

## **RELATIONSHIP BETWEEN CARE PROVIDED BY FOSTER FAMILIES AND PSYCHOSOCIAL WELL-BEING OF CHILDREN AFFECTED BY HIV AND AIDS IN KIAMBU COUNTY, KENYA**

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**Abstract:** *The study sought to evaluate the relationship between care provided by foster families and psychosocial well-being of children affected by HIV and AIDS in Kiambu County. The study adopted a cross-sectional survey because it is suitable for collecting data at a single point in time. Multi-stage cluster sampling was used to select 345 children aged 10-17 years from a target population of 3780 children. The study relied on key informant interview guides, questionnaires, observation checklist and child drawings for collection of data. Validity and reliability tests were done to establish the gaps in the research instrument using the Cronbach Alpha method. The formulated hypothesis was tested using chi-square and factor analysis. Qualitative data was transcribed, coded and categorized into themes and words to allow for analysis and presentation. Results of the study established that there was a significant relationship between care provided by foster families and psychosocial well-being of CAHA based on results of factor analysis at 61.4% and chi-square results ( $\chi^2 = 4.6607$ ;  $df = 4$ ;  $p = 0.001$ ). This study concluded that there was a significant relationship between care provided by foster families and psychosocial well-being of children affected by HIV and AIDS. The study recommended that national and county governments and non-governmental organizations can ensure sustainability of families and communities by empowering them with knowledge and skills for CAHA to thrive in responsive environments. The study recommended that the Kenya government should commit resources to promote the psychosocial well-being of CAHA at various levels through government-mandated departments. The study will provide credible practical information to identify gaps in knowledge and practices and the extent of provision of care in realizing unmet needs for inclusion in formulation of feasible policies.*

**Keywords:** *Foster Families, Psychosocial Support, CAHA*

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### **Background Of The Study**

According to Children on the Brink (2017), 15 million children under 18 years in ninety-three (93) developing countries have lost one or both parents to HIV and AIDS. In Africa, an estimated 15.7 million children (30%) of the 53 million children orphaned from all causes were reported to have lost at least one parent due to AIDS. More than 40 million people in Africa are living with HIV raising the infection rates and this in turn implies that the number of children affected by HIV and AIDS (CAHA) will increase dramatically in years to come and the impact will continue for the next decade and beyond.

Kenya was reported to be the fourth country in terms of HIV prevalence in the world. In 2015, an estimated 1.6 million people were living with HIV and approximately 57,000 people died from AIDS-related illnesses. In Kenya, HIV prevalence peaked at 10.5 percent in 1996 and by 2012 this had fallen to 6.1 percent due mainly to the rapid scaling up of antiretroviral treatment (Avert.org/HIV-Aids-Kenya, 2016).

Thika in Kiambu County is one of the industrial regions in Kenya with high incidences of adult HIV and AIDS infections compared to the national prevalence (5.6%). This high occurrence is coupled with high levels of poverty (36.6%), which complicates the management of HIV and AIDS (Kenya Demographic and Health Survey [KDHS], 2004; GoK 2008, Kenya AIDS Indicator Survey [KAIS], 2014; Kenya HIV Estimates, 2015). Kiambu County was seen to contribute to 4.7% of the total number of people living with HIV in Kenya, and was ranked the sixth highest County. A report on 2016 County HIV Profiles (National AIDS Control Council [NACC], 2017) indicated that by the end of 2016 a total of 70,971 people were living with HIV in the County, with 10% being young people aged 15-24 years and 4% being children under the age of 15 years.

Psychosocial well-being is the result of a child's psychological, emotional and social growth determined by a synthesis of the child's competencies and their social and physical environment. Psychosocial well-being is vital for children's existence and development, particularly in persistently challenging circumstances. To achieve psychosocial well-being CAHA need to have competencies to handle challenges in life like emerging stress and manage relations with people around them. This enables them to understand their environment as they engage with it and make choices and have hope for the future (Cluver, Orkin, Gardner and Boyes, 2012).

Children affected by HIV and AIDS experience psychosocial needs that may be best achieved when care and support are entrenched into their everyday activities (by receptive caregivers, school routines and community events). While most services and programmes like the cash transfer fund, are time bound, strengthening families provides a more sustainable approach to ensuring that children get the support they need in the long term (Coalition for Children Affected by HIV and AIDS, 2016).

