SELF-ESTEEM AND ACADEMIC PERFORMANCE LEVELS OF HIV/AIDS ORPHANED PRIMARY SCHOOL PUPILS IN CHILDREN'S HOMES IN NYERI SOUTH SUB-COUNTY, KENYA

TABITHA NJAMBI KIRAGU

A Thesis Submitted to the Graduate School in Partial Fulfillment of the Requirements for the Master of Education Degree in Guidance and Counseling of Egerton University

EGERTON UNIVERSITY

OCTOBER, 2015

DECLARATION AND RECOMMENDATION

Declaration

I declare that this thesis is my original work and has not been previously published or presented for the award of a degree in this or any other university.

Signature: ..... Date: .....

Tabitha Njambi Kiragu
Reg. No.EM16/1643/06

Recommendations

This Thesis has been submitted with our approval as University supervisors

Signed: ……. Date: ……..

Prof. M. C. Chepchieng
Department of Psychology, Counseling and Education Foundations
Egerton University

Signed: ……. Date: …….

Dr. B E.E. Omulema
Department of Psychology, Counseling and Education Foundations
Egerton University

DEDICATION

This thesis is dedicated with a lot of love and gratitude to the Almighty God who gave me strength to write it, my husband Ephantus Kiragu for being supportive all through, our daughters Shiphira Wagaki and Purity Nyawira and our son David King'ori for their understanding in this pursuit of postgraduate education.

ACKNOWLEDGEMENT

It is by God's grace and favor from various people for me to have come this far. I am particularly grateful to my academic supervisors Prof. M.C Chepchieng and Dr. B.E.E Omulema for their academic guidance, patience, encouragement and fruitful suggestions towards completion of this study. I also take this opportunity to thank the entire department and staff especially Prof. Fr S.N Mbugua, Prof. A.M. Sindabi, Mr. C.C. Cheruiyot, Prof. M. Kariuki among others. I am also grateful to those who allowed me to access their materials and I am particularly indebted to the Managers of children's homes, caretakers, and HIV/AIDS orphans who participated in this study.

I am sincerely grateful to my spiritual son and mentor Muchiri Gacheru who gave me professional guidance, encouragement and upheld me in prayers together with his family. Thanks to my students and my work colleagues and especially, Mr. Too, Mr. Muchiri, Mr. Kaniaru Wachira, Mr. Muturi Nderitu, Mr. Mwangi Gateru, Mr Kiiru Muthige, Miss Wangechi Thumbi, Miss Ann Kairebi, Mr Wachira Gathenya and Mr. Bwana Obuya for their friendliness, understanding, support and resourcefulness. I also thank my Principal, Mr. Mbekenya for mutual understanding and support during my study.

Special thanks to my sisters and friends especially Zipporah Macharia and Joycephine Kamotho who took care of our children when I was away. Special thanks to my family who sacrificed the little they had to ensure that I pursued postgraduate studies. I am sincerely grateful to my husband for allowing me to pursue the master's programme, his concern, encouragement and support during my study. Special tribute to our children for their understanding when many times they missed my company and material support in the course of my study. I wish to acknowledge most sincerely the Almighty God who gave me strength, self drive, direction, intervention and sanity to concentrate and to work towards this academic endeavor, without who all my struggles would have been in vain. I wish to crown all these acknowledgements by acknowledging God's power and presence in the past, present and in the future. To all those who in one way or another participated and contributed to the success of this study but are not mentioned herein, your contributions were most important and kindly accept this as recognition of your efforts. May God bless you abundantly.

ABSTRACT

Since the first case of HIV/AIDS was diagnosed in Kenya in 1984, it is estimated that over 1.5 million people have died of AIDS related illness, resulting to 1.1 million children who are HIV/AIDS orphans. A parent's death usually affects children's psychological well-being that includes self-esteem. Children who experience low self-esteem may have poor adaptation to human functioning and life experiences. This may in turn affect their academic performance. Therefore, the purpose of this study was to investigate self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes of Nyeri South Sub-county. The research adopted the descriptive survey design. The population of the study was 190 HIV/AIDS orphaned primary school pupils from five children's homes who were in class one to eight in Nyeri South Sub-county. The accessible population was 53 HIV/AIDS orphaned children in class six to eight and five caretakers who were purposively selected from children' home that had HIV/AIDS orphaned pupils. Since the accessible population was small, all the 53 HIV/AIDS orphaned pupils and five caretakers were involved in the study. HIV/AIDS orphans and caretakers were obtained through purposive sampling. Data was collected using a pupil's questionnaires, a self-esteem scale and interview schedules for caretakers. The face of validity of the instruments was ascertained by getting advice from experts and incorporating the suggestions given. Reliability was established by conducting a pilot study in a children's home in Nyeri North sub-county using Cronbach's alpha coefficient. A reliability coefficient of 0.84 was obtained and accepted for the study. Both inferential and descriptive statistics were used to analyze data. Consequently, frequencies, means, percentages, and t-test statistics were used. This was aided by the Statistical Package for Social Science (SPSS) version 18.0 for windows. An analysis of the major findings indicated that self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils were moderately low, girls being more predisposed to lower self-esteem and academic performance. The findings of this study may assist the Ministry of Education and Children's department to establish programmes that may address the needs of HIV/AIDS orphans. HIV/AIDS orphans may be helped to adjust better and have a sense of belonging. The school administrators, teachers, guardians and non-governmental organizations may use them to understand the HIV/AIDS orphans better.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
HIV	:	Human Immune-Deficiency Virus
KDHS	:	Kenya Demographic Health Survey
KENWA	:	Kenya Network of Women with AIDS
NGO	:	Non- Governmental Organization
SEO	:	Sub-county Education Officer
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNICEF	:	United Nations Children's Education Fund
USAID	:	United States Agency for International Development

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

According to UNAIDS/WHO (2013), AIDS epidemic global update, 32.7 million people were estimated to be living with HIV globally. Out of this number of people, 30.2 million were adults and 2.5 million were children under 15 years. There were 2.6 million new infections in 2013 of which 1.6 millions were adults while 430,000 were children under 15 years. Moreover, there were 2.3 million people who died from AIDS of which 1.8 million were adults and 0.4 millions were children. In the sub-Saharan Africa, there were 22.6 million people living with HIV thus making it the most seriously affected region, with AIDS remaining the leading cause of death. HIV epidemics in Sub-Sahara Africa are giving rise to a very large number of orphaned children. Between 1990 and 2012, the Joint United Nations Programme on HIV/AIDS found that the total number of children younger than 18 years who had lost one or both parents to AIDS had increased 5500 to 18.4millions (UNAIDS/WHO,2012).

There were 1.8 million orphans due to HIV/AIDS in Kenya (UNAIDS/WHO, 2012). According to the National AIDS Control Council (2012), the number of people who were HIV positive had increased to 3.3 million in Kenya. A study by the Government of Kenya (2013) showed that there were about 2.7 million children under 18 who were orphans of which 2.1 million were due to AIDS illness. According to the report of the Ministry of Health Kenya (2013), as of July, 2013, the HIV/AIDS data in Kenya was as shown in Table 1.

Table 1

HIV/AIDS Statistical Data in Kenya in 2013

HIV Infections	3.3 millions
HIV/AIDS death per day	0.0015-0.0017 millions
HIV/AIDS deaths per year	0.017 millions
Cumulative deaths	2.7 millions
HIV/AIDS orphans	1.8 millions

Source: Ministry of Health Kenya (2013)

National AIDS Control Council (2013) postulates that HIV/AIDS orphan hood has continued to be a major challenge to our social-economic development. Since the first case was diagnosed in Kenya in 1984, it is estimated that over 2.7 million people have succumbed to AIDS-related illnesses, resulting in 1.8 million of school going children left as HIV/AIDS orphans. It is also estimated that 3.3 million people in the Kenya were living with HIV. Parental death due to AIDS during childhood may have a lasting negative impact on all aspects of children's life (National Aids Control Council, 2013). HIV/AIDS can affect pupils when their parents die from HIV/AIDS related illnesses, they may have no one to provide for their basic needs and those of their siblings thus may drop out of school. Moreover, their self-esteem may be affected because of the stigma that is associated with HIV/AIDS and this may in return affect their academic performance (Odiwuor, 2006)

Ayier (2013) noted that in the Mediera Europe orphans and abandoned children were initially confined to orphanages. Lindsey (1994) indicates that Charles Brace founded the children's Aids society and developed the placing out system where children were distributed to families and foster homes to be taken care of, increasing their sense of self-respect and chances of schooling. LJUNGUIST (2003), states that almost throughout Sub Sahara Africa, there have been traditional systems in place to take care of children who lose their parents for various reasons. However, the spread of HIV has eroded this traditional practice by overstretching its caring capacity by large numbers of orphans needing support and care. HIV also undermines the caring capacity of families and communities by deepening the poverty due to the high cost of medical treatment and funerals.

