ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF PSYCHOLOGY

ADJUSTMENT CHALLENGES TO HEALTHY PSYCHOSOCIAL DEVELOPMENT OF AIDS-ORPHANED CHILDREN OF ADAMA TOWN

BY

DESALEGN GARUMA ADABA

JUNE 2006

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A THESIS

PRESENTED TO

THE SCHOOL OF GRADUATE STUDIES

ADDIS ABABA UNIVERSITY

IN PARTIAL FULFILMENT OF REQUAIREMENTS OF THE DEGREE OF MASTER OF ARTS IN DEVELOPMENTAL PSYCHOLOGY

JUNE 2006

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ACKNOWLEDGEMENTS

First and foremost, I would like to express my deepest gratitude and appreciation to my thesis advisor, Dr. Teka Zewudie, who really sacrificed his precious time in reading through and giving me very critical comments, both of which further motivated me to materialize the completion of this paper.

My special thanks also go to my former instructor, Professor Tilahun Sineshaw, for his unreserved positive criticisms which I found to be very useful while conducting this study.

Last, but not least, I would like to thank Ato Jira Mokonnin for material and moral support during this study.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHGA	Commission on HIV/AIDS and Governance in Africa
FHI	Family Health International
HIV	Human Immuno Virus
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	Non –Governmental Organization
OSSA	Organization for Social Services for AIDS
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
RCBS**S**	The Revised Check and Buss Shyness Scale
RCMASS	The Revised Children's Manifest Anxiety Scale
SAD	Social Avoidance and Distress Scale
TB	Tuberculoses
UNAIDS	Joint United Nations Program on AIDS
UNGASS	UN General Assembly on HIV/AIDS Special Session
UNICEF	United Nations Children's Fund
YDS	Yasavege's Depression Scale

Abstract

The objective of this study has been to investigate the adjustment challenges of AIDS orphans, that is, their psychological and social adjustment to AIDS related parental death, their assumed connectedness to their caregivers, the nature of their social interactions, their self-esteem and their emotional adjustments. Hence, 61 AIDS orphans and 4 counselors were selected from OSSA (Organization for Social Services for AIDS) in Adama city using random sampling method.

Regarding assumed connectedness, 32 (52.46%) of those children have no assumed connectedness to their guardians, 17 (27.86%) have very weak assumed connectedness to their guardian, 6 (9.84%) have weak assumed connectedness to their guardians, 5 (8.19%) have strong assumed connectedness to their guardians and one child has very strong assumed connectedness to his guardian. Thus, the majority of AIDS orphans do not assume themselves to be psychologically connected to their guardians. When Chi-square test of independence was computed to test whether depression was related to the assumed connectedness of these children, the calculated x^2 *value was 42.77 - significant. This shows that the level of depression is not independent of the extent to which these children assume themselves to be psychologically connected to their caregivers. This means, there was relationship between the levels of depression and degree of connectedness of AIDS orphans to their guardians/caregivers.*

It was also found out from the research that AIDS orphans have scary dreams, feel unhappy, prefer to be alone, are worried, view themselves as hopeless about the future, and demonstrate low self-esteem. Chi-square test of independence showed that there was no relationship between sex and age of these children.

Besides, the children exhibit social adjustment problems. This means, they are socially awkward, shy, and show no interest in social relationships. Independent sample t-test was used to test if the way AIDS orphans express their internal anxiety or emotion such as nervousness, tension and worry was related to the age and/or sex of these children. For age, the observed value of t was 1.29- not significant. This means, the way AIDS orphans express their internal anxiety or emotion such as nervousness, tension and worry was not related to the age of these children. For sex, the observed value of t was 3.08- far greater than the table value of t, and hence it is significant. This shows that there was relationship between the sex of AIDS orphans and the way they express their internal anxiety or emotion such as nervousness, tension and worry. Thus, no matter how both males and female AIDS orphans express their nervousness, tension and worry highly in the same way, male AIDS orphans seem to express their internal anxiety more than female AIDS orphans. Independent sample t-test shows that the more mature AIDS orphans (16-18 years) have more social adjustment problems when compared to the younger AIDS orphans (13-15).However, no significant sex difference had been obtained on the social adjustment problems of the AIDS orphans. Finally, it was recommended that training has to be given to communities at large, AIDS orphans and guardians.

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CHAPTER ONE

INTRODUCTION

AIDS orphans are those children who have already lost one or both of their parents to the ever devastating pandemic. They were once children of someone else who used to care, love and worry for them probably the same way we are doing for our children. Unfortunately, from the moment they had lost their parents, the direction of their lives were suddenly changed from one of hopeful and bright into that of total darkness and hopelessness. Hence, they are forced to face the challenges of the world that cannot easily be overcome starting from the very early years of their lives. Physical damages, social stigmatizations, lack of clothes, food and other needs, lack of parental love, and the like are some of the challenges they face from time to time. All these problems obviously affect the psychosocial developments of the children.

According to Kallian (2003) research findings conducted in South Africa, children's needs could be depicted on a wheel that shows five segments. These needs are emotional, social, cognitive, spiritual and physical needs. Certainly, all needs are equally important for a child's development and absence of any one of them may result in malfunctioning and eventually making the "wheel" unable to turn.

It could be understood that children, like the rest of us, need clothing, shelter, and in particular, school-related expenses. However, the mere provision of financial and physical needs cannot be sufficient for children to grow up to be

healthy. They need positive attachment, to accept and be accepted; to have security, encouragement, recognition from others; to have self-confidence and positive self-esteem, to be heard, to speak to others and form good social relationship in general. These are basically the psychosocial needs in nature, the lack of which result in the impairment of healthy development.

AIDS orphans, like any other children, need to have all these basic needs. However, research shows that the impacts of traumatic experiences they encountered during their parents' illness and death, memories and worries of their changed circumstances, affect the psychosocial adjustment of these children and result in unhealthy psychosocial development (Kallian, 2003;Tandria,2004).

In this research, therefore, the adjustment challenges to healthy psychosocial development of AIDS orphans: their assumed connectedness to their caregiver/guardians, the nature of their social relationship, their self-esteem, and their psychosocial adjustment and development will be investigated.

1.1 Background

According to UNICEF (2005), 15 million children under 18 had been orphaned by HIV/AIDS worldwide. The World Bank (2001) has stated that the virus, unheard of two decades ago, now has infected more than 60 million people worldwide including children and approximately 14,000 new infections occur each day.

According to UNICEF report of (2004), the level of orphanhood has always been high in sub-Saharan Africa due to the high mortality rate, in general, and that of maternal mortality, in particular. The AIDS pandemic, however, targeting the age

group consisting of caregivers and parents, has increased the number of orphans to unprecedented levels. It was estimated that there were 43.4 million orphans in Africa at the end of 2003, a number projected to increase to 50 million by 2010. The increase is largely due to AIDS, with an estimated 12.3 million AIDS orphans at the end of 2003, rising to 18.4 million in 2010(Tandria, 2004; UNICEF, 2004).Tandria (2004) further explained that in sub-Saharan Africa, the number of orphans in some countries exceeds half a million, and in some countries children who have been orphaned by AIDS comprise half or more orphan nationally.

As a country in sub-Saharan Africa, Ethiopia is also sharing the threats of this pandemic. In 2002, it was estimated that the number of orphans in Ethiopia would increase from 1.2 million in 2001 to 1.8 million in 2007 and 2.5 million in 2014, other things being equal. According to MOLSA (2004), about 1 million children have become orphaned by losing their mothers or both of their parents to HIV/AIDS in Ethiopia up to the year 2003. Besides, The Horn of Africa Journal of AIDS (2005) stated that the total number of children has been increasing as the population of Ethiopia continues its upward trend, but the exponential increase of the number and percentage of AIDS orphans are reaching an alarming proportion. The following table shows the situation of AIDS orphans in Ethiopia:

Table1: The progress of HIV/AIDS and the condition of orphans in Ethiopia

Year	Number of Children 0-14	Total orphans	Total orphans % of all children	Total orphans due to AIDS	Orphans due to AIDS % of all children
1990	21,147,000	2,700,000	12.8%	61,000	2.3%
2001	29,141,000	3,839,000	13.2%	989,000	25.8%
2005	32,084,000	4,414,000	13.8%	1,563,000	35.4%
2010	35,981,000	5,029,000	14.0%	2,165,000	43.0%

Source: The Horn of Africa Journal of AIDS, 2005

As can be seen from the above table, there were about 21,147,000 children aged from 0-14 years in Ethiopia out of which 2,700,000 (12.8%) were orphaned due to all cases while 61,000 (2.3%) were due to HIV/AIDS.

1.2. Rationale for the Selection of Research Topic

According to UNICEF (2005), about 4,414,000 children are orphaned due to all causes in Ethiopia. Of these, the number of children orphaned by HIV/AIDS is about 720,000. This means, 16.31 % of the total orphans in the country are due to HIV/AIDS. By the year 2010; however, this figure is predicted to increase to 43% according to The *Horn of Africa Journal of AIDS (2005).* In other words, after four years, 43% of the orphan will be due to AIDS related parental deaths. This is not, indeed, a situation which could be ignored, and hence the main reason that prompted the researcher.

According to several studies, children who are orphaned by AIDS usually grieve more than their counterparts who have lost their parents due to other causes. This is because of the complications the epidemic yields, bringing about material

and psychological stressors which come before and after parental death (Fleming, 1994; Dane, 1997). From a developmental point of view, it is reasonable to investigate the physical, cognitive, and psychosocial developments of AIDS orphans. However, since the investigation of the children's physical and cognitive development requires a controlled experiment to be conducted for an extended period of time, the present researcher intends to focus only on the psychosocial development aspect of these children.

To this effect, AIDS orphans of ages between 12 and 18 years were the focuses of this study. This is, according to Piaget's stages of cognitive development, they stipulate their "formal operational stage" of cognitive development.

1.3 Statement of the Problem

Even though a significant number of AIDS orphans receive various forms of material support (like financial support) from governmental and non-government organizations, the psychosocial and educational supports given to these children were found to be insignificant (UNAIDS, 2004).The type of support given to AIDS orphans were in the forms of financial assistance, clothing, food, shelter, health care, and school expenses that are generally related to their physical needs. The possible reason for the donors or supporters to focus on one aspect of the children's needs may probably be due to lack of adequate knowledge about the children's psychological and emotional needs, and their needs for social interactions. The other reason could be the scarcity of research undertaking that could address the problems of AIDS orphaned adolescents.

With regard to the latter issue, one can easily observe that few studies are undertaken in Ethiopia in the area of orphaned children in general. Most of the

works focused on the problems related to the physical development of HIV/AIDS orphans. However, these essential, meaningful, and positive elements of human development were not published or not available in book forms. There is, thus, a serious shortage of research output on this dimension of development. This research is, therefore, expected to contribute to the proper addressing of vulnerable children, so that other researchers would turn their attention to this crucial issue of our time. Generally, this research attempts to answer the following basic questions:

What are the major adjustment challenges (due to AIDS related parental illness and death) to healthy psychosocial development of AIDS orphans'? More specifically,

- What do the social interactions of AIDS orphans look like?
- How are AIDS orphans connected to their guardians?
- Is there a significant age difference among AIDS orphans with reference to their social adjustment?
- Is there a significant sex difference among AIDS orphans on their social adjustment?
- What does the emotional well-being of AIDS orphans look like?
- Is there a significant age difference among AIDS orphans on the level of their self-esteem?
- Do AIDS orphans have depressions that are related to their situations?

