

**ADDIS ABABA UNIVERSITY**  
**COLLEGE OF EDUCATION AND BEHVIOURAL STUDIES**  
**DEPARTEMENT OF SPECIAL NEEDS EDUCATION**

**Psychosocial Problems and Coping Mechanisms of HIV/AIDS Orphans in  
Hana Orphans Home**

**By: Hana Tarrekegn**

**May -2014**

**Addis Ababa**

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**A Thesis submitted to the Department of Special Needs Education in partial  
fulfillment of the requirements of MA degree in Special Needs Education.**

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## **ACKNOWLEDGEMENTS**

First of all, I would like to extend my deep gratitude for my advisor **Dr. Sewalem Tsega** for her constructive, critical, immediate and encouraging comments on the work throughout my study. It was really very difficult to prepare such work without her contribution. Therefore, I want to say thank you so much.

Next, my gratitude goes to all HOH workers and HIV/AIDS orphans. They were cooperative, devote their precious time, offices, providing related research materials and facilitate participants for interview and FGDs data collection. Leye also helped me in advising starting from the selection of research title to the successful accomplishment of the project. So their contribution in the work is paramount. Furthermore, the contribution of the participants (both interviewees and FGD Participants) was invaluable. Their willingness to devote their time for the research and their loyalty and genuineness were above all and which made them deserve many thanks.

Finally, I would like to thank my family (Leyikun, Amanueal...) who encouraged me to study my second degree without their reinforcement and praying, I could not be successful in the accomplishment of the study. So their contributions were also great and needs to deserve thanks.

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## **ACRONOMYS**

**HOH:** Hana Orphan Home

**WHO:** World Health Organization

**HIV:** Human Immune Deficiency virus

**UNAIDS:** Joint United Nations Programme on HIV/AIDS

**UNICEF:** United Nations Children's Emergency Fund

**USPEPFAR:** United States President's Emergency Plan for AIDS Relief

**FGD:** Focus Group Discussion

**NGO:** None Governmental Organization

**UNFPA:** United Nations Fund For population Activities

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## Abstract

*The purpose of the study was to find out the psychosocial problems of HIV/AIDS orphans and their coping mechanisms in Hana Orphan Home. Ten interview participants of HIV/AIDS orphans and four FGD participants (psychologist, social worker, supervisor & house mother) were participated in the study. The participants of the interview and FGDs were selected using purposive and simple chain-referral system sampling techniques respectively. An existential (phenomenological) qualitative design was utilized. In-depth interview and FGD were conducted within two months. Three overall themes (i.e. psychological & social problems and their coping mechanisms) were emerged from the interviews and triangulated with FGD. The study result on the first theme shows that participants have psychological problems (hopelessness and loneliness, depression, negative self image and need for love and care). Regarding the second theme some participants have poor social lives/relationship was manifested. On the last theme, most of the participants employed Emotion Focused Coping Mechanisms (talking to people, cognitive distraction and avoidant) and, situation Focused Coping Mechanisms (access support, Being an expert and spirituality)*

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1. Background of the Study**

Orphans are perhaps the most tragic long-term legacy of the HIV/AIDS pandemic because even though HIV/AIDS infections are going down, the orphan population continues to rise. The stigma attaches to HIV/AIDS exacerbates the trauma already experienced, and hampers the bereavement process due to secrecy of AIDS deaths (Bond & Nubani, 2011). The bereaved in most cases lack the necessary emotional support because they would not want to disclose to other people their pain and sorrow for fear other people will learn the cause of their relatives' death.

It is obvious that household incomes decline when the bread winner falls ill from HIV/AIDS and can no longer work full-time or at all. A study carried out to establish the socio-economic status of households with orphans compared to those households without orphans indicates that households with orphans were worse off than households without orphans (Seaman & Narangui, 2009).

It is obvious that HIV/AIDS related to parental death has physical, social, economic, health and psychological impact on children which was overshadowed by concern on social and economic impacts, especially in developing countries. Yet researchers have investigated that the impact of AIDS in developing countries is essentially the same as that of developed ones with most children showing psychological reaction to parental illness and death as well as stigma and discrimination associated to them (Forehand, 2008; Kalia, 2010).

Research by save the children South Africa shows that children and adolescents experience two main forms of stigma and discrimination on the bases of HIV/AIDS: general stigmatization and isolation by families, communities and institutions within communities. e.g, churches, orphanages etc.;and discrimination by service providers in accessing rights and services(Save the Children South Africa,2010).

Furthermore, among peers in school, some young people reported to the researchers incidents where orphans know to have lost their parents to AIDS had no friend, and in colleges no students was willing to share accommodation with an orphans known to have lost a relatives to AIDS.A study in the National Children's Forum on stigma showed that about 97% of the participants perceived themselves as having no close friends (Germann,2009).

To get rid of such sort of psychosocial problems HIV/AIDS orphans uses different coping strategies. Acceptance of the situation and increased knowledge about being HIV/AIDS orphan is a foundation on which those affected could develop individual and context-adjusted strategies, e.g. managing stress and having a supportive network, in order to stay well and avoid challenges (Russel & Browne 2011).

The other one is, accessing social support is an adaptive situation-focused strategy (Lazarus and Folkman, 1984). Social supports may be social networks such as churches, friends, and extended family, or they may be more formal networks such as health care or educational institutes (McCubbin, et al., 2008).

Besicallly, coping strategies can also be classified as being positive or negative. Some people use positive coping strategies to manage their situation, such as positive thinking and the utilization of appropriate social supports, which include family, friends, and holy places (Perkins, et al., 2004). Others may also use negative coping strategies, such as the use of avoidance behaviors, negative thinking, and substance abuse (Greeff, et al., 2010; Nehra, et al., 2010).

## **1.2 Statement of the problem**

Like adults, children are suffered by the loss of their parents. However, unlike adults children often do not feel the full impact of the loss simply because they may not immediately understand the finality of death. This prevents them from going through the grieving process of the loss of their parents immediately, which is necessary to recover therefore they are at risk of growing up with unresolved negative emotions which are often expressed with anger and depression. Unfortunately, adults do not seem to appreciate that children are also adversely affected by bereavement even though they may not have an adult's understanding of death. Therefore, children are not given the required support and encouragement to express their emotions nor are they guided to deal with them (Cluver, 2007).

Emotional support needs to be constantly looked at and improved because children will continue to suffer across the world. It is therefore appropriate that attention is given to developmental situation and well-being of HIV/AIDS orphans. There are very few research undertaken in Africa despite the growing concern about the psychosocial well-being of orphans, except some agencies effort to address the material needs of HIV/AIDs orphans, many of these orphans continued to

experience emotional and other psychosocial problems and little has been done in these area of support.(AAHAPCO,2007).

Related to different studies in the last two or three decades, several have been conducted on issues of psychosocial problems of HIV/AIDS orphans. Most of the literatures in this area are western based and there are, of course, few studies in African countries.

Cluver and Gardner (2008) conducted a qualitative study on psychosocial problems of HIV/AIDS orphans and vulnerable children in USA. According to their finding, Orphan-hood is frequently accompanied with multidimensional problems; depression, hopelessness, suicidal ideation, loneliness, anger, confusion, helplessness, anxiety and fear of being alone.

Coming to the African context, a study in Uganda showed that orphans had greater risk of anxiety, depression and anger than non orphans. Furthermore, orphans had significantly higher scores than non-orphans on individual items in the Beck Youth Depression Inventory are regarded as particularly “sensitive” to the possible presence of a depressive disorder .(Cantor, 2005).

Another study in south Africa also showed that children orphaned by AIDS were more likely to report symptoms of depression, peer relationship problems, post-traumatic stress, delinquency and conduct problems than both children orphaned by other causes and non-orphaned children. HIV/AIDS-orphaned children were more likely to report negative self-image. (Gardner, 2007)

In Ethiopia, there are few studies on the challenges and needs faced by orphans and other children made vulnerable by HIV/AIDS. One of the study deals psychosocial distress mainly associated with anxiety, loss of parental love and nurture, burden of caring for the sick, impact of family dissolution, stigma, discrimination, grief and frustration. (Mums, 2011)

Generally speaking, most of above mentioned studies are conducted in western world and some African countries, including Ethiopia. However, the coping mechanisms of the psychosocial problems of orphans are not yet dealt in many of these.

Therefore, this study was carried out to answer the central question of “what are the psychosocial problems of HIV/AIDS orphans and their coping mechanisms?” Accordingly, the following basic research questions related to the psychosocial problems and coping mechanisms were raised.

- What are the psychological problems of HIV/AIDS orphans?
- What are the social problems of HIV/AIDS orphans?
- How do HIV/AIDS orphans cope with these psychosocial problems?

### **1.3 Objectives of the Study**

The overall objective of this study was to find out and describe the psychosocial problems of HIV/AIDS orphans. Specifically, the study has designed:

- To investigate the psychosocial problems that HIV/AIDS orphans faces.
- To find out how HIV/AIDS orphans cope with challenges related to their psychosocial problems.

#### **1.4 Operational Definition of Basic Terms**

The following terms were defined operationally as they were used for this study.

**HIV/AIDS Orphans:** those orphans who have lost both parents with HIV/AIDS but not HIV/positive.

**Maternal orphans:** orphans who have lost their mother with HIV/AIDS.

**Paternal orphans:** orphans who lost their father with HIV/AIDS.

#### **1.5 Significance of the Study**

From the findings that are obtained from this particular study, different groups like HIV/AIDS orphans, care givers in orphanages and researchers would benefit.

**HIV/AIDS orphans:** The considerable influence of psychosocial problems gives rise to a growing need for support for these individuals. So, finding of this study would provide an insight on what issues/ daily lives they need support to strengthen their ability to manage suffering and to promote their own wellbeing. The study would help them to indicate some coping strategies that would help them and let them stay well in their real life context.

**Care Providers:** The study would help to ease the burden of care providers by helping them to use a more holistic view that incorporates the person's own need of care and whole life context in the orphanage, instead of focusing only on providing them food, shelter and closings. For example, if care providers understand the psychosocial problem these people faces they can

help them use different assistance modalities like psychotherapy. These in turn may gap and ease the interpersonal communication between the care provider, and HIV/AIDS orphans.

**Researchers:** In Ethiopia, there are a lot of orphanages that give care for HIV/AIDS orphans and other types of orphans all together. However, as to my knowledge, there is no research conducted on/about particularly of psychosocial problems and coping mechanisms of HIV/AIDS orphans. Therefore, this research is expected to fill this gap in the literature by exploring these problems and coping mechanisms.