Hussein (2008) observes that the magnitude of the problem of HIV/AIDS orphans and vulnerable children is being felt in Kenya today than ever before. Most of these children are deprived of basic needs besides being prone to different forms of abuse and exploitation. The situation is made worse by high level of poverty. This situation diminishes their rights. This is depicted by increased cases of child abuse and exploitation in some cases by the very people who are expected to protect them. Csete (2001) says that some of the children interviewed in Kenya said they had to withdraw from school so they could earn money for the family or care for a sick relative or in some cases find livelihoods on the streets or in domestic labor. Csete (2001) reports

that almost all the orphans had faced obstacles in inheriting the land they were entitled to and many did not have good enough information of HIV/AIDS to understand why their parents had suffered and died to combat the stigma they faced. Epstein (20120 reports that in South Africa AIDS has perpetuated the stigma associated with the disease, with obvious AIDS victims being said they were suffering from ulcers, tuberculosis or typhoid and orphans being told that their parents 'had gone away' or had been bewitched by a jealous neighbor. Shame and silence is the primary reason for high prevalence rates in South Africa.

According to a study done by Odiwuor (2006) in Homa Bay, Muranga and Nyeri District children orphaned by HIV/AIDS have various problems. For instance, they are isolated by other children because of the stigma associated with HIV/AIDS. They also face denial, lack of parental attention, emotional problems like low self-esteem and self-pity. Self-esteem influences real life achievement (Forgas & William, 2002). In effect, pupils with high self-esteem tend to slightly exaggerate their ability, competence or adequacy whereas low self-esteemed pupils judge themselves harshly (Wittrock, 1991). For this reason, high self-esteemed pupils unlike low self-esteemed pupils take more responsibility for their academic successes than for their failures (Wittrock, 1991). According to Boggiano (1992), high academic ability and performance are both predictors of self-esteem during primary school. High esteem during school has two important effects among young adults: it directly predicts high esteem in adulthood and it has direct effect on further educational accomplishment and occupational status (Adams & Gollaita, 1983). Parents and educators have been faced by the problem of low academic achievement in HIV/AIDS. According to Adams and Gollalta (2005), HIV/AIDS orphaned pupils ought to be helped to do well in school by establishing positive peer relationship and maintaining a supportive aspect to assure high self-esteem.

1.2 Statement of the Problem

In Kenya today, there is an increase of HIV/AIDS orphan hood. HIV/AIDS orphaned pupils experience physical, psychological and social problems. Physical problems include shelter, clothing, proper beddings and land and property rights. They have psychological problems such as isolation by other children because of the stigma associated with HIV/AIDS. In addition, they have emotional problems which may result in low self-esteem and self pity. Some of them grieve

secretly and as a result have socialization problems. They are also unable to relate closely with peers. These physical, psychological and social problems may affect their self-esteem and also their academic performance. In an attempt to help the HIV/AIDS orphans, guidance and counseling is used. Therefore, given that in Nyeri South Sub-county there were HIV/AIDS orphaned primary school pupils in Children's homes, it was necessary to establish the self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes and the effects of guidance and counseling on self-esteem and academic performance of HIV/AIDS orphaned primary school pupils .

1.3 Purpose of the Study

The purpose of this study was to establish self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes of Nyeri South Sub-county, Kenya.

1.4 Objectives of the Study

The study was guided by the following objectives:

i) To establish the self-esteem levels of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county.
ii) To establish the academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county
iii) To determine whether gender differences exist in self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county
iv) To determine the effects of guidance and counseling on self-esteem and academic performance of HIV/AIDS orphaned primary school pupils in Nyeri South Sub-county.

1.5 Questions of the Study

The research was based on the following questions:

i) What is the level of self-esteem of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county.
ii) What is the level of academic performance of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county

iii) Is there gender differences in self-esteem and academic performance levels of HIV/AIDS orphan pupils in children's homes in Nyeri South Sub-county

iv) What is the effect of guidance and counseling on self-esteem and academic performance of HIV/AIDS orphaned primary school pupils in Nyeri South Sub-county.

1.6 Significance of the Study

The findings of this study may hopefully be used by school administration and teachers to understand the problem faced by HIV/AIDS orphaned primary school pupils. As a result, they may be able to identify alternative positive measures that can be used by teachers and caretakers towards them for instance understanding their personal background that may influence self-esteem and academic performance. This may help the teachers to establish and strengthen guidance and counseling programmes in schools. The changes so instituted, may hopefully cater for the needs of the HIV/AIDS orphaned primary school pupils with regard to self-esteem and academic performance, with the ultimate aim of improving their self-esteem and academic performance. Also, the Ministry of Education, non-governmental organizations and Children's department may also use the findings of the study to institute changes in education sector so as to incorporate self-esteem and improvement of academic performance among HIV/AIDS orphaned primary school pupils. The study findings may therefore guide the teachers, guardians and other care takers on matters concerning the needs of HIV/AIDS orphaned primary school pupils. The study findings may also provide a base on which other researches might be carried on this subject.

1.7 Scope of the Study

The study was confined to HIV/AIDS orphaned primary school pupils from five children's homes and the care takers of the five children's homes and in Nyeri South Sub-county. Class six to eight pupils were studied alongside caretakers in five children's homes. The respondents in the selected classes were preferred because they were thought to be quite familiar with their family backgrounds and could therefore give their true feelings when responding to the items in the questionnaire. The study focused on self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes of Nyeri South Sub-county.

1.8 Limitations of the Study

The study was limited by the fact that some pupils and care takers found the study to be sensitive especially due to ethical issues involved. They were therefore suspicious as to the purpose of the study. The researcher however, assured them of confidentiality of the information provided. The researcher also reaffirmed that the information obtained was purely for research purposes. The other study limitation was that the findings of the study could only be generalized to the sub-county under study and that further generalization to other sub-counties should be done with caution.

1.9 Assumptions of the Study

This study assumed that:

i) The self-esteem and academic performance levels of the HIV/AIDS orphaned primary school pupils in children's homes have been contributed by parental roles.

ii) That the pupils knew precisely that their parents died of HIV/AIDS.

iii) Respondents gave honest responses in the questionnaire.

1.10 Definition of Terms

In this study, the following terms are operationally defined as:

Academic performance: This is the educational performance of a child. In this study, it referred to the mean score of a pupil's exams of three consecutive terms. It was measured as high, average and low.

AIDS-Acquired Immune Deficiency Syndrome (AIDS): It is the phase of HIV infection and is a condition characterized by a combination of signs and symptoms caused by HIV, which attacks and weakens body's immune system making the infected person susceptible to other life threatening diseases.

Counseling: According to Mutie and Ndambuki (1999), counseling is a learning orientation process which usually occurs in an interactive relationship with aim of helping the person learn more about self and also to be an understanding and effective member of the society. In this study it is the relationship between an orphan and a counselor with the aim of helping the orphan cope with his/her orphan hood.

Guidance: According to Mutie and Ndambuki (1999)guidance is a process, developmental in nature, by which an individual is assisted to understand, accept and utilize his/her aptitudes, interests and attitudinal patterns in relation to his/her aspirations. In this study guidance is the process of assisting an individual to cope with his/her orphan hood.

HIV-Human Immune-deficiency Virus: This is the virus that causes AIDS.

HIV/AIDS Orphans: According to Hornby (1995) an orphan is a child whose parents have died. In this study these include any pupils below 18 years who have no biological parents as a result of HIV/AIDS death.

Effects: This refers to how something influence the way a person thinks or behaves. In this study it referred to how HIV/AIDS orphan hood relates to self esteem and academic performance levels.

Orphan hood: This is the state of being without a biological parent: father, mother or both parents. In this study, it is the state of being without a biological father, mother or both parents as a result of HIV/AIDS death.

Pupil: It refers to a public primary school learner. In this study it referred to a public primary school learner in class six to eight.