1.4 Objectives of the Study

The study has the following general and specific objectives:

1.4.1 General objective

The overall objective of this research is to investigate the adjustment challenges to healthy psychosocial development of AIDS orphaned adolescents.

1.4.2 Specific Objectives

The specific objectives of the research are to:

- investigate the assumed connectedness of AIDS orphans' to their guardians;
- investigate the nature of AIDS orphans' social interaction;
- investigate if there was significant age difference among AIDS orphans on their social adjustment;
- investigate if there was significant sex difference among AIDS orphans on their social adjustment;
- investigate if there was significant age difference among AIDS orphans on their self-esteem;
- investigate if there was significant sex difference among AIDS orphans on their self-esteem.
- investigate the emotional well-being of AIDS orphans, and
- investigate if AIDS orphans have depression that was related to their situation.

1.5. Significance of the Study

The present study would be of significance for the following reasons.

- AIDS orphans' psychosocial development was investigated. Hence, the overlooked parts of these children's problems are hoped to get attention from the government and other concerned bodies.
- It could have theoretical contributions in the sense that it will shed some light on psychosocial development of AIDS orphans', thereby broadening our knowledge of these problems from developmental perspectives.
- The results of the research could serve as a base for planning available resources and determining feasible intervention strategies for bodies concerned.
- The fact that the research has been conducted on the area where little research pertinent to the case in point has been conducted is hoped to serve as a starting point for those who want to make more detailed research.

1.6 Delimitation of the Study

According to UNAIDS (2004), there were about 720,000 AIDS orphans in Ethiopia, both in urban and rural areas. It was, however, difficult to incorporate all these AIDS orphans into this study. So, the researcher has delimited the study to **64** AIDS orphans from Adama city. This was purposely done to have a manageable size of the target group and to avoid other expenses. Besides, the study focuses on adjustment challenges that may occur due to AIDS related parental illness and death as well as stigma and discrimination associated to them.

1.7 Limitation of the Study

One of the limitations of this study is the fact that adolescents –though operationally defined as children –were selected as participants of this research. Adolescents, as known, sometimes have adjustment problems due to the normal biological changes. Hence, those normal biological changes may affect the results of this research. This means, the normal biological changes that occur during adolescence period may affect the psychological, emotional and social adjustment of children under study in addition to AIDS- related parental death and affect the results of the study.

The other limitation of this study is scarcity of research conducted on AIDS – orphans' psychosocial development in Ethiopia. In other words, due to scarcity of research conducted in the psychosocial aspects of AIDS orphans', research conducted in other countries were frequently used in this research.

1.8 Operational Definitions

HIV/AIDS-orphaned children:- According to the Joint United Nations Program on HIV/AIDS (UNAIDS) convention, AIDS orphans are defined as children under 18 years of age whose mother, father or both parents have died to AIDS. They limit their estimates to children below age 18 because of the standard age cohorts that are used in reporting health statistics. For the purposes of this paper, following the upper limit, HIV/AIDS-orphaned children are defined as children above or equal to **13** and below or equal to **18** years of age who have lost both of their parents to HIV/AIDS .

Trauma: an emotional shock that produces long lasting and harmful effect on children.

Discrimination: is any distinction, exclusion or preference made on the basis of real or perceived HIV status that has the effect of nullifying or impairing equality of opportunity and treatment.

Stigma: a barrier that discourages individuals and their families from getting the help they need due to the fear of being discriminated against.

Double HIV/AIDS orphans: children from 13-18 years who have lost both of their parents to AIDS.

Depression: an emotional attitude sometimes pathological involving a feeling of inadequacy and hopelessness.

Self-Esteem: the experience of feeling and knowing that one is competent to live and worthy of living and being happy.

Adjustment challenges: the instabilities and insecurities that AIDS orphans experience as a result of trauma of AIDS related parental illness and death as well as the stigma and discriminations associated to them.

CHAPTER TWO

REVIEW OF RELATED LITRATURE

2. Impacts of HIV/AIDS Related parental death on Children

It is obvious that HIV/AIDS related parental death has physical, social, economic, health and psychological impact on children. Of all these, the psychological impact of HIV/AIDS on children 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 one's, with most children showing psychological reactions to parental illness and death as well as stigma and discrimination associated to them (Forehand, 2003; Kallian, 2003). Hence, literatures related to the psychosocial impacts of HIV/AIDS related parental illness and death will be presented under this chapter.

2.1 Impacts on children's Psychosocial Development

2.1.1 Stigma and Discrimination of AIDS Orphans

Many researchers who have conducted research on AIDS-orphaned have identified the existence of discrimination of AIDS orphans by the peer groups and the society at large. For some of them, even the term given to these children, "AIDS orphans" by itself reinforces labeling and discrimination. This means, the fact that the term "AIDS" attached to these children sets a ground for discrimination. Hence, they recommend ignoring singling out the cause of

parental death (Dane, 1997; UNAIDS, 2002). According to Belay (2005), AIDS orphans experience traumas and long term effects than other children who have lost their parents due to other illness as a result of stigma and discrimination. These traumas and long term effect have impact on the psychosocial development of AIDS orphans.

2.1.1.1 Stigma and Stigma Theory

According to USAID (2004), stigma and disease have been common companions throughout human history. The classic example being the extreme stigma experienced by person with leprosy that has persisted long after the discovery of the cure. The causes of stigma may vary from society to society, but they usually stem from practical, moral, economic, cultural, and political factors. Accordingly, lack of knowledge about HIV/AIDS prevention, transmission, or treatment, traditional or religious beliefs about the sickness and death, judgmental attitudes about the sickness and death, judgmental attitudes about the life styles of these affected by HIV/AIDS; fear and the like are the cause for HIV/AIDS related stigma and discrimination.

According to Crandel and Coleman (1992) cited in Gro Therese Lie (1996), AIDS and characteristic of the disease has renewed the classical theory of stigma especially in USA. They on the other hand proposed two sources of AIDS related stigma. Those are the nature of the disease itself (fear of lethal virus) and the fact that the disease is associated with already stigmatized groups. In Europe and North America, according to these researchers, for example, AIDS has been seen as a disease related to drug addiction and homosexuality though this is not the case in Africa.

2.1.1.2 The Cultural Contexts of Stigma and Discrimination

According to USAIDS (2002), AIDS stigma represents a set of shared values, attitudes and beliefs that can be conceptualized at both cultural and individual level. At cultural level, AIDS stigma is manifested in laws, policies, and social conditions of persons with HIV/AIDS and those at risk of infection. At individual level, it takes the form of behaviors, thoughts, and feelings, which express prejudices against persons infected with HIV. According to this report, examples of institutions and cultural manifestations of AIDS stigma include laws and policies, that directly punish People Living With HIV/AIDS (PLWHA) or promote discrimination against them; electoral campaigns that promote negative attitudes, beliefs, or actions against PLWHA and their loved ones, associates, care givers, institutional failures to address problems and needs related to AIDS or HIV because of its stigmatized status.

As cited in Gro Therese Lie (1996), Herek and Capitanio (1992) pointed out that are four important points that should be understood in relation to the specific characteristics of HIV and the modern AIDS epidemic. First, the nature and intensity of AIDS stigma are shaped by the social constructions of the epidemic in different locals. Though AIDS stigma is universal, it takes different forms in different countries. The specific groups targeted for AIDS stigma vary considerably across cultures and national boarders depending on the extent to which stigmatizing attitudes are enriched in laws and policies. This variation is shaped in each society by multiple factors, including the local epidemiology of HIV; pre-existing beliefs, and values surrounding sexuality, and drug use. Second, these researchers stated that stigma has been associated with AIDS from

the earliest days of the epidemic, documented in the forms of public attitudes, violence and discriminatory practices. People Living with HIV/AIDS (PLWHA) have been more negatively evaluated than persons living with other diseases. Thirdly, it was stated that AIDS stigma has been layered upon pre-existing societal stigma toward groups affected by HIV. Consequently, cultural AIDS stigma has been closely intertwined with the drug use, homosexuality, poverty and racial minority statuses. Fourth, with in particular society, AIDS stigma can vary across population subgroups. How different communities and groups react to AIDS stigma may vary depending upon how they have been affected by the epidemic.

2.1.1.3 Individual AIDS Stigma

According to Herek (1990), AIDS stigma can also be conceptualized at individual level (Herek, 1990). This researcher further stated the target of AIDS stigma as Primary AIDS stigmas in which People Living with HIV/AIDS suffer from states creates stress for such people. Secondary AIDS stigma on the other hand includes stigmatizations of People Living with HIV/AIDS relatives, loved ones, children, family members. Using Coffman's (1963) terminology as cited in Gro Therese Lie (1996), these individuals experience a courtesy stigma. Secondary stigma leaves these people without adequate social support. There is also another form of stigma discussed by this researcher. That is Instrumental AIDS stigma in which materials not directly related to HIV like eating with PLWHA, using the same toilet, and so on are ignored. In symbolic forms of AIDS stigma people attach social meaning to AIDS. This means, the use of the disease to express attitude toward the group associated with it and the behaviors that transmit it (Herek, 1990;Gro Therese Lie, 1996).

According to UNAIDS (2002), stigma affects children long before their parents have gone and results in social death and complicates the life of AIDS orphans. This stigma, according to Daniel (2003) is described as the root cause of social, community and governmental neglect of OVC. This researcher further identified that stigma undermines government's efforts to provide a basic safety net for AIDS orphans. For example, some families studied by the researcher in Botswana had chosen not to receive relief services like food and clothing benefits only to avoid stigma associated with HIV/AIDS. Negler et al (1995) have also highlighted that families may cut off themselves from social support relationships long before the parent's death in order to avoid disclosure and stigma.

The reason for all these are the fact that AIDS is commonly viewed as a punishment for immoral life styles such as promiscuity, homosexuality and drug use, and an irrational fear of contagion (Taylor et al, 1999; UNAIDS, 1999). Hence, persons with AIDS, their partners and children may be rejected by a society at large including friends and relatives which in turn related to psychosocial development of AIDS orphans (Negler et at, 1995).

A study conducted on adolescents in families with AIDS by Hudis (1995) found that only 62 % of youths had best friends and none had told this best friend of their parents' diagnosis due to fear of discrimination. This leaves AIDS orphans without any one with whom to share their feelings and fears (Dane, 1997; Mckerrow, 1995; Daniel, 2003).

According to Save the Children's (UK) report of (2001), the role of stigma and discrimination increases the vulnerability of OVC. This report further identified that AIDS orphaned face discrimination with their own families as well as in their own community, churches and schools, both before and after the death of their parents with the perception that all children of infected parents are also infected. However, these children expressed that they have discrimination upon other things that have no relationship with HIV infection. For example, those children who live with extended family reported that they were expected to work harder, and they tended to have less access to food, school fees, and emotional support .Including all these problems, some of the children in the above research refused to discuss the way they were treated for fear of strong discrimination that could be painful for them.

