 2003). This act brought together ecumenical religious leaders who agreed to work together with the government to stop the spread of the killer disease. Groups such as the Constituency AIDS Control Committees (CACC) and the District Technical Committees (DTCs) embody this multi-sect oral response in partnership with the AIDS Control Units (ACUs) and civil society. Now Kenyans are involved in a comprehensive effort to confront all aspects of the disease's spread and impact. The government has put in place policies and infrastructure to help implement programs at all levels and issued guidelines for conducting activities in all HIV/AIDS-related areas.

Greater international and national commitment to address HIV and AIDS throughout the world has been seen through the United Nations General Assembly Special Session on AIDS (UNGASS), the Abuja Declaration, and the Millennium Development Goals. This commitment has led to greatly increased resources and internal support, including the World Bank Multi country AIDS Project (MAP), the Global Fund for AIDS, the US President's Emergency Plan for AIDS Relief (PEPFAR), the Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH) which is a corroboration initiative between Moi University and Indiana School of Medicine (IU) from which 42,000 HIV-positive Kenyans have benefited by receiving free treatment and free antiretroviral drugs and which has been nominated for the Nobel Peace Prize (Kenyan News Paper, April, 2007). The WHO 3 by 5 initiatives to place 3 million people on antiretroviral therapy (ART) by the end of 2005 has been a rallying cry for efforts to bring Africa and developing countries around the world into the treatment era for HIV and AIDS.

These combined efforts both by the international bodies and the government has seen the prevalence trends go down-wards. A study carried out by the Ministry of Health and the Kenya Demographic and Health Survey (KDHS, 2003) showed a significant reduction of the prevalence rates from the 10 % mark to 7 % in 2003 in adults and 6.1% in 2004. It is important to note here that all these corroborative initiatives are all geared to stalling the infection spread and treating the already infected. These strategic plans unfortunately ignored the orphaned children and youth of AIDS. Strategies on how to support them both physically and emotionally, how to keep them in school to minimize the risks of contracting HIV/AIDS, the risk of becoming Street children and youth, risks of having to engage in hazardous labor and the risk of suffering severe psychological consequences due to their difficult circumstances and must be addressed.

The impacts are felt in all spheres of human development having varying manifestations both in the psychosocial aspects of individuals affected and general economic development of the country. The situation is exacerbated by the fact that the disease is most prevalent among the more productive sectors of the population, youths and adults in the age bracket of (15-59). However, there is generally a lack of concern as far as the psychosocial aspects of children and youth orphaned by HIV/AIDS is concerned as evidenced by very little or virtually non-existent empirical literature focusing on the psychosocial adjustments of orphans and other vulnerable children and youth advanced as priority for research and intervention (Bray, 2003; Foster, 1997; Geballe & Gruendal, 1995).

Statement of Research Problem

While the visible face of HIV/AIDS dramatically highlights the social and the economic hardships of children and adolescents (the youth) whose right to basic needs are constantly violated, the psychosocial burden of the HIV/AIDS epidemic may seem less important, less urgent, and less compelling. However, to the affected individuals, it is

urgent and their psychosocial concerns are real and require urgent intervention. The emotional demands on young people whose parents have HIV/AIDS are many. Long before the parent dies, the adolescent experience trauma and stress related to caring for terminally ill parents (Bauman & Germann, 2004).

The impact of HIV/AIDS is linked to fear, economic insecurity and other stress factors frequently reported in other unfavorable family circumstances, such as divorce and domestic violence (Gow & Desmond, 2002). It has been observed that children and young people are particularly vulnerable, in that they are exposed to all these factors with little support to make sense of or to develop skills to manage such household situations (Humuliza, 1999; Rotheram-Borus & Stein, 1999).

The multiple stresses and risk factors experienced by children and adolescents whose parent(s) or caregiver(s) are affected by HIV/AIDS include fear, worrying, observing and caring for ill parents in pain, social stigmatization, hospital visitation, shattered hope and eventually the loss of parent or parents or caregiver. The effects of these experiences depend largely upon the individuals, their developmental stage how well they can respond to “difficulty-situations” (resilience), whether they feel they are part of the larger community, and whether they can rely on the community for support and comfort (Germann, 2004). Psychological and emotional effects are less obvious and often go unnoticed or are neglected. In the case of young adults, changed behavior may be dismissed as a mere transitional stage, or dismissed as a temporary disorder that will pass, rather than an indicator of psychological trauma with possible long-term implications (Humuliza, 1999).

In Kenya, how the orphans sustain their disrupted life after loss of their parent(s) is an extended family affair. Their situation is compounded by the fact that AIDS-related deaths in the communities have increased at an alarming rate. The increase in population of orphans has made it hard for families and communities to cope. The multiplication of

households headed by young children and adolescents within communities is an indicator of the magnitude of the problem (Foster, Makufa, Drew & Kralovec, 1997; Makame, Ani & Grandtham-McGregor, 2002).

Hampered by weak social infra-structures and generally poor economies, developing countries in which HIV/AIDS has reached pandemic proportions, most of which are in Sub-Saharan Africa have often relied on donor funding to deal with the situation. Admittedly, there is a huge influx of funds channeled to respond to HIV/AIDS problems and many countries have established well funded national HIV/AIDS agencies. In Kenya, for example, all HIV/AIDS programs are coordinated by the National AIDS Control Council which receives massive donor support and disburses these funds through an elaborate system of government, non-governmental and local community organizations.

Overall, current HIV/AIDS intervention strategies are largely directed at creating awareness, and for the most part tend to be reactive rather than well designed proactive initiatives showing a clear understanding of the needs of those affected. However what is of greater concern is the rather “scatter-gun approach” to addressing the HIV/AIDS situation in the country, i.e., the simplistic view that if more economic resources are provided the HIV/AIDS affected population – hence the plethora of agencies purporting to do HIV/AIDS work in the country - the issue is being addressed. Although considerable clinical research has been undertaken by the University of Nairobi and Moi University, in collaboration with overseas universities, there is no systematic research available on psychosocial impacts of HIV/AIDS on orphaned young people.

The manifestations of the problem among college students and the approaches used to help them are no different from those of general population. There is still the dominant and naïve view that orphaned young people attending college need mainly to be given financial support in the form of bursaries or scholarships to complete their education so that in turn they can secure employment and be able to financially assist their siblings. The

reality, however, is different as many of the affected students have dropped out of college or as in a large number of cases spend many years traumatized through the university education and consequently end up performing only marginally in their academic work. To adequately understand and meet the needs of these young people, it is paramount to view their problems holistically, incorporating the physical, mental, emotional, spiritual and social dimensions (Mukwaya & Kamali, 2002). Viewing orphans' issues strictly in terms of physical and/or economic needs is clearly inadequate and may not be helpful in the end.

A psychosocial assessment of orphan issues would identify other needs beyond the physical thus giving a more realistic analysis of their situation in totality (Dane, 1997). The current study sought to document and establishes a psychosocial perspective of HIV/AIDS orphans among college-going young people in Kenya. A comparative study was carried out to compare students that are affected and those that are not. The study of resilience has shown that some people function competently despite noticeable risks and adverse conditions (Masten, Ann, Hubbard, Gest, Tellegen, Garnezy & Ramirez 1999). However, several other studies have uncovered a core set of factors that have consistently been shown to promote competence despite adversity. These factors include self-efficacy, relationships with caring pro-social others, and having good problem solving skills (Masten & Costworth, 1988). This study will explore this link by assessing the role of self-efficacy, social connections and the ability to problem solve in aiding the orphaned student to surmount their challenge.

Study Objectives

This study attempted:

- 1) To highlight through literature search and review the stressors that affects the young people orphaned by AIDS and their impact on their psychosocial well being.
- 2) To identify the risk factors these young people may be exposed to due to their circumstances.
- 3) To analyze and examine the extent to which self-efficacy, perceived social support and coping mechanisms buffer the orphaned students from the negative effects of orphan hood.

Hypotheses

It was hypothesized that

- I. Youth orphaned by HIV/AIDS will have more life hassles than life uplifts.
- II. Youth orphaned by HIV/AIDS will exhibit high levels of anxiety, will have poor self-esteem and be depressed.
- III. Youth orphaned by HIV/AIDS who have high levels of self-efficacy strong social supports (to family, caregivers, peers, significant others) who have good coping skills, will display few negative symptoms (low depression, low anxiety, high self-esteem).

CHAPTER 2: LITERATURE REVIEW

The Psychosocial Stressors Experienced by HIV/AIDS Orphans

Death of a parent is considered a crisis for any child (Dane, 1997; Fleming, 1997). However, clinical reports indicate that the grieving process may be particularly difficult for children and adolescents orphaned by AIDS due to the material and psychological stress that often accompany the parent's illness and death (Wild, 2001). Manifestations of these are varied and may include some of the aspects outlined below.

Economic deprivation

The loss of social and family support (loss of family unit and associated natural economic, social and emotional safety net) is possibly the most important direct consequence of AIDS for children and adolescents (Bray, 2003; Foster et al., 1997). Household incomes decline when the breadwinner falls ill from HIV/AIDS and can no longer work full-time or at all. A study carried out to establish the socio-economic status of households with orphans compared to those households without orphans indicated that households with orphans were worse off than households without orphans (Seaman, & Narangui, 2004).

The cost of treating illnesses caused by HIV/AIDS places a huge economic burden on families. Further studies in urban households in Côte d'Ivoire show that when a family member has HIV/AIDS, the household spends four times as much on health care than unaffected households (Ankrah, 1993). It has also been shown that even after death, funeral expenses contribute to the toll exacted by AIDS. For instance, studies conducted in four provinces in South Africa, showed that households with a HIV/AIDS related deaths in the past year spent an average of one third of their annual income on funerals

(Stein, 2003; UNICEF, 2002). Furthermore, households caring for orphans are more likely to become poorer, because the same income will now have to be shared amongst more dependants. As the rate of HIV/AIDS infection continues to rise, with a corresponding increase in orphans, available resources (which are for the most part already scarce especially among populations in Sub-Saharan Africa) are stretched above the capacity of extended families and communities to handle the large numbers of orphans (Foster et al., 1997; Hunter, 1990; UNAIDS, 2003).

Consequently, some of the orphans end up staying in their parents' homes alone without any adult supervision. This is now commonly referred to as child-headed households or adolescent-headed households. Some may move into impoverished households with a grandparent who is retired from child-raising and who under normal circumstances should be receiving care and support by the extended family members. The HIV/AIDS pandemic is causing considerable damage to the social fabric where family member roles are reversed even in communities where strong, traditional social support systems existed. This has become a common phenomenon in the African rural landscape. In other cases, children who are without relatives, or whose relatives are unable to take them in, end up on the streets of urban centers (Hunter, 1990; UNAIDS, 2000b; UNICEF, 2002).

Adolescents orphaned by AIDS are therefore likely to be at higher risk of having inadequate access to food, shelter, clothing, and health care even as they take on the heavy burden of caring for their siblings after the death of their parents (Foster et al., 1997). Further, such situations make these young people vulnerable to abuse and exploitation (Foster et al., 1997; Gilbon, Nyonyintono & Wadda, 2001). The economic abuse of AIDS orphans, such as the grabbing of their inheritance, is also very common. Nyamukapa, Foster and Gregson (2003) cite a case in which a director of a home-based care program in Mpumalanga, in Zimbabwe, was quoted as having stated that if they did not get to the

children as soon as possible after loss of the parents, the orphans would lose their possessions and homes to neighbors and greedy relatives. A study on succession planning conducted in Uganda underscored the same problem: property grabbing is widespread with women and children being particularly vulnerable. Several widows indicated that property was taken from them when their husband died, while orphans of ages 13 to 18 reported having lost their property through grabbing (Gilbon et al., 2001). This practice further undermines the livelihood of households that are already weakened by the death of adult breadwinners.

Despite the overwhelming financial crisis most orphans face, the aspect of the psychosocial impact of HIV/AIDS on children and adolescents has been generally neglected (Foster & Germann, 2002; Fox, Oyos & Parker 2002; Wild, 2001). This is particularly worrying since any material intervention without addressing the psychosocial needs is unlikely to yield much success for the affected children and young people.

Comparative studies on children orphaned by HIV/AIDS and non-orphans done in Dar es Salaam, Tanzania, seem to suggest that orphans suffer significantly more hunger than non-orphans (Makame et al., 2002). However, Ainsworth and Over (1994) contradict this and suggest that orphans are not in-fact necessarily more vulnerable or disadvantaged than other children in equivalent contexts. Poverty is a stressor not only to orphaned children but to all who find themselves in such circumstances. This stressor could have negative effects on children and adolescents if not addressed.

School attendance and performance

In addition to the increased poverty, adolescents, particularly those from poor families and who are orphaned by AIDS, come under intense stress that may linger for the rest of their childhood. These children take on the heavy burden of nursing their ailing parents before their death and may miss or drop out of school. Added to this is the constant worry about their parent's well-being and the family's future (UNICEF, 2005).

Research carried out in Uganda to establish the impact of HIV/AIDS on the older children of people living with AIDS, showed that 26 % indicated that their attendance at school declined since their parents fell ill. Reasons given for poor school attendance is that they had to remain home to take care of their sick parent(s) or attend to household responsibilities and falling household incomes (Gilborn et al., 2001; UNICEF, 2002). A better picture is provided by data gathered from all countries south of Sahara in a study sponsored by UNICEF (2005). This study compared orphans' and non-orphans' attendance at school and found out that the number of orphaned children in attendance was lower than those of non-orphans. Absenteeism from school is motivated by a multitude of needs and concerns that the affected youth has to address on a daily basis in order to maintain a semblance of physical well being. It can also be explained due to apathy that may arise when one feels misunderstood by peers and the school administration. Research aimed at establishing the dimensions of the emerging orphans crisis in sub-Saharan Africa (Bicego, Rustein & Johnson, 2003), found that more than a quarter of orphans' performance had dropped significantly, partly because of the frequent interruptions, and partly due to the psychological stress arising from the sickness of their parent(s) or their caregiver. Bicego et al. (2003), further report that even for those orphans who manage to remain in school, it has been observed that they are more likely not to be in their appropriate grade. In this instance, due to ignorance on how HIV/AIDS is impacting on students' performance, the student is likely to be labeled as a low achiever. A consequence of this negative labeling is loss of one's self confidence resulting on poor self esteem which ultimately may cause the student to drop out of school.

Other studies (e.g., Monasch & Boerma (in press); Muller & Abbas, 1990; Nyambetha, Wandibba & Hansen, 2003), reveal that orphans in general are less likely to be attending school than non-orphans. This was corroborated by a study of 28 African countries (Ainsworth & Filmer, 2000) that observed that rates of enrollment for orphans

correlated poorly with the overall enrollment rate. In countries with moderate enrollment, there were significant gaps between enrollment for poor and non poor children, and poor orphans were more disadvantaged than other poor children. Recognizing the link between poverty and school attendance, the Kenyan government abolished fees and levies in all primary schools in 2003 to enable the many poor orphans access education – a move that saw a sharp rise in the enrollment. However, older children still opted to stay out of school so that they could work to provide for basic necessities for their siblings.

Some young people orphaned by HIV/AIDS not only drop out of school but are also forced by their circumstances to work so that they can provide for themselves and their siblings. This early entry into the labor force by children not only denies them childhood rights, but also exposes them to risks of exploitation such as working in hazardous jobs unsuitable for young children; early marriages; and dangers of becoming pregnant for young girls. There is also the risk of sex exploitation and abuse, the risk of contracting HIV and the danger of becoming prostitutes or commercial sex- workers, or street children and adolescents (Anarfi, 1997).

The experiences of loss of a parent, the insecurity and subsequent poverty arising from the loss, the looming danger of dropping out of school and having to look for food on a daily basis can be stressful to the young people. It can therefore be hypothesized that the impact of assuming parental responsibility, the diminishing dream of not ever going to school to learn and enhance their chances of acquiring a good job in future, the uncertainty of their future outcomes and facing life without one's parent(s) is traumatizing. This impact may cause internalized and externalized outcomes depending on how the child is socialized. Successful psychosocial adjustment into adulthood of HIV/AIDS orphans could be the single most evident manifestation of resilience in such individuals. Thus a sampling of orphan college level students who have endured varying degrees of

deprivation and loss (depending on age or stage at which bereavement occurred) could be revealing indeed.

Multiple losses

As HIV is transmitted sexually, young people who lose one parent to AIDS will most likely lose the other parent as well (Dane, 1997; Wild, 2001). Young siblings who may be infected through the mother may also die. Once a parent dies, children are likely to be moved from the family home and may be moved from their school to another, thus depriving them of friendship and neighborhood networks and familiar environment (Dane, 1997; Wild, 2001).

The extended family may find it difficult to take in and support all the orphans left behind by their relatives when they die. For them to adequately give good care and quality support, both financially and emotionally, it becomes necessary to separate the sibling and place them in the larger extended family network and /or even into foster homes. This separation of siblings from each other is reported as difficult to adjust to and very traumatizing. Geballe, Gruendel and Andiman (1995) explain that orphans at this point need each other for comfort and for their emotional strength.

Given the high prevalence of HIV in the community, orphans are likely to experience other losses as relatives die. This is a common experience in Kenya among the tribes that practice wife inheritance (Nyambedha et al., 2003). Also when care giving is by elderly grandparents, chances are that the grand mother has only a few years to live exposing the orphans to further loss. Exposing children and adolescents to multiple losses threatens their emotional well-being during the course of change in the household, both before and after the parent dies. In a densely populated slum area of Korogocho in Nairobi, Kenya, aside from economic deprivation, orphans identified other needs as love, care, guidance, friendship and recreation (Human Rights Watch, 2001). Generally, it is observed that children and adolescents who lose their mother suffer immense grief over

the loss of love and nurturing, whilst the loss of the father is more directly related to a decline in their standard of living (Fox et al., 2002).

In many instances, dying is not discussed with young people, so they are left to draw their own conclusions as to what is happening until the time when the parent dies, causing them to lose their sense of security. Where only one parent remains, the children may live in fear of losing the remaining parent.

Death is not something that can be avoided altogether. Children and young people can see the changes that are taking place in their family but may feel helpless because they cannot change anything, making them feel anxious, guilty, depressed and helpless. Since no one seems to understand them, they tend to internalize their emotions, and given that children and young people are not generally encouraged to talk about themselves and to express how they feel, when given the opportunity they often have trouble verbalizing their emotions (Dane, 1997; Fox et al., 2002). Yet grief that is not expressed can manifest itself in various negative ways including nightmares, intrusive thoughts, somatic complaints, decreased self-esteem and anxiety (Makame et al., 2002).

When death occurs, the slow process of grieving begins. During this period, the grieving child or adolescent is faced with turmoil of emotions; life can seem meaningless and there can be a constant feeling of anxiety. When the cause of death is AIDS, the difficulties experienced can be compounded by stigmatization and guilt of the parents having died from HIV/AIDS. Denial of the presence of the virus is common in families that are affected by HIV/AIDS. Fear and stigma also contribute to denial, which can result in the reluctance to disclose the illness to children or other family members. However, in some cases it has been observed that denial can be healthy because it can act as a buffer that allows patients to remain focused on living and on the tasks of living (Alubo, 2000).

These multiple losses experienced by children and the young people could lead to internalized emotions (depression anxiety, and poor self-esteem) and/or externalized

emotions such as dysfunctional behaviors (Makame et al., 2002). Bereavement literature, though not HIV/AIDS specific, admits that children who are old enough to understand that death is final are affected differently than those children and adolescents who do not have such understanding. Those who understand the finality of death seem to be affected less severely but may nonetheless have difficulty expressing themselves (Kubler-Ross, 1983).

Young peoples' grief is distinguished as different from the grief of children and adults. It has been noted that young peoples' grief experience is profoundly personal in nature, therefore making them grieve more intensely than adults (Muller & Abba, 1990). Their grief may be expressed in short outbursts or the adolescent may try very hard to control his emotions, believing that their experience is unique. This belief may lead them to either retreat into themselves by listening to music, reading, writing, or engage in sports, or remain angry, and/or involve them in antisocial behavior (Muller & Abbas, 1990).

Age is another factor that is critical for understanding adolescent bereavement and grief. The stage of their development determines how an adolescent will handle death when it occurs (Rosenberg, 1989). In a longitudinal study that examined the effects of parental death to adolescents, their developmental tasks of feeling in control, found out that the attaining a sense of mastery and being able to predict events were seriously compromised. The study established further that the grieved adolescents expressed more anxiety and fear over time. Other effects observed were that school performance dropped for some, while the majority said they were either depressed or had engaged in risk behavior, and a sizable number said they felt useless and did not wish to live (Sengendo & Nambia, 1997).

The capacity to think in abstract helps adolescents to move out of simplistic ways of thinking but their sense of fairness and justice does not help them make sense of the compromises that are demanded by the social context. Death can seriously affect the

adolescents' sense of fairness and justice, and especially in the case of traumatic death, such as death resulting from HIV/AIDS that seems to be indiscriminately killing everyone including innocent babies (Sengendo & Nambia, 1997).

The effects of bereavement on individuals vary, but whether or not they appear to be affected, the death of a parent always impacts significantly on the children and the young people. Psychological impacts can emerge at any time, even years after traumatic events, and can greatly reduce a child's or young peoples' ability to integrate into family and social activities. It is therefore necessary to identify factors that may hinder the processes of grieving because it is these hindrances that may cause dysfunctional outcome in children and adolescents. The loss of consistent nurturing from a parent may lead to developmental problems and the loss of guidance makes it more difficult for a child or adolescent to mature and adjust well (Fox, 2001).

The work of Raphael and colleagues (2000) on adolescent coping with grief after the death of a loved one established that adolescents who received support from the family, peers and social support adapted well to the loss of loved ones, while those who did not have such support were found to have low levels of self-esteem and were depressed, lonely and withdrawn (Raphael, Cubis, Dunne, Lewin & Kelly, 2000). Given the multiple stressors in their lives, Raphael et al. (2000) note that adolescents of parents living with AIDS may be at risk for unprotected sexual intercourse with more than one partner, they are likely to involve themselves in substance abuse and could likely have mental health problems. However, given that empirical evidence on adolescents bereaved by AIDS is non-existent (Siegel & Gorey, 1994), there is need for research to establish the psychosocial impact of HIV/AIDS on resilience to guide intervention strategies.

Stigma and discrimination

People with HIV/AIDS experience stigma in different ways and at different levels. From the family setting, the health clinics and the community as a whole, stigma and

discrimination are communicated in different forms but all are based on wrong or poor understanding of the mode of transmission of the HIV virus as reported by The East African Standard News Paper (May 12, 2006) where a an orphaned youth by HIV/AIDS and who was infected himself was hacked to death by his uncle when he went to his home to seek for help. Stigma can be defined as an act of identifying, labeling or attributing undesirable qualities, targeted towards those who are perceived as being deviant from a social ideal, and as an attribute that is significantly discrediting and used to set the affected persons or groups apart from the moralized social order. Discrimination can be defined as ‘an action or treatment based on the stigma and directed towards the stigmatized (Alonzo & Reynolds, 1995).

The negative attitude and judgment projected towards persons with AIDS, their partners and children, and rejection by their extended family, friends and by society at large, may lead the affected persons to withdraw from social support networks because of the ramification of disclosure (Herek & Glunt, 1999). In Kenya, for example, many would not admit that a relative had died from AIDS.

Orphans are perhaps the most tragic long-term legacy of the HIV/AIDS pandemic because even though HIV/AIDS infections are going down, the orphan population continues to rise. The stigma attached to HIV/AIDS exacerbates the trauma already experienced, and hampers the bereavement process due to the secrecy of AIDS deaths (Bond & Nubani, 2002). The bereaved in most cases lack the necessary emotional support because they would not want to disclose to other people their pain and sorrow for fear other people will learn the cause of their relatives’ death.

The non-resilient may resign and internalize their painful emotions which manifest in many forms as observed. In their study, Makame et al. (2002) showed that 90% of the orphans studied reported having been punished for breaking school rules as opposed to

only 26% non-orphans. This defiance could be arising from the underlying unmet emotional needs or from the fact that they have not completed their grieving process.

Mann J. (1987), former head of WHO's Global Program on AIDS, identified stigma as a 'third epidemic', the first two being the hidden but accelerating spread of HIV and the visible rise of AIDS cases. He recognized that stigma and discrimination, blame and collective denial were potentially the most difficult aspects of the HIV and AIDS epidemic to address, but pointed out that addressing these issues was the key to overcoming the challenges of stigma (Mann, 1987).

Stigma remains one of the most significant challenges in the battle against HIV/AIDS in Africa generally and it is especially the case in Kenya. People's fear of the repercussions attached to stigma makes them reluctant to want to know their HIV sero-status thus increasing vulnerability to HIV and worsening the impact of infection (Alubo, 2000). Fear of being identified with HIV keeps people from not only learning of their sero-status, but also from changing their behavior to prevent infecting others. This fear of association also prevents many from caring for people living with HIV and AIDS, and from accessing HIV and AIDS services (Bond & Nubani, 2002)..

There is a small but growing body of literature on HIV-related stigma in countries severely affected by HIV/AIDS. This literature has highlighted the experiences of people living with HIV and AIDS and the forms of stigma they encounter. The negative experiences associated with stigma occur for example in the workplace, in the hospital clinics, in schools and in the community (Alubo, 2000; Bond & Nubani, 2002; Maman, 2001).

Most recently, literature has turned toward stigma interventions. Brown (2003) reviewed 22 evaluated interventions, six in the developing countries and sixteen in developed countries, all of which sought to improve attitudes toward people with HIV and AIDS, and also to assess people's willingness to treat and care for people living with HIV

and AIDS or to improve the ability of people with HIV or AIDS to cope with stigma. These studies found mixed reactions to these intervention strategies. The reluctance to embrace these intervention strategies suggest people might not be convinced about the modes of transmission and so they do not want to take risks.