### **1.6 Delimitation**

The study setting is HOH which is located in Addis Ababa, the capital city of Ethiopia. The orphanage was selected since it incorporates varies types of orphans. As a result, it is the best place to get informants. In addition, since the researcher is working with this orphan age, she had better opportunity to get participants in time of need. The study was also delimited to find out the psychosocial problems and coping mechanisms of these people. The study also focused on HIV/AIDS orphans.

### **1.7 Limitation of the Study**

The limitations of this study are those inherent in the use of a qualitative research approach. The study was limited to ten interviewees and four FGD participants. All the interviewees were HIV/AIDS orphans, regarding participants of FGD they were selected using simple chain-referral system sampling technique from the orphans' caregivers. As a result, lack of gender

diversity especially with FGD data was observed in which most of them were male participants due to the sampling technique used was also another limitation.

The researcher planned and conducted one session interview and FGD. So the research limited to have one session interview and FGD which might have some effect on the depth of the data and this also limited not to test/crosscheck the reliability of the information with participants themselves.

Research focusing on a larger scale, including nationwide will have a statistical meaning, to generalize the study's findings for population so diversity of the research sample will be enhanced. The psychosocial problems of maternal or paternal orphans who live independently in their homes or independent living communities also should be included with a representative sample.

## CHAPTER TWO

### REVIEW OF RELATED LITERATURE

#### 2.1 Definition of Orphan and HIV/AIDS orphans

**Orphan** is a child less than 18 years of age whose mother, father or both parents have died from any cause of death. (UNAIDS, 2004)

**HIV/AIDS Orphan** a child who lost one or both parents to HIV/ AIDS orphans. (Chitiyo,2008)

#### 2.2 Worldwide Prevalence of HIV/AIDS orphans

##### 2.2.1 Prevalence of HIV/AIDS orphans in the world

Globally in 2012,165 million children under the age of 18 years had lost one or both parents due to all causes of death, whereas 15million children had lost at least one parent to an AIDS-related death. (WHO, 2013).

The projections for 2013 indicate that the total number of orphans under the age of 18 due to all causes of death will decline to 145.2 million, whilst the number of orphans due to AIDS-related illnesses have been responsible for approximately 25 million deaths worldwide, and have generated profound demographic changes in the areas most heavily affected, examples ranging from dramatic decreases in life expectancy; increases in the number of orphans and increases in the number of child-headed households (UNAIDS,2008).

Furthermore, UNAIDS/WHO (2008) indicate that in 2007, two million people died due to AIDS-related illnesses. Mfecane and Davids (2006) attribute orphan hood and its impact on households and communities to the premature deaths of parents due to AIDS-related causes in sub-Saharan African if adults were not dying in large numbers due to AIDS, the world would not be expecting

such large numbers of orphans. Given the above statistics, it can be argued that HIV/AIDS is a threat to children and their families globally, and that will continue to be threat for many years to come.

### **2.2.2 Prevalence of HIV/AIDS orphans in Sub-Saharan Africa countries**

The report of UNAIDS indicate that, in 2007, sub-Saharan African had the highest number of orphans under the age of 18, with an estimate of 47.5 million from all causes of death globally. About a quarter of all orphans, 11.6 million, age up to 170years had lost one or both parents to AIDS-related deaths by the end of 2007. As the table below shows, the number of orphans in some sub-Saharan African countries exceeds half a million, and, in others, children who have orphaned by AIDS comprise half or more of all orphans nationally (UNAIDS/WHO 2008).

Other report also estimated that by 2010 the number of orphans will rise to 53 million from all causes death, whilst 12 million of those orphans will be due to AIDS related death (UNICEF/UNAIDS/PEPFAR 2006). The same report point out that, the proportion of children who are orphans generally increases with the age of the child, since 12% of orphans are in the 0- to 5-year-old age-group; 33% are in the 6-to eleven-year-old age group, and 55% are in the 12-to 17-year-old age group and, therefore, one could conclude that adolescents make up the majority of orphans in the sub-Saharan Africa.

### **2.2.3 Prevalence of Orphans in Ethiopia**

As an effect of the poor conditions of this developing nation, Ethiopia contains and struggle to care for millions of orphaned children. Though estimates vary, recent approximation used to

classify orphans including 1.5 million AIDS orphans in Ethiopia. The definition used to classify orphans is children under 18 years of age who have lost one or both parents. (Abebe & Asase, 2011; Gross & Connors,2007).

### **2.3 Definition of psychosocial Behavior**

The idea of psychology is that people structure and interacts with the world differently on the basis of the meaning they assign to events. While acting alone or in groups children interact. This interaction of children with the environment moulds their behavior. Besides, the interaction of children with the environment facilitates the psychosocial development of the children, resulting in proper emotional, personal, and social behavior. (Anderersen & chen,2002). Other scholar Puts psychosocial development as one of the three domains of development. These three aspects of development that make up the whole development are physical development, intellectual development and psychosocial development. Cobb (2001)

### **2.4 Impact of HIV/AIDS on children who has lost their parents with HIV/AIDS**

It is obvious that HIV/AIDS related to parental death has physical, social, economic, health and psychological impact on children was over shadowed by concern on social and economic impacts, especially in developing countries. Yet researchers have investigated that the impact of AIDS in developing countries is essentially the same as that of developed one's with most children showing psychological reaction to parental illness and death as well as stigma and discrimination associated to them(Forechand,2003;Kalian,2003)

#### **2.4.1 Psychological problems on HIV/AIDS orphans**

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

Traumatic experiences that threaten the well-being of children and youth include personal or parental chronic illness, maltreatment or neglect and cumulative life events and daily hassles. (Cicchetti & Brnett,1997).

**Depression** according to Polite (et al.,2004) depression classified as feeling sad, frustrated and hopeless about life, accompanied by loss of pleasure in most activities and disturbances in sleep, appetite and lack of concentration and energy .He also observed that internalized stress can cause anxiety, depression and poor self esteem. Further cognitive models of depression emphasize that negative cognition or maladaptive believe system as diathesis in the initiation and continuation of depressive symptoms.

According to Beck's cognitive theory on the other hand proposes that negative view of self, the world and the future, the negative cognitive triad serve as a possible cause for depression in the face of negative life events. The multiple stresses and risk factors experienced by youth whose parent(s) or caregiver are affected by HIV/AIDS that includes fear, worrying, observing and caring for ill parents in pain, social stigmatization, hospital visitation, shattered hope and

eventually the death of the parent(s) or care giver (Wild, 2001). These effects have the potential to cause anxiety, poor self esteem and depression (Germann,2004).

**Self esteem** according to Rosenberg self-esteem tends to be a positive or negative orientation towards oneself; an overall evaluation of one's worth or value. Self esteem is one component of self concept, which has been defined as 'totality of the individual's thoughts and feelings with reference to himself as an object' (Rosenberg, 1989). However, the cognitive theories have not only considered thoughts about oneself but also ones' self worth (Mc carthy, 2007). This model proposes that persons with depressions are likely to have a poor self esteem. Abramson et.al.,(2002) test on this model with children and youth (age7-21) reported a strong support for cognitive diathesis for depression among children and adolescents, further suggesting a strong correlation between depression and self esteem not only among adults but also among children and youth. Although this model was formulated for a different cultural setting, children and youth orphaned by HIV/AIDS who have reported as being depressed have been found to have poor self-esteem (sengendo & nimbi, 2004, Germann, 2001).

**Anxiety** Spielberger (1985), assumes state of anxiety as the actual emotional responsiveness or anxiety that one individual experiences at the present moment. Trait anxiety is defined as the tendency one perceives in several situations as threatening or dangerous. As noted in depression and self esteem models that have found a strong relationship between these two constructs, anxiety and depression have been found to have equally a strong correlation. This was established in a test of the tripartite model of anxiety and depression in elementary and high school of boys and girls.

#### **2.4.2 Social problems on HIV/AIDS orphans**

**Stigma and discrimination** People with HIV/AIDS experience stigma in different ways and at different level: From the family setting, the health clinics and the community as a whole, stigma and discrimination are communicated in different forms but are based on wrong or poor understanding of the mode of transmission of the HIV virus as reported by The East African Standard News Paper (May 12, 2006).

Discrimination can be defined as ‘an act or treatment based on the stigma and directed towards the stigmatized (Alonyo & Reynolds, 1995).Furthermore, The negative attitude and judgment projected towards persons with AIDS, their partners and children, and rejection by their extended family, friends and by society at large, may lead the affected persons to withdraw from social support networks because of the ramification of disclosure (Herek & Glunt,1999).

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

The non- resilient may resign and internalize their painful emotions which manifests in many forms as observed. In their study, Makame et al.(2002)showed that 90% of the orphans studied reported having been punished for breaking school rules as opposed to only 26% non-orphans.

This defiance could be arising from the underlying unmet emotional needs or from the fact that they have not completed their grieving process.

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

Most recently, literature has turned toward stigma interventions. Brown (2003) reviewed 22 evaluated interventions, six in the developing countries and sixteen in developed countries, all of which sought to improve attitudes toward people with HIV and AIDS, and also to assess people's willingness to treat and care for people living with HIV/AIDS or to improve the ability of people with HIV or AIDS to cope with stigma. These studies found mixed reactions to these intervention strategies suggest people might not be convinced about the modes of transmission and so they do not want to take risks.

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

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

**Economic deprivation** The loss of social and family support(loss of family unit and associated natural, economic, social and emotional safety net is possibly the most important direct consequence of AIDS for children and adolescents(Bray,2003;Foster et al.,1997).Household incomes decline when the bread winner falls ill from HIV/AIDS and can longer work full-time or at all. A study carried out to establish the socio-economic status of households with orphans compared to those households without orphans indicate that households with orphans were worse off than households without orphans(Seaman,&Narangui,2004).

The cost of treating illnesses caused by HIV/AIDS places a huge economic burden on families. Further studies in urban household spends four times as much on health care than unaffected households(Ankrah,1993).It has also been shown that even after death, funeral expenses contribute to the toll exacted by AIDS. For instance, studies conducted in four provinces in south Africa, shown that households with a HIV/AIDS related deaths in the past year spent an average of one third of their annual income on funerals (stein, 2003; UNICEF, 2002).Furthermore, households caring for orphans are likely to become poorer, because the same income will now have to be shared amongst more dependents. As the rate of HIV/AIDS infection continues to rise, with a corresponding increase in orphans, available resources (which are for the most part

already scarce especially among populations in sub-Saharan Africa) are stretched above the capacity of extended families and communities to handle the large number of orphans(Foster et al.,1997;Hunter,1990;UNAIDS,2003).