According to Tandaria (2004) gender discrimination and challenges to AIDS orphans reinforce each other. For example, girl orphans are doubly vulnerable, and particularly exposed to sexual abuse. Over worked, they are more likely to drop out of schools, and they are more often dispossessed of their parent's property. The other is the issue of stigma and discrimination. Even though both male and female AIDS orphans face stigma and discrimination, it is severe for female AIDS orphans.

According to UNAIDS(2004), high levels of violence against women and girls, particularly sexual violence exacerbate the sub ordinate situation for women as well as creating situations where , if the perpetrator is HIV positive , the risk of transmission of the virus is higher. Besides, violence against girl AIDS orphans

committed by strangers, and intimate partners as well as caregivers makes life for female AIDS orphans more difficult.

According to UNGASS (2001) gender and orphanhood challenges overlap in that girl orphans are particularly vulnerable to different forms of exploitation with less access to education, and health services. As studies showed, HIV/AIDS increases the educational disparity between boys and girls as girls are removed from school to nurse siblings care for sick parents' relatives in addition to cultural and school related problems (Emebet, 2002).

2.1.2 Impact of Parents' Illness

Wild L. (2005) stated that when parents become sick, the normal child-parent roles may be reversed, as older children take care of their ill parents, and assume household and child care responsibilities. This parentification process has certain kind of association with increased social isolation.

Belay (2005) also showed that children of sick parents have worries about the declining health of their parents and their own life. When parents develop HIV-related symptoms, children often shoulder new responsibilities including domestic chores such as cooking, cleaning, fetching water, care giving activities like feeding, bathing, toileting, supplying medicines and accompanying relatives for treatment and involving in self income generating activities. Hence, children's school attendance drops because families can not afford to pay school fees. Adults also make decision that children should drop out of school to provide care for sick relatives or young siblings (Sengendo and Nambi, 1997).

According to Save the Children's (UK) report of (2001), a very common experience described by children is the constant worry about going to school and leaving their parents in case they die alone. Besides, children also described worrying about their future life in case their parents die (Belay, 2005).

Research conducted on the impacts of HIV/AIDS on children by FHI in Zambia in the year 2002 (FHI,2002) showed that AIDS orphans who were the participants of the study gave detailed accounts of how they cared for their sick parents with a sense of helplessness and frustration that mounted from inability to provide a solution for the illness. Many children participated in the study indicated that they worry about the illness and death that comes from the disease. The children have reported that they usually wept while they watched their parents' health deteriorating. When these children were asked to describe what they felt at the time of their parents' death and how they feel now, they frequently showed a sign of distress and wept at times. This is also the tendency to be unable to adjust themselves to the changed state of affaires. They also expressed feelings of insecurity when they thought of who will look after them. Some of the children grieved over the fact that they had not been allowed to participate in funeral ceremony, which indicated frustration at not getting the chance to bid a final farewell to their parents. Some of them have also reported that they did not even know where their parents were buried. From the guardians' point of view, however, the purpose of doing so is to protect the children from negative feelings and sadness they may receive from burying their parents.

The above study further showed that many children have not only lost their parents, but they have had a whole section of their lives disappear when their inheritance from their parents, such as houses and other material goods, are taken from them by their relatives. For example, some children have no memories (or mementos) of the life they had with their parents. For these children who have mementos such as photos, jewelry, walking sticks, of their parent's, these objects evoke happiness when they remember that they had a parent who loved and cared for them, as well as memories of being loved by their parents. The objects also evoke extreme sadness as they remember their life as it was before the death of their parents or as they project how their lives might have been different if their parents were still alive. For those who had no mementos, it seemed to cause extreme sadness as children made statements referring to how frustrated and sad they were when they could not remember how their parents lived. Even though an item may cause both extremes of emotional sadness and happiness, children indicated that they wanted to have special memories of their parents (FHI, 2002)

Study carried out in New Orleans on children whose mothers were infected with HIV/AIDS by Forehand, 2003 revealed that they demonstrated difficulties in four areas of psychological adjustment: externalized problems like antisocial behavior, internalized problems like depression and anxiety; prosocial behavior like helping peer group and cognitive competence measured on their academic performance.

On the other hand, Sengendo and Nambi (1997) in their study in Uganda found that most such children have the feeling of hopelessness when their parents were sick and were scared by the fact that their parents would die. Most orphans were depressed with less expectation about their future. Fewer orphans expected to get

job, wanted to get married than the non orphans. Besides, depression was common among these children. Befikadu (2005) in his research conducted on AIDS orphans of Addis Ababa also found similar result regarding the impact of parental illness on children.

2.1.3. Impact of Parents' Death

Since the death of the parents is losing love, support, guidance, stability and security as wells as losing a link with the past and possibility of a shared future, this tragedy leads to crises for any child (Fleming, 1994; Befikadu, 2005).

In reaction to the death of their parents, children show such behavior as depression, helplessness, suicidal ideation, loneliness, anger, confusion, anxiety and fear of being alone (Aronson, 1995; Mckerrew, 1995). Besides, since children who lose one of their parents to AIDS are at risk of losing the other parents, they live in a constant fear that the other also could die once one parent dies (Dane, 1997; Befikadu, 2005).

According to Dane (1994), if there has been limited or distorted communication about the parents' illnesses and death, the feelings of frustration and helplessness are likely to occur to AIDS orphans .Hence, children may feel uncomfortably unique because of having dead parents and hence develop low self-esteem.

Belay (2005) in the research he conducted on double AIDS orphans of Kolfe Keranyo sub city (Addis Ababa) stated the fact that orphans have no information about the cause of parental illness and death. It was reported in the work that

many parents did not talk about the cause of their illness to their children .Even when children insist about it; they found their parents denying the truth. Dane (1997) also found that parents lie or not tell about the cause of their illness. Hence, this in turn, affects the psychosocial development of AIDS orphans.

For Fox (2002), AIDS orphaned have fear, insecurity and helplessness apart from grieving at the death of their parents. The loss of a care-giver undermines the children's sense of security which leaves them to reach on their own conclusions about what is happening.

Besides, economic deprivation and disrupted schooling, lack of adequate care and control, separation from siblings, relocation away from schools and friends, etc most of the time accompany parents' illness and death and affect the psychosocial development of AIDS orphans (Andaman, 1995; Sengando and Nambia, 1997;Befikadu, 2005).

According to Tremblay and Israel (1998), the loss of parents and loved ones is associated with such psychological conditions as low self-esteem and stress. Children react to this stress in different ways. Many will find it difficult to talk about their worries. They internalize their feelings and stress, believing that they are abnormal in some way, and suffer from low self-esteem. In this line, a study conducted in Suburbs of Dar Es Salaam, Tanzania by Makame and Granatharn (2002) compared 41 double orphans with 41 matched non orphans aged 10 to 14 years. Orphans scored higher than non - orphans on a semi- structured questionnaire that assessed the degree of low self-esteem.

A number of researchers have concluded that parents' involvement in children's activity is related to self-esteem in children. Those parents who were more affectionate are spend time with their children, contribute positively to the self esteem of their children (Lee, T. 1990; Nugent, J.K, 1991). Undoubtedly, those children with no parents due to AIDS are naturally predisposed to develop such behavioral state as low-self-esteem.

Generally, studies have shown that, after parental death, the children will be exposed to either HIV related or non related death or to problematic orphanhood of severe emotional and psychological consequences (Aronson, 1995; Abebe, 2004).

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

The nature of the present study necessitated both qualitative and quantitative methods. Quantitative study was used to measure the psychosocial adjustment of AIDS orphans. The qualitative method, on the other hand, was used to collect data related to problems of AIDS orphans that cannot be collected by quantitative methods as well as to see the reliability of data collected by quantitative methods.

3.1. Sample Selection

Report from Adama City Health Office as well as East Shewa Statistics Office showed that there was no compiled data that show the exact number of orphans in Adama city. However, they estimated that there were about 3395 orphans (due to all cases) in this city at the end of 2005. Following the national estimation, since 35.4 % of these orphans were due to AIDS according to the estimation of The Horn of Africa Journal of AIDS (2005), the estimated number of AIDS orphans was found to be 1201.

The participants in this research were selected from formally registered AIDS orphans that get home-based care service from different NGOs working in this city. First, OSSA (Organization for Social Services for AIDS) was selected using cluster sampling method among these organizations (Dawn of Hope,Medan Act, Forum, Goal Ethiopia, The Orthodox church, Wegen Lewegen, Save the Children (USA), Mekdim Ethiopia and OSSA). Cluster sampling method was used here due to the economic advantage of this method of sampling. This enabled the researcher to conduct the research with the allocated fund.

In OSSA, there were 302 AIDS orphans (only from Adama city) who were formally registered for home-based care services. Only 132 (80 male and 52 female) of these children were double orphans. For this study, 64 AIDS orphans (32 male and 32 female) were selected using purposive sampling method. Of these, 3 children (2male and 1 female) did not fill the questionnaire appropriately. Hence, the responses of 61 participants were used for analyses.

With reference to age, 32 of the participants were within the age group of 13-15 years and the other 32 were within the age group of 16-18 years. This is almost similar to Hurlock's (1959) division of adolescents into early and late adolescents.

3.2 Instrument for Data Collection

Primary data was used as the major source of information for this study, and was collected using questionnaire and in-depth interview with all groups concerned. The followings are some of the instruments used:

3.2.1 Psychological Adjustment Inventories

One part of psychosocial adjustment measure which is the psychological adjustment measure used in this study was the psychological distress scale which consists of self-esteem scale, depression and anxiety. Psychological distress and anxiety was measured using 15-item scale of Revised Children's Manifest Anxiety Scale (RCMAS) that focuses on behavioral expression of internal anxiety or emotions such as nervousness, tension, and worry. Self-esteem was measured using Rosenberg's Self-Esteem Scale (RSES) of 10 items which ask the respondents to indicate their perception in positive or negative ways. Depression was measured using Yasavege's Depression Scale (YDS) of 30 items which centers

on the feeling of dissatisfaction with oneself, one's ability and one's life. Psychological adjustment of these children was measured using the pooled sum of these items.

3.2.2. Social Adjustment Measure

The other part of psychosocial adjustment measure was social adjustment measure. This was measured using three different scales. These were:

a. Revised check and Buss shyness scale (RCBSS)

This is a fourteen item-scale developed by Check and Buss to measure shyness and orphans' perception of their social competence.

b. The Watson and Friend Social Avoidance and Distress scale (SAD)

This is a ten-item scale taken from Johns et at (1986) that measures anxiety, tensions and distress provoked by social encounter and desire to escape from the situation.

c. Loneliness and Social Dissatisfaction Scale

This is an eleven item-scale that describes loneliness in terms of incongruence between the kind of relationship that an individual perceives himself/ herself as having and what he/she would like to have.