Self-esteem: According to Gacheru (2005), it is the regard or opinion for oneself. In this research it refers to the thoughts and feeling that a pupil has about self in relation to others. In this study self-esteem was measured as high, moderate or low.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews the related literature in order to put this research in context of other similar research. The chapter focuses on literature from various authors as well as other researchers. It also examines: HIV prevalence, HIV/AIDS orphans in Africa, HIV/AIDS orphans in Kenya, HIV/AIDS orphans in Nyeri South Sub-county, Challenges of HIV/AIDS orphan hood, Major influence of HIV/AIDS orphan hood on education, Determinants of Self-esteem, Parents' Influence on Children's self-esteem, Influence of HIV/AIDS Orphan hood on Self-esteem and Academic Performance, Effects of high self-esteem on academic performance, Effects of low self-esteem on academic performance, HIV/AIDS orphaned pupils' self-esteem, HIV/ADS orphans self-esteem differences by gender, Effects of duration of orphan hood on self-esteem of HIV/AIDS orphaned pupils, the Role of Guidance and Counseling Programme in Schools in Kenya, role of guidance and counseling in building self-esteem, Theoretical framework and finally Conceptual Framework.

2.2 HIV Prevalence Globally

According to UNAIDS/WHO (2013), AIDS epidemic global update, 32.7 million people were estimated to be living with HIV globally. Out of this number of people, 30.2 million were adults and 2.5 million were children under 15 years. There were 2.6 million new infections in 2013 of which 1.6 millions were adults while 430,000 were children under 15 years. Moreover, there were 2.3 million people who died from AIDS of which 1.8 million were adults and 0.4 millions were children. In the sub-Saharan Africa, there were 22.6 million people living with HIV thus making it the most seriously affected region, with AIDS remaining the leading cause of death. HIV epidemics in Sub-Sahara Africa are giving rise to a very large number of orphaned children. Between 1990 and 2012, the Joint United Nations Programme on HIV/AIDS found that the total number of children younger than 18 years who had lost one or both parents to AIDS had increased 5500 to 18.4 millions (UNAIDS/WHO, 2013).

The total number of orphans in Asia from all regions exceeds 73 million though there is insufficient information available to provide figures for AIDS orphans in individual Asian

countries due to the stigma involved. Mercado (2010) reports that in Europe and USA, there has been a move to de-institutionalize care of vulnerable children by closing down orphanages in favor of foster care and accelerated adoption. Many countries have made bold move to reduce visibility of its children's institutions to meet conditions of joining the European Union. Romania is the country with the highest number of orphaned children in Europe with 24,227 orphans in 2009 and 19,000 in 2010. Due to the strong social services in places in most European countries, when a child loses one or both parents, the insurance or social services scheme in place helps to cushion the family from destitution.

Barrie (2010) observes that the Middle Eastern countries have relatively few numbers of orphans, in Afghanistan; orphans are supported by non Governmental Organizations (NGOS) whereas in Iraq there are 1,190 documented orphans in 25 state homes for orphans which are not well managed. In Bahtain the Royal Charity Organization founded in 2001 by King Hawai Bin Al Khalifa sponsors all helpless Bahrein orphans and windows through families. UNICEF (2007) reports that in India, orphans of 0-17 years by all causes, was 25,700,000 by 2005. In china the official records indicate that there are 100,000 orphans though they fail to account for many of the country's abandoned infants and children. Only a few of them are in any form of acknowledged state care.

There were 1.8 million orphans due to HIV/AIDS in Kenya (UNAIDS/WHO, 2013). According to the National AIDS Control Council (2012), the number of people who were HIV positive had increased to 3.3 million in Kenya. A study by the Government of Kenya (2013) showed that there were about 2.7 million children under 18 who were orphans of which 2.1 million were due to AIDS illness according to the report of the Ministry of Health in Kenya (2013), as of July, 2013, the HIV/AIDS data in Kenya.

Nonetheless, the current epidemiologic assessment has encouraging elements since it suggest the global prevalence of HIV infections is remaining at the same level, although the global number of people living with HIV is increasing because of on-going accumulation of new infections with longer survival times, measured over a continuously growing general population. In most of Sub-Saharan Africa, National HIV prevalence has either stabilized or is showing signs of a decline for example Kenya and Zimbabwe has all seen declines in national prevalence. In most of the

countries in East Africa adult HIV prevalence is either stable or has started to decline. The latter trend is most evident in Kenya where HIV epidemic has been declining amid evidence of changing behavior. National HIV prevalence in Kenya has decreased from 14% in the mid-1990s to 5% in 2012 (M.O.H.K, 2013, NACC, 2013). The downward trend was especially profound in the urban sites of Busia, Nyeri, Meru, Nakuru and Thika where prevalence declined from 20% in 1999 to 9% in 2005 and 29% in 1998 to 9% in 2002 among those aged 15-24 years (UNAIDS/WHO, 2013).

2.3 HIV/AIDS Orphans in Africa

Hussein (2008) reveals that of the total number of orphans in the word, 80 % of them are found in Sub Sahara Africa. In African countries that have already suffered severe epidemics, AIDS is generating orphans so quickly that family structures can no longer cope. Quieroz (2006) reports that the predominantly, Muslim north does not record very big numbers of orphans. In Egypt orphans are absorbed by the community and taken care of whereas Ethiopia is trying to de-institutionalize orphans through reunification and independent living.

Table 2 shows the number orphaned by AIDS in some of the worst affected African countries and the percentage of AIDS orphans to the total orphaned in certain badly affected African countries.

Table 2

Number of HIV/AIDS orphans in 2009, in Selected African Countries.

Country	Number (in millions)
Nigeria	2.50
South Africa	1.90
Tanzania	1.30
Uganda	1.20
Kenya	1.20
Zimbabwe	1.00
Mozambique	0.67
Malawi	0.65

(UNAIDS, 2010)

In some countries a large proportion of orphans have lost their parents to AIDS than to any other cause of death. Therefore, were it not for the aids epidemic, these children would not have been orphaned.

Table 3

AIDS Orphans as a Percentage of all Orphans in 2009 in Selected African Countries

Country	Percentage %
Botswana	72
Zimbabwe	71
Swaziland	69
Lesotho	65
Malawi	65
Zambia	53
South Africa	56
Kenya	46
Uganda	44

(UNAIDS, 2010)

Table 3 shows the countries in which the children who lost their parents to AIDS make up the highest proportion of the national number of orphans.

Gelder (2012), reports that 3.7 million children below the age of 17 have lost one or both parents to AIDS IN South Africa according to the 2011 census. Most orphans (64%) are in the care of grandmothers who bear the responsibility of a second motherhood. The age gap makes it challenging for grandmothers to connect with these children and warn them about HIV. Ascot (2012) attributes this to the legacy of denial and South Africa's failure to address the spread of HIV. He observes that the government has made an effort to avail a stipend for orphaned minors which make claiming of orphans attractive. He observes that some want to use the grant not in the interests of the orphaned children but for themselves. Suarez (2009) reports that, in resource poor regions, areas stricken hardest by AIDS pandemic, kinship care may not sufficiently serve the needs of AIDS orphans. Community based care models with appropriate government and community support preserving the family style and low child/caregiver ratio may constitute an

effective and sustainable care model for the best interest of the AIDS orphans in developing countries.

Yana, Poude and Jimba (2010) report that more than 1.5 million children under the age of 15 have been orphaned by AIDS in Uganda and 530,000 people are living with the virus. He reminisces that in the past people used to care for the orphans and love them but these days they are so many and many people have died who could have assisted them hence it is a common phenomena and not strange. The few who are alive cannot support them. He states that there is a large increase in the number of families headed by women, children and grandparents selling petty goods which do not suffice. He observes that older children caring for the younger siblings risk physical and psychological ill health and information need to be collected so that measures can be developed to mitigate the burden of orphans.

In Tanzania, the AIDS problem is escalated by the high number of refugees from war torn Cong, Rwanda and Burundi, giving it the largest refugee population in Africa. It has an AIDS prevalence rate of 9% and nearly 1 million AIDS orphans representing 40% of the orphaned population, (Madorivich, 2013). Gunderson 2012 reports that 70% of the AIDS orphans live in Sub Sahara Africa and observes that the numbers stun and then blur with time. He maintains that AIDS steal more than life, it steals the future.

The Nigeria Demographic Health Survey (2009) reveals that by 2009, there were 2.5 million AIDS orphans in Nigeria out of the 7 million orphans in the county. UNICEF (2010) observes that Nigeria has the largest burden of orphans in the world and weak social protection systems. It reports that with little or no social protection system, the children found it very difficult to cope with the risks of orphan hood with far reaching negative consequences especially for the girl child. Joulmes (2005) cites limited responsibility from the government with responses mostly confined to families and communities cannot cope with the increased number of orphans.