## **2.5 Coping mechanisms of HIV/AIDS orphans**

Lazarus and Folkman (1984) defined coping as, a transactional process, which changes over time and within its situational contexts. Pearlin and Schooler (1978, pp.30), defined coping as “any response to external life strains that serves to prevent, avoid, or control emotional distress”. They recognized that the act of coping is related to both the life strains and the state of one’s inner emotional life. Lazarus & Folkman (1984) view that even though stress is inevitable; it is the coping that makes the difference in adaptation outcomes. According to them, coping has two major functions (a) Regulating stressful emotions or Emotion-focused coping and (b) Altering the distressed person-environment relation or Situation-focused coping.

According to (Phyllis et al.2011), Emotion-focused coping deals with efforts to manage the negative emotions associated with the stressful situation which is used when events are perceived as uncontrollable, such as health situations. These coping strategies include cognitive distraction, seeking emotional support, emotional regulation and expression, selective attention, communicating with people about the situation and cognitive restructuring ( Phyllis et al. 2011).The other coping style is problem-focused coping which is referred to as the efforts used to change the basis of stress directly. This type of coping focuses on altering the environment, changing the external pressures, or seeking resources to help make the situation less threatening.

Problem-focused coping strategies usually are used by adult individuals in work contexts (Lazarus & Folkman, 1984).

Coping strategies can also be classified as being positive or negative. Some people use positive coping strategies to manage their situation, such as positive thinking and the utilization of appropriate social supports, which include family, friends, and holy places (Perkins, et al., 2004). Others may also use negative coping strategies, such as the use of avoidance behaviors, negative thinking, and substance abuse (Greeff, et al., 2006; Nehra, et al., 2005].

**Communication.** Phyllis (et al.2011) delt coping strategy that HIV/AIDS orphans could use to share information about their thoughts and feelings but the social stigma of being HIV/AIDS orphan is seen as a restraint to sharing information about their problem relative outside the family. Suppression of the problem has been viewed as preferable to disclosure due to the risk of negative reaction from others (Stengler-Wenzke, et al, 2004). Communicating with others is considered to be an Emotion-focused coping strategy and may be done through verbal or written contact (Lazarus and Folkman, 1984). They also stated that some HIV/AIDS orphans and other type of orphans cope with their situation by sharing their feelings only with their immediate relatives, and through this, receive support and understanding.

**Acceptance.** According to Lazarus and Folkman (1984) cognitive restructuring assumed to be where individuals appraise their thinking reactions to situations and change negative reactions to positive, or at least neutral ones . Getting correct understanding of the problem and acceptance of the situation is a first step in learning to stay well so HIV/AIDS orphans may use acceptance

as a strategy to get an accurate and beneficial view of their situation (PatriK, 2010). Incorporating acceptance in their life helps orphans to reduce stress and improve their relationship with others (McCubbin, et al., 1991).

The acceptance of the situation and increased knowledge about being HIV/AIDS orphan is a foundation on which those affected could develop individual and context-adjusted strategies, e.g. managing stress and having a supportive network, in order to stay well and avoid challenges (Russel & Browne 2005).

**Cognitive Distraction.** The use of cognitive distraction also noted to be an Emotion-focused coping strategy which includes passive appraisal.(Phyllis et al., 2011) It may be something that limits attention or prevents concentration, distracts the mind from thinking about stressful situations and limit reactivity and allows the individual to accept and minimize reaction to difficult situations. HIV/AIDS orphans are able to minimize their reaction by utilizing passive appraisal activities, such as watching television, relying on luck, feeling helpless about the problem, and believing that time will solve the problem (Lazarus & Folkman, 1984).

**Avoidance.** Avoidance presumed as an Emotion-focused coping strategy that some HIV/AIDS orphans use when they overestimate the solution of their situation or underestimate their own coping ability (McCubbin, et al., 1991). Avoidant strategies may include ignoring friends & classmate by decreasing physical and emotional contact, such as not communicating and visiting them regularly and limiting their affection. People may also totally avoid their HIV/AIDS orphan relative and cut off any type of contact (Nehra, et al., 2005). According to

Lesley (2005-) he said that some people who experience the same situation able to understand and listen to others but they wouldn't be able to talk to others who don't know much about it. People are frightened of the unknown.

**Religiosity and Spirituality.** The National Alliance on HIV/AIDS orphans (2010) presumed that some HIV/orphans use religious and spiritual support as a means for coping with the problem and/or coping with caring for a HIV/AIDS orphans relative. The use of spirituality is seen as a positive Emotion-focused coping strategy (Phyllis et al., 2011). Spirituality may mean different things to different individuals, but has been seen to increase levels of well-being and decrease the level of stress in one's life (Rammohan, et al., 2002). It can be both intra-physical, such as through values and beliefs, and institutional, such as through church attendance and performing rituals. Spirituality includes seeking advice from a minister, attending and participating in church services, and having faith in God. Spirituality may also include prayer, privately and with a community (Phyllis et al., 2011). With regard to spirituality as coping mechanism, Jan had developed a deep sense of spirituality and he described that "I came to accept the serenity prayer, to let God grant me the serenity to accept the thing I cannot change and my partner Eileen has also helped me just being there. Her support makes me feel I am not a burden or a failure of parents' failure" (DBSA & FDA, 2002, P7.)

**Joining a Support Group.** The coping strategies of a family member may influence the treatment outcomes of their relative positively or negatively (Enns et al., 1999). Accessing social support is an adaptive problem-focused strategy (Lazarus and Folkman, 1984). Social supports may be social networks such as churches, friends, and extended family, or they may be more

formal networks such as health care or educational institutes (McCubbin, et al., 1991). For example a person of HIV/AIDS orphan noted the importance of social support as “being with people who understand what it’s like to have this problem and sharing my experiences with others have been extremely helpful. He also believed in sharing experience, creating hope, inspiring people and makes them believe they can get better. (Support Alliance and Families for HIV/AIDS orphans [SAFH], 2002, p 6.)

**Being an Expert and protect oneself from being harmed** Not only psychologist but also HIV/AIDS orphans themselves are responsible for their psychosocial treatment; so being an expert or being well informed on the problem is an important one (NAMI, 2008). In addition, information needs to flow both ways (consumer/health care professionals), ask questions, and write them down before appointments. You and your health care provider should ideally work as a team to fine-tune doses, schedule appointments for monitoring, or make any other helpful changes (Ken Duckworth, 2008).

## **2.6 Model of Psychosocial Support**

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

HIV/AIDS undermines and destroys the fundamental human attachments to normal family life and youth development as observed by Foster & Jiwli (2001), Levine and Foster (2000). Youth affected by HIV/AIDS suffer fear and anxiety during parental illness then grief and trauma with

the death of a parent. These problems are further compounded by traditional taboos surrounding discussion of AIDS and death. Youth orphaned by AIDS cannot cope without support; they need plenty of opportunity to express their feelings without fear of stigma, discrimination or exclusion (Foster & Jiwli,2001;Levine & Foster,2000;REPSSI,2003).

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

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

Vocational training and apprenticeships is key to enhancing their ability to generate income. Further, the orphaned youth must be equipped with social and interpersonal skills necessary to make informed decisions, communicate effectively and develop coping and self management

mechanisms that will enable them to protect themselves from HIV infection and other risks. These young people should be encouraged to participate actively in planning and implementing all program that involve their welfare as explained by Williamson(2002),that by involving youths in the fight against HIV/AIDS, their confidence and self esteem is improved as they feel responsible and as partners.

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

This sensitization process should encourage leaders and their communities to take action in support of the affected households and monitor those most vulnerable. Their role should be to ensure such orphans are under the supervision of adults, that they are enrolled in school, have their basic needs met and can access all essential services. Of particular importance is alerting leaders to the risks the exposed to, for example, sexual abuse, exploitation labor, danger of losing their inheritances to relatives and early forced marriage for girls. The leaders should therefore create a culture in which abuse of any kind is unacceptable and violations are dealt with effectively. This heightened awareness provides attention to youth and children made vulnerable by AIDS and stimulate locally driven action in response to identified needs as observed by Williamson (2002).

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

**Providing spiritual needs support** children need a belief, which enables them to develop a hope for their future. They also need to develop trust and security in their survival. This gives them hope to keep trying. Also, this facilitates a sense of connectedness to deceased parents and ancestors. Traditional healers are among the custodians of African traditional culture and therefore the study expected some of the features in caring for the orphans will be manifested in their practice. (Levine & Foster,2000;UNAIDS,2003;Williamson,2002).

## **CHAPTER THREE**

### **RESEARCH METHODS**

#### **3.1 STUDY AREA**

This study was carried out in HOH. The orphanage is located in the capital city of the country (i.e. Addis Ababa). The orphanage was established by Hana in 1997 G.C with few numbers of orphans. Recently there are 200 orphans who were exposed to vary miserable condition: Orphans especially of HIV/AIDS, street children, juvenile delinquent, abused children, innocent children who stay in prison with their poisoned mothers. These orphans were accepted by the orphanage with the view to alleviate and transform these tragic conditions in to a conducive and decent atmosphere where by enjoy housing, feeding, closing etc and focusing on their education. Whenever the children face any social, emotional, physical etc problems, there is a professional psychologist who sees in to their personal problems and settles such problems. Furthermore, their social workers, house mothers and supervisors whose main task is to follow up their day to day activities and support them in checking are met.

#### **3.2 Research Design**

In this study, qualitative research was done as it allows the researcher to conduct an in-depth investigation of the psychosocial problem of HIV/AIDS orphans and their coping mechanisms. As Creswell (1998) pointed out, based on detailed accounts from informants and other sources of information, qualitative researchers attempt to develop a complex and holistic, phenomenon under study. Qualitative researchers typically seek to explore, understand, and represent the subjective experiences of people and make sense of and interpret their actions, experiences, and other psychosocial phenomena in terms of the meanings associated with them

(Ward, 2008). Specifically, this study was conducted employing descriptive *and interpretative* phenomenological approach. In phenomenological studies, one strives to present a description and possibly an interpretation of the meaning of an experience with a specific phenomenon (Thomas, 2004).

Phenomenology is a way to investigate subjective phenomena, and is based on the belief that essential truths about reality are grounded in everyday experience (Spiegelberg, 1975; cited in Ward, 2008). Two Phenomenological approaches (*descriptive and interpretative*) were used in the study. The aim of interpretative phenomenological approach is to explore in detail how participants are making sense of their personal and social world.

