

**THE PSYCHOSOCIAL WELL-BEING OF ORPHANS IN THE CONTEXT
OF HIV/AIDS IN TANZANIA: A CASE OF 13 TO 15-YEARS-OLD
ORPHANS IN KIHOLOGOTA WARD, IRINGA RURAL DISTRICT,
TANZANIA**

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**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SOCIAL
WORK OF THE OPEN UNIVERSITY OF TANZANIA**

2014

CERTIFICATION

I, the undersigned, do certify that I have read through and hereby recommend for acceptance by the Open University of Tanzania a dissertation titled: *The Psychosocial Well-Being of Orphans in the Context of HIV/AIDS in Tanzania: - A Case of 13 to 15-Years-Old Orphans in Kihologota Ward, Iringa Rural District, Tanzania*" in partial fulfillment of requirements for the Degree of Masters of Arts in Social Work at the Open University of Tanzania.

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.....

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.....

Signature

.....

Date

DEDICATION

I dedicate this work to my beloved son David Yona, may almighty God give him strength and grow in his wisdom.

ACKNOWLEDGEMENT

I am grateful to God for giving me life, strength and ability which enabled me to complete this study. I also thank everyone who contributed in one way or another to the successful completion of this study. I owe special gratitude to my supervisor Dr Deodatus Kakoko for accepting to supervise this study also for his invaluable and tireless supervision of my work. I treasure his advice, criticisms, support and suggestions which have contributed a great deal to bringing this work to its present form. I am highly indebted to my son David that he missed mother's care for some time while i was busy with this study and my parent Mr and Mrs Mgaya for the countless moral and material support during the course of my study. I owe special thanks to my respondents in Kihologota ward especial orphans from Isimila, Ngano, Ndolela primary schools and Isimani secondary School, Last but not least, am thankful to colleagues and classmates for their contribution towards the completion of this study.

ABSTRACT

This study investigated the psychosocial well-being of orphans in the context of HIV/AIDS in Tanzania, a case of 13 to 15-years-old orphans in Kihologota ward, Iringa rural district. The study intended to understand the psychosocial well-being of orphans aged from 13 to 15 year by analyzing their psychosocial needs, coping mechanism and psychosocial support available for them. Under the course of this study the sample of 10 respondents as well as data collected through in-depth interviews and further analyzed through narrative analysis. The study findings showed that there inadequate social and physical needs for the orphans, non parental disclosing of their health status to its children, orphans are not involved in the decision making affecting their welfare, and lack of formal psychosocial support. Furthermore study recommend on Inter-sectoral collaboration for mitigate the impact of the ensuing changes and challenges among orphans, government, NGOs, and other aid agencies to establish formal structures where foster families can be trained as to how to manage the changes and challenges that confront the orphans while parent with HIV/AIDS has to disclose their status to their children, government has to formulate a formal psychosocial support programme which will be used to orient those key people who are dealing with orphans frequently such as teachers or foster families and Community has to involve children in their matters affect their welfare such as in decision making because this will allow them to talk and share their views and orphans will appreciate that are being respected. Also family need to be re-evaluated in the light of the present reality that as we are losing conventional family units and children are often left with minimal care or none at all.

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LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
CAMFED	Campaign for female Education
HIV	Human Immunodeficiency Virus
MVCC	Most Vulnerable Children Committee
NGOs	Non Governmental Organizations
OVC	Orphans and vulnerable children
UNAID	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund

CHAPTER ONE

1.0 RESEARCH PROBLEM AND ITS SETTINGS

1.1 Background Information to the Problem

“Psychosocial well-being” is the term used to denote a positive age and stage appropriate outcome of children’s physical, social, and psychological development, it is determined by a combination of the child’s natural capacities, and his/her social and material environment (Richter, Foster & Sherr 2006). This implies living in an environment that promotes the emotional, physical and social welfare of an orphan. Indeed, the loss of one or both parents often compromises this psychosocial well-being of a child, some orphans are taken to extended families and looked after by guardian who are unskilled/unwilling to assume the role (being too young/too old to assume this formidable task (Davids, Nkomo, Mfecane, Skinner & Ratele, 2006).

Despite the loss experienced by orphans, it is still possible to live well, as long as the extended families, community, community-based organizations (CBOs), faith-based organisations (FBOs), non-government organizations (NGOs) and the government are playing their role in supporting the psychosocial well-being of orphans. Psychosocial well-being of orphans depends on to what extent they adjust to and copes with the loss and changes they experience. It is in this area that the roles of extended families, the community and it’s CBOs, FBOs, NGOs and the government become critical.

Different causes of parental-death are responsible for the orphans that, if disregarded, become a burden to the societies they inhabit. These causes range from “intentional”

injuries (like homicide) to “unintentional” injuries (like road accidents), and include non-communicable diseases (like deaths from heart disease), communicable diseases (like tuberculosis), nutrition-related causes of death and AIDS which though a communicable disease is considered separately, due to its magnitude as a cause of mortality (Muhwava & Nyirenda 2008).

While it is difficult to differentiate HIV/AIDS-related orphan hood from other types, it can be inferred that, since HIV/AIDS is the leading cause of death, it is also the largest cause of orphan hood (Muhwava & Nyirenda 2008). The United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United States President’s Emergency Plan for AIDS Relief (US PEPFAR) (2006) indicate that sub-Saharan Africa has the highest number of orphans in the world, with an estimate of 48.3 million (from all causes of death) at the end of the year 2005.

It is further reported that about 12% (12 million) of all orphans in sub-Saharan Africa are due to AIDS (UNICEF, UNAIDS & US PEPFAR 2006), identifying AIDS as the leading cause of orphan hood in sub-Saharan Africa. The study therefore assumed that HIV/AIDS somehow affected most participants and so the psychosocial well-being of orphans affected by HIV and AIDS was assessed.

This study sought to understand the psychosocial well-being of the teenaged orphans aged 13 to 15-years-old, with the intention of improving the psychosocial support available to them in Tanzania. Although “teenagers” include children aged 13 to nineteen, for the purpose of this study the age group was narrowed to 15, because it

is assumed that the needs of the children older than 15 will be qualitatively different from the needs of younger teenagers.

1.2 Problem Statement

In sub-Saharan Africa, nearly 12 million children under the age of 18 years have lost one or both parents due to AIDS-related causes (UNAIDS 2008). In Tanzania alone orphans housed to 1.2 million in the year 2000 and mostly due to the HIV/AIDS pandemic. This represented about 9% of all children under the age of 15 years by then it was estimated that by the year 2005 there will be 2 million orphaned children in the country and by 2010 estimated to be 4.2 million responded to 27% of all children under age of 15 (Humuliza,1999).

In view of the fact that HIV/AIDS is continuing to be a threat in the lives of many Tanzanians, it is expected that the magnitude of the problems associated with it may persist for some time and there is insufficient evidence regarding the extent to which the psychosocial well-being of these orphans is addressed.

Following the HIV/AIDS dilemma, children are not always told the truth about their parent's diagnosis and this fact creates different thoughts, feelings and actions (Nasaba, Defilippi, Marston & Musisi 2006) and the psychosocial well-being of these orphans tends to be ignored by society (USAID, 2004). It is acknowledged that family members, generally the children's biological grandparents, often take orphans in and look after them, but they do not understand the various psychosocial effects that need to be addressed (CINDI, 2007).

Case *et al.* (2003) and Nyamukapa *et al.* (2003) indicated that orphans who have lost a father live in poorer households than non-orphaned children however widows do provide the emotional and practical support that sustains these paternal orphans and protects them from the danger of educational disadvantages. On the other hand, although children who have lost their mother do not appear to live in the poorest households, they do tend to experience more detrimental effects on their educational attainment and enrolment (Bicego *et al.* 2003 and Nyamukapa *et al.* 2003). Orphans who lose both parents suffer the most detrimental impact on school enrolments and educational attainment (Bicego *et al.*, 2003).

This study assumes that the “teenage stage” is the most important stage in human development, with the most dramatic developments taking place, including the initiation of the lifelong processes of physical, behavioral, cognitive, emotional growth and change. Throughout these processes, each teenager develops the attitudes and values that guide their choices, relationships, and understanding of certain things. It is assumed that if the psychosocial well-being is addressed satisfactorily, teenagers will be able to view life positively and be able to take decisions that will not jeopardize their future.

1.3 Research Objectives

1.3.1 Broad Objective

The objective of this research work is to attain an in-depth understanding of the psychosocial well-being of the orphans aged 13 to 15-years in the context of Tanzania.

1.3.2 Specific objectives

This study has been guided with the following specific objectives:-

- (i) To describe the psychosocial needs of teenager orphans aged between 13 and 15-years-old.
- (ii) To find out the coping mechanisms of teenager orphans aged between 13 and 15-years-old.
- (iii) To understand the types of psychosocial support available to teenager orphans aged between 13 and 15-years-old.

1.4 Research Questions

The research questions of the study were:

- (i) What are the psychosocial needs of orphans following death of parent/parents?
- (ii) How do HIV/AIDS related orphans cope with the realities of HIV/AIDS?
- (iii) What kinds of psychosocial support are available to orphans in coping with their life?

1.5 Significance of the Study

Child-development passes through the adolescent stage and it is during this stage that most children start to behave differently from the way they behaved prior to this stage (Huberman 2002). “Adolescent stage” is referred to as a “teenage stage” and it brings the fear of a loss of a good relationship with their children to the majority of parents (Elium 1999). Behavior change is caused by the physical and biological growth in children, and it is a natural process in human development (Huberman, 2002). Parents sometimes try to protect their children by giving them extra attention,

support and guidance during this stage, all of which are factors in the psychosocial well-being of the child.

However, not all teenaged orphans are fortunate enough to experience this extra guidance and support and in the absence of parents to provide these, their psychosocial well-being may be compromised. About 40% of orphans develop post-traumatic stress as a result of losing their parents, symptoms of which can include withdrawal from society as a whole, feelings of guilt, depression, aggression as well as eating, sleeping and learning disturbances (Gilborn, Nyonyitono, Jagwe-Wadda & Kabumbuli, 2001). These children are often not only experiencing the death of their parents, but also being confronted with domestic violence in their foster families (Chipungu, Tricia & BentGoodley, 2004). The society, government, NGOs, FBOs and CBOs inherit the role of guardian to orphans, and they have to meet huge challenges when attempting to ensure the psychosocial well-being of the orphans.

