

**RELATIONSHIP BETWEEN THE TYPE OF PSYCHOSOCIAL SUPPORT AVAILABLE IN THE
COMMUNITY AND PSYCHOSOCIAL WELL-BEING OF CHILDREN AFFECTED BY HIV AND
AIDS IN KIAMBU COUNTY, KENYA**

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Abstract: *Children affected by HIV and AIDS (CAHA) are faced with psychological, social and economic challenges among others. HIV and AIDS has compounded the situation posing more suffering to children whose parents have died of the same. Children affected by HIV and AIDS have been supported in various ways by their extended families and many other organizations. While there are a number of programmes that address the material needs of CAHA, there is less emphasis in assisting these children cope with the distress associated with nursing or living with sick members of the family, witnessing deaths of their parents and suffering the consequences thereafter. The psychosocial well-being of CAHA may be affected because of illness and death of their parents, exploitation, stigma and separation from siblings as well as lack of adult support. The purpose of this study was to examine the relationship between psychosocial support and psychosocial well-being of children affected by HIV and AIDS. This was a cross-sectional survey targeting 3780 children between 10-17 years affected by HIV and AIDS living in foster families from registered CBOs in Kiambu County. Multi-stage cluster sampling was used to select 345 children aged 10-17 years. Key informant interview guides, questionnaires, observation checklist and child drawings were used to collect data. Both quantitative and qualitative data were organized and categorized for analysis. Chi-square and factor analysis were used to test the formulated hypotheses. Qualitative data was transcribed, coded and categorized into themes and words to allow for analysis and presentation. This study showed that there existed a significant relationship between the type of support available in the community and psychosocial well-being of children affected by HIV and AIDS ($\chi^2=7.8207$; $df=6$; $p=0.012$). This study concluded that there were established relationships between type of support available by the community and psychosocial well-being of children affected by HIV and AIDS. The study recommended that the community/faith based organizations can work together with governments to ensure psychosocial well-being of children affected by HIV and AIDS is addressed through implementation of support systems for children affected by HIV and AIDS while creating awareness and developing efficacious intervention programmes within affectionate environments.*

Keywords: *Psychosocial Support, Psychosocial Well-Being, CAHA*

1.0 BACKGROUND OF THE STUDY

The United Nations AIDS programme (UNAIDS, 2011) describes an AIDS orphan as a child under the age of eighteen years who has lost either one parent (maternal or paternal orphan) or both parents (double orphan) as a result of AIDS. Children affected by HIV and AIDS are those whose parent/s are ailing or have died as a result of HIV and AIDS living within an extended/foster family. The United Nations Global Report (2013) indicated that in the year 2013 about 17.8 million children were estimated to have lost one or both parents to AIDS globally and would rise to 25 million by 2015.

In East Africa, Tanzania has approximately 1.3 million children affected by HIV and AIDS while both Uganda and Kenya have 1.2 million. In Kenya, the distribution of CAHA by age in years is 0-4 at 15%, 5-9 at 35% and 10 -14 at 50% (UNAIDS, 2016). The United Nations General Assembly Special Session on HIV and AIDS (UNGASS 2015) report on Kenya estimated the numbers of children affected by HIV and AIDS at 2.4 million, out of whom 1.5 million are maternal, 1.4 million paternal and 0.5 million were double orphans.

Today, family and community bonds are weakening as evident in degeneration of the large, extended and close-knit family and community networks. In Sub-Saharan Africa, 90% of the extended family cares for the majority of the children affected by HIV and AIDS by providing a familial connection to these children, however the caregivers tend to experience stressors that impede their effective functioning as surrogate parents (UNAIDS, 2012). In Kenya, the extended family has traditionally raised and socialized children by providing vital informal support system. Newer family structures are emerging which include: families headed by grandparents, children and single parents and these are now taking up the role of caring for children affected by HIV and AIDS (National AIDS and STI Control Programme [NASCOP], 2010; UNAIDS, 2010).