### 3.3 Participants of the Study

Participants of this study were those who are HIV/AIDS orphans. The following criteria were applied to select the participants.

**Table-1:** Inclusion and exclusion criteria for selecting participants

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> <li>The respondent should be HIV/AIDS orphans.</li> </ul>	<ul style="list-style-type: none"> <li>Who is not HIV/AIDS orphan</li> </ul>
<ul style="list-style-type: none"> <li>Willing to give their consent ahead of the in in-depth interview as well as FGD.</li> </ul>	<ul style="list-style-type: none"> <li>Who are not willing to give their consent ahead of the in-depth interview as well as FGD.</li> </ul>
<ul style="list-style-type: none"> <li>Participants who are able to respond(age ten and above)</li> </ul>	<ul style="list-style-type: none"> <li>Participants who are not able to respond(age below ten)</li> </ul>

### **3.4 Sampling Technique**

Purposive sampling technique was used to select participants for this study. “Obviously qualitative researchers use purposive sampling, deliberately selecting respondents based on their ability to provide the needed information (Padgett, 2008 P.53).” Ten interviewees were selected using purposive sampling and four participants for FGD were selected using simple chain-referral system sampling technique in which interviewees were given the mandate to select their care giver who well aware about their psychosocial problems. The qualitative research usually relies on small numbers with the aim of studying in-depth (Miles & Huberman ,1984).

### **3.5 Instruments of Data Collection**

In-depth interview was used to collect data in this study. In-depth interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular situation (Thomas, 2004). It is useful when we want to get detail information about a person’s thoughts and behaviors or want to explore new issues in-depth (Carolyn & Palena, 2006). In order to increase the reliability and trustworthiness of the data collected for in-depth interview, the researcher used FGDs for triangulation.

### **3.6 Data Collection Procedures**

Before conducting the interviews, I selected HIV/AIDS orphans and gave them the informed consent form to request their willingness for the research and then we adjusted time and place for interview session. The data were collected in the months of (January –February/ 2013). Regarding the FGDs data collection procedure, first the orphans given the mandate to

select their care givers who can better understand their problem. Four participants of FGD were selected, the informed consent paper given and/or read for all participants. The researcher clearly presented the objective of the research and the research ethics. The FGDs were conducted with all the five participants. Finally, the researcher thank all the participants for their active participation, giving their time and their cooperation.

### **3.7 Data Analysis**

Thematic analysis was used, which is one of the data analysis strategies in qualitative research. The data analyses were carried out soon after the data collection, which is common in qualitative research (Padgett, 2008). Data analysis procedure which is specific to interpretive phenomenology was applied. According to Victoria Heather (2005) there is no universally accepted method for data analysis for interpretive phenomenology. However, it should be in line with the philosophical position of phenomenology. Since there are no uniform procedures to follow in transcribing and generating themes, the researcher used the following five 'steps' or phases of Hycner's (1999) data analyses process. These are:

- 1) Bracketing and phenomenological reduction
- 2) Delineating (outline) units of meaning
- 3) Clustering of units of meaning to form themes
- 4) Summarizing each interview, validating it
- 5) Extracting general and unique themes from all the interviews and making a composite summary

**Bracketing and phenomenological reduction:** Phenomenological reduction “to pure subjectivity” (Lauer, 1958, p. 50), is a deliberate and purposeful opening by the researcher to the phenomenon “in its own right with its own meaning” (Hycner, 1999). Here phenomenological reduction refers to the bracketing of the researcher’s personal views or preconceptions (Miller & Crabtree, 1992).

**Delineating units of meaning:** This is a critical phase of explicating the data, in that those statements that are seen to illuminate the researched phenomenon are extracted or ‘isolated’ (Creswell, 1998; Hycner, 1999). The researcher is required to make a substantial amount of judgment calls while consciously bracketing her/his own presuppositions in order to avoid inappropriate subjective judgments.

**Clustering of units of meaning to form themes:** with the list of none-redundant units of meaning in hand of the researcher must again bracket hers or his presuppositions in order to remain true to the phenomenon. By rigorously examining the list of units of meaning the researcher tries to elicit the essence of meaning of units within the holistic context. Clusters of themes are typically formed by grouping units of meaning together (Creswell, 1998) and the researcher identifies significant topics, also called units of significance (Sadala & Adorno, 2001).

**Summarize each interview, and validate it:** A summary that incorporates all the themes elicited from the data gives a holistic context. At this Point the researcher conducts a ‘validity check’ by returning to the informant to determine if the essence of the interview has been correctly ‘captured’ (Hycner, 1999, p. 154).

**General and unique themes for all the interviews and composite summary:** Once the process outlined in points 1 through 4 has been done for all the interviews, the researcher looks “for the themes common to most or all of the interviews as well as the individual variations” (Hycner, 1999, p. 154). The researcher concludes the analyses by writing a composite summary, which must reflect the context from which the themes emerged (Hycner, 1999; Moustakas, 1994).

### **3.8 Ethical Consideration**

According to Kellehear (1993), ethical concerns include the principles of privacy, informed consent, confidentiality, protection from harm, and avoiding deception. These broad principles were applied while undertaking the present study. To protect participants, names of people and places were changed to pseudonyms during transcription and analysis, and all data would not be identified: no participant details were stored with transcripts. Thus confidentiality applied to the presentation of the data, as well as recruitment. A letter of support from HOH was requested to provide counseling for the participants in time of need and included in the ethical applications. There is a personal and moral obligation on the researcher to treat participants with respect for their knowledge, experience and human rights. To this extent, phenomenological intersubjectivity enriched the ethical research relationship. Moreover, ethical clearance was obtained from Ethical Committees of HOH.

## CHAPTER-IV

### RESULTS

This chapter presents the major findings of the study. From the analysis of the qualitative data, three major pre-existing themes were emerged. (1) *The psychological problems of being HIV/AIDS orphan*; (2) *the social problems of being HIV/AIDS orphan*; (3) *coping strategies of HIV/AIDS orphans*. The first part of the chapter presents socio-demographic characteristics' of the interview and FGD participants. The second part presents the four themes one by one and their sub themes or categories. The researcher used pseudonyms to present each participant's psychosocial problems and their coping mechanisms.

#### 4.1 Socio-Demographic Characteristics of the Participants

In the study, 10 participants were interviewed and focused group discussions were conducted to find out the psychosocial problems of HIV/AIDS orphans and their coping mechanisms. Except four, all the other participants of the interview were male. The age of the participants ranged from 16-19 years. The educational level of the participants was from 8<sup>th</sup> grade to 10. That is three grades eight; four grade nine, three grade ten.

**Table-2:** Interview Participants' (HIV/AIDS Orphans) Socio- demographic Characteristics

Pseudo Name	Duration in years in the orphanage	Age	Marital status	Educational level/ Grade level
Fantahun(M)	7	17	Single	9
Kemal(M)	8	18	Single	10
Bertuma(M)	6	18	Single	10
Biratu(M)	3	16	Single	8
Kiflom(M)	5	18	Single	9
Annan(F)	5	18	Single	9
Tina(F)	4	16	Single	8
Buta(F)	2	17	Single	9
Selam(F)	3	18	Single	10
Yeneneh(M)	5	17	Single	8

As it is shown in Table-3 below, the socio-demographic characteristics' of the FGD participants are as below. Their age ranged 26-46 years; regarding sex, three of them are male and the rest one is female. Regarding their marital status two of them are married, the remaining two are single. The occupational statuses of them were house mother, psychologist, social worker and supervisor.

**Table-3:** FGD participants' (Care Givers) Demographic Characteristics

Pseudo name	sex	Age	Marital status	Occupation/duty
Belaynesh	F	46	Married	House mother
Abebe	M	30	single	psychologist
Ayana	M	26	Single	Social worker
Atomsa	M	42	Married	supervisor

## 4.2 Psychosocial problems of HIV/AIDS orphans and their coping mechanisms

According to the findings of the study, participants experienced different problems. The description provided by participants' highlighted on different themes. The sub themes are psychological, social & coping.

### 4.2.1 The Psychological problems of HIV/AIDS orphans

The findings of the study revealed that participants encountered psychological problems due to being HIV/AIDS orphan. The psychological problems are organized and described under the following categories:-hopelessness, need for love and care, depression and negative self-image.

**Hopelessness and loneliness:** one of the psychological problems of participants was the problem of hopelessness and loneliness. Majority of the respondents revealed that whenever they think about the cause of the death of their parents they feel empty, lonely and hopeless.

*After mother's death I felt hopeless and confused I stayed home after her death because I was unable to come to terms with her death. The realization that I was the only member of my family alive I became desperate. Every time I think about her, I always feel I am in the middle of nowhere. (Selam)*

*...I like being alone to deal with my pain and loss. At times it helps me.....(Yeneneh)*

Regarding to the same aspect, some participant feel bad about their parents' death and others believe that their parents are the root cause of their problem.

*...I feel my parents death was to punish me I feel bad about them for leaving to struggle alone.....(Tina)*

*..When my mother passed away I feel like the whole world had come to an end. There is nobody in this world who understand what is like to lose a father and a mother in life of two years.....(Kemal)*

The data from FGD also revealed that when these children involve in group counseling, most of the time they don't participate. Sometimes they even missed counseling sessions, believing that such counseling sessions aggravates their problems. Moreover, house mothers' reported that sometimes these children wants to be all alone.

### **Self-blame**

The other psychological problem was self-blame. Some participants blame themselves as the real cause for the death of their parents and other regrets that they should have to express their real feelings about their parent's before their death.

*.....I think I am the cause of all this mess. This is because it was after my birth that this entire problem aroused. So, I am in the course of hopelessness and emptiness....(Kemal)*

.....though my mom fulfill all my basic needs, my grandmother always told me that she was bully(Balege).This created negative image about her on me. As a result I didn't treat her while she was on bed. But know I wish I had told her my real feelings about her.(Buta)

.....I should be the one who supposed to be dead first. Why? Because it was after my birth, that my dad and my mom broke up. The reason for their broke up was my dad suspect ion of my mom had sexual relationship with others. Sometimes he looked my face and said "you resemble no one in my family". Furthermore he insulted me by calling "yebalege lij"(Betuma).

Though nothing has been said on this psychological aspect by most of FGD participant, the house mother reported that (Bertuma) had always said he was trouble maker in the broke up as well as death of his parents.