Although these institutions are willing to assume the guardian-role, efficiently addressing the psychosocial well-being of the orphans without clearly understanding their psychosocial needs and the coping mechanisms, as well as the types of psychosocial support available to them, is not impossible. Insufficient information creates a gap in the provision of proper psychosocial support to orphans.

This study attempted an in-depth understanding of the psychosocial well-being of these orphans and resulted in findings that may help the Aid agencies, government departments and society in general on the path to a better understanding of the support needed to attain desirable levels of psychosocial well-being.

1.6 Operational Definitions

1.6.1 HIV/AIDS Orphans

Chitiyo, Changara and Chitiyo (2008:384) define an “AIDS orphan” as “a child who has lost one or both parents to HIV/AIDS”.

1.6.2 Orphan

“Orphan” is defined by The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (2004) as “a child less than 18 years of age whose mother, father or both parents have died from any cause of death”. Orphans from all causes can be more specifically described as follows:

Single orphan - a child who has lost one parent.

Double orphan - a child who has lost both parents.

Maternal orphan - a child whose mother has died

Paternal orphan - a child whose father has died

1.6.3 Psychosocial Well-Being

Richter, Foster and Sherr (2006) define “psychosocial well-being” as the positive age and stage with appropriate outcome of children’s physical, social, and psychological development. It is determined by a combination of children’s capacities and their social and material environment. Psychosocial well-being is essential for children’s survival and development especially in chronically difficult circumstances

1.6.4 Psychosocial Support

Van Den Berg (2006) defines “psychosocial support” as an ongoing process of meeting physical, emotional, social, mental, and spiritual needs of a child, all of which are essential elements for meaningful and positive human development.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

In this chapter, literature on the psychosocial situations of orphans is examined and theoretical perspectives on the psychosocial development of adolescents have been given. This is followed by a discussion of studies on the psychosocial, social and economic needs of orphans as affected by HIV/AIDS, the support available to them and the coping mechanisms of the same.

2.2 Theoretical Perspectives on Adolescence

Different theorists view adolescence differently however they all agree that adolescence is a very important stage, one that needs to be handled with care. Therefore a clear understanding of adolescence is important since it provides a picture of the role expectations of adolescents.

Hall's storm and stress model of adolescence describes adolescence as a stage in life that is characterized by a high level of emotional turmoil and stress, due to the hormonal disruption associated with puberty (Hall 1904). He views adolescence as a time of sexual confusion, great emotional stress, and self-doubt.

It can be concluded, based on Hall's model, that adolescence is a stage wherein teenagers are not entirely in control of their lives and as a result become vulnerable to health-risk behaviours because of the ensuing confusion and self-doubt. During this stage, teenagers are expected to simply deal with the emotional stress caused by the biological changes taking place.

Hall (1904) suggests that good parenting is vital during this stage of human development if the teenagers are to adequately adjust to these new processes. On the other hand, Erikson's (1950) psychosocial theory of development argues that human beings pass through eight stages of development and each of these stages must be resolved successfully before the individual can progress to the next. Stage five of his psychosocial theory denotes the adolescent stage, described as personal identity versus role confusion.

Erikson (1950) views adolescence as a major stage in human development, one in which teenagers construct the roles they will occupy as adults. During this stage, teenagers re-examine their inherited identity and attempt to define one of their own making, sexually and occupationally. Like Hall, Erikson sees this stage as a very confusing and dangerous one in human development, since it determines how a teenager sees himself/herself in relation to his/her family and society.

Jessor's (1991) problem behaviour theory emphasizes the importance of adolescence, arguing that it is in this critical period that teenagers become vulnerable to risk behaviours. These risk behaviours may have negative health outcomes because this is in this crucial stage that risk-related learning takes place.

All these theories highlight the importance of adolescence and these insights are applicable to adolescent orphans affected by HIV/AIDS. Although this stage tends to coincide with conflict between teenagers and parents, the role that parents play in providing guidance for teenagers should not be underestimated.

2.3 The Situation of HIV/AIDS Orphans Worldwide

Globally in 2007, 145 million children under the age of 18 years had lost one or both parents due to all causes of death, whereas 15 million children had lost at least one parent to an AIDS-related death (WHO/UNAIDS/UNICEF/UNFPA 2008). The projections for 2010 indicate that the total number of orphans under the age of 18 due to all causes of death will decline to 132.2 million, whilst the number of orphans due to AIDS-related mortality will rise to 20.2 million (UNICEF/UNAIDS/PEPFAR 2006). AIDS-related illnesses have been responsible for approximately 25 million deaths worldwide, and have generated profound demographic changes in the areas most heavily affected, examples ranging from dramatic decreases in life expectancy; increases in the number of orphans and increases in the number of child-headed households (UNAIDS/WHO 2008).

UNAIDS/WHO (2008) indicate that in 2007, two million people died due to AIDS-related illnesses. Simbayi, Meintjes, Ngomane, Tabane, Mfecane and Davids (2006) attribute orphan hood and its impact on households and communities to the premature deaths of parents due to AIDS-related causes in sub-Saharan Africa -if adults were not dying in large numbers due to AIDS, the world would not be experiencing such large numbers of orphans. Given the above statistics, it can be argued that HIV/AIDS is a threat to children and their families globally and that it will continue to be a threat for many years to come.

2.4 The Situation of HIV/AIDS Orphans in Sub-Saharan Africa

WHO/UNAIDS/UNICEF/UNFPA (2008) indicates that, in 2007, sub-Saharan Africa had the highest number of orphans under the age of 18, with an estimate of 47.5

million from all causes of death globally. About a quarter of all orphans, 11.6 million aged up to 17-years had lost one or both parents to AIDS-related deaths by the end of 2007. The number of orphans in some sub-Saharan African countries exceeds half a million and in others, children who have been orphaned by AIDS comprise half or more of all orphans nationally (UNAIDS/WHO, 2008).

UNAIDS/WHO (2008) report that 22 million adults (15 to 49-years of age) were living with HIV in sub-Saharan Africa in 2007, which implies that this region will continue to have a high adult mortality rate due to AIDS. As long as this status remains unchanged, sub-Saharan Africa will continue to have high numbers of orphans.

It is estimated that by 2010 the number of orphans will rise to 53 million from all causes death whilst 12 million of those orphans will be due to AIDS related death (UNICEF/ UNAIDS/ PEPFAR, 2006). The significance of orphan hood is demonstrated by the drastic increase of orphans, from 330 thousand (1%) in 1990 to 12 million (35%) in 2005 (UNICEF/UNAIDS/PEPFAR 2006).

UNICEF/UNAIDS/USAID (2004) point out that the proportion of children who are orphans generally increases with the age of the child, since 12% of orphans are in the 0- to 5-year-old age-group; 33% are in the 6- to eleven-year-old age group, and 55% are in the 12- to 17-year-old age group. It is evident that older orphans greatly outnumber younger orphans and, therefore, one could conclude that adolescents make up the majority of orphans in the sub-Saharan Africa.

2.5 The Situation of HIV/AIDS Orphans in Tanzania

According to TACAIDS (2006) since the first cases were discovered in Kagera in 1983, HIV infection has spread to all regions and district in the country. However, the HIV prevalence rates show importation variations within the country. There is no single HIV epidemic in the country but multiple localized HIV epidemics which sometimes have regional or district dimensions. AIDS is a clustering disease, so once a parent is infected with HIV the husband/wife has a high chance of getting infected and pass away. ASAP (2008) in its 2007 annual reports shows that, the national adult HIV prevalence peaked at 8% in 1995 and then gradually decreased to 6.5% in 2004 and 5.8% in 2007. At the onset, the epidemic was growing fastest in areas with larger or border towns, high population mobility (temporary migration due to labor factors), amongst those who were employed, more wealthy, or more educated persons (strong correlation between these factors).

Also the absolute number of new infections has grown steeply over time, particularly in rural areas, due to population demographics. Currently, it is estimated that more than an estimated 1.8 million persons in Tanzania are living with HIV (ASAP, 2008). Due to HIV/AIDS in the country, children are left without parents, care and lack of assets which make them to be more vulnerable to the impacts of AIDS. UNAIDS/WHO as cited by Valerie, (2007) estimates that AIDS is responsible for about half of total orphan numbers in the country. It is estimated that the number of OVC in Tanzania Mainland was 930,000 in 2006, which is five per cent (5%) of the total child population and it was projected to reach 1, 044,097 by year 2010 (UNGASS, 2008).

2.6 The Psychosocial Well-Being of HIV/AIDS Teenagers Orphaned

The teenagers' well-being is so important because adolescence is such a significant stage in psychological development, and vulnerable adolescents, especially those affected by HIV/AIDS, face unique responsibilities and challenges, such as earning wages, managing households, and caring for younger children and sick adults (Gilborn *et al* 2006). It is therefore important to understand the limits of their psychosocial well-being and psychosocial distress in the context of socio-cultural and developmental stage of the child.

Gilborn *et al* (2006) defines a good (or high) psychosocial well-being as a period in which one's mental/emotional state and social relationships are predominantly positive, healthy and adaptive whilst a poor psychosocial well-being (or psychosocial distress) is when these are mostly negative, unhealthy or maladaptive.

Activities that support and promote the psychosocial wellbeing of children and families are critical because children are able to bear and recover from significant levels of suffering when they are surrounded by people who love and care for them (Richter, Foster & Sherr 2006). The sense of belonging and hope that is nurtured by these relationships enables children to cope better with hardships like hunger, general discomfort and the other privations of poverty and loss.

These efforts are "key investments" in "human capital" children who receive affection, stimulation and support in early childhood have a good foundation for growth and development are more able to cope with challenges, better at overcoming disadvantages and making positive contributions to the society (Richter, Foster & Sherr, 2006).

Gilborn *et al* (2006) hypothesized that “psychosocial well-being is influenced by:

- (i) Individual factors and experiences (such as age, sex, innate personality characteristics, family or household structure, personal exposure to stress, trauma and socioeconomic status).
- (ii) Contextual factors (example, community cohesiveness and support, presence of AIDS-related stigma, the socio-political environment, and availability of educational and employment opportunities).
- (iii) Access to programs and services, including psychosocial support programs” as illustrated in 2.1.