Research by Save the Children South Africa shows that children and adolescents experience two main forms of stigma and discrimination on the basis of HIV/AIDS: general stigmatization and isolation by families, communities and institutions within communities, e.g., churches, orphanages etc.; and discrimination by service providers in accessing rights and services (Save the Children South Africa, 2001).

Culturally, Kenyans have a strong tradition of extended family. But with the advent of HIV/AIDS, this social support system is breaking down because of the increase in numbers of the AIDS orphans, and the economic hard times. Orphans may be seen as adding to the burden of already overstretched meager resources. To avoid being seen as neglecting their responsibilities of caring for such children, the extended families may take up orphans only to mistreat them. Orphans are often stigmatized and blamed by relatives and guardians for the presumed promiscuity of their parents, for using the little money that there is, and for being potentially infected themselves. Some are abused verbally, physically and sexually. Orphans experiencing such abuse under their caregivers often see living on the street as a better option (Alubo, 2000).

One of the most severe consequences of stigma is that it impedes children's access to education. When care-giving families experience financial shortage, orphans are the first to be withdrawn from school. Girls may be taken in by relatives or sent to other households in exchange for household work or caring for other sick relatives or agricultural labor (Clay & Bond, 2005). These girls may be encouraged by their relatives to sell sex to earn money for food. The Zambart Research Project, in Zambia, investigated the experiences of 80 Zambian children aged 13 to 18 years (Haworth, 2000). This research

confirmed that orphaned children and youth are blamed by adults for things that go wrong in families that house them.

Orphans reported being given heavier tasks than other members of the family. Some reported not eating with other family members or living on leftover food and some go to bed hungry. These children are in most cases without parents and though most have a home, they spend much of the day on their own, isolated and neglected. This lack of affirmation, researchers believe, has a huge impact on children and young people's self-esteem and confidence, and its loss renders some children invisible (Clay & Bond, 2005; Germann, 2004). Despite schools providing the opportunity for development, peer play and interaction, they are not always a safe haven.

Young people infected and affected by HIV/AIDS are stigmatized and discriminated against in schools and institutions. A report run by one of Kenya's daily newspapers, The East African Standard, revealed how the education Minister in the Kenyan Government was sued by Nyumbani Orphanage for failing to admit orphans from this institution who are (HIV positive) to public primary schools (The East African Standard, July 9, 2003).

Among peers in school, some young people reported to the researchers incidents where orphans known to have lost their parents to AIDS had no friends, and in colleges no student was willing to share accommodation with an orphan known to have lost a relative to AIDS. A study in the National Children's Forum on stigma showed that about 97% of the participants perceived themselves as having no close friends (Germann, 2004).

Some studies carried out in Edinburgh, UK (Cree, 2003), on young adults who for a number of reasons had to take up the role of caring for their sibling or parent(s): either due to disability, chronic illness or alcohol abuse/drug abuse. The participants in the study reported a range of worries and problems, many of which were likely to have a serious effect on their overall well-being. Some of the worries highlighted in the study were about

the person they cared for, their own health, the behavior of the person they cared for, about their future, and about who would take care of them if they fell ill. The young people in this study worried about money whilst young people generally worry about money, this was compounded by financial difficulties attributed to being a care giver. As a result of their tight schedule, young people care- givers reported having no friends or being bullied. The bullying took many forms, verbal, physical or emotional abuse (Cree, 2003).

One interesting finding from the study was that young people surveyed felt the teachers did not seem to understand their difficulties or seemed not to care thus putting pressure on them that caused them considerable anxiety and stress.

Some participants reported that they found it hard to concentrate on their school work; others fell asleep in class, while others found school as a refuge, away from the worries and cares of their home. Emerging from the study is compelling evidence that seems to suggest that young people who take up care-giving responsibilities are under enormous pressures at a time in life when they are already predisposed to stresses emanating from their developmental changes occurring at this time. The added pressure has the capacity to affect their physical and emotional well-being, which may require specific attention from social practitioners.

Young people orphaned by Aids find themselves in a similar predicament of care-giving at a time when they are negotiating their developmental tasks. This, coupled with the new acquired roles and school pressures, could lead to enormous stress levels as they struggle to meet their daily demands. In a study of relatively young orphans (ages 10 to 14 years) conducted in Dar es Salaam, Tanzania, Makame et al. (2002), reported aggression which could likely be due to acting-out behavior of those who may be processing internalized emotions, or could also be attributed to discrimination or the failure of the institutions to understand orphans experiences and their emotional needs.

Psychosocial adjustment of adolescents orphaned by AIDS

Parental death in some cases reduces young people's self-esteem and increases depression, anxiety, conduct disturbances, academic difficulty, somatic complaints and poor behavior over time (Raphael et al 2000). Research carried out in USA with African American children has shown that children of parents with AIDS are at higher risk for long-term negative outcomes if their parents do not make custody plans (Rotheram-Borus, Stein & Lin, 2001). There has been little research on young people of parents with long-term chronic diseases in Africa. Studies that are HIV/AIDS specific and modeled to address adolescents and young adults in Africa are lacking.

The study by Rotheram-Borus et al., (2001) confirms the fact that adolescents with parents infected with AIDS do experience high levels of emotional distress, have multiple behavior problems and family related stress. These young people are also reported to have poorer self-esteem than adolescents who have non-infected parents and a happy family environment. The current study of psychosocial issues of orphaned students in Moi University investigated the unique experiences of young adolescents who have lost their parent or both parents to AIDS, to establish their vulnerabilities and whether they are at risk of poor psychosocial adjustment. Such young people endure the distress of nurturing their parent(s) through the illness before the parent(s) eventually die. They witness their pain, the distress and disfiguring of their physical bodies, and their eventual death. These young people have to face this reality alone in the absence of extended family to fall back on or supportive adults within the community, given that, unlike in developed countries, there is a non-existent social welfare support from the government that one can depend on.

The stresses experienced by adolescents who have lost their parent(s) to AIDS are likely to cause varied responses. There is no standard response, although reactions are likely to vary depending on the child's developmental level, personality and particular circumstances (Dane, 1997; Wild, 2001). Common reactions of young people to the

terminal illness or death of a parent include depression, hopelessness, suicidal tendencies, loneliness, anger, confusion, helplessness, anxiety and difficulties concentrating in school (Foster, 1997).

Risk factors for young people orphaned by HIV/AIDS

Young people in families with people suffering from HIV/AIDS are at risk of the inappropriate and premature assumption of adults' roles before they are emotionally or developmentally able to manage these roles successfully. Parenting their younger siblings, although many teenagers do this with great commitment and compassion takes a lot of their time and isolates them from their peer group (Hudis, 1995). Since the peer group provides most of the support during this developmental stage; the adolescent is consequently cut off from his or her support group (Hudis, 1995; Stein, 1999).

In addition to accepting enormous responsibility, the young person often feels alone, betrayed by relatives (including the deceased parent), and lonely. Loneliness at a time when support is needed weighs heavily on many young people. It makes them vulnerable to abuse of drugs and alcohol and other maladjusted behaviors (REPSSI, 2003). There are those who drop out permanently from college/University to look after their siblings and to earn a living, shattering their dreams and future hopes. For this reason many young people may feel hopeless and have no future aspirations. Stein (1999) observed that young people who due to HIV/AIDS have taken up parental roles may experience role strains in the short-term and have negative mental health consequences such as increased depression and substance abuse (Anarfi, 1997; Chesterfield, et al., 2001; Hudis, 1995).

Further, the potential risk of failing to address the need for psychosocial support among large populations of youth affected by HIV/AIDS can lead to secondary social problems such as rise in crime, violence, reduced literacy, high unemployment, homelessness, alcohol/drug abuse, forced migration, increased HIV infections,

exploitation and cheap labor. This may further lead to family disintegration, erosion of the extended family safety net, corrosion of culture, lack of parenting skills, destroyed social networks, lack of intergenerational mentoring and transfer of life skills, chronically traumatized adults and social-political conflicts (REPSSI, 2003). This would result in dysfunctional communities and societies. It could further lead to a breakdown of civil society, thus jeopardizing years of investment in national development; loss of security and stability at national levels, economic, political and societal instability (REPSSI, 2003), making it not only necessary to investigate and intervene in the psychosocial issues of orphaned youth by AIDS, but also it is an urgent matter.

Self-Efficacy, Problem Solving Skills and Perceived Social Support

Self-efficacy

Studies on youth who are homeless, refugees of war and from divorced families have indicated that despite their vulnerability and high risk situations, there are those youth who surmount their adversity and even thrive despite their challenging circumstances (Garmezy, 1993; Stein, 2003). To be able to develop effective intervention measures for youth affected by HIV/AIDS in schools/colleges/universities, a study of the resilient group may serve as a springboard for reaching out to the adversely affected.

Literatures on youth from divorced families, young refugees and homeless youth point out that young people who are resilient possess two important protective factors that are identified as internal and external resources. Stein (2003), in their twenty year study of competence and resilience in youth, discovered that youth who succeeded in the face of adversity had more internal and external resources. These youths were reported to be good problem solvers, active in daily life, had close adults in their lives who provided warmth and who placed high expectations on them in their studies and all other involvements.

They followed the prescribed rules, and were involved in activities at home, at school and in the communities. This group developed close friendships and had positive romantic relationships; this resilient group also was reported to have positive self-esteem.

Bandura and Jourden (1991) define self-efficacy as the individuals' belief in their capabilities to mobilize the motivation, cognitive resources and agency to exert control over a given event. It is the belief in one's capabilities to produce a certain outcome or achieve a certain goal. This is seen as the source or foundation of human agency: a belief that one maintains when facing an adverse event or challenge in their life, a belief that they will overcome, by controlling their thoughts and rejecting negative thoughts about self and their abilities (Ozer & Bandura, 1990).

Young orphans from the AIDS pandemic need this protective trait to enable them face and adjust to their challenging situations, particularly as they negotiate the risks and challenges associated with the transitional period of adolescence. Bandura & Jourden (1991) observe that success in this transitional stage is largely dependent on the strength of their perceived self-efficacy. Adolescents and young adults boost self-efficacy from affirming feedback received from peers, families and adults in their lives. This serves to reinforce individuals' self-efficacy beliefs and helps boost their confidence enabling them to face major challenges (Saarmi & Carolyn 1999).

Challenges such as war, parental divorce, chronic illness in the family, death of a loved one and poverty, become more tolerable when viewed as an opportunity for growth. The ability to master situations that are hard and challenging is evidence of self-efficacy (Bandura, 1995). Such success builds one's confidence and belief in personal efficacy (Masten & Coastworth, 1988). Self-efficacy does not just happen by chance. It involves the acquisition of the cognitive, behavioral, and self-regulatory tools for creating and employing appropriate courses of action to manage ever-changing life circumstances (Bandura, 1995).

When one overcomes obstacles through persistent efforts, this sense of mastery enables them to face future adversity and rebound from setbacks by sticking through tough times. This helps one emerge stronger from the adversity (Saarmi & Carolyn, 1999). Self-efficacy is equally modeled by role models or by encouragement from others who have excelled despite their difficult circumstances. Seeing people similar to themselves succeed by effort raises observers' beliefs that they too possess the capabilities to master similar situations (Bandura, 1995; Schunk, 1989). However, it is noted that by the same token, observing one fail despite high effort lowers observer's judgments of their own efficacy and undermines their level of motivation (Brown & Siegel, 1988).

Young people experiencing the death of parent(s) due to AIDS, divorce or homelessness, can draw strength from others who have had similar experiences. If for example, the mentor's way of coping with loss is through alcohol and drug taking or other maladaptive behaviors, most likely peers who follow them will adopt this maladaptive behavior as well. Where resilience is demonstrated and sustained there is likelihood of some young people adapting this model as well (Newcomb, Huba & Bentler, 1991).

Young people seek proficient models that possess the competencies to which they aspire (Bandura, 1995), models who excel through difficult situations, overcome life challenges, transmit knowledge and teach observers effective skills and strategies for managing environmental demands. The presence of such people in the communities helps to raise self-efficacy in young people who are not only experiencing the developmental transition but are also faced with multiple losses in their families and their communities due to the HIV/AIDS pandemic.

Another way of strengthening self-efficacy or beliefs is the idea that they possess what it takes to succeed, as appraised by others. Bandura (1995) refers to this as "social persuasion". Appraisal by others serves not only to move the subject to mobilize greater effort but also places on them high expectations. The realization by the individual that

people believe in them and the expectation of positive results acts as a motivator to persevere. To the effective person, challenges become motivators of high achievement and also serve as a measurement of one's limitations, therefore encouraging help-seeking from those who are perceived as potentially able to assist (Litt, 1988; Schunk, 1989).

Perceived self- efficacy and adaptation

In the context of stressful life transitions, general beliefs of efficacy may serve as a personal resource or vulnerability factor (Bandura, 1995; Schwarzer, 1992). Young people with a high sense of perceived efficacy trust their own capabilities to master different types of environmental demands. They tend to interpret demands and problems more as challenges than as threats or uncontrollable events. High perceived efficacy enables individuals to face stressful demands with confidence, feel motivated by physiological arousal, and judge positive events as caused by effort and negative events as due primarily to external circumstances (Bandura, 1995).

A generalized belief in one's efficacy serves as a resource factor that buffers against distressing experiences, fostering positive adaptation instead (Bandura, 1995). In contrast, individuals who are characterized by low perceived efficacy are prone to self-doubts, anxiety arousal, fear and poor coping mechanism when confronted with difficult situations and demands. Research on anxiety and self-related cognitions has demonstrated that a low sense of coping efficacy leaves people vulnerable to aversive experiences because they tend to worry, have weak task-specific competence expectations, interpret physiological arousal as indicative of anxiety, regard social feedback as evaluations of personal value, and feel more personally responsible for failure than for success (Brown & Siegel 1988; Carver & Cheiver, 1988; Jerusalem, 1990).

Difficult life situations under low sense of efficacy are accompanied by strong negative emotional reactions and somatic complaints, whereas a high sense of efficacy protects against psychological and physical harm (Jerusalem, 1990). Like other traits,

weak self-efficacy expectancies have numerous causes. A past failure, lack of supportive feedback, and attribution style of one's successes and failures by parents, teachers and peers may lead to the development of a tendency to scan the environment for potential dangers, to appraise demands as threatening and to cope with problems in dysfunctional ways (Jerusalem, 1990).

Perceived efficacy can change as a result of cumulative experiences in coping with complex demands (Jerusalem, 1990). Among the many difficulties that confront orphaned young people in Kenya include stressors that significantly threaten the quality of their lives, for example, loss of the family network because siblings are divided among the relatives in the extended families, loss of familiar friends and neighbors, social status, and economic power, and loss of inheritance to the extended family or unscrupulous neighbors (Ankrah, 1993; Humuliza, 1999; Stein, 2003). Other stressors include parentification where relatives are not forthcoming in adopting the orphaned children. Self-efficacy is therefore a necessary trait for the orphans to overcome their challenges.

As older orphans take the role of household head (Foster et al., 1997), they require a high sense of self-efficacy that will act as a resource to aid in coping. Youth are especially vulnerable to such detrimental psychological consequences because they still are striving to gain an established and valued position within the society (Jerusalem & Schwarzer, 1979). The long-term psychological consequences of orphanhood may include a sense of insecurity, helplessness, depression, anxiety and lowered self-esteem. These may however be buffered by perceived self-efficacy (Luthar, 1991; Luther, Suniya, Cicchetti, Dante & Becker, 2000).

Coping strategies

In Kenya the extended family network is seen and upheld as the traditional social security system and its members are responsible for the protection of the vulnerable and for providing care for the old, the poor and the sick. This family setting was in past times

responsible for transmission of traditional social values and education. In recent years, as in other African countries (Foster et al., 1997), this unit has disintegrated due to factors such as migration to urban towns and cities in search of paying jobs, and increase in population resulting in insufficient land resource to sustain the traditional large extended families making it necessary for families to migrate in search of land and pasture for their livelihoods and livestock. Labor migration and urbanization have led to a reduction in the frequency of contact with relatives and encouraged social and economic dependency, and possessions are no longer owned communally (Ayieko, 2000). Education about social values that was obtained through traditional mechanisms is no longer possible; the younger generation has to depend on interaction with peer in school/colleges (Ayeiko, 2001; Foster et al., 1997).

Despite the internal and external pressures exerted on the extended family network, this unit remains the predominant caring unit for sick relatives and orphans throughout Africa (Foster et al., 1997) and specifically Kenya. The extended family responsibility towards members of the family was without limit even where a family did not have sufficient resources. This was the basis of the assertion that traditionally ‘there is no such thing as an orphan in Africa.’ Even during the current crisis precipitated by HIV/AIDS, it is expected that orphans be under the supervision of an extended family member even when they are not adopted and not living under the same roof. This way of coping and adaptation to change and the challenge presented by AIDS, illustrates the strength, resilience and adaptability of extended family.

The phenomenon of child-headed households and youth-headed households appearing in communities affected by AIDS is an indication of saturation of the traditional extended family networks orphan coping mechanism (Foster et al., 1997; Ansell & Young, 2004). This development should be seen as a coping mechanism meant to address the orphan crisis within the communities and not an abandonment of their responsibility to

care for orphans with the family. In a study that analyzed the factors associated with the establishment of 43 child- and adolescent-headed households in Monicaland, Zimbabwe, Foster et al., (1997) observed that the extended families were supportive and paid regular visits and provided small amounts of material support. This coping strategy is commendable in that it kept the orphans together in their family home, enabling them to gain comfort from siblings and peers.

However, this coping mechanism may have serious flaws in the absence of an organized system that ensures proper care and protection. The orphans need emotional support and assurance; they need counseling and education on the new role as house-heads. They need support and encouragement to go on with school. The burden of household chores coupled with school work is stressful; youth orphans need direct interventions not only to sustain them in school but to minimize negative psychological impact such roles may have on the young person.

Strengthening the capacity of families is one way to address difficult psychosocial issues of orphaned youth. A study of psychological issues among 193 orphans in the Rakai district of Uganda looked at locus of control in orphaned children (age: 6-20 years), specifically between their external environment and their ability to adjust their behavior to it. Using in-depth interviews, including a 25 question depression index, the study found that about half of the orphans fell in the depressed range. The highest depression scores were among those living in child-headed households, emphasizing the need for a family connection. In reaction to their parents' deaths, 50 percent felt 'very sad and helpless,' while another 22 percent were too young to express themselves. The study reported that adolescents losing a parent are more likely to 'experience a special case of identity loss' (Sengendo & Nambia, 1997).

Atwine, Cantor-Graaea and Bajunirwe, (2005) in Uganda compared 123 orphaned children (age: 11-15 years) who had lost one or both parents to AIDS, and 110 children of

similar age and sex living in intact families in the same neighborhood. Symptoms of psychological distress were assessed using the Beck Youth Inventories of Emotional and Social Impairment. A multivariate analysis of factors with possible relevance for outcomes on these inventories found that orphan status was the best predictor of distress. Orphans had greater risk for higher levels of anxiety, depression and anger. The study further observed that the children had both fears and hopes about their future. Some children feared that their lives would be worthless now that they did not have their parents' support and protection. Most felt pessimistic about the future; while one fifth of the participants expressed the strongest hope if and when they get a good job in future, others hoped they could complete their education or attend vocational education. Among the interventions recommended in the study is providing training in psychosocial support to the community leaders, enabling the orphans to talk about their experiences and developing peer support networks with other youth in the community.

Perceived social support

When a household begins to feel the effects of HIV/AIDS, families provide the most immediate source of support: psychological, economical and social (Foster & Jiwli, 2001). Families are the best hope for orphans, but they require support from outside sources for both immediate survival needs and the longer term. It is therefore important to assist building the capacity of families to improve their economic standing, provide psychosocial support to the affected orphans and other caregivers and strengthen the young people's life skills. The capacity of families to protect the rights of orphans and vulnerable in their care depends largely on their economic strength. Possible interventions should aim to enhance the economic resiliency of the household, such initiatives as conditional cash transfer, insurance mechanisms, direct subsidies and material assistance can help alleviate the urgent needs of the most vulnerable households (Landgren, 2005).

Long term interventions should include studying closely what was left behind by their departed parents and assist the orphans to increase family production in terms of land and livestock, and provision of professional advice on how to access a micro-credit to start small business, for those who cannot continue with school/college. Vocational training should be made available as well for those orphaned youth who have been made to drop schooling to provide for their households.

Providing psychosocial support to affected youth

Interventions to orphans due to HIV/AIDS tend to focus on education and material needs and ignore the psychological needs. These needs are in most cases misunderstood and are difficult to assess.

HIV/AIDS undermines and destroys the fundamental human attachments to normal family life and youth development as observed by Foster & Jiwli (2001), Levine and Foster (2000). Youth affected by HIV/AIDS suffer fear and anxiety during parental illness then grief and trauma with the death of a parent. These problems are further compounded by traditional taboos surrounding discussion of AIDS and death. Youth orphaned by AIDS cannot cope without support; they need plenty of opportunity to express their feelings without fear of stigma, discrimination or exclusion (Foster & Jiwli, 2001; Levine & Foster, 2000; REPSSI, 2003).

Programs addressing the psychosocial needs of youth orphans should be incorporated into other programs/activities. Peer support, individual counseling and group approaches are needed. The school counseling and social welfare programs, faith-based organizations, non – government organizations, community volunteer outreach groups, all should be sensitized and equipped to offer psychosocial support to youth orphaned by AIDS. Teachers, health care workers and other stakeholders interested with the well-fare of youth should be trained to identify signs of distress and take appropriate action (REPSSI, 2003).

Providing youth orphaned by AIDS with life and survival skills

In the absence of parental guidance and support, adolescents and young people who have taken on the parental responsibility do so without much skill and preparations. These young people require training to enable them cope with demands of their new responsibilities. Young people need new and strengthened skills in areas including household management, caring for young siblings, budgeting and accessing services.

Vocational training and apprenticeships is key to enhancing their ability to generate income. Further, the orphaned youth must be equipped with social and interpersonal skills necessary to make informed decisions, communicate effectively and develop coping and self-management mechanisms that will enable them to protect themselves from HIV infection and other risks. These young people should be encouraged to participate actively in planning and implementing all programs that involve their well-fare as explained by Williamson (2002), that by involving youths in the fight against HIV/AIDS, their confidence and self-esteem is improved as they feel responsible and as partners.

Community support

When families cannot adequately meet the basic needs of the orphans and the vulnerable in their care, the larger community is the safety net in providing essential support. Local leaders, including traditional and religious leaders, administrators, women's groups, prominent citizens, journalists, teachers and others need to be sensitized to the impact of HIV/AIDS and to the circumstances of orphans and vulnerable children and youth within their communities.

This sensitization process should encourage leaders and their communities to take action in support of the affected households and monitor those most vulnerable. Their role should be to ensure such orphans are under the supervision of adults, that they are enrolled in school, have their basic needs met and can access all essential services. Of particular

importance is alerting leaders to the risks the youth are exposed to, for example, sexual abuse, exploitation labor, danger of losing their inheritances to relatives and early forced marriage for girls. The leaders should therefore create a culture in which abuse of any kind is unacceptable and violations are dealt with effectively. This heightened awareness provides attention to youth and children made vulnerable by AIDS and stimulates locally driven action in response to identified needs as observed by Williamson (2002).

Supporting cooperative activities

The rural poor communities provide examples of utilizing locally available resources to help children and households made vulnerable by HIV/AIDS. Community groups can provide direct help to the orphans. They are better placed to assist AIDS affected families in monitoring and visiting of affected households and the provision of volunteer programs that provide much needed psychosocial support; communal gardens; community child care services; community schools; pooling of funds to provide material assistances; youth clubs and recreational programs (Levine & Foster, 2000; UNAIDS, 2003; Williamson, 2002).

The Kenya community is known for its innovative ways of dealing with problems that threaten its cohesive nature. The Kenyan people deal with their community issues by forming community-based organizations or grouping to address issues such as burial, school fees problems, hospital bills and any threatening issues to families; a commonly used slogan to describe such initiatives is (*Harambee*- meaning to pull together for a common goal).

On recognizing the increasing vulnerability of orphans in their communities, groups are responding with ingenuity. Such attempts are meant to provide support for orphans and vulnerable within their locale. Most community initiatives grow out of the concerns of a few motivated individuals who work together to support vulnerable children and youth. These initiatives spring from a sense of obligation to care for those in need.

This is done without adequate support from any source other than from themselves.

Organizations such as self – help groups, burial associations, grain loan schemes, rotating credit otherwise known as ‘Mary go round’ and loan club are just a few set-up resilient and ingenious coping mechanisms (Williamson, 2002).

Kien Kes Temple in Cambodia is a good example of social support advanced by the community to young people affected by HIV/AIDS. The community trains volunteers to offer psychosocial support and sensitizes community against discrimination of those infected and affected by HIV/AIDS. It assigns volunteers to households to oversee that youth and children’s basic needs are met and they remain in school. The temple receives technical support from Family Health International to strengthen program management and community mobilization in reducing discrimination and increase compassion (USAIDS, 2003). An example of a private sector involvement in Kenya is the program by Pathfinder International which has developed partnerships with the Barclays Bank of Kenya and Citigroup through the Global Business Coalition for HIV/AIDS. The partnership supports a livelihood training project involving orphaned youth aged 15-21 years that learn carpentry, tailoring, and other skills. The participants are later guided to job and resources such as credit union (USAIDS, 2003).