Maintaining consistency within the foster families and providing continuous encouragement help the CAHA to manage the loss and adjust to their environment. The UNCRC (2001), endorses the role of the family as the source of care for children, and appreciates the government's duty in supporting the family in this task. This underscores the need to support spontaneous community responses to the endemic where the family is the first line of care, and the community the safety net that supports the most destitute family units. The Constitution of Kenya (2010), recognizes the full and harmonious development of the child; who should grow up in a family environment where there is happiness, love and understanding. Psychosocial support is the right of every child. Under the Bill of Rights in the Constitution of Kenya (2010), its purpose is to preserve the dignity of individuals and communities to promote social justice and the recreation of the potential of all human beings. Also in the constitution, a foster parent is recognized as a person registered under the Act to receive and retain a child for the purpose of caring for and maintaining the child apart from the child's parents or guardian or relative.

### **Study Objective**

The objective of this study is to establish the relationship between care provided by foster families on psychosocial well-being of children affected by HIV and AIDS in Kiambu County.

**Literature Review**

**Care Provided by Foster Families and Psychosocial Well-being of Children affected by HIV and AIDS**

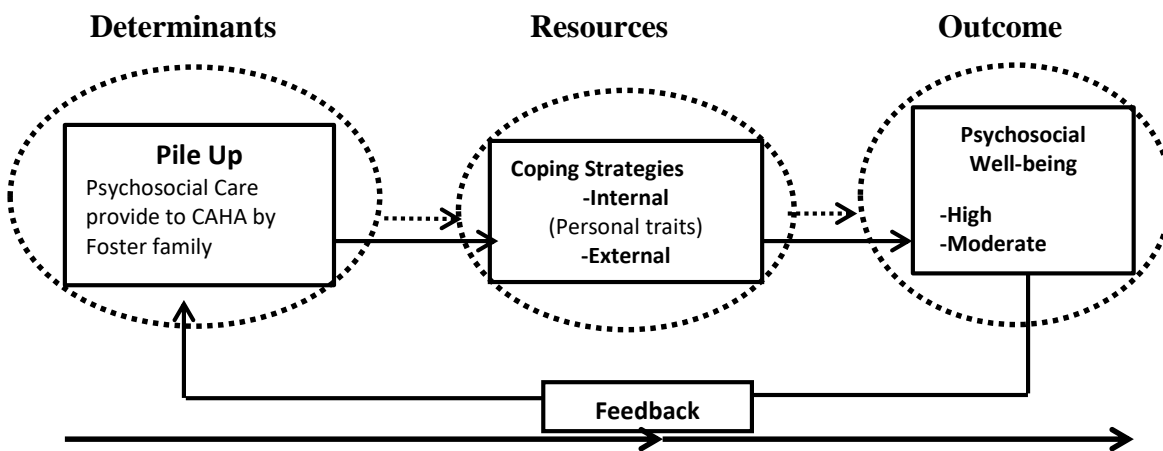
The family is perceived as the basic unit of society for growth and well-being of children. Increasingly, more children are being separated from their parents due to death, neglect, separation/divorce and many are affected by HIV and AIDS. As families continue to be destroyed, children are deprived of parental care (KIHBS, 2006). The extended families act as a safety net to CAHA and disconnection from these systems increases the children’s long-term vulnerability (AIDS Brief, 2014).

Households are bearing the burden of the HIV pandemic. Widows and grandparents may find it difficult to be effective parents to the CAHA because of poverty, poor health and loss of their children (UNAIDS/NACC, 2008). The caregivers need support in terms of adequate knowledge, skills and resources to be able to manage the children under their care and themselves (USAID, 2011). KAIS (2009) reported that in 75.6% of HIV affected households, the infected member was the head of household. Nationally, 11.1% of children below 15 years had lost one or both parents, representing an estimated 1.78 million children.

Psychological damage can arise at any point after a distressful episode and children may not comprehend the condition to be able to express their grief effectively (Government of Kenya [GoK], 2008; K’Oyugi and Muita, 2002). Psychological stress includes: fear, grief, guilt, low self-esteem, depression, peer problems, post-traumatic stress and socio-economic distress among CAHA (Cluver, Gardner and Operario, 2008). A study by Doku (2009) in Ghana concluded that children whose parents were infected by HIV and AIDS stand a high risk of emotional and behavioural disorders. Caring for sick parents and siblings places a heavy emotional burden on children. They witness the illness and death of parents and consequently suffer stigmatisation from society.