Kenya AIDS Indicator Survey (KAIS, 2014) reported that of the services offered to children affected by HIV and AIDS; emotional and psychological support was 4.1%, social support 1.3% while material support was 6.2%. The Government of Kenya has initiated programmes such as home-based care and cash transfer fund to provide for the material needs of CAHA. These programmes have not adequately addressed the psychosocial well-being of these children as cited in Kenya Integrated Household Budget Survey, (KIHBS, 2016). More care and support for CAHA is necessary to strengthen the social environment that nurtures their healthy psychosocial growth at different stages within the family and community rather than meeting their material needs only (UNICEF, 2010). Psychosocial development of CAHA is further compromised as a result of being in a family affected by HIV and AIDS. When children attain psychosocial well-being, they feel empowered to contribute to serving humanity and can perceive life beyond the individual.

Psychosocial support focuses on the provision of affection and attention to children within the community. Children affected by HIV and AIDS require strong social support from both family and the community. Psychosocial care and support is provided through social relations that occur in caring interactions in normal life, at home, school and in the community. Care and support enables children to nurture their self-esteem and sense of belonging essential for them to acquire, develop life skills, be involved in societal activities and have hope for the future. When families are supported to provide adequate care then few children need specific psychological or social programmes.

Psychosocial well-being is the outcome 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 paramount for children's existence and development, particularly in persistently challenging circumstances. Achieving psychosocial well-being requires CAHA 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).

2.0 STUDY OBJECTIVE

The objective of this study is to establish the relationship between type of psychosocial support available in the community and psychosocial well-being of children affected by HIV and AIDS in Kiambu County.

3.0 LITERATURE REVIEW

Psychosocial Support Available in the Community and Psychosocial Well-being of Children Affected by HIV and AIDS

A support group/system comprises of people who meet to resolve or cope with a common problem, condition or issue (UNICEF, 2010). Psychosocial support is the holistic help given to a child and takes into account the psychological and social aspects of their life (WHO *et al.*, 2012). The perception of psychosocial support is based on having knowledge, skills and attitudes that empower children and their families to deal with any situation (UNICEF, 2011). The major consequence of HIV and AIDS on children is the disruption of their lives at home, school or community. This may lead to loss of dependability and cohesion which affects the psychosocial well-being of children of all ages. The loss and grief that children experience from the death of parents may manifest internally through depression and anxiety or externally through behavioural problems (UNICEF, 2011).

The Psychosocial Framework of 2005-2007 of the International Federation (2007) defines psychosocial support as “a process of facilitating resilience within individuals, families and communities” (enabling families to bounce back from the influence of crises and assisting them to adjust to events they may face in the future). By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure”. The right to psychosocial support is enriched in the convention on the Rights of the Child (2001) and principles of psychosocial well-being evoked in the Constitution of Kenya (2010) therefore recognizing the need for all those caring and supporting children to act in the best interest of the child. The close connection between psychological aspects of the child’s experiences (thoughts and emotions) and their social experiences (relationships and practices) influences how they adapt in life.

Periods of psychosocial vulnerability for the children include: diagnosis of HIV positive parents, terminal illness, death and bereavement (Haihambo, 2004). When children are troubled they may not be able to verbalize their concerns. They may express themselves through actions and behaviours like crying, becoming withdrawn, aggression or playing (Save the Children, 2010). Caregivers need to understand that the way children behave is in response to their situation and emotions of which there is an underlying reason. It is therefore necessary to consider each child’s individual situation when determining an appropriate response for their psychosocial well-being. Death for children is difficult to comprehend and talk about. At ten to eighteen-years children recognize the irreversible nature of death, suppress their feelings and become depressed (Mallman, 2002). Children should be allowed to mourn according to the accepted cultural/societal norms.