CHAPTER 3: RESEARCH METHOD

Sampling Survey: Population of Interest

As argued in the theoretical framework, the focus of this study was on college going students, and to enable more detailed investigation, one university in Kenya (Moi University¹) with several campuses all within a radius of about 50 kilometers was selected for this study. The population represented diverse backgrounds but focusing on one university ensured all were found in one general environment subject to a similar administrative, academic and institutional setup to eliminate effects of confounding factors that could arise if different student populations (or those from different institutional contexts) were sampled. The sample consisted of 156 students enrolled in the 2005/2006 academic year and at different stages of their degree courses. Participants ranged in age from 18 to 30 years, 87 (55.77 %) male and 69 (44.23 %) female. Most (91.67 %) were unmarried. To provide insight into the pattern of student behaviors on campus, the study sought to disaggregate nature of student interaction with members of the opposite sex. From the sample, 18 (11.76 %) said they were in some sort of engaged relationship while, 43 (30.28 %) said they were exclusively dating. The sample of participants was selected from among students in various years of study but because of differentials in the scheduling of academic programs, the sample (154 respondents) was relatively over represented in 2nd year (29.22 %) and 4th year (38.96 %) students compared to 1st (12.99 %) and 3rd (18.18 %) year enrollments. Though the total number of students sampled was 156, the actual number of responses obtained varied according to the question or issue

¹ Moi University is one of six public universities in Kenya located in the town of Eldoret in the western part of the country. Being a public university, it draws students largely from public high schools and admission is strictly on a competitive basis. Out of over 70,000 high school graduates who obtain basic requirements for university admission, only about 10,000 get places in public universities. The rest travel overseas or join private universities in the country. Private university education is still quite underdeveloped in Kenya, very costly and hence inaccessible for many families. Therefore, all public universities usually admit students from all over the country representing a wide diversity of socio-economic and cultural, as well as religious backgrounds. Moi University has four campuses: Main, Chepkolel, Town and Eldoret West.

investigated. For example, of the 156 participants 37 (22 male and 15 female) participated in the in-depth interviews. These included 21 double and 16 single orphans due to AIDS, and among the 16 single orphans, 6 reported that their remaining parents were sickly and needed home-based care treatment. Key sample characteristics are summarized in Table 1 (Chapter 4).

Selection and methods

A snowball method was used to recruit the participants, who were then issued with the letters of participation (see Appendix, A) and letters of consent (see Appendix, B). Those who signed the letter of consent (see Appendix, C) were given the questionnaire (see Appendix, F) to fill out and asked to return it within a week or at their earliest convenience. The sample size was determined roughly on the basis of student population according to university campuses. Main Campus which has the highest population got 70 questionnaires, followed by the Chepkoilel Campus with 50; Town and Eldoret West Campuses each got 40 questionnaires.

Data collection commenced in February 2006. The survey instrument was designed to probe a) the participants' psychological profile, i.e., anxiety, depression and self-esteem of the orphaned youth due to HIV/AIDS in comparison to non-orphans and orphaned youth who have lost a parent or parents due to other causes, b) to assess their coping mechanisms and c) to test the role of self-efficacy and perceived social support in mitigating the impacts of HIV/AIDS on the orphaned youth. The survey instrument utilized different scales as outlined below.

The Survey Instruments

Hassles and uplift scale (HUS)

Hassles and uplifts were measured using the Hassle and Uplift Scale (HUS) which was developed to measure the irritating, frustrating, distressing demands that are experienced everyday as one transacts with life, and uplifts, the interactions that manifest love, relief at hearing good news etc. (Delongis, Folkman & Lazarus, 1988; Kanner, Coyne, Schaefer & Lazarus, 1981). Participants were given a list of items and were to respond on a 0-3 Likert type scale where 0= “Not applicable” 1= “Somewhat” 2= “Quite a bit and” 3= “A great deal. This measurement is widely used and its Alpha reports range from .76-.93 (Elder, Wollin, Hartel, Spencer & Sanderson, 2003).

State-Trait Anxiety Scale(STAI)

The State-Trait Anxiety Scale (STAI, Spielberger, et al. 1970) that was developed by Charles Spielberger (Spielberger, 1985), to assess state and trait anxiety was used. State-Trait scale was used in this study for its established adaptability and reliability. This instrument has high reported reliability and validity and has been used in a variety of cultures (Cohen, 2000). This instrument has been adapted into 43 different languages and dialects and has been used internationally in psychological research. Alpha reports range from .86-.95. The 20 items are each rated on a 4-point intensity scale, labeled “Not at all,” “Somewhat,” “Moderately so,” and “Very much so”. The higher the score the more state anxiety is being reported (Cohen, 2000).

The Zung self rating depression scale(ZSDS)

The Zung (1965) Self-Rating Depression Scale (ZSDS) consisting of 20 items (that measure affective, cognitive and physiological components of depression) was used. Participants responded on a 4-point scale (a little of the time, some of the time, good part of the time, most of the time) describing the frequency with which they experienced each

symptom. Items are framed in terms of positive and negative statements. This instrument has been used in a variety of settings including primary and psychiatric care, drug trials and various research situations. Each item is scored on a Likert scale ranging from 1 to 4. A total score is derived by summing the individual item scores, and ranges from 20 to 80. Most people with depression score between 50 and 69, while a score of 70 or above indicates severe depression. The scores provide indicative ranges for depression severity that can be useful for clinical and research purposes (Zung, 1965). This scale has an internal reliability with Cronbach alphas ranging from .83 .93 (Cohen, 2000).

Rosenberg self-esteem scale (RSE)

The Rosenberg Self-Esteem Scale, RSE (Rosenberg, 1989) includes 10 items rated from strongly agree (4) to strongly disagree (1). The RSE scale provides a global estimate of positive self-esteem. This scale is a well-validated and reliable measure for self-perception and appraisal for one's strengths, and is the self-esteem scale most frequently used by researchers to measure this construct (Cohen, 2000). Test-retest correlations are typically in the range of .82 to .88, and alpha for various samples is in the range of .77-.88 (Cohen, 2000). This instrument is widely used across cultures and is translated into many languages.

General self-efficacy scale (GSES)

This instrument that has been translated into 27 languages, and was created by Jerusalem & Schwarzer (1979), to assess a general sense of perceived self-efficacy with the aim to predict coping with daily hassles as well as adaptation after experiencing various kinds of stressful life events. This scale is designed for the general adult population, including adolescents. The construct of perceived self-efficacy reflects optimistic self-belief (Schwarzer, 1992). This is the belief that one can perform a novel or difficult task, or cope with adversity in various domains of human functioning. Perceived

self-efficacy facilitates goal setting, effort investment, persistence in face of barriers and recovery from setbacks. Ten items are designed to tap into this construct (Schwarzer, 1992). Each item refers to successful coping and implies an internal stable attribution of success. The scale has been shown to possess high reliability (Jerusalem, 1990), with alpha ranging from .76 to .90. Criterion related validity is documented in numerous studies (Schwarzer, 1992).

Ways of coping scale (WOC)

Problem-solving skills were assessed by a modified Ways of Coping Scale (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). This instrument was used to assess the participants' capabilities with regard to problem-solving behaviors and attitudes. The WOC uses 4-point Likert-type items (identifying if the statement is true, moderately true, barely true, and not at all true). Three subscales measure problem-solving confidence style (self-assurance while engaging in problem-solving activities), approach-avoidance style (a general tendency to either approach or avoid problem-solving activities), and personal control (the extent of control one feels they have over emotions and behavior while solving problems). According to research done by DeLongis & Gruen, 1999, among African – American, WOC scale was reported as having an internal reliability ranging from .70 to .90 .

Multidimensional Scale of Perceived Social Support (MSPSS)

Social support was assessed using the Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet, Dahlem, Zimet, and Farley (1988). This scale assesses participants' beliefs about a set of statements that tap the perceived social support from family, friends and significant others. Responses range from very strongly disagree to very strongly agree. The instrument also assesses the ability of the respondent to reach out for the available support at their disposal and the awareness of the need for such

support. This instrument was selected for this study because it is easy to understand and accesses information on support that is central to the study. Researchers have reported this scale as having an internal reliability rating ranging from .81 to .93 (Zimet & Farley (2003).

Procedure

After attaining the ethics clearance letters from both Queensland Australia (Appendix, D) and the ethics approval letter from Moi University (Appendix, E). Four research assistants were trained in the month of September 2005 to assist the researcher in the four participating campuses. The four were recruited from the Dean of Students offices: two assistant Student Counselors and two assistant Deans of Students were selected due to their experience of working with students and handling students' matters confidentially.

The research assistants were trained on the objectives of the study including a thorough explanation of the instruments and the procedures used. The aims of the pilot study were articulated and problems arising from the survey instruments, the procedures or any other arising issues were reported and addressed before the pilot and the actual study started.

The pilot study

The pilot study was conducted in Town Campus in October and November 2005 to test the appropriateness of the instruments (in context of Kenyan culture) and to ascertain their sensitivity and comprehensibility; and to test whether they captured the information intended.

Utilizing a snowball process of sampling, several orphaned students known by the Dean of Students' office were invited and given the letter of participation and the letter of

consent. Once the letter of consent was received, the participants were given the questionnaires which were to be returned in sealed envelopes after filling out all the questions within a week. The participants were requested to recruit other orphans (single or total) known to them. Through this process 23 orphaned students were recruited and of these, 22 returned the questionnaires. To avoid stigma, orphans not orphaned by HIV/AIDS were invited as well. Participants were requested to make comments at the back of the questionnaire indicating any difficulties they might have experienced in the process of filling out the questionnaire - such as questions they did not understand, or felt were not applicable to their situations or inappropriate and any other comment they felt would positively enhance the effectiveness of this questionnaire.

Participants did not indicate any major difficulties with the questionnaire albeit some typographical errors were indicated. Given that no major difficulties were reported it was assumed that the survey instrument was well understood. However, in the process of analyzing their responses, it was noted that there was a need to revise the demographic question that inquired about the cause of parents' death. Of the four choices given - Accident, HIV/AIDS, Long illness, Short illness -, it was noted the majority of participants indicated the cause of parent's death as a short illness. This made it necessary to revise the questionnaire to read as follows, "Indicate the cause of your father/mothers' death (Accident, HIV/AIDS, Others (Mention Illness))" to eliminate vagueness introduced by the two choices offered earlier i.e. (Long illness and Short illness) and encourage the participants to be more precise.

Once all the corrections and the amendments were made, data collection commenced late February to May 2006 utilizing the same sampling methods as the pilot study. It was difficult to know how long it took to fill the questionnaire because the participants were requested to fill the questionnaires at their own convenient time and return them after a week. In reality it took some participants more than a week, and in

some cases, research assistants had to do follow-up but about 50% returned their questionnaires without any prompting.

The in-Depth Inquiry

Rationale

Aside from the use of questionnaires, in-depth interviews were conducted on a sub-sample of student orphans that have lost a parent or parents to HIV/AIDS. This method was aimed at obtaining the details about the following phenomenon: feelings, thought processes, and emotions that are difficult to extract or learn about using conventional research methods (Strauss & Corbin, 1998). It was felt that relying on only the questionnaire could obscure the nuances and genuine complexity of the experience of the orphans. Moreover, the cultural context within which the study was conducted (African vis-à-vis Western culture for which the instruments were formulated) further justified a qualitative probing of issues; adopting a quantitative inquiry may totally obscure cultural variations in the experiences of the orphaned youth. It is also observed that the quantitative method relies on a priori assumptions about the range of relevant variables to be assessed. These assumptions may fail to capture some aspects especially in under-researched areas where little is known about subjects of inquiry (Schweitzer, Kagee & Greenslade, 2004).

Three questions were employed to the conveniently selected sample to elicit narratives and salient categories of experiences, as they emerged from the participants. This qualitative inquiry had two specific aims; 1) to tap orphans' special experiences as they adapted to the death of their parent(s), and 2) to understand their coping strategies that have assisted them to deal with their new situation.

Sub-sampling for in-depth interviews

Research assistants utilized in administering the survey instruments were also utilized in this process of identifying and carrying out the interviews. Participants who returned their questionnaires and had indicated their parent(s) had died of AIDS were requested to further participate in the interview if they so wished. However, some declined to take part highlighting fear of stigmatization while others expressed their inability to relive their experiences saying that it was too painful to talk about their dead parent or parents. Even those who participated were reluctant and uneasy sharing freely about their parents' illness and family situation. This situation made it necessary to persuade and at the same time assure them that this information would not be labeled just as the questionnaire was anonymous so as to protect the participants. Due to this data collected from interviews was analyzed separately from that gathered from the survey.

Because the matter under investigation was very sensitive and the possibility of the participants becoming distressed was real, referral procedures were put in place to address any such eventualities. Twelve referrals were made to the student counseling clinics for support and follow- up.

The interviews

Interviews were carried out in the research assistants' offices in the different campuses. The participants were allowed to choose the time that suited them best to take the interviews. Four participants changed the cause of their parents' death to causes other than AIDS as previously indicated in the questionnaires leading to rejection of their questionnaire and interview data for analysis.

The researchers were able to probe and clarify information in the interview that took 40-60 minutes. Detailed notes were written as soon as the interview was concluded to enable the interviewers to capture what was observed, heard and experienced during the

interview. The main researcher played a supervisory role making sure the research protocols were adhered to and that the process was conducted smoothly. Three questions were constructed to allow the participants explore how they had fared since the death of one or both parents. The interviewers also enquired whether there was any question or any aspect of the interview (both the questionnaire and the face to face interviews) that made the participants uncomfortable or that or had difficulty responding to; and finally if there was anything else they wished to add or say.

The first part of the interview was aimed at gathering themes and categories as they emerged from the participants' point of view. Where necessary the participants were prompted to detail their experiences and difficulties as they adjusted to the death of their parent/s along with strengths and resources they brought to bear on the situation that allowed them to cope. The second question allowed the interviewee to share their feelings about what was being investigated and where possible, learn from the interviewee how they would go about dealing with the issues in future, and what they considered as pertinent issues and why they felt the way they did. The third question was meant to allow the participant bring out any other issue that they felt was important to them and advise the researchers what they considered as their priority needs and how best these needs could be met from their point of view.

Data generated from the interviews were cleaned and filler words were removed. The second stage in the analysis involved the identification of themes that were considered expressions of the salient experiences and concerns of the participants. This process involved: open-coding where interview transcripts were read holistically and key issues mentioned by the respondents were identified and selective coding where key phrases, statements and comments were noted and put into categories according to their content. The third stage of the analysis involved treating data nomothetically (looking for the

general traits) and identifying connections between the codes identified in the first stage. The purpose of this stage was to identify emergent themes.

Patterns in the codes were checked by examining the frequencies of codes across participants. This technique for identifying patterns is also associated with grounded theory (Strauss & Corbin, 1998). The third stage of the analysis provided the basis for the explication of the data, which involves translating the emergent themes into a narrative account of the experience of the participants. The structures of the findings were confirmed by means of re-reading the original narratives and modifying the codes accordingly. A second investigator and an independent person checked the original narrative to confirm whether the same themes and categories emerged any differences were reconciled.

CHAPTER 4: RESULTS

Quantitative Study

Demographics and population attributes

From the sample data, key population attributes were analyzed and inferred and results are summarized in Table 1. Slightly more male 55.77 % compared to female students 44.23 % took part in the study from the total sample size (n = 156). Most students 92.81 % who participated in the study were in the age group 21- 25 years, meaning that the survey captured the usual college going age. A very small proportion 4.32 % and 2.88 % were in the age brackets 15-20 years and 26-30 years respectively. Half the participants (50 %) indicated that they were not married or engaged and only 43 % were involved in some form of dating with members of the opposite sex. This is an interesting observation as circumstantial evidence² would suggest the opposite – a much higher number of students being involved in some form of intimate relationship with members of the opposite sex at college going age. This may be a pointer to a more cautious approach to relationships with members of the opposite sex or student unwillingness to be honest about personal relationships. It is also interesting to note that 70 % of the respondents subscribed to Protestant religion; there may be a correlation between this and the low level of coupling reported with members of opposite sex.

On accommodation, 89.54 % of the participants said they were accommodated within the university hostels³ while the rest had private arrangements (stayed with relatives or had shared accommodation with friends outside campus).

² Public debate in Kenya in early 1990s was dominated by the view that high school education – especially single sex educational institutions (all-boys or all-girls boarding schools) created superficial and restrictive conditions and that once students went to university where they were exposed to unbridled freedom, cohabitation and various forms of sexual indulgences manifested in short term engagements (coupling) were more the norm rather than the exception.

³ Until the mid 1990s when the Government of Kenya implemented IMF driven Structural Adjustment Programmes (SAPs) and introduced elements of co-share funding (with parents/guardians), university education was exclusively publicly funded – hence student accommodation was wholly campus based.

A greater number of students, 66.23 %, reported that their father was deceased against 42.95 % who indicated that they had lost their mother. It is also worth noting that while most students 95.48 % reported having siblings, 70.75 % said their siblings were not in schools. This is rather surprising as education is the more socially acceptable form of support given in the event of death of a parent in Kenya today.

Table 1: Sample characteristics

Variable	Proportion In Sample	Variable	Proportion In Sample	Variable	Proportion In Sample
Age (yrs) (n = 139)		Year Repeated (if Any) (n = 12)		Who Pays Fees and Upkeep (n = 127)	
15-20	6 (4.32 %)	1 st	3 (25.00 %)	Parents	57 (44.88 %)
21-25	129 (92.81 %)	2 nd	3 (25.00 %)	Guardian	24 (18.90 %)
26-30	4 (2.88 %)	3 rd	2 (16.67 %)	Government	15 (11.81 %)
		4 th	4 (33.33 %)	Friends	8 (6.30 %)
				Parent / Government	3 (2.36 %)
				Other	20 (15.75 %)
Religion (n = 155)		Reasons for Repeating (n = 15)		Have Siblings (n = 155)	
Catholic	34 (21.94 %)	Parent illness	1 (6.67 %)	Yes	148 (95.48 %)
Protestant	110 (70.97 %)	Death of parent	6 (40.00 %)	No	7 (4.52 %)
Muslim	2 (1.29 %)	Absenteeism	3 (20.00 %)		
Traditional	4 (2.59 %)	Other	5 (33.33 %)	Whether in school (n = 147)	
Other	5 (3.23 %)			Yes	43 (29.25 %)
				No	104 (70.75 %)
Year of Admission to University (n = 156)		Accommodation Arrangements (n = 153)		Cause of Father's Death (n = 96)	
2000	2 (1.28 %)	College hostel	137 (89.54 %)	Accident	7 (7.29 %)
2001	3 (1.92 %)	Private hostel	1 (0.65 %)	HIV/AIDS	26 (27.08 %)
2002	64 (41.03 %)	With relatives	3 (1.96 %)	Other	62 (64.58 %)
2003	32 (20.51 %)	With college-mates	12 (7.84 %)		
2004	28 (17.95 %)				
2005	27 (17.31 %)				
Year of Study (n = 154)		Education Sponsorship (n = 150)		Cause of Mother's Death (n = 67)	
1 st	20 (12.99 %)	Parents	31 (20.67 %)	Accident	1 (1.49 %)
2 nd	45 (29.22 %)	Guardian	10 (6.67 %)	HIV/AIDS	19 (28.36 %)
3 rd	28 (18.18 %)	Government	93 (62.00 %)	Other	46 (68.66 %)
4 th	60 (38.96 %)	Friends	1 (0.67 %)		
6 th	1 (0.65 %)	Parent/Government	8 (5.33 %)		
		Other	7 (4.67 %)		

Private accommodation is a relatively new phenomenon in Kenyan tertiary education and still largely underdeveloped. Preferred form of accommodation is still university hostel.

When students were asked about what they thought was the probable cause of death for their parent, only a small proportion (27.08 %) attributed death of their father to HIV/AIDS, and 28.36 % attributed cause of their mother's death to HIV/AIDS.

Paired t-test results between hassle and uplift scores (hypothesis 1)

The paired t-test was used to compare the mean hassles and mean uplifts scores for each of the participating student status (Table 2).

Table 2: T-test results between hassle and uplift

Participants Status	Hassle mean (\pm SE)	Uplift mean (\pm SE)	Uplift>Hassle (by % of hassle)	n	t-value	df	Probability
Non-orphans	1.12 (0.07)	1.62 (0.06)	44	36	-5.54	35	<0.0001
Single non-AIDS orphans	1.25 (0.06)	1.63 (0.07)	30	50	-4.29	49	<0.0001
Double non-AIDS orphans	1.29 (0.09)	1.55 (0.08)	19	25	-2.27	24	0.032
Single AIDS orphans	1.29 (0.14)	1.47 (0.15)	15	17	-1.14	16	0.273
Double AIDS orphans	1.27 (0.12)	1.48 (0.09)	17	27	-1.5	26	0.146

SE = Standard error of mean

Based on the above results we observe that for non-orphans, single non-AIDS orphans and double non-AIDS orphans, their mean hassle scores are significantly different from their mean uplifts. However for Single-AIDS orphans and Double-AIDS orphans the mean uplifts and hassles are not significantly different, as also graphically illustrated (Fig. 1).

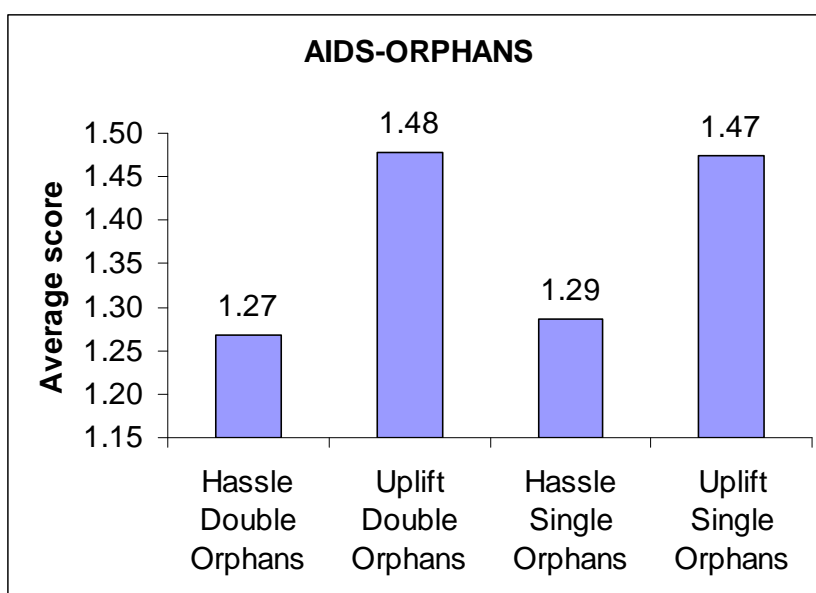


Fig 1: Average (Hassles and Uplifts) for single and double orphans

One-way ANOVA results

The one-way ANOVA was used to investigate whether the mean scores for the uplifts and hassles are associated with the participants' status as indicated in Table 3.

Table 3: One-way analysis of variance results (Hassles vis-à-vis uplifts)

Participants status	Hassle mean (\pm SE)	Uplift mean (\pm SE)
Non-orphans	1.12 (0.07)	1.62 (0.06)
Single non-AIDS orphans	1.25 (0.06)	1.64 (0.07)
Double non-AIDS orphans	1.29 (0.43)	1.55 (0.08)
Single AIDS orphans	1.29 (0.14)	1.47 (0.15)
Double AIDS orphans	1.27 (0.61)	1.48 (0.09)
<i>Between Groups DF</i>	4	4
<i>Within Groups DF</i>	150	151
<i>F-value</i>	0.69	0.8
<i>Probability</i>	0.603	0.526

SE = Standard error of mean

Based on the ANOVA test we observe that both the mean hassles and mean uplifts are not significantly different across the participant's status as indicated in (Table 2).

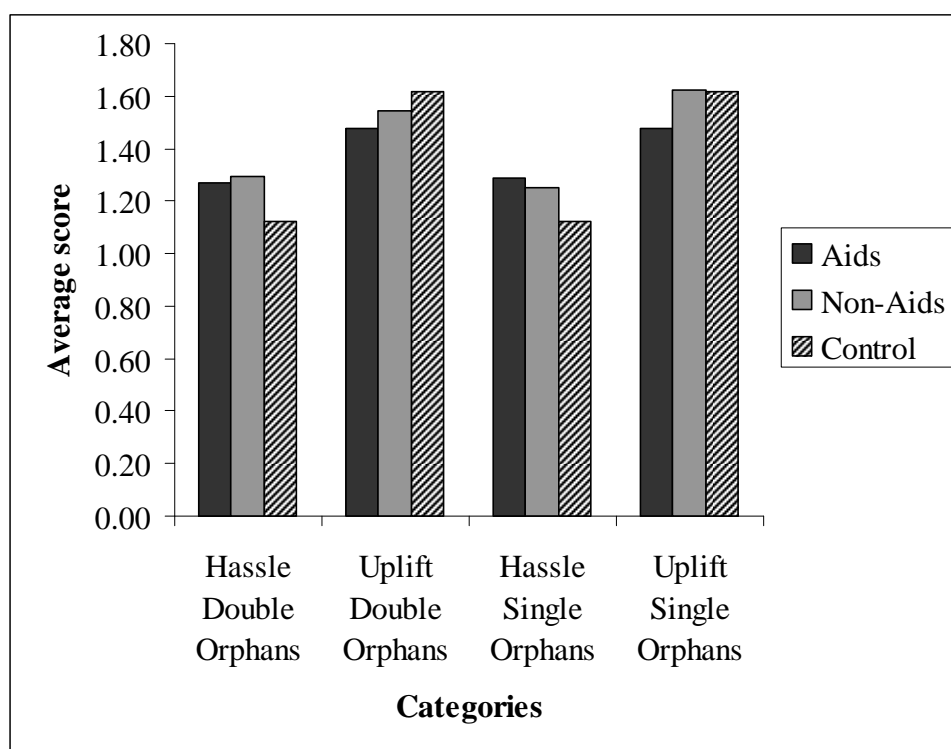


Fig 2: Average (Hassles and Uplifts) for various orphan categories

Table 4: One way ANOVA results for anxiety, self-esteem and depression

Participants status	Anxiety mean (\pm SE)	Self esteem mean (\pm SE)	Depression mean (\pm SE)
Non-orphans	2.29 (0.05)	3.19 (0.09)	1.82 (0.07)
Single non-AIDS orphans	2.26 (0.04)	3.21 (0.07)	2.06 (0.06)
Double non-AIDS orphans	2.13 (0.06)	3.03 (0.10)	2.28 (0.06)
Single AIDS orphans	2.26 (0.05)	3.09 (0.14)	2.33 (0.15)
Double AIDS orphans	2.12 (0.05)	2.73 (0.12)	2.38 (0.10)
<i>Between Groups DF</i>	4	4	4
<i>Within Groups DF</i>	151	152	150
<i>F-Value</i>	2.4	3.96	7.21
<i>Probability</i>	0.052	0.004	<0.001

From Table 4, we observe that based on the overall F-test the mean self-esteem and depression scores are significantly different at 0.05 level of significance while those for anxiety are marginally significant.

