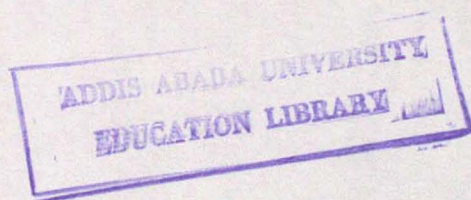


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SCHOOL OF GRADUATE STUDIES**

**PSYCHOSOCIAL PERCEPTIONS OF STUDENTS
ORPHANED BY HIV/AIDS:
THE CASE OF AWASSA BOARDING SECONDARY SCHOOL**



BY

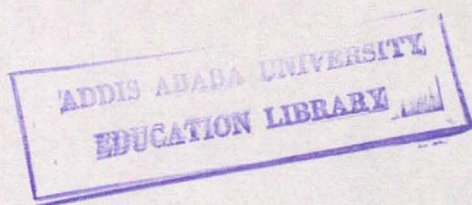
AEMIRO TADESSE

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BY

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ACRONYMS AND ABBREVIATIONS

AAU - Addis Ababa University
AIDS - Acquired Immune Deficiency Syndrome
CBO - Community Based Organization
FAO - Food and Agricultural Organization
FSS - Forum for Social Studies
HAPCO - HIV/AIDS Prevention and Control Office
HIV - Human Immunodeficiency Virus
HR - Human Rights
IAVI - International AIDS Vaccine Initiative
LSDA - Loneliness and Social Dissatisfaction
MoH - Ministry of Health
MOLASA - Ministry of Labor and Social Affairs
NAC - National AIDS Council
NGO - Non-Governmental Organization
RCBS - Revised Cheek and Buss Shyness Scale
SAD - Social Avoidance and Distress
SIV - Simian Immunodeficiency Virus
SS - Shyness and Sociability
SSA - Sub-Saharan Africa
UNAIDS - Joint United Nations Program on HIV/AIDS
UNDP - United Nations Development Program
UNFPA - United Nations Population Fund
UNICEF - United Nations Children's Fund
USAID - United States Aid International Development
WHO - World Health Organization

ABSTRACT

This study examined the psycho - social perceptions of students orphaned by HIV/AIDS at Awassa Boarding Secondary School. Psychosocial questionnaires were distributed among 150 (97 male and 53 female) students orphaned due to HIV/AIDS and interviews were held with the school director, social worker of the organization that provided boarding services and one teacher of students orphaned by HIV/AIDS. Quantitative and qualitative methods of data analysis were employed. The results indicated that the majority of the students had psychological problems (low self - esteem, depression and anxiety). Moreover, they had social problems (social avoidance and distress, shyness and sociability, and loneliness and social dissatisfaction). There was a significant relationship between psychological and social perceptions. Lack of counseling service, weak coordination between the school and boarding provider, limited boarding service for students orphaned by HIV/AIDS, little community awareness of the program, and lack of emphasis from other organizations were major contributing factors to the psychosocial perceptions of students orphaned by HIV/AIDS.

CHAPTER ONE

INTRODUCTION

1.1 *Background of the Study*

The history of AIDS is a short one. As recently as the 1970s, no one was aware of this deadly illness. Since then the global AIDS pandemic has become one of the greatest threats to human health and development. At the same time, much has been learnt about the causes of AIDS, as well as how to prevent and treat the disease.

According to UNAIDS (2008) report, the statistics for the end of 2007 indicate that around 33 million people are living with HIV, the virus that causes AIDS. Each year around 2.7 million more people become infected with HIV and 2 million die of AIDS in the world.

As one of the most deadly diseases in the world, HIV/AIDS is responsible for leaving vast numbers of children across Africa, without one or both parents (UNAIDS, 2006). The number of orphans' children impacted by HIV/AIDS is rising and it is expected to increase year to year (Gebrehiwot, 2005).

Although HIV/AIDS is found in all parts of the world, some areas are more affected than others. The worst affected region presently is Sub-Saharan Africa. Regarding this, UNAIDS (2008) states that, Sub-Saharan African is more heavily affected by HIV/AIDS than any other region of the world. An estimated 22 million people were living with HIV at the end of 2007 and approximately 1.9 million additional people were infected with HIV during that year. In just the past year, the AIDS pandemic in Africa

has claimed the lives of an estimated 1.5 million people in this region. More than 11 million children have been orphaned by AIDS.

Ethiopia is among sub-Saharan Africa country that is highly affected by the pandemic. UNICEF (2008) states that, approximately 1.5 million people are living with HIV in Ethiopia, some 120,000 of them children. Furthermore, Ethiopia is home to 4 million orphans or 12 percent of all children. More than half a million of these were orphaned as a result of AIDS.

The extent of the AIDS crisis is only now becoming clear in many African countries including Ethiopia, as increasing numbers of people with HIV are becoming ill. In the absence of massively expanded prevention, treatment and care efforts, it is expected that the AIDS death toll in Sub-Saharan Africa will continue to rise. This means that impact of the AIDS pandemic on these societies will be felt most strongly in the course of the next ten years and beyond. Its social and economic consequences are already widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general (UNICEF, 2006).

The trauma of HIV/AIDS orphans starts before, their parents' death. It starts during illness; and using medicine of their families. In fact, orphaned children due to HIV/AIDS are vulnerable in almost all aspects of their life. The vulnerability is experienced by children, both before and after the death of their parents. Many children constantly worry about going to school and leaving their parents. As one study suggests, parental death is the most stressful event for the child (Toomey & Christie, 1990).

Because of the death of their parents, other problems may include emotional, household (domestic), education and stigmatization.

The emotional impact starts to surface in children orphaned by HIV/AIDS long before parent's death. Children whose parents are living with HIV often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually, they suffer the death of their parent(s) and the emotional trauma that results. They may then have to adjust to a new situation, with little or no support, and may suffer exploitation and abuse (Sabbarao & Coury, 2004). Ethiopian culture views HIV/AIDS as the likely results of promiscuity; thus, those who have the virus and eventually their orphaned children are ostracized. Additionally, Ethiopia is one of the poorest nations in the world, which means that poverty has greater impact when some relatives are willing to face the negative social consequences of raising AIDS orphans (Meherte, 2008).

According to USAID (2002), the psychological problems can be more severe if a child is forced to separate from his/her siblings upon becoming orphaned. As one study showed, high levels of psychological distress were found in children who had been orphaned by AIDS. Anxiety, depression and anger were found to be more common among AIDS orphans than other children. (AVERT 2008).

Domestic (household) problems are also another area in which these children face trauma. The loss of a parent to AIDS can have serious consequences for a child's access to basic necessities such as shelter, food, clothing, health and education. Orphans are more likely than non-orphans to live in large, female-headed households where more people are dependent on fewer income earners (Monasch & Boerma, 2004). This lack of income puts extra pressure on AIDS orphans to contribute

financially to the household, in some cases driving them to the streets to work, beg or seek food (Salaam, 2005).

In terms of the impacts on education, the emotional, psychological, and domestic impacts may disrupt the child's education and lead him/her to drop out of school. If the child has younger siblings, he/she may also be forced to leave school to look after them and act as the head of the household. Studies have shown that orphans in sub-Saharan Africa are 13% less likely to attend school than non-orphans (Roeland & Boerma, 2004). Furthermore, children orphaned by HIV/AIDS miss out on school enrolment, have their schooling interrupted or perform poorly in school as a result of their situation. Expenses such as school fees and school uniforms present major barriers, since many orphans' caregivers cannot afford these costs (UNICEF, 2006). Extended families sometimes see school fees as a major factor in deciding not to take on additional children orphaned by AIDS (UNAIDS, 2004).

The AIDS pandemic also has the problem of stigmatization. USAID (2008) reported that, children grieving for dying or dead parents are often stigmatized by society through association with AIDS. Children who have lost their parents to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face discrimination and damage their future prospects. The distress and social isolation experienced by these children, both before and after the death of their parent(s), is strongly exacerbated by the shame, fear, and rejection that often surrounds people affected by HIV and AIDS. Because of this stigma, children may be denied access to schooling and health care. Once a parent dies children also be denied their inheritance and property. In this situation children may additionally be denied access to healthcare that they need. Sometimes this occurs because it is assumed that they are infected with HIV and their illnesses are untreatable.

2007

Different researchers in Ethiopia revealed that the major challenges of students orphaned by HIV/AIDS are psychosocial and educational problems. Abebe (2004) in his study of the psychosocial and educational problems of HIV/AIDS orphans indicated that, AIDS orphans faced problems in terms of social aspects; isolation, discrimination, and neglect by adults and their peers. Educationally many of them especially girls dropped out of school and those who managed to continue their education showed low school performance. Their psychological adjustments were also poor. The orphans were frustrated and full of worries.

Similarly, Kedija (2006) in her study of psychosocial problems of AIDS orphaned children showed that, AIDS orphaned children faced different psychological problems before, during and after the death of their parents. This included grief, anger, fear, shock, shame, anxiety, depression, hopelessness and lowered self-esteem. Socially, they were subjected to various problems such as stigma, discrimination, mistreatment, self-isolation, and abuse.

Furthermore, other researchers (Befikadu, 2005 & Desalegn, 2007) also came with similar results; they indicated that AIDS orphaned were vulnerable in almost all aspects of their lives. The impacts of parental death on children were complex and affected the child's psychological and social development. On the other hand, guardians (grand parents) relatives and neighbors took those orphans as a burden, and treated them unfairly. Accordingly, poverty, stigma, discrimination, mistreatment by their guardians, and dropping out of school were considered as causes that triggered the psychosocial problems of AIDS orphaned children.

Keeping in mind the above situation, the present study attempted to identify the psychosocial perceptions of students orphaned by HIV/AIDS in Awassa Boarding Secondary School. In fact, this issue is not new. As stated above, the psychosocial problems of HIV/AIDS orphans were observed by different researcher. However, identifying the psychosocial perceptions of students orphaned by HIV/AIDS in the case of institution is relatively a new perspective. Furthermore, it is believed that studying the psychosocial perceptions these students' experiences will motivate other researcher to further investigation.

1.2 Statement of the Problem

It has been recognized that AIDS orphans were vulnerable to a lot of social, economic and psychological problems. The total coverage of the services in terms of number of beneficiaries in the area of education and health and the attention given to AIDS orphans is far from satisfying (MOLSA, Italian Cooperation & UNICEF, 2003).

Studies revealed that children whose parents die of AIDS face the worst imaginable difficulties in life and confront psychological and social problems (Robryn 2004) cited in Kedija (2006). In fact, the vulnerability of AIDS orphans start well before the death of their parents. Children living with caregivers who had HIV/AIDS often experienced many negative changes in their lives and start to suffer neglect, including emotional neglect, long before the death of the parent or caregiver. Orphans run greater risks of being malnourished than children who had parents to look after them (MOLSA, Italian Cooperation & UNICEF, 2003). Thus, the ongoing failure to respond to the orphans' crisis had grave implications not just for the children themselves, but also for their communities and nations (Elshaday, et al, 2005).

As of 2005, there were 744,000 HIV/AIDS orphans in Ethiopia who had lost their parents and a social support system capable of meeting their basic human needs such as food, security, protection, love and a sense of belonging. Parents' death interrupted education, resulted in rejection by relatives, often followed by a harsh street life frequently resulted in an inevitable source of crime (Meheret, 2008).

A boarding school is a school where some or many students not only study, but also live during school time. It often has an explicit mission not only to educate students in the classroom, but also to help them to become all rounded individuals. So, the majority of boarding schools have different facilities for students of different needs. Awassa Boarding Secondary School provides education and boarding services for students orphaned by HIV/AIDS. The basic needs of students orphaned by HIV/AIDS in Awassa Boarding School have covered by boarding giver organization (Shiny Day) but not all needs of these students.

Although the Ethiopian multi-sector HIV/AIDS prevention and control strategy contained, useful elements and implementation modalities that had been proven to be effective in many African contexts. Practical experience showed that challenges were being faced in translating these conceptual strategies into actions on the ground. Resource limitation coupled with low level of commitment from various stakeholders involved in implementation of the strategy limited against the results of strategic plans (Elshaday, et al, 2005).

Generally, the magnitude of the problem at large, the general level of poverty and the growing demand for care and support of orphan and vulnerable children in Ethiopia leaved many children without fulfilling their basic needs and make them vulnerable to other psychosocial problems (HAPCO, 2004).

Thus, this research will aim to answer the following questions:

1. What are the psychological perceptions observed in students orphaned by HIV/AIDS in Awassa boarding school?
2. What are the social perceptions observed in students orphaned by HIV/AIDS in Awassa boarding school?
3. Is there any relationship between psychological and social perceptions observed in students orphaned by HIV/AIDS in Awassa boarding school?

1.3 Objectives of the Study

The general objective of the study is to investigate the major psychosocial perceptions of students orphaned by HIV/AIDS in Awassa boarding school. More specifically, the study has the following objectives.

1. To examine the psychological perceptions of students orphaned by HIV/AIDS in Awassa boarding school.
2. To assess the social perceptions of students orphaned by HIV/AIDS in Awassa boarding school.
3. To identify the relationship between psychological and social perceptions observed in students orphaned by HIV/AIDS in Awassa boarding school.

1.4 Significance of the Study

This study may help:

1. Teachers, social workers and other school societies to be aware of the psychosocial perceptions of students orphaned by HIV/AIDS.
2. To provide information to national and international non-governmental organizations (NGOs), who are engaged in the

improvement of the perceptions of students orphaned by HIV/AIDS.

3. For responsible bodies (government, decision makers) to take actions to address whether to keep students orphaned by HIV/AIDS in the boarding schools as well as to identify other areas in which to provide assistance to these children.
4. Identify further areas for study to be conducted by researchers in this area.

1.5 Operational Definitions

Psychological Perceptions: Self - reported feelings, perceptions, or experiences of children that reflect their feelings of sadness or hopelessness; stress and strain, anxiety and depression and satisfaction with personal life as measured by the Rosenberg's self-esteem scale, Beck Depression Inventory and Revised Children's Manifest Anxiety Scale.

Social Perceptions: Self - reported perceptions of children as indicated by their social relationships at schools and in the community in relation to their social competence, shyness, loneliness and social anxiety and distress as measured by the Watson and Friend Social Avoidance and Distress Scale, the Revised Cheek and Buss Shyness Scale and Loneliness and Social Dissatisfaction Scale.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 The General Situations of HIV/AIDS

HIV/AIDS has reached almost every part of the world (UNAIDS & WHO 2007), and HIV/AIDS is no longer restricted to cities. The disease is now spreading with alarming spread into rural areas and affects the farming population, especially people in their most productive years (ages 15 to 45) (FAO, 1997).

In the countries most heavily affected, HIV has reduced life expectancies by more than 20 years, slowed economic growth, and deepened household poverty (UNAIDS, 2008).

Moreover, in each country the details of the pandemic vary, having its own distinct origin, geographic patterns of dispersion and particular population subgroups affected. At present, reliable comprehensive statistics for HIV/AIDS infections do not exist, however, those that do exist are alarming (FAO, 1997).

2.1.1 Global Situation

The HIV pandemic has heightened global consciousness of health disparities, and catalyzed unprecedented action to confront some of the world's most serious development challenges. No disease in history has prompted a comparable mobilization of political, financial, and human resources, and no development challenge has led to such a strong level of leadership and ownership by the communities and countries most

heavily affected. In large part due to the impact of HIV, people throughout the world have become less willing to tolerate inequities in global health and economic status that have long gone unaddressed (UNAIDS, 2008).

The latest statistics on the world pandemic of AIDS and HIV were published by UNAIDS/WHO in July 2008, and refer to the end of 2007.