2.4 HIV/AIDS Orphans in Kenya

According to NASCO (2010) at nearly 8% HIV prevalence in Kenya is among the highest in the world and continues to grow. Between 11%-13% or about 2.5 million under the age of 15 are orphans and of these 1.5 million were orphaned by AIDS. Ramadhan (2009) indicates that as the

number of orphans varies between countries so does it between regions within those countries. Particular areas may have higher or lower percentage of orphans largely depending on the local HIV prevalence rates. There could also be a substantial difference between rural and urban areas. Moyoyo (2009) observes that according to the 2009 Kenya AIDS indicator survey, the lake region leads the country in AIDS prevalence with 15.3 % infection rate. A total of 1.4 million adults are infected with HIV in Kenya. The Lake Region, Rift valley and Nyeri County account for more than half of this number.

Human Immune-deficiency Virus (HIV) and acquired immune deficiency syndrome (AIDS) is a terrible epidemic occurring in every county in Kenya (M.O.H.K, 2013). It is responsible for deaths of 1.5 million people since the early 1980s.These deaths left behind more than one million orphans. About 500 people in Kenya die each day from AIDS. There is still no known cure and no effective, affordable vaccine. Estimates suggest over two million people out of a population of 29 million are infected. The cumulative number of deaths due to HIV/AIDS rose to 2.6 million by the end of 2012.

NACC (2013) estimated that about 65,000 people became infected with HIV in Kenya in the year 2010. HIV/AIDS kills people in the most productive age groups (25-49) years, majority of who are parents of school going children (G.O.K, 2010). This poses a serious threat to the children because most of the people who are dying are parents, leaving behind orphans. The scourge has left behind orphans and other vulnerable children often subjected to myriad complications and challenges for example lack of basic needs and poor education. It is with respect to this that the government and other stakeholders have designed policies to help guide collaboration and provide practical guidance in implementing strategies to empower families and communities to respond well to the needs of these orphans. However, well designed and implemented policies and strategies have not been adhered to hence the orphans are still in the web of poverty caused by HIV/AIDS (NACC, 2013) In return, this may have profound negative effect on education service delivery for all levels of education in Kenya (Kelly, 2005).

A study carried out by G.O.K. (2013), on the impact of HIV/AIDS in Kenya found that one of the worst impacts of HIV/AIDS was the death of young adults leading to an increase in the number of orphans. The report added that the number of orphans had reached 580,000 by the

year 2000 and increased to 2.6 million in 2013. NACC (2013), states that it is estimated that 11% of children under 15 years in Kenya are orphans, defined as having lost the only, one or both biological parents. However, there is considerable regional variation; the highest rate of orphans who have lost two biological parents is 6% in Nyanza province, 5% in the Rift valley and 4% in Nyeri County. It is estimated that around half of all orphans in Kenya are attributable to parental AIDS deaths.

The study found that those children who had been orphaned by HIV/AIDS lacked the proper care and supervision they needed. At family level, there was increased burden and stress for the extended family, which had the traditional mandate to care for the orphans (M.O.H.K, 2013). Due to this stress, the extended family was unable to provide sufficient care for the orphaned children. Mostly, grandparents were left to care for young children and some families in Kenya, were headed by children as young as 12 years old.

Many children who had lost their parents through HIV/AIDS were traumatized by the epidemic. The psychological trauma some of these orphans underwent instilled a feeling of despair on the part of the child. The children underwent a lot of psychological problems such as feeling of loss, emotional grief, denial, fear, low self-esteem, anxiety depression, lack of parental guidance and love (Odiwuor, 2006). HIV/AIDS orphans experienced the feeling of loss as they were left without parents they had always depended on for their livelihood. They also underwent denial; they didn't want to believe their parents had died from HIV/AIDS. The children also feared for their future, they did not know what was ahead of them or how to go about providing for them selves. Their self-esteem was depleted due to the stigma attached to HIV/AIDS and at times were treated as social misfits. This really depleted the orphan's self-esteem. The HIV/AIDS orphans also became depressed and anxious. They also lacked parental guidance and love especially if they didn't have a loving relative to foster them.

2.5 HIV/AIDS Orphans in Nyeri Sub-county

According to the Ministry of Health Kenya (2013), HIV/AIDS in Nyeri sub-county has far reaching effects in the whole sub-county from the household to sub-county level. It is estimated that 21% of the population in the urban areas are HIV/AIDS positive as compared to 18% in the rural areas. The age group 15-45 has been greatly infected by the scourge because it constitutes

the sexually active with women being the majority. This has resulted in high increase in number of HIV/AIDS orphans in the sub-county and loss of families' incomes which is directed towards addressing the pandemic in household. Many weekends are used for burials and many pupils are left orphaned with many homes closed down once the parents die. Most of the deaths are of young or middle aged parents who leave very young orphans, Nyeri Sub-county officer's office (2012).This has led to the creation of several children's homes that take care of the HIV/AIDS orphans like Mahiga children's home, KENWA children's home Mumbu-ini children's home among others. In these homes, the HIV/AIDS orphans are accommodated, feed and educated. Orphans are therefore assured of education and at least some food and a place to sleep. However, some greedy people use orphans to attract donor funding whereas they live in miserable conditions. Despite all this, many orphans still live with relatives and extended families or ageing grandparents, Nyeri Sub-county officer's office (2012).

2.6 Challenges of HIV/AIDS Orphan hood

Monasch and Boerma (2004) note that the loss of a parent to AIDS can have serious consequences for example a child's access to basic necessities such as shelter, food, clothing, health and education. These may also vary in relation to the developmental stage and other social factors that the child may present. Moreover, children orphaned by AIDS are more likely to require added emotional support from caregivers, (Zivor, 2007). This is said to be particularly true in sub Saharan Africa, where few support systems exist outside of families and where basic social services are largely inadequate. This lack of income puts extra pressure on AIDS orphans to contribute financially to the household and in some cases drives them to the streets to beg or seek food. There is a fear that they might come to constitute a lost generation of young people who have been marginalized and excluded for much of their life (Mwaniki, 2007).

Salaam (2005) observes that majority of children who have lost a parent continue to live in the care of a surviving parent or family member but often have to take responsibility of doing the housework, looking after siblings and caring for ill or dying parent(s). Evidence suggests that there is a relationship between AIDS orphans in Sub Sahara Africa and increased child labor.
Children who have lost one parent to AIDS are often at a greater risk of illness, abuse and sexual exploitation than children orphaned by other causes. They may not receive the health care they

need and often run a greater risk of being malnourished and stunted. Children may also be denied their inheritance and property and are then plunged into economic crisis and insecurity.

Families are in a crisis where children are taking on all the duties of getting their siblings fed, taken to hospital and getting them to school. Yana et al (2012) reveal that the greatest challenge for most orphans is loss of education due to lack of school fees or simply to look after sick parents. Morris (2012) indicates that orphans are likely to be poor and less healthy than non orphans. Their mental, physical and emotional development is likely to be stunted by the initial trauma and its resulting deprivations. Rotheram (2005)notes that bereaved children in a study carried out in South Africa had significantly more emotional distress, negative life events, and contacts with criminal system than non bereaved children. He observes that depressive symptoms, passive problem solving and risky sexual behavior were found to increase following the passing of a parent.

Tlou (2001) indicates that the orphans lose the feeling of security associated with home and their sense of direction. It is observed that even in cases where parents have been productive and have left assets the relatives squander everything. In some cases relatives may grab even the house in which the children are living in leaving them homeless. In cases where parents had left a will, it is normally disregarded as discussion of death in certain communities is a taboo. In Botswana, IRIN News (2004) notes that orphans are entitled to food rations. Those orphans who are left with nothing are just used by their caretakers to obtain food rations and not out of genuine care and empathy. This superficial concern and exploitation is likely to create a feeling of resentment among orphans.

The HIV/AIDS pandemic is not the only cause of disruption of the family support systems, and the resultant vulnerability and plight of orphans, three other causes are put forward. First, the monetization and modernization of the economy has led to a situation where extended family and clan ties are not as cohesive any more, and the spirit of voluntarism has been eroded. Second, the orphans seem to lack any legal baking to protect them against relations who are only interested in their diseased parents' estate, so that when the property is appropriated by relatives, the orphans are left with nothing. Third, as a result of weakening of traditional care system, there have been

temptations to go institutional. The institutions such as orphanages create the danger of stigmatizing children and abuse by the service providers. They uproot the children from their natural environments and are unable to provide the love, care and attention that the children need. Furthermore, they are expensive to run and do not offer a reliable solution in the face of the large numbers of the orphans created by the AIDS pandemic, (Chirwa, 2002).

