ASSESSMENT OF THE IMPACT OF EARLY PARENTAL LOSS ON THE PSYCHOLOGICAL, SOCIAL AND BEHAVIORAL PROBLEMS OF INSTITUTIONALIZED HIV ORPHANED

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ACRONYMS

ANOVA----------Analysis of Variance

EOCAPP----------Ethiopian Orthodox Church AIDS Prevention Program

HIV----------Human Immune Deficiency Viruses

UNAIDS ----------United Nations Agency for International Development Services

UNDP----------United Nations Children's Program

UNICEF----------United Nations Children's Fund

AIDS ----------Acquired Immune Deficiency Syndrome

USAIDS---------- United States Agency for International development

WHO ----------World Heath organization

MOLSA----------Ministry of Labor and Social Affaires

FAO----------Food Agriculture Organization

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Abstract

This study examined the psychological, social and behavioral developmental problems of institutionalized HIV orphans. A total of 63 participants were selected using purposive sampling method from SOS Children's village in Bahirdar, Orphans in age of 14-18, had lost one or two of the parents to HIV disease. Three questionnaires were independently administered to orphans, and based on the responses to the questionnaires; data were analyzed by using independent sampled t – test, rating scales, ANOVA, and Studentized Range statistic: q (Tukey) methods. The findings showed sex, age of admission, and duration of stay were found to be directly related to the psychological, social and behavioral development of orphans. Findings also showed double orphans were more affected and paternal orphans were the least affected from the loss of parents'. In accordance with the findings and conclusions, recommendations were forwarded.

CHAPTER ONE

1. Introduction

1.1 Back Ground of the Problem

The regard for children in all societies around the world through out ages is mainly of a humans desire to perpetuate its own natural race and social self. Children are the living investments of nation to foretell its future or dictate its destiny. They, therefore, need continuous assistance for their physical and mental development to enable them to develop the assumption and fulfillment of Adult role in the society.

One of the positive international contributions of twentieth century is the increasing focus on human rights. Thus, the young global institution the United Nations, has reached formal consensus on basic principles concerning rights in a life worth and dignity for all human beings, adults and children, including persons with disabilities and other Vulnerable groups and individuals (UN, 2000).

Children's rights arise from their status being dependent, immature individuals who need continuous assistance for their physical and mental development.

For most periods of history, however, childhood is not the ideally cozy, protected, and playful life style free from adult responsibilities. Children represent the most Vulnerable segment of society bearing the

brunt of Problems of natural and man made calamities, underdevelopment, exploitation and abuse.

Today, AIDS is responsible for leaving vast numbers of children across Africa without one or both parents. In some countries, like Ethiopia, a large proportion of orphans have lost their parents to AIDS than any other cause of death-meaning that, were it not for the AIDS epidemic, these children would not have been orphaned.

More than 8% adults in sub-Saharan Africa were infected with HIV, and prevalence rates are estimated to exceed 15% in 8 southern African countries (UNAIDS/WHO.2000). Death of prime aged has led to pronounced concentrations of orphans, where nearly 15% of all children under the age of 15 have lost one or both parents.

According to Bishai (2005), biological relatedness is an important predictor of the quality of care offered to children by different providers. Foster parents may not have offered the quality of care children needed. Foster parents may not have the same altruistic ties to the children, and may be less likely to realize financial gains from investments made in orphans, leading to abandoning than to invest in such children.

. The death of a mother may leave children especially vulnerable, even among those who continue to live with their father and who experience no reduction in income. Household expenditure on child-related goods-in particular, on healthy food-is lower when a child's biological mother is

absent. Moreover, mother is generally the gatekeeper for their children's health investments (Cases and Paxson. 2001)

Understanding the risks that orphan's face is important for policy. If extended families do provide adequate insurance, then government policies need not target orphans specifically.

Households could be singled out for help on the basis of other indicators (income poverty, for example). On the other hand if, holding all else equal, orphans are at risk for lower investments, then government may be well advised to target orphans specifically when designing policies to improve such out comes as school enrollment.

The scale of AIDS orphan crisis is somewhat masked by the time gap between when parents become infected and when they die.
If as expected, the number of adults dying of AIDS rises over the next decades, an increasing number of orphans will grow up without parent's care and love.

> *"The increased spiral of adult deaths in so many countries means that the number of children orphaned each day is expanding exponentially Africa's is staggering under load".*
>
> *Step Lewis (UN: 2001)*

Since Ethiopia is one of the poorest counties in the world, the country can not provide sufficient social services for those who are in need of it, particularly to the abandoned and orphaned children as a result we can find many children who are suffering from poor health

condition, malnutrition, low level of educational facilities and poor housing.

Such social evils have summoned state agenesis and various non-governmental organizations to get increasingly involved in the provision of various supplementary as well as substitute services for children in difficult circumstances.

1.1.1. Concept of Childcare Institution

The childcare institutions are a system in which society provides substitute care to those children who are faced by different factors to live outside normal family settings. According to Minty (1987), there are two main motives behind the provision of this care: the first is the concern to protect and assist those children who experience parental loss, neglect, abuse, and rejection. The second motive arises from the anxiety that if children are brought up in a hostile environment they may suffer long-lasting emotional damage and may grow in to anti-social adults with severe behavioral, social and psychological problems.

The child-caring institution is a facility that offers total substitute care for child whose parent cannot and/or will not implement their parental role. For example, the boarding home usually gives a temporary facility where as the adoptive home, gives a permanent one. Both have in common the fact that they provided the child with a family care arrangement. The institution is similar to the boarding home in that may provide temporary substitute care; it may be like the adoptive home in

that if offers permanent care, but unlike the boarding home or the adoptive home, it offers group care rather than family care.

Children's institutions are as group of unrelated children living together in the care of a group of unrelated adults. It is twenty-four hours residential groups care facility. There are many different kinds of institutions serving different kinds of children. Among them are the following:

- Institutions established for dependent and neglected children.

  This is the closest modern analogy of the old orphan asylum.

- Institutions for physically handicapped child. There are separated institutions for children who are blind, deaf, crippled, and so on
- Institutions for emotionally disturbed child.
- Institutions established to rehabilitate of juvenile delinquents.

The different institutions serving different groups of children are, of course, apt to differ in many essential details. All institutions have in common on the fact that they are group-care facilities that provide total substitution of the natural parents' care of he child.

The fact that, institutional care is group care in a separate twenty-four-hour residential care. Physically defined community gives it some unique advantages that can be explained to meet the meet the special needs of some particular groups of children, but there are also limitations that will be discussed below.

1.1.2. Merits and Demerits of Internal Care.

There is controversy over the merit of using institutional care. There are also different views regarding the use of institution for children. For instance, those who are against institutional care hold that institutional care cannot appropriately meet the needs of children for psychological care, however, the supporters of the use of institutions stress that institutions have unique features and appropriate use of those characteristics could help the development of children. The researchers in the last group contend that institutions are different in many respects and that out comes of their use depend, among other things, the kind of institution and the quality of services rendered to residents.

Despite the controversy, there are general assets and liabilities of well-run institution for children. The advantages of institutional life include primarily for group living through which respect for the rights and abilities of others may be recognized, regularity of personal habits; regularity of meals and well-balanced diets; impersonal objective attitude of adults; consistent discipline, and if handled constructively, whole some group competition. On occasion, training as a child unacceptable social behavior through the pressure of the contemporary group is sound if that objective adult sets the sprit.

On the other hand, certain disadvantages are prevalent in many institutions. Some of these are overly reutilized life, lack of personal

freedom and initiative, restriction on friendships and school life primarily to institution population, limited opportunity for economic experience, and insufficient outlets for emotional needs. Similar to institutionalization, early reparation is regarded to be damaging to the development of children (Bowlby, 1952, Bowlby, 1965) that will be treated in the next section.

1.1.3. Early Parental Loss and Childhood Stress

Of all the life stresses a child might experience, the death of a parent seems most devastating, the loss least reparable, and the potential for harmful psychosocial consequences greatest. In fact, parental death during childhood has been implicated in the development of immediate, intermediate, and long-term psychiatric morbidity. However, results have been mixed in studies that retrospectively examined bereavement disorders in late life in those who have experienced childhood parental loss.

Bowlby, (1965), makes the point that, the child who lacks continuous relationship with his/her mother or mother figure is subject to maternal deprivation. Of all children who lost their parents, a larger population has lost their parents AIDS than any other cause of death.

Almost throughout sub-Saharan Africa, there have been traditional systems in place to take care of children who lost their parents due to various reasons. But the onslaught of HIV slowly but surely erodes these good traditional practices by simply over loading its caring capacity by the

sheer caring capacity of families and communities by deepening poverty due to loss of labor and the high cost of medical treatment and others.

The vulnerability of AIDS orphans starts well before the death of a parent. Children living with caregivers who have HIV/AIDS will often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before the death of the parent or caregiver.

The economic impact of HIV/AIDS illness and death has serious consequences for an orphan's access to basic necessities such as shelter, food, clothing, health, and education. Orphans run greater risks of being malnourished than children who have parents to look after them.

In addition, there is the emotional suffering of the children, which usually beings with their parents' distress and progressive illness. Eventually, the children suffer the death of their parents and the emotional trauma that results. They them may have to adjust to a new situation, with little or no support, and they may suffer exploitation and abuse.

Since HIV can spread sexually between father and mother, once AIDS has claimed the mother or father, children are far more likely to lose the remaining parent. Children often then find themselves taking the role of mother or father or both doing the housework, looking after siblings and caring for ill or dying parent(s).

Children grieving for dying or dead parents are often stigmatized by society through association with HIV/AIDS. The distress and social isolation experienced by there children, both before and after the death of their parent (s), is strongly exacerbated by the shame, fear, and rejection that often surround people affected by HIV/AIDS. Because of this stigma and often-irrational fear surrounding AIDS, children may be denied access to schooling and health care. And 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 infected with HIV themselves. This further stigmatizes the children, reduces their opportunities in the future, and they may also not receive the health care they need, and sometimes this is because it is assumed that they are infected with HIV and their illnesses are untreatable.

1.2 Statement of the Problem

Over the past two decades, children's emergence as a topic of public and political concern has been truly striking. Following the ratification of the Declaration of Human Right and the –International Covenant on the Rights of the child (1998). The document ensures the protection of the child from all forms of discrimination or the belief of the child's parents, legal guardians or family members.

The commitments in this convention, however, contrast sharply with the abuses of children that surface in reality. Although most children live with their parents, many children lack the protection of guardianship.

Due to natural and man-made disasters all over the places, orphanage is a worldwide problem.

The problem of orphanage has been as serious concern in developing counties like Ethiopia where the government cannot provide adequate institutional care, protection and guidance if they are to survive and flourish. But a county like Ethiopia, because of its low level of socio-economic development, cannot provide these children with the necessary institutional care, the community take care orphaned and destitute children, as "Gudifecha" to bring them up.

