

## Overall Well-being of Orphaned and Vulnerable Children in Elgeyo-Marakwet County, Kenya

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### Abstract

*The purpose of this research study was to examine the overall well-being of orphaned and vulnerable children (OVC) in Elgeyo-Marakwet County, Kenya. Ten domains of OVC well-being were examined in the study: Food and Nutrition, Economics, Family, Education, Protection, Health, Shelter, Mental Health, Spiritual and Community care. The study sample comprised of 215 orphaned and vulnerable children. Data was collected using the OVC Well-being tool. Means and Standard deviations, T-tests of the ten domains were computed using SPSS software. The evaluation of the overall children's well-being yielded the following scores: Desirable (67.9%), Average (19.5 %), Below Average (11.2 %) and Undesirable (1.4 %). Spirituality, Shelter, Mental Health and Protection domains ranked at the top while Economic, Food and Nutrition, Community Care, and Family domains ranked the lowest. Overall this findings show favorable developmental outcomes for OVC. Children's well-being was enhanced because their basic needs were met in the short-term. The developmental outcomes of OVC will be more boosted by long-term and sustainable efforts.*

### Introduction

This study will examine the impact of one major factor, HIV/AIDS, on the well-being of orphaned and vulnerable children. HIV/AIDS has direct and indirect impact on all sectors of a society that support children well-being- political, health care, business and economic, education, religion, community and family. The global death toll and number of people living with HIV/AIDS has been on the rise over the past twenty five years. Even more disheartening is the impact of HIV/AIDS on children as evident by the rising number of orphaned and vulnerable children. Orphaned and Vulnerable Children (OVC) generally refers to orphans and other groups of children who are more exposed to risks than their peers. The children experience negative outcomes, such as the loss of their education, morbidity, and malnutrition, at higher rates than do their peers and are most likely to fall through the cracks of regular programs (Bryant et.al, 2012).

The Presidential Emergency Plan for AIDS Relief (PEPFAR, 2011) defines OVC as a child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS. An orphan refers to a child who has lost one or both parents to HIV/AIDS. Vulnerable children are children who are more vulnerable because of any or all of the following factors that result from HIV/AIDS: i) being HIV-positive, ii) lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child), iii) lives outside of family care (e.g., in residential care or on the streets), or iv) is marginalized, stigmatized, or discriminated against (PEPFAR, 2011).

Orphaned and vulnerable children are impacted in all aspects of their well-being: physically, emotionally, psychologically, socially, and academically. Many often face discrimination, victimization, and exclusion from social and familial structures. Because the children are financially desperate, they are more likely to be homeless or victims of sexual exploitation, drug trafficking, violence, and child labor; these situations often increase the chances of HIV infection (UNICEF, 2011).

The purpose of this study was to examine the well-being of orphaned and vulnerable children (OVC) in Elgeyo-Marakwet County, Kenya. Ten indicators of children's well-being were examined: Food and Nutrition, Economics, Family, Education, Protection, Health, Shelter, Mental Health, Spiritual well-being and Community Care. Some of the questions that were addressed in this study are: How is the overall well-being of orphaned and vulnerable children? What support systems do the children have? What impact do those support systems have on the children's well-being?

This study is just a glimpse into the lives of orphaned and vulnerable children. Some of the children were either affected by parental AIDS or were living with HIV. It is clear that the rising prevalence of HIV/AIDS and the impact it has on families and children is enormous and must be combated through a multi-dimensional approach. Deeper insights into this pandemic will improve our ability to tailor our treatments and services to combat HIV/AIDS.

## **Review of Literature**

### ***Global toll of HIV/AIDS***

AIDS is perhaps the most recognized pandemic in the 21st century. Its severity is documented in many statistical data. UNAIDS/WHO (2011) estimated 34 million people in the world were living with HIV/AIDS; 30.8 million adults and 3.3 million children under the age of fifteen, and 2.1 million people had died of HIV/AIDS globally in 2011.

Sub-Saharan Africa remains the region most affected by HIV/AIDS. It accounts for an astounding 69% of people living with HIV worldwide. This translated to 1 in 20 prevalence for HIV for those above 15 years of age. UNAIDS/WHO (2011) reported 23.5 million adults and children in the region were living with HIV/AIDS and 1.2 million deaths resulted from HIV/AIDS. This is more than two-thirds (71 %) of all deaths resulting from AIDS. Moreover, out of 2.5 million adults and children worldwide who newly acquired HIV in 2011, Sub-Saharan Africa contributed 1.8 million cases.