### **Need for love and care**

Poverty and in general the orphaned youth circumstances impacted negatively on the participants' self-esteem. The absence of a love, encourage and instill confidence creates feelings of hopelessness-the orphaned participants felt badly about themselves and their state. A common stressor described by participants was poor self-esteem, expressed through the way they viewed themselves or felt. Some participants reported that they felt odd and different when among their peers because of their status. They also reported feeling pity for themselves. One respondent stated,

*".....sometimes I feel unloved when among other students when I see them having a lot and happily talking about their families.....I feel I have nothing to share...I am unlucky."*(Biratu)

Others expressed their feeling related to growing outside home and with love of parents' in this way:-

*....being raised in different home is very difficult, that separation is very painful as we have lacked that love of growing up together.....(Annan).*

*...I have missed a father figure and motherly love in my life.....(Buta)*

*...My dad was a provider I went to the best school. I never lacked but now I am so poor I am a beggar indirectly.(Buta).*

The data from FGD also revealed that whatever effort house mother put they can sense that the children still felt gap.

*....Whatever effort I put to make them to feel at home and to see me as their mother, I can sense that they miss their real mom and dad.(house mother).*

## **Depression**

The negative outcome of the participants' experiences of losing a parent(s) was reported by most of them and this manifested in depression. The sub-theme was deduced from the participants' expression of sadness, fear, perpetual worries, and distress, lack of sleep, loneliness, and withdrawal as expressed by many of the participants.

*... I was not able to sleep well. I usually think that how can I manage my life with out my parent's...(Fantahun).*

*.....before my parent's passed way, my dad created a belief on me that education is the way out for success. Putting that on my mind, I kept on toiling on my study and other academic issue. I was also able to remember ever specific details of what have I thought in the class room .But now all these things blow away. (Kemal)*

*... Staying with people who are not your parents is not easy. They don't treat you the same as your parents-there is a lot of things that devastate and remind me of my parent's..(kiflom).*

*.....Sometimes I compare myself with delinquent children whose parents are in prison. I feel that they are better than me. Because that they do have a chance of seeing them. But my future is gone. All these things irritate me and kill me inside.( Bertuma)*

Other negative aspects mentioned by participants included low self-esteem, stigmatization and rejection, and self-pity. The sickness of parents and their death to AIDS was described as a very traumatizing experience. witnessing their parents go through the agony and pain, going in and out of hospital, not to mention the expenditure that went with it, made many participants feel helpless and disillusioned. Respondents described this experience as devastating. Being in school while one's parents were hospitalized or ailing from an incurable disease such as AIDS was reported to be particularly stressful.

Some reported being unable to go on with their studies for a while; the experience made some to withdraw from normal activities including interacting with family and friends. One participant reported

*"I felt like the world had come to an end...there is nobody in this world who understands what is like...to lose a father and mother in a span of two years..."*

**Negative self- image:** The third psychological problems of the orphans was negative self image which comprises over or under self-esteem, lack of confidence, hopelessness, inferiority, lack of motivation for change. All participants have negative self image about themselves, this is

due to the fact that, they have low self-esteem when they think that they are HIV/AIDS orphans. They view themselves as failure, useless, worthless, weak / incompetent, burden for others and fearful to describe their current self.

One of the self damaging behaviors in the family was stigmatization of HIV/AIDS orphans. In relation to this Kiflom said:

*.... Of my peers, some are supportive and others are so negative; they don't want to come near you because they think you will infect them with AIDS just because they heard your parents died.*

*..... after the death of my mother we felt stigmatized because when we sought help someone will tell you categorically that is not their faults we are the way we are. or that our parts should have behaved better.(yeneneh)*

Some other participant of the study described herself as unfortunate persons who have no hope to have families in the future because of my family back ground story of their death. She does not believe those who are HIV/AIDS orphans have parents (wife or husband) and she has low self esteem:

*Even if I know there is somebody who loves me and requested me for marriage, after knowing my parents death of HIV/AIDS. He would automatically change his mind and married somebody else; thinking that sometime in the future I might bring him the same problem in our marriage.(Annan)*

There are also unfortunate participant who has no relative support. And no one wants to accompany them as a whole. Not only the participant but also families are rejected or stigmatized by the society. So they have no hope, have low self esteem and have negative self-image:

*....During my parents sickness we don't have any supporter. Since nobody wants us and people hate us, we all are useless and hopeless... (Tina)*

With regard to negative self-Image, participants of the FGD stated that patients have negative self-image, they have feeling of inferiority compared with their peers/friends and have different complain like everybody hate me, no one consider me as person, do not want to eat with me, do not sit and play with me, laugh at, make fun and cheat me.

#### **4.2.2 The Social problems of HIV/AIDS orphans**

According to Cantor and Sanderson (1999 cited in Meles 2008), social isolation refers to living without companionship or social connectedness. It is the absence of significant others to interrelate with, to trust, and to turn to in a time of crisis which causes social isolation.

**Weak social lives/relationship:** the first social problem reported by the participant was poor social contact. In order to get deeper understanding into the challenges individuals face in their social lives (social relationship and social interactions) participants were asked to tell their social life. The finding revealed that there were observable differences in their social lives. Most of the participants said that before this problem their social relationship was good and predictable. They said we were sociable, have interest to be with others.

*“Before my parents’ gone they teach me the significance of social life. I’m also very much interested in making friends and being with others. In addition, I like joke and I am joyful. However, after my parent’s death of HIV/AIDS, I’m fearful of social life.(Selam)*

Most of the participants acknowledged that, they are less sociable because of fear of stigmatization, fear of conflict, distrust, lack of self confidence and have poor social interaction with others.

*“Whenever I played with my friend, I always remember the insult of my close friend. One day we were playing with our class met; it was a football. During the game I committed a foul and the referee gave me red card. But that foul wasn’t that much serious .So, I started to convince the referee in a good manner. Unfortunately, my friend called me “ante yeset wusha lige”( son of a bitch).Then after every attendant was laugh at me.(Buta)*

Some participants also have visible difference in their interpersonal relationship. Before their parents’ passed away they have friends and enjoyed social activities but after they lost, their social relationship completely changed from sociable behavior to loneliness.

*“When I am with others especially with those who knew my family background, I take care not offending them one way or another. As a result I became busy of selecting what to say. However, when I’m lonely there is no one who control me what to say. So I prefer my loneliness. (Yeneneh).*

*“I always remember Epiphany. This is because in this social gathering ceremony my dad usually bought me a new cloth and took me to the ceremony. But now he is gone, living me behind.”(Kemal)*

One of the reasons for self stigmatization was suspiciousness and feeling anxious when they join social activities/environments. One of the participants of the study avoids visiting his relatives.

*“When I mix with people, I feel anxious and become suspicious about what they talk. I feel that they talk my parents’ were dead of HIV/AIDS.I prefer them died of car accident.”(Kiflom)*

In relation to social relationship, the FGD participants stated that sometimes they do not want to have any social contact; they may lose motivation for work/talk.

#### **4.2.3 Coping mechanisms of psychosocial problems**

In this study coping strategies are ways of dealing with their psychosocial problems in a situation more competently. Coping strategies can be regarded as skills, activities or ways of thinking about things that can be used to help a person cope more effectively (Phyllis, 2011). From the collected data the researcher categorized the different coping mechanisms into six categories which merged in to two major themes (Emotion focused & Problem Focused Coping strategies)

#### **4.2.3.1 Emotion Focused coping mechanisms**

Emotion-focused coping refers to efforts to manage the negative emotions associated with the stressful situation or related with their situation. With regard to this most participants cope the stressful situation and their challenges using various emotion focused coping mechanisms like searching for people to talk/communicate, using cognitive distraction and avoidant coping.

**Talk to people as coping mechanism:** Some participants use Communication as a coping strategy in which they share information about their thoughts and feelings; especially the social stigma.

Most participants discuss and share their feeling with their family or significant others or for those people who approached and helped them. In previous time (Tina and Kemal) were not much interested to share their feeling so they refused social settings and isolated themselves from people. But now they try to socialize themselves and they feel better when they are with people, talk and discuss with people. With regard to this Fantahun says:

*“When I share my feeling with the supervisor, I get relief”*

In contrary to the above idea, Four of the participants were not comfortable to talk or share their feeling with friends, or any significant others. According to them, sharing feelings or ideas resulted in back biting, when secrete is disclosed for other people and make fun on you/exposed you for stigma. Hence; they were not interested to talk with people about their feelings. As a result their relationship with other people/close relatives was declining from time to time. For instance Bertuma has said the following:

*Since I have bad experience with regard to friendship (people requested me for friendship and entered with the relationship but suddenly they break up the relationship when they heard about the case of my parents' passed away with HIV/AIDS. Hence I am socially isolated and I become suspicious when I meet somebody since I anticipated what is to come.*

**Cognitive distraction as Coping Mechanism:** Some Patient's use of cognitive distraction which includes passive appraisal (utilizing passive appraisal activities, such as watching television, relying on luck, feeling helpless about the problem, and believing that time will solve the problem) to limit their attention or prevent concentration on stressful events distracts the mind from thinking about stressful situations and limit/minimize reactivity. With regard to this Selam and Tina utilize reading books as passive appraisal.

*Back to school learning and Reading book are the other new coping strategies experienced currently. Two of the participants read books to cope with depressive feelings;*

*I am back to school after a long time. I read book, I study hard and I hide myself inside the book. (Annan).*

With regard to reading books to shift their mind from thinking negative things, Tina says on her part as follow:

*I started to read different books and I try to make my mind busy so it helps me not to think so many things. I didn't think so much as pervious when I am concentrating on the book.*

One participant used work or undertaking various activities to distract depressive feelings, engaging in activities reduces the chance to listen what happened and resorting to self and ruminate. Regarding to this, Selam says:

*When I get myself busy it shifts my mind not to think negative thoughts and which reduces listening to my inner voice and worry too much.*

Positive cognition as coping strategy is used by one of the informants, changes in perspective about their problem such as, thinking positive things about their future and positive self- image. Fantahun stated as follows:

*I see positive things for the future because the future could be bright. If I am upset with something I will use different techniques' like thinking the past history of mine and listen GOD words.*

**Avoidant as coping mechanism:** Most of the participant's use sleeping and being alone as strategy during the worst feeling, most adolescent preferred to sleep and isolating themselves when they feel depressed and isolated.