Children’s psychological development includes ability to perceive, learn and experience emotion while social development includes the capability to form and maintain relationships to caregivers and peers (Save the Children, 2010). A child’s well-being and growth requires a strong and responsive social support system (Dancun and Arntson, 2004). The major material needs for children were education, health and food security while social well-being, protection, emotional and psychological health are the non-material needs (KAIS, 2011; Kagawa & Hindin, 2010).

**Conceptual framework**



**Figure 1.1 Conceptualized Interrelationships among Variables of Determinants of Psychosocial Well-being of Children Affected by HIV and AIDS**

## Research Methodology

This chapter details the study methodology on; the research design, measurement of variables, study area, target population, sample size and sampling procedures, data collection instruments, data analysis techniques and logical and ethical considerations. This study adopted a cross-sectional survey design to address the relationship between care provided by foster families and psychosocial well-being among children affected by HIV and AIDS in Kiambu County because it is suitable for collecting data at a single point in time. The target population of the study were all children in Kiambu County affected by HIV and AIDS and accessible population of 3780 children (10-17 years) living within a foster family in Thika Sub-County (Kenya AIDS Response Progress Report, 2018). The study targeted children 10-17 years because this is a period of ego identity in the personality development of children through social interaction with family and community, therefore enhances their psychosocial well-being. A sample size of 361 respondents was obtained by calculating the target population of 3780 with an error margin of 5% using the formula from Yaro Yamani formula (Israel, 2009). Multi-stage cluster sampling was used to select informative cases for the study. Thika West has the following six wards; Hospital, Township, Kamenu, Witeithie, Juja and Kalimoni while Thika East has two wards are Gatwanyaga and Ngoliba. In the first stage, Thika Sub County was purposively sampled from Kiambu County (area sampling) and five wards (three from Thika West; Hospital, Township, Kamenu, and both from Thika East; Gatwanyaga and Ngoliba) selected to include both the rural and urban industrial environments. Semi-structured researcher administered questionnaires were used to collect data from children affected by HIV and AIDS (assisted by CHWs and a child counselor) and their caregivers. This technique allowed for personal interaction with participants. Key informant interviews (KIIs) were conducted with CHWs and teachers to gather additional information on the psycho-social well-being CAHA since they closely interact with these children on a regular basis. This was necessary because key informants' diversity allowed the researcher to identify varying perspectives and underlying issues or problems. This study also used an observation guide (Appendix F) to observe the physical appearance of children and conditions of their homes because the guide provided first hand data as perceived by the researcher. Data collected were organized, categorized for coding and analyzed by both qualitative and quantitative methods. To ensure that data was exclusive and consistent, analysis was based on the stated objective and hypothesis of the study. In quantitative data management, descriptive and inferential statistics were used. Using Statistical Package for Social Sciences (Version 20) responses were analyzed by means, frequencies and percentages for stated objectives. Correlation analysis for formulated hypotheses was conducted to assess the nature of relationship among variables of the study. Chi-square ( $\chi^2$ ) at significance level ( $p < 0.05$ ), was used to test the formulated hypotheses ( $H_0$ ) to establish relationships between care (independent) and psychosocial well-being of CAHA (dependent). Using Stata software, the relationship between care provided by foster families and psychosocial well-being of the CAHA was then tested. Factor analysis was useful in predicting the determinant (outcome) of psychosocial well-being of CAHA. Qualitative data was transcribed by creating a verbatim text of each key informant interview by writing out each question and response. Analysis involved re-reading the interview transcripts to identify themes that emerged from the participants' answers and a combined list of themes was developed for the purpose generating recommendations.

## Findings Of The Study

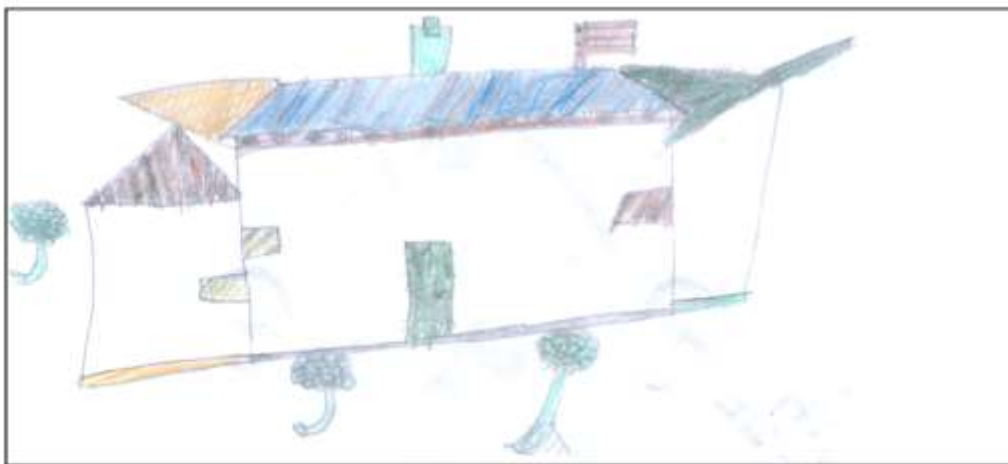
### Care Provided by Foster Families and Psychosocial Well-being of Children Affected by HIV and AIDS