Similar to other countries in Sub-Saharan Africa, Kenya has been adversely impacted by the AIDS pandemic. UNAIDS (2012) estimated 1.6 million adults and children (ages 0–49) in Kenya were living with HIV/AIDS at the end of 2011. The Ministry of Health in Kenya reported the national prevalence rate had declined from 8.3 % in 2003 to 6.1 % at the end of 2010. Noteworthy also was the significant decrease in HIV prevalence among adults aged 15–49 years in urban areas from 10.0% in 2003 to 8.7% in 2011. Much of the change was attributed to changing sexual behaviors. However, in rural areas the HIV prevalence increased from 5.6% to 7.0% (Kenya Ministry of Health, 2012).

### ***Effects of HIV/AIDS on Children***

Children in Kenya have also been severely affected by the AIDS pandemic. According to Kenya National Bureau of Statistics (2010). The Central Intelligence Agency (CIA, 2007) estimated children under age fourteen comprised 42.1% of Kenya's population. The Kenya National Bureau of Statistics. (2010). According to UNGASS (2008) there were 2.4 million orphaned children in Kenya in 2007, 1.1 million of whom were orphaned by AIDS. UNAIDS/WHO (2011) estimated the number of orphaned children had risen to beyond 2 million in 2010.

The loss of one or both parents is a devastating and traumatic experience to the child (Gruskin & Tarantola, 2005; Foster & Williamson, 2000). When this loss is coupled with societal discrimination, stigmatization, and burdened by poverty including loss of formal educational, a child may become depressed (Delva, Vercoutere, Loua, Lamah, Vansteelandt, Koker, Claeys, Tammerman, and Annemans, 2009). Delva, et. al., also reported that some children were exposed to engagement in child labor, food deprivation, and homelessness. Moreover, the effects of HIV/AIDS affected communities are already pronounced because of poverty, poor infrastructure and limited access to basic services (Foster, 2002).

There is limited research on psychological well-being of children orphaned by HIV/AIDS; similarly, are the effects of mental health factors on these children's lives (Ainsworth & Semali, 2000; Cluver & Gardner, 2007). Children orphaned by AIDS are likely to suffer from depression, anxiety, anger, and posttraumatic stress symptoms (Atwine, Cantor-Graaea, & Bajunirweb, 2005; Wang, et al. 2012). A related research conducted in China found stigma toward children in AIDS affected families included isolation, ignorance, and rejection (Wang, et al. 2012).

Findings of a related study of children living in communities affected by AIDS in Kenya showed that children risked basic necessity of life such as shelter, food, clean water, health care, and education (Bryant, Beard, Sabin, Brooks, Scott, Larson, Biemba, Miller, and Simon, 2012). All these difficulties and stigma may increase the psychological well-being and emotional stability of children orphaned by HIV/AIDS (Makame, et.al. 2002). It is evident from literature that the psychological difficulties described cannot be due to the death of one or both parents alone. Some communities were already poverty stricken long before the children were orphaned (Case et.al. 2004; Heymann, et.al. 2007).

### ***Available support for OVC***

The President’s Emergency Plan for Aids Relief (PEPFAR) provides financial aid to governments in developing countries to meet the needs of people living with AIDS. The most essential needs of children orphaned by HIV/AIDS that are met include education, food, and medical care (Andrew, Skinner, and Zuma, 2006). Some of these needs are also met by government officials, international organizations, and community-based services in the communities (Foster et.al. 1996; Subbarao, et.al., 2001).

From as early as 2002, Joint United Nations Programs on HIV/AIDS (UNAIDS), United National Children Fund (UNICEF), United States Agency for International Development (USAID), and United Nations (UN) have provided community based resources to support extended families and the community in caring for children orphaned by AIDS (UNAIDS, UNICEF, and USAID, 2004). Forms of support including daycare was provided for foster parents and parents in need of relief. For older children, programs such as learning parenting skills, support groups, counseling, and skill training were provided. Other support systems included strengthening the capacity of families to protect and care for orphans and vulnerable children by providing economic, psychosocial, and other supports. Moreover, mobilization and support community-based responses are utilized to ensure access for orphans and vulnerable children through improved policy and legislation by channeling resources to families and communities (Smart, 2003).