Psychosocial development in children is important as it provides the foundation for their confidence to reach their full potential (Wajahat & Chohan, 2011). Most CAHA may be traumatized from seeing parents dying but have not received any psychosocial support. It is therefore important that a sense of normalcy is re-established to create a security and purpose which will allow children affected by HIV and AIDS to fully function again (Dancun, 2004). The psychosocial support programmes underscore aspects such as strengthening social

environments that nurture children’s physical, cognitive, emotional and social development within the family and community. Psychosocial well-being of children affected by HIV and AIDS depends on extent to which they adjust to and cope with the loss and changes they experience. It is in this area that the roles of extended families, the community and its CBOs, FBOs, NGOs and the government become critical. Psychosocial support addresses a child’s emotional, social, mental and spiritual needs; all essential elements of positive human development. Psychosocial support builds internal and external resources for children and their families to cope with adversity from HIV and AIDS within their communities.

4.0 CONCEPTUAL FRAMEWORK

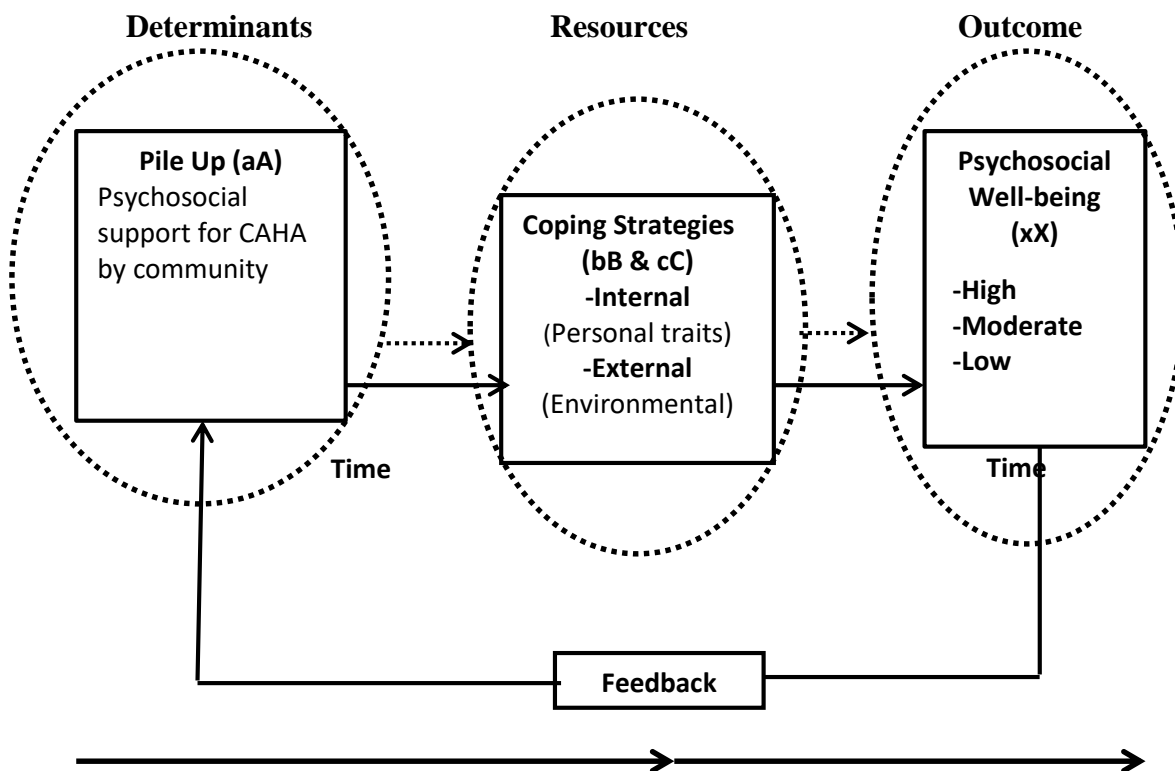


Figure 1.1 Conceptualized Interrelationships among Variables of Determinants of Psychosocial Well-being of Children Affected by HIV and AIDS

5.0 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 effect of foster families on 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 Gatuanyaga 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; Gatuanyaga 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 stated objectives and hypotheses 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 (χ^2) at significance level ($p < 0.05$), was used to test the formulated hypotheses (H_0 s) 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. 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.