This section presents findings on the relationship between care (economic, social, psychological and emotional) provided to CAHA by foster families and their psychosocial well-being.

#### *Economic Care Provided to Children Affected by HIV and AIDS*

The study categorized economic needs of children affected by HIV and AIDS as provision of basic needs comprising; food, shelter, clothing, health care and education by the caregiver. This was necessary to establish whether lack of/ inadequacy of the basic needs contributed to the psychosocial well-being of the children affected by HIV and AIDS. Provision of food in this study was perceived as adequate when CAHA received at least 3 meals a day and inadequate when only one meal was consumed or going without food for the day was reported. Most of the families (89.3%) were able to provide CAHA with at least two meals or more per day, while (10.7%) did not have adequate food as some had one meal per day whereas other Children reported that they went to sleep without supper.

Shelter in this study was reported as adequate where the housing unit had at least two rooms, kitchen and bathroom and made of bricks/stone. Mud/semi-permanent houses with one bedroom were considered inadequate. All the children affected by HIV and AIDS in this study lived in some kind of shelter with their foster family; brick houses (47.5%) and mud houses (52.5%). The researcher noted that most of the houses where the children lived did not meet the minimum requirements (at least two rooms) of a house as per the Housing Policy of Kenya, 2004. Additional information from the children's drawings showed that the children had a place to stay even when 52.5% of the dwelling places were rated as inadequate by this study as indicated in Table 1.1. Figure 1.2 shows a picture of a house drawn by a child in Gatuanayaga primary school.



**Figure 1.2 A Child's Home**

**(Source: 10 year old girl, Gatuanayaga Primary School , 2017)**

Clothing (63.8%) was recorded as not enough because most of the CAHA used school uniform and maybe a few other sets of clothing. The researcher made observations based on an observation guide on personal hygiene and the children's drawings with regard to the condition of the child's clothing/school uniform, whether hair was well maintained and general body cleanliness. Since general cleanliness indicates level of the

care, observations from the study showed that most of the children’s personal hygiene was rated as inadequate (63.8%). Figure 1.3 shows a drawing of a child in sports-wear as part of clothing.



**Figure 1.3 A Child in Sports Wear**

**(Source: 11 year old boy, Kamenu Primary School, 2017)**

Healthcare was reported at (87.8%) for children who had access to hospitals when sick, while education at (100%) because all the children were in school with 75.9% of them in primary school and 24.1% in secondary school. Education was measured by attendance to a school either primary or secondary. The economic care provided for CAHA is important as it is likely to enhance their psychosocial well-being. According to data in Table 4.3 food (89.3%), education (100%) and health care (87.8%) needs were reported as being adequate while shelter (52.5%) and clothing (63.8%) were reported as inadequate.

**Table 1.1**

***Basic Needs of Children Affected by HIV and AIDS as Provided by Foster Families***

Type of Care	Adequate	Not adequate
Food	308(89.3%)	37(10.7%)
Shelter	164(47.5%)	181(52.5%)
Clothing	125(36.2%)	220(63.8%)
Education	345(100%)	0(0.00%)
Healthcare	303(87.8%)	42(12.2%)

Key informant data indicated that basic needs were not adequately met for CAHA. An informant had this to say regarding clothing;

*“Most times the child comes to school very dirty and without necessary school equipment and uniform” (Teacher, Kilimambogo Primary School, 2017)*

***Psychosocial Care Provided to Children Affected by HIV and AIDS***

Measures of psychosocial well-being have both elements of psychological and social dimensions. On a Likert scale of five points, CAHA rated selected negative actions that may have been inflicted on them by their caregiver which affected their psychological well-being namely: shout, beat, humiliate, frighten, threaten and criticize. The children reported that 58.8% of the caregivers rarely shouted at them, 61.7% were rarely beaten, 56.2% never felt humiliated, 46.4% were never frightened, 67.5% rarely felt threaten and 44.6% were rarely

criticized. Further findings indicated that some of the caregivers sometimes shouted 26.3%, did not beat 35.1% the child and 29.3% frightened, 4.9% sometimes threatened the child, sometimes humiliated, 2.3% or criticized 22.0% as presented in Table 1.2.