Ljungvist (2003) observes that children grieving for dying or dead parents are often stigmatized by society through association experienced by children, both before and after the death of their parent(s) is strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV an AIDS. Because of this stigma, children may be denied access to schooling and health care. Once a parent dies, children may also be denied their inheritance and property. Often the children who have lost their parent(s) to AIDS are assumed to be HIV positive themselves, adding to the likelihood that they will face discrimination and damaging future prospects. Mosota (2010) reports that some orphaned children are mistreated and abused by their guardians in the hope that they will run away to either reduce the burden of care or pave way for disinheriting them.

Zivor (2007) observes that orphaned children absorbed into a fostering family were treated inferior to the biological children of the family. Many caregivers were also found I a study carried out in Kwa ZULU natal to be too young or too old to provide adequate care for the orphaned child. Due to the overwhelming demands of caring for an orphaned child, many families are only able to take in one child, resulting in separation of siblings. This separation places added emotional and psychological stress on the children. Many children hence opt for child-headed households to avoid this separation.

Hussein (2013) reports that in South Africa, discrimination of orphans exists even in racial lines, with one of the orphanages being described as ‘too white for donations’. They have 250 orphaned children between the ages of 8 months and 18 years of all financial support from large companies on account of the fact that 70% of them are white children who have been orphaned by AIDS. Suarez (2009) indicates that many orphans display symptoms of sleepiness and inattention that comes from hunger and acting out that follow the death of a parent. Many students come to school, just because they have an opportunity to be fed.

Outside school, AIDS orphans may also miss out on valuable life skills and practical knowledge that would have been passed on to them by their parents. Without this knowledge and basic school education, children may be more likely to face social economic and health problems as they grow up, Ljungwist (2003). Most of their caregivers still do not receive any type of external support in terms of healthcare, nutritional and psychological support (UNAIDS, 2010). Many times, the orphans do not understand what is happening around them because death is not discussed in the family. They suffer a sense of confusion as they may not understand their situation due to the trauma of loss.

UNICEF (2006) observes that the cases of orphans have completely overwhelmed the traditional caring systems and social workers are unable to reach them. Lewis (2003) gives a vivid account of the orphan problem encountered in a household in Zambia.

According to Zivor (2007) one of the most devastating social consequences of HIV is the extensive number of children orphaned by the AIDS illness. Typically, an epidemic places the greatest threat to the elderly of a population. However, the HIV epidemic is most likely to attack the productive age bracket and caregivers. As a result of the increase in orphaned children and escalating mortality rates among people in the reproductive years, an increasing demand is placed on the community for adequate childcare.

Mallman (2000) notes, when a parent has AIDS it causes children to worry the most. Children may be concerned about the parent dying or what will happen to them, they may feel pressured to tell others about their parents' illness and this may cause stigma and discrimination. Parents with AIDS may also have dramatic mood changes and may neglect their children. Children may not understand why their parents no longer show interest in them. Older children at school may worry about how their parents are coping in their absence and this may affect their performance at school.

Jackson (2002) observes that children feel lonely when a family is split by the death of one or both parents. They will be concerned about the resulting decrease in family income. Children will worry about who will look after them, what they will eat tomorrow and where the food will

come from. In cases of sibling separation, he recommends helping the pupils prepare a memory book, a diary that contains information and memories about the family. It is used to communicate with the pupil and helps bring the child's memories to life again. The counselor may address the pleasant memories but refer the unpleasant memories to a professional counselor. The memory book strengthens the sense of belonging to a particular family or genealogy.

Dooly (2004) observes that sometimes sick parents in an effort to protect their children do not tell them about their sickness so that they are ill prepared for the death. Children who are grieving often experience sadness, depression and their behavior may include crying, clinging, nightmares and aggression. One of the major problems when children are dealing with grief is that they are not given enough time to mourn and sometimes they are separated from their siblings. Parents also fail to leave wills because mostly it is considered a taboo to discuss imminent death and when they do, relatives disregard them in their rush to grab the deceased's property. According to Bellamy (2002) the silence that surrounds children affected by HIV/AIDS and the inaction that results is morally reprehensible. He notes that if this situation is not addressed urgently, millions of children will continue to die and tens of millions more will be further marginalized, stigmatized, malnourished, uneducated and psychologically damaged.
Children suffer so much when their parents become sick and pass away through AIDS. Their experience is often characterized by

2.6.1 Psychosocial distress

Children are psychologically traumatized by the illness and death of their parents. This change in children can cause them to show a range of behavior, during their grieving process. For instance they may regress which means they revert to an early stage, like wetting themselves or wanting to be fed (Turner, 1995). Ross (1994) as cited Sdorrow (2005) listed such behaviors that children may show namely; attention seeking and clinging, being withdrawn, inability to concentrate, aggressive behavior, temper tantrums, refusal of food and regression. As a result of parental death the children tend to seek psych-social support and satisfaction from as many peers as possible in turns enhances interpersonal relationships (Kiirya, 2003). This argument agrees with Erickson (1963) who said that children who are faced with loss of parents make up for

isolation by seeking social support from several people including fellow peers. This influences the HIV/AIDS orphans' academic performance and self-esteem.

Nabongo (1989) and Tagoboa (1993) indicate that HIV/AIDS orphans are sometimes stigmatized by fellow peer at school. Those who stay with their relatives are economically haunted by the death of the parents(s).This makes them to feel inferior, unworthy and believe that they should be or do better. Orphans are often sent out of school to collect fee and also lack collect scholastic materials, clothing and food. In primary schools such orphans feel inadequate and withdrawn and as a result this influences their academic performance and self-esteem.

2.6.2 Economic hardship

With parents unable to work and savings spent on care, children are forced to take on the adult role of supporting a family. Due to lack of family support there is low educational expectations of HIV/AIDS orphans and low prioritization of orphan's education over other children (ILO, 1992). Some children become caretakers and the feelings of need for dependency, are complicated by potential death of one or both parents (UNAIDS, 2012). According to gender and children affairs minister, the orphans represented the most vulnerable members of our society because they have no voice to defend their rights. Too often they are neglected, exploited and discriminated against.

2.6.3 Withdrawal from school

The pressures of caring for dying parents and other siblings by trying to earn an income can lead children to drop out of school, even while their parents are living. The pressure to abandon school intensifies when one or both parents die (Turner, 1991). Mostly girls in the upper classes take over the role of the mother to take care of the other younger siblings. This makes them stressed in life and is not able to concentrate in their class work which in turn makes them to withdraw from school. While in school, such orphans feel inadequate and withdrawn from the others and as a result this influences their academic performance and self-esteem.

2.6.4 Malnutrition and illness

HIV/AIDS orphans and other affected children are more likely to be malnourished or to fall ill and less likely to get the medical and health care they need. Poverty is the root cause of this

vulnerability, but often neglect and discriminated by adults in whose care they have been left are also contributing factors (WHO, 2005). Those orphans who lack or hardly get food may become mal-nourished and may suffer from diseases like Kwashiorkor and scurvy. These are HIV/AIDS orphans who are neglected by the relatives who are less concerned with them. In primary schools, many schools do not have feeding programmes for pupils and therefore the pupils either go home for lunch, or carry food to school. HIV/AIDS orphans who lack enough food and other basic needs wish their parents were alive and as a result this may influence their academic performance and self-esteem.

2.6.5 Loss of inheritance

When parents die, HIV/AIDS orphans are often cheated out of property and money that is rightfully theirs. Socially, the children may be discriminated against whereas greedy relatives at times deny them their rights of inheritance. Sometimes the children are forced to separate and shred out among relatives or move from the affluent urban areas to the poor rural areas (Appilla, 2000) as cited by Sdorrow (2005). This change of environment of home or even school affects the HIV/AIDS orphans' lifestyle and it takes time to adapt well. This in turn may affect their academic performance and self-esteem. Their concentration in class may be affected as they lack their parental support, guidance and love.