6.0 FINDINGS OF THE STUDY

Psychosocial support for children affected by HIV and AIDS was seen as the ongoing process of meeting their psychological, emotional, social and spiritual needs by members of the community. Children affected by HIV and AIDS reported that they received psychosocial support from the community as 93.4% healthcare and education 98.26%, majorly because the health and educational facilities are more of services provided by institutions in the community (Appendix C, section D). Emotional support was received from the community health workers who visited the children on a regular basis and partly by the teachers who also interacted with the children on a daily basis in school. The religious leaders provided spiritual support 78.8% to CAHA.

To establish their social support CAHA were asked; whether they had friends in school, were free to interact/play with other children and if they were free to speak with their caregivers about their feelings. All (100%) of the CAHA reported that they had friends in school, while nearly two thirds (64.9%) indicated that they were free to interact/play with other children, and (98.8%) were free to speak with their caregivers about their feelings. Teachers and community health workers in this study agreed that they gave social and emotional support to CAHA by encouraging them to interact with others, counselling and being friendly to them. Table 4.10 shows type of support given to children affected by HIV and AIDS by the community.

Table 1.1

Distribution of Type Support Given to Children Affected by HIV and AIDS by the Community

| Type of Support | Frequency | Percentage % |
|-----------------|-----------|--------------|
| Psychological | 321 | 93.04 |
| Emotional | 314 | 91.01 |
| Spiritual | 272 | 78.84 |
| Social | 339 | 98.26 |

* Multiple responses allowed



Figure 1.2 Children Playing Together in Teams
 (Source: 12year old boy in Gatwanyaga Primary School, 2017)

From the community CAHA identified teachers and religious leaders, as people who helped them with personal problems while best friends as those they had fun with. Community health workers (55.9%) were among those reported by CAHA as people who encouraged them the most. This can be attributed to the fact that the CHWs are acquainted to them therefore the children felt safe with them. Teachers being custodians of the children are knowledgeable in issues affecting them therefore are in a position to positively guide the children towards self-development.

Apart from routine teaching the teachers, further interacted with these children at a personal level where they observed various behaviours among the children; lack of self-confidence, insecurity, lack of social skills, being withdrawn, regression and poor performance in academics. The teachers felt that dealing with children affected by HIV and AIDS was challenging despite spending time with the children appreciating and guiding them. The teachers felt that the community be supported by the government for so as to provide holistic care to CAHA ensuring that they are retained in their families. The children affected by HIV and AIDS were also required to mention people in their lives who gave them social, emotional and psychological support (teacher, best friend, religious leaders and community health workers). About half of the children’s responses were; most of the encouragement was received from community health workers (55.9%) who visited them at least once a month and spent some time with the children in their homes. Religious leaders (24.9%) and teachers (9.0%) were also people who the children saw as being an encouragement in their lives. Best friend of the child

accounted for 1.2%. This was the lowest reported and can be explained by the fact that being their peers, they too are not be able to understand what CAHA go through and therefore not able to give adequate encouragement.

The community health workers (35.7%) were also reported by most of the CAHA as people they could confide in. Being in constant touch with the children affected by HIV and AIDS probably may help build confidence in the children to open up to them and share their experiences. The religious leaders were also seen as confidants (33.0%) as indicated by CAHA who look up to them to provide spiritual support. Best friends (14.78%) and only (0.6%) of the teachers were reported by CAHA to be their confidants. This clearly indicates that children affected by HIV and AIDS were more comfortable with their peers than their teachers.

Slightly more than half of the children (64.9%) played and had fun with their best friends. The community health workers (34.8%) also had time to play and have fun with the children affected by HIV and AIDS. Only (0.3%) of the children reported that their teacher played with them. Emotional support for CAHA by the community and type of interaction are cross tabulated in Table 1.2.