*.....when I depressed and isolated I tend to sleep on my bed and talk to curse my fate. If at that time any one come talk to me or something, I won't talk to that person.(Yeneneh)*

.....*I hate challenges in my life. Every time I face a problem relate to my present situation, I tend to sit down and think how foolish I am. Thinking that there is always a way that one couldn't go such problematic situations.(Buta)*

#### **4.2.3.2 Situation Focused Coping Mechanisms**

**Access Support as Coping Mechanism:** Four Participants(Tina,Biratu,Annan&Kiflom) believed on the importance of support networks to stay well. This included friends, community and health care professionals. With assistance from their support networks, participants described learning to set limits and boundaries and, set up harm minimization strategies. Many participants felt that they had no consistent and proper support.

*'No support really - had to adapt to looking after myself, I lost both of my parents. Since the community has no awareness about the HIV/AIDS, they hurt me. (Kemal)*

Burtuma also shares kemal's idea and he says on his part as follows:

*I had hardly any support from the friends nearby. I wasn't told very much on how to cope with the challenge that I have in my life. There was no support because both my parents' are gone. (Bertuma)*

In contrast to the above idea, the entire participants believe that the organization has been giving them extensive support.

**Being an expert and protect oneself from being harmed;** participants stressed the need for more information about the coping strategies to be an expert to their psychosocial problems and develop a good knowledge about it. Many participants need for information, was paramount importance not only for HIV/AIDS orphans but also to all care providers to cope the challenges. Some participants stated that even if the need for more information of all kinds to help themselves, understand the complexity and effects of the challenge to develop their coping strategies accordingly, they didn't find adequate information provision.

*Even if 'Information and knowledge about the coping strategies are vital, 'I wasn't told very much about it. But I pray and listen constantly to the words of the care providers so that I study hard and work very well. When I compare myself with others of the same problem, I feel better and I told my mind as my problem is not overwhelming. (Tina)*

One of the participants told me that, he tried to be an expert to his psychosocial problems and save himself not to be harmed. He critical observed the change when he applied whatever he has been told by care givers:

*Previously I use substance like kchat and drink alcohol as a coping mechanism; before I came to this orphanage. When I took the substances, it seems I feel very good, happy and forget about my parents' lose. But after some hours the feeling disappear and feel bad, become irritable, sleepless. When this happened repeatedly, I understand that taking substance is not good for my health and I decide not to take any substance. (Biratu)*

**Religiosity/spirituality as coping mechanisms:** Most participants defined the perceived, personally supportive components of their relationship with God as spiritual support. They believed spiritual support was important to their recovery from bad feelings. Their connection with God offered relieve, help, understanding, unconditional love and forgiveness. Their personal relationship with the Almighty God contributed to their sense of well-being. Whenever they face challenges which are beyond their capacity, they go to Church/mosque request him his mercy, his support; talk to God their problems openly, by crying out to God in prayer. They have hop and trust with God's support. During the interviews, the participants called God "higher power," "Lord and Savior" and "awesome."

One of the Participants believed that he is alive because of God's protection:

*My higher power is God. I pray five times a day and thanks him when I wake up in the middle of the night. If I get hard to sleep, I stand up and make abolition to connect with my God every night. I'm constantly thanking God for just being here today because if it wasn't for God's help, I would be HIV victim and lost my life; just like my parents.(Fantahun).*

The comfort the participants found in God was a component of spiritual support that helped them carry on whenever things were difficult. The relief they received from God eased the load to them:

*When I get difficult/stressful events I go to church pray and read the holy Bible request his support by crying and raising my hand and it really helps me in easing my shoulder. I*

*really believe that He is with me and looking after me. Anytime I get in a tense situation, I raise my hand to God. It helps me for some reason it calms me down. (Tina)*

The participants said they communicated with God through prayer. Most of them described having enthusiastic prayer lives. They felt their “constant” prayers to God were not only being heard, but were being answered:

*Every morning, I go to church listen God’s word and pray a lot. For me God is everything. I thank Him for waking me up in the morning and I pray every morning. Whenever I have suffered a lot with something, God erases it from my life. (Biratu)*

No matter what had happened in their lives, having a personal relationship with God helped them through it. Most of the participants identified God as a higher power in their lives and found comfort in knowing that the support and unconditional acceptance of God was available to them.

With regard to striving to cope with their psychosocial problems, the FGD data revealed that, most of their coping mechanisms are emotion based coping mechanism, they refuse social participation to avoid conflict/or distrust, or crying. Sometimes read books, watch televisions or films, used to go church, praying and singing a lot, listen to music, sometimes tried to be busy with work and so on.

## CHAPTER FIVE

### DISCUSSION

The discussion section attempts to relate the result of the analyses with the research questions forwarded at the beginning and/or to discuss the psychosocial problems and coping mechanisms of HIV/AIDS orphans (participants) in relation to various related research findings. The research result in relation to other related findings were briefly discussed as follow:

Ten HIV/AIDS orphans were interviewed. Participants' descriptions revealed four major themes as discussed in the previous chapter (1) *the psychological problems of being HIV/AIDS orphan*; (2) *the social problems of being HIV/AIDS orphan*; (3) *coping strategies of HIV/AIDS orphans*. This chapter explores the meaning of the themes and discuss participant experiences in relation to past research findings. Finally, come to conclusions and forward recommendations for the problems and for further research.

#### 5.1. Psychological problems of HIV/AIDS orphans

In this study, psychological problems like loneliness, negative-self image, need of love, are one of the challenges of HIV/AIDS orphans. Similar to this study from Uganda and South Africa psychological problems which include life stressors, negative self-image, ineffective socialization, and depression etc (Paul, et, 2007).But, in addition to these psychological problems, this study shows self-blame as an additional psychological problems.

In addition to the above, It has been shown that multiple stressors experienced by young people who have lost parents to HIV/AIDS have the potential to impact negatively by causing

undue anxiety, eroding their self-esteem and causing them to be depressed (Germann,2004;Wild,2001;Sengendo & Nambia,1997; Bicengo et al.,2003). Beside this finding, Atwine,et al.(2005) and Sengendo et al.,(1997) within the age brackets 15-24 years, which showed children and adolescents affected by HIV/AIDS had depressive symptoms and had poor self esteem and concluded that orphans due to HIV/AIDS had high levels of psychological distress compared to non-orphans. Related to aspects of depression and low self-esteem the same results have been found.

Furthermore, studies suggest that HIV/AIDS kills both parents in most cases, repeated grief/loss and negative future outlook has been reported as traumatizing and impacts negatively on psychological well-being of HIV/AIDS orphans (Humuliza,1999;Rotheram-Borus & stein,1999;Germann,2004).But in contrary to these findings, the result of FGD of this study shows as there is positive outlook on HIV/AIDS orphans about their future.

Moreover the study shows that since participants hate their life, they suffer with feeling of uselessness, worthlessness and hopelessness in time of their depression. This finding is also consistent with Dilsaver, (1996) and Kass et al., (1999) in which two-third of HIV/AIDS orphans are at substantial risk of loneliness. (Paul, et. al, 2007).

## **5.2 Social problems of HIV/AIDS orphans**

Research by save the children south Africa shows that children and adolescents experience two main forms of stigma and discrimination on the bases of HIV/AIDS: general stigmatization and isolation by families, communities and institutions within communities, e.g., churches,

orphanages etc.; and discrimination by service providers in accessing rights and services (Save the Children South Africa,2001).

Similar to this report, both the in-depth interview and FGD revealed the same result. Of course, besides the societal stigma and discrimination some participant of this study experienced self-stigma.

Furthermore, Foster (1997) found that HIV/AIDS orphans are vulnerable to interpersonal relation, which includes weak social life and poor social interaction. In this study it was also found that there is poor social interaction of HIV/AIDS with the society.

### **5.3 Coping mechanisms of HIV/AIDS orphans of their psychosocial problems**

Coping mechanisms can be regarded as skills, activities or ways of thinking about things that can be used to help a person cope more effectively in their day to day activities. The collected data are categorized the different coping mechanisms merged in two major categories which is Emotion focused & Problem Focused Coping strategies.

The study found that participants were striving to cope with their problem in their day to day activities. Their coping strategies are immature, weak, and inconsistent. Most of the coping strategies are emotion focused strategies which includes crying, avoidance, talk to people and cognitive distraction, and the problem focused coping strategies which are access to support, being an expert; not to be harmed and spiritual support. Supporting the above idea educators (Perkins, et al., 2004) found that some HIV/AIDS orphans use positive coping

strategies to manage and to help them manage their situation, such as positive thinking and the utilization of appropriate social supports, which include family, friends, and holy places.

Participants used their coping strategies when they face external life challenges or suffer with psychological problems like stress, depression, lack of people to trust etc. With regard to this scholars like Pearlin and Schooler (1978, pp.30), said coping as “any response to external life strains that serves to prevent, avoid, or control emotional distress”. In relation to the above idea Lazarus & Folkman (1984) view that even though depression is inevitable; it is the coping that makes the difference in adaptation outcomes.

The study identified the above coping mechanisms which are supported by different literature review but the participants did not cope effectively. Since their coping mechanism is not supported by professionals. On the other hand, some participants use negative coping mechanism like isolation and crying when the situation is beyond their capacity.

One of the emotion focused coping strategies of participants was *search people to talk to* with people and share their feelings when they face problems. Although they have challenges to get people who can listen and understand their problems, they want to talk/share their challenges. This finding is supported by the work of Lazarus and Folkman (1984), they stated that some HIV/AIDS orphans cope with their situation by sharing their feelings only with their immediate care givers, and through this, receive support and understanding. In contrast to this some participants used avoidance (prefer to be alone, decrease communication, limit their social interpersonal reactions) as coping strategies. This coping strategy is also

supported by Nehra, et al., (2005) they said that avoidant strategies may include ignoring care givers, friends, etc by decreasing physical and emotional contact, such as not communicating and visiting them regularly and limiting their affection.

Problem focused coping strategy was the second major category under the themes of cope with the psychosocial problems. Almost all participants have limited problem focused coping mechanisms. These mechanisms are access support, being an expert of their illness or and searching spiritual support.

As the participants said, they frequently went to church when they face difficult situation. They have strong believe and hope on God's help so they have strong contact (they pray, listen preaching or religious songs) with God. They are comfortable and feel good when they are in holy places. They also said that it is the only place where no difference among HIV/AIDS Orphans and the community. In favor of the above findings, Rammohan, et al., (2002) said that the use of spirituality is seen as a positive emotion-focused coping strategy. Spirituality may mean different things to different individuals, but has been seen to increase levels of well-being and decrease the level of stress in one's life.