Table 1: Global summary of HIV/AIDS pandemic

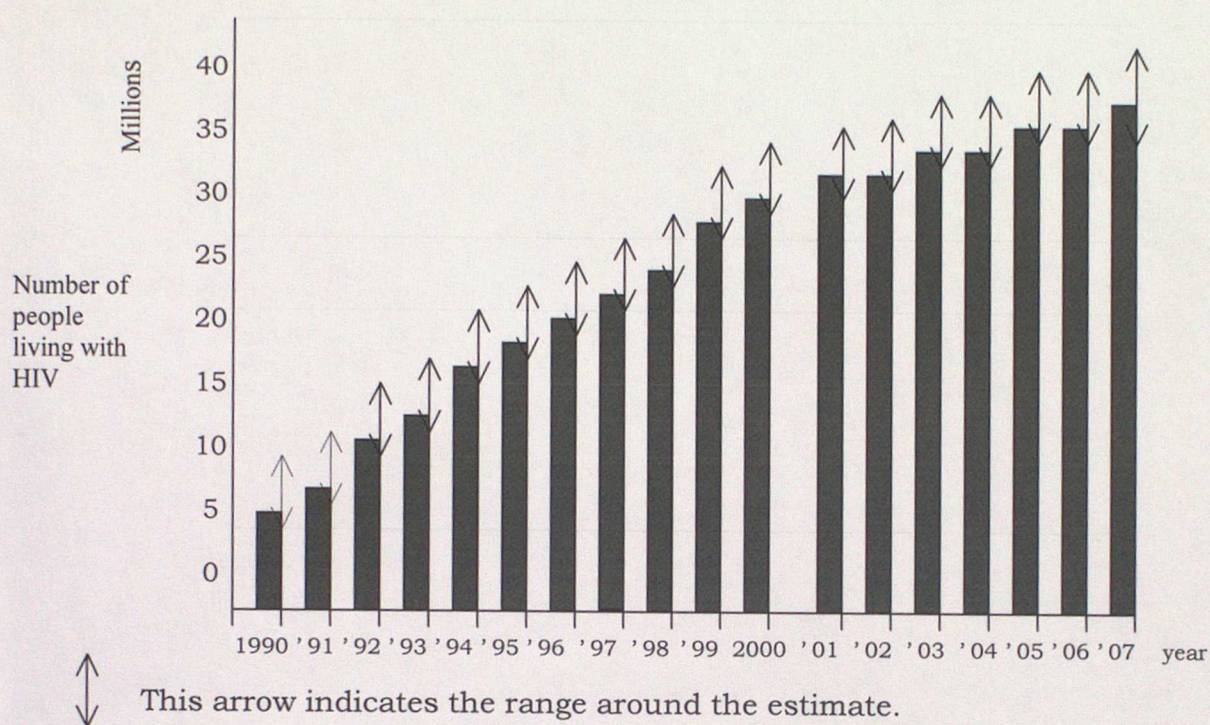
Number of people living with HIV in 2007		
	Total	33.2 million [30.6 - 36.1 million]
	Adult	30.8 million [28.2 - 33.6 million]
	Children under 15 years	2.5 million [2.2 - 2.6 million]
People newly infected with HIV in 2007		
	Total	2.5 million [1.8 - 4.1 million]
	Adults	2.1 million [1.4 - 3.6 million]
	Children under 15 years	420.000 [350.000 – 540.000]
AIDS deaths in 2007		
	Total	2.1 million [1.9 - 2.4 million]
	Adults	1.7 million [1.6 - 2.1 million]
	Children under 15 years	330.000 [310.000 – 380.000]

The ranges around the estimates in this table define the boundaries within which the actual numbers lay, based on the best available information.

From: AIDS Pandemic Update, 2008. UNAIDS/WHO, Geneva, Switzerland.

On the other hand, the number of people living with HIV/AIDS has risen from around 8 million in 1990 to 33 million today, and is still growing.

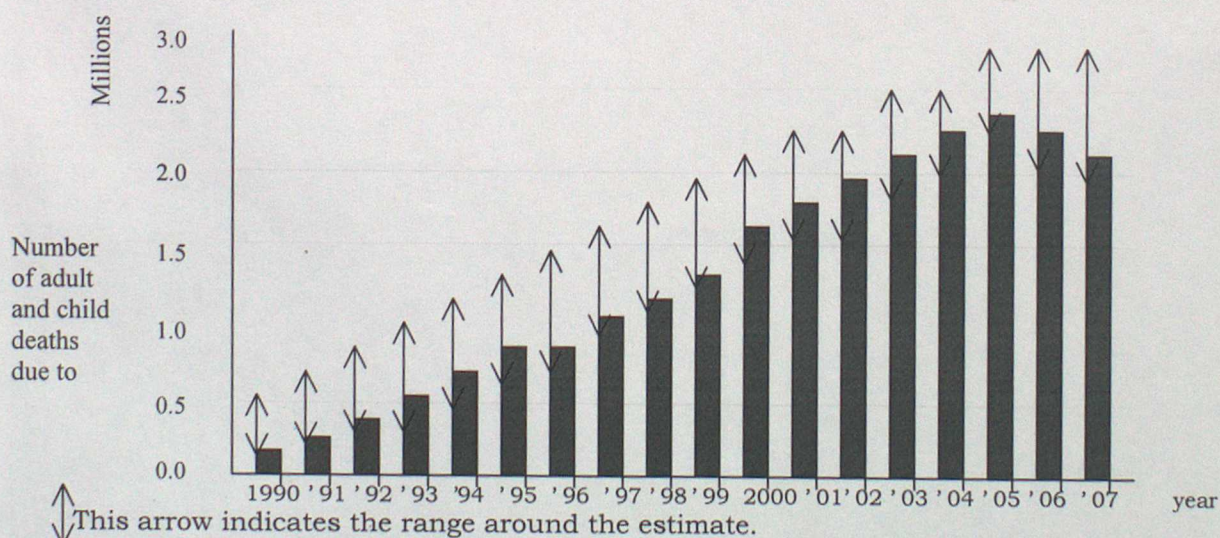
Figure 1: Estimated number of people living with HIV/AIDS globally, 1990 - 2007



From: AIDS Pandemic Update, 2007. UNAIDS/WHO, Geneva, Switzerland.

Moreover, the estimated number of deaths due to AIDS in 2007 was 2.1 million [1.9 - 2.4 million] worldwide, of which 76% occurred in SSA. Decline in the past two years were partly attributable to the scaling up on antiretroviral treatment services (AVERT, 2008).

Figure 2: Estimated number of adult and child deaths due to AIDS globally, 1990 - 2007



From: AIDS Pandemic Update, 2008. UNAIDS/WHO, Geneva, Switzerland.

AIDS remains a leading cause of mortality worldwide and the primary cause of deaths in SSA, illustrating the tremendous, long-term challenge that lies ahead for provision of treatment services, with the hugely disproportionate impact on SSA ever clearer (UNAIDS, 2008).

2.1.2 African Situation

No reason yet exists to suggest that, the HIV pandemic is significantly slowing down anywhere in Africa. The statistics on the toll that the pandemic has already exacted paint a grim picture, as do the forecasts of the consequences which are still anticipated to unfold over the medium to long term (Poku, 2005). According to Jenkins & Robalino (2003), the incidence of sexually transmitted infections, including HIV/AIDS, is increasing, and the total number of AIDS deaths has increased almost six fold since the early 1990s. The situation can change rapidly, and even conservative estimators indicted that AIDS poses a real threat to the region's long-term growth.

It is in Africa, in some of the poorest countries in the world, that the impact of the Virus has been most severe. At the end of 2007, there were 9 countries in Africa where more than one tenth of the adult population aged 15 -14 was infected with HIV. In three countries, all in the southern cone of the continent, at least one adult in five is living with the Virus (Essex et al., 2002).

SSA is more heavily affected by HIV and AIDS than any other region in the world. Based on UNAIDS (2008) report, an estimated 22 million people were living with HIV at the end of 2007 and approximately 1.9 million additional people where infected with HIV during that year. Two thirds (67%) of the global total of 32.9 million [30.3 million - 36.1 million] people with HIV live in this region, and three quarters (75%) of all AIDS deaths in 2007 occurred in SSA.

In just the past year, the AIDS pandemic in Africa has claimed the lives of an estimated 1.5 million people in SSA. More than eleven million children have been orphaned as a result of AIDS (AVERT, 2008).

UNICEF reported that children whose parents have died of AIDS are less likely to attend schools than those who have not lost a parent. The report further indicated that among AIDS orphaned children, girl orphans are at a double disadvantage and they contend with more severe challenges such as stronger cultural constraints, deeper poverty, discrimination, and early sexual activities that increase the risk of infection with HIV/AIDS (UNICEF, 2000).

In related issues, Philipos (2002) described, by citing the 2002 report of World Bank, it is indicated that AIDS pandemic poses paramount threat to development in SSA. HIV/AIDS has erased many of the development gains of the past generation and now threatens to undermine the next with so many African children who have been orphaned. AIDS is costing the region close to one percent of economic growth each year, while imposing an unsustainable and mounting burden on households, firms, and the public sector.

In Africa, some deaths have not been identified as AIDS-related, which can affect statistics and the information they provide. The usual causes of deaths; such as pneumonia, tuberculosis, septicemia, and the like were not seen to be related to AIDS at that time, but later on confirmed that they were related. Under-reporting of AIDS deaths has also occurred because relatives and others may not want any one to know why someone has died, to avoid stigma (Berer & Raly, 1993).

The fact that SSA has been seriously and severely affected region, AIDS is the remaining leading cause of death. Around 67% of people living with HIV are in SSA.

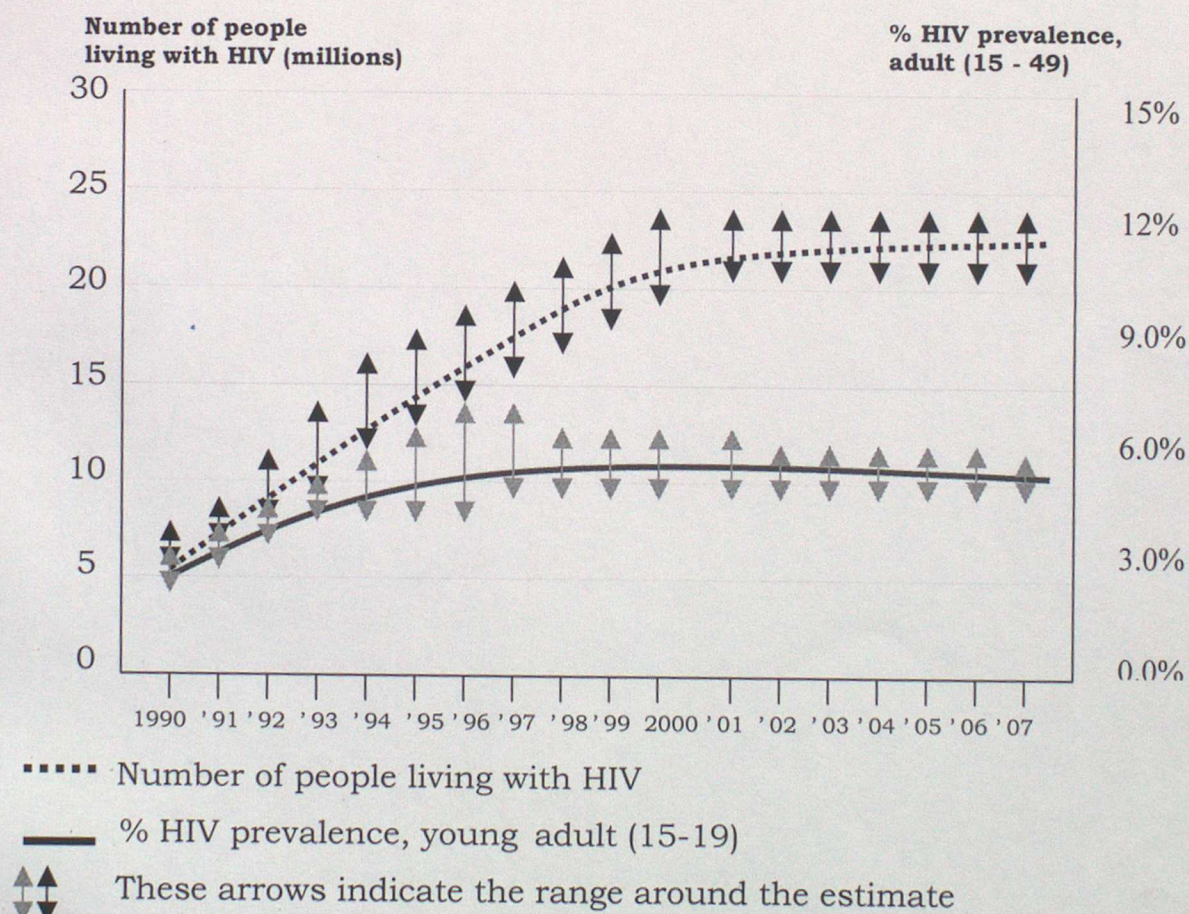
Table 2: Sub-Saharan Africa Regional Statistic for HIV and AIDS, end of 2007

SSA	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
Estimate	22.5 million	1.7 Million	5.0%	1.6 million
Range	[20.9 million - 24.3 million]	[1.4 million - 2.4 million]	[4.6% - 5.5%]	[1.5 million - 2.0 million]

From: AIDS Pandemic Update, 2007. UNAIDS/WHO, Geneva, Switzerland.

Even though the HIV prevalence stabilized in SSA, the actual number of people infected continues to grow because of ongoing new infections and increasing access to antiretroviral therapy.

Figure 3: Estimated number people living with HIV and adult HIV prevalence in Sub-Saharan Africa, 1990 - 2007



From: Report on the Global HIV/AIDS Pandemic, 2008. UNAIDS, Geneva, Switzerland.

The extent of the AIDS crisis is only now becoming clear in many African countries, as increasing numbers of people with HIV are becoming ill. In the absence of massively expanded prevention, treatment and care efforts, it is expected that the AIDS death toll in SSA will continue to rise. This means that impact of the AIDS pandemic on these societies will be felt most strongly in the course of the next ten years and beyond. Its social and economic consequences are already widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general (Bartlett & Gallant, 2003).

2.1.3 *Ethiopian Situation*

The first evidence of HIV infection in the country was seen in 1984, while the first cases were reported in 1986. Since then, the AIDS pandemic has spread to all parts of the country; some parts are worse hit than others, but no part of Ethiopia is exempted from the crisis (MOH, 2000). It is estimated that HIV is accounting for about a third of all adult deaths in the age group 15 - 49 years; has left behind nearly three-quarter of a million orphans' aged birth-17 years and over 30,000 newborns are borne with the virus. Updated reports indicate that the HIV pandemic is leveling off in Ethiopia (Getnet & Melesse, 2008).

With a population of over 77 million, Ethiopia takes a big share in the number of cases at global as well as regional levels. The HIV pandemic has penetrated almost all groups of population including the hard-to-reach rural areas. However, with the existing socio-cultural diversity of Ethiopia, the pattern and distribution of HIV in the country widely varies. Some regions are more affected than others; urban than rural; and, generally women than men (MOH, 2005). Similarly, gender inequality, which makes women more vulnerable to HIV infection, is mainly the result of economic deprivation and, hence, the lack of 'power' among women to negotiate sex (FSS, 2003).

According to Dessalegn (2003) the fast growth of HIV/AIDS infection in Ethiopia may be attributed to many years of poor governance, civil wars/ conflicts, drought/famine that have resulted in massive displacement and unemployment and, hence, undermined the cultural values and capacity of the people to tackle social, economic and health problems. To make things worse, the country has poorly developed infrastructure and limited resources. Health coverage is low and HIV/AIDS is spreading at a fast speed causing the death of hundreds of thousands of people mostly young and potentially productive.

Furthermore, FSS (2003) study suggests that, people living in poverty are at risk and are exposed to HIV infection more than any other group of people. People with fewer financial resources have less access to information and/or health services and their living perceptions force them to practice risky behaviors to meet their daily needs; poor women engage in commercial sex while poor men leave their families in search of jobs and, in the process, get exposed to HIV/AIDS infection.

Hence, based on this finding it might be concluded that poverty, indeed, is the major driving force behind the fast growth of HIV infection in the country. The Ethiopian people are at high risk of HIV/AIDS infection because the majority are poor, uneducated, and have little access to health services. As a result of this, poverty is a fertile ground for HIV/AIDS spread in Ethiopia. People are dictating the behavioral practices of the people. In the absence of tangible activities to alleviate the problems of poverty, the activities on HIV/AIDS prevention will not yield the outcomes expected. Poverty alleviation programs based on realistic economic policies need to be in place.

Because of the above mentioned reasons, Ethiopia is one of those countries highly affected by HIV/AIDS in SSA.

Table 3: Ethiopian Summary of the HIV/AIDS pandemic in 2008

Number of people living with HIV	Total	1.037.267
	Adults	969.131
	Women	612.815
	Children under 15 years	68.136
People newly infected with HIV	Total	125.147
	Adults	111.054
	Women	71.577
	Children under 15 years	14.093
AIDS death	Total	58.290
	Adults	49.006
	Women	33.084
	Children under 15 years	9.284
HIV prevalence	Total	2.2%
	Women	2.6%
	Men	1.8%
	Rural	7.7%
	Urban	0.9%

From: AIDS in Ethiopia, 2008. MoH, Addis Ababa, Ethiopia. Artistic Printing enterprise.

The Ethiopian Government responded to HIV/AIDS pandemic by establishing National AIDS Control Program in 1986 under Ministry of Health (MOH & UNICEF, 2000), a national health policy in 1993, which are designed to guide the implementation of successful programs to prevent the spread of HIV and AIDS (MOH & UNICEF, 2000; MOH, 2000).

HIV/AIDS has a large social, psychological, demographic and economic impact on both the individual and society, thus leading to painful stress, disability, death of adult parents and children and the induced orphanhood. In order to mitigate these problems, the government of Ethiopia has adopted the national HIV/AIDS policy on AIDS in 1998 and the national strategic framework in the year 2001 by realizing HIV/AIDS not only as a health problem but also a developmental challenge (MOH, 2000; NAC, 2001).