Table 1.2

Emotional Support for Children Affected by HIV and AIDS by the Community and Type of Interaction

| Persons | Encouragement | Confidant | Fun & Play |
|-------------------|---------------|------------|------------|
| Teacher | 31(9.9%) | 2(0.6%) | 1(0.3%) |
| Religious leaders | 86(24.9%) | 114(33.0%) | 0(0.0%) |
| Best Friends | 4(1.2%) | 51(14.8%) | 224(64.9%) |
| CHWs | 193(55.9%) | 123(35.7%) | 120(34.8%) |

*Multiple responses allowed

To test the relationship between type of support provided by the community to children affected by HIV and AIDS and their psychosocial well-being, chi-square test (χ^2) statistical technique was used. The community in this study comprised of schools, churches and government departments working with children. The community forms part of the child’s circles of interaction, and since families make up the communities whatever upsets the family affects the community. The type of support provided varied across each foster family with majority of the caregivers adequately providing physical support of food, shelter and clothing (47%) and psychological support (28.1%). However, social and emotional support were least provided. Consequently, the psychosocial well-being of the children affected by HIV and AIDS was observed to be greatly influenced by the economic and psychological support provided. Table 1.3 illustrates the relationship between type of support provided by community the psychosocial well-being of children affected by HIV and AIDS.

Table 1.3

Relationship between the Type of Psychosocial Support Provided by the Community and Psychosocial Well-Being of Children Affected by HIV and AIDS (N=345)

| Type of Psychosocial Support | Psychosocial Well-being | | | |
|------------------------------|-------------------------|---------------|-------------|---------------|
| | High | Moderate | Low | Total |
| Social | 14 (4.1%) | 10 (2.9%) | 6 (1.7%) | 30 (8.7%) |
| Emotional | 7 (2.0%) | 43 (12.5%) | 6 (1.7%) | 56 (16.2%) |

| | | | | |
|----------------------|------------------------------|------------------------------|----------------------------|-----------------------------|
| Economic | 62 (18.0%) | 86 (24.9%) | 14 (4.1%) | 162 (47.0%) |
| Psychological | 20 (5.6%) | 65 (18.8%) | 12 (0.6%) | 97 (28.1%) |
| Total | 103 (29.8%) | 204 (59.1%) | 28 (8.1%) | 345 (100%) |

($\chi^2 = 7.8207$; $df = 6$; $p = 0.012$). * $p < .05$

Chi-square test for the relationships between the type of psychosocial support and psychosocial well-being yielded a p-value of 0.012. At 5% significance level, the null hypothesis was rejected and consequently the two variables were dependent indicating significant relationship between type of support provided by the community to children affected by HIV and AIDS and their psychosocial well-being.

7.0 SUMMARY OF THE MAJOR FINDINGS

Based on the study findings the following types of support were isolated as available in the community to CAHA; social, emotional and psychological. The community has supported families caring for children affected by HIV and AIDS with material items but little has been done to enhance psychosocial support (KAIS, 2014). Children affected by HIV and AIDS in this study identified people from the community who provided the various types of support as peers, teachers, community health workers and religious leaders. Within the school environment teachers and friends of these children provided the social interaction that the children needed. Peers played together indicating positive relations with others as one of the measures necessary for psychosocial growth and development. This was reported by most of the children affected by HIV and AIDS (98.3%) since it was achieved by being in school. Teachers were recognized as people who assisted the children with personal problems while best friends played with them.

The teachers gave guidance to the children and were also able to recognize early signs of distress in the CAHA as they interacted with them at school. This view was informed by data from teachers who were part of the study as key informants. The school has a major role to play in the social growth of the children affected by HIV and AIDS as they spend a lot of their time in schools. They reported that teachers encouraged them despite the teachers observing lack of self-confidence, insecurity, lack of social skills, being withdrawn, regression and poor academic performance among the children. The teachers also recommended involvement of all the relevant stakeholders in the care and support of children affected by HIV and AIDS. They also advocated for the empowerment of foster families so that they can provide adequate care to these children to mitigate psychosocial problems that may persist into the later life of the child. Similar studies (WHO *et al.*, 2012; Chi, Barnett, Zhao and Zhao, 2013; Xiaoming *et al.*, 2015) underscore the significance of psychosocial support for CAHA to develop resilience in life.