2.6.6 Fear and isolation

Dispossessed HIV/AIDS orphans are often forced out to unfamiliar and even hostile places, by the camps for the displaced or the streets. HIV/AIDS orphans who witnessed their parent(s) deaths are faced with intense fear that affects their emotional and intellectual development. Others have hallucinations and bad dreams where they see their parent(s) alive and talking to them. Others have very hostile relatives who mistreat them and isolate them from their family members. This makes the HIV/AIDS orphans to miss love they obtained from their real parent(s). Some step mothers and fathers are also mentioned as in the category of those who isolate these orphans from their biological children. The school performance of the orphans and social life therefore, may deteriorate to unresolved psychological trauma, lowered self-esteem and acute absenteeism (Richer, 2004) as cited by Sdorrow (2005)

2.6.7 Increased abuse and risk of HIV/AIDS

Impoverished and without parents to educate and protect, HIV/AIDS orphans face every kind of abuse and risk, including becoming infected with HIV themselves. Many are forced to turn to exploitative and dangerous work, including exchanging sex for money, food, protection or shelter. This becomes corporal punishment which has serious psychological effect to the children. According to Susan (1991) as cited by Sdorrow (2005), corporal punishment has serious psychological effect in which the victim or the witness of physical punishment develops. Neurotic reactions such as depression, withdrawal, anxiety, tension and in older children substance abuse, interference with school work and sexual behavior develops. This influences their academic performance and self-esteem.

2.7 Major influence of HIV/AIDS orphan hood on education

The World Education Forum in Dakar, Senegal listed six goals on Education for All. One of the goals was to expand and improve comprehensive early childhood care and education especially for the most vulnerable and disadvantaged children. Among the vulnerable group are the HIV/AIDS orphans in primary schools. In Kenya primary education is free in terms of tuition, but other learning materials and development projects are still left under the parents. Those HIV/AIDS orphans who have no one to care for them may absent themselves from school due to this factor. This may end up affecting their academic performance and self-esteem. Despite the commitment to promoting the health and learning of school children, progress on this front is seriously threatened by HIV/AIDS. The capacity to supply education has decreased where large numbers of teachers and other staff have become infected and affected of HIV/AIDS. Children leave school due to change in the families, social and economic circumstances particularly those children who are orphaned by HIV/AIDS. Equal opportunity is limited especially girls vulnerability to infection, particularly in high prevalence settings and where effects of poverty and other stressors on social are exacerbated by the low status of girl and women (UNICEF, 2002).

Just as HIV targets the body's defense system, the HIV/AIDS pandemic is disabling the sector core function and proactive value. Achieving education for all will require making HIV/AIDS campaign the highest priority in the most affected countries. As committed to in Dakar,

education system has a responsibility for ensuring the right of every child to good quality education and HIV/AIDS prevention must be considered an integral part of quality education. Schools need to ensure that they actively fight against harassment, violence, and sexual abuse of infected children and all HIV/AIDS orphaned children. Special security measures and behavior protocols must be ensured to protect the right of children and young people in education system. Schools must work to reduce discrimination of girls and young women faced at school, by enforcing appropriate laws that will protect this vulnerable group (USAID, 2013). If not, this factor of HIV/AIDS orphan hood will continue to influence their academic performance and self-esteem in schools.

2.8 Determinants of Self-esteem

The way our mind is tuned determines the acquired self-concept and self-esteem. For instance, if one believes that he is worthless and incapable of doing well in school so he thus performs poorly. According to Dainow (1992), social interaction particularly that of peers, determines the self-esteem one is likely to have. If one interacts with peers who happen to motivate him, he gets high self-esteem and vice versa (Adam & Gollalta, 1983). Cole (1993) states that self-talk determine self-esteem.

Self-esteem reflects a state of inner security or lack of security. It reflects confidence in ones capability. Adam and Gollalta (1983), states that boys have healthy self-esteem and self-perception than girls. In adolescence, self-esteem is likely to decline for both boys and girls. Santrock (1996) saw the determinants of self-esteem in adolescence as being: Parental positive perception for instance lack of parental interest is measured by interest in child for example lack of dinner conversation was predictive of very low self-esteem in adolescence as human beings and environment, (social and physical) for example school setting, changes of environment affect self-esteem.

Congour (1984) noted that social relationship as a great determinant of self-esteem. He said that under achievers had more difficulties in interpersonal relationship with peers, appeared less co-operative, more selfish dependable and less social. Santrock (1996) noted the following as determinants of self-esteem: scholastic competence, social acceptance, physical appearance, behavior conduct, close friendship, romantic appeal, job competence and global worth. Pelt

(1984) states that low self-esteem among children originates from negative comments from parents. Coon (1980) postulates that the development of self-image is highly dependent on information from the environment.

2.8.1 Parents' Influence on Children's Self-esteem

According to Rainey and Rainey (1986), parents are probably the greatest influence on the development of a person's self-esteem as they are the children's primary advocates and provide the first psychological situation in which the child must survive and thrive. In addition to this, Bornstein (1998), noted that childhood is the stage of life cycle when parents provide experiences that are believed to exert significant and salient influences because the parent's attitudes, feelings and actions are always recorded in the child's mind and form a basis of his or her self-image (Mruk, 1983). The level of self-esteem is a product of the extent to which the child was praised, encouraged or relentlessly criticized (Rainey & Rainey, 1986).

Moreover, children who are emotionally secure tend to exhibit a high self-esteem and vice versa Mruk (1983). The parents who withhold unconditional love and acceptance create a child who must perform to be accepted, and looks to others for the missing approval. According to Newman (1993), parents impact on the child's self-esteem in that any negative communication lowers their self-esteem. Those children who have experienced a lot of love and fair discipline have a high self-esteem. They accept themselves because they have been accepted as cherished beings by parents. Conversely, children who have been pushed around, ignored, physically abused, live in uncertainty and fear, as well as those separated from their parents for long periods, develop a low self-esteem. Parents who are permissive, over protective, or label the children as 'stupid', dummies, who cannot do anything right, lead children to develop low self-esteem.

Parents are also important in influencing career choices, which are products of self-esteem. If they encourage independence and provide emotional support, this makes the child more likely to make use of available information for good career choices (Gichuru, 2005).

Ambron (1986) examined the characteristic behavior of the parents of the boys in his study. He found that certain child rearing practices of the boys were related to high self-esteem in their parents. Such parents were more accepting and affectionate toward their children; they took an

interest in their children's activities and friends and were generally more attentive to their children (Ambron, 1986). However, these characteristics are lacking in HIV/AIDS orphaned children whereby the parent is absent, thus does not influence the self-esteem of the children positively.

2.8.2 Influence of HIV/AIDS Orphan hood on Self-esteem and Academic Performance

According to USAID (2013) children are likely to be faced with a range of material and psychological stress after the parents' death. These include disruption of schooling, relocation and increased household responsibility. Since many of these children live in families and households which are already at risk due to issues of poverty, family fragmentation or unsafe neighborhoods, parental HIV/AIDS death typically serves as an additional stressor that places a child's adjustment at a further risk.

In addition to this, the nature of the disease causing the death can also result in children experiencing multiple losses, as well as considerable uncertainty, stigma, secrecy and isolation. Children of parents who have died from HIV/AIDS are at greater risk for emotional and psychological problems than children whose parents have died from other cause and problems are more likely to manifest as internalizing behavior such as depression than externalizing behavior such as aggression (USAID, 2013). Moreover, these children may also under-report their symptoms and problems so that they remain masked from the attention of significant others in their environment. Mureah and Kiarie (2005) also state that the HIV/AIDS orphans were likely to grow up lacking suitable guardians and mentors and thus hinder general development. If children lacked mentors, they were unlikely to achieve high goals in education and in life. Thus, the death of parents almost always had a long-term impact on the orphan's lives.

According to USAID (2013), World Education Forum in Dakar Senegal, listed six goals of education For All (EFA). One of the goals was to expand and improve comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. Among vulnerable are the HIV/AIDS orphans in primary schools. In Kenya, Primary Education is free in terms of tuition, but other learning materials and development project are still left under the parents. Those orphans who have no one to care for them may absent themselves from school due to this factor. This may end up affecting their academic performance, social life and

discipline. According to the care takers of Mahiga and Red Cross children's homes, school fees for HIV/AIDS orphaned Pupils who are in the children's homes is paid by those in charge of the children's homes. Since they depend on well wishers, sometimes the school fee is not paid in good time. Consequently, they may remain out of school for sometime which may affect their academic performance.

According to Gichuru, (2005) various factors have been identified as possible cause for variation in academic performance among pupils. These includes the level of intelligence, students desire to perform in school, anxiety level of the pupil's discipline, home environment, learning facilities in schools, teachers' qualification and the nature of tests. In addition to these, research has also been done to show the relationship between the pupil's self-esteem and their academic performance. For instance, Marsh and Yeung (1997) found that self-esteem can influence academic performance. Moreover, Byrne (1990) had earlier showed that self-esteem was effective in differentiating between poor and good performing pupils. Harmuth (1994) also asserts that self-esteem and academic performance seem to be related. Moreover, Weiner (1972) suggested that self-esteem can influence a pupil's expectation about future success based on the pupils' past experiences.