Though their number is increasing, there are non-governmental voluntary organizations, which offer institutional care to those children who lost their parents; SOS children's village is one of them.

1.3 Objective of the Study

The study will attempt to investigate whether there is relationship between psychological, social and behavioral problems of institutionalized orphans and such factors as age of admission, sex, and length of stay and loss of parents of institutionalized orphans. The study will further explore which of these independent variables are more related to behavioral, social and psychological problems of institutionalized orphans.

More specifically the study will try to answer the following questions?

1. Are the psychosocial and behavioral problems of orphans in SOS children's village significantly related with?

A, Children's age of admission

B, Duration of stay in the institutions

C, Sex of the individuals

D, Parental loss

2. To what extent does each of the above variables contribute towards social, psychological and behavioral problem of orphans?

3. To what degree, the institutions meet the needs of the children and which sex group (boy/girls) are beneficiaries.

4. Effects of community support and reaction towards orphan's psychological, social and behavioral development?

5. Which is the most disadvantage and vulnerable group from loss of a parent on psychological, social and behavioral development

1.4. Significance of the Study

The age at which children are admitted to institutional care was considered to have relation to the behavioral problems of children in institutions. The separation of children from their parents is also cited as having different effects in children of different ages (Bowlby, 1952). Children particularly the younger ones find the separation from home and parental figure as threatening and distressing events (Minty, 1987). Moreover, the duration of stay in residential care has been cited of having adverse effect on children (Minty, 1987, Rutter, 1983).

To the knowledge of the student researcher, there is no study that was carried out to find the possible effects of the above variables on children's residing in SOS children's Village. This study will answer the claims of SOS in an Ethiopia setting, which will help the professionals and researchers in the area of childcare. Furthermore, the results of the researcher have practical advantage in helping to deal with issues related to orphans such as psychological, social and behavioral defects and help to plan an appropriate intervention strategy to minimize the development of psychological, social and behavioral problems. The out come may also help the professionals in other similar institutions to deal with similar problems.

1.5 Limitation of the Study

The chances are very slim where retrospective data could wholly portray the state of project activity well as beneficiaries in the present time. The data is also liable to any extent of substantive deprecation as is dependent on the memory of respondents above their stay at the drop in the center.

In the writer's opinion the very fact that the sample respondents consider themselves and are also externally designated as beneficiaries had deceptive implication.

Respondents inclined to emphasizes only the virtues of project interventions eliciting a certain degree or Ultimate bias on the quality and reliability of primary data.

CHAPTER TWO

2. Review of Related Literature

2.1. Children and HIV/AIDS from an International Human Rights Perspective

The protection and promotion of human rights is crucial element of a global response to HIV/AIDS. While this concept has been increasingly accepted in terms of adults, the protection and promotion of human rights of children in the context of HIV/AIDS epidemic has not been fully addressed. There is a tremendous gap between the rhetoric of human rights and brutal reality of many children's lives.

The inherent vulnerability of children, the vast scope of the epidemic, the cascading impact on the economies of households and communities, and the psychosocial consequences of all these inevitably place human rights at the center of all types responses. The convention of the rights of child has four general principles: non-discrimination; best interests of he child; survival, life, and development; and participation. Children have human rights in relation to HIV/AIDS in three ways: as HIV infected children, as children affected; and in their vulnerability to becoming infected.

Most literature fail to describe the virus marginalizes children from enjoying their rights, but the available literatures show the complex nature of

HIV and AIDS. The illness and death of a parent or caregiver during a child's first year jeopardizes the fulfillment of child's basic needs. HIV/AIDS deprives of children's rights to grow in a family environment, which is crucial and fundamental for their overall development. HIV/AIDS causes the death of a caregiver followed by stigma and discrimination. It further isolates them from others at a time when they are most vulnerable and need as much cares and support as possible. These children due to the false assumption that they are infected themselves, losses out an opportunity to participate their community, religion, cultural activities, and sports (UNICEF 2005)

A strong prejudice results among the public due to the misconception and poor awareness leads to discrimination which linked to the violation of the rights of children stated in article 2 of the CRC (1989).

The article states:

> *" State parties shall respect and ensure the rights set forth in this convention to each child with in their jurisdiction with out discrimination of any kind, irrespective of the child's or his or her parent's legal guardians race, color, sex, language, religion, property, disability birth or other status"*

Similarly, the African charter (1990) made arguments, which is also incorporated in the Ethiopian constitution .The United Nations almost unanimously adopted the convention on the rights of the child in 1989 that

came in force in 1990 for protection against all forms of abuse, exploitation, neglect, and other forms of maltreatment.

Ethiopia being one of the members ratified and made the convention law of the country in 1991. Children, thus, are focused to share equally international as well as national human rights to be provided with basic requirements for their survival, growth and development. The following needs are out lined by CRC as essential for children's over all development: protection from all forms of exploitation, abuse and neglect; access to health and health service; access to appropriate information; privacy, freedom of association and expression of opinion, participation in recreation play and culture activities, leisure and rest opportunities.

In addition to their physical reeds, their psychological need such as adequate care, attention, security, love, acceptance and understanding have also to be met as well .HIV/AIDS evokes stigma up on the orphans that may eventually be manifested as discrimination, rejection, and isolation.

Relevant to the survival care, support, development and protection of children, the 1995 Ethiopia constitution of the Federal Republic of Ethiopia incorporates the penal law, the civil law, the labor law, education policy, health policy and social welfare development and other documents produce much and give rise to the well being of the children. In spite these, however, much has been left to do for the effective implementation of the rights of children. The problems of AIDS orphans with particular emphasis on stigma

and discrimination have not been adequately treated in this particular and similar other social policies. Although there were efforts, strategic plans have not been geared to fully address the problems of orphans. This situation has been affirmed by a study conducted in Ethiopia witnessed that the policy fails to address the issue of AIDS orphans adequately (UNICEF 2003).

2.2. Psychological and Social Impact of HIV and AIDS on Children

Although a family member's death from AIDS may be a catalyst that put children in to escalating trouble, the psychosocial needs of children are too often perceived as some how less important than their economic necessities. If children are to develop the psychosocial needs must be received proper and prompt attention.

The ways in which parent's illness and death are handled with in the family are critical to a child's future. Many mental health issues transform economic, political and cultural boundaries as young people vulnerable to the disease and their parents became embroiled in a down ward spiral of stigma, shame, secrecy and losses. The psychosocial impact of losing a parent is no less significant a children and youth in developing counties than in the developed world. However, the pressing needs for basic survival and education have tended to dominate research and intervention agendas in the former setting . Existing psychosocial research has concentrated primarily on developed countries and even that has been limited. HIV and AIDS

negatively affect the demography of a country; children are being alarmingly orphaned, economies are severely challenged, human resources are drastically affected and social services are depleting. Lack of treatment facilitates unaffordable cost of treatments and drug and also hospitals, home for terminally ill, care and support units impose a further treat. The never-ending misconceptions and false notion /evading to stigmatization, discrimination and isolation of people affected with HIV and AIDS make it not only a health problem but also economic and social issues.

A recent analysis by UNICEF approximately 3.2. Million children became orphans in the sub-Saharan Africa and will continue to increase through the years 2010. In regard to orphans, the distinctive characteristic of HIV and AIDS is that AIDS is more likely than other causes of death to create double orphans. It is known that if one parent is infected with HIV there is high probability that the other is or will become infected and both will eventually die. This means, countries with high prevalence of HIV and AIDS will also have a disproportionate of double orphans as the epidemic advance. Surveys consistently demonstrate that double orphans are more disadvantaged than single orphans.

Africa is a home of 90% of the children orphaned by HIV/AIDS. Estimates for 26 countries suggested that the number of children below the age of 14 who are paternal orphans or maternal orphans from any cause will

be more than double between 1990 and 2010. However, this fails to reveal the true extent of the number of children, affected by HIV and AIDS for the estimate exclude children, between the ages of 15 and 17, a group with the highest orphan's rate.

Many studies deal with the numbers and age of orphans and their material needs. There is little research on the quality of life childcare arrangements and psychosocial support needed. In one Canadian study families identifies their main problems as meeting the needs of their children, living with uncertainty dealing with the impact on family relationships, dealing with disclosure and finding adequate social support.

Affected and orphaned children are often traumatized and suffer a variety of psychosocial 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 disgrace 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. Inevitably many orphaned children will grow up at high risk of HIV themselves especially girls who are more likely to be with drawn from education when household resources are squeezed (Foster Karen 2002).

People believe that the HIV infections are caused by adultery their parents involved in. At times, the orphans may consider living on the street as an alternative to run away from the suffering, they face at home. Prostitution, for girls, could also be taken as source of income for there sustenance, which could, through time, make them, contract HIV and AIDS (ICRW 2003).

Existing studies of children's reactions suggest that they tend to show internalized rather than externalized symptoms in response to aggression and other forms of anti-social behaviors (Segundo and Nimbi; 1997). Research is depicting a reality of worry, sadness, fear, and hopelessness among children and adolescents during their parent's HIV/AIDS illness and death subsequently in orphanage.

The impact of parental death on children is complex and affects the child's mental health social energy. HIV and AIDS orphans might have stunted development of emotional intelligence and life skills such as communication, decision making, negotiations skills etc. Further more,HIV and AIDS orphans often show lack of hope for future and a low self-esteem (Sengendu and Nimbi 1997)

The practical observation in the life of thousands of orphans' leads to the conclusion that parental deaths especially double death as often is the case with AIDS is a high risk factor that causes psychological stress with long term development impact on children (German 2002).

2.21. Psychological Impact

Children who grow up with out the love and care of adults devoted to their well-being are at higher risk of developing psychological problems. It is difficult for agencies to concentrate on addressing psychological needs some times the fulfillment of psychological needs may be less pressing in the absence of meeting the basic needs such as food, clothing and shelter. However, it is undeniable that the impact of HIV and AIDS on households leads to sequential trauma associated with continuous traumatic stress syndrome. Separation of siblings is a major factor contributing to psychosocial distress among orphans.

Most children show psychological reactions to parental illness and death. A child's psychological health depends to a large extent upon the status of his or her parents. Signs of mother's depression, guilt, anger, or fear may be reflected in children behavior. Orphans most often say they miss the love of their parents and their families. A study in Zambia shows that parents noted that children become worried and sad that tried to help more in the home and stopped playing so as to stay near by. Children in house holds affected by HIV and AIDS were more likely to become solitary; to appear miserable or distressed, and to be fearful of new situations than were children in the household not affected by the epidemic. A study in Uganda shows that children expressed feelings of hopelessness or anger when their

parents become sick and feared that there parents would die. Most orphans were depressed and had lower expectations about the future.
Depression was highest among these between the ages of 10 and 14. The study also suggests that the loss of a mother is more distressing than the loss of a father. Orphans were found to internalizing behavior changes such as depression, anxiety and decreased self-esteem, rather than to exhibit acting out or socio-economic behavior such as stealing, truancy aggression and running away (Max Essex 2002).