2.2 The Impact of HIV/AIDS

In the approximately 25 years since AIDS emerged as a major health emergency, the pandemic has had a serious, and in many places devastating, effect on human development. In some countries, AIDS is undermining progress towards the Millennium Development Goals, particularly those related to poverty reduction, achieving universal primary education, promoting gender equality, reducing child mortality and improving the health of mothers (IAVI, 2005; UNFPA, 2003).

The AIDS pandemic has affected every aspect of life in the world especially in Africa, from people's livelihoods to the capacities of nation (UNAIDS, 2005). The scale of the pandemic's impact, highly varied from place to place, has been documented with increasing precision over the years as surveillance and analytical tools have improved. As a result, the interrelationship of AIDS with other problems of human development has become clearer (UNAIDS, 2006). Its deepening impact has been a key policy concern of many national and international bodies (UNAIDS, 2005).

Today the impact of HIV/AIDS is more serious in SSA than other regions in the world. According to UNAIDS (2008) report, two-thirds of all people living with HIV are found in SSA, although this region contains little more than 10% of the world's population. AIDS has caused immense human suffering in the continent. The most obvious effect of this crisis has been illness and death, but the impact of the pandemic has certainly not been confined to the health sector; households, schools, workplaces and economies have also been badly affected.

Although antiretroviral treatment is starting to lessen the toll of AIDS, still fewer than one in three Africans who need treatment are receiving it (WHO, 2008). The impact of AIDS will remain severe for many years to come (Feigal et al., 2000).

2.2.1 *The Impact on Individuals, Families and Communities*

HIV/AIDS inflict multifarious complicated sufferings on the infected individuals and their families. The pandemic does not simply affect the health condition of the infected; it also disturbs the economic, social and psychological situation of the family (HAPCO, 2006). In both low and high prevalence settings, HIV/AIDS hinder human development and it continues to exact a devastating toll on individuals, families and communities (UNDP, 2004).

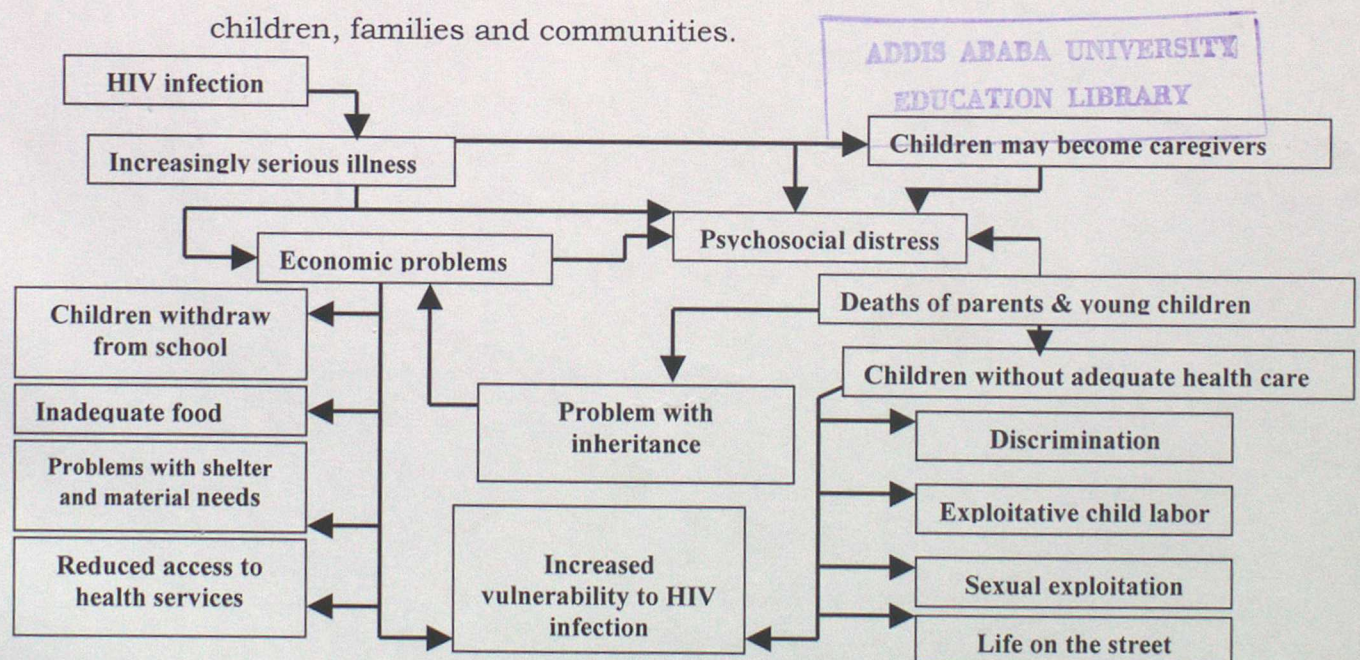
Because HIV/AIDS predominantly attacks people of childbearing age, the impact this has on children, extended families, and communities is devastating. If a parent dies of AIDS, the child is three times more likely to die even though he/she is HIV negative. Besides increased risk of death, children whose parents have died due to HIV/AIDS also face stigmatization and rejection, and often suffer from emotional distress, malnutrition, a lack of health care, poor or no access to education, and often most importantly, lack of love and care. They are also at high risk for labor exploitations, sex trafficking, homelessness, and exposure to HIV. Extended families and communities in highly affected areas are often hard-pressed to care for all children. In communities hard hit by the double hammer of HIV/AIDS and poverty, there are millions of children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are infected with HIV/AIDS might not receive the care and support they require, and may instead become their parents' caregivers, often dropping out of school and becoming the breadwinner. Research indicates that these children, caring for sick and dying parents, are the most vulnerable of all (UNAIDS, 1999; MOLSA, 2003; PEPFAR, 2006).

The alternative forms of families are constantly evolving and psychosocial distress affects their ability to cope. Within them, HIV/AIDS can lead to

loss of employment, loss of productive capacity, high expenditures for treatment of sick family member and care for children (Claudia & Jarratt, 1995). Another problem is that orphans' guardians are often poor women. Children in these households are significantly more disadvantaged than those children living with their parents; it is because women have less access to property and employment. Women also may feel pressure to exchange sex for material items or money, increasing their risk of HIV infection (UNAIDS, 2002).

Moreover, the impact of the pandemic is felt through communities and societies. The widespread loss of life from HIV/AIDS undermines entire communities. Highly skilled personnel in public management, social workers, teachers and farmers have died and continue to die in enormous number. The pandemic is reducing labor and agriculture productivity, weakening social structures, increasing demand for health and other service, and reducing the capacity to deliver those services (German et al., 2002).

Figure 4: The interplay of a sequence of factors and impact of HIV/AIDS on children, families and communities.



From: Comprehensive community - based care and support guideline for people living with HIV/AIDS, orphan and vulnerable children and affected families, 2006. HAPCO, Addis Ababa, Ethiopia.

2.2.2 The Impact on the Education Sector

The relationship between AIDS and the education sector is circular as the pandemic worsens; the education sector is damaged, which in turn is likely to increase the incidence of HIV transmission. There are numerous ways in which AIDS can affect education but equally there are many ways in which education can help the fight against AIDS. The extent to which schools and other education institutions are able to continue functioning will influence how well societies eventually recover from the pandemic (Gao et al., 1999).

A decline in school enrolment is one of the most visible effects of the pandemic. The contributing factors to these effects include: the removal of children from school to care for parents and family members; an inability to afford school fees and other expenses; AIDS-related infertility and a decline in birth rate, leading to fewer children; and the fact that more children are themselves infected and do not survive through the years of schooling (UNAIDS, 2000; World Bank, 2004). This is particularly a problem among children who have lost their parents to AIDS, who often struggle to generate income (AVERT, 2008).

Studies have suggested that young people with little or no education may be 2.2 times more likely to affect HIV as those who have completed primary education (UNAIDS, 2002; AVERT, 2008). In this context, the devastating effect that AIDS is having on school enrolment is a big concern.

AIDS is also hampering the ability of education systems to perform their basic social mandates, as more teachers succumb to the disease (World Bank 2004). In the early stages of the African pandemic it was reported that teachers were at a higher risk of becoming infected with HIV than

the general population, because of their relatively high socio-economic status and a lack of understanding about how the virus is transmitted. This trend appears to have changed, as evidence increasingly shows that the more educated an individual is the more likely they are to change their behavior. But HIV/AIDS are still having a devastating affect on the already inadequate supply of teachers in African countries (AVERT, 2008). Illness or death of teachers is especially devastating in rural areas, where schools often depend heavily on one or more teachers. Moreover, skilled teachers are not easily replaced (UNAIDS, 2006).

When a teacher falls ill, the class may be taken on by other teacher, may be combined with another class, or may be left untaught. Even when there is a sufficient supply of teachers to replace losses, there can be a significant impact on the students (UNICEF, 2006).

While the loss of teachers and administrators directly-affects the quality of education, there is also the danger that demands on the health and welfare services might divert resources from education other sectors. The costs associated with training new teachers and hiring substitute teachers will also strain budgets, crowding our investments in infrastructure, materials and human resources. Such improvements are especially necessary for countries aiming to compete in an increasingly knowledge-based word economy (UNAIDS, 2002).

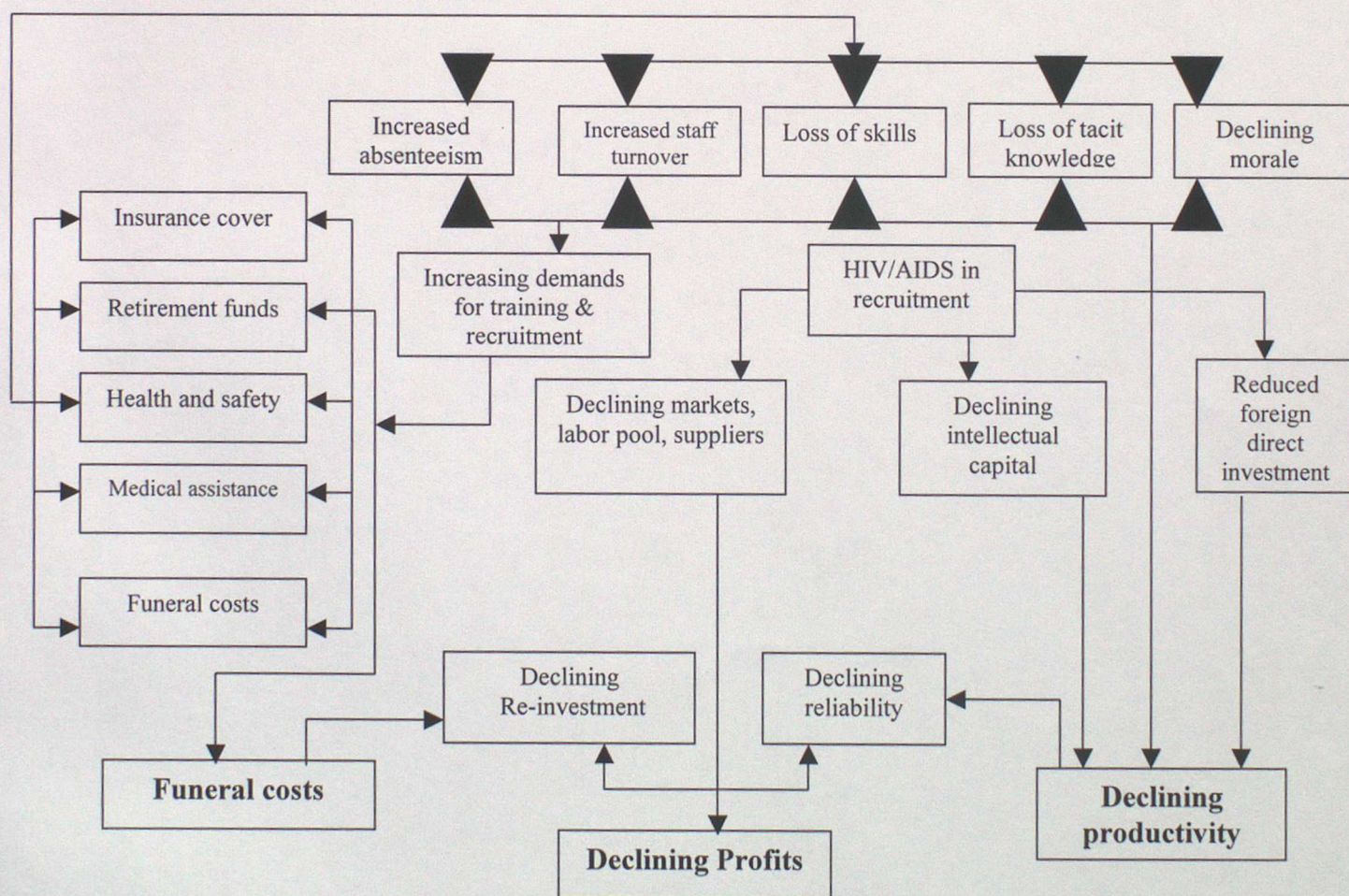
2.2.3 The Impact on Enterprises and Workplaces

HIV/AIDS dramatically affects labor, setting back economic activity and social progress. The vast majority of people living with HIV/AIDS worldwide are between the ages of 15 and 49 in the prime of their working lives (UNDP, 2005).

Production and profitability are core concerns for enterprises, large and small. AIDS weakens economic activity by squeezing productivity, adding

costs, diverting productive resources, and depleting skills. In addition, the impact on households grows more severe, market demand for products and services can shrink. The pandemic hits productivity mainly through increased absenteeism, organizational disruption, and the loss of skills and 'organizational memory'. Rising absenteeism tends to push visible costs up while forcing productivity down, putting profits at risk. Production cycles can be disrupted, equipment stands idle and temporary staff may need to be recruited and trained (UNAIDS, 2002; UNAIDS, 2003; AVERT, 2008).

Figure 5: The Impact of HIV/AIDS on Industries



From: Report on the Global HIV/AIDS Pandemic, 2002. UNAIDS, Geneva, Switzerland.

Furthermore, the impact on informal enterprises can be especial harsh. When the lead entrepreneur is no longer able to work, there is a high risk that the entire enterprise will collapse (HR, 2005).

2.3 People Orphaned by HIV/AIDS

Differences in orphan definition have program and policy implications. It is thus, very important that researchers, epidemiologists and policy-makers explicitly state their understanding and usage of the term "Orphan". Some cultures regard an orphan as a child who has lost both parents. Others consider an orphan to be a child who has lost one parent.

AIDS orphans: The literature tends to use three kinds of definitions; depending on which parent has been lost to AIDS; it refers to paternal, maternal, or double orphans. A paternal orphan is defined as a child younger than 15 who has lost a father to AIDS, a maternal orphan is one who has lost a mother to AIDS, and a double orphan is one who has lost both parents to AIDS (Deininger et al., 2001).

Although much literature used the term "AIDS orphan" to one or both biological parents of the child are died due to AIDS.

Worldwide, it is estimated that more than 15 million children under 18 have been orphaned as a result of AIDS. Around 11.6 million of these children live in SSA (UNAIDS, 2008). In countries badly affected by the pandemic, it is estimated that 20 percent of children under 17 are orphans, most of whom have lost one or both parents to AIDS. Even with the expansion of antiretroviral treatment access, it is estimated that by 2015, the number of orphaned children will still be overwhelmingly high (AVERT, 2008; UNAIDS, 2008).

Children orphaned by AIDS are found in almost every country of the world. But the worst orphan crisis is in SSA. As the table below shows, the number of orphans in some SSA countries exceeds half a million, and, in some countries, children who have been orphaned by AIDS comprise half or more of all orphans nationally.

Table 4: The Countries with the largest numbers of orphans due to AIDS, alive in 2007

Countries	Number of orphans due to AIDS
South Africa	1,400,000
Uganda	1,200,000
Nigeria	1,200,000
Zimbabwe	1,000,000
Tanzania	970,000
Ethiopia	650,000
Zambia	600,000
Malawi	560,000
Cote d'Ivoire	420,000

From: AVERT organization, information center on HIV/AIDS, 2008. AVERT.

AIDS orphans endure overwhelming and largely unmitigated losses, living as they do in societies already weakened by underdevelopment, poverty and the AIDS pandemic itself. In countries like Ethiopia where the society is already impoverished and the traditional social security system is weakened, HIV/AIDS deprived the children's right to access basic services (Selamawit, 2005). Thus, many of the AIDS orphans may end up as unskilled and unsocial, unable to contribute to the economy of the country due to the social, psychological, and economic impacts they

confront. These unsocial, uneducated children who grow up without parental care and love, deprived of their basic needs face immeasurable costs and bring enormous costs to the larger society because situations deprive them opportunities to realize their potential (Kweski, 2000; Barnett & Whiteside, 2002).

2.3.1 *The Perceptions of people Orphaned by HIV/AIDS*

So much has been said about the dramatic increase of HIV/AIDS but AIDS orphans are hidden away, invisible, voiceless and forgotten. The issue of their health and right to basic services is not on the normal agenda as children are voiceless.