**Table 1.2**

***Negative Psychological Actions Inflicted on Children Affected by HIV and AIDS by caregivers (N=345)***

Negative Actions	Frequency and Percentage				
	Always	Most times	Sometimes	Rarely	Never
Shout	0(0.0%)	7(2.0%)	92(26.3%)	203(58.8%)	43(12.5%)
Beat	0(0.0%)	1(0.3%)	10(2.9%)	213(61.7%)	121(35.1%)
Humiliate	0(0.0%)	0(0.0%)	8(2.3%)	143(41.5%)	194(56.2%)
Frighten	0(0.0%)	8(2.3%)	101(29.3%)	76(22.0%)	160(46.4%)
Threaten	0(0.0%)	2(0.6%)	17(4.9%)	233(67.5%)	93(27.0%)
Criticize	0(0.0%)	11(3.2%)	76(22.0%)	154(44.6%)	104(30.1%)

A Key informant reported psychological distress among the CAHA in the following way;

*‘They are psychologically unstable because of stigma, rejection, poverty and lack of hope’ (Teacher, Gatwanyaga Primary, 2017).*

***Emotional Care provided to Children Affected by HIV and AIDS***

Emotional care was perceived as feelings that resulted in psychological changes that influenced how CAHA thought or behaved. Caregivers were asked to indicate their perceptions on CAHA’s feelings about being separated from their families. As shown in Table 1.3 caregivers reported that 27% of CAHA felt isolated, 14.2% unhappy, 8.4% scared and 2.0% were angry.

The researcher noted that these were strong negative emotional traits with a possible negative impact on the psychosocial well-being of children affected by HIV and AIDS. However, 14.8% of the children felt comfortable and 21.5% were happy not from being separated but in their foster families. This was necessary to determine the emotional behaviours that the children displayed which further explained their well-being. The key informants observed that the CAHA were not happy and usually withdrawn. Research findings from this study indicated that 98.8% of the caregivers encouraged the children to speak out their feelings and keeping communication channels open (94.5%) as shown earlier in Table 1.3. This was confirmed by key informants who had this to say about CAHA;

*‘Most times they are alone and in deep thought; they are not happy and usually withdrawn’ (Community health worker, Ngoliba, 2017).*

*‘We visit the children once every month to listen to and encourage them on various issues’ (Community health worker, Township, 2017).*

**Table 1.3**

***Distribution of the Caregivers’ Perceptions of the Children’s Feelings about being Separated from their families***

<b>Actions</b>	<b>Frequency (N=345)</b>	<b>Percentage %</b>
Unhappy	49	14.2
Determined	25	7.3
Worried	17	4.9
Scared	29	8.4
Isolated	93	26.9
Angry	7	2.0
Comforted	51	14.8
Happy	74	21.5

\*Multiple responses allowed

To further explore the emotional state of CAHA, their caregivers were asked how often they observed selected behaviours in children under their care as tabulated in Table 4.6. The selected ten behaviours for the study indicated the emotional state of CAHA. This was necessary to be able to observe the inner communication of CAHA arising from a distressing situation; having an ailing parent or having lost them as a result of HIV and AIDS and living in a new home.

Based on a five point Likert scale, caregivers indicated whether they observed selected behaviours in CAHA. Children affected by HIV and AIDS were observed to cry most of the time 24.1% and sometimes 21.9% which was attributed to their age especially the younger children. A total of 44.4% of the children were either unhappy sometimes (23.5%) or unhappy most of the time (20.9%) a feeling that is normal for those children who were sometimes unhappy. Caregivers reported emotional behaviours in CAHA; 28.7% never cried, 34.5% were never unhappy, 88.4% never fought with other children and 45.2% never stayed alone. CAHA who never refused to go to school 55.7%, 59.1% never disobeyed, 73% never bullied others, 70.7% never worried, 55.4% never refused to eat and 75.1% never ran away from home.