**Research Design and Methodology-Research site and sample**

This study adopted a mixed methods research design. It was conducted within a 20 miles radius of AMPATH’s catchment area in Iten, a small town in Keiyo district, Elgeyo Marakwet County. The Academic Model Providing Access to Healthcare (AMPATH) program is housed at Moi Teaching and Referral Hospital in Kenya. It is a partnership between Moi University, Moi Teaching and Referral Hospital and a consortium of North American academic health centers led by Indiana University working in partnership with the Government of Kenya. AMPATH provides a comprehensive approach to the treatment and care of people living with HIV/AIDS. The program has enrolled 10,000-plus patients in income security programs, including agricultural extension services, micro-finance and small business initiatives. The program also provides school fees, nutrition, and other assistance to over 20,000 children left orphaned or vulnerable due to HIV/AIDS (AMPATH, 2014).

The study sample comprised of 215 children orphaned and vulnerable children drawn from families served by the AMPATH program. The purposive sample comprised of some children living with HIV/AIDS and others who did not. Some of the children had one or both parent(s) and living with HIV/AIDS, while others were total orphans. All participants were indigenous Africans. Frequency distribution of participants’ age, gender and zone are indicated in Tables 1, 2, and 3 below.

Table 1:  
Frequency distribution of participants’ age

Age	N	Percent
8-10	50	23.3
11-14	109	50.7
15-18	56	26.0
Total	215	100

Table 2:  
Frequency distribution of participants’ gender

Gender	N	Percent
Female	104	48.4
Male	111	51.6
Total	215	100

Table 3:  
Frequency distribution of participants’ zones

Zone	N	Percent
1—East of Iten town (rural)	49	22.9
2—Iten town (Small town)	67	30.8
3—North of Iten town (rural)	46	21.5
4—South of Iten town (rural)	22	10.3
5—West of Iten town (rural)	31	14.5
Total	215	100

**Data collection procedures**

**Ethical Considerations:** Permission to conduct the research was granted by the Institutional Review Board at University of Alabama at Birmingham, Institutional Review Ethics Committee at Moi Teaching and Referral Hospital, Kenya, and AMPATH Research office, Eldoret, Kenya. Permission to use the OVC well-being tool was obtained from Catholic Relief Services.

Data was collected over a period of two months using the OVC Well-being tool. Children above age 13 completed the questionnaires individually while those ages 8-12 were interviewed by the researchers. The interview sessions lasted 30 minutes. The Orphan and Vulnerable Children (OVC) Well-being tool is a valid and reliable tool recommended for use to collect data about the overall well-being of children in OVC programs. It was developed, piloted and adopted by Catholic Relief Services (CRS). The instrument comprises of 36 questions pertaining to the Well-being of OVCs on Ten Domains: Food and nutrition, Education, Shelter, Economic, Protection, Mental Health, Family, Health, Spirituality, and Community ([www.crs.org](http://www.crs.org)).

**Data storage and confidentiality:** Questionnaires were stored in file cabinets with lockable drawers. The electronic data was stored in a laptop with no identifiers. The computer was locked for login when not in usage. Only the researchers had access to the computer and file cabinets.

**Data verification and analysis:**

The following procedures described in the OVC Well-being (OWT) toolkit manual ([www.crs.org](http://www.crs.org)) were used to prepare, code and analyze data to determine the overall children’s well-being on the ten domains. 1) Enter the items for each of the variables for the domains and total scale for the OWT to the SPSS spreadsheet. For example, the variable “FN1” corresponds with the first question in the Food Security and Nutrition domain. 2) Coding: Reverse code the scores on questions 3, 6, 12, 15, 17, 18 and 28. The responses for these variables were recorded as 1=3, 2=2, and 3=1. 3) Check for completeness of the scores for the 36 questions on each field scoring sheet on each questionnaire. 4) Enter the score of each variable on each questionnaire to the SPSS database. 5) Compute the averages for each of the ten domains. For example: to compute the average of Food and Nutrition Domain, Compute FNA = MEAN (FN1, FN2, FN3). Each domain will receive an average score within the range of 1 to 3. 6) The ten domain scores were added together to create the total well-being score. The final score range from a low of 10 to a high of 30. Compute OWT = FNA+EDA+SHA+ECA+PRA+MHA+FA+HA+SPA+CCA. 7) Determine the overall well-being of the children based on the four recommended classifications with respect to their OWT score: 1) Desirable (25-30), 2) Average (23-24), 3) Below Average (16-22), and Undesirable (0-15).