In another longitudinal study examining a national sample of adolescents in the United states, it was found out that a link between pupils' test scores and grades with their level of self-esteem exist (Marsh &Yeung, 1997). This study found that the pupils who score well on tests tend to receive higher grades in school which in return leads to their having high level of self-esteem. Hence the relationship between self-esteem and academic performance seems to be reciprocal in nature, with each affecting the other.

2.8.3 Effects of High Self-esteem on Academic Performance

Ayier (2013) postulates that each of us wants to be successful in life, and one of the ingredients of success is health self-esteem. He observes that self-esteem is an important part of our personality and it predicts our performance in almost everything we do. Our levels of vitality, enthusiasm and personal magnetism are determined by our self-esteem. Lewis (2003) notes that, people with high self-esteem are positive, likeable and effective in every part of their lives. He equates self-esteem with the level of mental fitness and notes that self-esteem is measured by

how healthy and resilient one is dealing with the inevitable ups and downs in daily life. It also determines how much peace of mind and inner contentment one experiences. Ntata (1998) identifies how people with high self-esteem, although to continually strive to better themselves. People with high self-esteem, are motivated to challenge themselves and to see how much they can achieve and to continue work as on their deficiencies, as opposed to people with low self-esteem who act to protect their self-esteem through avoidance.

Yun (2001) describes self-esteem as a life skill which is a social competence used to cope with academic in order to meet fundamental challenges of forming stable human relationships and maintained hope about the future. Opolot (1997) defines self-esteem as a realistic evaluation of the self's characteristics and competences coupled with an attitude of self-acceptance and self-respect. According to Potter (2001) in a study carried out in Uganda, self-esteem has positive relationship with attitude towards education. The higher the level of self-esteem the more positive attitude is to education. When one has high self-esteem, one experiences excellent health and high level of energy. Our thoughts determine how we live and how we relate to life's challenges. According to Kweyu (2009) self-esteem is crucial and is a cornerstone of a positive attitude towards living. It is very important because it affects one's thinking and relation with other people. It affects ones potential to be successful.

2.8.4 Effects of Low Self-esteem on Academic Performance

Everyone at various times in their lives is vulnerable to attacks on their self-esteem. Zivor (2007) observes that, there is marked difference in how people with high self-esteem and people with low self-esteem react to these threats. The researcher reports that low self-esteem people tend to be more sensitive to criticism, and interpret these events as sign of inadequacy and rejection. She also found out that when faced with life stressors, such as financial stress, people with low self-esteem tend to be more inclined than people with high self-esteem to turn to alcohol as a means of coping with stress.

According to Zivor (2007) there are also large disparities between people wit low self-esteem and people with high self-esteem in terms of self confidence and self actualization. She reports that people with low self-esteem tend to view themselves as being less confident than people with high self-esteem. This negative self appraisal results in a self-fulfilling prophecy; because

they have low self confidence they are less inclined to explore new relationships and experiences, reducing the chances of positive feedback, and reinforcing the negative self-appraisal. As a result of their protective behavior and fear of rejection, people with low self-esteem approach live in a reactive way, unlike people with high self-esteem who are more proactive in their approach to life.

Perera (2007) observes that low self-esteem feeds one's negative thinking and makes one believe negative comments others make. Low self-esteem leads to poor confidence which also causes negative thoughts meaning that one is likely to give up easily rather than face challenges. It has a direct bearing on happiness and well being. Baron and Graziano (1991) reckon that research on self schemata suggests that individuals have a set knowledge that they use to interpret and remember social information about themselves.

One cause of depression is that the depressed persons have a large amount of negative bias. This facilities recall on negative information about the self. Negative schemata bias the way depressed people process information. They facilitate recall of negative experiences over positive ones and contribute to the negative expectations about future events. Clark Graham (2006) outline that, low self-esteem seriously impairs academic and job performance. It can lead to underachievement and increased vulnerability to many self destructive behaviors. These negative consequences themselves reinforce the negative self-image and can take a person into a downward spiral of lower and lower self-esteem.

According to Kaplan (2001) a deviant disposition can be conceptualized as the 'loss of motivation to conform to conventional patterns, and the acquisition of motivation to deviate from these patterns.' He further explains how deviant behavior is a result of rejection. However, constant attempts to 'fit in', which are met with constant rejection, result in the onset of protective behavior, so as to minimize the pain of rejection. The child abandons previous attempts to conform, and motivation shifts from conforming to deviating. This leads to poor performance in school or dropping out altogether.

Zivor (2007) reports that, youngsters with low self-esteem have frequently undergone unsatisfactory experiences in the conventional society, which has created painful feelings about their self-worth. Seeking to alleviate these feelings, may turn to the delinquent reference group to enhance their self-esteem. The delinquent group provides more favorable reflected appraisal, social comparison and self-attributions. Low self-esteem children who join deviant groups in an attempt to raise their self-esteem are at great risk of developing an unhealthy, unstable self-esteem. In their attempt to protect and maintain their desired self concept, the child may become caught in a deviant group that serves to boost their self-worth, the child instead develops an insecure view of the self and unstable self-esteem which is more dangerous than low self esteem.

Ausbel and Edmund (1980) report that rejected individuals have strong feelings for volitional autonomy but find it difficulty to assert themselves effectively in interpersonal relationships. They lack intrinsic self-esteem and suffer chronic anxiety. Ausbel and Edmund (1980) give the profile of a rejected individual as being alternatively described as shy, submissive and aggressive, quarrelsome, noncompliant and resistive to adult guidance. Without a secure home base, to which they can return, orphans tend to adjust less successfully than accept children to novel and stressful situations do. Children who are orphaned miss this essential socializing agent provided by parents. Low self-esteem can create stress, loneliness and increases likelihood of depression.

Kaplan (2001) observes that low self-esteem may be the result of a depressed mood, or may have been a vulnerability factor for the onset of depression. He indicates that low self-esteem has been associated with a number of other psychopathologies including mood disorders, personality disorders, anxiety disorders, schizophrenia, eating disorder, learning disorder, substance abuse and conduct disorders. According to Zivor (2007) the negative content of cognitions is also associated with low self-esteem, like pessimism, cynicism, uncertainty and weakness of conviction. People with low self-esteem view the future in a negative, fatalistic light, always expecting the worst and as a result never strive for better, they view daily stressors as being rooted in their identity, and as such, they do not see a possibility of overcoming and changing the outcome. These negative cognitions results in psychological distress and emotional vulnerability.

2.8.5 HIV/AIDS Orphaned Pupils' Self-esteem

Zivor (2007) reasons that, when considering the aforementioned stressors of AIDS orphans, the possibility of developing low self-esteem is high. Self-esteem is construct that significantly influences the quality of life of a child. It is concerned with an individual's global evaluation of their self worth and self efficacy. Correlates of high self-esteem are good personal adjustment, positive effect, managing stress, coping well with criticism, internal locus of control and personal autonomy. Low self-esteem has however been associated with poor psychological adjustment, mental health problems, like anxiety, depression, drug abuse eating disorders and suicide.

Gilbert (1992) argues that self-esteem was developed from a capacity for self awareness, motivated by social comparison. It is the collective experience of social comparative information and the position of oneself in a network. Bentall (2004) observes that negative self appraisal habitually results in lowered self-esteem which in turn is related to one developing a pessimistic attributive style. It results in negative appraisal of self, work and future. Gerald and Gerald (2005) postulates that a child's self-esteem is inevitably affected in the face of traumatic events. Self-esteem may play a vital role in the AIDS orphan's ability to adjust to their life circumstances and impact their quality of life and future.

The implication of an unhealthy self-esteem, experienced in conjuction with such adverse environmental factors of poverty, stigmatization, social isolation and inconsistent nurturance are potentially grave. This combination of an unhealthy self-esteem and negative environmental factors may result in such things as dangerous alcohol use, drug abuse and suicidal ideation or behavior. These may further influence school attendance, engagement in violent behavior and risky sexual relationship.

According to Salaam (2006), the physical needs of orphans such as nutrition and health care can often appear to be the most urgent. But the emotional needs of secondary school pupils who have lost a parent should not be forgotten. Having a parent becomes sick and die is s major trauma for any child and may affect them for life, IRIN News (2004). Secondary school pupils whose parents are living with HIV/AIDS often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually

they suffer the death of their parent(s) and the emotional trauma that results. They may have to adjust to a new situation with little or no support, and may suffer exploitation and abuse, Stein (2003).