The above three scales add up to give a pooled sum of 35 items. These items were statements stated in terms of the degree to which the statements were true about the participant on a 5-point scale: this means, from 1 (always true about me) to 5 (not at all true about me).Finally, these social adjustment measures were added together to give the scores that range between 35 and 175. Here, 35 indicate higher social adjustment problem while 175 shows absence of social adjustment problem. Before using the instruments, little modifications were made on the

instruments using data collected through pilot test to make them fit the cultural context under study.

3.2.3. In-depth Interview

An In-depth interview was used as the most important data collecting instrument for this study due to two basic reasons. Firstly, the above instruments tell us only whether these children have psychosocial problems or not. For example, they give us information on whether AIDS orphans have normal depression, mild depression or severe depression. However, they do not give us information on the source of AIDS orphans' depression in case they have. Secondly, research shows that people are more willing to talk than to write (John W., 2003). Hence, it was reasonable to use additional instrument to collect detailed information and also corroborate the quantitatively collected data with the qualitative one.

With reference to the selection of counselors for an in-depth interview, only four counselors were selected using simple random sampling method from 18 counselors by taking cost and time into consideration.

Hence, 14 (7 male and 7 female) participants were selected using simple random sampling method for the in-depth interview with 64 participants who had filled out the questionnaire. These 14 participants were assumed to be enough for the in-depth interview by considering the homogeneity of the group as well as cost and time needed to complete the research.

3.3. Data Collection Procedure

Originally, all of the instruments used for data collection in this study were prepared in English. Then, the items were translated into Amharic. The Amharic

version was administered to 16 double AIDS orphans for the purpose of determining the reliability of the instruments. Finally, the responses were collected and the reliabilities of the instruments were computed using Cronbach Alpha. The result was $\alpha = 0.802$ for Rosenberg's self-esteem scale, $\alpha = 0.841$ for Yasavage's Depression Scale, and $\alpha = 0.786$ for children's Manifest Anxiety Scale. For social adjustment scale, the reliability was $\alpha = 0.794$.For all of the instruments, the reliability was above the minimum reliability, that is, $\alpha=0.60$. Finally, these instruments were used for data collection after slight editions and improvements were made.

The items used in interview were originally prepared in Amharic language based on data that cannot be collected using the scales. Then, the researcher had given training for data collectors on contents and some important interview guidelines. Finally, the researcher collected data through interview assisted by two of his research assistants.

3.4 Data Analysis Procedure

Data collected using the above procedures were partly qualitative and partly quantitative. This necessitated both qualitative and quantitative techniques of analysis. The data obtained using in-depth interview were qualitatively analyzed and data collected using the psychosocial inventories were quantitatively analyzed. Chi-square test of independence (x^2) and independent sample t-test were used in testing the quantitative data.

EXPLANATIONS ON THE INSTRUMENTS AND DOMAIN OF DEVELOPMENT TO BE STUDIED

Domain of development to be studied	Issue to be raised	Data collecting instrument	Implication
Social development	• What does the social development of AIDS orphan looks like? • Has their social interaction changed after their parent's illness and death? • Did they have problem in social interaction? • Did they become shy? Isolated? Social? Enjoy group life or what?	Shyness and sociability scale + Social Avoidance and Distress scale + Loneliness and Social dissatisfaction scale ***N.B The instruments measure different social issues***	• The general social development of AIDS orphan will be investigated. ✓ Do AIDS orphan have age specific social problem? ✓ Do AIDS orphan have gender specific social problem? ✓ Do these problems relate to assumed connectedness to family setting?
Psychological Development	What kind of depression does AIDS orphan have? ➢Normal depression (0-9)? ➢ Mild depression (10-19)? ➢ Severe depression (20-30)?	Yasavage Depression scale	• Pathological tendencies that show the sign of pathological reaction will be investigated. ✓ Do these relate to these adolescents goal setting? ✓ Are these levels of depression age specific? Gender related? ✓ Do the types of depression that they have affect their future goal? ✓ Are these depressions related to the assumed connectedness of these orphans to their care giver?
	What does AIDS orphan's perception of themselves looks like? Low? High? Normal?	Rosenberger's self esteem scale	• The general perception of AIDS orphans towards themselves their potential/ was investigated.
Emotional development	Do AIDS orphan have internal anxiety? Worry? Nervousness?	Revised children's manifest Anxiety scale + In-depth interview	• Pathological tendencies that show the sign of pathological reaction will be assessed. • Emotional well being will be identified. Are these age specific, gender related, etc.

Source: Formulated by literature review ideas by the researcher (March, 2006)

Fig 1: EXPLANATIONS ON THE INSTRUMENTS AND DOMAIN OF DEVELOPMENT TO BE STUDIED.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE RESULTS

Under this chapter, results obtained using quantitative and interview methods will be presented first and then the discussion of these results will be followed.

4.1 Presentation and Discussion of the results

Table 2: Frequency distribution of Participants by age group and sex.

Group	Male	Female	Total
13-15	15	15	30
16-18	15	16	31
13-18 (total)	30	31	61

As we can see from the above table, 61 AIDS orphans were incorporated in this research. Thirty one of them were female AIDS orphans and the remaining 30 were male AIDS orphans. Their age ranges were from 13-18 years. Depending on their ages, they were divided into two groups: those whose ages were from 13-15 years and those whose age range from 16-18 years. In the 13-15 years age group, there were 15 males and 15 females. On the other hand, there were 15 males and 16 females in the 16-18 years age group. The average age of the group was 15.62 with standard deviation of 1.62.

Table 3: Person(s) with whom the orphans lived.

Guardian/Care- giver	Uncle	Aunt	Grand-Mother	Grand-Father	Brother	Sister	Alone	Neighbor	Others	Total
Number of AIDS Orphans	16	13	10	6	5	4	3	3	1	61
Percentage	26.23	21.31	16.39	9.83	8.19	6.55	4.92	4.92	1.64	100

As we can see from the above table, 16 (26.23 %) of the AIDS orphans live with their uncles, 13(21.31 %) live with their aunts, 10 (16.39 %) live with their grandmothers, 6(9.83%) live with their grandfathers, 5(8.19%) live with their brothers, 4(6.55) live with their sisters, 3 (4.92%) live alone and 3 (4.92%) live with their neighbors.

Table 4: Child-guardian/Care-giver social relationship

Subject	Response	N	%
What is the condition of your relationship with your guardian/caregiver?	Very poor	36	59.01
	Poor	16	26.23
	Good	6	9.84
	Very good	-	-
	Total	58 *	95.08
How do you evaluate the strength of your assumed connectedness to your guardian/caregiver?	Very strong	1	1.63
	Strong	5	8.19
	Weak	6	9.84
	Very weak	17	27.86
	No connection	32	52.46
	Total	61	100
What did you feel when you first separated from your home?	Very sad	31	50.81
	Sad	20	32.78
	Worried	4	6.54
	Anger	3	4.91
	Fright	1	1.63
	Could not accept	3	4.91
	Total	61	100.00

* *The total number of children does not add to 61 on some of the questions due to the three children who live alone.*

The above table shows that 36 (59.01%) AIDS orphans have very poor relationship with their guardians, 16(26.23%) have poor relationship with their guardian, 6(9.84) AIDS orphans have good relationship with their guardians, and no child has very good relationship with his/her guardian /caregivers. This shows that the majority of AIDS orphans have poor relationship with their guardians.

Regarding assumed connectedness, 32 (52.46%) of those children have no assumed connectedness to their guardians, 17 (27.86%) have very weak assumed connectedness to their guardians, 6 (9.84%) have weak assumed connectedness to their guardians, 5 (8.19) have strong assumed connectedness to their guardian and one child has very strong assumed connectedness to his/her guardians.

As can be seen from the same table, 31(50.81%) of AIDS orphans have felt extreme sadness, 20 (32.79%) become sad, 4(6.55%) worried, 3(4.92%) felt anger, 1(1.63%) felt frightened and 3(4.92%) could not accept the truth of their separation from their home.

It can be interpreted from the table that there was poor relationship between AIDS orphans and their guardians/caregivers. Besides, the extent to which these AIDS orphans assumed themselves to be psychologically connected to their guardians/caregivers was almost absent.

An issue related to caregiver/guardian relationship was also discussed as a useful point when these children were interviewed on their problems. These were lack of parental love and support, absence of good assumed connectedness to

their guardians, absence of good social relationship and others. One 16 year old girl, for example, explained the relationship she has with her caregiver as follows:

> *"I would like to talk about love. When I was living with my parents, they used to give me the love that parents give their children. Now, they are no longer here. I have already missed their love. They used to provide me with school expenses; they used to give me what I would ask for without hesitation. Now, I live with my grand mother and she complains about taking care of me. She hurts me in what she says that makes me think and worry a lot. I do not live as I used to live with my parents any more."*
>
> [16 year old girl]

Table 5: Depression Experiences of AIDS Orphans.

	Normal depression	Mild depression	severe depression
Male	6(9.83)	11(18.03)	13(21.31)
Female	3(4.92)	8(13.11)	20(32.79)
Total	9(14.75)	19(31.14)	33(54.10)

*Number in the parentheses show percentage

$x_{obt}^2 = 2.95$ $x_{crt}^2 = 5.99$ $\alpha = 0.05$ $df = 2$ x^2 is *not significant.*

As we can see from the above table, 9(14.75) AIDS orphans have normal depression, 19(31.14) AIDS orphan have mild depression and 33(54.09) AIDS orphan have severe depression. In terms of gender, 6(9.83), 11(18.03) and 13(21.31) male AIDS orphans have normal, mild and severe depression, respectively. Whereas, 3(4.92), 8(13.11) and 20(32.79) female AIDS orphans have normal, mild and severe depression, respectively.

Besides, chi-square test of independence (x^2) was used to investigate the relationship between sex and depression. Accordingly, the calculated value of x^2 as shown under the above table, was 2.95. The critical value of x^2 ,at df = 2 and 0.05 level of significance was 5.99. This means x^2 is not significant. This shows that the different levels of depression are not related to the gender of these AIDS orphans.

Table 6: The depression experiences of AIDS orphans by age.

Age	Normal dep.	Mild dep.	Severe dep.	Total
13-15	5	5	20	30
16-18	4	14	13	31
Total	9	19	33	61

$x_{obt}^2 = 6.00$ $x_{crit}^2 = 5.99$ $\alpha = 0.05$ $df = 2$ x^2 is *significant.*

NB. The numbers in the boxes show number of orphans.

As shown in table 6 above, 5, 5 and 20 AIDS orphans in the 13-15 age group have normal, mild, and severe depression, respectively. On the other hand, 4, 14 and 13 AIDS orphans in the age group of 16-18 years have normal, mild, and sever depression, respectively.

The relationship between depression and age was investigated using Chi-square test of independence (x^2). The calculated value of x^2 was 6.00 and the table value of x^2 at α 0.05 and df = 2 is equal to 5.99. This is slightly less than the calculated value of x^2. Hence, x^2 was significant. This shows that there is relationship between age and depression. Apparently, 13-15 age group AIDS orphans seem to have more severe depression than the 16-18 age group children.

Table 7: The relationship between guardian Connectedness and depression of AIDS orphans'.