We computed two descriptive statistics; Means and Standard deviations of the ten domains of OVC Well-being. We also ran a T-Test analysis to determine statistical significant of each of the ten domains of children’s wellbeing. Finally, we computed the correlations coefficients to determine the correlations between Food and Nutrition and the other domains.

**Results**

Results of the overall OVC well-being yielded the results in Table 4 below.

Table 4: Evaluation of OVC Well-Being

Evaluation of Well-being	Score	Number	Percentage (%)
Desirable	25-30	146	67.9
Average	23-24	42	19.5
Below Average	16-22	24	11.2
Undesirable	0-15	3	1.4
Total		215	100

Results for the Means (M), Standard deviations (SD), Minimum and Maximum scores of the ten indicators are shown in Table 5.

Table 5:  
Descriptive Statistics for the Ten Indicator Domains of OVC Well-being (N=215)

	FNA	EDA	SHA	ECA	PRA	MHA	FA	HA	SPA	CCA
M	2.53	2.66	2.85	2.07	2.70	2.72	2.55	2.66	2.82	2.26
SD	0.44	0.40	0.34	0.50	0.43	0.35	0.47	0.43	0.41	0.50
Minimum	1.33	1.4	1	0.67	0.5	1	0.25	1	1	1
Maximum	3	3	3	3	3	3	3	3	3	3

Note:

FNA – Food and Nutrition    ECA – Economics    FA – Family    EDA - Education  
 PRA – Protection    HA – Health    SHA – Shelter    MHA – Mental Health  
 SPA - Spiritual    CCA – Community Care

Results of one-sample T-Test for each of the ten domains of OVC Well-being are in Table 6.

Table 6:  
One Sample T-Test for the Ten Domains of OVC Well-being

Domain	Key	t	p
Food and Nutrition	FNA	-1.558	0.121
Education	EDA	2.171	0.031**
Shelter	SHA	11.771	0.000***
Economics	ECA	-15.064	0.000***
Protection	PRA	4.261	0.000***
Mental Health	MHA	5.898	0.000***
Family	FA	-1.000	0.318
Health	HA	2.295	0.023**
Spiritual	SPA	8.033	0.000***
Community Care	CCA	-9.600	0.000***

T-Test Sample Mean = 2.58

DF= 214 for all domains

\*p<0.05, \*\* p<0.01, \*\*\*p<0.001

Results for the Correlations between some of domains of children’s overall well-being are indicated in Table 7 below.



Table 7

Correlation Coefficients and Statistical Significance for the Ten Domains of OVC Well-being

Domains	Key	Correlation Coefficient (r)	p
Food and Nutrition and Protection	FNA, PRA	.796	.000
Food and Nutrition and Shelter	FNA, SHA	.819	.000
Food and Nutrition and Health	FNA, HA	.790	.000
Food and Nutrition and Mental Health	FNA, MHA	.821	.000
Food and Nutrition and Education	FNA, EDA	.806	.000
Education and Health	EDA, HA	.807	.000
Education and Mental Health	EDA, MHA	.826	.000
Education and Protection	EDA, PRA	.886	.000
Education and Shelter	EDA, SHA	.825	.000
Health and Mental Health	HA, MHA	.850	.000
Health and Protection	HA, PRA	.842	.000
Health and Spiritual	HA, SHA	.857	.000
Mental Health and Protection	MHA, PRA	.822	.000
Mental Health and Shelter	MHA, SHA	.917	.000
Protection and Shelter	PRA, SHA	.830	.000

## Discussion

Results in *Table 4* indicates overall well-being of 67.9 % of the participants was desirable, 19.5 % was average, 11.2 % was below average, and only 1.4% was considered undesirable. These study findings are not typical of the status of the well-being of orphaned and vulnerable children. Findings in many prior studies showed deficits in the overall OVC well-being. For example, one study conducted in Kenya found OVC were at risk and lacked basic necessity of life such as shelter, food, clean water, health care, and education (K'Oyugi & Muita, 2002). Another study conducted in Kenya by Mishra et al., (2005) found that Kenyan children with one or more HIV-infected parents were significantly less likely than other children to be in school, more likely to be underweight, were less likely to receive basic medical care.