2.3 Social and Behavioral Status of Orphans.

There is no doubt that HIV/AIDS epidemic has and will precipitate enormous suffering for countless children families and communities. Unknown numbers of children will go hungry, starve, and suffer stunted physical and mental growth. Similarly, many children will endure enormous anguish as they potentially find themselves alone and unsupported, the butt of cruel commentary and behavior, exclude, exploited, beaten, raped, and forced in to labor. Many children will have to make their own way in the world, sleeping rough, doing opportunistic work, begging, and soliciting patronage and protection from street groups. However, individual suffering even on a massive scale does not necessarily imply that children will lack critical socializing experiences or that they will become alienated disturbed, or poses a potential threat to social stability.

Children who do show enduring maladjustment because they have few if any opportunities for recovery. What we do know is that children exposed to multiple severe stresses, without compensating support, are more likely than other children to show disordered behavior. Social support at the level of family, school and the wider community reduces the impact of stresses on children living in adverse conditions.

Lack of social support through poor coping by available adults, the depletion of social networks and isolation from regular social institutions increases children's vulnerability to stress by reducing their resources for dealing with stress.

Individual or group predisposition to socially disorder behavior does not necessarily accompany or follow from aggregated human suffering. Disordered behavior of such kind threatens security, such as widespread aggression and disregard for social harms has, a closer association with the weakening of social institutions than with individual level experiences. For this reason, the strength and quality of social institution such as the family, school, church, and community associations are critical for children's capacity to cope with the effects of the epidemic and to avert personal distress maladjustment and social disorder. It is also true that these institutions are likely to be weakened as a result of the epidemic as key individuals become ill and die, and as these losses and the demands place on them by difficult conditions.

Children out of school, working children, children not living with either biological parents and adult sickness and death are all indicators of potential vulnerability.

The study by Save the Children UK(2002) noted that older orphans were frustrated about themselves, younger siblings' situations, and their social status in the in the social environments. Many emotional problems were reported by orphans as a result of the culture considered HIV/AIDS as punishment for wrong doing families and also associated with promiscuity and witchcrafts in addition to stigma and discrimination.

As to international HIV/AIDS Alliance (2003), AIDS orphan children and adolescents often felt guilty and responsible for he death of their parents. Most orphans' felt that their parents risked their lives the extent of engaging in commercial sex works, in an attempt to provide them with their needs. On the other hand, some AIDS orphans especially male adolescent have felt anger against their decreased parents for abandoning them and living them to suffer alone in caring of their younger siblings.

Faster and Williamson (2000) indicated that many orphans of urban areas of Africa, especially male adolescents living in disorganized communities where crime prevalence was high, often engaged in juvenile crimes due to lack of adult guidance in their social environment. Besides, many orphans living in such communities have engaged in substance abuses such as taking alcohol and illicit drugs to cope with the multiple adversities of their lives. Female orphans on the other hand often withdrew from others

2.4. A Framework for the Protection Care and Support of orphans and Vulnerable Children

Words cannot describe the profound sadness of children as they watch their mother or father or both fall ill and die from AIDS. It is an experience that has been endured by more than 14 million children still under the age of 15 and that countless more will face. Lose of a parent is terrible enough but it often precipitates a further downward spiral. Children who have been orphaned by AIDS are frequently shunned by society, denied affection and care and left with few resources to fall back on. The epidemic has not yet peaked. In the next ten years, death's from AIDS will increase dramatically so too will the number of orphans and vulnerable children. By 2010, it is estimated that more than 25 million children will have lost one or both parents to AIDS.

Families and communities have shown remarkable resilience and compassion in dealing with children affected by HIV/AIDS. However, in many communities the scale of the crisis is over-whelming the ability to cope thousands of community program have been implemented to support orphans and vulnerable children but of then these program meet only immediate needs, leaving desperate at youngsters with precarious futures. Moreover, organized efforts have reached only a fraction of the children hit hardest by HIV/AIDS. At the national level orphans and Vulnerable children have received little attention in development agendas, and international

donors have yet to put their full political cult behind the welfare of these children. Clearly, responding to this crisis is not yet seen as global priority.

The challenge of protecting the rights and ensuring the well being of children affected by HIV/AIDS is unprecedented and will require concerted action over the next 20 to 30 years. No single government or agency can respond effectively to the wide array and immense scale of the problems created by the epidemic. Collaboration, creativity and continual program monitoring and refinement are essential at community, local, national, regional and global levels.

Families and communities are our best hope for a meaningful response. Building their capacity to protect and care for orphans and vulnerable children is the most viable means to providing sensitive support at the scale needed for the many years that this crisis will be with us.

Targeting assistance exclusively to children affected by HIV/AIDS can increase the stigma and discrimination against them. Rather, interventions should direct towards all vulnerable children, households, and communities. The frame work for protection and care is structured at the UN General Assembly Special Session on HIV/AIDS, however, implementation of the framework will also make a significant contribution towards the Millennium Development Goals and other global commitments including education for all and the elimination of harmful child labor. The framework is based on the best interests of the child and other principles that guide the convention on

the rights of the child, including the rights to survival, well-being and development, nondiscrimination and participation.

The five key strategies put forward in the framework are as follows:

1. Strengthening the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic psychosocial and other support.
2. Mobilizing and support community based responses to provide both immediate and long-term assistance to vulnerable households;
3. Ensuring access for orphans and vulnerable children to essential services including education, health care, birth registration and others.
4. Ensuring that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities.
5. Raising awareness at all level through advocacy and social mobilization to create and supportive environment for children affected by HIV/AIDS.

2.5 Care for HIV/AIDS Orphans

Basically care for orphans can be categorized in to two major divisions: Household based care and institutional care.

2.5.1. Household Care

The household based care in the sub Saharan Africa fostering with in family illness still the most common safety net for the care of orphans in

Tanzania for example 95% of the orphans were taken by relatives. A similar pattern was found in Zambia and Uganda (Deininger 2002)

The argument is staying with known relatives and other children orphans may grow up in a more stable and secure environment favoring their psychological, intellectual behavioral and social development. Inspire of this however, they may be discriminated in basic needs allocation such as food, clothing, education, because parents may favor biological children first, either because of the resource depletion effect (the decrease in per capital house hold resources following the entry of orphans in the household).

The death of one parent especially the mother is followed by dissolution of the family. Although the surviving parent is the principal caregiver single orphans do not always remain with their living parent. For example, 73% of maternal orphans and 29% of paternal orphans were not living with their surviving parents in Malawi (Case et. Al 2002).

Double orphans and single orphans who are not taken care by their surviving parent are usually absorbed by their extended families, Uncles /Aunts the traditional first choice as substitute caregivers is less available either because they are themselves victims of AIDS or because they are now more reluctant to foster orphans usually forcing grand parents and older orphans to take on this mew role (Foster et.al 1996)

In most of the Sub-Saharan countries grandparents appear to be the most common caregiver. They may provide a securing and love environment that helps children to socialize they may have difficulties responding to children's psychological, legal economic and basic needs. In Northern Uganda and rural Tanzania 22% and 43% of the orphans were taken care of by their ground parents respectively on the other hand 20% and 7% are taken care by older orphans.

2.5.2. Institutional Care

It can be said that globally institutional care is quit limited according to Mac Lead (2001) only 1 to 3% of the orphans are cared for institutional settings (like SOS children's village) in some specific areas can reach to 5% with sharp increase in orphans in developing countries like Africa new and innovative forms of intuitional or semi-institutional care have emerged such as children's home and children's village

Children's home type of care consists of having a paid and usually trained foster mother living with a group of orphans usually 4-6 children in an ordinary home with in the community children with a family-like setting and a trained mother get basic needs, safety and psychological needs may be met (Kalandhi 2003).

As far as children's village are concerned different concepts of "children's villages" have emerged in recent past one of them is developed by "SOS children's village" consists of the gathering of about 10 to 20 houses which form a community and provide a family like setting for vulnerable

children. The sense is that children grown up in conditions comparable to that of "normal families". The assumption is that biological siblings are not split-up, children of different ages are related and becoming brothers and sisters, and all are enrolled in public schools and are strongly encouraged to maintain contacts with the community (Kalanidhi 2003

2.6. Absence of Adequate Cares and Control

Affected parents are struggling with their own disease or and have great difficulty in providing their children with a "Secure base". The common reactions in people diagnosed with a life threatening disease could be denial, anxiety, depression, and anger are likely to be exacerbated by the social stigma attached to HIV/AIDS and the parent's felling of quilt and anxiety about "abandoning" their children when they die.

Taylor (1999) states that parents over protect their children in an effort to compensate for their perceived failures and distancing themselves from their children as a way of reducing the intensity of their feelings. A study of a adolescents in families with AIDS in New York found that parents reported decreasing their influence over their adolescents behavior as their illness progressed, in part because they become less able to supervise and in past because they feared that disciplining would threaten their already fragile relationship with their adolescent children.

Some times multiple family members are infected so that illness and death can preoccupy the family over a period of several years and children are left with little care. On the other way the normal parent-child roles may be reversed as older children and adolescents assume responsibilities such as taking care of the ill parent, home and younger siblings (Dane, 1997, Geballe and Gruendel, 1998).

2.7. Research and Action Agenda for Future

A research agenda could be action oriented focusing on key areas that can guide and refine program development and implementation. Further more, the field experience of workers in a major resource that should be documented. In order to be of value, any research agenda should recognize several other assumptions.

- The way in which a problem is defined determines the solution.
- Research must be carried out in the context of human rights;
- Research must recognize the dynamic nature of the epidemic

In order to develop effective and non-discriminatory interventions, allocate resources equitably and minimize subjectivity in research, agreed upon definitions are needed .Two important examples are definitions of "Orphan" and the maximum age of orphan designation. It is difficult to determine the existing number of orphan or to make future projections because of problems of both under numeration and over numeration. Improved enumeration methodologies can arm policy planners to be more proactive in developing

appropriate community based responses to anticipated needs. Knowing the age at which orphan hood occurs is also crucial to planning incidence studies of orphans over time are need to arrest the impact on children more fully and to provide insight in to migration patterns.

The psychosocial implication of orphaned and the utility of such mitigating practices as youth counseling and should community education be examined. It is also be important to understand the impact on all children of growing up in an environment where so many adults and children are ill and dying. Out comes research is needed to measure how children are faring based on a range of criteria including school performance, physical and mental health, percentage of orphans who become HIV infected and the percentage who became sex workers and street youth. Measures of bereavement loss and the impact of stigma will also provide a fuller picture of surviving children.