It has been also recognized that AIDS orphans are vulnerable to a lot of social, economic and psychological problems. The total convergence of the services in terms of number of beneficiaries in the area of education and health and the attention given to AIDS orphans is far from satisfying. The existing government agencies, NGO and community institutions that provide services to AIDS orphans are confined in few selected areas addressing the needs of a limited section of AIDS orphans population. Thus, a majority of AIDS orphans are left out without any form of assistance (MOLSA, 2003).

Therefore, the impacts of parental death on children are complex and affect the child's psychological and social development. UNAIDS (2008) reported that, orphaned children might have stunted development of emotional intelligence, and life skills such as communication, decision making, negotiation skills etc. Moreover, they often show lack of hope for future and have low self-esteem.

2.3.1.1 Psychological Status of People Orphaned by HIV/AIDS

Affected and orphaned children are often traumatized and suffer a variety of psychological reactions to parental illness and death. In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatization as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of children's reactions suggest that they tend to show internalized rather than externalized symptoms in response to such impacts-depression, anxiety and withdrawal-as opposed to aggression and other forms of anti social behaviors (Sengendo & Nambi, 1997).

According to German, et al., (2002), one key factor regarding the long-term impact is the psychological and mental health of children who have nursed and lost their parents under traumatic perceptions due to AIDS.

A child whose mother or father is HIV positive begins to experience loss, sorrow, and suffering long before parent(s) death. Moreover, since HIV is transmitted mainly by unsafe sexual intercourse between couples, once HIV already claimed the mother or the father; the children are far more apt to lose the remaining parent. This causes children find themselves trust in the role and responsibilities of mother or father or both; doing the household chores, looking after siblings, farming and caring for the ill or the dying parent(s), experiencing stress that would exhaust even adults.

Children affected by HIV/AIDS from stigma and discrimination associated with the disease, the loss of caring adults, and depletion of

household financial resources. Intervention must go beyond health issue and respond to the broad ranged of child and family needs (UNAIDS, 2002). The prejudice and stigmatization of AIDS orphans goes to the extent in which AIDS orphans are "expelled from school, physically beaten, verbally abused, discriminated, given separated seats, emotionally tortured, etc". The emotional distress of AIDS orphans is reflected in the degree of unhappiness, and worry they show, their level of patience, fatigue, and depression, feeling of hopelessness, pessimism and other symptoms that could result in long term consequences such as chronic depression, low self esteem, learning disabilities and disturbed social behavior (UNAIDS, 1999; MOLSA, 2003). The loss of parents and loved ones is associated with internalized psychological perceptions including anxiety, rumination, depression, social isolation, survivor's guilt and low self-esteem (Tremblay & Israel, 1998).

Children react to stress in different ways. Many will find it difficult to talk about their worries. They internalize their feelings and stress, believing that they are abnormal in some way, and suffer from low self-esteem, depression or anxiety. In this line a study conducted in suburbs of Dares Salaam, Tanzania by Makame & Grantham (2002) compared 41 orphans (primarily double orphans) with 41 matched non-orphans aged 10 to 14 years. Orphans scored higher than non-orphans on a semi-structured questionnaire that assessed internalized problems. Nearly three times as many orphans say they had contemplated suicide in the last year. Going to bed hungry and not going to school were independently related to internalizing problems and accounted for some but not all of the association with the orphan-hood: orphans still had significantly higher internalizing problems. The authors noted that orphans who were living with a surviving parent or with adult relatives had the lowest scores, and girls tended to have the most internalized problems.

In fact, there are some feelings which experienced commonly for orphans children; these include guilt, anger and sadness (Perlin & Cohen, 2002). Moreover, Gifford (2003) argued that, the psychological effects on orphaned children who are living with extended families will lead to emotional disturbance often characterized by stress, anxiety, depression, poor management of changes, poor self-esteem, lack of confidence, sense of not belonging, fears for the future and so on.

The trauma of HIV/AIDS orphans starts way before, their parents' death. It starts during illness; selling assets for medicine and child care responsibility beyond their years. Many children constantly worry about going to school and leaving their parents to die. As one study suggests, parental death is the most stressful event for the child (Toomey & Christie, 1990).

In general, HIV/AIDS orphans are vulnerable in almost all aspects of their lives. They have lower access to basic health care, show lower school enrollment rate and nutritional status, are emotionally and sexually abused, exploited and physically abused. As a result, the impact of parental death on children especially because of HIV/AIDS is complex and affects the child's mental health and social energy.

2.3.1.1.1 Self - Esteem of People Orphaned by HIV/AIDS

Self-esteem is the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. It is confidence in the efficacy of the mind, in the ability to think. By extension, it is confidence in the ability to learn, make appropriate choices and decisions, and respond effectively to change. It is also the experience that success, achievement, fulfillment-happiness are right and natural for the individual. The survival-value of such confidence is obvious; so is the danger when it is missing (Brnaden, 1997).

When we consider, the aforementioned stressors of AIDS orphans the possibility of developing a low self-esteem is possible (Carol, 2007). Low self-esteem has been associated with poor psychological adjustment, mental health problems such as anxiety and depression (Gifford, 2003).

The absence of a healthy sense of self - esteem could have far reaching implications for AIDS orphans; conversely, the presence of a healthy self-esteem could function as a protective factor against the assaulting variables imposed on AIDS orphans (Parekh, 2004). Moreover, when considering the vast impact of self-esteem on the individual, it is clear that this construct may have a significant impact on AIDS orphan. A child's self-esteem is inevitably adversely affected in the face of traumatic events. Furthermore, self-esteem may play a vital role in the AIDS orphan's ability to adjust to their life circumstances and impact their quality of life and future (Carol, 2007).

2.3.1.1.2 *Depression of People Orphaned by HIV/AIDS*

Depression is a deep sadness with long-term, harmful effects on the health and development of the individual. When parent(s) died, children not only missed their physical presence, but also many positive things they gave them when they were alive, such as love, care and protection (Kedija, 2006).

According to research conducted by Alcorn (2007) in South Africa, AIDS Orphans suffer significantly higher levels of psychological depression than other orphans. The research team, led by Lucie Culver, interviewed 1025 children aged 10-19 in poor neighborhoods of Cape Town using a standardized questionnaire. They found that children orphaned by AIDS had significantly poorer psychological health than other children in the study, and suffered levels of post-traumatic stress equivalent to those of children experiencing sexual abuse. AIDS orphans also were less likely to

have psychological ill health if they lived in a household with access to social security grants, food security and at least one member in employment, suggesting that efforts to alleviate poverty could mitigate the psychological problems manifesting as depression and delinquency in AIDS orphans (Alcorn, 2007).

If AIDS orphans are given enough food, enabled to go to school, and given a social grant, it reduces depression and behavioral problems (Culver et al., 2007).

2.3.1.1.3 *Anxiety of People Orphaned by HIV/AIDS*

Anxiety is not an illness! It is a behavioral 'condition' which results from a re-setting of the benchmark anxiety level (Gross, 2001).

In one study carried out in rural Uganda, high levels, of psychological distress were found in children who had been orphaned by AIDS. Anxiety was found to be more common among AIDS orphans than other children (AVERT, 2008).

Moreover, anxiety can become more severe if a child is forced to separate from his/her siblings upon becoming orphaned. In some regions this occurs regularly: a survey in Zambia showed that 56% of orphaned children no longer lived with all of their siblings (USAID, 2002).

On the other hand, some parents find it too difficult to talk to their children about HIV/AIDS; in addition this lack of communication can confuse them. The children may have their own source of information outside the family and draw their own conclusions. This also creates anxiety, as the children worry about their parents and their future (Kedija, 2006).

2.3.1.2 Social Status of People Orphaned by HIV/AIDS

AIDS is commonly viewed as a punishment for "immoral" life styles such as promiscuity, homosexuality and drug use. Additionally irrational fear of contagion prevails (Taylor et al., 1999). Persons with AIDS, their parents and children may be rejected by their extended family, friends and/or by society at large. For these reasons, they may cut themselves off from social support networks (Nagler et al., 1995)

Initially the social impact of HIV/AIDS often causes families and communities to be paralyzed, a response that is linked to the fear of the unknown new situation in communities where traditional coping patterns give no easy answers to the problems. Fear is followed by stigmatization of the affected individuals and families. Family/houses hold and community pattern can change this situation and traditional society safety nets start to adapt to the new crisis in an attempt to mitigate the negative impact.

According to Guest (2001) the experience of major international child welfare organization has shown that orphans benefit greatly from, the care, personal attention, and social connection that extended families and communities can provide, particularly in the developing world, where the extended family and community are the primary social safety net. The absence of such connections greatly increases long-term vulnerability of children who lost their parent (s).

The extended family was the traditional social safety net in most African countries, including Ethiopia. Over the past decades, poverty in general and the magnitude of the problem of orphans and other vulnerable children weakened extended family networks. The combined social

impact of AIDS, such as the care for terminal ill family members, increased number of orphans to look after with reduced number of prime-age caregivers, has put the extended family safety net under great stress. As result, many orphans slip through that traditional society security net (Desalegn, 2007).

Some children may be lied to, or not told about, the cause of their parent's illness and death. Others may be aware of the diagnosis, but be required or choose to keep it as a secret (Dane, 1997). A New York study by Hudis (1995) found that very few parents had chosen to reveal their HIV status outside the family. Although this "conspiracy of silence" is understandable given the stigma that still surrounds AIDS, it can leave AIDS orphans without any one with whom to share their feelings and fears (Pivnick & Villegas, 2000), heighten their feelings of being "different" from other children and associate their loss with a sense of shame.

Moreover, a study conducted by MOLSA (2003) stated that AIDS to have negative impact on children's socializations with respect to their identity, understanding and participation. The health and nutritional status of orphans compared with non-orphans is also lower. This is a matter of concern, as not only it is a child rights violation but also as childhood, malnutrition is associated with reduced productivity in later life (Stefan, 2002). Hence, stigma, discrimination, rejection, self-isolation and mistreatment are some of the severe emotional problems orphaned children by AIDS are facing beyond the tragedy of losing their parents and the insecure living perceptions. This in turn will affect psychosocial wellbeing and educational condition (Hubley, 1995).

2.3.1.2.1 *Social Avoidance and Distress of People Orphaned by HIV/AIDS*

Children grieving for dying or dead parents are often stigmatized by society through association with AIDS (UNAIDS, 2008). The distress and social isolation/avoidance experienced by these children, both before and after the death of their parent(s), is strongly exacerbated by the shame, fear, and rejection that often surrounds people affected by HIV and AIDS. Because of this stigma, children may be denied access to schooling and health care. Once a parent dies children may also be denied their inheritance and property. Often children who have lost their parents to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face discrimination and damage their future prospects. In this situation children may also be denied access to healthcare that they need. Sometimes this occurs because it is assumed that they are infected with HIV and their illnesses are untreatable (Marcus, 1993).

Moreover, as the rights of children are inextricably linked to those of their surviving parent, laws and practices that deny window their rights and property have deviating consequences for children after their parent's death (UNICEF, 1999).

2.3.1.2.2. *Shyness and Sociability of People Orphaned by HIV/AIDS*

One of the most disabling features and consequences of AIDS orphans is a marked impairment of social skills. Normal social interactions involve components of perception, assessment, and response to interpersonal cues. Behavioral deficits in social functioning such as poor lack of eye contact and social withdrawal are also characteristic of temperamental shyness, and parallel those behavioral deficits present in the symptom profile of AIDS orphans. Although there is research suggesting that

shyness and related construct are contribution factors for social dysfunction in AIDS orphans (UNAIDS, 2008).

Moreover, AIDS orphans said that “we want to involve in social interactions”, but they avoid the exposures of social activities because of their extreme emotional distress. Such anxiety is triggered by the fear that others may scrutinize them and that they may do something humiliating or embarrassing. These perceptions make them shy (USAID, 2008). In addition, some studies indicated that shyness is associated with lower self-esteem, social isolation and feelings of loneliness (Grohol, 2008)

2.3.1.2.3 Loneliness and Social Dissatisfaction of People Orphaned by HIV/AIDS

Of the many vulnerable members of society, children who have lost one or both parents due to HIV/AIDS are at risk; this is particularly true in SSA, where few social support systems exist outside of families and where basic social services are largely inadequate (Rose and Sue, 2003). As a result, loneliness and social dissatisfaction will occur for AIDS orphans.

In one study carried out in China on 72 orphans, who had lost both parents, and were effectively disconnected from both family and society. The feelings of loneliness and social dissatisfaction are difficult for many AIDS orphans to bear. Using financial subsidies to encourage families to raise these children will allow more children to return home and grow up in a loving healthy family environment.

The national policy is in the process of being set, but just a policy is not enough. It is still essential to have the full participation of society, to have more people concerned for them (orphans). The children's parents died of AIDS, but they are healthy children. Though they are not

themselves infected, because they were in the proximity of AIDS, people are worried about the state of their lives.

2.3.1.3 The relationship between Psychological and Social Perceptions of People Orphaned by HIV/AIDS

As indicated in children on the Brink (2004), a joint report of USAID/UNICEF, cited in Befikadu (2006) HIV/AIDS starts to affect a child early in a parent's illness, and its impact continues through the course of the illness and throughout the child's development after the parent's death.

Studies revealed that the right of HIV/AIDS orphans was abused. They were discriminated, whether they are identified as HIV negative or HIV positive, they run a high risk of stigmatization that will have a great effect on their normal development (Tedla, 2005). This development consists of psychological and social.

A study carried in Zambia showed that, 82% of orphans children were affected their psychological and social development after their parent(s) death. Caregivers noticed that these children become worried, sad, and tried to help more in the home and stopped playing so as to stay near by. According to this study, these children more likely to become solitary; to appear miserable or distressed, and to be fearful of new situations than children not affected by the pandemic. Therefore, the losses of the parents continued to affect the children's developmental stages. At first, their psychological and social development was affected (Max, E et al, 2002).

Tremblay & Israel (1998) argued that the loss of parents and loved one is associated with internalized psychological and social perceptions including low self – esteem, depression, anxiety, social isolation, feelings of dissatisfaction with peer relationships, shyness and survivor's guilt.

2.3.1.4 Educational Status of People Orphaned by HIV/AIDS

Education is the means whereby HIV/AIDS orphans can realize the possibility of productive employment, minimizing their risk of being exploited and of themselves becoming infected with HIV. But for many African countries like Ethiopia, poverty and HIV/AIDS have forced them to exclude children from school (Matshalage & Powell, 2002).

According to MOLSA (2003) one of the first visible impacts of prolonged parental illness on children can be that their education is disrupted due to a lack of financial resources and the children's increased responsibility for household and care giving chores. Even for orphans that continue with schooling, their performance is often lower than for non-orphan peers. The pandemic also takes its toll on the quality of education as the numbers of teachers are reduced due to AIDS-related mortality rates.

It is reasonable to think that in normal circumstance at their age children should be enrolled in school where they could at least acquire the rudiments of education in terms of reading, writing and arithmetic. But this is far from being the case. In Africa, even in the cities, schooling is still out of reach for many children for needy families, especially when they have been rejected and neglected. Schooling costs both time and money. All pupils must have a uniform and various items of school equipment, which was difficult, if not totally impossible, for street children and orphans to acquire (Veils, 1995). This situation explains that the problem is not only for AIDS orphans. What is special about the AIDS orphans is the issue of shortage of money and drop outting from school, lack of love, exclusion or discrimination and the stigma attached to AIDS in the school.

Half of adults in SSA are unable to read or write. Illiteracy is particularly prevalent in areas where HIV rates are highest. In many African countries because of the cost of basic education most children orphaned by AIDS are growing up without any schooling at all (Lyans, 2001). Similarly, the World Bank research report (1997) indicates that AIDS orphans are less likely to have proper schooling because the death of bread winner in the household reduces a child's attendance at school. Thus, AIDS orphans have higher rates of absenteeism, dropout, repetition and less academic performance. The difficulty faced by AIDS orphans to attend school is also explained by Loudon (2002), in a way an orphan child may have to take care of a house hold or engage in income earning activities for survival. When a child go to another household after parental loss, the obstacles to go to school become greater as the child is not their own.

As several studies indicate, orphans who lost either one or both parents to AIDS have a much harder time staying in school. The trauma for these children is either too difficult to manage or they are discriminated against by their peers. According to MOLSA, Italian Cooperation and UNICEF (2003) study, majority of the children who drop out of school, because of AIDS are girls. Girls take on the responsibility of caring for sick parents or their orphaned siblings at home. The findings of the national survey by MOLSA (2003) also indicated that the numbers of AIDS orphans who attend school are fewer than non AIDS orphans. In fact after the death of the mother, one out of every five orphans drops out of school due to inability of caretakers to cover school fees, supplies and uniforms. The problem to benefit from social services such as education become more severe for AIDS orphans due to stigmatization and the probability of losing both parents. Thus, unless mitigation measures are not taken on time achieving universal education by 2015 will be illusion.

2.4 Need of People Orphaned by HIV/AIDS

Needs of AIDS orphans are the same as the general needs of children, except in the areas of skills. Orphans may require skills at an early age in order to cope with additional responsibilities that they assume (Desalegn, 2007). These needs are best given according to the age categories of children as shown below.