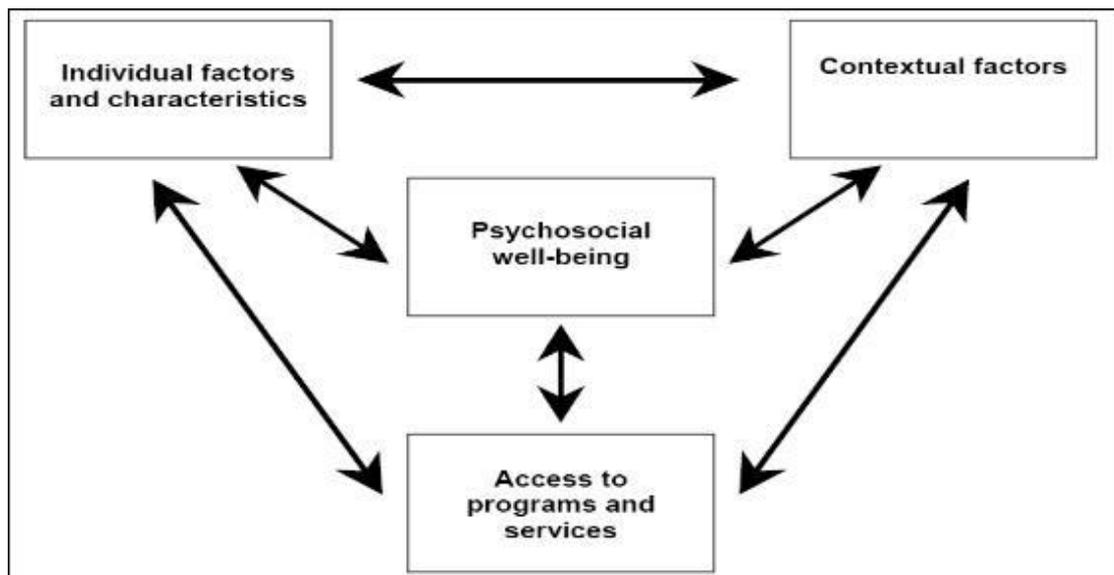


Figure 2.1: Psychosocial Well-being Framework

Source: Gilborn *et al* (2006)

Gilborn *et al* (2006) report high levels of psychosocial distress, like feeling guilty for bad things that have occurred/feeling worried or stressed/feeling irritable or sad/difficulty in concentrating/feeling overwhelmed and hopeless about the future. In

addition, despite adverse circumstances and feelings of distress, there are signs of psychosocial well-being among teenagers peer relationships emerge as an important source of social support and coping. Some teenagers report that they feel they can do things to help themselves/feel confident in themselves/feel hopeful about the future/feel able to cope with difficulties in life (Gilborn *et al* 2006). This suggests some level of resilience amongst the vulnerable group of teenagers.

2.8 Psychosocial needs of HIV/AIDS orphans

The psychosocial impact of HIV/AIDS on orphans is a neglected topic, due to the shocking financial crisis that confronts them, programmes tend to focus on providing for material needs rather than counseling and other forms of psychosocial support (Foster & Williamson 2000). This section focuses on the psychosocial needs HIV/AIDS orphans experience in relation to parenting with a terminal illness, witnessing an AIDS-related death, the psychological impact of death, psychosocial stressors and stigma.

Research evidence shows that orphans face many psychosocial challenges that involve the lack of parental guidance, love, care, and acceptance in the new families they join (Nasaba, Defilippi, Marston & Musisi 2006). They also face social problems, which include the lack of supportive peer groups and role models, stigma and other risks in their immediate environment (Skinner *et al.*, 2006).

PEPFAR (2006) adds that HIV/AIDS affects orphans in a number of ways including:

- (i) Living with a high risk of becoming infected themselves

- (ii) Being required to work and/or put their education on hold as they take on the household/care-giving responsibilities of a chronically ill parent/s
- (iii) Experiencing greater poverty because of the disease
- (iv) Being subjected to stigma and discrimination because of their association with a person living with HIV.

When the health of HIV-infected parents begins to fail, the basic needs of the children may be compromised, as the parent possibly loses his/her job due to bad health and/or the household income is redirected towards caring for the sick parent (Population Council 2004). At times, the normal parental-child role may be reversed, as older children may have to take care of the ill parent and assume household and childcare responsibilities (Smart 1999).

Stein (2003) argues that some terminally ill parents may become overprotective of their children, and may begin to distance themselves from their children in the hopes of reducing the impact of the future loss. This overprotection might have a negative impact in children since they might feel that their parent is neglecting them. After the traumatic experience of witnessing the death of a parent, orphans are often sent to different households, separated from their siblings, and relocated away from schools and friends (UNAIDS 2002).

Cluver (2003) indicates that children with parents infected with HIV are likely to experience more disrupted routines, and more periods of informal fostering than other children who have parents with other terminal illnesses. A study conducted in Zimbabwe by Nemapare and Tang (2003) reports that the loss of a father (who is the symbol of financial security) results in untold worries about the future, and the loss

of a mother, who loves, nurtures, and guides the child is the most difficult thing for any child to handle.

Orphans suffer emotional stress; higher levels of anxiety, depression, and anger, along with the associated inactivity induced by depression; feelings of hopelessness and thoughts of suicide due to the hardships they face after a parent dies (UNICEF 2006). Hunter and Williamson, cited in Gilborn *et al*, (2001) found that orphans who witness the prolonged illness and death of one or more family members suffer effects like

- (i) Mental distress
- (ii) Depression
- (iii) Increased malnutrition
- (iv) Lack of health care and proper schooling
- (v) Early entry into paid (or unpaid) labour
- (vi) Loss of inheritance through “property-grabbing”
- (vii) Homelessness
- (viii) Early marriage
- (ix) Exposure to abuse
- (x) An increased risk of HIV/AIDS

Orphans and vulnerable children who are affected by HIV/AIDS have the additional burden of becoming the victims of the stigma associated with the AIDS pandemic (Economic Commission for Africa 2004). Bray (2003) argues that this stigma causes varying levels of additional trauma, which is then added to the traditional long-term effects experienced by non-HIV/AIDS orphans.

Children whose parents are presumed to have died because of AIDS are often thought to be HIV-positive themselves, and are consequently stigmatized, which manifests as being excluded from school and denied treatment when they are sick (Richer, Foster & Sherr 2006). Children have powerful emotions regarding death, and may exhibit these emotions for extended periods of time at random intervals (Kristin, Close, Andrea & Rigamonti). Nasaba *et al* (2006) summarize the psychosocial problems that affect HIV/AIDS orphans, starting from the illness until to death of the parent, which includes the following:

- (i) Children are not always told the truth about their parents' diagnosis. This doubt causes anxiety.
- (ii) Children start worrying about what will happen to them when their parent dies.
- (iii) Illness and death of parents create traumatic feelings in children.
- (iv) After the death of a parent, the child may be required to head the family.
- (v) Children may be "distributed" to different relatives after their parents die, resulting in a breakdown of the original family unity.
- (vi) Often children who lose their parents lack parental guidance, love, care, and acceptance in the new families that take them in. It takes a long time to adjust to the new an environment without their parents.
- (vii) In some instances, children fail to be taken in by relatives and they end up heading their own families. Others opt to move to town and start working as "house girls", or even commercial sex workers.
- (viii) At school, children affected by HIV/AIDS face stigma and discrimination.

2.9 The social needs of HIV/AIDS orphans

The fulfillment of the orphan's social needs is very important to the processes of human development. Muller, Sen and Nsubuga (1999) report that the increased risk of malnutrition, inadequate shelter, lack of clothing and interrupted schooling are commonly cited as the consequences of the death of wage earning adults in AIDS affected households. Other common impacts include deepening poverty and the ensuing.

- (i) Pressure to drop out of school to begin working
- (ii) Food-insecurity
- (iii) Reduced access to health services
- (iv) Deteriorating housing conditions
- (v) General worsening material conditions
- (vi) And the loss of access to land and other productive assets

Research shows that in households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for other survival activities. For example, a study in Zambia indicates 75% of non-orphaned children in urban areas were enrolled in school, compared to 68% of orphaned children (Richter 2004). Another study conducted by Patterson (2003) reveals that orphans affected by HIV/AIDS do not *want* to participate in school or youth activities because they are rejected by their friends and schoolmates or relatives. (Simbayi, et al., 2006)

These orphans experience financial deprivation, which begins during the prolonged HIV/AIDS related illness of the parents and is compounded when the adult breadwinner dies (Muchiru, 1998). Orphans are vulnerable to financial exploitation,

which includes the use of children as cheap labour, the siphoning off of childcare grants, and the misappropriation of inheritance monies, as well as homes and property, by surviving adult relatives (Foster, 1997).

Such exploitation and abuse contributes to an increased likelihood of anti-social behaviour and criminality, which might even include commercial sex work (Schonteich, 1999). Loening-Voysey (2002) argues that, whilst welfare provision in the form of financial grants for fostering orphans affected by HIV/AIDS is a vital way to address the needs of these orphans, grants do not necessarily reach them. Furthermore, it is argued that, due to welfare provision, orphans are being viewed as an economic asset, to be cared for nominally and as a means of providing financially stressed households with an additional income (Loening-Voysey, 2002).

According to Richter (2004) children affected by HIV/AIDS may receive poorer care and supervision at home; suffer from malnutrition and may not have access to health services. Stein (2003) notes that comparative studies of orphans and non-orphans suggest that orphans suffer more hunger than non-orphans, since a nutrition surveillance study in Zimbabwe indicates that the proportion of children who are underweight are higher among orphans than among non-orphans (22% versus 17% respectively).

Simbayi *et al* (2006) emphasize that children may also suffer the loss of their home through the sale of livestock and land and asset stripping by relatives. Gilborn, Nyonyitono, Kabumbuli and Jagwe-Wadda (2001) indicate that this “property grabbing” undermines the livelihood of orphans, already weakened by the death of

parents. They further point out that the overcrowding caused by households taking in orphans can lead to increased psychosocial stress and the larger risk of abuse, especially if adults and teenage girls and boys are sleeping in the same room.

2.10 Psychosocial Support Available to HIV/AIDS Orphans

Philippi Namibia (2006) defines “psychosocial support” (PSS) as “an ongoing process of meeting the physical, emotional, social, mental, and spiritual needs of a child”, all of which are essential elements for meaningful and positive human development. It includes “formal and informal services that address psychosocial well-being either

- (i) Directly and specifically (example through interpersonal moral support, counseling, spiritual support and creation of memory books)
- (ii) Indirectly (example school and nutritional support programs that may alleviate stress and worry)” Gilborn *et al.* (2006).