One factor that could have significantly contributed to desirable outcomes in the children's well-being is the forms support the children receive from AMPATH. As discussed earlier in the paper, the children in this study were drawn from the 20,000 OVC children served by AMPATH program in its catchment area in Western Kenya. The program provides assistance in the form of food and nutrition, treatment and medications, blankets, school fees and uniforms to the children (AMPATH, 2014). Findings of this study support research evidence of improvements in indicators of children's well-being when basic needs are met, even in the short term (Bryant et al., 2012).

Despite the significant contribution made by AMPATH program to the children in our research sample, the study found some gaps in the overall well-being of close to one-third of OVC in the research sample. Close to a fifth of the children (19.5%) scored about average in their well-being score. There were 11.2 % (52 children out of 215) who scored below the desired average, and 1.4 % of the children (3 out of 215) whose overall well-being score was undesirable. The three participants with undesirable OVC well-being outcome had very similar experiences. The child whose well-being score was the lowest was living with HIV and had lost both parents to AIDS. They all three scored lowest in Economic (ECA), Food and Nutrition (FNA) and Family (FA). They also admitted either going to bed hungry all the time or some of them time. Finally, they reported that their caregivers neither had a job nor any money.

Results of the Means, Standard Deviations, and T-Tests of the ten domains gave us more insights into the strengths and areas that needed improvement. As indicated in *Table 5 and 6* participants scored Shelter, SHA domain the highest. The T-test results show Shelter to be a statistically significant factor in OVC well-being ( $M= 2.85$ ,  $SD = 0.34$ ,  $P$

= 0.000). Three questions in OVC well-being tool for this domain were: 9) I have a house where I can sleep at night. 10) I feel secure in my neighborhood. 11) I feel safe where I live.

All participants in our study had a house to sleep at night. As indicated in *Table 3*, close to 70 % resided in rural areas within 30 miles radius from Iten Township. Families in rural areas in our research setting lived together as a community and thus children were protected within the safety of the community. 30.8 % of the children lived within the small town of Iten, which has a very low crime rate. Iten is located 22 miles from Eldoret town and has a population of 42,312 (Kenya National Bureau of Statistics, 2010).

The domain that the children scored second highest was Spirituality (SPA) ( $M= 2.82$ ,  $SD 0.41$ ). The T-test results showed the domain was also statistically significant ( $P = 0.000$ ). There were three questions in this domain. 31) My belief in God gives me strength to face difficulties. 32) My belief in God gives me comfort and reassurance. 33) My faith community is important to me. Therefore, from the children's perspective, Spirituality plays a very crucial role in their well-being. We did not find many studies that address the spiritual domain as a crucial strategy to support orphaned and vulnerable children. Obviously, this gap needs to be filled on future research studies and while designing programs to meet the needs of OVC.

Education domain, EDA, received among the top highest ratings,  $M = 2.66$ ;  $SD = 0.40$ ). The T-test analysis showed it was statistically significant ( $P=0.031$ ). Education also had high correlations with Health ( $r = 0.807$ ,  $P = 0.000$ ), Mental health ( $r = 0.826$ ,  $P= 0.00$ ), Protection ( $r = 0.886$ ,  $P = 0.000$ ), and Shelter ( $r = 0.825$ ,  $P = 0.000$ ). One factor that may have led to a high score in this domain is the free primary education policy in Kenya. This policy was effected in 2003 and has led to high enrollments in elementary schools in the country. Despite the mandatory school attendance policy, some children still missed going to school because they had to work so as to raise money to feed themselves, their siblings, and their ailing parents.