Table 5: Need of HIV/AIDS orphans and vulnerable children by age category

0 - 5 Years: Early Childhood Development	6 - 14 years: Primary School Children	15 - 18 Years: Secondary Tertiary Education /Youth out of School
➤ Immunization ➤ Nutrition/breastfeeding ➤ Stimulation/psychosocial care ➤ Basic health care ➤ Shelter and clothing ➤ Guidance, ➤ pre-school education ➤ Protection; Behavior formation	➤ Education ➤ Shelter/clothing ➤ Food ➤ Health ➤ Guidance and counseling ➤ Behavior formation ➤ Stimulation, ➤ psychosocial support ➤ Reproductive health education ➤ HIV/AIDS education ➤ Life survival skills ➤ Protection	- Basic needs (education /health/food /shelter) ➤ Reproductive health/HIV/AIDS education ➤ Protection (legal protection /property inheritance) ➤ Behavior change ➤ Career guidance/counseling ➤ Vocational training/ entrepreneurial training ➤ Income generating activities ➤ Socio-economic reintegration

From: Community based support of orphans and vulnerable children: A manual for frontline workers in Africa, 2004. Seroney, E & Pfahler, K. Germany: The Kindernet hilfee.

CHAPTER TREE

METHODOLOGY

In this section, the procedures for selecting subjects, developing measurement instruments, data collection and analysis are described.

3.1 Approach and Design

The main purpose of this study is to investigate the condition of students orphaned by HIV/AIDS in Awassa Boarding Secondary School. Hence, in order to meet the goal of the research deeply, quantitative approach mainly and qualitative approach as a complementary were considered appropriate.

3.2 Participants

The study area for this research is Awassa city administration. In the city, there are eighteen regular high schools and one boarding school, providing education for grade 9 to 10. From these schools the researcher selected one school based on the following criteria:

- providing academic and boarding services for the students.
- differing in its delivery system i.e. inclusive school, students orphaned by HIV/AIDS and non-orphaned students.

The school selected for this study is Awassa Boarding Secondary School. There are 157 students orphaned by HIV/AIDS and 132 non-HIV/AIDS orphaned students found in the school. These students are classified in 5 sections from grade 9 to 10.

For the purpose of this study all 157 students orphaned by HIV/AIDS were included using population study. However, seven students were rejected from the study, because they did not complete the questionnaire properly. As a result, 150 (97 male and 53 female) students orphaned by HIV/AIDS were included in the study. In addition, the director of the school, social worker of boarding giving organization (Shiny Day) and a teacher from the school were selected purposefully and included for the study.

Table 6: The number of participants with mean and standard deviations of their age

Subjects	Sex	No	Age	
			Mean	SD
Students orphaned by HIV/AIDS	M	97	17.08	1.76
	F	53	17.22	1.96

3.3 Tool Development

The instrument was prepared for tryout after passing many processes. The process includes collecting items, adopting scales and doing forward and backward translation. After preparing the instruments in English, it was translated into Amharic language for the ease of communication with the participants. The instrument was first translated into Amharic by graduate English language and psychology students. The instrument was also translated back into English by English instructor. Minor differences were observed corrected through discussion held among those translators and the researcher. Then, the instrument was given to two experts of Special Needs Education and two psychologists to judge their applicability to the participants. Finally, the instrument was made ready for pilot test.

3.4 Instruments Used for Data Collection

The instruments used to collect data from subjects have four major parts.

Part I - Background Questionnaire

In this part the instrument items were prepared to gather background information of the participants in addition to the scales adopted and mentioned below. As part of the study the demographic questionnaire includes age, sex and background information of the participants.

Part II - Psychological Scales

A psychological scale, which measures psychological distress included, subscales for self-esteem, depression, and anxiety. These subscales classified into three sections.

Section I – Self - Esteem Scale

Self - esteem was measured by Rosenberg's self - esteem scale which contains 10 items and taken from Rosenberg (1965). The item asks respondents to indicate their perceptions of themselves in positive or negative ways. Primarily the Rosenberg's self - esteem scale contained 10 items. Therefore, for the betterment of the research result, the researcher took all the 10 items without any amendment except minor word changes.

Section II - Depression Inventory

Depression was measured by Beck Depression Inventory (BDI-II) contains 20 items and taken from Beck (1996). It focuses on the feeling of dissatisfaction with one self and one's ability to achieve desired outcomes. In the firsthand, the Beck Depression Inventory (BDI-II) contained 21 items; however, the researcher used 20 items by discarding one item which is not relevant for the research result. In addition, the researcher amended some words so as to suite the result of the research.

Section III - Anxiety Scale

Anxiety was measured by the Revised Children's Manifest Anxiety Scale (RCMAS) which contains 16 items and taken from Gilor & Devilly (2008). This item centers on behavioral expressions of internal anxiety or emotionality such as nervousness, tension, and worry. Primarily, the Revised Children's Manifest Anxiety Scale (RCMAS) contained 42 items; but the researcher discarded 26 items and selected only 16 items which were more appropriate for the research purpose. Moreover, the researcher amended some words of the selected 16 items in order to make more clear for the participants.

In general, measures of psychological distress were a pool of 46 items. The items were statements to which HIV/AIDS orphans responded on a 5 - point Likert scale (5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree and 1 = strongly disagree). The negative statements were reversibly scored.

From 46 items almost half were stated positively and other half negatively. The reason was to reduce the effect of response bias. In addition to this, way of minimizing response bias, the statements were randomly placed in the questionnaire.

Part III - Social Scales

The others indicators of the condition of students orphaned by HIV/AIDS in this study are social scales, which labeled social scales, were made by aggregating various subscales that assess orphan's self - perceptions regarding there social experiences. The components covered by the items dealt with subjects' perceptions of their social peer relations, perceptions of their social competence, intimacy of friendship, shyness and feeling of dissatisfaction with peer relationships and loneliness. The measures were classified into three sections.

Section I - Social Avoidance and Distress Scale (SAD)

Social Avoidance and Distress was measured by the Watson and Friend Social Avoidance and Distress scale (SAD). It contains 15 items taken from Jones, et al, (1986) and which center on the anxiety, tension, and distress provoked by social encounters and on a desire to escape from or avoid such situations. In the firsthand, the Watson and Friend Social Avoidance and Distress scale (SAD) contained 28 items; however, the researcher discarded 13 items and selected only 15 items which were more appropriate for the research purpose. Furthermore, the researcher amended some words of the selected 15 items in order to make more clear for the participants.

Section II - Shyness and Sociability Scale (SS)

Shyness and sociability was measured by the Revised Cheek and Buss Shyness Scale (RCBS) developed by Cheek and Buss. The scale contains 13 items taken from Cheek & Buss (1981) that assess the constructs of shyness broadly and orphans' perceptions of their social competence. At

first, the Revised Cheek and Buss Shyness Scale (RCBS) contained 13 items. Therefore, for the betterment of the research result, the researcher took all the 13 items without any amendment except minor word changes.

Section III - Loneliness and Social Dissatisfaction Scale (LSDA)

Loneliness and Social Dissatisfaction was measured by the Loneliness and Social Dissatisfaction Scale (LSDA) which contains 13 items taken from Cassidy & Asher (1992) that describes loneliness in terms of a subjectively felt discrepancy between the kinds of relationships that the individual perceives himself/herself as having and what he would like to have. Primarily, the Loneliness and Social Dissatisfaction Scale (LSDA) contained 24 items; however, the researcher discarded 11 items and selected only 13 items which were more appropriate for the research purpose. Additionally, the researcher amended some words of the selected 13 items in order to make more clear for the participants.

In general, these three scales provide a pool of 41 items. The items were statements to which HIV/AIDS orphans responded on a 5 - point Likert scale (5 = always true, 4 = true most of the time, 3 = true sometimes, 2 = hardly every true and 1 = not true at all). The negative statements were reversibly scored.

From 41 items almost half were stated positively and other half negatively. The reason was to reduce the effect of response bias. In addition to this, way of minimizing response bias, the statements were randomly placed in the questionnaire.

Part IV – Interview

Semi structured interview was used to assess the condition of students orphaned by HIV/AIDS and to supplement the information obtained through questionnaire. Face to face interview was conducted with director of Awassa Boarding Secondary School, social worker of boarding giving organization (Shiny Day) and a teacher from the school. Many probes were made at the time of the interview. Interviewees were guided whenever they left the main themes during interview. The interviews were conducted by the researcher himself. The interviews were tape recorded and translated verbatim. The average time spent on a single interview was 35 minutes.

3.5 Instrument Tryout

The main objective of the pilot test was to improve the instruments. Since items of the measures were collected and adopted from literature, checking their reliability was necessary. In doing so, the questionnaire was distributed among 30 (15 male and 15 female) students orphaned by HIV/AIDS found in Awassa SOS children Village. The data obtained were analyzed by using SPSS 15.0 to see the reliability. Following is summary table which contains the reliability of each scale and number of items improved in each scale.

Table 7: Summary of reliability of the scale

No.	Scale	Reliability (Cronbach alpha)	No. of items improved after the pilot test
1	Self - esteem	.81	1 (item 9)
2	Depression	.72	3 (item 3, 15 and 19)
3	Anxiety	.78	2 (item 2 and 8)
4	SAD	.84	1 (item 12)
5	SS	.87	1 (item 5)
6	LSDA	.80	1 (item 7)

Reliabilities found from the pilot test were acceptable to conduct study (Rubin & Babbie, 1997). No item was discarded. Rather wording of the items were improved after inspecting the value of item - total correlation (items with low correlations were considered for improvement).

3.6 Data Collection Procedure

After identifying the target subjects, participants were informed about the objective of the study and asked to participate in filling the questionnaire. The participants were assured that information obtained remain confidential and not be used for other purposes. All participants were volunteered to participate in the study. Then, the questionnaire was distributed and collected the completed forms. Finally, participants agreed to fill and return within five days. After five days, the questionnaires were collected from each participant. The return rate of the questionnaire was 100%.

3.7 Data Organization and Analysis

The data collected to measure the psychological and social perceptions of students orphaned by HIV/AIDS through questionnaire were entered into the computer using the SPSS 15.0 for windows program. To analyze the data descriptive statistic was used. Frequency, percentage, means, standard deviation, range and t – value were computed to see the general pattern of the variables and demographic characteristics. Product moment correlation (Bivariate) was used to see scale - correlations and inter - correlations among variables. The data obtained through interviews were presented by using reported speech and explanations were also given.

CHAPTER FOUR

RESULTS

In order to achieve the desired objective of the study (i.e., identify the psychological and social perceptions of students orphaned by HIV/AIDS), students orphaned by HIV/AIDS at Awassa Boarding Secondary School, were given a questionnaire. Director of the school, social worker of boarding giving organization (Shiny Day) and a teacher of the school were also given a semi-structured interview. The results from the questionnaire and the semi-structured interview are presented in the following sections:

4.1 The Participants' Background Information

Table 8: Background information of students orphaned by HIV/AIDS

No	Personal Information		Frequencies & Percentages of Responses	
			Frequency	Percentage
1	Age	14-18 year	136	90.7%
		19-23 year	14	9.3%
		Total	150	100%
2	Sex	Male	97	64.7%
		Female	53	35.3%
		Total	150	100%
3	Grade Level			
	Grade 9	Male	54	36%
		Female	32	21.3%
		Total	86	57.3%

	Grade 10	Male	43	28.7%
		Female	21	14%
		Total	64	42.7%
4	Parental Situation			
	Paternal Orphans	Male	42	28%
		Female	22	14.7%
		Total	64	42.7%
	Maternal Orphans	Male	18	12%
		Female	14	9.3%
		Total	32	21.3%
	Double Orphan	Male	37	24.7%
		Female	17	11.3%
		Total	54	36%
5	With whom the respondent lives now?			
	Father		25	16.7%
	Mother		54	36%
	Sister		11	7.3%
	Brother		8	5.3%
	Aunt		10	6.7%
	Uncle		12	8%
	Grand parents		6	4%
	Friends		8	5.3%
	Alone		3	2%
	Non relatives		13	8.7%
	Total		150	100%

Of the students orphaned by HIV/AIDS a total of 150 students from ages 14 -18 year (90.7%) and 19 - 23 (9.3%) were included in the study. Of these 64.7% were males and 35.3% females. The average age of the respondents was 18 (Table 8).

In relation to their grade level, 86 students were attending in grade nine (57.3%), of which 54 were males (36%) and 32 were females (21.3%). The remaining 64 students were attending in grade ten (42.7%), of which 43 were males (28.7%) and 21 were females (14%).

With regard to their parental situation, of the 150 respondents, the majority of the respondents (42.7%) were paternal orphans, 36% had lost both parents and the remaining (21.3%) were maternal orphans.

Findings from the study also showed that the majority of the respondents (36%) were living with their mothers, 16.7% of the orphaned students stated that they were living with their fathers, 8.7% were living with non relatives, 8% were living with their uncles, 7.3% were living with their sisters, 6.7% were living with their aunts, 5.3% were living with their brothers, 3.5% were living with their friends, 4% were living with their grand parents and the remaining 2% were living alone.

4.2 Response Category of the Respondents for the Variables Treated in the Study

4.2.1 Psychological perceptions of students orphaned by HIV/AIDS

The respondents were categorized into three groups based on their responses to the self-esteem, depression and anxiety scales that measured the psychological perceptions of students orphaned by HIV/AIDS.

Thus, for the psychological measure: (a) the total score of self-esteem could range from 10-22 (low-self-esteem), 23-36 (moderate self-esteem), to 37-50 (high-self esteem); (b) the total score of depression could range

from 20-46 (low depression), 47-73 (moderate depression) to 74-100 (high depression); and (c) the total score of anxiety could range from 16-37 (low anxiety), 38 - 59 (moderate anxiety) to 60 - 68 (high anxiety).

4.2.1.1 Category of respondents for self-esteem

Table 9: Responses given by respondents for self esteem

No	Category	Frequency	Percent
1	High	5	3.3%
2	Moderate	125	83.3%
3	Low	20	13.3%
	Total	150	100%

In Table 9, majority of respondents (83.3%) scored themselves as having moderate self-esteem, 13.3% had low self-esteem and the remaining (3.3%) had high self-esteem.

4.2.1.2 Category of respondents for depression

Table 10: Responses given by respondents for depression

No	Category	Frequency	Percent
1	High	28	18.7%
2	Moderate	106	70.7%
3	Low	16	10.7%
	Total	150	100%

Regarding depression, (Table 10), the majority of the participants (70.7%) had moderate depression, 18.7% had high depression and the rest (10.7%) had low depression.

4.2.1.3 *Category of respondents for anxiety*

Table 11: Responses given by respondents for anxiety

No	Category	Frequency	Percent
1	High	32	21.3%
2	Moderate	104	69.3%
3	Low	14	9.3%
	Total	150	100%

As can be shown in Table 10, the majority of respondents (69.3%) rated themselves as having moderate anxiety, 21.3% had high anxiety and the remaining (9.3%) had low anxiety.

4.2.2 *Social Perceptions of Students Orphaned by HIV/AIDS*

The respondents were categorized into three groups based on their responses to the scales in SAD, SS and LSDA that measured the social perceptions of students orphaned by HIV/AIDS.

For the social measures: (a) the total score of SAD ranged from 15-34 (low SAD problem), 35-55 (moderate SAD problem), to 56-75 (high SAD problem); (b) the total score of SS ranged from 13-31 (low SS problem), 32-47 (moderate SS problem) to 48-65 (high SS problem); and (c) the total score of LSDA that could ranged from 13-31 (low LSDA problem), 32-47 (moderate LSDA problem) to 48-65 (high LSDA problem).

4.2.2.1 *Category of respondents for SAD*

Table 12: Responses given by respondents for SAD

No	Category	Frequency	Percent
1	High	28	18.7%
2	Moderate	110	73.3%
3	Low	12	8.0%
	Total	150	100%

The majority of respondents (73.3%) rated themselves as having moderate SAD problem, 18.7% had high SAD problem and the remaining (8.0%) had low SAD problem (Table 12).

4.2.2.2 *Category of respondents for SS*

Table 13: Responses given by respondents for SS

No	Category	Frequency	Percent
1	High	24	16.0%
2	Moderate	107	71.3%
3	Low	19	12.7%
	Total	150	100%

Regarding SS results in Table 13 indicated that the majority of orphans (71.3%) had moderate SS problem, 16.0% had high SS problem and the rest (12.7%) had low SS problem.

4.2.2.3 Category of respondents for LSDA

Table 14: Responses given by respondents for LSDA

No	Category	Frequency	Percent
1	High	20	13.3%
2	Moderate	119	79.3%
3	Low	11	7.3%
	Total	150	100%

The results for LSAD reported in Table 14 the presents data suggesting that the majority of the participants (79.3%) had moderate LSDA problem, 13.3% had high LSDA problem and the remaining (7.3%) had low LSDA problem.

4.3 Descriptive Statistics of the Variables Treated in the Study

4.3.1 Psychological Perceptions of students orphaned by HIV/AIDS

To determine the psychological perceptions of students orphaned by HIV/AIDS, the scores on the three scales of the psychological measures (46 items) were calculated by averaging the valid scores of the items on each scale.