Duncan and Arnston, cited in Gilborn *et al* (2006), argue that social connectedness, such as having supportive relationships with primary caregivers and members of one’s cultural or faith groups and access to community resources are widely recognized as protective factors that buffer the consequences of negative experiences on children. Gilborn *et al* (2006) indicate that, although teenagers report that they feel very well supported by the adults in their lives and their religious communities, many youth do not receive the social support needed from peers and adults to effectively mitigate the impacts of the stressful and traumatic events in their lives. Orphans experience many challenges, including unmet psychosocial needs due to the

lack of guidance, psychosocial support and meeting these adequately is very important for a child's development (Giese, Meintjes, Croke & Chamberlain, 2003).

Since the onset of the AIDS pandemic, numerous individuals, groups and organizations have come forward to offer help to children orphaned by HIV/AIDS. Germann (2004) criticizes the approaches used to support orphans because they undermine children's own coping capacity, which creates and reinforces a dependency syndrome that may have serious long-term consequences. He further indicates that such approaches tend to be biased towards children's' material and formal educational needs and often fail to address the less obvious social, mental, and emotional needs that children have.

2.10.1 The Psychosocial Support Model

The Family Health International (2001) recommends a model of psychosocial support in order to provide a better understanding of the different needs, since meeting these is essential in the development of children. It is envisaged that the understanding of these needs by the communities, aid agencies, NGO and the government will assist in better meeting them and so eventually improve the orphans' psychosocial well-being. This model supports Maslow's theory of needs since it emphasizes the importance of balance in acquiring the basic skills needed for survival. This model states that these skills form a wheel comprising five elements but asserts that none of the five elements would be adequate if provided for without input from the others.

At the centre of the model is the awareness of cultural practices, beliefs, and rituals which informs one about the manner in which all of the other needs are met, since culture serves as a storage of knowledge, values, connectedness, belonging and traditional practice. The first element of the wheel represents the physical needs of a child, which incorporates financial needs such as food, shelter, clothing, school uniforms, school fees and basic health care. Most of these economic needs of children are combined with educational needs. The simple provision of financial assistance is not the only need children have from a psychosocial perspective but their needs for financial support must be met in an on-going and reliable fashion.

The second element is the emotional needs of children. This includes the need for love, security, encouragement, motivation, care, self-esteem, confidence, trust and security, a sense of belonging, guidance, and understanding. Children need to be heard and need to learn to express their feelings in an appropriate manner. At times, children's emotional needs may include assisting them to cope with especially difficult circumstances, like bereavement and loss. The third element is the mental needs of the child, incorporating three aspects, namely.

- (i) Formal education (schooling)
- (ii) Informal education (opportunities for acquiring observational knowledge and adaptation skills, which would support the child in their ability to exercise an appropriate amount of control over their environment and access positive reinforcement).
- (iii) General skills (life skills, general knowledge) combined with the motivation to succeed.

The fourth element is the children's social needs. It is essential that these needs be met for proper integration into a community without feelings of stigmatization, and in developing a sense of belonging. These needs being met fosters the ability to form friendships and community ties, which promotes self-acceptance and a healthy sense of personal identity, and elicits acknowledgement from peers and more opportunities for social interaction, from which orphans learn socially acceptable behaviour (through feedback from others).

The last element is the children's spiritual needs. Children need a belief that enables them to develop hope for, and a belief in their future, they need to develop a sense of trust in the security of their survival. This enables them to keep trying when facing obstacles, and facilitates a sense of connectedness to deceased parents and ancestors.

2.10.2 Family and Community Responses

Support at the community level, whether initiated by individuals or groups, offer material and non-material assistance to children and households affected by HIV/AIDS. This assistance includes food and nutritional support, educational support, psychosocial support, household visits and home-based care-giving, treatment-support, and child-fostering (Mathambo & Richter, 2007).

Prior to the AIDS pandemic, orphans were traditionally incorporated into the extended family. According to Matshalaga (2004) defined “mother” and “father” are very broad in the traditional African extended family, including both the mother’s

sisters and father's brothers. "Kin" (or blood relationships) make up the extended family network of people connected to the orphans. When a parent dies, the traditional system provides an elaborate framework for arranging for the provision of the surviving spouse and children.

There are opposing views in the available literature regarding the capacity of extended families to care for and support orphans. Foster *et al* (2000) and Richter (2007) argue that extended families are actively responding and coping with the growing demand of orphans whereas Ntozi *et al* (1999) and Richter (2007) suggest that the extended family's ability to cope is starting to fail, buckling under the increased strain, and leading to its collapse. Mutangadura and Richter (2007) shows that the major share 90%, of assistance to orphans is provided by extended families and community groups with only 10% being supplied by the government/NGOs.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents Research study approach, Study design, Study area, Data collection method and techniques, Study sample, Tools for data collection, Data analysis techniques and, ethical considerations.

3.2 Research Study Approach

This study used qualitative research approach to enable the researcher to gain an in-depth understanding of the effects of HIV and AIDS on the psychosocial well-being of teenager orphans aged between 13 and 15-years. This approach is informed by philosophical view of realism. Realist philosophers point out that true knowledge is obtained by exploring hidden mechanisms in order to explain physical manifestations of social phenomenon prevailing in the society. This philosophical position predetermined the research methodology opted to carry out this study. Another reason is that with this kind of research approach it has been easier to explore

orphans and attain an in-depth understanding of the psychosocial well-being of the orphans aged 13 to 15-years in the context of Tanzania based on Kihologota ward in Iringa region.

3.3 Study design

This study used a qualitative approach in the form of narrative work in particular oral history. Qualitative research uses a naturalistic approach that seeks to understand phenomena in context specific settings, a real world setting where the researcher does not attempt to manipulate the phenomenon of interest (Golafshani, 2003). An oral history approach was chosen, as it is a good method to elicit personal testimonies as evidence. Oral history allows an in-depth exploration of the research topic with people who have had the relevant experiences (Charmaz, 2006). This research approach in this study enabled the recording of the orphan's memories of their unique life experiences before and after the death of their parent(s), using the power of verbal communication.

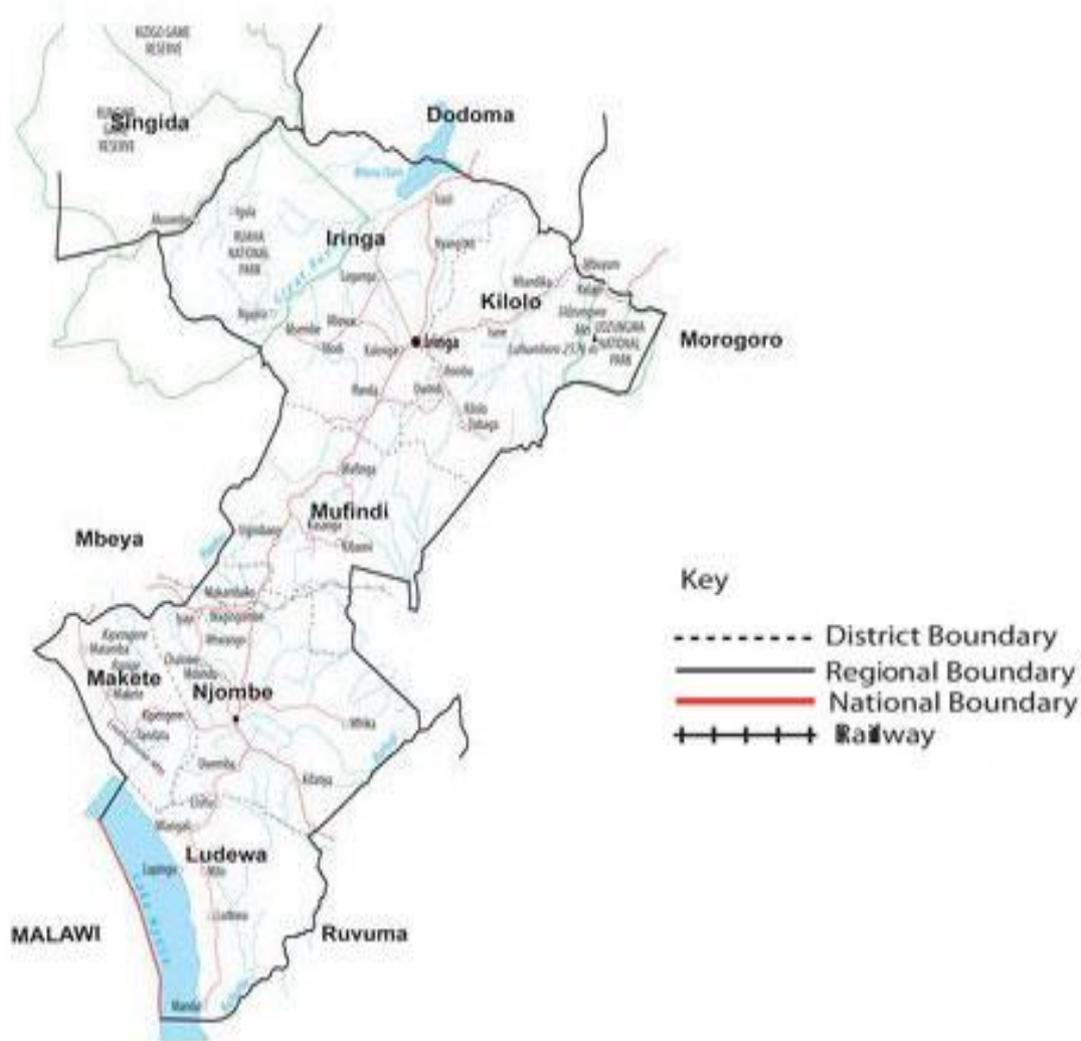
3.4 Study Area

The study site was in Kihologota ward in Iringa rural district which is in Iringa region. The research site was purposefully selected due to higher prevalence rate of the regional which is 9.1% and is a second region country wide with high prevalence. Furthermore, most of deaths occur among people aged between 15 to 45 year age group in Iringa rural district and suspected to be due to HIV/AIDS (TACAID, 2012).