For self-esteem and depression a further analysis was performed to investigate which of the participants status are different based on multiple test comparison with a Bonferroni correction. The mean self-esteem score for Double-AIDS orphans is statistically different from that of Non-orphans and from that of single non-AIDS orphans.

The mean depression score for Non-orphans is statistically different from that of: Single-AIDS orphans, Double-AIDS orphans and Double non-AIDS orphans. We also observe that the mean depression score for Double-AIDS orphans is statistically different from that of Single non- AIDS orphans.

Figures 3 and 4 illustrate graphically mean scores for anxiety and depression across different categories of participants in this study.

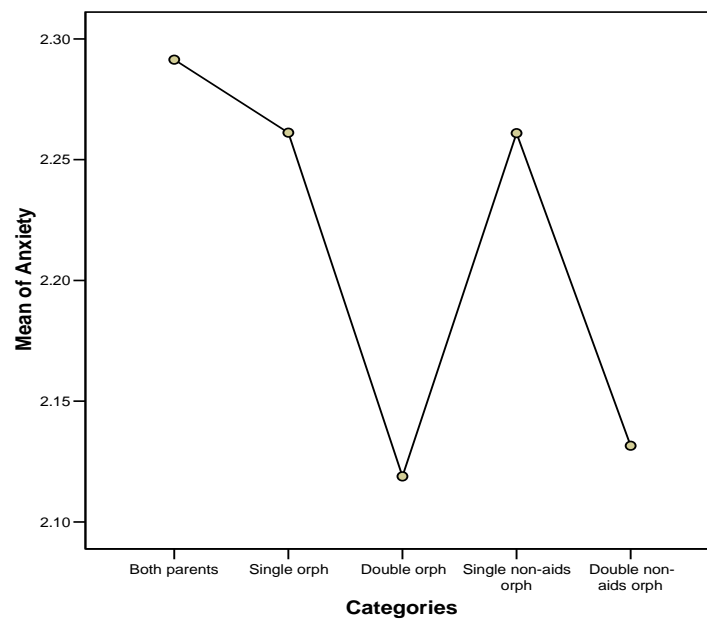


Fig 3: Average anxiety scores against orphan categories

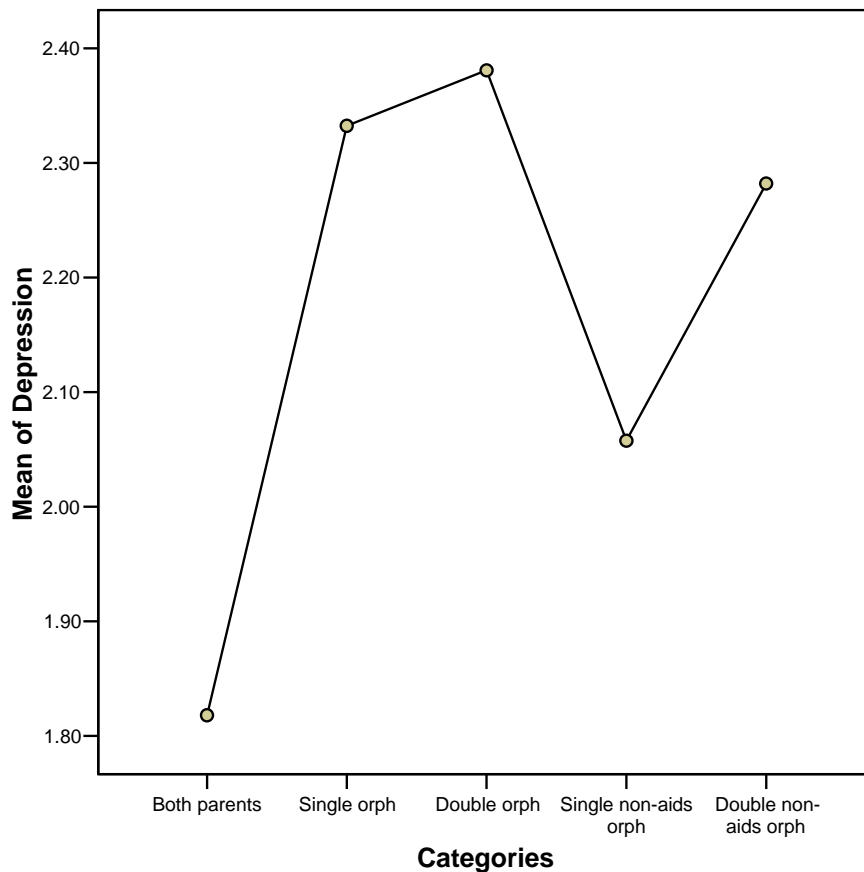


Fig 4: Average depression scores against orphan categories

Pearson correlation coefficients matrices (hypothesis 3)

To investigate whether anxiety, depression and self-esteem scores are positively associated with coping skills, self-efficacy and social support score, a pair-wise Pearson correlation was performed. The results are summarized in Tables 5-9 for each of the participant's status.

Table 5: Non-orphans

		Anxiety	Depression	Self-esteem
Coping skills	r	0.163 (<i>df</i> = 34; <i>p</i> = 0.35)	-0.124 (<i>df</i> = 35; <i>p</i> = 0.47)	-0.046 (<i>df</i> = 35; <i>p</i> = 0.79)
Self-efficiency	r	0.072 (<i>df</i> = 33; <i>p</i> = 0.69)	-0.223 (<i>df</i> = 33; <i>p</i> = 0.20)	0.067 (<i>df</i> = 33; <i>p</i> = 0.71)
Social support	r	0.243 (<i>df</i> = 33; <i>p</i> = 0.17)	-0.508 ** (<i>df</i> = 33; <i>p</i> = 0.002)	0.387 * (<i>df</i> = 33; <i>p</i> = 0.02)

Depression and self-esteem significantly correlated with social support. Thus the depression and self-esteem scores seem to be positively related with the social support

scores for non-orphans. For depression, the correlation in the negative direction indicates that lack of social support seems to have an effect on depression ($r = -0.508$). However social support seem to improve non-orphans self-esteem since the correlation is in the positive direction ($r = 0.387$).

Table 6: Single non-AIDS orphans

		Anxiety	Depression	Self-esteem
Coping skills	r	0.195 ($df = 50; p = 0.17$)	0.034 ($df = 50; p = 0.81$)	-0.132 ($df = 50; p = 0.36$)
Self-efficiency	r	-0.038 ($df = 49; p = 0.79$)	-0.245 ($df = 49; p = 0.09$)	0.237 ($df = 49; p = 0.10$)
Social support	r	-0.017 ($df = 49; p = 0.91$)	-0.423 ** ($df = 49; p = 0.002$)	0.38 ** ($df = 49; p = 0.01$)

Depression and self-esteem were significantly associated with social support. Thus the depression and self-esteem scores seem to positively associated with the social support scores for single non-AIDS orphans. For depression the correlation is in the negative direction, indicating that lack of social support seems to have an effect on depression ($r = -0.423$). However social support seems to improve single non-AIDS orphans self-esteem since the correlation is in the positive direction ($r = 0.38$).

Table 7: Double non-AIDS orphans

		Anxiety	Depression	Self-esteem
Coping skills	r	0.168 ($df = 25; p = 0.41$)	0.108 ($df = 24; p = 0.61$)	-0.163 ($df = 25; p = 0.43$)
Self-efficiency	r	-0.022 ($df = 25; p = 0.91$)	-0.235 ($df = 24; p = 0.26$)	0.589 ** ($df = 25; p = 0.002$)
Social support	r	0.007 ($df = 25; p = 0.98$)	-0.391* ($df = 24; p = 0.05$)	0.277 ($df = 25; p = 0.17$)

Depression is significantly associated with social support while self-esteem is significantly associated with self-efficacy. Thus the depression scores seem to positively relate to the social support scores while the self-esteem scores seem to be positively associated to self-efficacy scores for double and non-AIDS orphans. For depression the correlation is in the negative direction indicating that lack of social support seems to have an effect on depression

($r = -0.391$). However self-efficacy seem to improve the double-non-Aids orphans' self-esteem since the correlation is in the positive direction ($r = 0.589$).

Table 8: Double-AIDS orphans

		Anxiety	Depression	Self-esteem
Coping skills	r	-0.142 ($df = 26; p = 0.48$)	0.568 ** ($df = 25; p = 0.002$)	-0.331 ($df = 26; p = 0.09$)
Self-efficiency	r	-0.132 ($df = 26; p = 0.51$)	-0.202 ($df = 25; p = 0.32$)	0.116 ($df = 26; p = 0.57$)
Social support	r	-0.128 ($df = 26; p = 0.52$)	0.069 ($df = 25; p = 0.74$)	-0.028 ($df = 27; p = 0.89$)

For the double-AIDS orphans depression scores are significantly dependent on their coping strategies' scores.

Table 9: Single-AIDS orphans

		Anxiety	Depression	Self-esteem
Coping skills	r	-0.016 ($df = 16; p = 0.95$)	0.098 ($df = 16; p = 0.71$)	0.024 ($df = 16; p = 0.93$)
Self-efficiency	r	0.233 ($df = 16; p = 0.37$)	-0.3 ($df = 16; p = 0.24$)	-0.027 ($df = 16; p = 0.92$)
Social support	r	0.48 * ($df = 16; p = 0.05$)	-0.443* ($df = 16; p = 0.08$)	0.613 ** ($df = 16; p = 0.01$)

Depression, anxiety and self-esteem are significantly associated with social support. Thus the depression, anxiety and self-esteem scores seem to be positively associated with the social support scores for single-AIDS orphans.

Qualitative Study

This component of the study sought to obtain more insight by requiring participants to respond to three research questions as follow:

1. Generally how have you fared since the death of your parent(s)?
2. What are the resources you utilized to enable you cope?
3. Do you have anything to say about the interview or the research in general?

(Appendix G contains summaries of interviews narratives as stated by the interviewee).

Responses generated three main themes which included poor economic status that makes it hard for the orphaned youth to meet their basic needs; positive and negative outcomes as far as their psychological well-being is concerned, as indicated by the resultant depression, poor self-esteem, perpetual worries concerning their future for themselves and their siblings, loneliness; and lowered academic performance. Positive outcomes are indicated by the following emerging categories; a positive future outlook despite difficulties in life; a determination to succeed in order to change their current situation into a successful one in future, while others have developed a stronger character and courage and have “matured” through the process. The social support themes are dominant in almost all the respondents. These include perceived social support from family, friends, the religious community and the community at large. The identified connections between the codes helped in identifying emergent (super-ordinate themes). These themes are utilized in this report to facilitate in the describing the experiences of orphaned youths as we listen to their voices.

Table 10: Economic themes

Themes	Frequency of Mentions	Percent of Interviewees
Beg from relatives and others	7	18.9 %
Depend on self for all financial and other needs	20	54.0 %
Support from paternal side	6	16.0 %
Support from maternal side	9	24.3 %
Support from well-wishers	8	21.6 %
Support from HELB	12	23.0 %
Sold possessions for fees	9	24.0 %
Deferred their studies due financial difficulties	8	21.0 %

Difficulties in meeting basic needs

Orphans experience household decline when the breadwinner falls ill from HVI/AIDS. The families divert their time and money to caring for the sick, straining the family resources on the increased health care costs. The burden of caring for sick and dying parents coupled with loss of household income perpetuates poverty by preventing children and youth from attending school or developing a trade (Ainsworth & Filmer, 2000). Those who participated in this interview though in college attending various courses indicated that they are struggling to keep themselves in school.

Respondents indicated that life changed significantly after the death of their parent(s). The first impact as described by this group of participants is the inability to pay fees for themselves and their siblings. The other impact identified is the difficulties of having food and clothing and for those who lived in urban settlements, paying rent became a problem making it necessary to move to cheaper housing or to rural areas. Migration to rural settlements did not only make the young persons change housing, but they had to change schools for those in primary and secondary schools or dropped from school altogether. Respondents reported that it became necessary for them to turn to their relatives and well-wishers as indicated on the table above where 18.9 % said they had to beg from their relatives and other members of their community. While a high 54 % indicated they depended on self to provide for their needs and for their siblings. It is hard to comprehend how the orphans do it given that in Kenya there are no part time jobs for college-going students as is usually the case in developed countries.

The added burden on the extended family network by orphans strains the meager resources of those families in a country where poverty levels are very high – recent reports revealed that a significant proportion of the Kenyan population (over 50 %) lives below the poverty line with household income estimated at less than US\$ 1 per day (Ayieko, 2000). This further strains relationships as family members compete for the

limited available resources. Respondents observed that help from relatives is not always a guarantee; in some cases it is dependent on the kind of relationship one has with the relatives. Financial assistance is also dependent on the availability of resources. Orphans are the last in line to receive assistance and the first to be pulled out of school when resources become scarce. One respondent reported, *“you have to ask for fees and money for food from your relatives...but you have to ask politely otherwise you know... it is not your right.”* Another one describing their difficulties in getting food and clothing observed, *“even though our uncles took up the responsibility to raising us up, they are not good to us... they complain when we ask for money for anything.”* (Appendix, G)

Several orphans indicated that they preferred reaching out to their maternal relatives for support as opposed to the paternal side: a greater number (24.3 %) depend on the maternal side in comparison to the paternal side (16.2 %). Participants felt more welcomed by their mother’s relatives than their father’s side as reported by one respondent who said *“... our maternal relatives check on us now and then but those from our father’s family don’t even care whether we are alive or dead.”* This trend indicates a shift from what is inherently considered traditional in Kenyan society. Kenyan society is predominantly patriarchal where children and everything in a given family belongs to the man. It is not the tradition for children therefore to seek help from their mother’s side of the family, yet a good number of respondents reported that they rely more on their maternal rather than paternal relatives for support.

Frustrations experienced by the orphans while searching for a livelihood have made several of the participants opt for living in their parents’ home alone without an adult (or relative), as a way to minimize the pain of being a burden to their relatives. One participant reported that, *“... one feels frustrated having to ask for money from other people, it is frustrating...”* This kind of living arrangement though positive in that the siblings remain together therefore becomes a source of comfort to each other, often poses

risks to the children and youths. These risks may involve the orphans in the university deferring their studies for some time to look for a job or farm the family land to provide for the siblings; the children may also be exposed to abuse, poor health due to lack of proper care, and the dangers of contracting HIV/AIDS.

Participants mentioned that in some cases poverty experienced by the orphans causes many female orphans to engage in commercial sex to make money so that they can adequately provide for themselves and their siblings. As reported by one respondent, “...some of us here go prostituting on Friday night and the whole weekend...” and a few admitted that they engaged in illegal trade like selling drugs and alcohol within the student community.

Table 11: Psychological themes

Themes	Frequency of Mentions	Percent of Interviewees
Negative outcome	23	62.3 %
Sad	15	40.5 %
Fear	12	32.0 %
Poor self-esteem	19	51.0 %
Perpetual worries	21	56.7 %
Hopelessness	18	46.6 %
Distressed	6	16.2 %
Lack sleep	8	21.6 %
Loneliness	8	21.6 %
Uncertain future for self and siblings	25	67.5 %
Felt odd different – AIDS Orphan	12	32.4 %
Self pity	12	32.4 %
Stigmatized	27	72.9 %
Felt rejected	13	35.0 %
Felt disadvantaged	20	54.0 %
Positive Outcome	12	32.4 %
Positive future outlook	6	16.2 %
Determined to succeed	10	27.0 %
Strength in character	11	29.7 %
Matured	7	18.9 %

Assumed parental roles

Table 11 summarizes key psychosocial issues experienced by orphans. Assuming parent responsibility was cited as a key stressor - taking up parental responsibility for

siblings when parents became sick and finally when they died was found to cause considerable difficulty and stress. The respondents indicated that this was a difficult task because they were only students and young without any income, resources or the knowledge of caring for a family; they themselves needed care and support. Worry about how life could turn out to be for them and their siblings, was reported by a majority of the participants (56.7 %). The respondents worried about a broad range of issues including their siblings' security, food security, the siblings' health, school performance and future outcomes and behavior. One participant reported that he worried a lot about his siblings who were at home alone: *"...I worry so much while here in the university... I don't know whether they have food ...and how they are fairing."* They also got distressed when siblings went wayward as expressed by one female respondent:

"... I am very distressed by my younger sister who dropped from high school and went to live in Mombasa...I am not happy, I don't know what to do to get her to come back home..."

Young girls who drop out of school and move to live in large cities like Mombasa or Nairobi and are not living with a relative are assumed to have moved there for prostitution (cf The Kenya Daily Nation News Paper, Sept 21, 2006).

The participants appreciated the little loan that the Government of Kenya gives them to cater for their upkeep and pay for fees, but reiterated that the amount given was very little and they had to look for other sources of funding to supplement government support. For the orphaned student, however, this loan often was used to support their siblings and buy medicines for their sick parent(s). This was identified as a major source of stress because the student after using the money to support family is left with nothing for their own food and fees balance. Almost half of the interviewees complained that they had not paid fees; one said, *"...I am not sure the university administration will allow me to sit for my exams."*

The added responsibility of providing care and support to ailing family members and caring for siblings was described as interfering with their ability to concentrate on their studies and was also reported as affecting their performance. Almost half (48.9%) of the respondents reported they felt hassled by their responsibility to a point of desiring to defer their studies so as to look for a job to provide for their siblings. However, students in Moi University are allowed to defer their studies for only one year. Participants in this study observed that this was not enough time for them to look for a job and organize the family. This dilemma made some of the participants feel disillusioned and overwhelmed as stated by one participant, *“I feel I should defer my studies so that I can see how to provide for my sisters...but there is no guarantee for a job out there, and I might lose my place here in the University... somebody should understand what I am going through...”*

Fear of failing exams is another stressor reported among the participants. They explained that the family burdens exacerbate an already stressful situation caused by high and rigorous academic demands (assignments - continuous assessment tests, term papers, project reports and end year exams), making university life unbearable. Fear reported by 32% of participants, was mainly related to failing exams and becoming nothing. One respondent expressed his fears that *“ I travel home often to check on my sick brother... and my friend takes lecture notes for me he tells me what was taught,... see I depend on his notes, if they are not good I will fail... I have nothing else I can do.”* Fear of finishing university and not finding a job, and having no access to the little loan money that is provided by the Government created a lot of anxiety for those who are about to finish their studies.

Frustrations encountered in securing parents’ retirement benefits and inheritance

Some participants reported that they felt frustrated by the various government departments where their parents worked before they died. Participants described efforts to access their parents’ retirement benefits/ lands title deeds or any documents related to their

parents as a very difficult task because of greed and corruption among family members and government officials. One participant narrating his experience stated, *“I have been going to the office where my father worked to collect his terminal benefits but in vain, the officers there kept asking me to come again after one month now it has been two years and nothing has been done...I haven’t seen those documents,”* while another narrated how his uncle colluded with the Department of Lands to change his father’s title deed to the uncle’s name. He reported: *“whenever I went to this office they would tell me to come with my uncle who was never available... after going there for more than five months, one kind woman told me, that the officials had been paid some money by my uncle and therefore there was no longer land in my fathers’ name and that I was wasting time...”* This kind of unfair treatment by the government officials and those who should be protecting them made the participants feel unprotected, rejected and stigmatized by both the families and community at large; as one stated, *“...nobody wants us... you really feel an orphan!”*

Participants complained about the unfair treatment by the government administration when they went to seek identification cards. Double-AIDS orphans reported being asked to produce their parents’ identity cards or a letter from parents. Respondents said it was hard to access their parents’ documents - some claimed the parents did not have the required documents or simply did not know where to get them. Hence respondents reported having difficulties establishing their identity and family ties which could contribute to them being denied the right to inherit parental property. Another difficulty cited by participants as contributing to their frustrations in gaining authority to administer their parents’ estates was the fact that parents often had not registered their (children) births thus denying them the right to a name, nationality and legal identity. There is also the frustration arising from the cost of obtaining official documents: these include fees and levies usually charged by government before such documents could be released, which in most cases are unaffordable to the orphans and

their families. There is also the cost related to frequent journeys one has to make before the document is finally obtained. All these barriers made the orphaned feel helpless and distressed about losing their inheritance and feel discriminated against as the government should have special arrangements to reduce or eliminate barriers orphans encounter in accessing their families' estate.

Need for love and Care

Poverty and in general the orphaned youth circumstances impacted negatively on the participants' self-esteem. The absence of a parent to love, encourage and instill confidence creates feelings of hopelessness - the orphaned participants felt badly about themselves and their state. A common stressor described by participants was poor self-esteem, expressed through the way they viewed themselves or felt. Some (51 %) participants reported that they felt odd and different when among their peers because of their status. They also reported feeling pity for themselves. One respondent stated, *"...sometimes I feel low when among other students when I see them having a lot and happily talking about their families...I feel I have nothing to share... I am unlucky."* Participants reported that they were not comfortable being in the company of their peers because they felt they did not have anything to share with them except pain. Others expressed that they were ashamed of how they looked and the kind of clothing they wore. One had this to say, *"I keep to myself because I have nothing good to share with my peers but pain...see the kind of clothes I wear ... I don't think they will appreciate me in their company."*

There is an expressed need for care and emotional support for orphans who are taking care of their siblings, as mentioned by one participant while recounting his difficulties of taking care of his siblings with limited resources. The participant mentioned that when overwhelmed, he handled the problem by withdrawing from the situation or through over-indulgence: *"when at home with my brothers and sisters and we are all*

unhappy because there is no food and no money and there is no one to talk to... and they are all looking at me to come up with a solution...and I don't have one...when I feel overwhelmed I sometimes go to a friend's house and leave them alone...or I go to a disco the whole night and drink with friends ... that way I release my stress."

These are young people without the necessary skills for parenting and in need of love and the space for them to develop into mature members of the community without the push to assume parental roles prematurely. Some respondents reported that they were hesitant or reluctant to go home during school breaks because there was no one to talk to them or give them guidance at this stage of their development. There was a general feeling among the participants (63 %) that there is need for an adult figure who would give them emotional support and encouragement as they negotiate through their difficult times - the need for someone to talk to.

Another aspect shared by the participants is the pain of siblings being separated from each other. This arose when the family lived in urban areas and was separated from the larger family network that lived in the rural areas. When the parents die, the children are forced to move back to their rural areas to live among their extended family network. Due to limited resources and poverty inherent in the rural areas, the children in such situations are shared among the extended families. This separation further compounds their sense of loss, and makes them feel displaced, further increasing their emotional distress. This phenomenon is described as one of the most traumatizing experience by one of the participants: *"...we longed for each other but there was nothing we could do to meet one another... we only could write letters and encourage each other to bear the injustices done to us... one day God will unite us ... and meet all our needs."*

Negative outcome

The negative outcome of the participants' experiences of losing a parent(s) was reported by (62.3 %) and this manifested in depression. This sub-theme was deduced from

the participants' expression of sadness, fear, perpetual worries, hopelessness, and distress, lack of sleep, loneliness, and withdrawal as expressed by many of the participants. Other negative aspects mentioned by participants included low self-esteem, stigmatization and rejection, and self-pity. The illness of a parent and their death to AIDS was described as a very traumatizing experience -- witnessing their parent(s) go through the agony and pain, going in and out of hospital, not to mention the expenditure that went with it, made many participants feel helpless and disillusioned. Respondents described this experience as devastating. Being in school while one's parent was hospitalized or ailing from an incurable disease such as AIDS was reported to be particularly stressful. The fear that the parent(s) might die at any time was unsettling and made it hard for the participants to concentrate on their studies. Many interviewed said that in such situations, they perpetually remained expectant of the bad news, as captured in the words of one participant: *"during that time I did not want to see anyone from home just in case they came to bring the bad news."* Another reported her reaction when she was informed about the death of her mother: *"I felt guilty that I was not there to help my mom ...I feel bad and sad that I could not help her."* This sense of helplessness made the participants not only feel guilty, but also hopeless. Some reported being unable to go on with their studies for a while; the experience made some to withdraw from normal activities including interacting with family and friends. One participant reported *"I felt like the world had come to an end...there is nobody in this world who understands what it is like... to loose a father and mother in a span of two years..."*

Stigma and rejection is another stressor experienced by the participants. Stigma for this group was described indirectly. For example, the majority of participants felt discriminated against by their extended families. While some reported that their extended family treated them well, others felt they were denied better education even though the family could afford it. Some reported that their siblings were sent to low-quality schools

even though they had attained grades good enough to get them into better schools.

Respondents often reasoned that their siblings were sent to poor day schools (boarding high schools are the preferred option) so that they could come home every evening and help with the household chores as a way of paying back for being sent to school. Some reported that they did not feel treated especially well by their extended families; they felt they were mistreated and blamed when things went wrong in the family. Respondents often blamed the extended family's neglect and rejection as contributing to some of the children running away from home to live on the streets in Kenyan urban areas.