There is an urgent need to understand the circumstances of those who care for children who have been orphaned by HIV/AIDS to document the availability and limitations of financial and material support to caregiver, and to understand the nature and extent of caregiver burnout and the need for emotional support. Research is also needed to analyze the cultural ethnic and social economic variations in families affected by HIV/AIDS and to identify the strength of family support systems, communication net works and patterns of closeness and partnership.

In summary what is ultimately needed is a global strategy that embraces specific local responses, that recognize, interconnections but facilitate local ingenuity and strengthens communities and families to provide environments in which children are protected nurtured and given opportunities to thrive. These beings with greater information sharing across national boundaries encourage research collaborations and bringing greater visibility to children's issue. Other appropriate intervention strategies; strengthen the capacity of families to cope with their problem; stimulated and strengthen community based resources; ensure the governments protect the most valuable children and provide essential services; build the capacities of children to support themselves; create enabling environment for affected children and families; monitor the impact of HIV/AIDS on children and families.

CHAPTER THREE

METHODOLOGY AND DESIGN OF THE STUDY

This chapter presents the procedure of subject selection, developing measurement instruments, data collection and data analysis.

Method

This study was aimed at examining the psychological, social and behavioral problems of orphans, resulted from death of parents due to HIV /AIDS. To see whether there is significant difference among orphans a qualitative and a quantitative approaches were used.

Population

The target population of the study was consisted of orphans of the SOS children's village in BahirDar. The site was selected for its importance that, the center focuses on vulnerable children especially of HIV orphans. For the purpose of the study orphans aged between 14-18 years were taken. A purposive sampling technique was employed. Accordingly, 45 orphans aged between 14-18 were selected. To counter check the data collected from the questionnaire, the researcher raised questions in the form of interview.

Table 1 Below Shows the Number of Participants with Mean and Standard Deviations of their Ages.

Participants	Sex	No	Mean Age	SD
Orphans	M	22	16.04	13.2
	F	23	16.6	18
Caregivers	M	10	33	19.5
	F	8	29.3	17.2

Instruments

Towards the beginning of the scale a questionnaire was included to collect the personal data of the orphans, the questionnaire part contain three divisions:

A. The first section contains 50 items in the form of statements reflecting the psychological problems of orphans. The questions were suppose to cover; orphans perception of themselves, psychological distress, depression, anxiety, feeling of distress, reaction with one self, one's ability to achieve a desired out comes and behavioral expressions of anxiety or emotions: nervousness, tension, worry.

B. The second part contains 50 items; which assess orphans self-perceptions regarding their social experiences. Some of the component items are covered as peer relations, sociability, perceptions of their social competence, intimacy or friendship, shyness, and feeling of

dissatisfactions with peer relation, tension and distress provoked by social encounters and on a desire to escape from such situations social competence, loneliness, and social dissatisfactions.

C. The third part contains 48 items, regarding orphans self-perceptions of their behavioral experiences. Some of the items described were disruptive behavior, aggressive behavior, withdrawing, lack of motivation and interest, and usually lies to avoid punishment.

A total of 148 items were prepared. Towards the end of each section a response category (namely Never, Occasionally, sometimes Disagree, Strongly Disagree) was included. The second instrument was interview, which contained structured and semi- structured questions .The researcher has tried to interview some of caregivers and principals. Besides, informal talks were held to supplement the data.

Regarding tool development, the items reflect both negative and positive statements, developed from literature review.

The following were stages of tool development:

A. After extensive reading of literature, questions were prepared in English and given to the academic advisor to make the necessary corrections and approval

B. The questions were translated in to Amharic both by the researcher and a literature masters student to counter checks one another.

C. All the necessary thematic and grammatical inspections and corrections were made

D. To see the correct translations, the amharic version of the instrument was given to an English expert to translate it back to English.

E .At the end, taking all corrections from academic advisor, literature student, and language expert, the researcher made appropriate modifications on the instrument.

The Pilot Study

To establish final version of the tool, a pilot study was conducted .The total participants in the try out were, 15 orphans and caregiver. After administering the instrument, some of the participants were requested for feedback and hence unclear items were modified and accordingly to minimize misunderstanding and ambiguity. Further more, some items were still modified.

Procedures

To the knowledge of the researcher, there was smooth relation with principals, caregivers, and orphans, although some orphans declined to participate, to achieve the purpose of the study.

The initial step was explaining the objective of the study and ensuring transparency, written brief was given to them. The questionnaires had three parts, and it was administered in the following ways:

In the first section, a psychological measure containing 50 items were distributed to 45 orphans and collected after a week. The second, social and behavioral measures were administered with in the interval of a week. All questionnaires were collected with in 21 –22 days, although some orphans with unknown reasons left to answer some of the items. In all cases the Amharic version was used.

Data Analysis

To examine the psychological, social and behavioral development of orphans' appropriate statistics were employed. After collecting the data the responses were coded, the results of each section were tabulated, summed up and treated using statistical analysis such as mean, percentage, and standard deviations. More over, rating scale, t- test. ANOVA, Tukey methods were used to see whether there are significant differences between paternal, maternal and double orphans on measured dimensions. Furthermore, samples were divided into various groups and compared using t – test.

In the second section qualitative data was used from interview (structured and semi- structured), formal and informal talks, and data from the institution.

CHAPTER FOUR

4. Results and Discussion

In an attempt to examine the psychological, social and behavior problems of institutionalized orphans 148 items with five-point response category was administered on a total of 45 (22 male and 23 female) participants. Out of these 15, for each group were paternal, maternal and double orphans. In addition 15 caregivers and three principals were participated in the interview session.

Demographic/ Background Information

Table 1. Sex, Age of Admission, and Duration of Stay of Institutionalized Orphans.

Demographic variables	Paternal orphans		Maternal orphans		Double orphans		Total		
Sex	N	%	N	%	N	%	N	%	%
	Male	7	46.7	8	53.3	7	46.7	22	100
	Female	8	53.3	7	46.7	8	53.3	23	100
	Total	15	100	15	100	15	100	45	100
Duration of stay	2-4 years	4	26.7	5	33.3	3	20	12	26.7
	5-years	11	73.3	10	66.7	12	80	33	73.3
	Total	15	100	15	100	15	100	15	100
Age of admission	7-9 years	9	60	10	66.7	11	73.3	30	66.6
	10-12 years	6	40	5	33.3	4	26.7	15	33.4
	Total	15	100	15	100	15	100	15	100

As indicated in table above, 48.9% of the orphans were females where as 51.1% of the orphans were males. The age of both orphans' ranges from 14-18 years .66.6% of the sampled respondents, their age of admission ranges between 7-9 years while 33.4% ranges 10-12 years. On

the other hand 26.7 % of the respondents their duration of stay ranges 2-4 and 73.3 % ranges 5-years.

Table 2 Mean and Standard Deviations of Orphans

Type of orphans	Category	Psychological	Social	Behavioral
Paternal	Mean	122	121.8	107.6
	Std. Dev.	14.7	12.6	11.7
	N	15	15	15
Maternal	Mean	107.2	114.5	93.2
	Std.Dev.	12.5	10.3	14.2
	N	15	15	15
Double	Mean.	83.2	105.2	70.8
	Std. Dev.	10.7	8.6	9.6
	N	15	15	15

The psychosocial and behavioral development of institutionalized orphans were determined by sum of individuals means score values. Those individuals with mean score value greater or equal to 150 for psychological and social measures, were considered as having better development, and those with mean score value of less than 150 were considered as having difficulty in their psychological and social development. Like wise, those with mean scores of equal or greater with 144, or less 144 were considered as having better and difficulty in their behavioral development respectively.

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	N	15	15	15
Double	Mean.	83.2	105.2	70.8
	Std. Dev.	10.7	8.6	9.6
	N	15	15	15

The psychosocial and behavioral development of institutionalized orphans were determined by sum of individuals means score values. Those individuals with mean score value greater or equal to 150 for psychological and social measures, were considered as having better development, and those with mean score value of less than 150 were considered as having difficulty in their psychological and social development. Like wise, those with mean scores of equal or greater with 144, or less 144 were considered as having better and difficulty in their behavioral development respectively.

The result indicates that paternal, maternal and double orphans have mean score values of (1348, 1138), (108.4, 114.7), (103.6, 98.4) for psychological, social and behavioral development. This means that the mean scored by both parental, material and double orphans were below the neutral value and this consequently indicates that both orphans have difficulty in their psychological, social and behavioral development

Results of the Psychological, Social and Behavioral Problems of Orphans.

On the basis of orphan's responses to each item, means and standard deviations were computed in order to describe the position of the participants. Consequently, the mean difference on orphans' variables using a t-test and analysis of variance, ANOVA, were computed. More specifically, mean difference on sex and parental loss effects were computed. Besides, age of admission and duration of stay were described by using a rating scale.

Table 3 Sex Difference and Psychological Problems of Orphans

Sex	N	Mean	SD	t	df
Male	22	128.7	9.46	2.34*	43
Female	23	121	12.38		

* Significant at 0.05

As indicated in table, the mean scores of male and female orphans are 128.7 and 121 respectively with standard deviation of 9.46 and 12.38 respectively. The observed t- value is 2.34, which was statistically

significant. Hence, female orphans showed higher psychological problems than male orphans.

Table 4 Sex Difference and Social Problems of Orphans

Sex	N	Mean	SD	t	df
Male	22	121.3	7.54	0.793*	43
Female	23	132.47	15.5		

* Not significant at 0.05

As seen in table, the mean scores of male and female orphans are 121.3 and 132.47 respectively with standard deviation of 7.54 and 15.5 respectively. The observed t- value is 0.793, which was not statistically significant. Hence, sex may not act as a variable for the social problems of orphans in the institution.

Table 5 Sex Difference and Behavioral Problems of Orphans

Sex	N	Mean	SD	t	df
Male	22	126.3	13.2	3.59*	43
Female	23	118.8	13.85		

*Significant at 0.05

As indicated in table, the mean scores of male and female orphans are 128.7 and 121 respectively with standard deviation of 9.46 and 12.38 respectively. The observed t- value is 2.34, which was statistically significant. Hence, female orphans showed higher psychological problems than male orphans.

Table 6 The Mean Scores of Psychological Problems of Orphans in Relation to Ages of Admission and Duration of stay

Variables	Category	paternal	maternal	double
Age of admission	7-9	107.2	105.6	78
	10-12	132	110.6	97.7
Duration of stay	2-4	100	84.8	67.4
	5-7	130	118.5	87.3

As indicated in the table, the mean scores of orphans whose ages of admission 7-9 and 10-12 were 107.2 and 132 for paternal, 105.6 and 110.6 for maternal, and 78 and 97.7 for double orphans respectively. In both cases the mean values were below the expected or neutral values. Hence, orphans showed problems in relation to their ages of admission. On the other hand, orphans joined the institution early showed higher problems than orphans joined the institution in their late ages.