In many African countries, including Kenya, education does not necessarily guarantee a high likelihood of employment let alone occupational mobility. This is due to the scarcity of jobs in the white-collar sector. However, education still remains fiercely competitive due to population growth and slow economic development. Thus, despite the wide availability of schooling, the decision to send children to schooling involves a myriad of factors such as economics and cultural restraints. An additional layer of uncertainty is added with factors such as HIV/AIDS and orphaning. Interestingly, our sample population consisted of 83% female headed households which is a striking deviation from the normal family structure in Kenya. This study exposed the conditions of children living with HIV/AIDS in rural Kenya to raise awareness and guide resource allocation in sectors such as hygiene, healthcare, food and shelter, and education.

The domain with the lowest score on the overall children's wellbeing was Economic, ECA ( $M=2.07$ ;  $SD =0.50$ ). The T-Test results showed it to be statistically significant ( $P=0.000$ ). The three questions in this domain were: 12) My school attendance is affected by my need to work. 13) My family has enough money to buy the things we need. 14) One of the adults taking care of us (me) earns money working at a job. Some participants said they did manual work outside the home, such as hand weeding in maize farms or rearing cows in other people's farms in the community. Others sold merchandise on the streets so as to get little income to purchase food for themselves, siblings or ailing parents. Some participants worked over the weekend while others worked during the week and did not attend school.

Other researchers have examined the economic impact of HIV/AIDS. A report by Development Gateway Foundation (2004) indicated that millions of children in AIDS-affected families are now care-givers and home-makers. Looking for work to supplement the family income or scavenging for food is the most important focus in their lives. The orphaned children are malnourished, under-educated, overworked and financially insecure. AIDS orphans who have lost both parents face stigma and discrimination - often being victimized and thrown out of social and familial structures. As outcasts, children quickly become prey to sexual abuse, trafficking, prostitution and forced labor – situations, which in turn, increase their vulnerability to HIV infection.

The researchers also observed abject poverty in this community as they conducted interviews from house to house. The overall monthly income based on demographic information of 100 caregivers raising the OVC in our study is indicated in *Table 8* below.

Table 8:  
Caregiver Income

Monthly Income (in Kenya Shillings)	U.S Dollars	Participants	Percentage (%)
No Income	0	12	12.4
1-999	<12	24	24.3
1,000-9,999	12.5-120	57	56.7
10,000- 19,999	122-244	7	6.6
Above 20,000	Above \$2435	0	0
Total		100	100

Food and Nutrition is another domain that is closely related to Economic domain. It received a low rating in this study, Food and Nutrition, FNA (M=2.53; SD= 0.44). The three questions pertaining on the OVC well-being tool pertaining to this domain were: 1) I eat at least two meals a day. 2) I have enough food to eat. 3) I go to bed hungry. T-test results in *Table 6* results indicated Food and Nutrition domain was not statistically significant (P=0.121). However, when we ran the coefficient analysis we found statistical significance and very high correlation with other domains of children’s wellbeing (*Table 7*: Food and Nutrition/Protection:  $r = 0.796$ ,  $P= 0.000$ ; Food and Nutrition/ Shelter:  $r = 0.819$ ,  $P= 0.000$ ; Food and Nutrition/Health:  $r = 0.790$ ,  $P = 0.000$ , Food and Nutrition/Mental health  $r = 0.821$ ,  $P= 0.00$ ; Food and Nutrition/Education,  $r = 0.806$ ,  $P= 0.000$ ).

There are several reasons why Food and Nutrition domain may have ranked among the lowest domains in this study. First, as shown on *Table 8* subject poverty is quite evident in this community. Some children indicated they ate only one meal per day. The children who ranked the lowest three in all ten indicators in this study scored Food and Nutrition (FNA) and Economic (ECA) indicators the lowest and admitted either going to bed hungry all the time or some of the time. The children also reported that their caregivers neither had a job nor money to purchase food. Though we mentioned earlier in this paper that participants received food provisions from the AMPATH program, we later found out that the program was almost running out of funding for the food and nutrition budget.

Second, the supply for corn and other staples tend to be lowest in the months of May-July in the geographical region where the study was conducted. The community’s economic base is agriculture and maize, the food staple is harvested towards the end of the year. Given that the study was conducted in the months of June and July, some families may have been out of their food supply.