Caregivers reported that 13.6% of CAHA worried most of the time as a result of losing their parent(s) and being taken up for foster care. At least 15.9% (2.3% always, 4.9% most times and 8.7% sometimes) of the children were reported to have run away from their foster home at some point. The children who refused to eat were 15.4% (9.0% most times and 6.4% sometimes) despite 10.7% of the children having been reported to have inadequate food. As earlier noted for some of the selected behaviours for this study; refusing to eat can also be explained as a manifest of an underlying problem. When children display some of these behaviours it may be difficult for the caregivers to completely understand them and provide the necessary appropriate care. From the results in Table 1.4 on ten selected emotional behaviours, the researcher observed that majority of the children never displayed retrogressive traits indicating that the children may have settled in the foster homes and therefore relatively comfortable.



**Table 1.4**

***Frequency of Selected Emotional Behaviours Observed in Children Affected by HIV and AIDS by Caregivers (N=345)***

Behaviours	Frequency and Percentage				
	Always	Most times	Sometimes	Rarely	Never
Cry	5(1.5%)	83(24.1%)	74(21.5%)	84(24.4%)	7(28.7%)
Unhappy	11(3.2%)	72(20.9%)	81(23.5%)	62(18.0%)	19(34.5%)
Fights	0(0.0%)	0(0.0%)	30(8.7%)	10(2.9%)	305(88.4%)
Stays alone	2(0.6%)	14(4.1%)	65(18.8%)	108(31.3%)	156(45.2%)
Refuse school	17(4.9%)	12(3.5%)	53(15.4%)	71(20.6%)	92(55.7%)
Disobedient	3(0.9%)	13(3.8%)	39(11.3%)	86(24.9%)	204(59.1%)
Bully others	0(0.0%)	5(1.5%)	2(0.6%)	86(24.9%)	252(73.0%)
Worried	10(2.9%)	2(0.6%)	35(10.1%)	54(15.7%)	244(70.7%)
Refuses to eat	0(0.0%)	27(9.0%)	22(6.4%)	101(29.3%)	191(55.4%)
Runs from home	8(2.3%)	17(4.9%)	30(8.7%)	31(9.0%)	259(75.1%)

\*Multiple responses allowed

Through drawings children aged 10- 12 years were able to indicate their feelings. Worth mentioning is the message in Plate 4.6 the child says, 'Niko tu sawa- ni safari ndio kali' (translated as 'all is well but the journey is difficult'). This indicates determination on the part of the child, an attribute that is internal but manifested as an overt behaviour.



**Figure 1.4 A Determined Child**

(Source: 12 years old boy, Kamenu Primary School, 2017)

***Social Care Provided to Children Affected by HIV and AIDS***

The study sought to establish perceptions of the caregivers concerning the social care of children affected by HIV and AIDS under their care based on a number of questions. In this study social care was measured using seven indicators on the caregivers questionnaire namely: participation in family activities, communication with caregivers, expression of feelings, guiding the children, setting boundaries/restricting the child, challenges experienced and knowledge of parental death.

As indicated in Table 1.5 most of the caregivers allowed children to participate in family activities (87.5%), provided guidance (92.5%), listened to the children (94.5%) and encouraged the children to express their feelings (98.8%). These responses were significant for the study because this was perceived to provide a platform where children can be heard thus contributing to psychosocial growth. The caregivers also reported that they restricted the children to certain activities (53.9%). Sixty-four percent of the caregivers admitted that they talked with CAHA about their parents’ death. This was necessary to assist the children go through the stages of loss and bereavement therefore speeding up the process of grieving and adjustment by CAHA. Caregivers who had not talked to the children about the cause of their parents’ death were 28.1% while 7.8% did not respond.

**Table 1.5**

***Caregivers’ Responses on Social Care of Children Affected by HIV and AIDS***

Statements	Frequency		
	Yes	No	No Response
Do you allow the children to participate in family activities?	302(87.5%)	41(11.9%)	2(0.6%)
Do you keep communication channels open with the children?	326(94.5%)	9(2.6%)	10(2.9%)
Do you encourage the children to speak their mind and express opinions/anger/feelings?	341(98.8%)	0(0.00%)	4(1.2%)
Do you guide to the children?	319(92.5%)	5(1.5%)	21(6.1%)
Do you set boundaries with the children/ restrict the child?	113(32.8%)	186(53.9%)	46(13.3%)
Do you experience any challenges as you care for these children?	322(93.3%)	16(4.6%)	7(2.03%)
Have you ever talked with the children about the death of their parent(s)?	97(28.1%)	221(64.1%)	27(7.8%)