Regarding about their duration of stay, those stayed between 2-4 and 5-7 had mean scores of 100,132 for paternal, 84.8,118.5 for maternal and 67.4, 87.3 for double orphans respectively. In both cases the mean scores again were below the expected values. Hence, orphans showed problems in relation to their duration of stay. On the other hand, orphans who had short duration of stay in the institution showed higher problems than orphans stayed for longer periods.

Table 7 Social and Behavioral Problems of Paternal Orphans in Relation to Ages of Admission

Social						Behavioral				
Rating Scale	7-9	%	10-12	%	Total	7-9	%	10-12	%	Total
Never	7	14	12	24	19	4	8	6	12	10
Occasionally	5	10	9	18	14	7	14	6	12	13
Sometimes	4	8	3	4	7	1	2	5	10	6
Frequently	21	42	16	32	37	33	66	21	42	54
Always	13	26	10	20	23	5	10	12	24	17

As indicated in the table, 37 % of the orphans showed frequent social problems in the institution. On the other hand, the majority (42 %) of respondents who joined the institution in the age range between 7-9 disclosed they had frequent social problems and 26% of the orphans responded always they had social problems.

Concerning the behavioral problems of orphans, the majority 54% responded they had frequent behavioral problems. However, age of admission may not be an important factor to influence the social and behavioral development of orphans. That is, orphans joined early 7-9 and lately 10-12 showed frequent behavioral problems.

Table 8 Social and Behavioral Problems of Maternal Orphans in Relation to Ages of Admission

Social						Behavioral				
Rating Scale	7-9	%	10-12	%	Total	7-9	%	10-12	%	Total
Never	7	14	4	8	11	6	12	10	20	16
Occasionally	1	2	13	26	14	-	-	6	12	6
Sometimes	10	20	19	38	29	13	26	20	40	33
Frequently	23	46	11	22	34	9	18	7	14	16
Always	9	18	3	6	12	21	42	7	14	28

Table 8 displays, the majority (34%) of the maternal orphans had frequent social problems while maternal orphans joined the institution in their late ages (10-12) had better social development as compared to orphans joined in their early ages.

As to the behavior of orphans, it seems that maternal orphans were less affected in their behavioral development. 33 % of them reacted sometimes they showed behavioral problems. On the other hand, 42 % maternal orphans in the age rage between 7-9 showed always-behavioral problems.

Table 9 Social and Behavioral Problems of Double Orphans in Relation to Ages of Admission

Social						Behavioral				
Rating Scale	7-9	%	10-12	%	Total	7-9	%	10-12	%	Total
Never	4	8	12	24	16	3	6	1	2	4
Occasionally	1	2	14	28	15	5	10	21	42	26
Sometimes	29	58	10	20	39	-	-	12	24	12
Frequently	6	12	11	22	17	31	62	9	18	40
Always	8	16	3	6	11	11	22	7	14	18

The social development of double orphans, the majority (39 %) said sometimes they showed social problems while double orphans joined the institution in later ages had better social development as compared to orphans joined in their early ages.

The majority (40 %) of the respondents indicated they had frequent behavioral problems. 62 % and 42 % of double orphans who joined the institution between 7-9 and 10-12 showed frequent and occasional behavioral problems respectively. It may be interpreted as double orphan's behavioral development could be influenced by their ages of admission.

Table 10 Social and Behavioral Problems of Paternal Orphans in Relation their Duration of stay.

Social						Behavioral				
Rating Scale	2-4	%	5-7	%	Total	2-4	%	5-7	%	Total
Never	3	6	9	18	12	5	10	11	22	16
Occasionally	-	-	5	10	5	12	24	9	18	21
Sometimes	7	14	6	12	13	3	6	7	14	10
Frequently	21	42	5	10	26	27	54	9	18	36
Always	19	38	25	50	44	3	6	15	30	18

As table 10 displays, the majority (44%) of paternal orphans had serious social problems in relation to their duration of stay. Both orphans who joined early and lately showed higher social problems .It might be said that duration of stay could not influence the social development of paternal orphans.

The majority of the paternal orphans (36 %) said, they had frequent behavioral problems. On the other hand, 54 % and 30 % of orphans whose duration of stay between 2-4 and 7-9 showed frequent and always behavioral problems respectively. It may be argued that duration of stay was one of the important variables, which predict the behavioral development of orphans.

Table 11 Social and Behavioral Problems of Maternal Orphans in Relation to their Duration of Stay.

Social						Behavioral				
Rating Scale	2-4	%	5-7	%	Total	2-4	%	5-7	%	Total
Never	12	24	9	18	21	2	4	5	10	8
Occasionally	4	8	11	22	15	11	22	9	18	20
Sometimes	11	22	19	38	30	1	2	10	20	11
Frequently	20	40	2	4	22	27	54	18	36	45
Always	3	6	9	18	12	9	18	8	16	17

From the table above, 40% and 38 % of the maternal orphans whose duration of stay between 2-4 and 5-7 responded they showed frequent and some times social problems respectively, which means orphans who had short duration of stay had difficulty in their social development

54 % and 36 % were responded for behavioral developmental problems of maternal orphans respectively for 2-4 and 5-7 years duration of stay as having frequent problems. On the other hand, orphans who had sort duration of stay showed higher behavioral developmental problems.

Table 12 Social and Behavioral Problems of Double Orphans in Relation to their Duration of stay

Social						Behavioral				
Rating Scale	2-4	%	5-7	%	Total	2-4	%	5-7	%	Total
Never	11	22	7	14	18	8	16	3	6	11
Occasionally	9	18	6	12	15	10	20	9	18	19
Sometimes	24	46	21	42	45	6	12	18	36	24
Frequently	4	8	13	26	12	12	24	15	30	27
Always	2	4	3	6	5	14	28	5	10	19

Both double orphans whose duration of stay between 2-4 (46 %) and 5-7 (42 %) showed as having behavioral problems sometimes. However, double orphans who had more duration of stay showed higher social problems.

Concerning about the behavioral problems of double orphans 28 % and 36 % were responded for 2-4 and 5-7 duration of stay as having behavioral problems always and some times respectively. It may be interpreted as orphans who had short duration of stay were more affected than orphans stayed relatively for longer periods.

Table. 13 Analyses of Variances (ANOVA) – Psychological Problems of Paternal, Maternal and Double orphans

Source	Ss	df	Ms	F
Between groups	5835.6	2	2917.8	44.65*
With in groups	2744.4	42	65.34	

*Significant at 0.05

As table 11 displays the F- valve at F (2,45) is 44.65, which is significant at 0.05 level hence, there is variation in the psychological developmental problems between paternal, maternal and double orphans.

Table 14 Analysis of Variance (ANOVA) Social Development of Paternal, Maternal and Double orphans

Source	SS	Df	Ms	F
Between groups	3058.95	2	3058.95	18.39*
With in groups	3992.9	42	83.16	

*Significant at 0.05

As the above table shows, the F-valve F (2.42) is 18.39, which is significant at 0.05 level. Therefore, there is a variation in social developmental problems between parental, material and double orphans.

Table 15: Analysis of variances (ANOVA) Behavioral development of Paternal, Material and Double Orphans

Source	SS	Df	Ms	F
Between groups	2079.75	2	1039.87	8.26*
With in groups	5282.93	43	125.78	

*Significant at 0.05

As a table 13 shows the valve of F, (2,42) is 8.26 which is significant at 0.05 level Hence, there is variations at least in one of the groups: paternal material and double orphans.

Table 16 Comparing Mean Variations Using a Tukey Method

	X_1	X_2	X_3	Sx	q_{12}	q_{23}	q_{13}
Psychological	122	107.5	83.2	2.087	2.57*	2.587*	2.58*
Social	121.8	114.5	105.8	2.35	7.31*	2.12**	8.21*
Behavioral	107.6	93.2	70.8	2.89	2.84*	1.8**	5.64*

* q values are significant at 0.05 ** q values are not significant at 0.05

The value of q_{13} for psychological mean difference (X1 and X_3) is 2.58, which is significant at 0.05 level. Hence, $X_1 > X3$. Similarly, the value of q_{12} and q_{23} are 2.57 and 2.587 respectively, which are statistically significant. Therefore, $X_1 > X_2 > X_3$ with paternal, maternal and double orphans respectively. On the other hand, the value of q_{12}

and q_{13} for social development mean difference are 7.31 and 8.21 respectively which are statistically significant. Hence, $X_1 > X3$ and $X_1 > X2$. The q_{23} value is not statistically significant implies X_2 and X_3 had almost no mean variation. Similarly, the values of q_{12} and q_{13} for behavioral development mean variations are 2.84 and 5.64 respectively, which are significant at 0.05 level. Hence, $X_1 > X_3$, $X_1 > X_2$ but the value of q_{23} is not significant implies X_2 and X_3 did not have mean variation .

Data Obtained from Interview

As indicated earlier, our respondents were orphans and caregivers. To supplement and validate the data gathered from questionnaires, structured and semi-structured interviews were held with orphan caregivers.

Initially I asked the principle of the center about the objective of the center, he forwarded one of the main objective is to help the vulnerable children especially of HIV/AIDS orphans, in a way to prevent and control HIV/AIDS. Besides, to rehabilitate economically, psychologically, socially and behaviorally, so that children lost their parents would have better future and development.

For the question, what mechanisms do you use to solve the psychological, social and behavioral problems of HIV/AIDS orphans, the principal reacted again, our main goal is providing their basic daily needs

such as food, shelter, clothe. (almost all of the caregivers interviewed responded similarly). However, the center is trying to solve the above-mentioned problems. For example, giving additional trainings for caregivers, creating relations with different organizations such as EOCAPP (Ethiopian Orthodox Church AIDS Prevention Program), and employing councilors.

I asked a similar question to the psychologist in the center what psychological, social and behavioral problems do you noticed? He said that some orphans before they joined to the center caring for sick parents place a heavy emotional burden, when they came in the center they not only witness the illness and death of their parents, but also suffer the stigmatization, and neglect based on their parents death by AIDS, although such problems are decreasing with an encouraging future.

The psychologist further added, discrimination and neglect of orphans causes, them to act anti-social behaviors this may be because they were frustrated easily and as means to relieve from their stress usually involve in such behaviors. Adding the fact, orphans in the center faced difficulty in expressing themselves and in making friends this was especially true in outside of their institution. Partly this is because they are afraid of the stigma and tend to isolate themselves (voluntary withdrawal from social interactions) and partly because others isolate

them. Above all, leveling orphans by the community as AIDS orphans aggravate their psychological problems.

The caregivers were asked about the psychological, social and behavioral problems of the orphans most of them had the following idea, regarding social relations they were treated badly by classmates, peers even teachers this may be because of the false assumption that orphans were considered as disobedient, according to some caregiver's response. They added, it seems that orphans accepted the norms and values that level them as having negative characteristics, which affect there over all development.