This is an indication that there are many orphans in Kihologota ward, and the greater percentage of these is a result of AIDS. The study had being undertaken in Iringa

rural district which is administrative districts of Iringa region. The district is located between latitudes 7.00' – 8.30' South of Equator line and longitudes 34' - 37' East of the Greenwich Meridian. It is bordered by Mpwapwa District (Dodoma region) to the North Kilolo District to the East Mufindi District to the South Chunya District (Mbeya region) to the West Manyoni District (Singida region) to the North west.

The District has a total of 20,576 square kilometer, of which only 9,857.5 square kilometer are habitable and the rest are occupied by National Parks, Forest, Rocky Mountains and water for more than one third of the total regional surface area. The



district has 6 divisions, 25 wards and 123 villages and 718 sub villages with the average area of 167 square kilometer per village.

Figure 3.1: Geographical Location of Iringa Rural District

Source: Iringa Rural District Profile (2005)

According to the National population Census (2002) the district had 275,454 peoples of whom 137,178 males and 138,276 females with the population growth rate of 1.3.

The area was selected due to high prevalence rate of HIV/AIDS, where in 2012 prevalence rate was 9.1% and was the second district in the region with high level of prevalence rate and more than 340,000 orphans generated.(NACP, 2011). The numbers of orphans in Kihologota ward itself comprised 524 of orphans of whom Boys 208 and girls 316) in a ward population of 10,436 people for 4126 Males and 6310 female (Iringa Rural Social economic profile 2013).

Also the district is predominantly rural with 95% of its population residing in rural areas engaged mainly in agriculture and livestock as their major activities. Crop growing include pyrethrum, coffee, tobacco, sunflower, maize, beans, millet, sorghum, cabbage, sweet and Irish potatoes, peas, tomatoes, paddy, groundnuts, wheat and fruits. Other activities are fishing, forestry, tourism and trading.

3.5 Data collection Method and Techniques

Data was gathered by means of a semi-structured interview schedule (interview guide), used in conjunction with audio-recorded, personal, face-to-face interviews between the researcher and each participant. Also in-depth interview has been used in order to elicit the various perspectives, reflections and observations from HIV/AIDS orphans. The interviewer used probes in order to elicit a deeper understanding necessary for this study because “when probing an interviewer encourages a respondent to produce more information on a particular topic, without injecting his or her own ideas into the discussion” (FHI/ IMPACT/ USAID 2005). In addition, the non-verbal clues have been observed during the interview process.

3.6 Study Sample and Sampling Procedure

Sampling method used was non-probability sampling method whereby purposive sampling technique was used to select the sample on the basis of known orphans found in the ward. Sample characteristics based on age, gender, location and vulnerability status. Sample size was ten respondents who have been interviewed using in-depth interviewing technique. Although the number of the participants may appear small but the focus of the oral history is not on the number of participants but rather on the richness of data obtained from these participants.

Therefore, participants were able to give sufficient information for the purpose of this study. Sampling procedure as the process of selecting a subset of respondents (study sample) from the population based on orphans received support from the one of the NGO called CAMFED operating in the study area.

3.7 Tools for Data Collection

The research study made use of an in-depth interviewing technique using *in-depth interview schedule*. Cunningham (1993, cited in Lewis, 2000) from a general review regards interviews as an important method of data collection that represent important parts of any social research project because it provide the opportunity for the researcher to investigate further, to solve problems and to gather data which could not have been obtained in other ways. With these interviews, the goal is to explore a topic more openly and to allow interviewees to express their own opinions and ideas in their own words (Esterberg, 2002).

The interviewees' responses shape the order and structure of the interviews. Hence, in-depth interviews are particularly useful for exploring a topic in detail. In the same vein, Terre Blanche and Kelly (1999) state that interviewing gives the researcher the opportunity to engage with participants, so that he or she can obtain a better understanding of how they think and feel. This instrument employed to teenagers orphans in focus of understanding the psychosocial well being of orphans due to HIV/AIDS.

Also an in-depth interview guide was pre-tested with a group of teenagers outside Isimani Village a week prior to the commencement of the interview in order to check the appropriateness and relevance of the interview guide, the selection criteria, and the feasibility of completing interviews with selected participants.

3.8 Data Analysis Techniques

In-depth individual interviews with ten orphans were conducted, using a narrative inquiry process. Narrative analysis was selected as the primary analytic method for this study, since it emphasizes the stories that people tell, in the course of interviews and other interactions with the qualitative researcher (Bryman 2004).

The narrative enquiry process is important for both the research participants and the researcher. According to the narrator's point of view, the narrative's importance lies in its being one of the main forms through which the interviewee perceives, experiences, and judges his or her actions, and how he/she makes sense of the social world (Hydén 1997: 49; Somers 1994). Then Stories were re-written to form chronological sequence. The narrative segments and categories within the story were

isolated to determine larger patterns and meanings or themes.

3.9 Ethical considerations

Research ethics covers a number of concerns including ensuring the welfare and dignity of those who participate in the research, maintaining honesty in conducting research and treating information given by participants with utmost anonymity and confidentiality (Field,2004). In the process of adhering with ethical issues, ethical clearance was sought and obtained from Open University of Tanzania (OUT) prior to the study. Research permit was also sought and obtained from the Iringa region and Iringa Rural district authorities.

Furthermore, informed consent has been sought and obtained from participants before they participate in the study. Specifically, participants were informed about the objectives of the study and that their participation was voluntary as there were no any kind of coercion for participation. Furthermore, participants were freely to decline or withdraw at time in the course of the study without any repercussion. It was clearly clarified that the information to be provided whether orally or in writing was for research purposes and would therefore be strictly anonymous and dealt with confidentially.

Prior commencing the research study, an official approval obtained from the ward executive officer, directed a researcher to the heads of schools therefore heads of schools handled a researcher to the teacher mentor in respective school which appoint relevant student aged 13 to 15 years (Camfed beneficiaries) who will give responsible answers.

As the study was orphans who might have been the victims of HIV/AIDS or likely to be the victims of HIV/AIDS, there is a likelihood that they may develop feelings of anxiety especially if they recall some episodes. In this way, researchers were standby to provide social support or counseling to participants who developed such feeling.

CHAPTER FOUR

4.0 FINDINGS

4.1 Introduction

This chapter presents a brief profile of each research participant, as well as themes that emerged from the analysis of the recorded interviews and the field notes taken during the interviews. This study aimed to explore and possibly attain an in-depth understanding of the psychosocial well-being of orphans aged 13- to 15-years. To achieve this aim, the researcher opted for a qualitative approach, the objectives were to identify the psychosocial needs of the research participants, their methods of coping and testing their perceptions of the types of psychosocial support available to them, and others like them.

This study used a narrative analysis approach to gauge and analyze the life histories of the research participants. Narration enabled the creation of a framework for relating experiences, as well as a model for ascribing meaning, understanding, and judgments to these experiences, linking them to situations typical of the narrator's life (Hydén 1997). Narrative analysis allowed the researcher to formulate broad themes and sub-themes to analyze the voices of the research participants and through his interpretation brought meaning and insight to their words, actions, and

experiences (Neuman, 1997).

4.2 Brief Profiles of the Research Participants

Working on the principles of constant comparison, saturation of themes and simultaneous collection and analysis of data, the researcher collected narratives from ten teenager children affected by HIV and AIDS. These research participants were all orphans and their ages ranged from 13- to 15-years. Six of the participants were female and four male.

4.2.1 Participant One

The first participant is a 13-year-old boy who lives with his maternal aunt, younger sister, and 2 cousins at Isimani Village. He attends standard seven at Isimani primary school, and aspires to be a policeman when he grows up. This choice may be affected by the fact that he is from a rural background, and there are not many options in this setting that allow for a variety of career-choices.

He used to live in Iringa town with his aunt, whilst his mother stayed at Mtera. When his mother's health deteriorated, he and his aunt joined her there and they stayed with his mother until her death two years later. His parents were not married and did not stay together, although they both died the same year. This respondent proved difficult to interview because he was very reserved. Most of the information was obtained after some probing. He appeared to be introverted by nature.

4.2.2 Participant Two

The second participant is a 15-year-old boy who lives with his aunt and four female

cousins at Igula Village. He is enrolled in form one at the Isimila secondary school. Previously he stayed with his father at Ndolela village. His mother died when he was very young, before starting his primary education, his father died when he was ten years old. He went to stay with his aunt at Igula village because of the difficulties he faced when his father died exacerbated by the sour relationship he has with his grandmother. Unlike the first interviewee, he spoke freely and openly about his life. However there were instances where he displayed some emotional distress, when he remembered his lost inheritance and when he spoke about his father's illness.

4.2.3 Participant Three

The third participant is a 13-year old girl who lives with her 2 sisters and brother in Ndolela village. She stayed in a homestead that belonged to her grandmother, who had died in 2008. Her guardian is her older sister, who was still a minor at the time of the interview. Her parents were not married; she used to stay with her mother, siblings, and grandmother before her mother and grandmother died. Her mother died in 2007.

This young woman does not know her father and he has never been part of her life, although she has been told that he is alive. This interviewee was talkative, frank, very forthcoming, and very easy to converse with, however she displayed some emotion when talking about her aunt. She seemed angry about the treatment she received from her aunt. Halfway through the interview, the aunt walked into the house (where the interview took place) and seemed upset, stating that she had not been told about the visit. She claimed that she was the participant's guardian, yet the

interviewee insisted that she was not -consent for the interview had been negotiated with the elder sister, the interviewee's legal guardian, and the interviewee.

The interviewee was crying with fury and exchanged harsh words with her aunt. The researcher calmed them down and repeated the consent process with the aunt, the interviewee, and her sister. After this, all parties agreed that the interview could continue. It is important to note here that the ethical requirements were met, the consent signed and the research procedure explained to the legal guardian. However, the actions of this particular adult demonstrated some of the pressure felt by teenagers who have to share dwellings with members of their extended family after the death of a parent. Reflecting on her dreams about the future, this participant expressed a desire to be a nurse when she finished her basic education. She is in form one at Isimila secondary school.

4.2.4 Participant Four

The 4th participant is a 15-year old girl who stays with her grandmother, 2 siblings, and cousins at Kihologota village. She is in form two Isimila secondary schools, and wants to study to become a journalist after completing school. Her mother died in 2002 and her father two years later. Since her mother's death, her maternal grandmother has been her primary care giver. Her mother was not married to her father, and he did not pay child-support or offer any form of sustenance to her or her siblings when he was still alive. Her grandmother supports her and her siblings with the aid of social grants.