## CHAPTER-SIX

### 6. CONCLUSIONS AND RECOMMENDATION

#### 6.1. Conclusions

This study captured the psychosocial problems of HIV/AIDS orphans and their coping mechanisms. Study participants explained about the detail and complexities of their psychosocial problems.

Participants are losing their ability to function and they are dependent on orphanages at almost ages of their productive time. The participants were also trying to overcome the consequences of their negative feeling and poorly managed social affairs. The stigmas associated with their problem also made them feel like they were not valued and challenged them not take their life properly. Participants sought comfort, acceptance and forgiveness in spiritual settings. The participants need to be heard, accepted and forgiven by society since they are devalued, rejected and stigmatized because of being HIV/AIDS orphan. Acceptance, forgiveness, listening and understanding would allow them to move forward and maintain a successful life.

Participants need comprehensive or an integrated or holistic approach which address their psycho-social aspects. So, care giving professionals (psychologists, house mothers, sociologists, social workers and more importantly owners), and the community should work together for better improvement of their life and give them the opportunities to make them productive society.

Generally, the implication of the study is that organizations who are concerned with the social needs of HIV/AIDS orphans should also focus on their psychological/emotional needs as

well by strengthening their counseling services and raising the awareness of the community about the troubles of HIV/AIDS orphans so that people take the initiatives themselves in their immediate communities to support these children. This is highly essential because when favorable conditions are created there is a good chance that these children may be able to cope relatively well with the trauma of losing their parents and other related psychosocial problems. These effects include depression, low self esteem, fear and loneliness as to the cause of parental death, and unsolved grief. Thus, it is recommended to people concerned about and working with orphanages that are working with such HIV/AIDS orphans, such as social welfare officers, health care workers, government agencies, and nongovernmental orphanages organizations, particularly to the orphanage institutions.

## **6.2. Recommendations**

The determination of prevalence of psychological distress and associated factors of HIV/AIDS orphans is important because orphan-hood by HIV causes psychological distress particularly vulnerable group in terms of emotional and psychological problems which will certainly affect their present and future life. Assessment helps in planning intervention activities for the prevention of these problems in the orphanage institutions and community. Following the death of parents, children need emotional/psychological support, care and assistance in coping with and /or avoiding stigmatization and socialization.

As it shown in the finding some participants have no trust on the psychological treatment and give priority for spiritual treatment so they need Self-help programs/survival skill that are designed to assist them in raising money that is shared among them in times of emergencies. The

team spirit was said to be very helpful in helping the orphan forget the misery and focus on improving their livelihood and self-reliance. This creativity, focus and diversion of energy were a clear determination to succeed instead of wallowing in self-blame or engaging in self-destructive behaviors.

One of the accomplishments of this study was providing the participants with a chance of expressing their psychosocial problems and their coping mechanisms. Participants described feeling as if they were not heard. This was evidenced by their behaviors and feelings of devaluation. It is imperative that care giving professionals and society recognize that these people need to be heard in their voices they requests for psychosocial support. These individuals are demanding for acceptance by society so responding to their need for support can improve the outcomes. Ultimately, it will lead to a decrease in devastating in life.

It is important that orphanage services are organized in a way that gives possibility to work health-promoting by strengthening self-management ability and social functions of HIV/AIDS orphan. A collaborative approach is necessary both between the professionals and these people.

More knowledge and understanding are needed about what it means being HIV/AIDS orphan by the society in order to combat the prejudiced attitudes to these people. Efforts made by society are needed to help or give this people possibility of regaining a place in and feel part of society.

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## APPENDICES

### APPENDIX-A CONSENT FORM

Thesis Title: The psychosocial problems of HIV/AIDS orphans and their coping mechanisms.

Researcher name: Hana Tarrekegn      Participant's Name: .....

**Description and explanation of procedures:** My name is Hana Tarrekegn, I am graduating student of Special Needs Education. I am conducting a study for master's thesis on **The psychosocial problems of HIV/AIDS orphans and their coping mechanisms.** The objective of the research is to find out psychological, social problems of HIV/AIDS orphans and the coping mechanisms. Therefore, if you are willing, I am going to ask you about this. The purpose of this study is primarily to fulfill the requirement of Masters Program in Special needs Education; the result of study will be used only for educational purposes. It also contributes for further research and intervention to improve the services provided to HIV/AIDS orphans.

To appropriately understand your problems I will use mobile phone as a recorder during the interview if you are comfortable with it and I will keep all the recording in safe place until I finish the transcription. When the study is finished I will remove the recordings from the phone. Therefore, I assure you that all the information you provide me will not be disclosed to a third person and the study do not have any relation with your service provision. You may talk about things that become stressful for you and if you feel the conversation is too stressful you may ask that the tape recorder be turned off and the interview be stopped.

By signing this form, you are agreeing to participate in the research described to you by the researcher.

---

Participant's Signature

---

Date

**APPENDIX-B**  
**INTERVIEW GUIDING ITEMS**

Q1, what are the psychosocial problems of orphans?

- Would you tell me the problem you face; because of being HIV/AIDS orphan?
- How does being HIV/AIDS orphan affect your daily life?  
*(Probe, psychosocial)*
- How do you perceive about yourself?
- Does being HIV/AIDS orphan made a difference to how you see yourself?
- Did it change the way other people see you?  
*(Probe, friends, care givers, teachers, relatives)*
- How do you describe your social relationship before and after being HIV/AIDS orphan?
- How do you compare fulfilling your responsibilities before and after being HIV/AIDS orphan?
- What are the problems you are currently experiencing in this orphanage b/c of being HIV/AIDS orphan? Any changes from the past?  
*(Probe recent challenges regarding psychosocial problems)*

Q2, How persons of HIV/AIDS orphans cope with their illness?

- On day to day basis how you deal with problems of being HIV/AIDS orphan?
- Do you have particular strategies for helping yourself? Ways of coping?  
*(Probe, Could you describe your strategies/ways of coping with example?)*

**APPENDIX-C**  
**FOCUSED GROUP DISCUSSION GUIDE**

1. Facilitator Name -----
2. Place of Meeting----- Date -----Time Allowed -----
3. Before the FGD is started, the facilitator should follow /apply the following guidelines
4. Should get the informed consent of each participants
5. Be sure every participant is sited comfortably and the meeting room has enough light and fresh air.
6. Please introduce each other, informed them how they are selected
7. Inform them as they have the right to omit the discussion at any time and do not obliged to respond on the issue which creates any discomfort on you
8. Informed them how their participation is necessary for the research and read the objective of the Research and its significance as follow:
  - ❖ **General Objective:** The overall objective of this study is identifying the psychosocial problems and their coping mechanisms of HIV/AIDS orphans.
  - ❖ **The Specific Objectives are:**
    - To find out the psychological problems of HIV/AIDS orphans.
    - To find out social problems of HIV/AIDS orphans.
    - To find out their coping mechanisms of their psychosocial problems.
  - ❖ **Significance of the study:** It will have implication for
    - Persons of HIV/AIDS orphans and their care givers.
    - ❖ What problems HIV/AIDS orphans face, in what way they manage, the psychosocial problems they face; according to their context.
    - ❖ The care givers can also learn how to provide care and support for HIV/AIDS orphans.
    - ❖ Care givers will have common understanding on the psychosocial problems and coping strategies of HIV/AIDS orphans.
9. Raise FGD items for discussion, facilitate the FGD, and finally summarized the issue and thanks the participants.

**APPENDEX-D**  
**FGD GUIDING ITEMS**

Q1, how do HIV/orphans perceive about themselves?

- Can you discuss about the brief history of each/some of HIV/AIDS orphans in the orphanage?

(Probe; related with their feeling, self understanding and perception change, can you elaborate it with example)

Q2, what are the psychosocial problems HIV/AIDS orphans face?

- Would you explain the problem they face in their daily life because of being HIV/AIDS orphan?

*(Probe, psychosocial)*

Q3, How do persons of HIV/AIDS orphans cope with their psychosocial problems?

- On day to day basis how they deal with being HIV/AIDS orphan?
- Do they have particular strategies to help themselves? Ways of coping?

*(Probe, Could you describe their strategies/ways of coping with example?)*

## APPENDEX-E

### Brief Narrative of the research participants

#### Selam

-After my parents' death I felt hopeless and confused I stayed home after her death because I was unable to come to terms with her death. The realization that I was the only member of my family alive I became desperate. Every time I think about her, I always feel I am in the middle of nowhere.

-Before my parents' death I'm very much sociable, I like to be with people and it make me relax and easily make friends. In addition, I like joke and I am joyful. I forget negative/bad things quickly and easily.

-You cannot read well when you have problems-I tell myself my parents are gone but at times it is very difficult.

-life has been challenging as an orphan both financially and psychologically-now that I don't have a mother or father .I am all alone.

-Being raised in different home is very difficult, that separation is very painful as we have lacked that love of growing up together.

-Life is very stressful-life is very hard but I have to cope.

-I am frustrated family wise and financially. I feel I want to work hard though the future looks dark right now I will work hard to change my circumstances.

-Relatives are not good to me. They are harsh and refuse to meet our financial needs.

-Back to school learning and reading book are what I am experienced currently.

-When I get myself busy it shifts my mind not to think negative thoughts and which reduces listening to my inner voice and worry too much.

-My situation makes me to work harder. I burry myself in books, instead of worrying and feeling bad about my situation.

-Orphan should work hard and trust God.

-For coping I draw strength from my friends and the fact that my dad taught me to be responsible.

-Some of my friends are my source of strength.

## **Kemal**

- Before my parent's passed way, my dad created a belief on me that education is the way out for success. Putting that on my mind, I kept on toiling on my study and other academic stuff. I was also able to remember ever specific details of what have I thought in the class room .But now all these things blow away.

-When my mother passed away, I feel like the whole world had come to an end. There is nobody in this world who understands what is like to lose a father and a mother in life of two years.

-Even though my fee is paid by this organization, I have many emotional needs. I need to feel loved and welcome in the families that welcomed us.

-No support really - had to adapt to looking after myself, I lost both of my parents. Since the community has no awareness about the HIV/AIDS, they hurt me.

-It is difficult to be happy. I don't remember when I last felt happy.

-I am distressed about one of my younger sister who left home to go big down to look for a job....I hope someone can speak to her to come back home.

-When I see other students happy and confident it motivated me to work hard and not to feel bad.

-My difficulties have inspired me to work hard. So that I can help family and I want to make people and wrong that I can make it in life.