Strength of connectedness		Depression			
		Normal	Mild	Severe	Total
	Very strong	1	0	0	1
	Strong	3	1	1	5
	Weak	1	3	2	6
	Very weak	2	6	9	17
	No connection	2	9	21	32
	Total	9	19	33	61

$x_{obt}^2 = 42.77$ $x_{crit}^2 = 20.09$ $\alpha = 0.05$ $df = 8$ x^2 is *significant.*

NB. The number in the boxes show number of AIDS orphans

As we can see from the above table, one child who has very strong assumed connectedness to his guardians/care-givers has normal depression. Of the five AIDS orphans who have strong assumed connectedness to their guardians/care-givers, 3 have normal depression, 1 has mild depression and 1 has severe depression. Besides, out of 6 AIDS orphans who have weak assumed connectedness to their caregivers, 1 has normal depression, 3 have mild depression and 2 have severe depression. From 17 AIDS orphans who have very weak assumed connectedness to their guardians, 2 have normal depression, 6 have mild depression, and 9 have severe depression. Moreover, from 32 AIDS orphans who have no assumed connectedness to their guardian/care-giver, 2 have normal depression, 9 have mild depression and 21 have severe depression.

When Chi-square test of independence was computed to test whether depression was related to the assumed connectedness of these children as shown above, the calculated x^2 value was 42.77. The table value of x^2 at df = 8 and α =0.05 was found to be 20.09. Since the calculated value of x^2 is greater than the critical value, x^2 is significant. This shows that the level of depression is not independent of the extent to which these children assume themselves to be psychologically connected to their caregivers. This means, there was relationship between the levels of depression and degree of connectedness of AIDS orphans to their guardians/caregivers. That means the stronger their assumed connectedness to their guardians, the lower the level of their depression and vice versa.

Table 8: Emotional stability of AIDS orphans.

Subject	Most of the time	Sometims	Never
How often would you say that you have scary dreams?	40(65.57)	21(34.42)	-
How often would you say that you feel un- happy?	33(54.09)	28(45.90)	-
How often would you say that you prefer to be alone instead of being with others?	30(49.18)	25(40.98)	6(9.83)
How often would you say that you feel worried?	36(59.01)	25(40.98)	-
How often would you feel hopeful about the future ?	2(3.27)	12(19.67)	47(77.04)

Numbers in the parentheses show percentages

As can be seen from the above table, 40 (65.57) AIDS orphans most of the time, say that they have scary dreams; 21(34.42) AIDS orphans say that they sometimes have scary dreams and no AIDS orphans has said that he/she has no scary dream. This shows that AIDS orphans seem to have scary dreams though the magnitude varies.

Regarding happiness, 33(54%) AIDS orphans have reported that they feel unhappy most of the time, 28(45.90) AIDS orphans said that they feel unhappy some times, and no child says he/she has never felt unhappy. The implication is those AIDS orphans seem to feel unhappy though the frequency varies.

Regarding their style of life, 30(49.18) AIDS orphans prefer to be alone most of the time, 25(40.98) AIDS orphans some times prefer to be alone and 6 (9.83) never prefer to be alone. Besides, 36(59%) of these children worry most of the time, 25(41%) of them worry sometimes, and none of these children have reported that he/she does not worry at all. Hence, it seems that AIDS orphans worry about their life.

Regarding their view about the future, 2(3.27 %) of these children have hopes about the future most of the time, 12 (19.67) of these children sometimes feel that they are hopeful about the future, and 47 (77%) of these children are not hopeful about the future. This shows that orphan seem to have no hopeful vision about the future.

Table 9: Score distribution of orphans' self-esteem by sex.

	Levels of Self-esteem of AIDS orphans		
Sex		High	Low	Total
	Male	11(18)	20(32.78)	31(50.81)
	Female	7(11.47)	23(37.70)	30(49.19)
	Total	18(29.51)	43(70.49)	61

$x_{obt}^2 = 1.08$ $x_{crit}^2 = 3.84$ $\alpha = 0.05$ $df = 1$ x^2 is not *significant.*

As shown in table 9 above, 18(29.51) of AIDS orphans have high self-esteem, and 43 (70.49%) of AIDS orphans have low self-esteem. In terms of sex, 11(18%) male AIDS orphans and 7(11.47%) of female AIDS orphans have high self-esteem. Whereas, 20(32.78%) of male AIDS orphans and 23(37.70%) female AIDS orphans have low self-esteem.

The calculated value of x^2 was 1.08. On the other hand, the table value of x^2 at df = 1 and 0.05 alpha level was 3.08. This showed that most AIDS orphans seem to have low self-esteem, though there was no significant relationship between self -esteem and sex of these children.

Table 10: Age and self-esteem of AIDS orphans.

	Levels of Self-esteem of AIDS orphans			
		High	**Low**	**Total**
Age Group	13-15	9	21	30
	16-18	9	22	31
	Total	**18**	**43**	**61**

$x_{obt}^2=0.006$ $x_{crit}^2=3.84$ $\alpha=0.05$ $df=1$ x^2 is not *significant.*

The above table shows that 9 AIDS orphans from 13-15 of years age and 9 AIDS orphans from 16-18 age group have high self-esteem whereas, 21 children from 13-15 age group and 22 AIDS orphans from 16-18 age group have low self-esteem.

The calculated value of x^2 was 0.006. The table value of x^2 at 0.05 alpha level and 1 degree of freedom was 3.84.This means, x^2 is not significant. This shows that self-esteem was independent of age. In other words, the different levels of self-esteem were not related to the age of these AIDS orphans.

Consistent with previous studies, this study has found out that AIDS orphans have low self-esteem. Though the researcher has not come across studies that investigate the relation between self-esteem of AIDS orphans and their age and/or sex, further analysis of chi-square test shows that the self esteem of AIDS orphans was not related to the age and/or sex of these children. Sangando Nambi (1997) also stated that AIDS related parental death results in children's low self-esteem. This research also shows that female AIDS orphans have stronger problems compared to their male counterparts.

Table 11: Behavioral expression of AIDS orphans' internal anxiety score .

Age	**Mean**	**St. deviation**	**Number**
13-15	65.63	2.77	n=30
16-18	64.35	3.21	n=31

t_{obt} =1.29 t_{crit} =2.00 *df=59* α=0.05 (two tailed) t is *not significant.*

The average internal anxiety score of AIDS orphans' was in the range of high score. That was 65.63 with standard deviation of 2.77 for the age group of 13-15 and 64.35 with standard deviation of 3.21 for age group of 16-18 years.

The observed value of **t** was 1.29. However, the table value of **t** at 0.05 alpha level was 2.00. Hence, **t** was not significant. This means, the way AIDS orphans express their internal anxiety or emotion such as nervousness, tension and worry was not related to the age of these children.

Table 12: Behavioral expression of AIDS orphans by sex.

sex	**Mean**	**St. deviation**	**Number**
Male	66.96	1.63	n=30
Female	64.21	3.81	n=31

$\mathbf{t}_{obt}$ =3.08 $\mathbf{t}_{crit}$ =2.40 α=0.01 (one tailed) *df=59* **t** is *significant*

The above table shows that both male AIDS orphans and female AIDS orphans have high internal anxiety score. That is, averages score of 66.96 with standard deviation of 1.63 for males and 64.21 with standard deviation of 3.81 for females.

The observed value of **t** was 3.08. The table value of **t** at 0.01(one tailed) was 2.4. Since the calculated value of **t** was far greater than the table value of **t**, the value is significant. This shows that there was relationship between the sex of AIDS orphans and the way they express their internal anxiety or emotion such as nervousness, tension and worry. Thus, no matter how both males and female AIDS orphans express their nervousness, tension and worry highly in the same way, male AIDS orphans seem to express their internal anxiety more than female AIDS orphans (Lewis, 1995; McKerrow, 1995; Foster et al., 1997; Befikadu, 2005).

Generally, those children who have mild and severe depression have also low self-esteem. Besides, the average score on Children's Manifest Anxiety scale for these children was 64.98-and it was in the high internal anxiety problem. Hence, AIDS orphans seem to have high psychological adjustment problem.

Table 13: Social adjustment measure of AIDS orphans.

Age	**Mean**	**St . deviation**	**Number**
13-15	41.82	2.37	n=30
16-18	47.70	1.46	n=31

t_{obt} *=15.47* t_{crit} *=2.40* α=0.01 (one tailed) *df=59* **t** is *significant*

The mean score of social adjustment was 41.82 with standard deviation of 2.37 for the 13-15 years age group and 47.70 with standard deviation of 1.46 for 16-18 age groups. For both age group AIDS orphans, the score was in the range of high social adjustment problem. Thus, AIDS orphans have high social adjustment problem.

In order to determine if there was age difference in social adjustment, independent group **t**-test was used. Accordingly, the calculated value of **t** was found to be 15.47. That was far greater than the table value of **t**, that is, 2.4 at 0.01 alpha level. This shows that AIDS orphans that were at the age of 16-18 had seem to have more social adjustment problems than AIDS orphans whose age were in the range of 13-15 years.

Table 14.Social adjustment measure of AIDS orphans' by sex.

sex	**Mean**	**Standard deviation**	**Number**
Male	45.23	3.61	n=30
Female	44.70	3.55	n=31

$\mathbf{t}_{obt} = 0.74$, $\mathbf{t}_{crit} = 2.40$ (α=0.01-one tailed, *df=59*) **t** is not *significant*

The mean score of social adjustment measure of male and female above were in the range of high social adjustment problem. For male AIDS orphans, the mean score was 45.23 with standard deviation of 3.61 and for female AIDS orphans; it was 44.70 with standard deviation of 3.55. Hence, both male and female have difficulty of social adjustment problem.

In order to determine if there was sex difference on social adjustment, independent sample **t** test was used. Hence, the calculated value of **t** was 0.74 and the table value of **t** at 0.01 alpha level, 59 degree of freedom and one -tailed test was 2.40. This shows that the difference between male and female AIDS orphans on social adjustment problem was statistically not significant. Hence, both male and female AIDS orphans have high social adjustment problems. The social adjustment problem of AIDS orphans' as well as the fact that they face stigma and discrimination may complicate their strong desire for friendship selection and social acceptance (as far as they are adolescents). Social acceptance on the other hand plays an important role in adolescents' attitude and behavior. The popular adolescents feel secure, happy, develop self confidence, and develop optimistic behavior about the future. However, AIDS orphans suffer from stigma and discrimination and feel pessimistic about the future. All these complicate the healthy psychosocial development of AIDS orphans which were already on complication due to the normal biological changes.

Besides, the orphans who were interviewed on issues related to social relationship explained that they want to avoid social relations as they feel anxious and distressed whenever they encounter any group of people. This is because of fear of discrimination, lack of interest in social relations, fear of labeling and so on. One 18 years old boy for example said the following.