Furthermore, caregivers were asked their role in coping the problems, as the psychologist described above caregivers responded most of us are here to give services of their daily needs and helping them to accept their reality of death of their parents. Even some said that they are working as a means of income earning which reflects they never treat them properly.

Regarding the question about the reaction of the community towards AIDS orphans the society had mixed feelings about them. Some of them were believed that they were like parents have HIV in their blood. Some of them were believed that the children might get HIV from their mothers as a result, they discriminate or isolate them (avoiding relations)

are not volunteer to help and cooperate them. In spite of these, however, attitude of the society are changing rapidly.

Finally they were asked the challenges, development and coping mechanisms to solve the problems?

They reported usually they get support from the SOS children's village in different branches of the country. Ethiopian Orthodox Church Development and Inter Church AID Commission at Bahirdar branch and from other volunteers. It is difficult to see the changes acquired by orphans but the majority of the orphans show running away, crying, shouting, trying to attack other children; and voluntary isolation are observed.

Discussion

In this section, major findings of the present study would be discussed in line with the main research questions raised

The psychological, social and Behavioral Problems of Orphans

The psychosocial and behavioral problems of orphans were determined by individuals means score values. Accordingly from the responses to statements, individuals mean score was computed. Those individuals with mean score value of greater or equal 150 (for psychological and social measures) and 144. (for behavioral Measures) were considered as having better development, and those with mean score value of less than 150 and 144 respectively for psychological ,social

and behavioral measures were considered as having problems in their development.

The result indicates that orphans have mean scores 122, 121.5, and 107.6 for paternal, 107.2,114.5 and 93.2 for maternal and 83.2, 105.2 and 70.8 for double orphans respectively for psychological, social and behavioral developmental problems of orphans. This means that the mean scored in both the three cases were below the neutral value and this consequently indicates that orphans in the institution have development problems.

In this regard pouter, 1997 pointed out that, children who had lost one or both parents and living in the institutions were significantly more likely to be unhappy and worry about many things than living with both parents, even if the parents are in well.

Altshuler and Poertner (2002) conclude youth living in institutions take more risks, have more threats to achievement and have poorer peer influences. Another study by youngleston (1973) revealed that institutionalized children are less well adjusted and that they manifest less self-esteem compared to control group.

It is worth mentioning that, caregivers have taken short-term workshops or seminars even some of them haven't received any training.

Therefore if the caregivers are not skilled, they may not fulfill the demands of the orphans.

This idea was emphasized by Tsegaye (2001) institutional life characterized by lack of psychosocial services, shortage of trained personnel as well as lack of long-term strategic planning and lack of adult guidance. As a result of theses and other problems, the children in the institution often elicit the following behaviors feeling of inferiority, depression, anxiety, feeling of loneliness, and hopelessness.

Anthony (2001) further pointed that residential care (as the SOS children's village) is the least desirable options for orphans care it is an option of last resort when there is no better placement option is found.

Is there any sex difference on the psychological, social and behavioral development among the institutionalized orphans?

As indicated in table 3-an attempt was made to compare sex difference towards the psychological, social and behavioral development of orphans by using a t-test as a statistical model. The mean scores of male and female orphans found to be 128.7 and 121 respectively with standard deviations of 9.46 and 12.38 respectively. The observed t-valve is 2.34, which was significant at 0.05 level. Hence, there is statistically significant difference in psychological development. Similarly, the mean scores of male and female on their social problems are 121.3 and 132-47 respectively with standard deviations of 7.54 and 15.5 respectively. The

observed t-valve is 0.793, which is not significant at 0.05 level. Hence, there is no statistically significant difference between male and female orphans.

On the other hand, the mean scores of male and female in their behavioral problems are 126.3 and 111.8 respectively. The observed t-value was 3-59, which was significant at 0.05 level. Hence, there is statistically significant difference between male and female in their behavioral problems.

Regarding the above issue one study explained the effects of orphanage differ across boys and girls there is a presumption in much of the literature that female orphans are at a disadvantage. The present study seems consistent with this studying in relation to maternal orphans this is because as explained above, female maternal orphans showed problems in their psychological, social and behavioral development, but it is inconsistence regarding paternal and double orphans. This is because the present study showed male paternal and double orphans were more affected with the loss of a parent. MLOSA (2003) said there is no statistically significant difference between male and female orphans in their social development levels. Which is inconsistent with the present study.

Kaffaman and Elizur (1979) found more behavioral development difficulties in boys than girls through out their follow-up which appears to be consistent with the present study.

The Mean Values of Orphans Psychological Problems in Relation to their Ages of Admission and Duration of Stay.

The mean scores of orphans whose ages of admission 7-9 and 10-12 were 107.2 and 132 for paternal, 105.6 and 110.6 for maternal, and 78 and 97.7 for double orphans respectively. In both cases the mean values were below the expected or neutral value. Hence, orphans showed problems in relation to their ages of admission. On the other hand orphans joined the institution early showed higher problems than orphans joined the institution in their late ages.

Regarding about their duration of stay, those stayed between 2-4 and 5-7 had mean scores of 100,132 for paternal, 84.8,118.5 for maternal and 67.4, 87.3 for double orphans respectively. In both cases the mean scores were below the expected values. Hence, orphans showed problems in relation to their duration of stay. On the other hand, orphans who had short duration of stay showed higher developmental problems.

Arnold (1990) described that the stress of loss is greater for younger child who has a limited ability to test reality of life. This argument seems to have been similar to the present study. This is because orphans joined the institution in their early ages showed higher problems than who admitted in the later ages.

Social and Behavioral Problems of Orphans in Relation to Ages of Admission and Duration of Stay

The majority (37 %) of the paternal orphans showed frequent social problems in the institution. On the other hand, 42% and 26 % of respondents who joined the institution in the age range between 7-9 showed frequent and always social problems respectively.

Concerning the behavioral problems of orphans, the majority 54% responded they had frequent behavioral problems. However, age of admission may not be an important factor to influence the social and behavioral development of orphans. That is, orphans joined early 7-9 and lately 10-12 showed frequent behavioral problems.

From the above findings one can say that the death of a father in the early years of ages had impacts on inter personal relationships , however, age of admission may not have an impact on the behavioral development.

Arnold (1990) said the age at which the child is separated from the father appears to be important. Boys who are separated from their father early are likely to score lower than those who are separated later .The argument seems consistence with the present study.

On the other hand, the majority (34%) of the maternal orphans had frequent social problems while maternal orphans joined the institution in

their late ages (10-12) had better social development as compared to orphans joined in their early ages.

As to the behavior of orphans, it seems that maternal orphans were less affected in their behavioral development. 33 % of them reacted some times they showed behavioral problems. On the other hand, maternal orphans in the age rage between 7-9 showed always (42%) behavioral problems. This result may be interpreted as, although maternal orphans were less affected in their behavioral development, maternal orphans who had the age of admission between 7-9 showed behavioral development difficulties as compared to orphans who had the ages of admission between 10-12 years.

The social development of double orphans, the majority (39 %) said sometimes they showed social problems while double orphans joined the institution in later ages had better social development as compared to orphans joined in their early ages.

The majority (40 %) of the respondents indicated they had frequent behavioral problems. 62 % and 42 % of double orphans who joined the institution between 7-9 and 10-12 showed frequent and occasional behavioral problems respectively. It may be interpreted as double orphan's behavioral development could be influenced by their ages of admission.

Orphans Developmental problems in relation to their Duration of stay.

As table explained, the majority (44%) of paternal orphans had serious social problems in relation to their duration of stay. Both orphans who joined early and lately showed higher social problems .It might be said that duration of stay could not influence the social development of paternal orphans.

The majority of the paternal orphans (36 %) said, they had frequent behavioral problems. On the other hand 54 % and 30 % of orphans whose duration of stay between 2-4 and 7-9 showed frequent and always behavioral problems respectively. It may be argued that duration of stay was one of the important variables, which predict the behavioral development of orphans. This finding seems to contradict with the notion of institution. This is because orphans stayed in the institution for relatively for longer periods showed developmental problems than orphans stayed for short periods.

40% and 38 % of the maternal orphans whose duration of stay between 2-4 and 5-7 responded they showed frequent and some times social problems respectively, which means orphans who had short duration of stay had difficulty in their social development.

54 % and 36 % were responded for behavioral development of maternal orphans respectively for 2-4 and 5-7 duration of stay as having frequent problems. On the other hand maternal orphans unlike paternal orphans, who had short duration of stay showed higher behavioral developmental problems.

Both double orphans whose duration of stay between 2-4 (46 %) and 5-7 (42 %) showed as having behavioral problems some times. However, double orphans who had more duration of stay showed higher social problems.

Concerning about the behavioral problems of double orphans 28 % and 36 % were responded for 2-4 and 5-7 duration of stay as having behavioral problems always and some times respectively. It may be interpreted as orphans who had short duration of stay were more affected than orphans stayed relatively for longer period

This findings seems consistent with the previous studies the youngest age group of orphans is most sensitive to the orphan problems, because many of them are double orphans and less aware of what is what is happening to them and both of them lack parental care, on the other hand, the oldest ones are the least affected by orphan problems since they can adjust more easily to the care by non-parents than do younger children. Arnold (1990) added, those children who experience insufficient parenting or cares are at a greater risk of disorders in adulthood.

Children who experience a lack of parental caring in the early years are ore apt to have emotional reactions in later life and to use defense maneuvers to prefect themselves against stress (the stress of loss is greater for the younger child, who has a limited ability to test reality and to overcome anxiety and dependence on the adult this can result in behavior difficulties later)

Hence, one may say that the ages of admission to the institution had an effect on the psychological social and behavioral development. That is those joined the institution early (7-9 in our case) showed psychological and behavioral development problems

Comparing Paternal, Maternal, and Double Orphans on their Psychological, Social and Behavioral Development.

The psychological social and behavioral development variations among paternal maternal and double orphans were compute with ANOVA and Tukey methods (to compare the extent of variations)

Accordingly, the psychological development of parental, maternal and double orphan was computed with F-value at F (2,42) was 44.6 which is significant at 0.05 level. Hence, there are variations in the three types of orphans on their psychological development. It might be interpreted as; orphans depending on the type of loss they had developmental variations in the institution. And to see extent of variation Turkey was computed, hence q_{13} of X_1 and X_3 with standard error Sx was 12.649 which is significant at 0.05 implies $X_1 > X_3$. Again q_{23} value with X_2 and X_3 was

2.587 which is significant at 0.05 level, implies $X_2 > X_3$. Lastly, X_1 and X_3 was computed and q_{12} value was 10.06 which is significant at 0.05 level implies $X_1 > X_2$. Therefore, One may conclude that double, maternal and paternal orphans had higher to lower psychological development respectively

The social development variation was also computed on the types of orphans. The F-valve at F (2.42) was 18:39, which was significant at 0.05, level hence; there were variation in social development.