\*Multiple responses allowed

Key informant information on social interaction with CAHA indicated that children affected by HIV and AIDS felt insecure because of fear of losing/having lost their parents. The children also lacked social skills because of stigmatization, isolation and inability to form relationships. Alluding to this finding one Key informant observed: -

*‘Most of them are loners while others are bullies; they are stigmatized by peers and end up lonely. They are withdrawn and develop low self-esteem’ (Teacher, Ndula Primary, 2017).*

Based on predetermined actions relating to how CAHA interacted with other children, the caregivers were asked to comment on this association. Eighty-three percent (83%) of the caregivers reported that CAHA played together with other children at home indicating social interaction. One of the aspects of psychosocial well-being is positive relations with others therefore this was important for this study. Children need to be around people who will enhance their development as argued by psychologists. The caregivers reported that 6.7% of the children were withdrawn, 0.9% hostile, 8.9% did not respond. These findings are presented in Table 1.6.

**Table 1.6**

***Distribution of Nature of Interaction of Children Affected by HIV and AIDS with Other Children***

<b>Actions</b>	<b>Frequency</b>	<b>Percentage %</b>
Play together	288	83.4
Withdrawn	23	6.7
Hostile	3	0.9
No response	31	9.0

\*Multiple responses allowed

Guided by a child counselor, selected pictures depicting children’s social interaction and activities they are happy to engage in. The pictures show children playing together as a team, happy together and with a sibling; a significant element in social support achieved through interaction with peers and siblings who provide an enabling environment for social development.



**Figure 1.5 Children Happy Together**

**(Source: 11year old, girl in Gatuanyaga Primary School, 2017)**

To establish the relationship between care provided by foster families to CAHA and their psychosocial well-being chi-square statistic was used. Care provided by foster families to CAHA was perceived as; basic needs of food, shelter, clothing, education and healthcare which was ranked on a three-point rating scale that was converted to a percentage value based on calculated composite scores on selected care indicators as; good at 75% - 100%, acceptable at 50% - 74% and inadequate at 0 - 49%. For CAHA whose basic needs were provided for by the family; living in a flat and managing to have three meals a day, living in a brick/permanent house, had several sets of clothing, attended school and had access to healthcare was seen to be under good care.

Acceptable care was observed where children were living in a semi-permanent house, had two meals a day and other clothing apart from school uniform, and occasionally went to school or a health facility. Inadequate care on the other hand was considered as a case of less than 50% of the basic needs provided, living in a traditional hut/mud house, could only manage at most one meal a day and had no access to health care. Care for this study was considered as the provision of basic needs by families, as well as psychological, social and behavioural care.

Of the number of children affected by HIV and AIDS under study 29.9% were rated to have high psychosocial well-being, 11.0% were rated as having low psychosocial well-being while slightly more than half of the CAHA (59.1%) had moderate psychosocial well-being. A significant 52.8% of the children affected by HIV and AIDS received good care with 29.3% and 17.9% receiving acceptable and inadequate care respectively

from their foster families. The study therefore established that CAHA received good care from foster families. Table 1.7 shows the relationship between care provided by foster families in Thika Sub County to children affected by HIV and AIDS and their psychosocial well-being.

**Table 1.7**

***Relationship between Care Provided by Foster Families to Children Affected by HIV and AIDS and their Psychosocial Well-being***

Psychosocial well-being	Care Provided			Total
	Good	Acceptable	Inadequate	
<b>High</b>	52 (15.1%)	41 (11.9%)	10 (2.9%)	103 (29.9%)
<b>Moderate</b>	120 (34.8%)	50 (14.4%)	34 (9.9%)	204 (59.1%)
<b>Low</b>	10 (2.9%)	10 (2.9%)	18 (5.2%)	38 (11.0%)
<b>Total</b>	<b>182</b> <b>(52.8%)</b>	<b>101</b> <b>(29.3%)</b>	<b>62</b> <b>(17.9%)</b>	<b>345</b> <b>(100%)</b>

( $\chi^2 = 4.6607$ ;  $df = 4$ ;  $p = 0.001$ ). \*Significant at  $p \leq 0.05$

Chi-square results ( $\chi^2 = 4.6607$ ;  $df = 4$ ;  $p = 0.001$ ) indicate that in the study caregivers made an effort to provide good care to children under their care implying that families have been able to adequately care for children they have taken in. Therefore, the variables are dependent, indicating an association between the two variables. The results showed that the relationship between care provided by foster families and the psychosocial well-being of children affected by HIV and AIDS was significant at  $p < .05$  therefore,  $H_{01}$  was not accepted.