Table 15: The 3 psychological Scales (46 items) score results

Scales	N	Observed Mean	Calculated Mean	SD	Min	Max	Range	One tailed significant	T - value
Self-esteem (10 items)	150	2.38	3	0.46	1.8	3.0	1.2	1.65	-2.02*
Depression (20 items)	150	2.75	3	0.39	2.0	3.4	1.4	1.65	-0.96*
Anxiety (16 items)	150	2.54	3	0.45	1.8	3.4	1.6	1.65	-1.53*

*p < 0.05

High scores for each scale (i.e., observed mean was greater than the calculated mean and statistically significant at $p < 0.05$ level) indicated that, students orphaned by HIV/AIDS had good psychological perceptions. Whereas, lower scores indicated (i.e., if the observed mean was less than the calculated mean) students orphaned by HIV/AIDS did not have good psychological perceptions.

Table 15 portrayed the mean scale score for the self-esteem was 2.38 ranging from 1.8 to 3.0 (SD = 0.46); the depression mean scale score was 2.75, which ranged from 2.0 to 3.4 (SD = 0.39); and the anxiety scale ranged from 1.8 to 3.4 (SD = 0.45), with a mean scale score of 2.54. All were statistically significant at $p < 0.05$ level (Table 15). The anxiety scale score had the widest range of values; while, the self-esteem scale score had the narrowest range of values compared with the depression scale score which ranged of values was 1.4 (Table 15).

In sum, the above result indicated that students orphaned by HIV/AIDS in Awassa Boarding Secondary School did not have good psychological perceptions of themselves.

4.3.2 Social perceptions of students orphaned by HIV/AIDS

To study the social perceptions of students orphaned by HIV/AIDS; the SAD, SS and LSAD was administered. Scores on the three scales (41 items) were calculated by averaging the valid scores of the items on each scale.

Table 16: The 3 social scales (41 items) score results

Scales	N	Observed Mean	Calculated Mean	SD	Min	Max	Range	One tailed significant	T - value
SAD (15 items)	150	2.64	3	0.33	1.9	3.1	1.2	1.65	-1.64*
SS (13 items)	150	2.48	3	0.44	1.7	3.3	1.6	1.65	-1.77*
LSDA (16 items)	150	2.56	3	0.48	1.8	3.4	1.6	1.65	-1.38*

*p < 0.05

High scores for each scale (i.e., observed mean greater than calculated mean and statistically significant at p<0.05 level) indicated that, students orphaned by HIV/AIDS had good social relationships. On the other hand, low scores for each scale indicated (observed mean less than calculated mean) the students did not have good social connections.

The mean scale score for the SAD was 2.64 ranging from 1.9 to 3.1, with SD of 0.33; the values on the SS scale ranged from 1.7 to 3.3 (SD = 0.44), with a mean scale score of 2.48; and the LSDA had a range of 1.8 to 3.4 (SD = 0.48) with mean scale score of 2.56. All scales were statistically significant at $p < 0.05$ level. The SS and LSDA scale scores had the widest range of values; whereas, the SAD scale score had narrowest range of values (Table 16).

In general, the result suggested that students orphaned by HIV/AIDS in Awassa Boarding Secondary School did not have good social perceptions.

4.4 Correlation analysis of the variables in the study

The result of correlation coefficient indicated the degree of relationship that existed between the scales. For this purpose, the Pearson Product Moment Correlation Coefficient was used to determine the association among the sub-scales. The number of the participants in each variable was 150.

4.4.1 Correlation Matrix of the Psychological Variables

Table 17: Correlation matrix between the psychological variables

Variables	1	2	3
1. Self-esteem	1		
2. Depression	-.615**	1	
3. Anxiety	-.600**	.676**	1

** $P < .01$

The bivariate correlation matrix (Table 17) indicated that depression ($r = .676, p < .01$) was positively correlated with anxiety. While, self-esteem ($r = -.600, p < .01$) was negatively correlated with anxiety and both were statistically significant. On the other hand, self-esteem ($r = -.615, p < .01$) was negatively correlated with depression and was significant.

4.4.2 Correlation Matrix of the Social Variables

Table 18: Correlation matrix between the social variables

Variables	1	2	3
1. SAD	1		
2. SS	.648**	1	
3. LSDA	.808**	.847**	1

** $P < .01$

The data suggested that SS ($r = .847, p < .01$) and SAD ($r = .808, p < .01$) were correlated significantly with LSDA. In addition, SAD ($r = .648, p < .01$) correlated significantly with SS.

4.4.3 Inter - correlation Matrix of the Psychological and Social Variables

Table 19: Inter - correlation matrix between the study variables

Variables	1	2	3	4	5	6
1. Self-esteem	1					
2. Depression	-.615**	1				
3. Anxiety	-.600**	.676**	1			
4. SAD	-.404**	.565**	.585**	1		
5. SS	-.449**	.509**	.526**	.648**	1	
6. LSDA	-.535**	.641**	.606**	.808**	.847**	1

** $P < .01$

Table 19 showed that, SS ($r = .847, p < .01$), SAD ($r = .808, p < .01$), anxiety ($r = .606, p < .01$) and depression ($r = .641, p < .01$) were positively correlated with LSDA and were significant. While, self-esteem ($r = -.535, p < .01$) was negatively correlated with LSDA and was significant. The correlations of SAD ($r = .648, p < .01$), anxiety ($r = .526, p < .01$) and depression ($r = .509, p < .01$) were positively correlated with SS and were significant. Whereas, self-esteem ($r = -.449, p < .01$) was negatively correlated with SS and was significant. On the other hand, anxiety ($r = .585, p < .01$), and depression ($r = .565, p < .01$) were positively correlated with SAD and were significant. However, self-esteem ($r = -.404, p < .01$) was negatively correlated with SAD and was significant. The correlations of depression ($r = .676, p < .01$) was positively correlated with anxiety. While, the correlations of self-esteem ($r = -.600, p < .01$) was negatively correlated with anxiety and both were significant. Finally, self-esteem ($r = -.615, p < .01$) correlated negatively with depression and was significant.

4.5 Data Obtained Through Interview

The purpose of the interview was to answer questions about psychosocial perceptions of students orphaned by HIV/AIDS, and to supplement the information obtained through the questionnaire.

As the result obtained from the director of the school indicated that the objective of the school was mainly to provide education for the students orphaned by HIV/AIDS and non-orphaned students. Boarding service was given for students orphaned by HIV/AIDS by Shiny Day which was funded by People IN Need (PIN), an international NGO. This service is not available for all orphaned students in the school. In order to solve the psychological and social problems of students orphaned by HIV/AIDS, the school did not use any unique methods. There were different clubs in

the school and these students participated in the clubs as they chose. Presently the school employed a social worker; however, currently there was no counseling service in the school, Therefore, the school provided no special psychosocial support which addressed students orphaned by HIV/AIDS. When asked "What do you think should be made in the future to solve their psychosocial problems?" the director replied that the school may not have the capacity to solve their problems in particular. However, he suggested that it was possible to respond to some of the psychosocial problems of these students by:

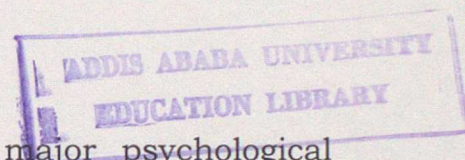
- strengthening clubs,
- providing counseling service,
- doing activities together in the community,
- promoting awareness of the school in the community and society,
- giving boarding service for all AIDS orphans in the school,
- emphasizing the special needs of these students with the Regional Educational Bureau, and
- strengthening the capacity of Shiny Day.

In an interview with the social worker, she stated that the objective of the organization was helping students orphaned by HIV/AIDS. Boarding service was provided for half of HIV/AIDS orphaned students in the school, which included food service, school uniform, stationary materials, psychosocial support and vocational training. When asked "What kind of support is provided by your organization for the students orphaned by HIV/AIDS in order to solve their psychosocial problems?" the social worker said that, counseling service offered by the social worker, not by a counselor. Regarding social support there was little awareness of intent to create a program. The social worker added that, the psychosocial support that was provided was not enough. The social worker concluded that the organization should build its capacity,

different professionals should be assigned to different posts and finally the professionals should work hard in their positions. This is what she saw lacking in the support of Shiny Day.

The social worker restated, as the director said, that it was possible to solve their psychosocial problems by:

- doing together with the school, community, NGOs and governmental organizations,
- giving boarding service for all students orphaned by HIV/AIDS found in the school,
- creating awareness for the school community and society,
- building the capacity of Shiny Day, and
- giving long term service for these students.



Finally, a teacher in the school said that the major psychological problems observed in students orphaned by HIV/AIDS were fear, worry, depression and low-self-esteem. On the other hand, the major social problems of these students were separation from friends, not actively participating in group discussion in the teaching learning process, experiencing discrimination from other students by their friends and preferring to be alone instead of playing with friends. In addition according to the teacher, the sources of the psychosocial problems included little awareness in the community about AIDS orphans, absence of a counselor in the school and poor coordination between the school and Shiny Day.

CHAPTER FIVE

DISCUSSION

5.1 *Psychological Perceptions of Students Orphaned by HIV/AIDS*

Children's experiences of psychological problems cannot be separated from the wider context of their lives. AIDS orphans felt psychological problems long before their parents' death. The findings provided consistent evidence that the death of the parent(s) was a crisis for any orphan, as it meant losing the love, support, guidance, stability and security that parents provided.

As the finding indicated students orphaned by HIV/AIDS at Awassa Boarding Secondary School did not have favorable psychological perceptions. These students felt worried, felt alone, had nightmares and were not happy most of the time. These findings were consistent with previous studies (Poulter, 1997), which suggested that children who had lost one or both parents were significantly more likely to be unhappy and worry about many things than those living with both parents, even if the parents were unwell.

The findings also showed that, feelings of hopelessness and worthlessness were students' experiences when their parents become sick and they feared that their parents would die. In line with this, a study conducted in Uganda by MOLSA (2003) stated that, children orphaned by HIV/AIDS showed, grief even before their parent(s) death and after death some acted in ways that seemed strange.

Students orphaned by HIV/AIDS were significantly more likely to be worried about many things, fearful of new things or situations, did things alone, and were distressed. This finding was in agreement with Dane (1997) who found that, when separated from their siblings, HIV/AIDS orphans felt sad, worried, scared and isolated. He concluded that this was due to the multiple losses HIV/AIDS orphans faced. Once a parent died, children were likely to be moved from the family home, and relocated to another area and school, thus depriving them of their siblings, friends and neighborhood networks and predictable surroundings.

Looking into the psychological perceptions of students orphaned by HIV/AIDS (self-esteem, depression and anxiety) in the present study, they did not have good psychological perceptions (Table 15). Although these students had received services from the Shiny Day organization which met their physical needs, they had problems with psychological perceptions. These problems were reflected in the degree of depression and anxiety they showed and lowered self-esteem.

In a study conducted in Ethiopia by MOLSA (2003) HIV/AIDS orphans had problems with emotional adjustment reflected in the degree of unhappiness and worry they showed, their level of patience, the degree of fatigue and depression, and feelings of hopelessness because of their lower self-esteem and pessimism.

The death of parent(s) was generally recognized as the most stressful that could happen to a child. One's sense of the future and the security associated with having a parent was altered forever. However, HIV/AIDS orphans varied in their response to the death of a parent as a function of age, gender and cause of death (Joslin, 2002). All suffered the tragedy of

losing parents to AIDS, and many were growing up in deprived and traumatic circumstances, without the support and care of their immediate family.

Hence, parent's death appeared to have long-term negative effects on most students. In line with this the response of the respondents revealed that, they worried about many things. They were fearful of new situations, did things alone, and appeared unhappy and distressed, when separated from their parents. This was due to multiple losses that AIDS orphaned students faced. After their parent's death, children were likely to be moved from their family home and reallocated to another area and school; this separated them from their siblings and neighbors. Williamson (1995) said that most of the time extended families accept the overwhelming majority of orphans who lose both parents. However, in many cases, orphaned siblings are sent to different households and experience a second profound loss due to this separation. As a result, the orphans experience grief and related stress; depression, loss of self-esteem, a poor sense of identifies and negative coping mechanisms.

Discrimination and neglect of students orphaned by HIV/AIDS, on the other hand, may cause further emotional problems. According to this study, these students faced difficulty in expressing themselves and making friends. They disclosed that they had few friends. This may have been due in part to the fear of stigma. As a result, they tended to isolate themselves from social interaction and in turn, others isolated them. In line with this, Ainsworth and Over (1994) explained that, a child who experienced discrimination and neglect was more likely to develop feelings of fear and anxiety. Moreover, caring for sick parents and siblings placed a heavy emotional burden on students. They not only witnessed the illness and death of their parents, but also suffered the stigmatization, and neglect based on their parents' death by AIDS.

The finding from the interview argued that there was a lack of counseling service for the students orphaned by HIV/AIDS. Counseling service was important because it was a vital mechanism in reducing psychosocial problems of AIDS orphaned children (Dwaine 2000). Particularly, psychological support should be promoted. It allowed children to cope with their grief and understand their parent's illness. It also provided children with a comfortable space to discuss their parents HIV status, and could help to prepare those who were soon to become orphans.

5.2 Social Perceptions of Students Orphaned by HIV/AIDS

The results of the questionnaires showed that stigma and discrimination were major social problems among students orphaned by HIV/AIDS. Stigma was an attitude of identifying, labeling or attributing undesirable qualities targeted towards those who were perceived as being 'shamefully different' and deviant from the social ideal. Whereas, discrimination was an act of distinction, exclusion, restriction or preference which was based on exclusionary perceptions or structures. The stigma of HIV/AIDS came from the powerful combination of shame and fear. The shame arose from its transmission by sex or drug injections that were surrounded by taboo, and fear because AIDS was relatively new and deadly. As a result, most of the respondent agreed that they were socially isolated. In relation to this, Dessalesgn (2003) reported that, the outcomes of HIV related stigma and discrimination were damaging because they had a direct and negative impact on AIDS orphans. Fear, anxiety, depression, anger, including suicidal attempts and revengeful behavior and resentment towards AIDS orphans were some of the outcomes of HIV related stigma and discrimination.

According to the participants, they themselves did not want to play with others, worried about being stigmatized and isolated themselves from friends and neighbors for fear of stigmatization and discrimination. Stigma and discrimination at home can result in rejection of orphans by extended families. This in turn could lead to being a child headed household (Horizons, 2001). On the other side, guardians often felt that they were difficult children and a burden. This led to exclusion from family gatherings and other social activities. Furthermore, stigma and discrimination against a child at school frequently led to withdrawal and profound depression, failure to concentrate in class, poor academic performance, a fear of infecting others and a reluctance to go to school.

The finding of this study confirmed that students orphaned by HIV/AIDS at Awassa Boarding Secondary School did not have fulfilling social relationships. Majority of them had the feelings of frustration, failure, social isolation, sadness, a sense of not belonging and a sense of alienations. A study conducted by MOLSA (2003) suggested that AIDS seemed to have a negative impact on children's socializations with respect to their identity, understanding and perception.

Moreover, Gilborn (2001) cited in Befikadu (2006) stated that separation of children found in Uganda from siblings was another source of trauma. Even older children were distressed by separation from their siblings; 44 percent felt sad and 17 percent said it made them feel isolated.

When we see the social perceptions of students orphaned by HIV/AIDS assessed in this study, they did not have good social perceptions (Table 16). Even though, these students had service from Shiny Day, they still experienced social problems.

These difficulties were manifested in such behaviors as poor social peer relations, feelings of dissatisfaction with peer relationships, shyness, difficulty talking with strangers, perceptions of their social incompetence, and distrusting other peoples.

To support this finding a study by MOLSA (2003) concluded that AIDS seemed to have a negative impact on children's socializations and influenced their development of identify, understanding and participation in social situations.

Stigma, discrimination, rejection, self-isolation and mistreatment some of severe emotional problems orphaned children faced beyond the tragedy of losing their parents and an insecure living condition. This in return affected psychosocial well-being and educational perceptions (UNAIDS, 1999).

The result of the interview showed that these students preferred to be alone. This self-isolation was the result of stigma (UNIDS, 2008). The interview also revealed that there was a shortage of awareness in the school community and society. As a result, the school community and the society did not take serious care when they met orphaned students. As Ownes (1993) concluded this kind of relationship affected the self-esteem of those children, since the self-esteem of an individual was affected by the reflective appraisal of the others.

The result of the interview indicated there were contributing factors for their psychosocial perceptions. These are little awareness of the school program, little coordination between the school and Shiny Day, boarding service for only half of HIV/AIDS orphaned students and a lack of emphasis from other governmental and non governmental organizations. In order to solve the psychosocial problems of HIV/AIDS orphans, the

community and school problems must be resolved and the service giving organization needs to provide service in a sustainable way. To solve the psychosocial problems of HIV/AIDS orphans, service provider organizations have their own vital role. If service provider organizations organized well, they could improve the access to basic survival needs of AIDS orphans in a sustainable way (e.g., expenditures and fees related to schools, health care services and housing facilities) (Philipos, 2002). As a result, the psychosocial well-being of orphans' children will improve.