Stigmatization associated with gossip was also cited as a big problem. Participants mentioned that whenever someone fell sick in the family, people quickly speculated that it must be HIV/AIDS; people would then keep away from that person. One participant observed, "*...it is like there is no other disease in this world except AIDS.*" Because of stigma participants in this study refused to have their interviews taped by explaining that they would never want anyone to know that what killed their parent(s) was AIDS but were willing to share their experiences in the hope that confidentiality would be observed. But they strongly felt it was important for someone to know their experiences, and hopefully solutions could be found to improve their condition.

Positive outcome

While respondents identified various hardships associated with the loss of their parent(s) to HIV/AIDS, they have also identified resources that contributed to their capacity to cope with the demands of being an orphan and caring for their siblings and ailing parent(s). Coping mechanisms identified included personal attitudes and beliefs, family, community and religion.

The personal qualities included the capacity to accept their situation. Several respondents referred to their personal attitudes and beliefs as a factor that allowed them to cope. For example, one respondent said, "*...I told myself, this has happened and it cannot*

be reversed so I just have to move on.” Another one stated, *“losing my parents has taught me a lot about life...I told myself I must wake up and work hard so that I don’t let down my parents, myself, and those that are assisting me.”* Many of the participants reported that they saw their problem as a challenge, as opposed to looking at it as permanent situation. Others observed that they were not the first to lose a parent -- others had and were still moving on with life.

The ability to think through a problem and come up with a solution was another positive quality identified in the participants. For example, the respondents described two ways they have worked out to help deal with their problem of lack of finances. Three respondents reported that they had formed a focus group that met every lunch hour when every one else was out having lunch. This focus group was purposely scheduled during the lunch hour break to distract the respondents from feeling bad that they did not have money to buy lunch. In this focus group they discussed a range of issues including how to help themselves as orphans, shared how they went about their different challenges, and also counseled each other. Within the focus groups the participants reported that they had formed self-help programs that are designed to assist them in raising money that is shared among them in times of emergencies. Two participants shared about their self-help project where they help buy a certain amount of maize and bean seed for planting in their farms. This group worked as a team during the weeding period and harvesting. The team spirit was said to be very helpful in helping the orphan forget the misery and focus on improving their livelihood. This creativity, focus and diversion of energy was a clear determination to succeed instead of wallowing in self-pity or engaging in self-destructive behaviors.

However, only 16.2 % of interviewees indicated that their experience has assisted in their having a positive future outlook and gaining a stronger character (29.7 %), or that they became more mature (18.9 %). It was expected that this sample would score high on self-efficacy because being able to continue with their studies and at the same time

provide care and support to their sibling and ailing parent is seen as an indicator of success. One would expect then that this “coping model” could be adopted to assist others that are not experiencing this same success. That was clearly not the case – the foregoing perceptions and experiences imply, therefore, that HIV/AIDS impact on youth is a much greater problem than is visibly seen on the outside and hence the need for deliberate actions and tools to respond to the situation beyond just a “physical needs provision” approach.

Table 12: Social support themes

Themes	Frequency of Mentions	Percent of Interviewees
Extended family	6	16.0 %
Paternal side	5	13.5 %
Maternal side	13	35.1 %
Community support		
▪ Religious org.	7	18.9 %
▪ University	10	27.0 %
▪ Lecturers	2	5.0 %
▪ Peers	18	48.6 %
▪ Student Counselors	9	24.3 %

There is compelling evidence that families are struggling under the strain of HIV/AIDS, which is reducing their capacity to provide and care for the orphans within their families and communities. The increased numbers of the orphaned children and youth in urban and rural parts of Kenya have weakened the families’ capacity to care and adequately meet the needs of the orphans. Orphans are therefore reaching out to other support systems to enable them to cope (Table 12). Participants in this study identified seven key support systems that in one way or another enabled them to cope. These included the family of the parent still alive, the extended family, faith-based organizations (e.g., churches, mosques, and charitable organizations), well-wishers from the community, friends, the government and the university.

Extended family support

Under normal circumstances, Kenyan families should be playing a leading role in caring and protecting the orphaned children and youth. That only 16 % of the interviewees indicated that the extended family played a key role is of great concern. Also of concern is the indication by participants that the maternal side was more supportive (35.1 %) than the paternal side (13.5 %). As pointed out earlier, this shift in “support provision roles” – from a patriarchal-dominated society in favor of matriarchal dominance, coupled with resource constraints -- will most certainly introduce a new dimension in the HIV/AIDS pandemic response dynamic. The role of grandparents was also underscored. Respondents often reported that they were living with their grandparents from the maternal and paternal side but maternal grandparents were especially commended as being very supportive -- and aunts were reported to be more concerned than uncles. However, the single-AIDS orphans said mothers were more supportive than fathers who they observed quickly entered into other relationships causing increased misery because orphans felt their mothers were being replaced.

Community support

Other important players mentioned by the respondents included peers in youth groups, friends, teachers, pastors/priests, imams, chiefs, the government, and the university. Peers were said to play a major role in helping the orphaned youth cope and adapt. As indicated in Table 12, peers are a primary source of support (48%). Respondents pointed out that peer groups provided support in three main areas: raising funds that were shared among the orphans to improve their economic base; providing informal counseling to individuals in the focus groups; and being there for each other. Lecturers and student counselors were not often said to be supportive (5 % and 24.3 % respectively). One would have expected these professionals to be proactive and instrumental in counseling and encouraging the orphans given that they are often in

contact with this population. It would be expected that these service providers would give priority attention to their students and especially to those who are disadvantaged. It was particularly disappointing to hear that counselors were not as supportive to students in difficulties as expected. Counseling services offered by the Moi University were mentioned by a few respondents as helpful and essential. But many respondents did not seem to know that counseling services were offered at the university. Several reported that they needed the service and would use it if it was available, as one interviewee said: *“the University should know that orphans are there, and should offer counseling services to them.”*

Some participants (18.5 %) indicated that religious organizations had assisted them in their emotional, spiritual and physical needs. One respondent had this to say: *“...there is a priest who has become like my father...he talks to me about life, and encourages me when I am feeling low and lonely... he even bought me a book that is about the struggles of Mahatma Gandhi... I am encouraged I know I will make it.”* Another respondent said, *“Our church pastor comes to pray with us and know how we are fairing on every week.”*

The Higher Education Loans Board (HELB), an entity appointed by the government to manage university student loans (at the national level), was also cited as being helpful in providing financial support by some of the beneficiary orphans. However, other participants complained that they had applied repeatedly but had never been awarded a loan. Deep-seated cynicism toward the Board could be detected from a disappointed participant: *“I wonder who gets these loans if students who have no parents are not considered as qualified.”* The work-for-study⁴ program provided by the University was

⁴ Moi University had in the past secured grants from bilateral donors and private foundations (e.g., the President Clinton Foundation) to support work-for-study programs and this created opportunities for extremely needy students to do small jobs on campus in exchange for some financial support. Though this is a potentially practical way of dealing with needy cases, a strategy to make the program available to more students is constrained by lack of resources and hence sustainability is at present questionable. It must be pointed out that the cost of university education in Kenya continues to evolve and various models are explored to deal with disparities in student socio-economic backgrounds and until a stabilized situation is achieved and more stakeholders

considered helpful, but many participants lamented that the program responded only to emergency situations; for example, only those reported to have gone for days without food qualified to get work under the program. The respondents observed that because of this limitation this program served only a few students yet a lot more poor students could benefit. This has been a “pilot funding program” offered in one of the University campuses but quite limited in scope. In a sense, the implementation of the work-for-study program in the Town Campus of Moi University suggests that opportunities exist that could be developed to make financial resources more available to needy students. It does however, call for visionary and innovative leadership on the part of the university to push the idea further to be able to attract a larger volume of funds.

(e.g., private sector) get involved in funding tertiary education, an effective response to economic needs of students – especially those affected by HIV/AIDS will continue to pose a great challenge.

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Discussion

The overall purpose of this mixed comparative study was to add to the body of knowledge on the orphaned youth by AIDS phenomenon, obtain insights to inform official policy and propose practical intervention strategies (in the immediate, medium and long term) to effectively respond to the orphaned youth problem. The research set out to address three objectives to aid in establishing the impact of HIV/AIDS: to highlight through literature search and review stressors experienced by and targeting the youthful population (generally regarded as those in 15-30 years age range); to examine the risk factors as far as psychological well-being is concerned; and to examine and analyze the role of self-efficacy, coping skills and perceived social support in buffering the orphaned youth from the negative impacts highlighted above. In-depth interviews with the double-AIDS orphans and single-AIDS orphans were incorporated to allow for deeper understanding of the study issues as expressed by the participants. This investigation allowed the researcher to probe and to clarify issues that perhaps could be glossed over in the questionnaire survey. Based on empirical observations, it was clear at the outset that a detailed literature search would be key in unraveling not only the magnitude of the HIV/AIDS pandemic in Sub-Saharan Africa (with primary focus on Kenya), but would offer a portrayal of the extent to which channeling of resources effectively addressed that problem. Although literature is replete with negative manifestation of HIV/AIDS in many African countries (loss of productive sectors of population and hence economic decline), this study established an obvious paucity of data on psychosocial aspects of HIV/AIDS. The choice to focus on orphaned youth was deliberate, to deconstruct the conception that orphans by definition are only children under the age of 18 years (18 being the legal

definition of adult used by most countries including Kenya) who lose parents. It is argued here that family or “socio-economic support units” in the African social fabric are solid units of dependency (albeit battered by forces of rapid globalization) so that parental support goes way beyond the age of 18. Thus, even at age 25 college-going students are in every sense as dependent on their parents as those below age 18 still in high school. The psychosocial profile of HIV/AIDS orphans interviewed in this study attested to this. The literature review and theoretical treatment of the topic sought to piece together evidence to lay a firm basis for HIV/AIDS issues affecting the youth sector of the population; the conceptual framework was to underpin the extent to which scholarship (both in geographic scope and issue relevance) paid attention to the HIV/AIDS problem for various sectors of the population in sub-Saharan Africa, and in particular young people.

Very limited literature was found that specifically addressed the psychosocial issues affecting youth orphaned by HIV/AIDS; almost all of the published literature addressed issues affecting younger children -- this despite the wealth of common knowledge that youth orphaned by HIV/AIDS in Kenya (and indeed in much of sub-Saharan Africa) bear the most burden as far as care-giving to their infected, ailing parents and siblings, and the fact that youth assume the role of parenting of their siblings when parent(s) die. One possible explanation for the scarcity of published reports on the subject, especially in sub-Saharan African (except the Republic of South Africa), is the emergency-response, “containment” approach taken by most governments and international support agencies channel resources to “addressing physical needs” arising from effects of HIV/AIDS. Very limited resources are available for research and where research is being undertaken this has tended to be more in the aspect of clinical medicine. For example, in Kenya, the University of Nairobi faculty of medicine has been involved in collaborative HIV research with foreign institutions (universities) or with Kenya Medical Research Institute (KEMRI). It is interesting to note that much of the published literature

on psychosocial HIV/AIDS issues focusing on selected countries (regions) in Africa is by western scholars, suggesting weak or non-existent capacity on the continent itself for reflection on the resource constraints.

Studies of children orphaned by HIV/AIDS and studies of youth who are homeless, war refugees, and from divorced families established that young people experienced stressors similar to youth orphaned and made vulnerable by HIV/AIDS. Some of the common stressors highlighted included poverty, risk of dropping out of school, being stigmatized, and being predisposed to psychological risks, and negative consequences occasioned by grief and losses and separation from family members. Given that HIV/AIDS kills both parents in most cases, repeated grief/loss has been reported as traumatizing and impacts negatively on psychological well-being (Humuliza, 1999; Rotheram-Borus & Stein, 1999; Germann, 2004). Hence, analysis of the qualitative interviews with the single-AIDS and double-AIDS orphans conducted in this study seems remarkably consistent with published data. Participants often highlighted poverty, poor school performance, grief and loss, loss of inheritance to relatives, and assuming the role of parenting of siblings as some of the stressors they experience. It has been shown that multiple stressors experienced by young people who have lost parents to HIV/AIDS have the potential to impact negatively by causing undue anxiety, eroding their self-esteem and causing them to be depressed (Germann, 2004; Wild, 2001; Sengendo & Nambia, 1997; Bicego et al., 2003). Lack of intervention threatens the psychological well-being of orphaned youths; given widespread effects of HIV/AIDS scholars point out that future generations will be weakened hence the urgent need for holistic response. The analysis of literature served to additionally support the second objective of the study and provided a basis for formulation of testable hypotheses discussed below.

The second study objective examined risk factors that youths orphaned by HIV/AIDS may be exposed to due to their circumstances. Psychosocial issues experienced

by the youth orphaned by HIV/AIDS were examined by carrying out a survey of life hassles and life uplifts (basis of hypothesis 1 - H1) to shed light on the two constructs (hassles and uplifts) compared in double-AIDS orphans and single-AIDS orphans in comparison to non-orphans (those living with father and mother), double orphans and single orphans due to other causes. Second, anxiety, depression and self-esteem were measured to further facilitate understanding how the psychological well-being of youth is impacted when they are orphaned by HIV/AIDS (hypothesis 2 –H2).

Life hassles and life uplifts

The paired *t*-tests and the one-way ANOVA carried out to compare the mean hassles and mean uplifts for each of the participants revealed that for non-orphans, single non-AIDS orphans and double non-AIDS orphans, there exists a significant difference between the mean hassle scores and the mean uplifts scores. Interestingly, for single-AIDS orphans and double-AIDS orphans there was no statistically significant difference between mean uplifts scores and mean hassles scores ($p > 0.05$). This means that from the data, there is no evidence to support the hypothesis that youth orphaned by HIV/AIDS would have more life hassles than life uplifts (Table 1; refer also to Figs 2 and 3). While a number of reasons could be advanced for this finding, it is plausible that in this case the survey was not well understood by the participants. However, this does not seem to apply to all the participants across the board – this seemed to be an outcome specific to the participants orphaned by HIV/AIDS. This peculiar characteristic demonstrated by this category of participants (HIV/AIDS) orphans could be indicative of their self-efficacy, separating them from other orphans.

These results seem to suggest that double-AIDS and the single-AIDS orphans did not appraise hassles as irritancies or difficulties but as challenges – hence an indication of resilient behavior developed by the orphans as they adapted to their traumatic and difficult situations. This would seem to confirm Bandura's theory of self-efficacy in which he

observed that individuals with high perceived efficacy tend to interpret their demands and problems as challenges rather than threats and uncontrollable events and further explained that such individuals would develop internal resources that enable them to appraise difficult situations optimistically and that enhance the ability to face stressful events with confidence (Bandura, 1995; Stein, 2003). Responses received from participants in the interviews further lent credence to Bandura's theory: some participants indicated that despite hardships associated with the loss of their parents(s) to AIDS, personal beliefs and attitudes had helped them cope. One participant said, *"I am not the only one experiencing this problem, there are many others and are moving on with life I told myself I must move on."* Another said, *"I told myself if I worry too much I will not be able to assist my brothers and sisters and will let my parents down so I woke up and I am doing well."*

Other themes emerging from the qualitative data that further seem to support the self-efficacy theory include seeking support from extended family and friends, religious communities, religious beliefs, and recognition of personal attitudes and beliefs that allowed respondents to deal with adversity. These coping strategies are consistent with those pre-stressor characteristics that have been identified in other populations as protective to the development and maintenance of psychological disturbances. Specifically, personal attitudes and beliefs, social and family support, spirituality and religious faith (Stein, 2003; Greef & van der Merwe, 2004) are important factors in promoting resilience.

One other possible explanation for this unexpected result could be attributed to the social environment of the Kenyan society vis-à-vis the questionnaire survey instruments. Although rapidly changing, the Kenyan society is still largely a complex of family and community networks that formally or informally acts as protective to family members and individuals in times of adversity. This therefore means that the individual voices are less manifest than the voice of the larger entity – family or community - so much so that most

people would often internalize their own issues rather than verbalize them. Use of questionnaires as a tool for probing social issues in Kenya (especially self-administered), therefore, is yet to find full potential and cultural acceptability and practical utility. It is not uncommon to visit many public service utilities in Kenya where simple customer satisfaction comments are openly requested and yet hardly anybody bothers to respond to the simple questions perhaps because of the attitude “it does not really matter.” So, was the observation an indication of resilience on the part of the participants, or simply an attitude of mind about the futility of revealing personal issues on paper? Personal revelations recorded in the detailed one-on-one interviews appear to validate the latter: there was much more expression of hassles felt than was apparent in the analysis of the questionnaire. Hence, to disentangle hassles-uplifts construct, questionnaire sampling and externally induced response biases must be controlled. Perhaps one effective way would involve training of participants in the value of such research and the instruments used prior to administration of a questionnaire.

Self-Esteem

To address the second hypothesis a one way ANOVA test was used to examine whether participants’ status influences the psychological welfare outcome (Table 4, see also Fig 3). The mean self-esteem score for double-AIDS orphans was statistically different from that of non-orphans and from that of single non-AIDS orphans. This could mean double-AIDS orphans have lowered self-esteem in comparison to the non-orphans and single non-AIDS orphans. The extended family and the communities adversely affected by HIV/AIDS may lack the capacity to care and give adequate support for youth orphaned by HIV/AIDS. The coping strategies adapted often involve leaving the orphaned children and youth to stay together in their parents’ home alone. While the extended family would visit the orphans to offer occasional emotional and material support, this support is insufficient and cannot substitute for love, care, parental guidance and support.

This living arrangement could be interpreted as rejection and isolation. Literature highlights a general stigmatization and isolation by families, communities, institutions within communities and discrimination by service providers in accessing rights and service.

Studies carried out in Zambia, Zimbabwe, and Rwanda with orphaned children who are taken in by relatives have shown that they are blamed for everything that goes wrong within their families, are overworked, and are the first to be withdrawn from school whenever there is shortage of money in the family; while older youth complained of gossip within their communities about families infected and affected by HIV/AIDS (Bray, 2003; Save the Children South Africa, 2001; Germann, 2004). These experiences have the potential to negatively impact on the self-esteem of youth orphaned by HIV/AIDS.

This observation was further observed by the qualitative inquiry that established youths orphaned by HIV/AIDS have poor self-esteem. In the qualitative interviews, 53 % (n = 37) of double-AIDS and single-AIDS orphans manifested poor self-esteem - many of them said they preferred to stay alone while in college, as described by one: *“I keep to myself because I have nothing good to share with my peers but pain...see the clothes I am wearing, I don’t think they will appreciate me in their company.”* Others explained that when college-mates came together they talked about things they did with their families, e.g., how they spent their holidays and places they visited; youths orphaned by AIDS said they felt pity for themselves for they had no families to talk about or take them to places. One said, *“I pity myself when I see my colleagues happy talking about how they spent Christmas and what presents their parents gave them, me and my siblings we were more worried about our meals for the day.”* This finding is closely associated with the findings of the study by Rudolph & Clark, (2001) carried out in America, with young adolescents and which found out that in line with cognitive interpersonal theories, the diathesis extend to interpersonal areas as young adolescents with depressive moods hold more negative

interpersonal experiences and have maladaptive relationship – oriented beliefs and more negative conceptions of peer relationships, and process and view interactions more negatively.

A greater proportion of those who participated in the interviews expressed low self-esteem (62 %) were double orphans which indicates having one parent or a care giver did/could boost self-esteem to some extent.

Depression

The mean depression score for non-orphans was found to be statistically different from that of single-AIDS orphans, double-AIDS and double non-AIDS orphans. Also observed is that the mean depression score for a double-AIDS orphan was statically different from that of single non-AIDS orphans. Though this study is not theories based, the cognitive theory which proposes that persons with depression or prone to depression are likely to have poor self esteem; seem to be supported based on the self – esteem results both for the quantitative and the qualitative above. Further, a strong support has emerged for the cognitive diathesis for depression among children and adolescents stating that negative attribute style and low self esteem have been found to be associated with depressive symptoms and clinical depression across age, gender, and sample type (Abramson et al., 2001). These theories though formulated for a different cultural setting, amazingly here seem consistent with work done with younger children and adolescents orphaned by HIV/AIDS in Tanzania and Uganda by Makame et al. (2002), Atwine, et al. (2005) and Sengendo et al., (1997) within the age brackets 15-24 years, which showed children and adolescents affected by HIV/AIDS had depressive symptoms and had poor self esteem and concluded that orphans due to HIV/AIDS had high levels of psychological distress compared to non-orphans.

Like adults, youth are grieved by the loss of their parents. However, unlike adults youth hide their grief because in the case of African culture it is seen as a sign of weakness

to mourn openly especially by young men. This prevents them from going through the grieving process which is necessary to recover from the loss (Cree, 2003). Youths are therefore at risk of living with unresolved emotions which are often expressed in anger and depression. Unfortunately, adults do not seem to appreciate that youth are adversely affected by bereavement and need someone to reach out to them, in terms of support and encouragement to express their emotions, nor are they guided to deal with them. When they lack strength to perform their chores or fail to attend school they are branded as rebels or punished (Sengendo & Nambia, 1997).

Death of parent(s) comes with major changes in the life of a vulnerable youth. This change may involve relocation to a poor neighborhood, or moving in with relatives that one is not too familiar with, or may cause separation from a sibling which is usually done without consultation with the orphans, causing them much pain (Sengendo & Nambia, 1997). Examples were given in this study in which affected participants shared how they struggled to continue with their education while at the same time feeding for their siblings. All these changes and social adjustments could easily affect not only the physical but also the psychological well-being. Moreover, the sample interviewed for this study and which consisted of double-AIDS orphans and single-AIDS orphans described their experiences as traumatizing and one that left some feeling a sense of hopelessness and disillusionment. The double and single-AIDS orphans reported that the sense of helplessness made it hard for them to function normally - some withdrew from attending college for some time while others said they preferred to withdraw from everybody including their family members and sought for opportunities to relieve their emotional pain in overworking or drinking alcohol. Other depression symptoms reported included feeling sad, guilt, anger, insomnia, and loss of interest in recreation activities and interacting with peers.

Surprisingly, several participants indicated they had not seen their student counselor even though there are student counseling offices in all the campuses covered in

this study. Reasons cited included lack of knowledge of the existence of such services within the university, and lack of trust in the officials to keep confidential the information provided. The participants feared their matters could easily become accessible to the administration and feared being stigmatized. Two observations emerged from those who utilized counseling services offered by the university: some felt the counselors were not well trained in mental health counseling, while others said they were helped and felt supported.

Anxiety

The results failed to support the hypothesis that youths orphaned by HIV/AIDS would exhibit high levels of anxiety. The inconsistency with the hypothesis could be due to the sample size, insensitivity of the survey instrument to capture this attribute or failure by participants to understand the survey. It must also be noted that measuring anxiety at one point in time can be quite misleading as mood swings fluctuate greatly and it is conceivable that since the time chosen by the participants to fill the questionnaire was under their control any measure or interpretation of anxiety in those conditions was likely to be artificial. However, the tripartite model seem to suggest that there exists a strong relationship between anxiety and depression with correlations between self report measures of anxiety and depression typically ranging from .50 to .70. This model views symptoms of anxiety and depression along three broad dimensions as explained by (Watson & Clack, 19995). The first general affective distress or negative affective (NA) is associated with both depression and anxiety. The second, physiological hype- arousal (HP) is specific to anxiety and the third, a lack of positive affect (PA), is specifically associated with depression. The nonspecific shared symptoms of negative affect are thought to explain the strong association between measures of anxiety and depression. Though this study did not investigate the relationship between anxiety and depression; from the tripartite model it seem anxiety proceeds depression. It maybe possible that the

participants in this study were anxious though the instruments failed to capture this. This is so given the fact that the one way ANOVA mean self – esteem scores and depression scores were found to be significant at 0.05 levels. It seems before one becomes depressed there is a likely hood of them first becoming anxious before the onset of depression.

In the interviews the participants indicated they felt anxious when they did not know where their next meal would come from. They equally felt anxious when they did not have money for fees. These experiences were not captured by the quantitative measure though captured by the qualitative interviews. The participants also talked about being worried about their siblings when they did not behave well or went wayward.

Coping skills/ self-efficacy/perceived social support

The third study objective examined and analyzed the extent to which coping skills, self-efficacy and social support protect the young person from the negative impacts of orphanhood due to HIV/AIDS. Pearson correlation coefficient tests were performed to investigate whether anxiety, depression and self-esteem scores depended on the coping skills, self-efficacy and social support scores (hypothesis 3). Results seem to suggest that depression and self-esteem scores are associated most with the level of social support, except for double-AIDS orphans whose depression scores were related to their coping skills. Interestingly, these results seem to partially support the proposed hypothesis

Coping

Though coping mechanism was not appraised as a key play for all the categories in protecting the participants from the negative impact of HIV/AIDS, it is important to note here that in the interviews the participants have clearly indicated their coping strategies that have enabled them to cope. For example the engagement coping theoretical approach is seen as responsible for the positive outcome described in the result section.. Those who reported positive outcome stated that they had a creative way of dealing with their problems including reaching out to others with similar issues and the administration for

economic and psychological assistance. Those who reported negative outcomes said they were withdrawn and felt self – pity, they also reported poor – esteem. Some reported that they kept to themselves which is a poor strategy for coping (disengagement coping). This study did not attempt to compare these means for conceptualizing purposes; however there is need for such a study.