This interviewee is a soft-spoken teenager who appeared relaxed and comfortable

during the interview, not displaying any visible signs of emotional distress. Upon reflection, the researcher ascribes some of this composure to the fact that, by all accounts, this girl feels loved and cared for by her grandmother.

4.2.5 Participant five

The 5th participant is a 13-year old girl staying with her grandmother, aunt, and twin sister at Ngano village. Since birth, she and her sister lived with their mother, a single parent, who died in 2007. Although her father was still alive and he is living with her stepmother in a close-by dwelling, her mother never encouraged the girls to visit their father, or to build any type of relationship with him. Although the father never paid maintenance for his twin daughters while their mother was alive, he did support them after her death. At various points during the interview, the interviewee broke down in tears as she related instances of her aunt's ill treatment of her and her twin sister. The interviewee was given time to calm down before the interview continued.

4.2.6 Participant Six

The 6th participant is 14 years old and she stayed with young brother and sister at Ndolela Village and she is in standard seven at Ndolela primary school. She is heading her family because her parents passed away last four years started with her mother and the next six months her father passed away too. When their parents were alive she used to take care of them due to their terminal illness, Ndolela was not domicile rather they parents were migrated from Dodoma since 1995 and most of their relatives are staying there. They never met their relatives since they born and

after their parents died none of their relatives showed up to the funeral services. So these children were excommunicated with their relatives and this was the reason why this participant heads her family.

4.2.7 Participant Seven

The 7th participant is a 15-year-old boy who lives with his aunt and two female cousins at Isimani Village. He is in form one at the Isimila secondary school. Previously he stayed with his father and his mother at Mafinga. His mother died when he was 5 years old, before starting his primary education, his father died later when he was ten years old. He went to stay with his aunt at Isimani village because at particular area he has no relative.

4.2.8 Participant Eight

The 8th participant is a 13-year-old girl who lives with her mother, at Ngano Village. She attends standard seven at Ngano primary school. Her mother has been sick for long time and her health has been deteriorating day to day. She is depending on support from neighborhood and sometimes fetching for casual labour in order to support her mother and herself.

4.2.9 Participant Nine

The 9th participant is a 15-year old boy who stays with her grandmother, and four siblings, at Kihologota village. He is in form two at Isimila secondary schools, and wants to study to become a lawyer after completing school. His mother died in 2005 and his father two years later. Since his mother's death, her paternal grandmother has

been her primary care giver. His mother was married to his father, and she was a third wife to his father, his father did not render any support to his wife due to economic hardship and large family he has. His grandmother was very old and supports his and her siblings with the aid of social grants.

4.2.10 Participant Ten

The 10th participant is a 14-year-old girl who lives with her step sister and her 3 children at Igula Village. She is in form one at Isimani secondary school, and aspires to be a teacher when she grows up. He used to live at Iringa town with her father, whilst his mother stayed at Njombe. Her father died four years back and she has no communication with her mother. She shifted to her step sister since she was 9 years old when her father was serious sick and cannot support her anymore and the next year passed away

Hence the research study included 10 participants of which 6 are girls and 4 are boys whom they have been taking care by aunt, grandmother, step sisters and child themselves after their parental died or being ill.

4.3 Themes that Emerged from the Collection and Analysis of Data

In the section, three broad themes that emerged from the narrative analysis and their sub-themes are presented. The three broad themes are description of the psychosocial needs, coping with orphan hood and future aspirations and psychosocial support available to orphans

4.3.1 The Psychosocial Needs of Teenaged Orphans

The psychosocial needs as narrated by the research participants emerged as needs related to the disclosure about HIV in the family, the social and physical needs experienced by the research participants. These needs arising from relocation changed households, living arrangements and emotional, trauma and abuse. This situation presented a multifaceted context where respondents expressed the fact that they were exposed to different levels of traumatic experiences at a very young age, essentially robbing them of a carefree childhood. They were faced early on with the multiple losses of very significant members of their families, and were pushed from different households, in need of care, which contributed to their feelings of being uprooted from their original families. The fact that they participated in the activities of local organizations demonstrated further challenges with regards to fulfilling the psychosocial needs in their lives as teenagers. Each of these sub-themes is discussed in turn below.

4.3.1.1 Disclosure about the Parents' HIV-Statuses

All of the research participants reported that their parents did not disclose any information about their illnesses, and all of them expressed a deep regret that they have not given an opportunity to discuss their parent's health with them before they passed away. They felt that such openness would have enabled them to better deal with their parents' illness and death. They also reported that they mounted with unanswered questions about the deaths of their parents. One participant gave the following response to the question of what he knows about the illness of his parents:

I did not have any information about my father's sickness (pause)... except that I was told by my aunt that he was sick. I was young and I

could not probe further because my father was not staying with me... I would have loved to know more about his sickness but nobody said anything about it. Whist for my mother...I only know that she was suffering from headache and my aunt took care of her when she was sick.

This participant emphasized that even though he felt that he needed to know more about his mother's condition, he was too young to ask his mother or aunt those kinds of questions. In Tanzania cultures, young children are not supposed to confront elders, even if the matter at hand may impact negatively on the child.

Like to other two participants also they did not have enough information about their parents' illness as one stated:

"Although my father did not say anything about his sickness, I knew that he was suffering from stomach-ache because I was the one who was taking care of him. Few days before he died, he told me was that I must inherit all his belongings when he died. It became clear to me that my father will die but I did not have courage to ask more about his illness even though I wanted to know".

Another participant did not know what her mother was suffering from; although her mother told her that she was sick but she did not explain the cause of her ill health.

She narrated her mother's experiences during her illness:

"My mother believed that she was witched and consulted one of the traditional healer in our place and she had given some medicines still the condition become worse. She has been advised to go the regional hospital for further diagnosis and after check up the result showed that she was suffered with tuberculosis. She was fine for a short after started TB treatment and then later TB got worse. She went back to hospital and that was the time I last saw my mom. She died in hospital".

Further more research participants declared clear that their parents were not clear of what they are suffered until they die. As it narrated by one of respondent:

"I trusted my mother a lot but I wonder if she told me everything about her

illness. Since TB is curable if you treat it, why did my mother die? Unfortunately I can't ask anyone but this question is always coming up in my mind".

Research Participants vindicated that they did not know what their parent was suffering from. One respondent narrated:

"I do not know what my mother was suffering from before my mother died; I only know that my mother was bedridden. When I think about my mother I sometimes speculate that maybe she was suffering from AIDS since she was bed bound and my father also died. I also did not know anything about my father's sickness and I feel that it would have been better if I was told what my parent was suffering from before they died".

This participant declared that her mother did not tell formally that she was HIV-positive, but could relate memories of her mother suffering from TB and chest sores.

She mentioned that during that time she did not know what AIDS was. She argued:

I know I am not supposed to diagnose my mother with this disease but from what I was taught about the symptoms of AIDS, I think my mother was suffering from it. I did not think like this when she was sick because I did not know about the symptoms then but now I do.

The last participant explained just after his father death, he enquired also about his mother's death from his aunt. She told him that his mother suffered from stomach-ache. That triggered some questions in his mind, he stated:

I asked myself...why my parent suffered a similar condition. I started asking myself that, could it be HIV related death? I answered myself.... no, it can't, answer myself in denial. I asked all these questions with no answers and who was going to give me those answers? I guess those are the questions I will always have throughout the rest of my life without getting answers for (he displayed some emotional distress)

4.3.1.2 Social and Physical Needs

Majority of the research participants spoke with longing of things that they had when their parent/s were still alive which they now have to do without. This longing for

material things indicated that these teenagers have internalized the loss of their parents, but these feelings of grief have not been dealt with directly. At the same time, however, the participants were appreciative of the efforts by their extended/foster families to provide for them, even though this was not enough, as one of respondent commented:

"It is very painful that other children are getting everything they like and I am not. My aunt is trying everything to provide what I need but the gap still remains... (a long pause seem like want to cry) it would have been better if my mother was still alive because my aunt would not be struggling to raise me.... As much as my aunt loves me, she cannot replace my biological mother, I was very happy when my mother was still alive because she used to love me so much and provided everything I asked from her".

Another respondent declared how loss of parent may sometimes miss some need as he reported that he used to like playing soccer, but had stopped after his father's death because he did not have soccer boots. In any society, sport is an integral part of youth development, but since his aunt could not afford to buy the soccer boots, As well as a girl participant explained difficulties she experienced after her mother died, in her early life she lost hope for the future, and doubted that it had anything positive in store for her. She reported:

"I was living a good life when my mother was alive but now, life is no longer the same as before. I was getting everything I needed; she was buying me the full set of uniforms, which I don't have now. Now I have one skirt instead of two; I don't have a school tie; I have old shoes".

Despite having unfulfilled needs, another respondent was very aware of the fact that her grandmother provided for her basic needs. She did not display any emotional attachment toward her deceased parents, happy instead that her grandmother was "always there", supporting her. When asked about the feelings she had regarding the loss of her parents, she responded:

"I did not feel any change due the death of my father because I had never felt how good or bad it is to have a father. Mind you, my father has never showed love to me since he was not supporting me. I however felt the change about my mother but I am grateful that my grandmother is always there for me".

4.3.1.3 Relocation and Changed Living Arrangements

Most of participants reported that they were forced to migrate from their original dwelling places to either join households where their ill/dying parent(s) were cared for, or to new foster or extended households. In some cases, this meant more than one move in a short period. This uprooting, to new, unfamiliar places was reported as a traumatic experience as narrated by one respondent:-

"I was told to move in aunt house immediately after my mother died, my aunt has a small house where all children were accommodated in a single room with regardless of our sex"

Furthermore other respondent declared that children were not involved in decision to where they want to live after their father and mother died as narrated by one respondent:

"After my mother's funeral, the family had a meeting in our absence (the children's absence) and decided that I should go and stay with my aunt since I was the youngest. This was difficult for me because I was not consulted, I was just forced to go and stay with her... if I was consulted I would have preferred to stay here where my mother was staying (grandmother's house) before she died".

Another research participant added:

"After my mother's funeral, the family had a meeting in our absence (the children's absence) and decided that I should go and stay with my aunt since I was the youngest. This was difficult for me because I was not consulted, I was just forced to go and stay with her... if I was consulted I would have preferred to stay here where my mother was staying (grandmother's house) before she died".