5.3 The Relationship between Psychological and Social Perceptions

The impact of parental death on children was complex and affected the child's psychological and social development. Fredirksan & Kandous (2004) stated that orphaned children often had stunted development in emotional intelligence, and life skills such as communication, decision – making skills etc. Moreover, they often showed a lack of hope for future and had low self-esteem.

According to the finding of this study, the bivariate correlation matrix (Table 19) showed that, there was statistically significant relationship between each variable in particular and statistically significant relationship between psychological and social variables in general. The correlation between anxiety, depression SS, SAD and LSDA were positively correlated each other and were statistically significant. Whereas, self-esteem was negatively correlated with the above mentioned variables (i.e., anxiety, depression SS, SAD and LSDA) and was statistically significant. As a result, if their psychological perceptions affected their social perceptions and the social perceptions affected the psychological perceptions.

In this regard, Max et al, (2002) showed that, the losses of parents affected the child's developmental stages. If child's psychological development was affected, his/her social development would be affected. This indicated that there was a relationship between psychological and social adjustment of AIDS orphans children.

Furthermore, Tremblay and Israel (1998) argued that the loss of parents and loved is associated with internalized psychological and social perceptions including low self-esteems, depression, anxiety, social isolation, feelings in dissatisfaction with peer relationships, shyness and survivor's guilt.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 *Summary*

The present study was conducted to address the psychosocial perceptions of students orphaned by HIV/AIDS. In this effort, the following research questions were formulated for investigation.

1. What are the psychological perceptions observed in students orphaned by HIV/AIDS in Awassa Boarding Secondary school?
2. What are the social perceptions observed in students orphaned by HIV/AIDS in Awassa Boarding Secondary school?
3. Is there any relationship between psychological and social perceptions observed in students orphaned by HIV/AIDS in Awassa Boarding Secondary school?

There were eighteen regular high school and one boarding high school, providing education from grade 9 to 10 in Awassa city administration. Of these, Awassa Boarding Secondary School was selected and students orphaned by HIV/AIDS were included in the study. The total number of participants was 150 (Male = 97 and female = 53).

Two types of instruments (questionnaire and interview) were used to collect the necessary information. The instrument was pilot tested using 30 students orphaned by HIV/AIDS in Awassa SOS Children Village. Based on this, items were modified and clarified. Analyses were carried out using descriptive statistics (mean, standard deviation, percent,

frequency, range, bivariate correlation and t-value). The data obtained through interview were presented by using reported speech and analyzed qualitatively.

The result of the study revealed that students orphaned by HIV/AIDS suffered from psychological (low self-esteem, depression and anxiety) and social problems (problems of social avoidance and distress, shyness and sociability, and loneliness and social dissatisfaction).

The result revealed that there was a statistically significant relationship between psychological and social perceptions of students orphaned by HIV/AIDS. The psychological perceptions affected the social perceptions and the social perceptions affected the psychological perceptions.

The result of the interview suggested that contributing factors for psychosocial perceptions of these students were little awareness in the community of the school's program, a lack of counseling, little coordination between the school and boarding provider (Shiny Day), boarding service offered to only half of HIV/orphaned students in the school, and a lack of emphasis from other governmental and non-governmental organizations.

6.2 Conclusions

From the findings of this research, the following conclusions may be drawn:

1. The majority of HIV/AIDS orphaned students found at Awassa Boarding Secondary School faced psychological problems (low self-esteem, depression and anxiety).

2. The majority of HIV/AIDS orphaned students found at Awassa Boarding Secondary School faced social problems (problem of social avoidance and distress, shyness and sociability, and loneliness and social dissatisfaction).
3. Most of HIV/AIDS orphaned students found at Awassa Boarding Secondary School were angry, felt guilty, shocked, fearful, shamed, inferior, hopeless, sad, worried, lonely and had frightening dreams when they are separated from their siblings.
4. The majority of HIV/AIDS orphaned students found at Awassa Boarding Secondary School were subjected to various forms of negative social reaction such as stigmatization, discrimination, mistreatment, social isolation, separation from siblings and friends and preferred to be alone rather than playing with others.
5. There was statistically significant relationship between psychological and social perceptions observed in students orphaned by HIV/AIDS. If their psychological perceptions affected their social perceptions and the social perceptions affected the psychological perceptions.
6. Finally, the lack of counseling service in the school, little coordination between the school and boarding provider, limited boarding service for students orphaned by HIV/AIDS in the school, little awareness of the program in the community, and shortage of emphasis from other organizations were the major contributing factors for psychosocial perceptions of students orphaned by HIV/AIDS.

In general, the present research findings were not new. The psychological and social problems of HIV/AIDS orphans as well as stressors of their

lives had been reported in the research literature. However, identifying the psychosocial perceptions of students orphaned by HIV/AIDS in the case of an institution (boarding school) that provided stability was a relatively new perspective.

There were several limitations in the present study. One of the foremost limitations was that the participants were reluctant to be identified as HIV/AIDS orphans. Moreover, they were not happy to remember their family. There was limited literature on the psychosocial perceptions of HIV/AIDS orphans in a setting where basic needs were provided.

6.3 Recommendations

Based on the findings of this study, the problems identified by respondents had policy implications. To strengthen their ongoing activities, stakeholders can promote the survival of students orphaned due to HIV/AIDS by providing the essentials of life, strengthening the coping capacity of the orphaned students in particular and extended families as well as the community in general. The following points are recommended:

- The school should be assigned a counselor to give counseling services to the students.
- Efforts need to be made to strengthen coordination between the school and boarding provider in order to resolve some of the psychosocial problems of students orphaned by HIV/AIDS.
- The boarding provider needs to provide boarding service to all students orphaned by HIV/AIDS in the school.

- Schools and communities such as Awassa Boarding Secondary School need to avoid words that have negative impact on the psychosocial well-being of these students.
- The role of peers, friends, relatives and neighbors should not be underestimated they need to be interactive and friendly as much as possible.
- Efforts need to be made to raise awareness of caregivers of students orphaned by HIV/AIDS, and the school communities to promote the psychosocial well-being of these students
- Provision of some psychosocial support to the family before the death of the parents (especially during illness) is important to help students orphaned by HIV/AIDS so that they develop coping skills with problem they will face after the death of their parents.
- Counseling students orphaned by HIV/AIDS and their caregivers is a vital mechanism in reducing psychosocial problems of AIDS orphans. Psychological support should be provided. It allows students to cope with their grief and understand their parents' illness. It also provides students with a comfortable space to discuss their parents HIV status, and can help to prepare those who may soon become orphans.
- Keeping orphans at school is crucial for their future. It can provide education that can work as a safety net in the child's life. Schools can also play an important role in psychosocial well-being for AIDS orphans. Schooling itself helps normalize life and promote student's psychological and social perceptions. With training, teachers can

identify signs of distress and provide appropriate emotional and psychosocial support. In addition, non-orphaned students can support their peers, learn ways to advocate, show compassion and care within their communities, and reduce stigma.

- All efforts of various stakeholders such as Awassa town educational bureau, Awassa town health bureau, Awassa town work and social affairs bureau and different NGOs need to help children orphaned by HIV/AIDS in general, and students orphaned by HIV/AIDS at Awassa Boarding Secondary School in particular.

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Appendix A

Dear respondents,

Thank you for the willingness to respond to my questions. I am going to ask you some questions for research purposes. The information obtained from the responses of the items will not be used for other proposes but for research. Your name will not be written in this form, and will never be used in connection with the information you gave me. Therefore, there is no need of being secretive in your responses. Please, complete all items according to the instructions given in each part. Since your frank and honest response for each item has practical and valuable significance for the success of this study, you are kindly requested to respond accordingly.

Thank you for your help in responding each question.

General Information

This questionnaire has three parts. Each part has its own instruction that helps the respondent on how to provide the response. Please, read carefully each item and answer all questions. Honesty and frankness is highly appreciated.

PART I

Background Information

Instruction: Below are questions related to background information about yourself. Indicate your answer for each question by putting a tick () mark and by writing the answer when necessary.

1. Age -----

2. Sex

A- Male ☐

B- Female ☐

3. Grade level

A- Grade 9 ☐

B- Grade 10 ☐

4. Family condition

A- Maternal orphan ☐

B- Paternal orphan ☐

C- Double orphan ☐

D- Other (specify) -----

5. With whom do you live now?

A- Mother ☐

B- Father ☐

C- Sister ☐

D- Brother ☐

E- Aunts ☐

F- Uncle ☐

G- Grand parent ☐

H- Friends ☐

I- Other (specify) -----

PART II

Instruction: This part has three subsections. The statements in each section refer to the experiences that people have in their daily life. You are to indicate, on a five-point scale, the extent of agreement between the feelings expressed in each statement and your own personal reactions. Please, read each item carefully and decide to what extent it is characteristic of your feelings and behavior.

Section I

Instruction: Mark a tick (✓) on the box provided for the point which best indicates your agreement or disagreement.

Item No.	Items	Response Categories				
		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	I feel that I am a person of worth, at least on an equal with others.					
2	I feel that I have a number of good qualities.					
3	All in all, I am inclined to feel that I am a frailer.					
4	I am able to do things as well as most other people.					
5	I feel I do not have much to be proud of.					

Item No.	Items	Response Categories				
		Strongly Agree	Agree	Undecide	Disagree	Strongly Disagree
6	I take positive attitude toward myself.					
7	On the whole, I am satisfied with myself.					
8	I wish I could have more respect for myself.					
9	I certainly feel useless at times.					
10	At times I think I am no good at all.					

Section II

Instruction: Mark a tick (✓) on the box provided for the point which best indicates your agreement or disagreement.

Item No.	Items	Response Categories				
		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	I don't feel sad.					
2	I am not discouraged about my future.					
3	I feel I am a total frailer as a person.					
4	I can not get any pleasure from the things I used to enjoy.					
5	I feel guilty all the time.					

Item No.	Items	Response Categories				
		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
6	I don't feel I am being punished.					
7	I dislike myself.					
8	I don't blame myself more than usual.					
9	I would kill myself if I had a chance.					
10	I feel like crying, but I can not.					
11	I am no more restless or would up than usual.					
12	I have not lost interest in other people or activities.					
13	I have trouble making any decision.					
14	I do not feel I am worthless.					
15	I have as much energy as ever.					
16	I sleep most of the day.					
17	I am no more irritable than usual.					
18	I have no appetite at all.					
19	I find I can not concentrate on any thing.					
20	I am no more tired or fatigued than usual.					

Section III

Instruction: Mark a tick (✓) on the box provided for the point which best indicates your agreement or disagreement.

Item No.	Items	Response Categories				
		Strongly Agree	Agree	Undecide	Disagree	Strongly Disagree
1	My sleep is restless and disturbed.					
2	I work under a great deal of strain.					
3	I never say things that I shouldn't.					
4	I am usually calm.					
5	I have many problems that cause me a great deal of worry.					
6	I always have enough energy when faced with difficulty.					
7	I give up easily when things get hard.					
8	I have frequent headaches for which there is no reason.					
9	When I try to make something everything seems to go wrong.					
10	I feel worrying and nervous.					
11	I worry about what other people think about me.					
12	Often I feel sick in the stomach.					
13	I worry about what is going to happen.					
14	I have bad dreams.					
15	My feelings get hurt easily.					
16	I often worry about something bad happened to me.					

PART III

Instruction: This part has also three sub sections. The statements in each section express the experiences, feelings, perceptions and reactions that people have in their relationship with people or friends. For each statement there are five possible responses: Always true, true most of the time, true sometimes, hardly ever and not true at all. Please, read each item carefully and decide how much a true description of each statement is about your experience.

Section I

Instruction: Please, indicate your answer on the box provided to each item. Use a tick (✓) mark to indicate your response.

Item No.	Items	Response Categories				
		Always True	True most of the Time	True Sometimes	Hardly Ever	Not True at all
1	I welcome the opportunity to mix socially with people.					
2	I tend to withdraw from people.					
3	I would be unhappy if I were prevented from making many social contacts.					
4	I try to avoid situations which force me to be very sociable.					

Item No.	Items	Response Categories				
		Always True	True most of the Time	True Sometimes	Hardly Ever	Not True at all
5	I often think up excuses in order to avoid social engagements.					
6	I usually feel relaxed when I am with a group of people.					
7	I often find social occasions upsetting.					
8	I try to avoid formal social occasions.					
9	I usually feel calm and comfortable at social occasions.					
10	I get much satisfaction from the group I attend.					
11	I try to avoid talking to people unless I know them well.					
12	I have no particular desire to avoid people.					
13	I usually feel relaxed when I meet someone for the first time.					
14	I sometimes take the responsibility for introducing people to each other.					
15	I usually go to whatever social engagement I have.					

Section II

Instruction: Please, indicate your answer on the box provided to each item. Use a tick (✓) mark to indicate your response.

Item No.	Items	Response Categories				
		Always True	True most of the Time	True Sometimes	Hardly Ever	Not True at all
1	I feel tense when I am people I don't know well.					
2	I am socially somewhat awkward.					
3	I don't find it difficulty to ask other people for information.					
4	I am often uncomfortable at parties and other social functions.					
5	When in a group of people, I have trouble thinking of the right things to talk about.					
6	It does not take me long to overcome my shyness in new situation.					
7	It is hard for me to act natural when I am meeting new people.					
8	I feel nervous when speaking to someone right in the eye.					
9	I have no doubts about my social competence.					
10	I have trouble looking someone right in the eye.					
11	I feel inhibited in social situations.					
12	I don't find it hard to talk to strangers.					
13	I am more shy with members of the opposite sex.					

Section III

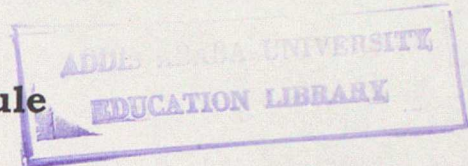
Instruction: Please, indicate your answer on the box provided to each item. Use a tick (✓) mark to indicate your response.

Item No.	Items	Response Categories				
		Always True	True most of the Time	True Sometimes	Hardly Ever	Not True at all
1	It is easy for me to make new friends at school.					
2	I am good at working with other children.					
3	It is hard for me to make new friends wherever.					
4	I don't get along with kids.					
5	I can find a friend when I need one.					
6	I have nobody to talk to.					
7	I don't have any friends.					
8	I am good at working with everybody.					
9	I am not very open with my friends.					
10	My friends come to me for emotional support.					
11	I have a deep sharing relationship with a number of friends.					
12	My friends gave me the moral support I need.					
13	Few of my friends understand me the way I want to be understood.					

Appendix B

**Addis Ababa University
School of Graduate Studies
Department of Special Needs Education**

Interview Schedule



**Interview to be held with director of Awassa Boarding
Secondary School**

**Semi - structured interview themes on psychosocial conditions of
students orphaned by HIV/AIDS**

1. What is the objective of the school?
2. What kind of support is provided by the school for students orphaned by HIV/AIDS in order to solve their psychological problems?
3. What kind of support is provided by the school for students orphaned by HIV/AIDS in order to solve their social problems?
4. Do you believe that this support is enough? If not, what is lacking?
5. What do you think should be made in the future to solve their psychosocial problems?

Appendix C

**Addis Ababa University
School of Graduate Studies
Department of Special Needs Education**

Interview Schedule

**Interview to be held with social worker of boarding services
providing organization (Shiny Day)**

**Semi - structured interview themes on psychosocial conditions of
students orphaned by HIV/AIDS**

1. What is the objective of your Shiny Day?
2. What kind of support is provided by your Shiny Day for students orphaned by HIV/AIDS in order to solve their psychological problems?
3. What kind of support is provided by your Shiny Day for students orphaned by HIV/AIDS in order to solve their social problems?
4. Do you believe that this support is enough? If not, what is lacking in this support?
5. What do you think should be made in the future to solve their psychosocial problems?

Appendix D

**Addis Ababa University
School of Graduate Studies
Department of Special Needs Education**

Interview Schedule

**Interview to be held with teacher of students orphaned by
HIV/AIDS at Awassa Boarding Secondary School**

**Semi - structured interview themes on psychosocial conditions of
students orphaned by HIV/AIDS**

1. From your personal experience, what are the major psychological problems of students orphaned by HIV/AIDS?
2. Based on your personal experience, what are the major social problems of students orphaned by HIV/AIDS?
3. What do you think are the causes of the psychological problems of students orphaned by HIV/AIDS?
4. What do you think are the causes of the social problems of student orphaned by HIV/AIDS?