**Summary Of The Major Findings**

The study sought to establish the relationship between care provided by foster families and the psychosocial well-being of children affected by HIV and AIDS in Kiambu County. The study established that CAHA benefited from a responsive social environment within the foster families as a result of interaction with people around them hence boosting their psychosocial well-being. The significant people in the life of CAHA as recorded in this study were; siblings and caregivers whom they lived with in the same households, peers as friends and CHWs who visited them at home once a month. The children interacted with people around them through participation in family activities. Their caregivers provided guidance, kept communication channels open and encouraged the children to express their feelings. The caregivers who talked to the children about the death of their parents (64%) helped the children to go through grieving and thus were able to adjust positively. Social care was extended to the children from within the foster family as well as the community. Data from the observation guide on drawings for children 10-12 years who could not express themselves verbally indicated that children can communicate through various ways when encouraged. The children were able depict interactions with either other children around them at home. The pictures showed children happily playing together. Whereas children were in familiar foster families, their caregivers reported that some were hostile, unhappy and withdrawn. Self-stigma/isolation in children affected by HIV and AIDS may contribute to poor social development in the family and community.

The results of this study point to three levels of psychosocial care in the foster families; high, moderate and low. Specific elements of psychosocial well-being were observed in the children. Children affected by HIV and AIDS reported possible adverse actions that inflicted on them by their caregivers as; 28.3% were shouted at, 3.2% beaten, 2.3% humiliated, 31.6%, frightened, 5.5% threatened while 25.2% criticized. A high percentage of the negative actions inflicted on CAHA contributed to developing low self-esteem, lack of confidence, self-guilt and fear in children. These attributes in combination lead to distressful moments in the life of a child thus having a negative impact on psychosocial development. Children further lose trust in people around them hence not being able to form and maintain relationships with peers, caregivers and people in the community. Psychosocial distress can only be observed through overt behaviour and could be challenging in cases where people around the child are not able to identify signs. Caregivers in this study rarely (44.6%) or never (30.1%) criticized CAHA living with them. Criticism is a strong negative verbal action that may lead to negative adjustment psychologically (doubt, low self-esteem and lack of confidence). Emotional care for children affected by HIV and AIDS was closely associated with their psychosocial well-being. Underlying emotional problems may be conveyed in diverse behaviours and could be positive or negative. Negative emotional problems in this study manifested as; the child feeling isolated (26.9%), unhappy (14.2%), scared (8.4%), worried (4.9%) or angry (2.0%) as observed by either the caregivers or teachers. In as much as evidence shows efforts by those around the child to care and support them unfortunately emotional development can only be achieved by the child. These emotional problems need to be handled appropriately so that children exhibiting these traits adjust properly. When children are emotionally stressed exhibit certain traits that do not constitute positive psychosocial well-being and development. Data were also collected from statements based on emotions and children required to draw pictures that depicted their feelings. This affirms the study findings that indicated that 94.8% of the caregivers encouraged the children to speak out their feelings and also keeping communication channels open 94.5%. Children feel isolated as a result of being in an unresponsive environment therefore it is necessary to include them in relevant activities at home and in the community.

## **Conclusions**

The study established a significant relationship between care provided by foster families and psychosocial well-being of children affected by HIV and AIDS. Care was provided by the caregivers as economic (food, shelter, clothing, healthcare and education), psychological, emotional and social. This was confirmed by results of factor analysis that indicated care provided by the foster families as crucial to the psychosocial well-being of children affected by HIV and AIDS.

## **Recommendations**

Recommendations to guide policy and practice include:

- i. National and County governments and non-governmental organizations can ensure sustainability of families and communities by empowering them with knowledge and skills so that CAHA can thrive in responsive environments.
- ii. The Government of Kenya should commit resources to ensure the psychosocial well-being of children affected by HIV and AIDS is promoted at the County level through government arms (Children's Department, Ministry of Education) mandated with the promotion of the well-being of children.
- iii. Children's rights can be prioritized so that all government departments uphold the principle of the best interest of the child as adopted from the UN Convention on the Rights of the Child (2001) and domesticated into various instruments on child protection in Kenya.

- iv. The study will provide credible practical information to identify gaps in knowledge and practices and the extent of provision of care in realizing unmet needs for inclusion in formulation of feasible policies..

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