Social support

On the other hand there seems to be a consistent relationship across the categories indicating that social support may be key in minimizing the negative impacts of anxiety, depression and poor self-esteem. This finding is in agreement with the approaches suggested by scholars and the international agencies interested with the welfare of orphaned children and youth by AIDS who recommend that families and communities where these orphans live should be strengthened and enabled to protect and care for the orphans. This is in recognition that families and communities are better placed than external sources to provide support for orphans. Ayieko (2000) observed that most Kenyans live within communities of extended families and kin in rural areas. The villagers are endowed with basic resources, production information, and customs and traditions essential for sustaining life and raising families in a rural community. Literature has tended to recommend the strengthening of the capacity for families, extended family networks and communities to care and protect orphans and vulnerable children and youth (Ayieko, 2000; Foster & Germann, 2002). However, the capacity of families and communities to protect the rights and ensure the well-being of their youth and children depends largely on the ability of a household to meet immediate needs, ensure a steady income and maintain the integrity of its economic safety net. Possible interventions should aim to enhance the economic resilience of the households, by advancing households conditional cash transfers, direct subsidies and material assistance to help alleviate the urgent needs of the most poor as lasting measures are sought. Some of the measures

recommended to enhance capacity of affected households (families) include: improving household economic capacity; provision of psychosocial support to affected children and youths; strengthening and support towards child-care capacities; and supporting succession planning, prolonging the lives of parents and strengthening of young people's life skills (UNAIDS/UNICEF, 2004).

The finding that double-AIDS orphans' depression scores significantly related to their coping skills seems to indicate further that families and communities are perhaps being weakened by the scourge of HIV/AIDS making it hard for these institutions to play their traditional role of caring for and protecting the orphans and the vulnerable. Two observations are advanced here as possible reasons why double-AIDS orphans depend on themselves and not the perceived support from family, peers and the community. On one hand the frequent deaths occurring in the families and communities are weakening the extended family system and threatening to separate household members. This trend is likely to continue reducing surviving members' capacity to manage and support each other until an effective educational program is established.

The growing individualistic trend could also be attributed to calamities such as frequent droughts, famine and civil strife that have weakened and undermined the social safety of the Kenyan society as a whole. The current urban lifestyle and tendency to emulate western media driven influences and portrayals of nuclear family are also playing a role in eroding the concept of extended family support system. Funeral rituals and expenses which were once an affair of the whole community are becoming a household burden. Children are no longer the collective responsibility of communities, a legacy that has been historically associated with child-rearing in Africa. Extended families no longer feel obliged to welcome orphans when they are not even sure of the future for their own children. Increasingly hard economic times have forced many households in urban and rural areas to overstretch household resources and the sheer magnitude of the HIV/AIDS

pandemic and resultant socio-economic and psychological effects have exacerbated the situation. Kenyan communities have always been known for their spirit of support. Families and friends would unite in pooling resources together to help each other during major financial needs. Such devotion and attachment are slowly fading away as each family fends for its own survival. The observations are further supported by Ayieko's research on single parents and child-headed households in which he reported that orphans of HIV/AIDS who live alone are experiencing fewer and fewer or no contacts with their extended families. Respondents to the question of frequency of relative visits to orphans indicated that 52 % had no one to visit them (Ayieko, 2000).

Stigma could also be a contributing factor as to why the double-AIDS orphans rely on their coping strategies to overcome negative psychological impact. Examination of results from the interview carried out with single and double-AIDS orphans' shows that 56.7 % felt stigmatized while 54 % felt disadvantaged as far as receiving community communal services, e.g., the university loan and bursaries. Youth may face stigma due to HIV and AIDS in the family, their own status, or their AIDS-related poverty or orphanhood. This stigma can prevent youth and families from seeking help or prevent others from offering assistance (UNCHR, General Comment Number 3, 2003). Stigma can prevent equal access to financial opportunities. Youth who are deprived of the means for survival and development are at high risk for sexual and economic exploitation.

Self - efficacy

Self – efficacy the capacity to believe in the ability to overcome obstacles, challenges and adversities in one's life (Creer & Wigel, 1993). Self – efficacy can give a person certain beliefs that they can accomplish certain behaviors and that they have control of certain situations in their environment (Bandura, 2001). Self – efficacy though only inferred by the fact that the double AIDS' orphans seem to depend on their coping. The orphaned youth by AIDS who were interviewed identified recourses that contributed

to their capacity to cope with the demands of being an orphan and caring for their siblings and ailing parent(s). Resources identified included personal attitudes and beliefs, family, community and religion. The personal qualities included the capacity to accept their situation.

The ability as reported by the participants, to see their problems as a challenge as opposed to looking at it as a permanent situation is resourceful and a creative way of minimizing an otherwise tragic situation. Further, the participants demonstrated an ability to think through their problem by forming cohesive focus groups that served to provide both the emotional and financial support. This ability to handle stress by making ones' environment less threatening is perhaps a demonstration of high self – efficacy.

One clear observation from the interviewees is their optimism; participants indicated that their experiences has assisted in their having a positive future outlook and have gained a stronger character or that they became more mature. It is important to note here that the University students were selected for participation so as to learn from this rather successful group their adaptation models so it can be replicated with other children and youth who maybe struggling.

Study Conclusions

The following conclusions were drawn from the study:

Self-efficacy

As discussed above youth orphaned by HIV/AIDS have high levels of self – efficacy. The challenge experienced has made them develop a positive future outlook; have enabled them gained strength in character and have matured through the problem.

Though not very clear why the participants failed to appraise life hassles as difficulties or as life threatening; the findings further suggest that the meanings that

orphaned youth attributed to their experiences allowed them to consider themselves not as victims but as people needing to engage with the demands of their unique situation. This point is illustrated by most respondents' feeling responsible for their siblings' well-being while simultaneously adapting to their own situations.

Depression and poor self-esteem

Strong evidence was deduced from the study that double-AIDS orphans and the single-AIDS orphans are depressed and have poor self-esteem, which was in agreement with work of others (e.g., studies done by Atwine et al. (2005) in Uganda with adolescents aged 14-24 and that done by Makame et al (2002) in Tanzania with children aged 13-17 in which they demonstrated depressive tendencies among children and youth orphaned by AIDS). Further data from the interviews seem to strongly support this finding seen in the manners which double orphans view themselves while in company with other students some said they felt they did not have anything good to share since they did not have a family to share about. Others withdrew and felt pity about them-selves, while others were ashamed by their state and the kind of cloth they wore.

Social support and coping skills

Analysis of data revealed that for all categories of participants, social support played a key role in protecting the participants from negative psychological impacts except the double-AIDS orphans who do not seem to benefit from such support. Preliminary indications seem to suggest that double-AIDS orphans depend more on their coping mechanisms to overcome depression and not social support.

Though no evidence was obtained to indicate that self-efficacy plays any role in as far as protecting the single and double-orphans due to AIDS from negative psychological impacts of HIV/AIDS from the quantitative data analysis; the qualitative data indicate otherwise the participants reported high levels of self – efficacy as responsible for their

positive adaptation and protection against negative psychological well – being.. (p. 105,106)

Study Limitations

The study findings need to be considered in the light of various potential limitations. Students who returned the questionnaire package may have exaggerated their response in hope that this will move the University administration and the government to consider increasing their HELB loan and bursary. This is a common flaw of social surveys where responses are influenced by expectation-induced responses. This was evidenced by pleas expressed during the interviews requesting the University and the government to increase the loan and bursary allocations advanced to the orphans in general. Another important limitation of this study was time. More time is required to carry out in depth investigations in a concentrated way and giving adequate time to allow the participants to explore their issues in more relaxed atmosphere. It was particularly challenging as the study focused on a group with high demands on their time. As alluded to in discussion above, time constraints could also have influenced quality of responses given in the questionnaires. The number of students interviewed was lower than intended as most potential participants simply could not afford the time.

Funding was a major constraint: only partial funding was obtained to conduct the research and the involvement of research assistants, running the pilot study, the added component of a qualitative study and distances between the study sites escalated the costs estimated earlier further limiting the study. In the end, the researcher was forced to focus only on critical components of the study to be within available resources.

Little is known about instruments used in this study in an African setting, though the pilot study conducted demonstrated satisfactory internal reliability of the instruments. It was not possible to conduct an external validation of the instruments as no other sources

of information about youth orphaned by HIV/AIDS were available and no other study has used similar instruments in the region.

Recommendations

Practical implications of the study

Orphaned youth by HIV/AIDS need special guidance and counseling programs. This is a specialized service which demands adequate training on the part of the counselors. It is therefore recommended that the institutions of higher learning in conjunction with the Ministry of Education consider recruiting qualified school social workers and youth psychologists who have the skills to diagnose psychosocial problems and to offer psychotherapy to all.

There should be workshops to inform the University administration and the teaching staff about the orphans and other vulnerable groups for care and support. Workshops training should be carried out to educate orphans on survival techniques that will help them know how to manage their resources well; how to raise a family, and matters concerning nutrition and hygiene.

The institutions of higher learning and the government should review the loan facility and bursary allocation advanced to all orphans in general. The current amount provided is insufficient given that orphans use this little amount to sustain themselves and to support their ailing parent(s) and their siblings.

Institutions of higher learning should source for scholarships specific for orphaned students to enable them complete their studies.

The orphan self-help groups formed within the university should be supported by the university administration and utilized to enhance group counseling, vocational training, survival skills, time management and parenting skills

Nationally, the government should work with civil society organizations to plan social protection programs that include social transfer (conditional cash advanced to orphaned families to alleviate income poverty and enable vulnerable households to meet their basic needs), including assisting the orphaned children and youth to remain in school

Gaps identified in the study

There is need to investigate the relationship between anxiety, self – esteem, and depression based on the tripartite model in the Kenyan context.

How can additional risks for HIV infections among orphans be addressed?

What kind of psychosocial interventions can best help those orphaned to adapt well?

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APPENDIX A: Information Letter To Participants (Interviews)

TITLE OF PROJECT: PSYCHOSOCIAL ISSUES OF YOUTH ORPHANED BY HIV/AIDS.

PRINCIPAL INVESTIGATOR: Dr. JOHN BARLETTA

STUDENT INVESTIGATOR: LUCY KIYIAPI

Dear Participant,

I am writing to invite you to participate in a research project which will seek to understand the issues that orphaned youth who have lost parents to AIDS face. This research project will be conducted as part of studies by Lucy Kiyiapi for her PHD at Australian Catholic University. The participants will be requested to fill in a questionnaire.

To understand the issues that orphaned youth face, a survey will be carried out in Moi University involving both orphaned and non-orphaned students. The participating students will be required to answer short questions included in the questionnaire. The short questions are phrased in a manner not meant to cause any emotional discomfort or distress but should that happen included here below are telephone numbers of Student Counsellors, feel free to conduct the Student Counsellor in your campus.

Main Campus:	John Ayieko	Tel: 53-2061403
Chepkolel	Winne Kotut	Tel: 53-2063634
Eldoret West	Lydia Omoha	Tel: 53-2062970
Town Campus	Eva Amayamu	Tel: 53-2062645

It is estimated that the questionnaire will take no more than 45 min - to one hour to fill. However the participants have the option of taking the questionnaire home to fill and return to the research assistant in a week's time.

The project has many potential benefits to the orphaned students, the University and the Kenyan communities in general. The study gives the orphaned youth an opportunity to share their experience and difficulties. This project will not only contribute to better understanding of the orphaned student's issues but also their live in general. Information gathered will be published for the purpose of encouraging support and understanding for orphaned youth in the universities and in the communities.

Your agreement to participate in this study is highly appreciated. However should you feel you do not wish to continue you have the right to withdraw from the study at anytime and do not have to provide any reasons for that decision. There are no risks for withdrawing your participation in this study at all.

To ensure confidentiality, you are requested not to write your name on the questionnaire. Data for this study will be reported in aggregate and descriptive form. Result from the study will be reported in Lucy Kiyiapi's doctoral thesis and may be summarized and

appear in publication and conference presentations in a form that does not identify the participants in any way.

In case you have any questions or concerns regarding this project please direct your questions to

Dr John Barletta MAPS (Principal Investigator)
The School of Psychology
P.O. Box 456 Virginia Q. Australia 4014
Email: j.barletta@mcauley.acu.edu.au
Tel 617 3623 7327

And

Lucy Kiyiapi
P.O Box 7095
Eldoret Kenya
Email: legilisho@yahoo.com
254 53 2062895
245 0733496480

Results from the study will be made available for the participants in form of bound thesis and may be found in all the libraries of Moi University.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any questions that the Researcher has not been able to satisfy, you may write to the Chair of the Human Research ethics Committee on the address below. Any complaint or concern will be treated in confidence and fully investigated. The participant will be informed of the outcome.

Chair, HREC
C/o Research Services
Australian Catholic University
Locked Bag 2002
Strathfield, NSW 2135
Tel: 02 9701 4159 Fax: 02 9701 4350

If you agree to participate in this study, please sign both copies of the Consent form, retain one copy for your record and leave the other copy with the research assistant in your campus.

Regards,

Dr. John Barletta MAPS
Senior Lecturer in Counselling and Psychology
School of Psychology
Australian Catholic University

APPENDIX B: Consent Form - Participant's Copy

TITLE OF PROJECT: Psychosocial Issues of Youth Orphaned by HIV/AIDS

PRINCIPAL INVESTIGATOR: Dr JOHN BARLETTA

STUDENT INVESTIGATOR: LUCY KIYIAPI

I.....(the participant) have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I can withdraw at any time.

I agree that data collected may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT.....
(block letters)

SIGNATURE.....DATE.....

SIGNATURE OF PRINCIPAL INVESTIGATOR.....

Date.....

APPENDIX C: Consent Form - Researcher's Copy

TITLE OF PROJECT: PSYCHOSOCIAL ISSUES OF YOUTH ORPHANED BY HIV/AIDS

PRINCIPAL INVESTIGATOR: DR JOHN BARLETTA

STUDENT INVESTIGATOR: LUCY KIYIAPI

I..... (*the participant*) have read and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I can withdraw at any time.

I agree that data collected may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT.....
(block letters)

SIGNATURE.....DATE.....

SIGNATURE OF PRINCIPAL INVESTIGATOR.....
DATE.....

APPENDIX D: Ethics Approval Letter From Queensland

QLD Ethics" <QLD_Ethics@mcauley.acu.edu.au>  [View Contact Details](#)

To: "john barletta" <j.barletta@mcauley.acu.edu.au>,
"Anne Tolan" <A.Tolan@mcauley.acu.edu.au>,
legilisho@yahoo.com

Subject: Q2004.05-25 (Barletta) Ethics Approval

Date: Fri, 10 Jun 2005 12:38:57 +1000

Dear John, Anne and Lucy,

Thank you for returning the amendments to your ethics application Q2004.05-25 Barletta *Psychological Issues of Youth Orphaned by HIV/AIDS*.

In light of the received amendments, the Deputy Chair of the Expedited Review Panel that assessed your ethics application has granted ethics approval.

The approved period of data collection is the **1 October 2005 to 30 March 2006**. A progress report is due at the end of this period. The relevant form may be obtained via the ACU website or by contacting Research Services directly.

A hard copy of the Approval Form has been put in the internal mail (to John Barletta).

We wish you well in this research project.

Kind Regards,


Kylie

Kylie Pashley
Research Services
McAuley at Banyo Campus
PO Box 456
VIRGINIA QLD 4014
AUSTRALIA

Tel (+61 07) 3623 7429 Fax (+61 07) 3623 7328
EMAIL: k.pashley@mcauley.acu.edu.au

Australian Catholic University Ltd
ABN 15 050 192 660
CRICOS Registration codes:00004G, 00112C, 00873F, 00885B

APPENDIX E: Ethics Approval Letter From Moi University


MOI UNIVERSITY
OFFICE OF THE DEPUTY VICE CHANCELLOR

Tel: (0321) 43001-6
Fax: (0321) 43047
Telex: (0321) 35047

P.O. Box 3900
Eldoret
KENYA

Ref. No.MU/DVC/REF/14

8TH APRIL 2005

The Vice Chancellor
Australian Catholic University – National
4 – 117 Flower Street
Northgate
QLD AUSTRALIA 4013

Dear Sir/Madam,

RE: LETTER OF AUTHORITY TO LUCY I. KIYIAPI TO CARRY OUT RESEARCH IN MOI UNIVERSITY

The University has received an application from Lucy I. Kiyiapi who is currently your Ph.D. student requesting for a letter of authority to carry out research in our University Campuses.


It has been noted that the research topic is **“The Psychosocial Impact of HIV/AIDS on orphaned students: an exploration of self-efficacy, social connections and problems solving skills”**. As a partial fulfillment of the requirements for the defence of her proposal.

The content the proposal addresses is an important health issue, which will contribute positively to the understanding of the HIV/AIDS pandemic at the University.

It is on this basis that I grant authority to conduct research in the University so long as she complies with Moi University regulations for ethics and research.

Please do not hesitate to contact us for any further information.

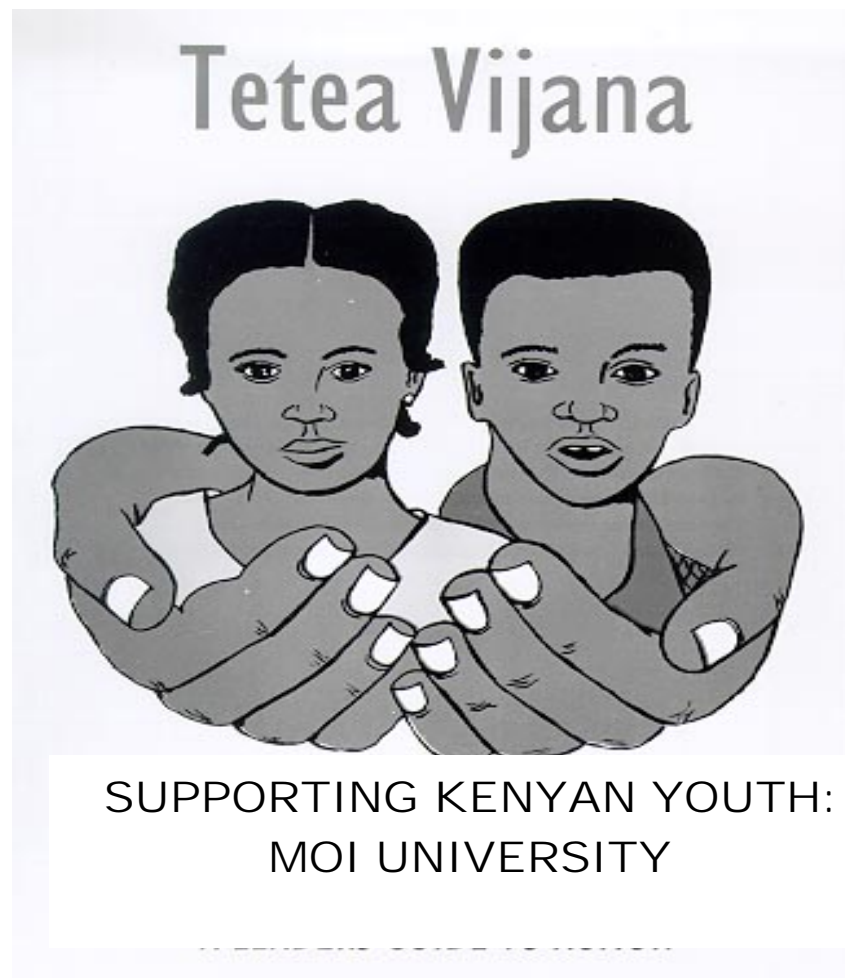
Yours faithfully,


PROF. M. J. KAMAR
**DEPUTY VICE CHANCELLOR
(RESEARCH & EXTENSION)**

Encl.

/gjk

APPENDIX F: Questionnaire



Your willingness to participate in this study is highly appreciated.

Below is a series of questions. Please respond to each question. There are no right or wrong answers – just answer each question based on your situation now. Return the filled copy to the research assistant in the Dean of Students Office in your campus. DO NOT write your name on the questionnaire.

Instructions

Please think about how much of a hassle and how much of uplift each item listed below has been for you today. Please indicate on the left-hand side of the page (under “Hassles”) how much of a hassle the item was by circling the appropriate number. Then indicate on the right-hand side of the page (under “Uplifts”) how much of an uplift it was for you by circling the appropriate number.

Remember, circle one number on the left-hand side of the page and one number on the right-hand side of the page for each item.

How much of a hassle was this item for you today?	How much of uplift was this item for you today?
0 = Not applicable	0 = Not applicable
1 = Somewhat	1 = Somewhat
2 = Quite a bit	2 = Quite a bit
3 = A great deal	3 = A great deal

0	1	2	3	1. Your bothers/sisters	0	1	2	3
0	1	2	3	2. Your parents	0	1	2	3
0	1	2	3	3. Other relative(s)	0	1	2	3
0	1	2	3	4. Your girlfriend/boyfriend	0	1	2	3
0	1	2	3	5. Time spent with family	0	1	2	3
0	1	2	3	6. Health or well-being of a family member	0	1	2	3
0	1	2	3	7. Peers	0	1	2	3
0	1	2	3	8. Intimacy	0	1	2	3
0	1	2	3	9. Family-related obligations	0	1	2	3
0	1	2	3	10. Health or well-being of a family member	0	1	2	3
0	1	2	3	11. Fellow students	0	1	2	3
0	1	2	3	12. social obligations	0	1	2	3
0	1	2	3	13. troubling thoughts about your future	0	1	2	3
0	1	2	3	14. Thoughts about death	0	1	2	3
0	1	2	3	15. Your workload	0	1	2	3
0	1	2	3	16. Not enough money for housing, clothing and	0	1	2	3

0	1	2	3	17. Financial responsibility for your siblings	0	1	2	3
0	1	2	3	18. Enough money for necessities (e.g. food,	0	1	2	3
0	1	2	3	19. Enough money for education	0	1	2	3
0	1	2	3	20. Enough money for emergencies	0	1	2	3
0	1	2	3	21. Enough money for extras (e.g. entertainment,	0	1	2	3
0	1	2	3	22. Financial care for someone who doesn't live	0	1	2	3
0	1	2	3	23. Investments	0	1	2	3
0	1	2	3	24. Your smoking	0	1	2	3
0	1	2	3	25. Your drinking	0	1	2	3
0	1	2	3	26. Abuse drugs	0	1	2	3
0	1	2	3	27. Your physical appearance	0	1	2	3
0	1	2	3	28. Too many responsibilities	0	1	2	3
0	1	2	3	29. Exercise(s)	0	1	2	3
0	1	2	3	30. Your medical care	0	1	2	3
0	1	2	3	31. Your health	0	1	2	3
0	1	2	3	32. Your physical abilities	0	1	2	3
0	1	2	3	33. Concerned about the meaning of life	0	1	2	3
0	1	2	3	34. Trouble relaxing	0	1	2	3
0	1	2	3	35. Too many interruptions	0	1	2	3
0	1	2	3	36. Being lonely	0	1	2	3
0	1	2	3	37. Fear of rejection	0	1	2	3
0	1	2	3	38. Overloaded with family responsibilities	0	1	2	3
0	1	2	3	39. Getting enough sleep	0	1	2	3
0	1	2	3	40. Your physical abilities	0	1	2	3
0	1	2	3	41. Cooking	0	1	2	3
0	1	2	3	42. Having time for rested	0	1	2	3
0	1	2	3	43. Friendly neighbours	0	1	2	3
0	1	2	3	44. Having enough time do what you want	0	1	2	3
0	1	2	3	45. Being with young people	0	1	2	3
0	1	2	3	46. Praying	0	1	2	3
0	1	2	3	47. Having someone listen to you	0	1	2	3

0	1	2	3	48. Recreation and entertainment outside the home	0	1	2	3
0	1	2	3	49. Laughing	0	1	2	3
0	1	2	3	50. Church or community organizations	0	1	2	3
0	1	2	3	51. Getting unexpected money	0	1	2	3
0	1	2	3	52. Being loved	0	1	2	3
0	1	2	3	53. Feeling safe	0	1	2	3

A number of statements which people have used to describe themselves are given here below, read each statement and then select by ticking the appropriate one to indicate **how you feel right now, that is at this moment**. There is no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

1. =Not at all 2 = Somewhat 3 = Moderately 4 = Very much so

1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I am regretful	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel rested	1	2	3	4
9. I feel anxious	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self-confident	1	2	3	4
12. I feel nervous	1	2	3	4
13. I feel extremely nervous	1	2	3	4
14. I feel tense	1	2	3	4
15. I feel relaxed	1	2	3	4
16. I feel content	1	2	3	4
17. I feel worried	1	2	3	4
18. I feel over-excited	1	2	3	4
19. I feel joyful	1	2	3	4

Please read each group of statements carefully, then pick out the one statement in each group which best describes the way you have been feeling the PAST ONE WEEK, INCLUDING TODAY! Circle the number that corresponds to the statement that describes how you feel at the moment. Even though several statements in the group may seem to apply equally well, **choose only one.**

1.	a) I do not feel sad	0
	b) I feel sad	1
	c) I am sad all the time and I cannot come out of it	2
	d) I am so unhappy that I can't stand it	3
2.	a) I am not particularly discouraged about the future	0
	b) I feel I have failed more than the average person	1
	c) I feel I have nothing to look forward to	2
	d) I feel that the future is hopeless and that things cannot improve	3
3.	a) I do not feel like a failure	0
	b) I get as much satisfaction out of things as I used to	1
	c) As I look back on my life, all I can see is a lot of failures	2
	d) I feel I am a complete failure as a person	3
4.	a) I get as much satisfaction out of things as I used to	0
	b) I don't enjoy things the way I used to	1
	c) I don't get real satisfaction out of anything anymore	2
	d) I am bored with everything	3
5.	a) I don't feel particularly guilty	0
	b) I feel guilty a good part of the time	1
	c) I feel quite guilty most of the time	2
	d) I feel guilty all the time	3
6.	a) I don't feel I am being punished	0
	b) I feel I may be punished	1
	c) I expect to be punished	2
	d) I feel I am being punished	3
7.	a) I don't feel disappointed in myself	0
	b) I am disappointed in myself	1
	c) I am disgusted with myself	2
	d) I hate myself	3
8.	a) I don't feel I am any worse than anybody else	0
	b) I am critical of myself	1
	c) I blame myself all the time for my faults	2
	d) I hate myself	3

9.	a) I don't have any thought of killing myself	0
	b) I have thoughts of killing myself, but I would not carry it out	1
	c) I would like to kill myself	2
	d) I would kill myself if I had the chance	3
10.	a) I don't cry any more than usual	0
	b) I cry more now than I used to	1
	c) I cry all the time now	2
	d) I used to be able to cry, but now I can't cry even though I want to	3
11.	a) I am no more irritated now than I ever am	0
	b) I get annoyed or irritated more easily than I used to	1
	c) I feel irritated all the time now	2
	d) I don't get irritated at all by the things that used to irritate me	3
12.	a) I have not lost interest in other people	0
	b) I am less interested in other people than I used to be	1
	c) I have lost most of my interest in other people	2
	d) I have lost all of my interest in other people	3
13.	a) I make decisions as well as I ever could	0
	b) I put off making decisions more than I used to	1
	c) I have greater difficulty in making decisions than before	2
	d) I can't make decisions at all anymore	3
14.	a) I don't feel I look any worse than I used to	0
	b) I am worried that I am looking old or unattractive	1
	c) I feel that there are permanent changes in my appearance that make me look unattractive	2
	d) I believe that I look ugly	3
15.	a) I can work about as well as before	0
	b) It takes an extra effort to get started at doing something	1
	c) I have to push myself very hard to do anything	2
	d) I can't do any work at all	3
16.	a) I sleep very well	0
	b) I don't sleep as well as I used to	1
	c) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep	2
	d) I wake up several hours earlier than I used to and cannot get back to sleep	3
17.	a) I don't get more tired than usual	0
	b) I get tired more easily than I used to	1
	c) I get tired from doing almost anything	2
	d) I am too tired to do anything	3

18.	a) My appetite is no worse than usual.	0
	b) My appetite is not as it used to be.	1
	c) My appetite is much worse now.	2
	d) I have no appetite at all anymore.	3
19.	a) I haven't lost much weight, if any, lately	0
	b) I have lost more than 5 pounds	1
	c) I have lost more than 10 pounds	2
	d) I have lost more than 15 pounds	3
20.	a) I am no more worried about my health than usual	0
	b) I am worried about physical problems such as aches and pains, or upset stomach, or constipation	1
	c) I am very worried about physical problems and it's hard to think about anything else	2
	d) I am so worried about my physical problems that I cannot think about anything else	3
21.	a) I have not noticed any recent change in my interest in sex	0
	b) I am less interested in sex than I used to be	1
	c) I am much less interested in sex now	2
	d) I have lost interest in sex completely	3

Below is a list of Statements dealing with your general feelings about yourself. Circle the number that indicates how much you agree that each statement fits your feelings about yourself.