"I know that there is no one who lives on this world for ever. Every body is mortal though the cause varies. Some one may die of car accident; the other may die of TB, cancer and so on. This means, there are thousands of causes for parental death. Thus, thousands and thousands of children are orphaned due to thousands of reasons. HIV/AIDS is one of these causes. Of these thousands and thousands of orphaned children, only those children who have lost their parents to HIV/AIDS are referred to by the cause of their parents' death. For example, have you heard the name cancer orphan? TB orphan? Car accident orphan? So, why do we say AIDS orphan? What makes us different? In my opinion, this is the initial step towards stigma and discriminations. Hence, this upsets and depresses me whenever I remember it. Thus, I have no interest in social relationships because they hurt you knowingly or unknowingly by labeling you as such, tell you that we are son of adultery parents, we deserve our work and so on".

[18 years old boy interviewee]

These children were also asked to discuss the major activities they were engaged in during their parents' sickness. The children reported that they cleaned houses, fetched water, fed their young brothers and sisters, looked after, and served the sick parents. To do all these things, they should be absent from school. They said that they used to perform all these activities with the hope that their parents will be healed. However, when they observed that their parents' health deteriorated, they became hopeless and frustrated. When these children observed that their parents had finally died, they have said that they became totally hopeless and frustrated and could not forget the truth of their parents passing. For some of these children, lack of the chance to participate in the funeral ceremony of their parents was something that worried them most of the

time. For example, the following idea was taken from an interview made with one of the children under study:

> *"Seeing my mother suffer from her illness made me feel a lot of pain. I was with her all the time. I even stopped going to school because I had to take care of her. I was the one to clean her bed room and check on her every morning. I used to feel very sad during her illness because she used to worry and complain so much. She used to say, 'who will look after my children?' and some times she would weep. Every time I saw her in that mood, I would also burst into tears. The day she was taken to hospital, she told us not to worry. She stayed in the hospital for few days and then died. When I heard that she was dead, I cried so much because I was hurt, worried, depressed and frustrated. What hurts me through out my life is, the fact that I was not allowed to participate on her burial ceremony. I was simply pushed to remain behind and look after our house. Starting from her death, my friends isolated me as if I am an AIDS patient. I can not forget my mother anyway."*
>
> [18 years old boy.]

After the death of their parents, some of these children indicated that they had moved from their homes and had become extremely sad as a result of being deserted from their peer group and neighbors. This was found to be one of the most painful events that usually occurred to them after the death of their parents. Other painful events after the tragedy could be lack of parental love and protection, stigmatization from others and exposure to physical hazards, over doings, lack of their parents' mementos, miserable life situations, and many others. Regarding this situation a grade eight AIDS orphan, for example, said the following.

> *"We have lots of problems. We have no food, no cloth, no money, no love, and no mementos of our parents. No one considers you as human being. Every body isolates you. What I am saying is, if both parents die, even the people you ask to look after you do not look after you properly. They instead take away your parents' property that you love and respect for the memory of your parents. School materials are not provided properly. Sometimes, their child may not do well at school and if you outshine him/her, this could also be source of problem between you and your caregiver."*
>
> [16 years old girl.]

These children also pointed out that they were discriminated against on many circumstances. These could be manifested on social relations, on provision of some basic needs (like food, clothes, education) and other social situations. For some AIDS orphans, this discrimination has always been the cause of their depression. However, they do not consider discrimination as the sole cause of their depression. Other causes like lack of materials left by their parents, lack of basic needs, lack of hopeful future, and even lack of sleeping were also explained. On the issue of sleeping, the children reported that they worry about their own situation as well as trauma of their parents' illness and death before sleeping. During sleeping also, they worry about trauma of these things that come to them through dreams. One 15 years old boy interviewee explained how the memory of his father's sickness disturbed him in the following way.

> *"Whenever I am at home or out, asleep or awake, tears flow down my cheeks. I used to feel sorry for him and seeing him suffer hurt me so much. I feel this pain day and night, even in my dreams. Currently, I have no peace at all because I could not forget how he suffered before his death on one hand and why my friends rejected me on the other hand."*

Counselors who were interviewed on the issue of AIDS orphans have also explained ideas similar to those explained by these AIDS orphans. Like the orphans, they accept the presence of discrimination and stigma, depression, social relation problem, the children's scary dreams, and their lack of emotional stability. Generally, how all these problems affected the psychological, social and emotional well beings of the children were deeply discussed by these counselors. Rather than presenting each and every point raised by the counselors, which is of course similar, it is better to condense idea taken from interview made with one of the counselors of the AIDS orphans.

> *"I am sorry to tell you about an issue that worries and makes me think a lot. Because, the ideas may make you worry a lot like me. Of course, I guess that you will feel the same way if you were in my shoes. To begin with, AIDS related parental death is not a simple thing. If you work with these children, you understand how difficult and worrying the problem is. To your surprise, your clients (AIDS orphans) always come to you with the problem that you cannot solve at the time. For example, he/she may come and asks you the meaning of his/her own life; why his/her own guardian took away his/her parents' property etc. Any way, if you look at the situation of these children attentively, you unquestionably conclude that they were affected by their parents' death.*
>
> *Most of the time, you find them depressed; unhappy, disturbed, frustrated and so on. They always raise and discuss with you the life they had with their parents and finally weep for what has happened to them. When you give counseling services for these children, you read a lot of things from their faces. You can see them disappearing mentally while you discuss with them. In the middle of hot discussion, you can read sign of depression, and frustration. They come and tell you that they were stigmatized and discriminated by their neighbor as well as their friends, insulted by their situation (**Ye AIDSam lij, gadabis, gafi etc**) are some of the ways they tell you to be insulted.). Sometimes, however, the children also tell you their*

perception rather than real discrimination. For example, they tell you that their friend has passed behind him/her without greeting. But, it is difficult here to know the reality of the claim because we have no evidence that this has happened. Due to fear of the existing discrimination, you can observe while they fear and hence we do not talk to them publicly.

The depth of the problems of these children is also related to their sexes. You can see female AIDS orphans facing severe problem compared to their male counter parts. Most of the time, you find that male AIDS orphans come for assistance. However, this does not mean that female AIDS orphans have no problems but due to lack of time, they do not usually come for assistance. Besides, you know that female AIDS orphans face varieties of problems if they want to live alone, and also if they live with a guardian who is not closely related to them ."

From the intensive discussions held with the orphans and counselors, it seems reasonable to say that AIDS orphans have depression, frustration, scary dreams, social relationship problems and many others. Specially, the way these children explain their problems, the emotional disturbances that they show during interview, the strength of the problems that they discuss, and other non verbal communications that can be understood during interview show that these children were affected by their parents' illness and death. The way these children express their ideas shows that these children had developed a sense of hopelessness, optimism and frustration. The fact that the children want to explain their problems give a hint that orphan children have no best friend to share their problem with. From the different questions that these children raise, one may understand that they thought about their problems a lot. The way they express their problems also show that they blame the society and themselves for their situation. The way they tell you to be insulted seem to show that they had

faced all forms of AIDS related stigma (primary stigma, secondary stigma, material stigma and symbolic stigma) and had developed lack of interest in social relationships. This obviously led to affect their psychosocial development. The ways these children express how their parents suffered due to illness before death show that they were affected by traumatic impacts of their parents' illness and death.

Each of the issues we have seen above like depression, self-esteem problems, lack of assumed connectedness to their guardians, social relation problems show that AIDS orphans have adjustment challenges to their healthy psychological development. The groups studied were adolescents who had other adjustment challenges to their healthy psychosocial development. As adolescents, they have certain psychosocial developmental needs that distinguish them from children and adults. One of these is the young adolescents' instability. For some of the adolescents, this instability stem from the gap that exists between their aspiration and their attainment. This means, the goals that they put are beyond their reach to attain. Hence they become frustrated and unhappy. AIDS orphans simultaneously face all these instabilities, frustrations, unhappiness that stem from the normal biological changes from one direction and the stigma and discrimination that they face due to AIDS related parental death from the other direction.

Accordingly, the present study indicated that AIDS-related parental death greatly affects the psychosocial development of AIDS orphans. This effect starts during parental illness and continues after their death. Because, children who lost their parents had also lost parental love, support, guidance, optimism, peace and

stability with their own and their relatives. Hence, they are susceptible to develop low self-esteem (Fleming, 1994; Gebele, 1995).

During parental illness, children worry about what would happen to both of their parents. Besides, the condition forces these children to engage in new social roles like cooking, fetching water, serving the younger brothers and sisters, taking care of their sick parents and other dependent members of their family. Most of the children engage in all these activities at the expense of their school time (Brey, R.2003; MOLSA, 2003). All these conditions may further complicate the adolescent period for these children. Besides, though research shows that early adolescents put goals that are difficult for them to attain, the present study showed that AIDS orphan have no future goals.

As cited in Hurlock (1959), adolescents' frustration may also stem from their expectation. This means, adolescents have high expectation for something to happen. If the thing they expected to happen fails, they develop a sense of hopelessness, frustration, unhappiness, depression and worry. AIDS orphans as far as they were adolescents, had these behaviors. The present study in support of this showed that when these children served their sick parents, they did it with the hope that their parents will recover. However, when they observe their parents' health condition was worsening from time to time, they came to develop a sense of hopelessness and frustration. When their parents eventually died, they could not be in a position to accept the truth of what happened to them and found it quite difficult to adjust themselves to their change life conditions. This serious condition usually results in being depressed, pessimistic, lonely, and helplessness. Besides, those who had not participated in the funerals of their

parents worried about the fact that they had not seen the final state of their parents. Hence, these children who had no mementos from their parents' worry about what to remember about their parents (Dane, 1997; Foster et al., 1997; Williamson, 2000; Befikadu, 2005). All these worries, instabilities, depressions seem to be additional instability source for these children.Similar result was obtained by Pivnick and Villages (2000) who had conducted study on 25 uninfected children of 10 to 18 years all of whom had at least lost one parent to AIDS. The researchers found that the children reported heightened feelings of anxiety and depression as well as difficulties with sleeping, eating; somatization problems like stomachs and headaches. This agrees with Collins-Jones (1997) study that children who had multiple family members' diagnosed with HIV/AIDS were characterized by chronically elevated levels of depression and anxiety .However, Lewis (1995) pointed out that there are many children who cope successfully after their parents' illness and death, who have no adjustment difficulties and no elevated depression scores. This apparent contradiction may be due to cultural differences among the children.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

The main objectives of this research were to investigate the social, psychological and emotional developments of AIDS orphans and their adjustment towards the changed life situations. More specifically, it was: to investigate the nature of AIDS orphans' social interaction, to investigate their assumed connectedness to their guardians, to investigate if there was significance age and/or sex difference among the orphans on their social adjustment, as well as their self-esteem and emotional well-being.

To attain the stated objectives, therefore, 61 (30 male and 31 female) double AIDS orphans whose ages were greater than or equal to 13 and less than or equal to 18 years were selected using simple random sampling method from the office of OSSA in Adama City. Then, relevant instruments which were appropriate to attain the stated objectives were taken from previous studies and were used for data collection. To corroborate the gathered data and also collect more information, in-depth interview was made with 14 AIDS orphans and 4 counselors.

Initially, pilot test was used on the instruments and the reliabilities of the instruments were checked. Finally, data was collected using these instruments. The data collected using the instruments were partly qualitative and partly quantitative. Hence, they were analyzed both qualitatively and quantitatively.