The community health workers from the various CBOs were also mentioned by CAHA as people who visited them once a month and provided support to the families but more importantly, they spent time with the children (55.9%). This indicated that the CHWs had a closer relationship with the children than with the teachers. The role of the CHWs in supporting children affected by HIV and AIDS has been appreciated by other studies (NACC and NASCOP, 2012; KDHS, 2014). This observation concurs in thought with comparable studies that have indicated the major role played by CHWs in the support of children affected by HIV and AIDS. The religious leaders were also said to be confidants (33.0%) to the children affected by HIV and AIDS.

Social interaction between children and significant people around them is an important aspect of social development. Children have been observed to adjust positively when in the company of their peers. They are able to relate more freely with children of the same age. Appreciation from peers provides opportunities for social interaction of CAHA giving them an opportunity to learn socially acceptable behaviour (through feedback from others). Religious leaders were seen to give hope to the children especially on religious matters necessary for the children to move from dissonance to a sense of wholeness. Pastoral care and support can focus children on hope in the future.

When economic support was related to psychosocial well-being results indicated that CAHA who had high psychosocial well-being received mostly economic care from the community. Moderate psychosocial well-being was low for both social and emotional support provided. To explain this, it is important to note that economic support was easily achieved because it entailed provision of basic needs for CAHA. This is evident in government programmes such as home-based and cash transfer to families fostering children affected by HIV and AIDS in Kenya (KIHBS, 2006). Psychological support was also realized since most of the mental issues are provided for within the schools, while emotional and social support was low because these aspects of development are internal to individual children. The children can therefore be supported to realize their internal capabilities by attaching them to mentors.

The emphasis of this research was to link the type of psychosocial support provided by the community to the psychosocial well-being of children affected by HIV and AIDS and results indicated a significant relationship ($\chi^2=7.8207$; $p=0.012$). The major consequence of HIV and AIDS on children is the disruption of their lives at home, school or within the community. When the lives of these children are disrupted crucial social systems are at stake. Psychosocial support is largely anchored on psychological and social dimensions therefore providing an enabling environment for children affected by HIV and AIDS is imperative. Preventive psychosocial support is necessary to promote basic services provided to avert the onset of psychological challenges in the children. The International Federation Reference Centre for Psychosocial Support (IFRC PSS, 2009) suggests that, the psychosocial support can reduce the possibility of emergent mental difficulties in children and enable them to overcome and manage psychosocial distress arising from the effects of HIV related crises.

In this study, the community health workers from registered CBOs played a vital role in ensuring the support of these children. The monthly visits to the homes of the children affected by HIV and AIDS were an enriching experience for them. The children appreciated the time spent with the CHWs in their homes because they were also able to guide on various issues and were also noted as confidants to the children. The community health workers were seen as a link between the foster families of children affected by HIV and AIDS and the community. The community was important for the children affected by HIV and AIDS to develop their psychosocial well-being. Other studies have also emphasized the importance of the community in providing continued support to families caring for children affected by HIV and AIDS. Members of the community interacted with the children at different levels indicating that the social needs of the CAHA were reasonably met by the community.

8.0 CONCLUSIONS

The study established that type of psychosocial support was available as provided by various people (teachers, peers, CHWs and religious leaders) in the community who related with the children. Secondly, the type of support available was determined as psychological, emotional and social. Thirdly, there was a significant relationship between type of psychosocial support available in the community and psychosocial well-being of

children affected by HIV and AIDS. However, support by the communities was observed as inadequately provided to the children affected by HIV and AIDS

9.0 RECOMMENDATIONS

Recommendations to guide policy and practice include:

- i. Community/faith based organizations can work together with governments to ensure psychosocial well-being of children affected by HIV and AIDS is addressed through implementation of support systems for children affected by HIV and AIDS while creating awareness and developing efficacious intervention programmes within affectionate environments.
- ii. In a bid to ensure protection of the CAHA, the national government should ensure that their parents come up with permanency plans to ease transition of care for the children after their demise. The parent can decide where the children will live once they pass on so that children remain in families and the community because best care can be achieved within these environments.

The government should develop policies for legal framework for protecting and caring for children affected by HIV and AIDS which emphasizes on the adequacy of current policies that affect children's well-being in provision of services.

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