Community Care is often one of the factors considered to have strong impact on OVC wellbeing. However, in this study it is ranked second lowest after Economic domain, ECA. Community Care, CCA (M = 2.26; SD = 0.50). The T-Test result showed it was statistically very significant (P = 0.001). The three questions that related to this domain were: 34) People in my community try to help me. 35) I feel welcome to take part in religious services. 36) My household receives free support to care for the children who live here. As shown in *Table 3*, approximately two-thirds of the participants lived in rural areas with parent(s) affected by HIV/AIDS or with a relative if the parent(s) had passed away. Community and Community Care are hallmarks of families living in rural communities. Therefore it is surprising that the children scored this traditional source of support as one of the lowest.

Several studies have addressed the extent to which HIV/AIDS has torn the ancient safety nets for the children. Grandparents often assume responsibilities for child care in many families affected by parental AIDS. A report by UNICEF (2003) indicated that extended families care for 90 percent of all orphans. The children may be more difficult to care for due to their own physical needs and parental losses. The majority of households are also generally poorer and progressively less able to adequately provide for the children in their care. Eventually, the responsibility assumed by grand parents may lead to the depletion of their meager resources and increase their physical illnesses (Jepkemboi & Aldridge, 2009).

The situation is of increasing concern because the size of the crisis is overwhelming traditional systems of caring for children. The support networks, communities and extended families are overstressed and continue to be



overburdened as the number of AIDS orphans increase. The economic pressure often becomes too much for them to bear especially in developing countries. (Jepkemboi & Aldridge 2009; UNICEF, 2003). In many developing countries, particularly in Africa, children’s social networks have been weakened by HIV/AIDS and national policies that address the needs of OVC in the long-term need to be emphasized (UNICEF, 2003; United Nations Foundation, 2004; Jepkemboi & Aldridge, 2009, Jepkemboi and Aldridge, 2014).

**Recommendations for practice**

This study provides a glimpse to the well-being of orphaned and vulnerable children. Recommendations for action on the four well-being categories are listed in Table 9 below.

Table 9

Evaluation of Well-being and Associated Recommendations

Evaluation of Well-being	Recommendations
Desirable	Vulnerable children have improved in all domains. No immediate action required.
Average	Vulnerable Children in this group have room to improve well-being in certain domains.
Below average	Special attention need be paid to programs when the well-being. This may signify deficits within certain domains.
Undesirable	Immediate action to determine if there was an error in response or if there is a problem affecting the children that needs to be addressed.

*Source: Catholic Relief Services (2009). Orphans and vulnerable children well-being tool.*

As indicated in *Table 4*, 67.9% of participants had desirable well-being. Children in this category have improved in all ten domains and no immediate action is required. However, the research findings also indicate close to a fifth of the children (19.5%) were average in their well-being score. Based on the recommendations in *Table 9* above, there is still more room to improve the well-being of children in this category. There were 11.2 % of children in the study who are still adversely impacted despite the support they received. Therefore programs need to pay special attention to the needs of the children in this category so as to improve their overall well-being. This finding may also signify a deficit within certain domains of the children’s development such as Economics, (ECA = 2.07); Community Care, (CCA =2.26), Food and Nutrition (FNA= 2.53) and Family (FA=2.55). The last category is that of 1.4% of the children with undesirable well-being. As indicated in *Table 9*, immediate action needs to be taken to determine if there was an error in response to the children’s needs or if there are other specific problem affecting the children that needs to be addressed.

Whereas the findings yielded some desirable outcomes much needs to be done to make the projects sustainable so as to meet the needs of OVC in the long-term. OVC will continue to have essential needs such as education, food, and medical care as they continue to grow (Andrew, Skinner, & Zuma, 2006). There is therefore a strong need for governments and funders alike to adopt policies that will yield long-term outcomes and mobilize and support long-term community-based projects and resources to families and communities (Smart, 2003).

**Limitations of the study**

There are several limitations that are associated with this study. First, we used qualitative design of research. Findings from this study may not be generalizable to other populations of orphaned and vulnerable children living in different contexts. Second, participants in this study was drawn from a population served by the AMPATH program and received nutrition, medical treatment, school fees and economic support. Hence findings of this study may not reflect the psychosocial needs of orphaned and vulnerable children in different contexts. Third, the OVC well-being tool used in this study was developed to serve as a fast, easy method of securing data about the overall wellbeing of children in OVC programs. Additional systematic and long term observations need to be done to identify patters and trends that can be used for real-time assessment and response to current issues of OVC.

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