Finally, chi-square test of independence and independent sample t-test were used to test the results. The independent sample t-test was used to test if there was significant age and/or sex difference among AIDS orphans on their social adjustment problems, and behavioral expressions of their internal anxiety, tension and worry. The following figure shows the findings of this research.

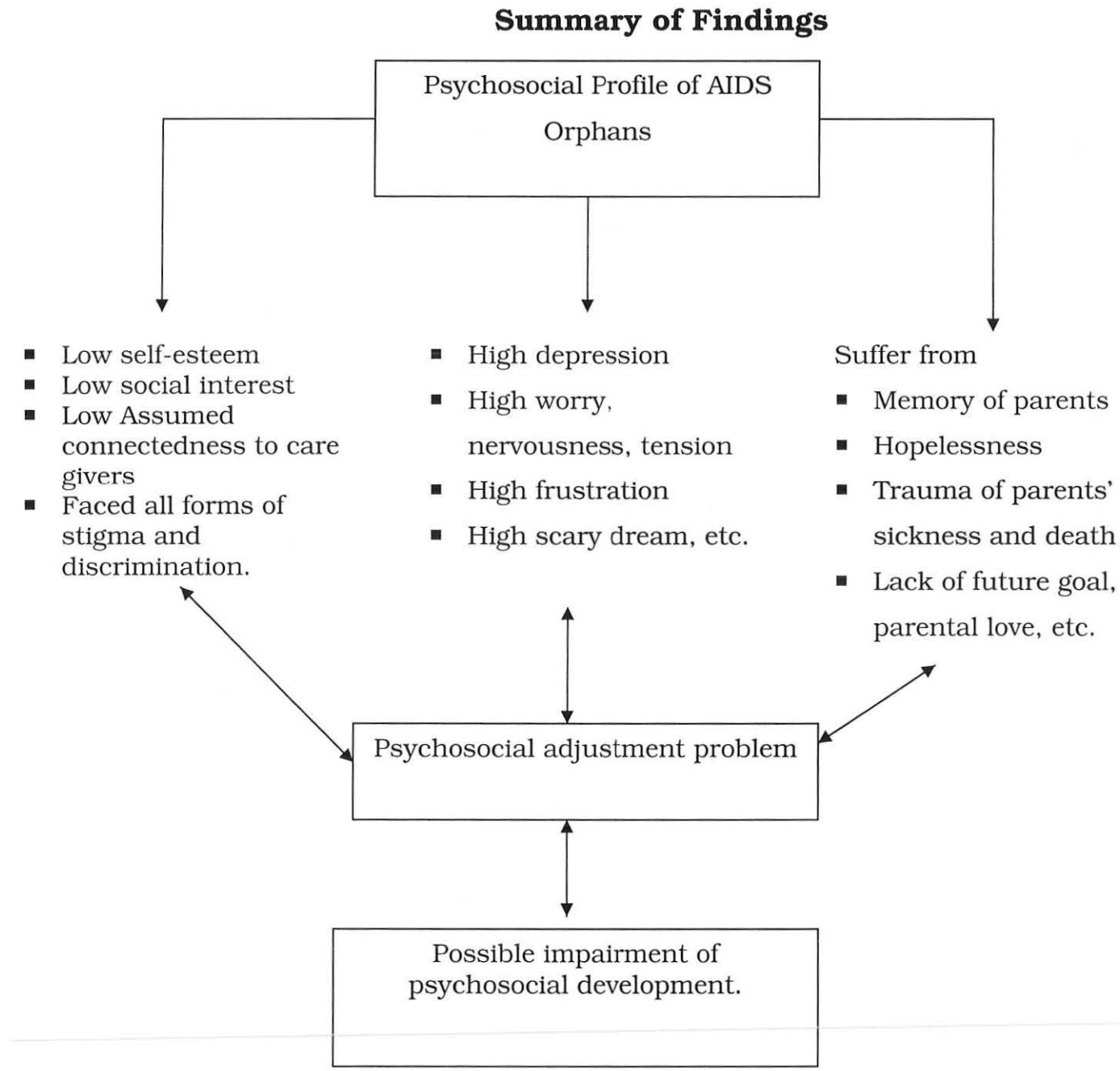

Fig. 2: Summary of findings

5.2. Conclusion

The study discussed the psychosocial profiles of AIDS orphans based on data obtained from 61 double AIDS orphans that were registered at OSSA in Adama city. The following conclusions can be made from the findings of the research.

- The majority of AIDS orphans (90%) have no good relationship with their caregiver/guardian. They do not assume themselves to be psychologically connected to their guardians/caregivers. Most of them either worry, become sad, frightened, or could not accept the truth of their parents' death. As a result, they were depressed, frustrated, worried, or hopeless. According to David Elkind, since adolescents take their experiences to be unique, the fact that these AIDS orphans experience all these things may affect their emotional development.
- AIDS orphans had either mild or severe depression. The depression was not directly related to the sex of AIDS orphans. In other words, x^2 test of independence showed that AIDS orphans have depression irrespective of their age and sex. Moreover, chi-square value further showed that those children who were relatively more mature (16-18 years) have more severe depression as compared to those who were less matured (13-15 years).
- The extent to which AIDS orphans assume themselves to be psychologically connected to their caregivers has relationship with their depression. Those children who have depression beyond normal were those whose assumed connectedness to their caregiver were weak, very weak or absent.
- AIDS orphans had scary dreams, felt unhappy, preferred to be alone, were worried, and view themselves as hopeless about the future most of the time.

- AIDS orphans had negative perception about themselves irrespective of their sex and/or age. The chi-square test of independence value showed that both male and female AIDS orphans perceived themselves negatively. Unlike depression, negative perception of AIDS orphan towards themselves was not related to the age of these children. Since one's perception of himself is important in social interactions, the fact that majorities of AIDS orphans had developed negative perception of themselves may affect their interpersonal relationships which may eventually affect their social development.
- AIDS orphans had high internal anxiety such as worries, frustration and nervousness that were due to their changed life situations. The reasons behind their internal anxiety were memories of their parents' sickness and death as well as the existing life situation after parental death.
- The calculated value of independent sample t-test shows that these children expressed internal anxieties, worries, nervousness and tensions nearly in the same way when age was taken into consideration.
- Even though AIDS orphans as a group had these problems, independent sample t-test showed that male AIDS orphans expressed the problems cited above overtly than the females. All these problems show that AIDS orphans have psychological adjustment problems.
- AIDS orphans have social adjustment problem. This means, they were socially awkward, did not like to be with people, were shy, had no interest in social relationships, felt uncomfortable.
- The social adjustment problem of AIDS orphans' was related to the age of the children. Hence, independent sample t-test showed that more matured

AIDS orphans (16-18 years) had more social adjustment problem when compared to the younger AIDS orphans (13-15 years age group) though both of these two groups have social adjustment problems in general. Independent sample t-test showed that there was no sex difference on social adjustment problem. This means, both male and female had similar interaction problems. The reason behind this was fear of labeling, discrimination, trauma of parental sickness and death, lack of love. The problem, is since development is cumulative, the fact that these children preferred to be alone, no interest in social relationships, had depression that may affect the interpersonal relationships ,seem that the psychosocial development of these children may be affected by these external factors-traumatic impacts of AIDS related parental illness ,death ,stigma and discrimination.

- AIDS orphans also engage in different kinds of activities during parental illness. The major activities that these children engage in were cleaning, fetching water, feeding young brothers and sisters, looking after the sick parents, and serving the sick parents. They did all these activities at the expense of their school time.
- The most painful events regarding the AIDS orphans were their lack of parental love, being stigmatized, their exposure to physical hazards, overdoing, lack of materials left by their parents (for those who had not), lack of chance to bury their dead parents , and their separation from their friends.
- Finally, one can further conclude from the findings, discussions, and presentations made so far that AIDS orphan have psychological, emotional

and social adjustment problems, that is, psychosocial adjustment problems. These adjustment problems were due to traumatic impacts of parental illness and death and also related stigma and discrimination. Consequently, the psychosocial development of these children can be affected by these factors. For example, we have already seen above that, AIDS orphans have depression beyond normal. When we compare them in terms of age, however, the more matured groups (16-18 years) were found to have more severe depressions compared to younger groups (13-15 years). Besides, the more mature groups (16-18 years) showed more social adjustment problem when compared to the younger groups (13-15 years). These two points show that the strength of the problems increases with the age of these children and seems to be related to their adjustment pattern.

5.3. Recommendations

Based on the literature reviewed and the findings of this study, the following recommendations can be provided.

- Training has to be given for AIDS orphan so that they can:
  - Improve negative perception of themselves.
  - Be hopeful about the future and visualize the bright side of life.
  - Accept the truth of their changed life situations and make all they can to live a better life.
  - Develop the habit of interacting with others and in the mean time share their experience.
  - Develop social interest and resolve conflicts reasonably if happened.
  - Improve their social interaction with their peer groups and their guardians/caregivers.
  - Avoid their stress, tensions and depressions.
  - Make appropriate adjustment in all walks of life.
- The community at large has to be sensitized about the impacts of labeling an orphan as "AIDS orphan". Attaching the term "AIDS" to orphans who have lost their parents to AIDS sets the ground for stigma and discrimination of these children which in turn affect their social development. The mass media, schools, churches, mosques, community leaders and local administration should play great roles in this regard.
- The different NGOs and concerned government bodies working on AIDS orphans have to focus on both the psychological, social and emotional needs of AIDS orphans in addition to the basic physical services they provide them.

They have to design mechanisms through which AIDS orphans can release their emotional problems, avoid fear and insecurity at large.

- Training has to be given for guardians/caregivers of AIDS orphans so that they could properly accept these children, show genuine love, form good social relationship with and help the children to develop strong assumed connectedness towards themselves (the guardians).
- The guardians/caregivers have to have enough time to discuss with these children and allow them to express their ideas, opinions and release their emotions freely.
- The society has to respect the right of the orphans, avoid stigmatizing as well as discriminating those children, and value the material objects left by the children's parents.

- Though the group studied was operationally defined as 'children', the study was conducted on adolescents. Adolescents, obviously, have other adjustment problems that arise from normal physical changes. When these problems add to the ones identified, the children will move into more severe psychological adjustment problems like neurotic and psychotic behavioral problems. Besides, the domain of development which is affected by these psychosocial adjustment problems has to be investigated. Hence, further study on the area is recommended if the psychosocial adjustment problem of these children and how the problems relate to their development is to be tackled.

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Appendices

Appendix I

Addis Ababa University

School of Graduate Studies

A. Questionnaires and Scales used to Measure the psychological And Social Adjustment

Introduction: - My Colleagues and I are collecting information on problems of adolescents so as to assess the social, emotional and psychological development of these children for the requirement of Masters Degree in Developmental psychology at Addis Ababa University. Having the experience that you have on the issue would help the researcher in achieving the stated objectives. There fore, we would like to find out from you various things about the lives of orphan. I promise you that the information you give us will be held in **strict confidence** and used **only for research purpose**. Hence, please feel at ease and give your frank and honest response for each item accordingly.

Background Information

Instruction: put a tick mark (✓) in front of the answer that represents your agreement.