1 = Strongly Agree

2 = Agree

3 = Disagree

4 = Strongly Disagree

1. I feel that I'm a person of worth, at least on an equal plane with	1	2	3	4
2. I feel that I have a number of good qualities	1	2	3	4
3. All in all, I am inclined to feel that I am a failure	1	2	3	4
4. I am able to do things as well as most other people	1	2	3	4
5. I feel I do not have much to be proud of	1	2	3	4
6. I take a positive attitude towards myself	1	2	3	4
7. On the whole, I am satisfied with myself	1	2	3	4
8. I wish I could have more respect for myself	1	2	3	4
9. I certainly feel useless at times	1	2	3	4
10. At times I think I am no good at all	1	2	3	4

Please read each item below and indicate, by using the following rating scale, to what extent you use these items when solving a problem

0 = Not used 1 = Used Somewhat 2 = Used quite a bit 3 = Used a great deal.

1. Just concentrate on what I had to do next – the next step	0	1	2	3
2. I tried to analyze the problem in order to understand it better	0	1	2	3
3. Turned to work or substitute activity to take my mind off things	0	1	2	3
4. I felt that time would make a difference – the only thing to do was to wait	0	1	2	3
5. Bargained or compromised to get something positive from the situation	0	1	2	3
6. I did something which I didn't think would work, but at least I was doing something	0	1	2	3
7. Tried to get the person responsible to change his or her mind	0	1	2	3
8. Talked to someone to find out more about the situation	0	1	2	3
9. Criticized or lectured myself	0	1	2	3
10. Tried to cut ties, but left things open somewhat	0	1	2	3
11. Hoped a miracle would happen	0	1	2	3
12. Went along with fate – sometimes I just have bad luck	0	1	2	3
13. Went on as if nothing had happened	0	1	2	3
14. I tried to keep my feelings to myself	0	1	2	3
15. Looked for the silver lining, so to speak. Tried to look on the bright side of things.	0	1	2	3
16. Slept more than usual	0	1	2	3
17. I expressed anger to the person(s) who caused the problem.	0	1	2	3
18. Accepted sympathy and understanding from someone	0	1	2	3
19. I told myself things that helped me to feel better	0	1	2	3
20. I was inspired to do something creative	0	1	2	3
21. Tried to forget the whole thing	0	1	2	3
22. I got professional help	0	1	2	3
23. Changed or grew as a person in a good way	0	1	2	3

24. I waited to see what would happen before doing anything	0	1	2	3
25. I apologized or did something to make up.	0	1	2	3
26. I made a plan of action and followed it.	0	1	2	3
27. I accepted the next best thing to what I wanted.	0	1	2	3
28. I let my feelings out somehow.	0	1	2	3
29. Realized I brought the problem on myself.	0	1	2	3
30. I came out of the experience better than when I went in.	0	1	2	3
31. Talked to someone who could do something concrete about the problem	0	1	2	3
32. Got away from it for a while, tried to rest or take a vacation.	0	1	2	3
33. Tried to make myself feel better by eating, drinking, smoking, using drugs or meditation	0	1	2	3
34. Took a big chance or did something very risky.	0	1	2	3
35. I tried not to act too hastily or follow my first hunch	0	1	2	3
36. Found new faith.	0	1	2	3
37. I maintained a brave face.	0	1	2	3
38. Rediscovered what is important in life.	0	1	2	3
39. Changed something so things would turn out all right.	0	1	2	3
40. Avoided being with people in general.	0	1	2	3
41. Didn't let it get to me; refused to think too much about it.	0	1	2	3
42. I asked a relative or friend I respected for advice.	0	1	2	3
43. Kept others from knowing how bad things were.	0	1	2	3
44. Made light of the situation; refused to get too serious about it.	0	1	2	3
45. Talked to someone about how I was feeling.	0	1	2	3
46. Stood my ground and fought for what I wanted.	0	1	2	3
47. Took it out on other people.	0	1	2	3
48. Drew on my past experience; I was in a similar situation before.	0	1	2	3
49. I knew what had to be done so I doubled my efforts to make things work.	0	1	2	3
50. Refused to believe that it had happened.	0	1	2	3

51. I made a promise to myself that things would be different next time	0	1	2	3
52. Came up with a couple of different solutions to the problems.	0	1	2	3
53. Accepted it since nothing could be done.	0	1	2	3
54. I tried to keep my feelings from interfering with other things too much.	0	1	2	3
55. Wished that I could change what had happened or how I felt.	0	1	2	3
56. I changed something about myself.	0	1	2	3
57. I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58. Wished that the situation would go away or somehow be over with.	0	1	2	3
59. Had fantasies or wishes about how things might turn out.	0	1	2	3
60. I prayed.	0	1	2	3
61. I prepared myself for the worst.	0	1	2	3
62. I went over in my mind what I would say or do.	0	1	2	3
63. I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64. I tried to see things from the other person's point of view.	0	1	2	3
65. I reminded myself how much worse things could be.	0	1	2	3

Instructions: I am interested in how you feel about the following statements. Read each statement carefully and indicate how you feel about each statement by circling the relevant number using the following rating scale:

1 = Very strongly disagree

2 = Strongly disagree

3 = Mildly disagree

4 = Neutral

5 = Mildly agree

6 = Strongly agree

7=Very strongly agree

	1	2	3	4	5	6	7
1. There is a special person with whom I can share my joys and sorrows	1	2	3	4	5	6	7
2. My family really tries to help me	1	2	3	4	5	6	7
3. I get the emotional help and support I need from my family	1	2	3	4	5	6	7
4. I have a special person who is a real source of comfort to me	1	2	3	4	5	6	7
5. My friends really try to help me	1	2	3	4	5	6	7
6. I can count on my friends when things go wrong	1	2	3	4	5	6	7
7. I can talk about my problems with my family	1	2	3	4	5	6	7
8. I have friends with whom I can share my joys and sorrows	1	2	3	4	5	6	7
9. There is a special person in my life who cares about my feelings	1	2	3	4	5	6	7
10. My family is willing to help me make decisions	1	2	3	4	5	6	7
11. I can talk about my problems with my friends	1	2	3	4	5	6	7

Read the statements below carefully. Then select your answer from the provided responses below. Write the number at the end of the sentence.

1 = Not at all true

2 = Hardly true

3 = Moderately true

4 = Exactly True

1.	I can always manage to solve difficult problems if I try hard	1	2	3	4
2.	If someone opposes me, I can find the means and ways to get what I want	1	2	3	4
3.	It is easy for me to stick to my aims and accomplish my goals	1	2	3	4
4.	I am confident that I could deal efficiently with unexpected events.	1	2	3	4
5.	My resourcefulness enables me to handle unforeseen situations.	1	2	3	4
6.	I can solve most problems if I invest the necessary effort	1	2	3	4
7.	I can remain calm when facing difficulties because I can rely on my coping abilities	1	2	3	4
8.	When I am confronted with a problem, I can usually find several solutions	1	2	3	4
9.	If I am in trouble, I can usually think of a solution	1	2	3	4
10.	I can usually handle whatever comes my way	1	2	3	4

Your age (in years):	
Your sex:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Marital status:	Single <input type="checkbox"/> Married <input type="checkbox"/> cohabiting <input type="checkbox"/>
Engaged :	Yes <input type="checkbox"/> No <input type="checkbox"/>
Exclusively dating:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion:	Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Hindu <input type="checkbox"/> Traditional religion <input type="checkbox"/> Other <input type="checkbox"/> (Specify)

Educational Background:

Year admitted to University:	
Year of study now	
Years repeated, if any	

Repeating an academic year has many reasons. Tick any of the following that apply to your situation?

Parent illness and hospitalization	<input type="checkbox"/>
Death of parents	<input type="checkbox"/>
Frequent absenteeism from University to attend to your siblings' matters	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>

Accommodation arrangement:

College hostel	<input type="checkbox"/>
Private hostel	<input type="checkbox"/>
Home with parent/s	<input type="checkbox"/>
With relatives	<input type="checkbox"/>
With college mates in the slums near the University	<input type="checkbox"/>

Family Background

Father:	Alive <input type="checkbox"/>	Deceased <input type="checkbox"/>
Mother:	Alive <input type="checkbox"/>	Deceased <input type="checkbox"/>
If father deceased, how long ago (in years):		
If mother deceased, how long ago (in years):		
Cause of father's death	Road accident <input type="checkbox"/>	
	Short illness <input type="checkbox"/>	
	AIDS <input type="checkbox"/>	
	Other <input type="checkbox"/>	
Cause of mother's death	Road accident <input type="checkbox"/>	
	Short illness <input type="checkbox"/>	
	AIDS <input type="checkbox"/>	
	Other <input type="checkbox"/>	
Who sponsors your education?	Parent/s <input type="checkbox"/>	
	Guardian <input type="checkbox"/>	
	Government <input type="checkbox"/>	
	Friends <input type="checkbox"/>	
	Others <input type="checkbox"/>	
Do you have brothers and sisters?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How many siblings do you have from the same mother?		
Are they all in school?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How many are enrolled in school?		
Who pays their fees and upkeep?	Parent/s <input type="checkbox"/>	
	Guardian <input type="checkbox"/>	
	Government <input type="checkbox"/>	
	Friends <input type="checkbox"/>	
	Others <input type="checkbox"/>	
Do you all live in the same household?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have any of your siblings been moved to live with extended family?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

APPENDIX G: Summary of Narrative from the Participants

Case 1:

(Single orphan)

Father died 1996-AIDS

Mother died 2003-AIDS

4 siblings

- My siblings learn in poor schools – because they cannot be put in better school due to finances I appreciate what is done to me to my brothers and sisters.
- We feel welcomed in our uncles' home and we do appreciate the little that can be done – because he has others to take care. I wish I don't have to beg or be in someone's house you know...
- You have to ask for fees and money for food from your relatives... but you have to ask politely otherwise you know...others wise you know it is not your right.
- Due to poverty makes one feels sorry for themselves– because you beg from other people one has to be responsible for one self. This has made me be motivated to be something in life so I am working very hard.
- Since there is nothing one can do to change their situation we accept this as God's plan for our lives; there is nothing to do.
- Family support is very important because it helps one to cope with the situation
- Friends have helped me very much in coping and in knowing they are there and I can talk to them. But not all of them there some who refuse to associate with you especially those from rich background.
- Maternal grandmother played a very big role in support us. She also assisted us settle down when we lost our both parents.
- Our maternal relatives check on us now and then but those from our fathers' family don't even care whether we are alive or dead.
- Orphans need advice and nature on how to go about life now that they are without parental guidance. When I try to talk to my sibling on life matters they do not take me seriously and so we quarrel all the time.

Case 2:

(Single orphan)

Father died 2002-AIDS

.Mother alive – (but she is sickly)

3 siblings.

- Because of this I did not attend the school of choice due to poverty – circumstance changed after death of my father we moved back to our rural home to join our clan members so we can be protected. I felt displaced and lost my friend and home in town.
- I felt very bad and sad but had to just accept my circumstances.
- Someone promised to support but let me down.
- I was made to repeat the same grade because there was no money to take me to high school even though I had passed and was admitted to a high school, my sister though very young had to look for a job in somebody's home so she could supplement my mother's income.
- Our biggest struggling is finances and the pain of how people view you when you are an orphan. Many people think you are after their money even when you just want to be friends with them. We are people and need to feel accepted the way we are.
- When my father died we were at lose as what to do next, my mother and I were depressed for long because I think we felt life was unbearable.
- After I joined the University, I was very worried what to eat and other requirements while here in the university and my family at home due to these constant worries, I feel I have not reached my academic capability.
- I travel home every weekend to check on my mother and sibling because she is sickly and therefore I miss many lectures, I ask my friends to take good notes so I can copy from them, I feel bad about this

because I miss class often which means I depend on my friends notes whether good or bad. I hope I will make it through University.

- Families are willing to support but they do not have much enough to support all in their care and who are in need of their support. Government should come forth and support orphans because orphans are there and they are many.
- Orphans need to feel loved and accepted within the community; neighbors should stop treating us as outcasts.
- People gossip about you it is like there is not other disease in this world except AIDS.
- My situation has made me to work hard to provide for my family where I can especially during holidays I work the little garden we have so that we can have food to eat and so and some to sell for cash.

Case 3:

(Total orphan)

Father died 2001-AIDS

Mother died 2003-AIDS

9 siblings.

- Our paternal uncles took the responsibility of raising us up but were unable to pay our fees.
- Well-wisher therefore pay our fees through a certain organization where we were introduced by the chief of our area.
- Even though our fee is paid by this organization, we have many emotional needs. We need to feel loved and welcome in the families that have welcomed us.
- One feels frustrated having to ask for money from other people, it is frustrating because it is like they do not remember your need unless you remind them and sometimes it comes very late after you have been sent away from school.
- I also feel frustrated when I see my sibling suffering without food and other important needs such as a sense of belonging.
- Relative are not good to us – they are harsh and refuse to meet our financial needs.
- Feel lonely and pained.
- When my mother passed away I felt like the whole world had come to an end...there is nobody in this world who understands what it is like... to loose a father and mother in a span of two years.
- Out of my experience I am determined to work very hard to achieve something and become something in life.
- Frustrated family wise and financially I feel I want to work hard though the future looks dark right now I will work hard to change our circumstances.
- I have been talking the Student Counselor seeking help so as to cope with my problems. I have found this helpful because he has helped me look at my situation better and develop a positive attitude.
- Some well- wishers are very kind and encouraging – I feel I don't want to let them down – so am working very hard.
- I look to God all the time if it was not his mercy I will not be here.
- Not attended class fully because of the frustrations of fees not coming in time and also the need to help my siblings whenever they in need.

Case 4:

(Total orphan)

Mother died 1996-AIDS

Father died 2003-AIDS

5 siblings

- It has been difficult, but I have tried to adjust. Some of the difficulties we have experienced include:
- Difficult of paying fees. I have a sister in the secondary school that I pay school fees for. It is very difficult because I don't have any income except that I use the small loan am awarded by the Higher Education Loans Board (HELB) to support my siblings. It is very little but what do I do that is all I have.
- A time I feel I should discontinue with education because of these difficulties – but I have managed to get to the 4th year now. I am concerned about the situation of the children who are still young –

because I would like to see to it that they go to school and possibly be provided for very well – so that they can live like other children.

- A time it is so painful – I miss my parents and life is difficult.
- Life is very stressful – life is very hard but I have to cope.
- I don't talk to people much about it but I believe God had a purpose for this to happen – I have to adjust.
- A time it so hard in payment of fees – in August when we opened University – I had to pay fees and maize was not yet ready because this is the only other resource we have.
- Sometime my auntie chips in to assist but that is not often.
- I keep to myself since I don't feel welcome by my peers, I am poorly dressed and don't have much in common with them so I keep to myself .
- You cannot read well when you have problems – I tell my self my parents are gone but at times it is very difficult.
- I like being alone to deal with my pain and loss a time it helps – other times I go to my aunties.
- What have learned from all this.
- I have learned a lot from this situation, I know it is not in vain, God has a purpose and am willing to perceive so I can discover his purpose in this.
- I have become a very responsible person. I do things with a purpose to achieve what I want to be in future.
- I resist pressure from friends to do wrong things of drinking because I believe by doing so I will not be achieving my purpose in life.
- University should solicited scholarship for orphaned student and find for them jobs so that they can feed as part of the society.

Case 5

(Single orphan)

Mother died 2002-AIDS

7 siblings

- Brother passed away due to AIDS.
- Was left with a lot of responsibilities for yourself and other siblings and a lot of financial
- Financial difficulties which made them sold everything at home so as to continue with school.
- Organized a mini harambee (fund raising) when my mum was sick – I used these funds to take her to
- I was full of fears at this time, fears of her dying and leaving us alone...during that time I did not want to
- See anyone from home just incase they came to bring the bad news...
- After her death I worry a lot about my siblings who were left behind about their studies and future life support.
- The villagers gives us support which am grateful about, I wish our family members will alsoassist.
- Our uncles / paternal we all live together harmony not very good – may be because our parents are not there.
- Concentration on studies diminished because I worry a lot about our life.
- Relationship with friends is not as before because I feel bad about my self.
- I am withdrawn – not happy other times I become moody when things are not going on well at home and when I don't do well in school.
- Some of our cousins are encouraging while others speak very badly about us.
- We put our faith and hope in God.
- I tell myself – life has to go on.
- Student welfare clubs are very helpful because when am completely without food they come together and raise funds for us students that are needy.
- I am more determined in life than I was before; I am motivated and find I make my decision better than before.
- The university should show concern to the orphaned by offering them guidance and counseling.
- Work and study/ program should be offered to those that are orphaned and suffering.

Case 6:

(Total orphan)

Father died 1995-AIDS

Mother died 2001-AIDS

6 siblings

- She lost her younger sister (2002) who at the time of death had a baby girl.
- The baby is live and lives with our grandmother.
- Life has been a struggle – since the death of my parents.
- I felt guilty that I was not there to help my mom...I feel bad and sad that I could not help her...
- The last words of my mother that I should be strong and take care of my brothers – I am the 1st born and I do hope that they will do well. I worry a lot about my sibling – I look all over for money to feed and make sure they go to school.
- I am distressed about one of my younger sister who left home to go big down to look for a job... I hope someone can speak to her to come back home.
- My grandmother provides with food from the farm – but other needs I have to struggle to meet them.
- Grandmother talks to me and gives advice.
- I cope by self motivation and by having friends that are mature and helpful in terms of advice.
- Financially – I depend on (HELB) which is not sufficient.
- I use my loan I share with my brother. I send some to my brother. I send some to my grandmother through it is not enough.
- When I see other students happy and confident it motivated me to work hard and not to feel bad.
- The University provides bursaries
- Secure accommodation for orphans fee waver.
- W/ study given priority come up with organization that would bring the orphans where they're their ways coping and survival.
- Talk to them about careers family matter how to organizer their life.
- There should be orphan represent in senate and council to articulate their matter.
- Many-orphaned student engage in alcohol and drugs so they feel like the others.
- The administration should not send orphans home due to fees or poor performance, they should instead check to know why they are performing poorly.
- University should carry our seminars to equip orphans with survival skills.

Case 7:

(Single orphan)

Father died 2005-AIDS

Mother a live but-(mother sickly).

3 siblings.

- After the death of our both parents life moved from worse to worse in all areas of our life.
- Conflict of land my relatives this was impacted negatively on our lives. My father death has impacted us very negatively.
- Retirement benefits – he had changed the next of kin – he had written his mother – my grandfather.
- (Very distressed and in deep thought) usher my father died I was in the field attachment and my week was interfered with I never got to finish some parts.
- The whole thing is very distress.
- Looking for the documents is an uphill task because my father had not written down anything about us.
- My uncle is a big threat to us I fear he will try to get my father's benefits
- Coping has been hard – I tell myself that it has happened and life has to continue. I have been trying to push on with life.
- Relatives and the administration have made it very hard – because I expected them to be supportive but instead they are very angry with me and unhelpful making things very unbearable.
- I worry so much as the elder son – I have to see my family is moving on – I worry about my mother now that she is also sick – I feel she will die any time – life is very difficult.
- My friends and roommate are very good to me I talk to them frankly and they are very understanding that way I feel I have somebody to share my worries with and that is how I cope.

- Financially I depend on HELB money – I also seek help from my sister who is married in Nakuru – she does assist sometimes but she also has her own problems.
- University should counsel student who are grieving – because it a very painful.
- We are going through tribulation you know many of us here are paining because of all the deaths happening around us.
- When we fail to pay school fees the administration should understand us because we have no assured source of income.
- With this pain one is unable to do well in school.

Case 8:

(Single orphan)

Father died in 1993-AIDS

6 siblings

Mother alive

- Hard to be without a father and our mother is not educated at all. Our income is from the small farm our father left.
- Fees are hard to find in time– not like any other students whose fees is paid on time and without problems.
- Feel bad about this because I am sent from school all the time to go and look for school fees.
- We have sold all the animals to pay fees for all of us now there is nothing more to sell I don't know what will happen especially with my siblings who are still in high schools.
- So far I can say it God who has help my mother to remain well and healthy to support us.
- People in the community are also very supportive one helped before I joined University to learn some computer applications packages.
- First year sold cows to pay for 1st years in University.
- But God has really helped me cope with the problem.
- Due to my situation I have learned many things including how to budget my money and limit myself to what is reachable to me.
- I feel oppressed sometime I feel as an outcast of the society.
- Many times I feel very bad about my self, I ask myself why this did happen to me. Sometime I feel am not accepted by my friends just because I am poor or because I don't have as many things as they do.
- My situations make me work hard because I don't have anyone to look to other than my self and God.
- The University or Government should provide seminars for young people on how to live without parents since I see my friends do everything they want and no one to tell them to stop, or even inform them the dangers of such behaviors. Many of us relieve stress by drinking alcohol and taking drugs if no one comes to our aid we will all perish.

Case 9:

(Total orphan.)

Father died 2000-AIDS

Mother died 2002-AIDS

7 siblings

- Life has been so hard – full of up and down.
- I use my loan to assist my sister and buy food.
- Relatives don't keep their promises they are full of lies and want even to take what we have. One uncle is supportive.
- We live alone in the town, our brother works as our father.
- I am ever stressed last year when I was called home because my sister was sick. I had to stay at home to take care of her and was so worried because I thought she was going to die
- It is hard to be happy I don't remember when I last felt happy.
- My peers some are supportive others are so negative; they don't want to come near you because they think you will infect them with AIDS just because they heard your parent died.
- My difficulties have inspired me to work hard. So that I can help family and I want to make people and wrong that I can make it in life.
- People did not think good of us. They don't see anything good in us.

- I take this as a challenge and I am determined to make it.
- I cope by
- I talk to my friends
- I cry it out.
- I play hockey/ chess.
- I used to go for karate but I stopped.
- I go to church – youth Programs and teachings. That keeps me away from youthful thing that can get me into trouble.
- I used to feel intimidated and I felt really an orphan.
- Universities to know that orphan are there and should be offered counseling as ways to assist them cope with their loneliness.
- Many orphans don't get the HELB Loan I wonder who gets these loans if students who have no parents are not considered as qualified.

Case 10:

(Total orphan)

Mother died 1997-AIDS.

3 siblings.

- We live with our grandmother she helps me look after our young siblings when I am the university. My grandmother is 89 years she cannot do much but in terms of providing but is good watching on the little ones.
- I feel all alone - nobody loves me; I miss a family, a dad and mum when others are going home to meet their dad and mum I feel bad when I go home. There is no one to listen to what I have gone through in the University. There is no one to give me that affection and love.
- When I am so lonely or down I go to my sister or my grandmother she encouraged me a lot and we talk a lot. My friends sometimes.
- Going to church also helps – they give social support and moral support and sometimes financial support as well.
- I do encourage myself – I am determined – to make it I am motivated and do want to be different because of the difficulties. I have encountered.
- Because of my circumstances I feel more responsible even better than those who have both parents. My situation has been a way of learning. I am very motivated.
- In fact I am doing an extra course nothing will stop me; I want to be the best I can be.
- I don't get anything from home but I don't worry too much about it I manage the little I have well.
- Many orphans lack love and affection guidance and counseling should be strengthened.
- Your social, relationship, financial when home be guided on what to – avoid engaging in bad ways

Case 11:

Father died 2002-AIDS

Mother alive but illiterate

5 siblings.