4.3.1.4 Emotional Trauma and Abuse

Losing a parent is emotionally taxing, but some of the research participants vindicated that they suffered the additional ordeal of emotional trauma or abuse by some of their new caretakers as one respondent narrated:-

"My relationship with my grandmother is not good because she did not take good care of my father's belongings, that is. She did not give me the money she got from selling my father's belongings, and the money that came from my father's employer".

Moreover, the grandmother took all useful documents, including the father's identity document and death certificate and hid them so that research participant could not get them. In addition one respondent told about verbal and emotional abuse at the hands of her aunt. The aunt's frequent emotional outbursts against her and her sister were a source of deep pain for this young woman, and she cried when she narrated the following:

"My aunt shouts at us and she tells us that she will chase us to go where we belong. When we tell our grandmother, she just keeps quiet and when we tell our father, he normally tells us that he will take us so that we could stay with him. Sometimes my father asks my aunt about this matter and she says we are lying... I am very confused, I do not know what to do now because I always wanted to go and stay with my father but I know that my step mother did not want me to stay with my father".

In this case, the acutely felt emotions were grief, trauma, and an overriding sense of loss. Although not always explicitly articulated, it was evident in a number of the interviews. On the number of occasions during the interview, one respondent cried when she spoke about the trauma of losing her mother. With her mother gone, she felt there was no one left to provide for her, despite her father still being alive. She termed her father as person who is dead as narrated:-

"I would have been better if my father died instead of my mother

because he is “dead-alive”, so there is no meaningful reason for his existence in my life”.

4.4 Coping with Orphan Hood and Future Aspirations

A major theme that emerged from the analysis of the recorded interviews related to what the research participants considered as the things that helped them to cope with orphan hood. One Participant recounted that sport; holidays: and excelling at school made him happy, and helped him cope with orphan hood. In addition, other added positive reinforcement from his caretaker was a source of great pride for him. This young man aspired to be a policeman after completing form four.

Another participant in contrast, was still locked in the memory of the great emotional pain of having to take care of his dying father. Paradoxically, this pain was also the source of his coping mechanism -he felt that coming to terms with the inevitability of his father’s death helped him steel against the hardships of life, he stated:

"It was fine caring for my father though it was painful, but it came to a stage whereby it became apparent that my father was going to die soon. I had to prepare myself for his death. I therefore waited for his death because he had suffered for a long time and I was hurting to see my father feeling such pain. This prepared me for the hardships ahead of m".

Furthermore other participant spent many hours in a day riding on his bicycle. This, he told the researcher, helped him to cope when he missed his father. His future aspiration was to be a soldier after completion of his secondary school education.

Also another participant related how the fact that she was attending school, like other children in the community, despite being an orphan was a great source of pride for her. She liked going to school and enjoyed playing and doing her homework with

friends. She aspired to be a nurse when she completes secondary school.

Majority of respondent reported that the source of strength was their religion. They are actively participated in the activities of their Christian church, which gave them strong sense of fulfillment and consolation. They credited their religion with enabling them to survive in times of difficulty, helping them to cultivate a forward-looking orientation. Also they enjoyed playing volleyball with their friends at school. They only regret was not having someone to talk to when they felt sad at home, but they reportedly felt comfortable talking to their friends at school. They aspired to be one doctor, another journalist, and the last want to be a teacher

In the narrations of this research participant, the recurrent theme of conflicting emotions about her father surfaced many times. She told the researcher how her father started to provide financial support to her after her mother's death, which was not something he had done before. She interpreted this change in her father's attitude as proof of his love for her. Like the previous research participant, the emotional support at her home was almost non-existent, poor but she was able to draw strength from her acceptance in her church and in participation in church-based activities. This young woman wanted to be a nurse in the future.

4.5 Psychosocial Support Available to Orphans

Although the research participants experienced severe challenges and radical changes, they nonetheless reported elements of support from community members and organizations. This theme has the following sub-themes which were Support from family and friends and Support from Institutions/organisation.

4.5.1 Support from Family

All of the research participants were able to report some moral, spiritual, and social support from families and friends. This kind of support was narrated as vital to help them cope with orphan hood. Support in this sense took on the form of care-giving; taking care of specific needs such as health, food, shelter, clothing and school fees; treating the teenager as a member of the family as opposed to treating them like an interloper, listening to the teenager; and helping him or her keep the memories of their deceased parents alive.

Research participant told how his mother had showered him with love, and that these memories of her kept her alive in his thoughts. She also related that he felt a different kind of love from his aunt's when retelling his story, Participant revealed that there were many occasions where he missed his mother terribly, and it was then that he had a burning desire to tell stories of "the good times" he had enjoyed when his mother was still alive. He felt that these stories would connect him to her again, and make his plight more bearable. At the same time however, he felt that these reminiscences could not be shared with just anybody in this respect, his cousin was the one person who was always willing to listen to him. He voiced his deep appreciation for the support he received from his aunt and for the fact that she made every effort to treat him like a son.

Another participant told the researcher how he had felt loved and wanted when his aunt invited him to come and stay with her. He felt that his aunt treated him like her own child, and his fondest memory was when she gave him money to buy his

bicycle. In his account of support, participant noted that he felt “at home” with her, and “well taken care of” and, as a result, he did not have plans to go back to stay with his grandmother at Igula village. He felt comfortable talking to his uncle and aunt about his late mother and father, the loss of his inheritance and any other issues that worried him. Over the course of the fieldwork, this respondent’s uncle also died and his aunt was the only person left that he felt he could talk to. Part of the loving care he received from his aunt was the fact that she sent him to a local clinic for medical attention when he was ill and paid his school fees.

This research Participant told the researcher that, since her grandmother has always assumed full responsibility for her care, she felt deeply loved and completely at home with her, praising her grandmother for taking such good care of her. As well as other Participant told the researcher how her father used to pay maintenance support while her mother was still alive, but that soon after her mother’s death this support ceased. Her uncle stepped in to help her with material needs like food and clothes, her emotional and psychological needs remain unmet, and this is where Camfed and friends stepped in to meet these unfulfilled needs, as she narrated:

"Even though it was difficult to live in a household I used to share with my mother and my grandmother, who both died...but staying here made me believe that I am still connected with them, therefore I am safe despite all odds. I cannot imagine myself staying in any other household than this one and that is why I could not resist coming back home when my aunt started humiliating me".

In addition another participant told a research that she was happy to live with her grandmother, a woman who tried everything in her power to continue to provide for this young girl.

Contrary to the above-mentioned participants, this participant found herself in a very confusing situation: she did not know whether she belonged with her grandmother or with her father. This was caused, in part, by the ill treatment they reportedly received from their aunt. This participant wanted to go and stay with her father and her father repeatedly made promises that he failed to fulfill. Not only did this create stress for this girl, but she experienced feelings of guilt that leaving her grandmother would mean betraying her current caregiver. She felt certain that her grandmother loved her, but her aunt's angry outbursts and emotional abuse made it unbearable for her to develop a sense of belonging at her grandmother's household.

Moreover, she was still haunted by her late mother's instructions that she should not stay with her father, or have any type of relationship with him. This emotional turmoil created distress in this participant and, as she narrated this during the interview, she broke down in tears, saying that she did not know how to solve this problem. In the end, she connected her current situation with the loss of a parent due to death and the potential loss of another due to a poor relationship and said through her tears: "It would have been better if my mother did not die".

4.5.2 Support from Institutions/Organization

An overwhelming number of respondents described how, through the association that they have developed with Camfed they were able to fulfill their basic needs. They considered the role played by this organization as a vital one in helping them restore their sense of purpose and confidence in life and one participant narrated how this organization has helped him to find hope:

"I feel so different ever since I started supported with Camfed. They give us scholastic materials, paying school fees and school contribution, life skills lessons and formed clubs (Tuseme Club). I meet other children who are in the same situation as I am, and we talk and share common issues with one another. This has really helped me a lot and I think other children feel the same way as me".

In additional next participant appreciates the availability of the Camfed's services provide and remarked:

"Apart from the support I get from my aunt, Camfed has done wonders in my life. Here (home) I get food and clothes but Camfed has given me, among other things, the life orientation training and life skills that I would never have received".

Furthermore other participant added, the organization has given him more than just the basic needs –it has given him the social skills that he needs in order to cope with his orphan hood. In additional to that another respondent supported the effort of that NGO and also added church as an institution prayed a lot in their place to give comfort to orphans as she narrated:

"When I am feeling sad about something, I confide to my school friends, but if I miss my mother I do not talk to my friends but I prefer going to church for prayers... [Pause] I am afraid of talking about my mother with my friends because they would ask me questions that I am not ready to answer about my mother".

The other participant enjoyed the support she received from friends at school when she was feeling bad about something, which suggests that the role played by the schools is as vital, and should not be underestimated. She further had this to say:

"While my mother was sick some teachers and student were joining me at home even after my mother passed away, my fellow student contributed 20,000/= and they participate in the funeral services, I was very pleased by their action".

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses study findings base on the understanding the psychosocial well being of teenager orphans aged between 13 and 15 years old. Hence the study findings showed that psychosocial well being of teenagers orphans in Kihologota ward is not pleasing due to inadequate of social and physical needs, orphans are not involved in decision pertaining their welfare, lack of formal psychosocial support and non parental disclosure as further explained below:-

5.2 Inadequate Social and Physical Needs

The study findings showed that research participants coped with orphan hood, despite the challenges and hardships they were confronted with, all of them verbalized future aspirations. Things like sport, privacy, having school material be comforted were very important to these interviewees. They drew strength from these things and they added meaning to their lives. So when orphans taken into foster or extended families have been provided with shelter and clothing but this was often insufficient. Problems that were reported were insufficient space and the resulting lack of privacy, not having new clothes, lack of love, not having a full school uniform, and not having sport clothes.