No	Demographic Questions	Answer	
1	In what month and year were you born?	Month	
		Year	
2	Sex	Male	
		Female	
3	With whom are you living?	Aunt	
		Uncle	
		Grand mother	
		Grand father	
		Sister	
		Brother	
		Neighbor	
		Cousin	
		Alone	
		Others(Kindly specify)	
4	How did you evaluate the connection that exists between you and your Caregiver?	very strong	
		strong	
		weak	
		very weak	
		No connectedness	

Appendix II

YDS

GIVE YOUR BEST ANSWER BY PUTTING "✓" SIGN ON YOUR CHOICE

	0	1
1. Are you satisfied with your life?	YES	NO
2. Have you dropped many of your interests?	NO	YES
3. Do you feel that your life is empty?	NO	YES
4. Do you often get board?	NO	YES
5. Are you hopeful about the future?	YES	NO
6. Are you bothered by thoughts you cannot get out of your head?	NO	YES
7. Are you in good spirits most of the time?	YES	NO
8. Are you afraid that something bad is going to happen to you?	NO	YES
9. Do you feel happy most of the time?	YES	NO
10. Do you often feel helpless?	NO	YES
11. Do you often get restless and fidgety?	NO	YES
12. Do you prefer to stay at home rather than go out and do things?	NO	YES
13. Do you frequently worry about the future?	NO	YES
14. Do you feel you have more problems with memory than most?	NO	YES
15. Do you think it is wonderful to be alive now?	YES	NO
16. Do you feel downhearted and blue?	NO	YES
17. Do you feel worthless the way you are now?	NO	YES
18. Do you worry a lot about the past?	NO	YES
19. Do you find life very exciting?	YES	NO
20. Is it hard for you to get started on new projects?	NO	YES
21. Do you feel full of energy?	YES	NO
22. Do you feel that your situation is hopeless?	NO	YES
23. Do you think that most people are better off than you are?	NO	YES
24. Do you frequently get upset over little things?	NO	YES
25. Do you frequently feel like crying?	NO	YES
26. Do you have trouble concentrating?	NO	YES
27. Do you enjoy getting up in the morning?	YES	NO
28. Do you prefer to avoid social occasions?	NO	YES
29. Is it easy for you to make decisions?	YES	NO
30. Is your mind as clear as it used to be?	YES	NO
TOTAL		

5	What is the condition of your relationship with your guardian/caregiver?	Very good	
		Good	
		poor	
		very poor	
6	What did you feel when you first separated from your brothers/sister or other children?	Very Sad	
		Sad	
		Worried	
		Angry	
		Could not accept	
		Frighten	

Appendix III

Emotional Well - being Measures

	Response		
Demographic variables	Most of the time	Some times	Never
7. How often would you say that you have scary drams?			
8.How would you say that you ever feel unhappy?			
9 How often would you say that you prefer to be alone instead of being with others?			
10. How often would you say that you ever feel worried?			
11. How often do you feel hopeful about the future?			

Appendix IV

Section 2: Psychological and social Adjustment Measures

I Psychological Adjustment Measures

Instruction: - The following statements refer to the experience that people have in their daily life. You are to indicate, on a five print scale the extent of agreement between the feelings expressed in each statement and your own personal reactions. Please read each item carefully and decide to what extent it is characteristic of your feelings and behavior. Mark (✓) the point which best indicates your agreement or disagreement.

S.A=Strongly Agree **D.A=Disagree**

A=Agree **SDA=Strongly**

Disagree

UD=Undecided

Item NO	Items	Response Categories				
		S.A	A	U.D	D.A	S.D.A
1	I feel that I am a person of worth, at least on an equal plan with others.					
2	I feel that I have a number of good qualities.					
3	All in all, I am inclined to feel that I am a failure.					
4	I am able to do things as well as most other people.					
5	I feel I do not have much to be proud of					
6	I take a positive attitude toward my self.					

Item NO	Items	S.A	A	U.D	D.A	S.D.A
7	On the whole, I am satisfied with myself.					
8	I wish I could have more respect for myself.					
9	I certainly feel useless at times.					
10	At times I think I am not good at all					
11	My sleep is restless and disturbed.					
12	I work under a great deal of strain.					
13	I seat very easily even on cool days.					
14	I am usually calm.					
15	I have many problems that cause me a great deal of worry.					
16	I always have enough energy when faced with difficulty.					
17	I give up easily when things get hard.					
18	I have frequent headaches for which there is no reason.					
19	When I try to make something everything seems to go wrong.					
20	I feel worrying and nervous.					
21	I worry about what other people think about me.					
22	Often I feel sick in the stomach.					
23	I worry about what is going to happen.					
24	I have bad dreams.					
25	My feelings get hurt easily.					

Appendix V

Social Adjustment Measures

Instruction: - Each of the following statements expresses the experiences, feelings, perceptions, and reactions that people have in their relationship with people or friends. For each statement, there are five possible responses: Always true, true most of the time, true sometimes, hardly every true, and not true at all. Thus for each of the items give your response by marking (✓) on the space provided on a five point scale how much a true description of each statement is bout your experience.

No	Items	Response Categories				
		Always True	**True most of the time**	**True some times**	**Hardly every true**	**Not true at all**
1	I am socially some what awkward.					
2	I feel inhibited in social situations.					
3	I feel tense when I am with people I don't know well.					
4	I like to be with people.					
5	I welcome the opportunity to mix socially with people.					
6	I find it hard to talk to strangers.					
7	I prefer working with others rather alone.					
8	I am shy with members of the opposite sex.					
9	When conversing I worry about saying something dumb.					
10	I would be unhappy if I were prevented from making many social contacts.					

		Always True	True most of the time	True some times	Hardly every true	Not true at all
11	I try to avoid situations which force me to be very sociable.					
12	I feel often uncomfortable at parties and other social functions.					
13	I often think up excuses in order to avoid social engagement					
14	I usually feel relaxed when I am with a group of people.					
15	I tend to withdraw from people.					
16	I often find social occasions upsetting.					
17	I try to avoid formal social occasions.					
18	I usually feel calm and comfortable at social occasions.					
19	Few of my friends understand me the way I want to be understood.					
20	I get much satisfaction from the groups I attend					
21	My friends given me the moral support I need.					
22	I have a deep sharing relationship with a number of friends.					
23	My friends come to me for emotional support					
24	I am not very open with my friends.					

		Always True	True most of the time	True some times	Hardly every true	Not true at all
25	It is easy for me to make new friends at school .					
26	I am good at working with other children.					
27	It is hard for me to make new friends.					
28	I don't get along with kids.					
29	I can find a friend when I need one.					
30	I have no body to talk to.					
31	I don't have any friends.					
32	I am good at working with other people.					
33	I have trouble looking someone right in the eye.					
34	I don't find it difficult to ask other people for information.					
35	It is hard for me to act natural when I am meeting new people.					

Appendix VI

In-depth interview for AIDS orphans

Addis Ababa University

School of Graduate Studies

Department of Psychology

Introduction: - The purpose of this interview is to collect information on problems of AIDS Orphans so as to assess the social emotional and self esteem of these children for the requirement of Masters Degree in Developmental Psychology at Addis Ababa University. Having the experience that you have on the issues related to AIDS Orphans problems would help the researcher in achieving the stated objectives. There fore, we would like to find out from you various things about the lives of orphan. I promise you that the information you give us will be held in **strict confidence** and used **only for research purpose**. Hence, please feel at ease and explain all your ideas and express your emotions associated to it freely.

1. Tell me about your life-daily routine; (going to school, playing, ...)

1. Children who lost their parents to AIDS are called "AIDS Orphans"
   - 1.1. What do you think about this labeling?
   - 1.2. What do you feel when people call you "AIDS Orphan?"
   - 1.3. What do you feel for the reason that you lost your parents to AIDS?
2. What problems do you have?
   - 2.1. What is the hardest part of your problem?
   - 2.2. What do you do about these problems?
   - 2.3. If you talk to people, who do you talk to?
   - 2.4. How do you feel when you talk to this person?
   - 2.5. Of all your problems what makes you upset when you remember it?

NB Question number 1 will not be analyzed. It will be used to put children at ease.

3. What worries do you have?
    3.1. How often do you worry?
    3.2. What make you worry?
4. What new roles did you have to take up during your mothers/father's sickness?
    4.1. Who take care of your mother/father during their sickness?
    4.2. How did you feel about your parents sickness?
    4.3. How did you feel as your parents sickness progressed?
    4.4. What did you feel about your education during your parent's sickness?
    4.5. What did your parents discuss with you about their illness?
5. How did you feel when your parents finally died?
    5.1. How did you find out about your parents death?
    5.2. How did you feel when you find out this information?
    5.3. What role did you play in the funeral of your parents?
    5.4. What do you feel about your parents funeral ritual?
    5.5. What did you feel after your parent's/parents' death?
    5.6. What was the cause of their death? Who gave you this information?
    5.7. Who do you preferred to get the information from? Why?
    5.8. Have you told the cause of your parents' illness and death to at least one of your friends? Why?
    5.9. From losing the mother and the father, which one is mere distressing for you?
6. What did you feel when you first moved from your home? (For those who moved from their previous home)
7. What items left by your parents do you have?
    7.1. What happened to the items belonging to your parents?
    7.2. What do you feel about the items?
    7.3. What still bothers you about your parents death?
8. What changes have you faced since the death of your parents?
    8.1. Do you think that there is sex difference on type and difficulty of problems that AIDS Orphans have? Why?

9. Discuss the discriminations and stigmatizations you faced because of your situation? (If any)

   9.1. Who discriminated and stigmatized you? (if any)

   9.2. What do you feel about your friends?

   9.3. What do each of the following do for you to make you feel loved, accepted, cared for

      a) Your care giver?

      b) Relatives of your parents

      c) Your neighbor?

      d) The church?

      e) The masque?

      f) The community?

10. What make young people like you to have difficulty in sleeping?

   10.3. What are your plans for the future?

Thank you very much for your participation

Appendix VII

In-depth interview for key Informants

The key informants are those who have the knowledge and experiences of AIDS orphans.

1. Children whose parents died of AIDS are called "AIDS Orphans" what do you think about the labeling?
2. What are the problems of AIDS orphans?
3. Do all these problems of AIDS orphans got attention from the body concerned? How?
4. Is there sex difference on type of problems AIDS orphans have? How?
5. Is there any sex difference on the strength of problems AIDS orphans have? How?
6. What are the impacts of parental sickness on children?
7. How does these impacts relate to those children's a) social development b) psychological development c) emotional development?
8. What are the impacts of parental sickness and death on children?
9. How do these impacts relate to these children's
    a) social development
    b) psychological development
    c) emotional development
10. AIDS orphans face stigmatization and discrimination? How?
11. Do AIDS orphan have scary dream? What tangible evidence do you have for your response?
12. Do AIDS orphan have depression? What tangible evidence can you give for your response?

Declaration

I the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of the materials used in this thesis have been duly acknowledged.

Name: Desalegn Garuma

Signature

Date: June 2006

Advisor's Approval

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

Name: Teka Zewudie(Dr.)

Signature _____

Date of Approval July 31, 2006