- I was doing my final year in High School when father died, I was terribly affected I always wanted to give up.
- The memory of my dad comes when I see my dad's brothers – I miss him - I am sad.
- Other times when I think of him it is because of what someone has said or done – so I try to keep away from people who make me feel bad.
- I always wish I could help so that someone else does not to go through what I have gone through.
- I have missed a father figure in my life – there a thing I want to be advised – sometimes it is uncle who does that but they can never be like my dad.
- My dad was a good provider I went to the best school. I never lacked but now I am so poor I am a beggar in the real sense. Sometimes one finds themselves doing things they would not normally do so as to survive. Some of us orphaned girls here go hooking over the weekends not because we want but because you want to help your siblings go to school or survive especially when you see your mum struggling so hard.
- I have lack food etc.
- I have very understanding friend – my friends are there for me – they make sure I am comfortable.

- I talk to them – they give a listening ear.
- One thing that gets me is how we as a family have reacted to the loss, it has pulled us apart than together.
- My situation has strengthened me as a person; I have grown closer to God – because he is the only one who will never leave me.
- I can relate to others who are struggling – I can give them a shoulder to learn on.
- I have learned to believe in myself.
- I am more outgoing and confident – I feel I am leaving out his legacy.
- The loans and the bursaries the University gives is not sufficient, it actually does not go to those who desperately need it because when I talk to other orphans I find they don't get this loan.
- Have encouraged orphans to form counseling groups, counseling each other it is easier to talk to someone who is going through the same situation.
- We need mentors – it is easy for us to do drugs and drink alcohol.
- Have workshop and seminar – address the issues.

Case 12:

(Total orphan)

Mother died in 1998-AIDS

5 siblings

- The death affected me both emotionally and physically.
- I dropped out school for some time until some members of a group that my mother was a member collected some money and put me back to school.
- I thought it was the end of life. There was nobody to cry to -I was hopeless.
- I was very anxious because I saw no hope.
- The chaplain in our school encourage me and his constant talk enabled to cope with my situation
- I talk to friends and relatives and teachers.
- I work hard because after sometime I realized I was the only hope for the family.
- I felt I was to be the leader and so I self-motivated my self.
- Life has been challenging as an orphan both financially and psychologically – now that I don't have a brother or father am all alone.
- I feel life is empty – I am sometime very depressed – but I involve my self in activities that make me feel better.
- Despite all this I have worked hard and not failed
- Like this semester I reported 3 weeks late because I had no money to pay to the University.
- The money I had I paid my brothers fees.
- I feel isolated – the world is not favoring me – they don't know what on earth is happening to me.
- work/study program should be give to orphans
- Bursary for orphans and any other programs that would assist orphans cope and survive financially.
- Dean of student should intervene with cases that are genuine about fees problems and in cases where one is going without food.

Case 13:

Father died 2004 – (sick for along time) AIDS.

Mother alive (but sickly).

8 siblings

- I was in final year in high school when he died; the first impact was lack of fees.
We started struggling financially.
- I had started working in a local school – which assisted us financially. When I went to University, I stopped working so we had no income at all.
- I feel sad about his death and my situation.
- Emotionally affected us – I am the only one educated and have to act as a role model.
- Church members come and encouraged us and pastors give us emotional support.
- My friends here in university have helped me – I stopped pitying myself we all have problems
- My problems have given me a heart to work hard – because people in life have problems – I feel my problem have motivated me in away.

- My sibling have problem of school fees – I feel worried about them I use my money to help my sibling so it is not much but we share.
- I worry so much while here in the University because I don't know whether they have food and how they are fairing.
- I also pay for my mother's medication, knowing what killed my father I worry so much because I feel I will lose her as well.
- I travel home often so to check on her and make sure she is ok.
- Relatives are not good to us; they do not help and worse of all they want to take what was left behind.
- We have a court case with my uncle who took our land and changed the Title Deed into his name. This makes life even more unbearable since you have no one to lean on.
- The university should help the student emotionally and financially
- The university should source support for the orphans.

Case 14:

(Single orphan)

Father died 1995-AIDS

Mother Farmer (sickly)

5 siblings

- The first things you notice is that you are very poor.
- Very many bad things happen
- My mum has been having health problems all through.
- Properties were taken. Our relatives are not that friendly. I worry about our future.
- When I worry I pray a lot about these things.
- The things I experience have made me look at life is a more serious way. I want to work hard to change the situation.
- Should understand us and try to reach us on a personal level.
- When the university doesn't understand us we feel as outcast.
- The University should try to intervene with the HELB loans so that we can get at least a reasonable loan and bursary.
- Peer counselor should over free counseling to orphans and others that are going through emotional problems

Case 15:

(Total orphan)

Father died 1999-AIDS

Mother died 1998-AIDS

7 siblings

- I lack fees and I feel nobody cares how I am emotionally: When my parents died no one cared to support me psychologically; not relatives or friends.
- I therefore sought refuge in things like alcohol and drugs and relationships that are not healthy. I got into all this because I felt too lonely and scared to be sober.
- Relatives left us and took away things that belonged to our family. My married sisters got tired of supporting us.
- I feel I should defer my studies so that I can see how to provide for my sisters only that there is no guarantee for a job out there, and I might lose my place here in the University surely somebody should understand what I am going through.
- I feel my parent death was to punish me I feel bad about them for leaving to struggle alone.
- I am very bitter towards everybody. I feel odd around people. I am very moody.
- I have a poor - self -esteem (too stressed to continue with the interview).

Case 16:

Single orphans

Lost father 1996-AIDS

Mother alive (Subsistence farmer)

7 siblings

- It is rough and painful. He was the breadwinner.
- We rely on our relatives for everything,
- You have to ask for fees and money for food from your relatives, but you have to ask for it politely otherwise you know... it is not your right.
- I feel sad; I feel there is something I am missing in life. I feel bad about myself especially when my colleagues share what sort of thing they do with their father or what he bought them I feel bad that I don't have someone like that.
- After my father death I started worrying a lot. I feel I could be a better person than I am now.
- My father's death has however helped me work hard in life so that I can be like everybody else.
- The university should offer counseling and should look for ways of supporting them financially – and especially those who find themselves without money for food and upkeep.
- Some of us here go prostituting on Friday night and the whole weekend...to raise money to upkeep while here in the University.

Case 17:

(Total orphan)

Father died 1991-AIDS

Mother died 2001-AIDS

10 siblings

- I felt so bad helpless but I took it the way it came because life has to continue.
- After the death of my mother we felt stigmatized because when we sought help someone will tell you categorically that it is not their faults we are the way we are. Or that our parents should have behaved better.
- I pitied myself a lot
- My loss affected my studies my performance dropped because am most time depressed.
- I was unable to read because I thought about my loss so much.
- I was not able to sleep well. My financial needs were not met. My brothers struggled to pay my fees – I feel they struggle a lot I am sad about this – if only my parents were here with me.
- It hurts a lot being all alone I wish everything can be reversed.
- Orphans should seek God and take life the way it is.
- Orphans need to be advised on how to cope.
- God helps a lot my advice to orphans is that they should depending on Him.
- Financial aspects are a challenge for orphaned students.
- Orphans should work hard and trust God.

Case18:

(Total orphan)

Father died 2001-AIDS

Mother died 2003-AIDS

An only child

- After mother's death I felt hopeless and confused I stayed home after her death because I was unable to come to terms with her death. The realization that I was the only member of my family alive I was desperate.
- But had to move on
- My hopes were dashed looked to God for support. I have purpose in life to keep moving on.
- For coping I draw strength from my friends and the fact that my dad taught me to be responsible.
- Faith in God has played a major part.
- Friends has been a source of strength
- The experience has produced in me a stronger person in terms of character and courage.
- I felt bad that I did not go where I want to because he would have paid for it I used to worry initially
- Now I just live my life.

- There is no reach out by the administration to the students that are orphaned.
- Emotional support would go along way in assisting the orphans to settle down.
- The University should have advisors who oversee the orphan's welfare.
- Lecturers should be interested with the orphans welfare
- Orphans lack people to lean on: - first year was very hard as orphan suffer neglect and betrayal and find it hard to trust anyone.

Case 19:

(Single orphan)

Father died 1999-AIDS

Mother alive but sickly

8 siblings

- Life has been challenging it is stressful and I don't like talking about.
- Relatives' not supportive only grandmother – we are staying with her.
- My other brother and sister are living in local school with a well-wisher.
- I use my loan to keep them.
- When at home with my brothers and sisters and we are all unhappy because there is no food and no money and there is no one to talk to... and they are all looking at me to come up with a solution... and I don't have one...when I feel overwhelmed I sometimes go to a friends house and leave them alone... or I go to a disco the whole night and drink with friends... that way I release my stress.
- I am destructed and enable to concentration
- I would have performed better if this was not my situation
- The challenge of bring up my siblings while away is very stressful.
- Uncles' extended families act as source of comfort and encouragement.
- Our maternal relatives check on us now and then but those from our father's family don't even care whether we are alive or dead.
- I avoid talk about because I don't see what others would do for me.

Case 20

(Total orphan)

Father died 2001-AIDS

Mother died 2005-AIDS

7 siblings

- Being orphaned is a very difficult situation.
- We have no one to depend upon.
- We leave together even after the death of my mother I act as the mother of my siblings.
- Relatives abandoned us and to make matter worse one took our property from us.
- The well-wishers support comes once a while – we have managed to survive.
- I had to be courageous and cope with the situation because I had nothing else to do.
- I traveled home often to check on my sick brother...and my friend takes lecture notes for me he tells me what was taught...see I depend on his notes, if they are not good I will fail...I have nothing else to do.
- My situation has motivated me to work hard but other times I feel discouraged now that they are not there.
- I feel bad when my peers are talking about their experiences with their families how they spent their Christmas holidays and what kind of gifts they received I have nothing exciting to share so I keep to myself.
- University should organize some financial support – bursaries that can assist orphaned students.
- Work-study programs should be offered to orphaned students.

Case 21:

(Total orphan)

Father died 1997-AIDS

Mother died 2003-AIDS

4 siblings.

- I have had a lot of problems because I have to support my younger siblings. We moved to our grandmothers' house so she is taking care.
- The stress of making sure my siblings go to school and are providing for is a constant worry.
- My situation makes me work harder. I bury myself in books instead of worrying and feeling bad about my situation.
- Brother to my mum has encouraged me by way of advice and financial assistance to my sister.
- I seek assistance from other people. I apply for bursaries. I have to learn to stand on my own and solve problems.
- My difficulties have helped me learn patience. Problem solving skills like knowing who to learn to where to apply for what etc.
- I have learned to be responsible about my things because I have no other person to depend upon.
- The university should lower the cost of learning for orphans.
- The University should provide stationary / and assistance in general.

Case 22:

(Total orphan)

Father died 1999-AIDS

Mother died 1993-AIDS

5 siblings

- When my mother died, I lost that motherly love.
- Maternal uncles took us in but I felt very lost all the same.
- We were separated from each other.
- Being raised in different homes is very difficult, that separation is very painful as we have lacked that love of growing up together.
- When we were separated we longed for each other but there was nothing we could do to meet one another...we only could write letters and encourage each other to bear the injustices done to us...one day God will unite us...and meet all our needs.
- I long for when I will finish university and look for a job so I can be the breadwinner for my sibling – we long for each other.
- We have come to accept our situation but we try not to look behind but forward to make our life better.
- My situation has motivated me to work very hard – I am determined to make it – if we don't work hard who will change the situation for us – I have to focus on where I am going.
- At first I was very stressed and hopeless – but I realize that they have gone and will never come back.
- Maternal relatives are very helpful – they have treated us well.
- Church has helped me I trust God and I pray a lot.
- God has helped me accept myself.
- Our church pastor comes to pray with us and know how we are faring on every week.
- The University should provide counseling and guidance – because we are very lonely people.
- HELB to offer us the maximum and bursaries.
- Work study program should be offered to those that are very needy and especially orphans.
- Sometimes we don't even have money for food or transport home.

Case 23:

(Total orphan)

Mother died 2000-AIDS

4 siblings

- I was very distress and depressed because I have to shoulder the responsibility of caring for my younger siblings.
- Family relatives have helped and especially auntie.
- Inner drive have helped me cope and especially the desire to show that my mum is not a failure.
- Stigma has been a big issue in our life when we go to look for our mothers' benefits people send you from office to another no one want to help maybe they think you will infect them with AIDS just because your parent died from AIDS.
- I work for myself – I make garment to sell to meet my siblings' needs.
- Siblings' behaviors can be a great discouragement.
- Am very distressed by my younger sister who dropped from high school and went to live in Mombasa...I am not happy, I don't know what to do to get her to come back home...
- Her situation disturbed me a lot.
- Relatives talk badly about us – I am affected by my sister behavior.
- The university should provide counseling for the orphans.
- Most of us starve we go for a week or so without food.
- Work study program should be strengthened – to provide cash that assist the orphans from abuse by those who buy them cheaply for food.
- The administration should recommend orphans for a full be loan and bursaries.

Case 24:

(Total orphan)

Father died 2003-AIDS

Mother died 2002-AIDS

8 siblings

- It has been very difficult land was taken away – and family displaced to their maternal family
- The government offices are not helpful at all when it comes to helping orphans access their parents' retirement benefits.
- I have been going to the office where my father worked to collect his terminal benefits but in vain, the officers there kept asking me to come again after one month now it has been two years and nothing has been done...I haven't seen those documents.
- I am currently looking for money so that we can file the case in the law courts to try and get our land back from our relatives.
- I feel depressed about this but life must continue.
- I engage in sports to overcome these feelings.
- Sometimes you just cannot overcome and so I wish I can sleep "completely" never to wake up again.
- I use my loan to support my brother and sisters.
- The university should see to it that orphans are given full loan and full bursary.
- Group of orphans should come together to share their experiences.

Case 25:

(Single orphan)

Father died 1999-AIDS

Mother alive but sickly

3 siblings

- I had to move to my grandmother from my mother's side so that I can go on with schooling.
- My sister went to stay with my other uncle because she would get better schooling.
- My uncle paid for my school fees.
- It has been a tough - I have been disturbed psychologically because staying with ones parent is better than staying with someone else.
- Staying with other people all your needs cannot be met – you feel you don't belong. You are fear to ask for things as you wish. One is therefore forced to suppress my needs.

- Even though our uncles took up the responsibility to raising us up, they are not good to us... they complain when we ask for money for anything.
- This situation does not make me happy.
- I am anxious about my future I would wish to work hard so that my offspring don't go for what I am going through.
- I am determined to work hard to get a job to help the family and to keep my family together.
- I pray a lot – I go to church
- I also talk to my friends about my situation.
- Some relatives are good I talk to them too.
- The University should give bursaries or reduce the amount of fees paid by orphans and other poor students.
- They should provide work study program
- Make sure that all orphans are taken care and not send them away when they do not perform that well, they should instead investigate what is the cause for this.
- Some have given up.

Case 26:

(Total orphan)

Mother died 2003-AIDS

6 siblings

- Starting from the time my mother fell sick, she stopped speaking.
- We were disturbed because who was to care for her now that we were all in school. I was very disturbed because I loved my mother a lot; I had a lot of concern.
- Our family situation economically became very bad paying fees for me became a real problem – there were time I did not have fees or fare to go home.
- Our older sister stayed with our mum but medication and ways to keep her alive was difficult.
- I used my HELB loan to buy her medicine that meant I stayed a lot of time without money for food or transport to go and see her.
- I did not want to receive any visitor from home because I feared they could be bring bad news of her death.
- It was very difficult when she died
- Friends did not help as I thought and their words were discouraging.
- Nobody came forward to help in anyway.
- It was really disturbing – I did not know how I could perform in my exams since it was towards the end of a semester.
- One of the things that I miss is someone to love comfort – someone to listen to you.
- When with friend they talk of the good things that have done with their parents – you have nothing to share only pain.
- After my results nobody cared to celebrate my success.
- As first-born son, I had to take up a lot of responsibility because I had to work to educate my siblings. My brother however dropped and refused to go on with school I was distressed about this. He looked for a job which is not well paying but he drinks a lot and spends his money in bad ways, I fear he may get AIDS.
- But I had to pay fees for my sister from my HELB loan.
- Teachers/ priest have been an encouragement – they cultivated strength in me that I did not know existed
- There is a priest who became like my father...he talks to me about life, and encourages me when I am feeling low and lonely...he even bought me a book that is about the struggles of Mahatma Gandhi...I am encouraged I know I will make it.
- I am well groomed both altitude wise and physically.
- Because of my situation I believe I will be a leader in the nation because I am not going to let my situation put me down.
- During long vacations – we have no money, no family –we get into situation that because we have no families that care about our welfare

Case 27:

(Total orphan)

Father died 2000-AIDS

Mother died 1994 -AIDS

5 siblings

- Our uncle took us in even though he has his own kids as well – so that it was not all that good – have moved to stay with our grandparent parental.
- I am not happy – their death has affected me – you know we have our home and we are not staying there we have come to stay with our grandparents.
- I worry about my sibling welfare.
- The administration is not sensitive to our situation either...whenever I went to this office they would tell me to come with my uncle who was never available...after going there for more than five months, one kind woman told me, that the officials had been paid some money by my uncle and therefore there was no longer land in my fathers' name and that I was wasting time...
- I have learned to be independent. I have nothing back at home to look for or depend on
- I therefore work hard to make my life better.
- University should have counseling services for orphans.
- They should give some financial support.

Case 28:

(Single orphan)

Father deserted us

Mother died 1994-AID

5 siblings

- Life has not been so good though not so bad either.
- Staying with people who are not your parents is not easy
- They don't treat you the same as your parent – there is a lot of quarrels about every small thing that reminds one of ones' parents.
- Sometimes these things made me feel bad about our parents why they put us to this.
- The four of us stayed together but one stayed else: it was painful to be separated.... Leaving home was painful... someone was employed to look after our home – but he died so no one lives there now.
- My father had rental house etc. but conflict with step mother has made it hard for use to settle and move on with life.
- Sometimes I feel low when among other students when I see them having a lot and happily talking about their families... I feel I have nothing to share...I am unlucky.
- But encouragements and hope has kept us going
- My situation has helped me to be hard working and positive in life – to be wise in thinking and carrying out ourselves, one has to have a vision their life.
- I have to be responsible and take care of myself and the others.
- I have good friends – very close friends. I make sure that my siblings go on with life. I pray for them and counsel them.
- I try not to care for many things. I try not to worry so much.
- I don't allow myself to cry too much
- We keep to ourselves because people seem not happy with us – because of our stat.
- Find a way of giving little money.
- Many orphans engage in drugs alcohol and pre- marital sex.

Case 29

(Total orphan)

Father died 2002-AIDS

Mother died 2003-AIDS

6 siblings

- I have managed to cope with the challenges.
- I had to defer my studies so I could take care of my other siblings.
- I had to raise their fees and rent I performed in theater to raise money.
- Other times worked as a night guard.
- I use my loan to pay for there fees
- These challenges have helped me be bold and courageous in life.
- My life taught me to be responsible.
- My siblings performance in school is encourage.
- I encouraged myself and my siblings as well.
- Friends/ relatives at times offer emotional support.
- Youth organizations have also offered emotional support.
- A club should be formed for orphans.
- Counselor, share experiences and ways of coping.
- Financial support from the university.

Case 30:

(Total orphan)

Father died 1999-AIDS

Mother died 2000-AIDS

5 siblings

- Life is not easy. A guardian is supporting me here.
- My siblings dropped out of school because of fees problems.
- It is not easy – I think of a lot of things. I worry about our situation. We stay with my grandmother.
- Brother to my dad is caring for my sisters.
- We lived in separate homes when our parents died.
- My guardian is like a mother to me in providing counsel and financial support.
- I share my problems with friends – I talk with them – I discover that my problems are not as bad after all – there are some who have more problems than me I get encouraged.
- On financial side – we have an arrangement like merry-go-round sort of things for only orphans- this enables to raise money an support each other here this is our way of coping with our problems.
- I keep busy – so that I don't idle around.
- Sometimes have no money for food
- But friends do help because we hang out together.
- Together we just chat – we forget out situations.
- Fee increment orphans should be assisted.
- Free accommodation
- Be allowed to form a group or forum where they can air their concern
- Share life experience.

Case 31:

(Total orphan)

Father died 2000-AIDS

Mother died 1988-AIDS

5 siblings

- Life has been tough – I have been close to my parent.
- I miss my parents socially, financially and emotionally.
- Guidance and love is not there - I wish there was someone to give us guidance.
- I do what I want at least someone should tell me what to do and what not to do.
- I keep things to myself that makes me feel bad. I wish I have a parent to share things with.
- Financially I am not comfortable because my father did not organize himself well when he was alive.
- The University should provide Loan and bursary for orphans.
- We are very lonely lot; sometimes no one comes to visit us.

Case 32:

(Single orphan)

Father died 1999-AIDS

Mother primary school teacher

7 siblings

- Life is a little bit difficult because my mother had to pay fees for all of us with her little salary.
- Our financial situation worsened.
- She ended up looking for loans for payment of fees and other family needs.
- A time I am not psychologically comfortable – because like now we have not paid our fees yet exams are coming – this is worrying and I am anxious about what will happen, am not too sure I will be allowed to sit for my end year exams.
- The University or the government should look for ways of helping orphans.
- There should be advisory centers to guide those that are depressed and not coping well.

Case 33:

(Total orphan)

Both parents

Father died 1998-AIDS

Mother died 1998-AIDS

- Life has been difficult in many ways.
- My uncle was to take us in but we refused and we instead opted to stay alone with grandmother – being separated was going to create lot of anxiety.
- A priest took one of my brothers and he pays his fees.
- He was picked and taken to Starehe Boys Center.
- We miss parents' guidance and love.
- However they taught us to depend on ourselves. We are surviving. We are more united because of our problems.
- I am self-motivated now than ever before.
- Relative have not help much.
- A time one feels bad but you have nothing to do
- When you are without and have to beg you feel very bad about yourself and pity your self.
- I get motivated to work so that I can get what I need because I have no one to depend upon.
- The university should know that orphans are there.
- Should not send orphan home because there is no one to go to.
- Bring the orphan together so they can share their experiences together.

Case 34:

(Single orphan)

Father died 2000-AIDS

Mother alive

Sibling 7

- Most siblings dropped from school due to school fees problems.
- My mum has really struggled to pay our school fees and to keep us going.
- Well- wishers from the church have assisted me with both emotional support and fees.
- I worked in church to raise money and at night as a watchman.
- I roasted maize on the street to raise money for my fees.
- I am currently housed by a lecturer since I could not afford to pay for my accommodation, I don't know how long he will keep me; I am worried I don't know if I will finish my studies.
- But I believe God will do something.
- The going has been rough and is still rough, I wish my father was alive so I can share my difficulties with him.
- I am discouraged very much.
- I feel hopeless – But I am motivated about my future, I feel something will happen that will change my current circumstances.

Case 35:

(Single orphan)

Father alive but remarried does not take care of us.

Mother died 1999 -AIDS

5 siblings

- Life has been very difficult in many ways. e.g what to eat, clothing and fees.
- Money I get from my sponsor is shared with my siblings because I act as their parent.
- My two sisters dropped out of school so they can look for work to help support the family.
- They kind of work one does is not good I can even talk about it here.
- We stay alone – we need parents/ guidance.
- We stay alone because of the treatment we get from them our relative – the words sometimes we get – e.g. – that “I did not kill your parents” are very hurting.
- So we would rather stay on our own.
- Our difficulties has harden us and made us to work hard so that we can be something for future.
- I tell myself that.
- I am responsible – I try not to succumb to my peers and engage in things that will interfere with my life and commitment to help my siblings, I don’t want to fail them so I work hard and avoid things that will get me to be destructed. When they engaged in alcohol and other things I keep off.
- A time I feel bad about my problem. I am enable to buy things that I want – but a times I appreciate – it and laugh at my situation.
- Association with youth groups has helped a great deal we share information – some financial situation
- I try not to be idle.
- There should be organizations for orphans to met and share their experiences.
- At least cater for orphan who cannot pay for their fees by getting sponsorship.
- Write a proposal through the peer counseling to some donor agencies to raise support for orphans.

Case 36:

(Total orphan)

Father died 1999-AIDS

Mother died 2002-AIDS

4 siblings

- Things have changed financially and in every way
- Socially – I feel excluded because I don’t have something to share
- Emotionally – I feel I don’t take it kindly because I feel I have no one who can fight for me.
- My loss has deepened my faith in God.
- You feel all alone - you don’t have someone to share with your tears: I hiding away from people because I feel bad about my situation. I am so poor but life has to continual. The small ones they need us so much.
- When I look at the younger ones I harden and keep going on.
- I trust God and keep praying to him to help us out.
- I feel good helping other orphans in way of sharing the word of God given that I understand their situation.
- University should look for sponsorship for orphans.
- At least you feel accepted in the society.
- Sometimes the orphans give up and drop out of school because they believe no one will hold their hand to look for a job.
- University advice the HELB people who fail to recognize the orphan.

Case 37:

(Single orphan)

Father died 2003-AIDS

Mother alive (But without a job and sickly)

3 siblings

- I am responsible for my family.
- It is by God grace.
- The Christian children fund assisted my brother.
- The community helped me raise my first year University fees.
- I use my HELB loan to support my family.
- When my mum became sick I became very worried - in fact don't know how my exams will turn out to be – it is by God's grace that I will make it
- It is quite challenging – but I trust God will help us.
- I worry a lot about our family situation – when I finish will I get a job – if not how will my family be.
- Sometimes I pity myself – but I feel that I am not the only one.
- The university should understand us orphan; when orphans owe some money they should intervene.
- The university should look for other sources to support to help keep the orphans in the university.
- The University should know that orphans are there, and should offer counseling services to them.
- Guidance and counseling should be strengthened and the student body should be open to the counselor about their problems so they can be assisted.