Appendix E

ውድ የጥናቱ ተሳታፊ

በቅድሚያ ይህንን መጠይቅ ለመሙላት ፈቃደኛ በመሆን/ሽ አመሰግናለሁ። በመቀጠልም የግል ጉዳዮች ላይ ያተኮሩ ጥያቄዎች ቀርበዋል። ጥያቄዎቹም ሆኑ ከጥያቄዎቹ የሚገኙት ምላሾች አገልግሎታቸው ለጥናትና ምርምር ስራ እንጂ ሌላ ተግባር ላይ እንዲውሉ አይደረግም። በመሆኑም ይህንን ጥናት በተሳካ ሁኔታ ለመጠናቀቅ ይቻል ዘንድ አንተ/አንቺ የምትሰጣቸው/የምትሰጫቸው መረጃዎች እጅግ በጣም ጠቃሚና አስፈላጊዎች ናቸው። ስለሆነም ለጥያቄዎቹ በቅንነትና በግልጽነት እንዲሁም በትዕዛዛቸው መሰረት መልስ እንድትሰጥ/ጪ በትህትና እጠይቃለሁ። የምትሰጣቸው/ሚሰጡ መረጃዎች በሚስጢር የሚጠበቁ ሲሆን በመጠይቁ ላይ ስም መጻፍ አያስፈልግም። ለእያንዳንዱ ጥያቄ መልስ በመስጠት ስለተባበርክኝ/ሺኝ ከፍተኛ ምስጋና አቀርባለሁ።

አጠቃላይ መረጃ

ይህ መጠይቅ ሶስት የተለያዩ ክፍሎች አሉት። እያንዳንዱ ክፍል የራሱ የሆነ ተፅዕኖ ያለው ሲሆን ትፅዕኩም ለጥናቱ ተሳታፊዎች እንዴት መልስ መስጠት እንዳለባቸው ፍንጭ ይሰጣል። ውድ የጥናቱ ተሳታፊ ሆይ እያንዳንዱን ጥያቄ በሚገባ ካነበብክ/ሽ በኋላ በቅንነትና በግልጽነት ለጥያቄዎቹ መልስ ስጥ/ጪ።

ክፍል 1

ግላዊ መረጃ

ትፅዕኑ፡ ከዚህ በታች ግላዊ መረጃን የሚመለከቱ ጥያቄዎች ቀርበዋል። የጭረጽ ምልክት ($\sqrt{\quad}$) በማድረግ እንዲሁም እንዳስፈላጊነቱ ተገቢውን መልስ በመስጠት ለእያንዳንዱ ጥያቄ መልስ ስጥ/ጪ።

1. እድሜ -----

2. ጾታ ሀ) ወንድ ☐ ለ) ሴት ☐

3. የክፍል ደረጃ ሀ) 9ኛ ክፍል ☐ ለ) 10ኛ ክፍል ☐

4. የቤተሰብ ሁኔታ ሀ) እናቱን/ቷን በሞት ያጣ/ች ☐

 ለ) አባቱን/ቷን በሞት ያጣ/ች ☐

መ) እናቱን/ቷን እና አባቱን/ቷን በሞት ያጣ/ች ☐

ሠ) ሌላ ካለ ይገለጽ -----

5. በአሁኑ ወቅት ከማን ጋር ትኖራለክ/ሽ?

ሀ) እናት ☐

ለ) አባት ☐

መ) እህት ☐

ሠ) ወንድም ☐

ረ) አክስት ☐

ሸ) አጎት ☐

ቀ) አያት ☐

በ) ጓደኞች ☐

ተ) ሌላ ካለ ይገለጽ -----

ክፍል 2

ትዕዛዝ፡ ይህ ክፍል ሶስት የተለያዩ ንዑስ ክፍሎች አሉት። በየንዑሱ ክፍሎቹ የሚገኙት አረፍተ ነገሮች የሰው ልጅ በየአለቱ የሚያከናውናቸውን ተግባራት የሚገልጹ ናቸው። መጠይቆቹን በሚገባ በማንበብ ትይዩ ከቀረቡት የመስማማት ወይም ያለመስማማት መጠንን ከሚገልጹ አምስት አማራጮች መካከል የአንተን/የአንቺን ትክክለኛ ስሜትና ባህሪ የሚገልጹትን ለይ/ዩ።

ንዑስ ክፍል 1

ትዕዛዝ፡ በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጠህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (√) በማድረግ አመልክት/ቺ።

ተ.ቁ	መጠይቆች	ምላሾች				
		በጣም እስማማለሁ	እስማማለሁ	አልወሰንኩም	አልስማማም	በጣም አልስማማም
1	ቢያንስ በደረጃዬ ካሉ ሰዎች እኩል የምጠቅም ነኝ ብዬ አስባለሁ።					
2	በርካታ ጥሩ ጎኖች/ብቃቶች እንዳሉኝ ይስማኛል።					
3	በአጠቃላይ ወደ ውድቀት ያዘነበለ ሰው ነኝ ብዬ አስባለሁ።					
4	በአብዛኛው ሰው የሚያከናውነውን ነገር ማከናወን እችላለሁ ብዬ አስባለሁ።					
5	ብዙ የሚያከራ ነገር አለኝ ብዬ አላስብም።					
6	ስለ ራሴ ጥሩ አመለካከት አለኝ።					
7	በጥቅሉ በራሴ እረካለሁ።					
8	ለራሴ የተሻለ አክብሮት አንዲኖረኝ እመኛለሁ።					
9	አንዳንድ ጊዜ ምንም ጥቅም/ዋጋ እንደሌለኝ ይስማኛል።					
10	አንዳንድ ጊዜ ጥሩ ሰው እንዳልሆንኩ ይስማኛል።					

ንዑስ ክፍል 2

ትዕዛዝ፡ በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጦህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (✓) በማድረግ አመልክት/ቺ፡፡

ተ.ቁ	መጠይቆች	ምላሾች				
		በጣም እስማማለሁ	እስማማለሁ	አልወሰንኩም	አልስማማም	በጣም አልስማማም
1	ሀዘን አይሰማኝም፡፡					
2	ስለ ወደፊት ተስፋ አልቆርጥም፡፡					
3	እንደ ማንኛውም ሰው ጉድለት ይሰማኛል፡፡					
4	በምዝናናበት ነገር ምንም አይነት ደስታ አላገኝም፡፡					
5	ሁልጊዜ ሀፍረት ይሰማኛል፡፡					
6	የቅጣተኝነት ስሜት አይሰማኝም፡፡					
7	እራሴን እጠላለሁ፡፡					
8	በተለየ ሁኔታ እራሴን አልተችም/አልወቅስም፡፡					
9	እድል ባገኝ ኖሮ እራሴን እገድል ነበር፡፡					
10	የለቅሶ ስሜት ይሰማኛል፤ ነገር ግን ማልቀስ አልችልም፡፡					
11	በተለየ ሁኔታ እረፍት አልባ ወይም ጉዳተኛ አይደለሁም፡፡					
12	በሌሎች ሰዎች ወይም ክንውኖች ዘንድ ተቀባይነትን አላጣሁም፡፡					
13	ማንኛውንም ውሳኔ ለመወሰን እቸገራለሁ፡፡					
14	ዋጋ/ፋይዳ እንደሌለው አይሰማኝም፡፡					
15	ከመቼውም ጊዜ በላይ አቅም/ሀይል አለኝ፡፡					
16	በአብዛኛው ቀን ቀን እተኛለሁ፡፡					
17	በተለየ ሁኔታ ጭንቀት አይሰማኝም፡፡					
18	የምግብ ፍላጎት ፈጽሞ የለኝም፡፡					
19	ምንም ነገር ላይ ትኩረት ማድረግ እንደማልችል እገነዘባለሁ፡፡					
20	በተለየ ሁኔታ ድካም አይሰማኝም፡፡					

ንዑስ ክፍል 3

ትዕዛዝ፡ በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጠህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (✓) በማድረግ አመልክት/ቺ።

ተ.ቁ	መጠይቆች	ምላሾች				
		በጣም እስማማለሁ	እስማማለሁ	አልወሰንኩም	እልስማማም	በጣም እልስማማም
1	የምተኛው እንቅልፍ እረፍት የሌለውና የተረበሸ ነው።					
2	ብዙ ጊዜ ስራዎቼን የማከናወነው በጭንቀት ውስጥ ሆኜ ነው።					
3	የማልችለውን ነገር ፈጽሞ አልናገርም።					
4	ብዙ ጊዜ የተረጋጋሁ ነኝ።					
5	እንድጨነቅ የሚያደርጉኝ ብዙ ችግሮች አሉብኝ።					
6	ሁል ጊዜ ችግሮች ሲገጥሙኝ ለመፍታት በቂ አቅም አለኝ።					
7	ነገሮች ሲከብዱኝ/ሲያስጨንቁኝ በቀላሉ እርግፍ አድርጌ እተዋቸዋለሁ።					
8	ምክንያቱን በማላውቀው ሁኔታ በተደጋጋሚ እራስ ምታት ያጋጥመኛል።					
9	አንዳንድ ነገር ለማከናወን ስሞክር ሁሉ ነገር ትክክል ያልሆነ ይመስለኝል።					
10	ቁጡና ጭንቀታም እንደሆንኩ ይሰማኝል።					
11	ሌሎች ሰዎች ስለ እኔ የሚያስቡት ያስጨንቀኛል።					
12	ብዙ ጊዜ የሆድ ህመም ይሰማኛል።					
13	ወደ ፊት ምን ይፈጠር ይሆን ብዬ በማሰብ እጨነቃለሁ።					
14	መጥፎ ህልም አልማለሁ።					
15	ስሜቶቼ በቀላሉ ይጎዳሉ።					
16	ሁል ጊዜ ስለሚደርስብኝ መጥፎ ነገር እጨነቃለሁ።					

ክፍል 3

ትዕዛዝ: ይህም ክፍል ሶስት የተለያዩ ንዑስ ክፍሎች አሉት። በየንዑስ ክፍሎቹ የሚገኙት አረፍተ ነገሮች የሰዎችን ማህበራዊ ጉዳዮችና ተሳትፎዎች የሚመለከቱ ናቸው። መጠይቆቹን በሚገባ በማንበብ ትይዩ ክቀረቡት አምስት አማራጮች መካከል (ሁል ጊዜ ትክክል ÷ ብዙ ጊዜ ትክክል ÷ እንዳንድ ጊዜ ትክክል ÷ በጣም በጥቂቱ ትክክል እና ሀሰት) የአንተን/የአንቺን ትክክለኛ ስሜትና ባህሪ የሚገልጹትን ለይ/ዩ።

ንዑስ ክፍል 1

ትዕዛዝ: በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጠህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (√) በማድረግ አመልክት/ቺ።

ተ.ቁ	መጠይቆች	ምላሾች				
		ሁል ጊዜ ትክክል	ብዙ ጊዜ ትክክል	እንዳንድ ጊዜ ትክክል	በጣም በጥቂቱ ትክክል	ሀሰት
1	በማህበራዊ ጉዳዮች ላይ ለመሳተፍ የማገኛቸውን አጋጣሚዎች በደስታ እቀበላለሁ።					
2	ከሰዎች ጋር ላለመሆን እፈልጋለሁ።					
3	ከተለያዩ ማህበራዊ ግንኙነቶች ብገደብ በህይወቴ ደስተኛ አልሆንም።					
4	የማህበራዊ ህይወቴ ተሳትፎ እንዲጨምር የሚያስገድዱኝን ሁኔታዎች አልቀበላቸውም።					
5	ብዙ ጊዜ በማህበራዊ ግንኙነቶች ላይ ላለመሳተፍ ስል ያልሆኑ ምክንያቶች አቀርባለሁ።					
6	ብዙ ጊዜ ከተለያዩ በርካታ ሰዎች ጋር መሆን ይመቸኛል።					

ተ.ቁ	መጠይቆች	ምላሾች				
		ሁል ጊዜ ትክክል	ብዙ ጊዜ ትክክል	እንዳንድ ጊዜ ትክክል	በጣም በጥቂቱ ትክክል	ሀሰት
7	ብዙ ጊዜ የማህበራዊ ግንኙነት ተሞክሮዎቼ የማያስደስቱ ሆነው አገኛቸዋለሁ።					
8	መደበኛ የሆኑ ማህበራዊ ጉዳዮችን ላለመቀበል ጥረት አደርጋለሁ።					
9	ብዙ ጊዜ በማህበራዊ ጉዳዮች ላይ እርጋታና ምቹት እንደሚሰማኝ አስበለሁ።					
10	እስካሁን በተሳተፍኩባቸው ቡድኖች ብዙ እርካታ አግኝቻለሁ።					
11	በደንብ ከማላውቃቸው ሰዎች ጋር ላለመነጋገር ጥረት አደርጋለሁ።					
12	ከሰዎች ጋር እንዳልገባባ የሚያደርገኝ ፍላጎት የለኝም።					
13	ከማላውቀው ሰው ጋር ለመጀመሪያ ጊዜ ስገናኝ ሁል ጊዜ ደስታ ይሰማኛል።					
14	አንዳንድ ጊዜ ሰዎችን ለማስተዋወቅ ሀላፊነትን እወስዳለሁ።					
15	ብዙ ጊዜ በማንኛውም ማህበራዊ ጉዳዮች ላይ እገኛለሁ።					

ንዑስ ክፍል 2

ትዕዛዝ፡ በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጠህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (√) በማድረግ አመልክት/ቺ፡፡

ተ.ቁ	መጠይቆች	ምላሾች				
		ሁል ጊዜ ትክክል	ብዙ ጊዜ ትክክል	እንዳንድ ጊዜ ትክክል	በጣም በጥቂት ትክክል	ሀሰት
1	በደንብ ከማላውቃቸው ሰዎች ጋር ስሆን የመጨነቅ ስሜት ይሰማኛል፡፡					
2	ማህበራዊ ግንኙነቴ በተወሰነ መልኩ የተዛባ ነው፡፡					
3	መረጃ ለማግኘት ሌሎች ሰዎችን መጠየቅ አይከብደኝም፡፡					
4	ብዙ ጊዜ በመዝናኛ ጥሪዎች/ፓርቲዎችና በማህበራዊ አገልግሎቶች ላይ ምቹት አይሰማኝም፡፡					
5	ብዙ ሰዎች ባለብት ስፍራ ትክክል ስለሆነ ነገር ማውራት ይቸግረኛል፡፡					
6	በአዲስ ሁኔታ ውስጥ አይናፋርነቴን ለማስወገድ ብዙ ጊዜ አይወሰወድብኝም፡፡					
7	ከአዳዲስ ሰዎች ጋር ስገናኝ እውነተኛ የሆነውን ስሜቴን መግለጽ እቸገራለሁ፡፡					
8	አንድን ሰው ፊት ለፊት ሳወራ ብስጩነት ይሰማኛል፡፡					
9	በማህበረሰቡ ውስጥ ላለኝ ተሳትፎ ጥርጥር የለኝም፡፡					
10	አንድን ሰው ፊት ለፊት/አይን አይኑን ማየት ይቸግረኛል፡፡					
11	በማህበራዊ ጉዳዮች ላይ ተሳትፎ ውስን የሆነ ይመስለኛል፡፡					
12	ከማላውቀው ሰው ጋር ማውራት አይከብደኝም፡፡					
13	ከተቃራኒ ጾታ ጋር ስሆን አይናፋርነቴ በደንብ ይጎላል፡፡					

ንዑስ ክፍል 3

ትዕዛዝ፡ በነጥቦቹ ላይ ያለህን/ሽን የመስማማት ወይም ያለመስማማት ደረጃ ከተጠቀሱት አማራጮች መርጠህ/ሽ በቀረበው ክፍት ቦታ ላይ የጭረት ምልክት (√) በማድረግ አመልክት/ቺ፡፡

ተ.ቁ	መጠይቆች	ምላሾች				
		ሁል ጊዜ ትክክል	ብዙ ጊዜ ትክክል	እንዳንድ ጊዜ ትክክል	በጣም በጥቂቱ ትክክል	ሀሰት
1	በትምህርት ቤት ውስጥ አዲስ ጓደኛ ለማፍራት ይቀለኛል፡					
2	ከሌሎች ልጆች ጋር ለመስራት እችላለሁ፡፡					
3	ጓደኛ ለማፍራት በየትም ቦታ ቢሆን አይከብደኝም፡፡					
4	ከህጻናት ጋር አልጋባባም፡፡					
5	ጓደኛ ማግኘት ሲያስፈልገኝ አገኛለሁ፡፡					
6	ሀሳቤን የማካፍለው ሰው የለኝም፡፡					
7	ምንም አይነት ጓደኛ የለኝም፡፡					
8	ከማንኛውም ሰው ጋር ለመስራት እችላለሁ፡፡					
9	ለጓደኞቼ ግልጽ አይደለሁም፡፡					
10	ጓደኞቼ የስነ-ልቦና ድጋፍ ያደርጉልኛል፡፡					
11	ከጓደኞቼ ጋር ያለኝ ግንኙነት ከልብ ነው፡፡					
12	ጓደኞቼ የምፈልገውን የሞራል ድጋፍ ይሰጡኛል፡፡					
13	ጥቂት ጓደኞቼ እኔን እንዲረዱኝ በምፈልገው መንገድ ይረዱኛል/ይገነዘቡኛል፡፡					