-I talk to my friends.

-I think I am the cause of all this mess. This is because it was after my birth that this entire problem aroused. So, I am in the course of hopelessness and emptiness

## **Yeneneh**

-I like being alone to deal with my pain and loss. At times it helps me.

- After the death of my mother we (I and my siblings) felt stigmatized because when we sought help someone will tell you categorically that is not their faults we are the way we are. Or that our parents should have behaved better.

-I always remember Epiphany. This is because in this social gathering ceremony my dad usually bought me a new close and took me to the ceremony. But now he is gone, living me behind.

-When I am with others especially with those who knew my family background, I take care not offending them one way or another. As a result, I became busy of selecting what to say.

However, when I'm lonely there is no one who control me what to say. So I prefer my loneliness.

-When I am depressed and isolated I tend to sleep on my bed and curse my fate. If at that time any one comes and talk to me or something, I won't talk to that person.

-I felt guilty that I was not there to help my mom.....I felt bad and sad that I could not help her.

-I thought it was the end of life. There was nobody to cry to-I was hopeless.

-I am destructed and enable to concentration.

-Staying with people who are not your parents is not easy. They don't treat you the same as your parents-there is a lot of quarrels about every small things that reminds one's parents.

-When my mother passed away I felt like the whole world had come to an end..there is nobody in this world who understand what is like....to lose a father and mother in a span of life of two years.

-I have been talking the student counselor seeking help so as to cope with my problems have found this helpful because he has helped me look at situation better and develop a positive attitude.

-I have learned a lot from this situation, I know it is not in vain, God has a purpose and I am willing to perceiver so I can discover his purpose in this.

-I cry it out.

-I play chess.

-I go to marshal art classes.

-I go to church –youth programs and teachings. That keeps me away from youthful thing that can get me in trouble.

## **Biratu**

-Sometimes I feel low when among other students when I see them having a lot and happily talking about their families.....I feel I have nothing to share...I am unlucky.

-Previously I use substance like kchat and drink alcohol as a coping mechanism; before I came to this orphanage. When I took the substances, it seems I feel very good, happy and forget about my parents' lose. But after some hours the feeling disappear and feel bad, become irritable, sleepless. When this happened repeatedly, I understand that taking substance is not good for my health and I decide not to take any substance.

-Sometimes I feel low when among other students when I see them having a lot and happily talking about their families.....I feel I have nothing to share...I am unlucky.

-I feel all alone-nobody loves me; I miss a family, a dad and mum when others are going home to meet their dad and mum I feel bad when I go home.

-Every morning, I go to church listen God's word and pray a lot. For me God is everything. I thank him for waking me up in the morning and I pray every morning. Whenever I have suffered a lot with something, God erases it from my life.

### **Tina**

-I feel my parent's death was to punish me I feel bad about them for leaving to struggle alone.

-I was not able to sleep well. My financial needs were not met.

-During my parents sickness we don't have any supporter. Since nobody wants us and people hate us, we all are useless and hopeless.

-Life is stressful and I don't like talking about.

-People did not think good of us. They don't see anything good in us.

-Back to school learning and Reading book are the other new coping strategies experienced currently. Two of the participants read books to cope with depressive feelings;

-I started to read different books and I try to make my mind busy so it helps me not to think so many things. I didn't think so much as pervious when I am concentrating on the book.

-When I get difficult/stressful events I go to church pray and read the holy Bible request his support by crying and raising my hand and it really helps me in easing my shoulder. I really believe that He is with me and looking after me. Anytime I get in a tense situation, I raise my hand to God. It helps me for some reason it calms me down.

-Even if 'Information and knowledge about the coping strategies are vital, 'I wasn't told very much about it. But I pray and listen constantly to the words of the care providers so that I study hard and work very well. When I compare myself with others of the same problem, I feel better and I told my mind as my problem is not overwhelming.

### **Annan**

-Being raised in different home is very difficult, that separation is very painful as we have lacked that love of growing up together.

-Even if I know there is somebody who loves me and requested me for marriage, after knowing my parents death of HIV/AIDS. He would automatically change his mind and married somebody else; thinking that sometime in the future I might bring him the same problem in our marriage.

-I am back to school after a long time. I read book, I study hard and I hide myself inside the book.

-Many orphans lack love and affection guidance and counseling should be strengthened.

-I like being alone to deal with my pain and loss a time it helps.

-One feels frustrated having to ask for money from other people, it is frustrating because it is like they do not remember your need unless you remind them and sometimes it comes very late after you have been sent away from school.

-I pitied myself a lot.

-I avoid talk about because I don't see others would do for me.

-I try to keep away from people who make me feel bad.

-I am back to school after a long time. I read book, I study hard and I hide myself inside the book.

-My situation have motivated to work very hard-I am determined to make it -if we don't work hard who will change the situation for us-I have to focus on I am going.

-We have come to accept our situation but we try not to look behind but forward to make our life better.

### **Fantahun**

- I was not able to sleep well. I usually think that how can I manage my life without my *parent's*

-My dad was a provider I went to the best school. I never lacked but now I am so poor I am a beggar in the real sense.

-I was not able to read because I thought about my loss so much.

-My peers some are supportive others are so negative; they don't want to come near you because they think you will infect them with AIDS just because they heard your parents died.

-When I share my feeling with the supervisor, I get relief.

-I see positive things for the future because the future could be bright. If I am upset with something I will use different techniques' like thinking the past history of mine and listen GOD words.

-My higher power is God. I pray five times a day and thanks him when I wake up in the middle of the night. If I get hard to sleep, I stand up and make abolition to connect with my God every

night. I'm constantly thanking God for just being here today because if it wasn't for God's help, I would be HIV victim and lost my life; just like my parents.

-Our church pester comes to pray with us and know we are fairing on every week.

### **Bertuma**

-I had hardly any support from the friends nearby. I wasn't told very much on how to cope with the challenge that I have in my life. There was no support because both my parents' are gone.

-Even though our fee is paid by this organization, we have many emotional needs. We need to feel loved and welcome in the families that welcomed us.

-I would have performed better if this was not my situation.

-Life has been so hard-full of up and down.

-I was not able to sleep well.

- I should be the one who supposed to be dead first. Why? Because it was after my birth, that my dad and my mom broke up. The reason for their broke up was my dad suspect ion of my mom had an unfair. Sometimes he looked my face and said "you resemble no one in my family". Furthermore he insulted me by calling "yebalege lij"

-One of the things that I miss is someone to love comfort-someone to listen to you. Friends did not help as I thought and their words were discouraging.

-Since I have bad experience with regard to friendship (people requested me for friendship and entered with the relationship but suddenly they break up the relationship when they heard about the case of my parents' passed away with HIV/AIDS. Hence I am socially isolated and I become suspicious when I meet somebody since I anticipated what is to come.

-Sometimes I compare myself with delinquent children whose parents are in prison. I feel that they are better than me. Because that they do have a chance of seeing them. But my future is gone. All these things irritate me and kill me inside.

-Going to church also helps-they give social, moral and sometimes financial support.

-I do encourage my self-I am determined-to make it I am motivated and do want to be different because of the difficulties. I have encouraged.

-Because of my circumstances I feel more responsible even better than those who have both parents. My situation has been a way of learning. I am very motivated.

## **Buta**

-I have missed my father's figure .

-My dad was a provider I went to the best school. I never lacked but now I am so poor I am a beggar indirectly.

-Whenever I played with my friend, I always remember the insult of my close friend. One day we were playing with our class met; it was a football. During the game I committed a foul and the referee gave me red card. But that foul wasn't that much serious .So, I started to convince the referee in a good manner. Unfortunately, my friend called me "ante yeset wusha lige"( son of a bitch).Then after every attendant was laugh at me.

-I hate challenges in my life. Every time I face a problem relate to my present situation, I tend sit down and think how foolish I am. Thinking that there is always a way that one couldn't go such problematic situations.

-I feel bad when my peers are talking about their experiences with their families how they spent their holidays and what kind of gifts they received I have nothing exciting to share so I keep to myself.

-My situation motivated me to work hard but other times I feel discouraged now that they are not there.

-When my mother died, I lost that motherly love.

-The memory of my dad comes when I see my dad's brothers-I miss him-I am sad.

-I am very bitter towards everybody. I feel odd around people. I am very moody

-Nobody came forward to help in any way.

-Teachers/priests have been an encouragement-they cultivated strength in me that I did not know existed

-I have very understanding friend-my friends are there for me-they make sure I am comfortable. I talk to them they give me listening hears.

-Have encouraged orphans to form counseling groups, counseling each other it is easier to talk to someone who is going through the same situation.

-I can relate to others who are struggling-I can give them a shoulder to learn on.

-Though my mom fulfill all my basic needs, my grandmother always told me that she was bully(Balege).This created negative image about her on me. As a result I didn't treat her while she was on bed. But know I wish I had told her my real feelings about her.

**kiflom**

- Staying with people who are not your parents is not easy. They don't treat you the same as your parents-there is a lot of things that devastate and remind me of my parent's
- When I mix with people, I feel anxious and become suspicious about what they talk. I feel that they talk my parents' were dead of HIV/AIDS.I prefer them died of car accident.
- Financially I depend on "HELP" which is not sufficient.
- After mother's death I felt hopeless and confused I stayed home after her death because I was unable to come to terms with her death. The realization that I was the only member of my family alive I was desperate.
- I feel intimidated and felt really an orphan.
- Relatives don't keeps their promises they are full of lies and want to take what we have.
- Socially I feel I don't take it kindly because I feel I have no one who can fight for me.
- My guardian is like a mother to me in providing counsel and financial support.
- I have learned to believe in myself.
- I am more outstanding and confident-I feel I am leaving out his legacy.
- Despite all this I have worked hard and not failed.

## **Declaration**

**Hana Tarrekegn Alemu** the author of this thesis is MA candidate who is responsible for the conception, design, analysis and interpretation of the study data. She had collected original data, thus, she had full access to all the data in the study, and responsible for the integrity of the data and the accuracy of the data analysis. I, the under signed, declare that this thesis is my work, and that all sources of materials used for these thesis were acknowledged.

**Dr. Sewalem Tsega** was the advisor of the candidate. She had contributed in critical review of the document and she approved the final one.

**Name: Hana Tarrekegn Alemu**

Signature \_\_\_\_\_

A.A.U      2014

This thesis has been submitted for examination with my approvals thesis advisor

**Name: Dr. Sewalem Tsega**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_