Muller, Sen, and Nsubuga (1999) found similar challenges where shelter, lack of clothing and interrupted schooling were identified as the challenges that were inadequately addressed. The foster families or extended family are not capable to fulfill all these social and physical needs to the orphans this was due to these families has responsibilities of fulfilling the same needs to its children. And become overwhelming of needs demands with relation to economic hardship and orphans become partial fulfilled of their needs

5.3 Non-Parental Disclosure

The study findings showed that parents are not disclosing their HIV/AIDS status to its children and stigma found as main cause for such behavior. The kinds of stigma found within patients themselves and from other community members. Such

behavior used as patient's defending mechanism against stigma from community members and protecting their children against stigma. Even through continuous campaigns made by the government and Non - Governmental Organizations still society has negative altitude on the spread of HIV/AIDS as associated with adultery and this become a reason why parent are not disclosing their health status to its children because they fearing of being understood wrongly as unfaithful or adulterous as well as be free from stigma. The ideas above were confirmed too by the research conducted by Stein (2004) on HIV/AIDS and the culture of silence in disclosing HIV/AIDS information to children. According to Stein's study, positive parents often indefinitely delay disclosure to children on the grounds that their children are too young to understand the nature of HIV/AIDS. Most parents are afraid to talk about HIV/AIDS due to the stigma attached to it and the impacts HIV/AIDS have on their children. In all this cases orphans especial teenagers left with many questions and afraid to pose questions to their relatives and become psychological disturbed.

5.4 Orphans are not Involved in Decision Making Pertaining their Welfare

From this study it found that orphans are not involved in the meeting of discussing their welfare immediately after parental die. Family members were meeting to discuss how the remaining children will be distributed and orphans themselves are not involved. May be if they could involve them, they can identify whom the wish to stay among their relative and enhance orphans to become more comfortable to where they going to stay and also disintegrate the family unit.

It supported too by Nasaba (2006) who advocates that distribution of children to different relatives after their parents die resulting on breakdown of family unit, lack of parental guidance, love, care, and acceptance and lack of the kind of support that would help orphans to quickly adjust to the new environment without their parents. Also is in line with study of UNAIDS (2002) reports that this re-distribution of orphans to different households, involving relocation away from schools and friends, is a common occurrence, obligating the teenagers to cultivate new friendships, and learn to deal with different teachers in a new setting.

5.5 Lack of Formal Psychosocial Support

The study finding indicated that unmet need expressed by the research participants was the lack of a formal and clear support system to assist them with their feelings of sadness and grief for their parents because foster families focus on providing them with physical needs like food, clothes and school contribution and forgetting the crucial need of psychosocial needs which will calm the pain, confusion and grieving experienced by teenagers orphans. This is consistent with the study conducted by Foster and Williamson (2000), who found that the psychosocial impact of HIV and AIDS in orphans is neglected due to the shocking financial crisis that orphans confront; therefore the programmes tend to focus on providing for their material needs whilst neglecting counseling and other forms of psychosocial support. This study found that there was a lack of formal psychosocial support, however it was noted that ad hoc psychosocial support was available to orphans. The kind of support given included the provision of shelter; food; paying for the school fees and giving love. Churches provided spiritual support to some of the research participants,

which helped them cope with orphan hood. The study further found that the organisation grants help the orphans and their caretakers to fulfill in some of their material needs.

Many of the interviewees expressed their appreciation for the affection and support they received from their caretakers, regarding this as a major contribution to their personal growth and development. This finding is similar also to that of Richter, Foster, and Sherr (2006) who report that the sense of belonging and hope that is nurtured in these relationships enables children to cope better with hardship, including hunger, discomfort, and other privations of poverty and loss. This suggests that orphans are in a position to bear and recover from suffering when they are surrounded by people that love and care for them.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This study explored an in-depth understanding of the psychosocial well-being of teenaged orphans aged 13- to 15-years old, with an intention of bringing awareness on psychosocial support to orphans in Kihologota ward in Iringa rural district. It has

been understood that adolescence is a period of transition, in which young people reconsider their identities, adult roles as exerted by social expectations. It is from this perspective, the term psychosocial well being became a useful to assess orphans of 13 to 15 years of age who are considered to be in transition phase from young to adulthood. It has been noted that this period for orphans manifest complicated traumatic events associated with death of parents. It is also a moment for an orphan seeks coping life strategies for him or her to continue surviving. In so doing the development of psychosocial well is become predetermined.

Both the review of related secondary sources of data and evidence including narrations stemming from field all have been analyzed to provide depth-understanding in relation to teenaged orphans showed that the loss experienced by these teenagers represents a progression of experiences. These range the gamut of emotions, from the onset of a parent's illness through the physical and emotional impact of their deaths and into the aftermath of their dying which including having to relocate to a different area and facing that ensuing uncertainty. The findings from this study clearly demonstrate that orphan hood brings great challenges for the teenagers concerned. However, their inherent ability to cope with those challenges (mediated by social, spiritual and cultural factors) cannot be undervalued.

This chapter finalizes a report by drawing conclusions, each specific objective of the study is concluded in response to a related research question, findings and the theoretical explanation that guided the study. Based on research findings this chapter based on the recommendations, it suggests both theoretical and practical implications

concerning psychosocial well being of orphans in the context of study area and country-wide.

6.2 Conclusions

6.2.1 The First Specific Objective of the Study Described the Psychosocial Needs of Teenaged Orphans Aged between 13- to 15-Years Old

The study findings reveal that teenaged orphans face harsh and shocking realities in the community where they live. Furthermore it has been revealed that the high the rate of HIV-infections and AIDS-related mortality in Kihologota ward, the heavier negative impact on orphans. The most noted negative impact on orphans has been the lack of psychosocial needs. Ever-changing environment of Kihologota ward leaves most of the households with weak economic base leading them to incapable of supporting orphans left by their relatives. In some cases, children whose parents have died due to AIDS-related causes are labeled as ‘AIDS Orphans’ and stigmatized. The grief of the loss of parents and significant others is made more difficult by multifaceted challenges, as children are uprooted to seek care in foster homes or the homes of relatives.

6.2.2 The Second Specific Objective of the Study Described the Coping Mechanisms of the Teenaged Orphans

In this regard, the study explored the practical ways that teenagers use to cope with trauma on a daily life basis. The study learned that teenaged orphans are coping with the challenges they confront, despite the lack of concrete or formal support structures to enhance resiliency. For example, playing favourite sports; going to holidays and excelling at school are all factors which bring joy to teenaged orphans, and as a result

assist them to cope with the realities of orphan hood. The support they receive from extended or foster families instills a sense of belonging in the teenaged orphans, enabling them to accept their new situation as orphans. The fact that most foster families treated teenagers as members of the family made them realize that they still have bright future ahead of them, even though their biological parents had died.

The restoration of this sense of purpose was evident from the nature of career options that research participants wanted to explore after finishing school. The pattern observed from their career choices was one of community-service oriented careers, e.g. policing, journalism, and nursing. These choices might have been influenced by the fact that the community is contributing towards their upbringing, instilling in them the desire to “give something back” to society. Support from churches and from Camfed helped teenaged orphans develop a positive outlook and attitude about themselves. This study has ascertained that teenaged orphans utilize the support offered by various stakeholders, unstructured or not, as their primary coping mechanism, enabling them to acquire a positive view of themselves, and a determination to survive against all odds.

6.2.3 The Third Objective was to Describe Types of Psychosocial Support

Available to the Teenaged Orphans

The study revealed that teenaged orphans obtained psychosocial support at a family and institutional level. At the family level, foster families are providing support in a form of “care-giving”, taking care of specific needs such as those of health, food, shelter, and clothing and more specifically, things like school fees. Proper management of the integration process of the teenaged orphans into the new foster

family treating these orphans as members of the family brings solace and makes them feel loved and wanted. The study also reveals that teenaged orphans are enjoying the presence of at least one family member who is always willing to listen to them when they want to share their memories about the deceased parents, helping them to keep the memories of their deceased parents alive as well as to cope with orphan hood.

Since foster families are able to send orphans to school, orphans further enjoyed social support from friends at school that they would otherwise not have received. Friends at school offer support by offering their time for listening to the orphans when they feel badly about something that they do not want to discuss with the foster-family members. Such support encouraged and motivated them when they were confronted with challenges at home. Teenaged orphans receive spiritual support from churches, which assist them in dealing with issues that were deemed too sensitive to talk about at all. They found comfort in the prayers from church members. Camfed is the only organization that provided support services to these young persons in the area. The support from this organization has made a huge impact in shaping the lives of these teenagers, since it fulfills those needs not addressed within their foster families. This study revealed that, although they were not structured, the orphans enjoyed familial and institutional support.

6.3 Recommendations

The study findings emerged with the following recommendations:-

- (i) It is clear that drastic changes take place in the lives of teenaged orphans who

have lost parents due to HIV/AIDS. Inter-sectoral collaboration could mitigate the impact of the ensuing changes and challenges, and so it is very important for the government, NGOs, and other aid agencies to establish formal structures where foster families can be trained as to how to manage the changes and challenges that confront the orphans. Such training might enable the members of the community to understand the physical and social needs and the changes that take place when children lost their parent to HIV and AIDS.

- (ii) Parent with HIV/AIDS has to disclose their status their children because will help them to take precaution while caring them and reduce new HIV/AIDS infection. Also parents openness of HIV/AIDS status will prepare their children cope with challenges faced them when parent died.
- (iii) The government has to formulate a formal psychosocial support programme which will be used to orient those key people who are dealing with orphans frequently such as teachers or foster families.
- (iv) Community has to involve children in their matters affect their welfare such as in decision making because this will allow them to talk and share their views and orphans will appreciate that are being respected.
- (v) This study has exposed the reality that the concept of “family” need to be re-evaluated in the light of the present reality that as we are losing conventional family units, and children are often left with minimal care, or none at all. This challenges future researches to explore/create workable innovative and holistic approaches at a community-level towards caring for vulnerable youth and children. Since orphans are residing within the community, there is a need to investigate the involvement of the local community in the provision of

psychosocial support services to orphans.

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APPENDICES

APPENDIX 1: IN-DEPTH INTERVIEW GUIDE**Objective 1: To describe the psychosocial needs of teenaged orphans aged between 13- and 15-years-old**

1. What has changed for you since the death of your parent(s)?
2. What was discussed with you concerning what would become of you after your parent(s) passed away?
3. Although this might be painful, for you, could you please tell me what happened at home prior to your mother's/father's passing?
4. What was the impact of your mother's/father's illness:

Objective 2: To describe the coping mechanisms of the same

1. How did HIV and AIDS change your life?
2. What kind of needs being met since parental loss:

Objectives 3: To describe the types of psychosocial support available

1. What kind of support was available to you to deal with the death of your parent?
2. Please describe to me what happened after the passing of your parent until you were placed with your current caregiver.