To compare their difference Tukey (q-value) was computed. Accordingly q values 8.21, 2.12, and 7.31, which are significant at 0.05 level. Hence $X_1 > X_2 > X_3$. In other works like psychological development, social development paternal, material and double orphans showed from lowest to highest social development respectively.

Similarity, behavioral development variations with in the types of orphans was computed. The F-value at F (2,42) was 8.26 which was significant at 0 .05 level implies there are variations in behavioral development

The q of values were 5.64 , 1.8, and 3.84 which were significant at 0.05 hence the of value for q_{23} was 1.8 which not significant either 0.01 or 0.05 levels. The value for x_1, x_2 and sx was 3.84 which was significant at 0.05 level hence $x_1 > x_2$ therefore, one may say that as psychological and social development paternal orphans too also less affected than material and double orphans.

Arnold (1990) argues that of all life stressors a child might experience, the death of a parent seems most devastating, the loss least reparable, and the potential for harmful psychological consequences greatest. Further he added fathers are valued as less vital in parenting and therefore less value in attached to their role as parents the present findings seems to be consistent that paternal orphans were less affected than other types this may be because, the core problem is that, men have the few role in the family life which restricts their personality the father for instance, has usually been considered the bread winner, spending less time in the home, and taking less responsibility for child care.

On the other way, the death of a mother may leave children especially vulnerable, even among those who continue to live with their father and who experience no reduction in income. Moreover, Mothers are generally the gatekeepers for their children's health investment (Case and Paxon 2001).

L. Johnson and R. Dorrington (2001) added to the above fact a loss of mother their young age may have the longest effects on childr

Chapter Five

Summary conclusion and Recommendations

The objective of the present study was to examine the psychosocial and behavioral development of institutionalized orphans and the problems they encounter during their stay in the institution. Accordingly, 45 institutionalized orphans 15 caregivers and 3 principals were surveyed. In an attempt to investigate the effects of parental deaths as a result of AIDS on psychological, social and behavioral developmental problems, rating scales were used and comparison was made based on age of admission, sex, duration of stay and the type of parental loss.

To determine HIV/AIDS orphans development t- test was employed for the above variables. Besides, analysis of variance (ANOVA) was used to see the variations of paternal, maternal and double orphans, Tukey (the studentized range statistic: q) was also applied to compare the mean differences of the three groups and finally to describe the position of orphans rating scale was also employed.

Hence, from the out comes of the present study and the foregoing analysis the following conclusions were made:

CONCLUSIONS

1. The psychological, social, and behavioral development mean scores were below the neutral or expected means. Thus, orphans have Psychological, social and behavioral developmental problems.

The possible reasons could be lack of appropriate care replacing biological parents, the nature of death of their parents, society's negative attitude towards orphans, stigma and discrimination, lack of psychological, social and behavioral support.

2. There is significant difference in psychological, social and behavioral development between male and female paternal, maternal and double orphans. Therefore, it may be said that male paternal orphans, female maternal orphans, double male orphans, have psychological, social and behavioral developmental problems.

3. Age of admission to the institution was one of the most important variables, which predict the social and behavioral development of orphans hence; most orphans joined the institution in their early age showed higher developmental problems

4. Results showed that double orphans were more affected in their development than maternal and paternal orphans.

5. Support or care for orphans in the institution focused on material provisions

6. The community had negative reaction due to the assumption that either orphans like their parents have HIV or orphans might get HIV from their parents.

7 . It seems that orphans accepted the norms and values that level them as having negative characteristics.

8 There is statistically significant difference in psychological, social and behavioral development of paternal, maternal, and double orphans. From the analysis of variance, it is possible to say that double orphans have the highest psychological, social and behavioral development problems while paternal orphans have the least development difficulties in the institution.

In general, issues about the orphans are not new. The psychological, social and behavioral development of orphans as well as stressors of their life can be observed in the research literature. However, the comparison in their age of admission, duration of stay, sex difference and the types of orphans, to the knowledge of the researcher, are relatively new perspective.

RECOMMENDATIONS

The psychological, social and behavioral development of institutionalized orphans were not encouraging, therefore, effective measures need to be taken to tackle the prevailing problems. Based on the findings and conclusion drawn, the following recommendations were made

a) As the number of children orphaned by AIDS increasing at an alarming rate, providing them with care and protection is an increasing national and global concern. So further research should be made to identify children who are at particular risk of

psychological, social and behavioral developmental problems and intervention efforts for them.

b) Strengthening the protection and care of AIDS orphans with community, government as well as non-governmental organizations (as SOS children's village).

c) Emphasis has to be given most on material provisions but equivalently psychological, social, and behavioral needs must be met. Caregivers and communities needs be trained on issues related to child development

d) Raising awareness among caregivers and community about the orphans is an effective way to avoid and provide psychological, social and behavioral support.

e). Organizations like SOS children's village that deal with care and support for orphans must give counseling service, which in away would help children to accept the realities of death.

f). Special attention should be given to all orphans in general and to double orphans in particular.

g). Provision of curly support for orphans and support to the family before the death of parents, is important to help orphans for better development and increase in coping skills with problem they face after the death of their parents.

h). Finally if children are to develop the resilience to deal with challenges in their lives, their psychological, social and behavioral needs must be received proper and prompt attention before and after the death of their parents.

References

Altshuler, S., and Poetner, J.(2002).The Child Health and Illness Profile – Adolescent Edition: Assessing well-being in Group Homes and Institutions. *Child Welfare.* 81(3), 495-515.

Anthony, L. (2001). Orphans and other Vulnerable Children what Role for Social Protection? The World Bank http:// www. World Bank org/ sp.

Alem Ezezew (2002). Problems of AIDS Orphan Female Students in some Selected Primary and Secondary High School in Addis Ababa. Addis Ababa (Unpublished)

Ayalew W/ Semaite (1993). Report on the Second African Conference on Child Abuse and Neglect. Cape Town

Bishai, H. (2005). The Condition of Orphans in the Sub –Saharan Africa: The case of 19-Countries. Uganda, Kampala.

Bowlby, J. (1952). Maternal Care and Mental Health. Geneva: World Health organization No 2.

Bowlby, J. (1965). Child Care and The Growth of Love (2nd ed.) London: The White Friars pres. Ltd

Case, A., (2003). "*Orphan in Africa.*" Center for Health and well-being, Research Program in Development Studies, Princeton University.

Case, Anne., Christian Paxson and Joseph Ableidinger. (2003) .The Education of African Orphans. Princeton; Center for Health and well being Research Program in development studies: Princeton University

Children on the Brink, (2004). A Joint US AID/ UNICEF / UNAIDs Report on Orphan Estimated and Program Strategies.

Conger, J, Jane way (1991). Adolescence and Youth: Psychological Development. In Changing World (4th ed.) Harper Collins Publisher.

CRC (1989). The UN Convention on The Rights of Children.

CSA (2003). Statistical Abstract Addis Ababa, Ethiopia.

Dane, B.O (1994). Death and Bereavement. AIDS and the Orphans: Coping with death. Westport, ct; Auburn House

Dane, B.O, (1997). Children *Affected by AIDS in Philippines.* Children in the Urban Environment: Linking Social Policy and Clinical Practice (PP. 175-190) spring field, IL: Charles Thomas

Deininger, K., (2002). "AIDS Included Orphans as Systematic Shock: Magnitude, Impact and Program Interventions in Africa. The World Bank

Elmore- Meegon, M., Convoy, R. and Tompkins, A. (1999). Kenya Orphans Comparison Study, presentation at the collaborative Symposium on AIDS Research. Nairobi

Emebet Mulugeta (2000). Some Problems and Coping Strategies of Female Students in Addis Ababa High Lights, Addis Ababa, (Unpublished).

FAO (1996). Food and Agriculture Organization, News and Highlights. http://www. FAO .Org/New

Forehand, R.,(2001). *An Investigation of Children who are HIV Infected.* The Family Health Project New Orleans.

Foster, G., (1996). " Supporting Children in Needs Through a Community- Based Orphan Visiting Program "AIDS Care, 8,389-403

Foster, G., (1997). Factors Leading to the Establishment of a Child – Headed HouseHold: The Case of Zimbabwe. *Health Transition Review*, supp, 7,155-168.

Foster, G., (1997). Perceptions of Children and Community Members Concerning the Circumstances of Orphans in Rural Zimbabwe. AIDS Care, 9,391-405:

German, S., Madorin, K, and Ncube, N. (2002). Psychological Support for Children Affected by AIDS. Practical Responses from Zimbabwe and Tanzania, New York UNICIF.

Giliborn, L. (2002). Strengthening HIV/AIDS Care and Support in the Home and Community. Kampala: Horizons.

Gordon, Chad., and Kenneth J.Gergen (1968). The Self in Social Interaction: Classic and Contemporary Perspectives New York: J. Wiley

Grainger, C., Douglas Webb and Lyn Elliott (2001). Children Affected by HIV/AIDS Rights in the Developing World. London: Save The Children

Gust, E. (2001). Children of AIDS: Africa's Orphan Crisis; London: Pluto Press.

ICRW (2003). International Center for Research on Women Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia.

ICRW (2005) Common at its Core: HIV –Related Stigma Across Contexts.

International HIV / AIDS Alliance, (2003). Psychosocial Support. Building Blocks: Africa-Wide Briefing Notes, 3, 1-24.

Kalandi, S. (2003). Orphan in Sub-Saharan Countries: *A Frame Work for Public Action Region Human Development.*

Levine, C., and Foster, G. (2000). The white Oak Report: Building International Support for children Affected by AIDS, The Orphans project.

http://www.aidsinfonyc.org/orphan/UNAIDS/.

Mac Lead, H., (2001), Residential Care. In Orphans and other Vulnerable Children: What role for social protection? Proceedings for world bank/ world Vision conference, June 6-12, 2001 Ed.A. Levine

Makame, V., and Grantham. Mc Gregor, S. (2002). Psychological Well-Being of Orphans in Dare Salaam, Tanzania Center for International Child Health in *Actapaediatrica,* 91,4,459-464.

Matshalage, N and Powell, G. (2002). Mass Orphan hood in the Era of HIV/AIDS Zimbabwe: Institute of Development Studies, University of Zimbabwe.

Max Essex., (2002). AIDS in Africa. New York, Plenum Publishing Second Edition.

Ministry of Health (2002). AIDS in Ethiopia Fourth Edition. Addis Ababa; Disease Prevention and Control Department.

Ministry of labor and Social Affairs. (2004). Ethiopia's National Plan of Action for Children (2003-2010 and Beyond) Addition: Ethiopia

Minty, B. (1987). Child Care and Adult Crime Manchester. Manchester University Press.

MOLSA; Italian Cooperation and UNICEF (2003) Survey on the Prevalence and Characteristics of AIDS Orphans in Ethiopia, Addis Ababa

Mukoyogo, M. and Williams, G. (1991). AIDS Orphans. A community perspective from Tanzania. Network UNICEF.

Piaget, J. (1972). International Environment from Adolescence to Adult hood. Human Development 15,1-12.

Poulter, C. (1997). Vulnerable Children A Psychological Perspective of Children in Urban Lusaka.

Poulter, C. (1998). A Psychological and Physical Needs Profile of Families Living With HIV /AIDS in Lusaka. Lusaka: Family Health Trust.

Ross Kidd and Sue. (2003). Understanding and Challenging HIV Stigma.

Rutter, M. (1971). Parent Child Separation: Psychological Effects on Children Journal of Child Psychology and Psychiatry 12,pp.233-260

Rutter Mouinton, D and Liddle, C.(1993). Parenting in Two Generations in Families at risk, ed. Nmadge SSRC / DHSS Studies in Deprivation and Disadvantages, No 8. London, Heinemann Educational Books.

Save the Children (UK). The Role of Stigma and Discrimination in Increasing the Vulnerability of Children and Youth Infected with and Affected by HIV/AIDS, Research Report, Arcadia, South Africa, November 2001

Sengendo, J. and Nombi, S. (1997). The psychological Effect of Orphan hood: A Study Orphans in Rakai District in Uganda. Health Transitions Review, 7,Supp., 105-124.

Taylor, V., (1999*). HIV/ AIDS and Human Development South Africa.* UNDP and UN AIDS.

Tedla Diressie and Mesert Tadesse (2005). An assessment on the Situation of Ex-Institutionalized Children of Four Orphans Ethiopia Addis Ababa, Ethiopia Network for Orphans and Vulnerable Children, Jerusalem Association Children's Homes and pack-Ethiopia.

Tilahun Chernet, (2001). "Over View of Service for Orphans and Vulnerable Children in Ethiopia"

Tony Barnett and Allen white Side. (2002). AIDS in the 21st Century Disease and Globalization; Published by pal grave Mc Cmillan, Great Britain.

Tsegaye Chernet (2001). Overview of Services for Orphans and Vulnerable Children in Ethiopia Prepared for a Work Shope held March 27-29, 2002, in Kigali, Hosted by the Ministry of Local Government and Social Affairs of the Republic of Rwanda.

UNAIDS (2002). A Conceptual Frame Work and Basis for Action: HIV/AID Stigma and Discrimination. Joint United Nations Program on HIV/AIDS

UNAIDS (2002). Children on the Bike. A Joint Report on Orphans Estimates and Program Strategies. Unpublished.

UNAIDS, UNICEF, USAID (2004). Children on the Brik. A Joint Report of New Orphans Estimates and a Framework for action

UN AIDS / UNICEF, Children Orphaned by AIDS; Front Line Responses from Eastern and Southern Africa, joint United Nations Program on HIV/AIDS and Untied. Nations Children's Fund, New York, December 1999

Velies, M.J.(1990) .Blossems in the Dust: Street Children in Africa. France:UNESCO.

WHO (2002). Community Home-Based Care in Resource Limited Setting. A Frame Work for Action Geneva World Health Organization

Williamson, J. (2000*). Finding away forward: Principles and Strategies to Reduce the Impacts of AIDS on Children and Families.* Cambridge University Press Cambridge

Wills, T.A. (1990). Social Support and the Family. In Blemmane (Ed). Emotion and the Family for Better or for Worse. New Jersy: Lawrence Eralbaum Associates Inc.

Appendix A

Assessment of Social Development of Institutionalized HIV Orphans

Instruction:

Each of the following statements express the experiences, feeling, 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 times**, **true sometimes**, **hardly true and not at all true**. Thus, for each item give your responses by making [√] on the space provided according to the above five point rating scale

Item No	Items	Always True	True most of the times	True some times	Hardly true	Not at all true
1	I feel I am socially passive					
2	I feel I am matured enough to accomplish things					
3	I feel I am cooperative with my friends					
4	I have low self-esteem					
5	I am shy with members of opposite sex					
	I find it hard creating relation in times of difficulties					
	I find it interesting the opportunity to mix socially with people					
	I feel tense when I am with people I don't know well					
	I like to spend my time with people					
0	I prefer working with others rather than alone					
	I feel I am active in social situations					

12	When talking to people I worry about saying some thing dumb					
13	When I feel sad I usually shout, fight, or intimidate to resolve conflicts					
14	I am rigid to accept others opinionated					
15	It is difficult for me to give constructive contributions during group activities					
16	I enjoy group activities					
17	I blame others for problems					
18	I would be un happy if I were prevented from making many social contacts					
19	I try to avid situations which forces me to be very sociable					
20	I feel often uncomfortable to mix with people during holidays.					
21	I often think up excuses in order to avoid social engagements					
22	I usually feel relaxed when I am with a group of people					
23	I feel I am selfish					
24	I don't want help from teachers or peers					
25	I have usually interest to participate in violence					
26	I don't show concern for others feeling and property					
27	I don't enjoy when I am in group					
28	I often find social occasions upsetting					
29	I try to avoid formal social occasions					
30	Teachers and friends give me the moral support I need					

31	I get much satisfaction from the group I attend					
32	My friends understand me as I want					
33	I feel relaxed whenever I come across social occasions					
34	My friends come to me for emotional support					
35	I have a deep sharing relationship with a number of friends					
36	I am not open with my friends					
37	I am suspicious of others					
38	It is easy for me to make new friends at school					
39	I am effective with group activities					
40	It is hard for me to make new friends					
41	I don't want to be with old people					
42	My friends don't like me					
43	I can find a friend when I need one					
44	I have no body to talk to					
45	I don't have any friends					
46	I display inappropriate humor					
47	I am good at working with other people					
48	I have trouble looking some one right in the age					
49	I don't find difficult to ask other people for information					
50	It is hard for me to create relation when I am meeting new people					

Assessment of Psychological Development of Institutionalized HIV Orphans.

Instruction. The following questions refer to the experiences that children have in their daily activities. You are asked to indicate, on a five point rating scale the extent of agreement between the feelings expressed in each item and its behavior. Mark [√] the point which best indicates your agreement

	Items	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	I am able to do the things as others can do					
2	I have wide mood change					
3	Often, I get depressed					
4	I have a positive attitude towards myself					
5	I feel that I have a number of good qualities					
6	I am inclined to feel that I am a failure					
7	I feel I don't have much to be proud of					
8	I feel that I am a person of worth, on an equal plane with others					
9	I am often anxious					
10	I am shy and timid					
11	I often seem over excitable					

12	On the whole I am satisfied with myself					
13	I am confident					
14	I feel as I have experienced some emotional loss					
15	I feel ineffective					
16	I am satisfied with my appearance					
17	My goals reflect my personality					
18	I feel as if I never actually attain my aspiration					
19	I feel incompetent when something bad happens to me					
20	I have certainly feel useless at times					
21	I have the energy to do the things I would like to do					
22	I wish I could have more respect for my self					
23	At times I think I am no good at all					
24	I never seem to have the motivation to do things I would like to do					
25	I don't seem to obtain gratification from any thing					
26	My sleep is rest less and disturbed					

27	I have a hopeless outlook on the world					
28	I see fulfillment of my aspiration as quite possible					
29	I feel inadequate					
30	I get what I want					
31	I am hopeful					
32	I worked under a great deal of strain					
33	I feel chronically frustrated in my personal life					
34	I see myself as less competent than I would like to be					
35	I actively pursue the goal which I have set for my self					
36	I often seem to lose my identity and purpose of existence					
37	When some thing good happens to me it is usually because I have worked for it					
38	I feel worrying and nervous					
39	Often I feel sick in the stomach					
40	I worry about what is going to happen					
41	My feelings get hurt easily					
42	I sweat very easily even on cool days					

43	I am usually calm					
44	I give up easily					
45	I have frequent headaches for which there is no reason					
46	When I try make something, every thing seems to go wrong					
47	I worry about when other people think about me					
48	I have bad dreams					
49	I always have enough energy when faced with difficulties					
50	I have many problems that causes me a great deal of worry					

Assessment of Behavioral Development of Institutionalized HIV Orphans

Instruction. Below are statements referring to the behavioral experiences that children have in their day-to-day activities. For each expression you have five alternatives on rating scale so you are requested to answer based on the extent of agreement between the described behaviors and your personal experiences. Mark [√] the point which best indicate your agreement.

	Items	Always	Frequently	Sometimes	Seldom	Never
1	I usually avoid doing work in class					
2	I give up easily					
3	I have difficulty beginning tasks on time					
4	I ask questions constantly					
5	I feel I have lots of good qualities					
6	I have trouble starting and continuing tasking					
7	I have difficulty changing from one assignment to another					
8	I often shift to other activity					
9	I have difficulty in working independently					
10	You are easily distracted					
11	I don't seem to listen					
12	I feel I have lots of unwanted behaviors					

13	I usually show disruptive behavior					
14	Talk excessively					
15	Often interrupt others					
16	Speak out of turn					
17	Make comment not related to topic being discussed					
18	Have difficulty remain seated					
19	I prefer to stay seated for long					
20	You don't arrive on time for class					
21	Fail to return on time to class					
22	I have limited persistence					
23	Fail to home work					
24	Behaves inappropriately					
25	Use drugs or alcohol					
26	Use immature vocabulary					
27	Seek attention constantly					
28	I feel dissatisfied easily					
29	I am cruel to animals					
30	Destroy others property					
31	I am out of chair when supposed to be doing work					
32	Speak slowly					
33	I usually shout for no reason					
34	I hate my friends					
35	I feel my behavior is not acceptable for others					
36	Often injuries self					
37	Do not tolerate changes in routine					
38	Day dreamer					
39	Tell lies					

40	Have numerous physical complaints					
41	Frequently absent from class					
42	Have poor eye contact					
43	Require constant supervision					
44	Engage in dangerous behaviors					
45	Prefer not to try new activities					
46	Tire easily					
47	Steal things					
48	Unorganized					

Appendix C

Addis Ababa University
School of Graduate Studies
Department of psychology

Interview Guide For HIV/AIDS Orphans, Caregivers, and Principals of SOS Children's Village.

1. What are the main aims of the Organization?
2. What kind of measures you are taking to solve the (if any) psychosocial and behavioral problems?
3. What are the major problems you are facing?
4. What are the roles of caregivers?
5. What are the reactions of the community?
6. What are the relationships of the orphans?
7. Have you noticed any change and suggest the possible solutions?

THANKYOU FOR YOUR COOPERATION

Declaration

I, The undersigned declare that this is my original work done under the guidance of Dr. Dubey and that all relevant sources of materials used for the thesis have been duly acknowledged.

Name Habtamu Mekonnen

Signature: _____

Place: Addis Ababa

Date June, 2006

This thesis has been submitted for examination with my approval as a University advisor

Name Dr. S.N Dubey

Signature:_____

Date of Approval 26.6.06