Atwine, cantor and Banjuriwe (2005) report that in one study carried out in rural Uganda, high levels of psychological distress were found to be children who had been orphaned by aids. Anxiety, depression and anger were found to be more common among aids orphans than other children. In the study, 12% of aids orphans affirmed that they wished they were dead, compared to 3% of other children interviewed. USAID (2005) reiterates that these psychological problems can become more severe if a child is forced to separate from their siblings upon being orphaned. In some regions this occurs regularly. A survey in Zambia by USAID in 2006 showed that 56% of orphaned children no longer lived with all of their siblings.

Atwine et al (2005) observe that orphans had greater risk for higher levels of anxiety and anger and were sensitive to the presence of depressive disorder with negative symptoms like feelings of hopelessness and suicidal ideation. Gunderson (2012) reports that, a pastor from Namibia, gave him an instance of a mother in their church, who was diagnosed to be HIV positive. Her husband threw her out, away from her children, her birth family would not take her back and so she died in a box in the church. This definitely impacted negatively on the children and they started suffering psychologically when the mother was thrown out, they suffered from the breakup of the marriage, the isolation and stigmatization of the mother.

Yun (2001) observes that often, loss of a parent was observed as one of the most tragic and stressful events in a child's life. Instead of the child detaching him/herself from the loved ones and resolving the loss there was a greater attachment to 'the deceased parent resulting to denial of death. He indicates that previous studies conducted in Uganda showed that loosing a parent to HIV/AIDS for the adolescent was a more stressing process which was unfortunately shrouded with stigmatization, secrecy and shame. They experienced a double abandonment, one from the parents and the other from a society that shunned them for being associated with HIV/AIDS. According to Baguma (2000), a study in Uganda revealed that these negative factors drove teenagers underground as their coping capacities were stretched to their limits. They had to

maintain the precarious balance of continuing their normal routines while acknowledging that within several months or years, their parents were lost forever. The stigma attached to HIV/AIDS made the situation worse for girls orphaned by HIV/AIDS.

Ljungvist (2003) reveals that orphaned children suffer distress and social isolation before and after the death of their parents. This is strongly exacerbated by the shame, fear and rejection that often surround people affected by HIV/AIDS. In view of their genuine need for volitional independence, they resent any subservience to which they are subjected and may eventually, react explosively. Tlou (2001) reports that, orphans are exposed to a lot of negative occurrences, the worst being the loss of parent(s). This may predispose them to low self esteem because they may easily be preoccupied with sad, negative thoughts. Musau (2003) states that, students grieving for dying or dead parents are stigmatized by society due to HIV/AIDS. The students may have to deal with many psychological stresses which may have the effect of eroding their self-esteem.

Zivor (2007) indicates that low self-esteem does not appear to be the root cause of delinquent behavior in aids orphans, but is associated with them being less happy in life, and experiencing greater psychological distress. The researcher explored the needs and support required by HIV/AIDS orphans in their psychosocial development and found that depression, sadness and stigmatization were the primary influences on their psychosocial behavior. Low self esteem has also been shown to be a vulnerability factor to a number of psychological dysfunctions. In light of the negative impact that low self-esteem has on an individual's motivation for life, optimism for the future and overall emotional and psychological well-being, there is need to change self-esteem.

2.8.6 HIV/AIDS Orphans' Self-esteem Differences by Gender

Csete (2001) observes that there is increased dependence from the increasing number of orphans, reduced number of hours spent inn economic activities to take care of the ill and helplessness. The reduced family income is reducing the ability of OVC caregivers to keep students in schools. Salaam (2006) reports that losing parents to AIDS means that, orphans have to assume new roles and responsibilities, within the nuclear family as well as the extended family. Traditional roles, duties and responsibilities of family members like providing food, cooking or farming become

unclear as aids places additional demands and pressure on orphans. Many students result to child labor to fend for themselves and their siblings and in some cases the elderly grandparents, whom most of them stay with. Many aids orphans are deprived of the opportunity for moral, intellectual, physical and spiritual development as they are often mistreated, lured into sexual activities at early age or enslaved by their adopters leading to self-esteem, Odundo and Owino (2004).

Onyango (2004) reports that boy students are many times expected to take the responsibility of head of the family after the demise of both parents. They may have to drop out of school to seek employment in people's homes and farms to get food for their siblings. In Nyeri Sub-county some boy pupils fall victim to the wiles of widows who pay them for sexual services, Kokul (2005). Atwine et al. (2005) observes that this pressure to measure up to their parent's responsibilities sometimes makes the boys let out their frustrations on their siblings by being extremely harsh, abusive or dictatorial. Others resort to drinking, drug abuse or crime to counter their depression which causes low self esteem, or run away from home all together to towns to look for jobs due to inability to cope.

According to Njagi (2004) girls seem to be bearing the brunt of the burden within the home and are given more responsibilities and duties than boys as some are withdrawn from school and drafted into child labor. Musau (2003) gives an account of an orphan who had lost her parents at the age of eleven (11) and had to start taking care of her siblings. She observes that due to the trauma that orphans go through after watching their parents die, a new need arises that of counseling them. Reuters (2004) indicates that the likelihood of orphans especially girls remaining in school is of considerable concern. Emphasis on their being in school offers them the best chance of escaping extreme poverty and associated risks.

Epstein (2012) reports about a 17 year old South African girl called Phathiswe whose mother had a steady job, but when she became bed ridden in 2008 the girl had to struggle to look for work to buy her food. She had to drop out of school when her mother was unable to bear the jeers from neighbors who tormented her because of her HIV status and she had to move back to her rural home where she was born. Morris (2012) also gives an account of Medriatrice Kakiye (17) who

lost the mother to AIDS in 1997 and the father in 2000. Her major problem was that she was too young and had the responsibility of looking after five other children who were also young and it was difficult to get food.

Mwanzia (2009) indicates that girls normally find themselves doing the housework, looking after their siblings and caring for ill or dying parents. They are plunged into emotional and economic crisis and insecurity by their parent's death and this poverty pushes them into prostitution with older men hence the spread of the disease in the girls of ages 15-24. Epstein (2012) reveals that emotionally and physically abused girls are more likely to end up in abused relationships and that South African girls from homes affected by AIDS are six times more likely to engage in sex in exchange for gifts or money than girls who have lost parents to other reasons. Girls are therefore also in greater risk of becoming infected at a younger age than boys, because they are biologically, socially and economically more vulnerable which predisposes them to low self-esteem, stein (2003).

According to Amongin and Oonyu (2012), studies carried out in Ugandan secondary schools indicated that orphaned girl students were shy, timid, lacked confidence and were not usually part of the best ranked performers in examinations at most levels of the educational system in Uganda. They observed that education increased the orphaned girl students, self confidence and self-esteem. The study also observed that school drop out rates were higher among female students who were orphaned (6.6%) compared to males (6%). Most reasons for female students drop out were due to socio cultural reasons, including illness of parents due to HIV/AIDS, orphan hood due to HIV/AIDS or other causes.

Other socio cultural reasons according to Uganda Bureau of Statistics (2006) include the gender inequality accorded to girls. Boys were generally provided with opportunities to continue with their education uninterrupted while girls were usually requested by their families to stay at home and continue providing household services in the event of illness or demise of their parents. The study reveals that orphan hood due to HIV/AIDS has been one of the greatest effects of HIV/AIDS on school girls' education in Africa leading to school absenteeism during their parents' illnesses and emotional stress manifested in inappropriate behavior.

Information from the District Education Office indicates that in Nyeri South Sub-county there are total of 628 girls against 834 boys who are orphaned in secondary schools, Nyeri SEO Guidance and Counseling Report (2012). This indicates that girls tend to drop out to take care of their siblings or to get married. With poverty index of 47% according to information obtained from the District Commissioner's Office (2010), the plight of the orphaned girl cannot be gainsaid.

2.8.7 Effects of Duration of Orphan hood on Self-esteem of HIV/AIDS Orphaned pupils

Ausbel and Edmund (1980), observe that the most important consequences of early parent child relations has been the pronounced tendency for influencing children's later interpersonal relations with peers and other adults. This reflects the influence of social attitudes, expectancies and adjustive techniques experienced in dealing with their socialisers, their parents. To children, the world of interpersonal relations is completely unstructured. It is most natural for them to use the model provided by their parents and to employ adaptive techniques previously utilized in the home situation. Children's social behavior is also profoundly affected by whether or not they have undergone satelization, which in turn is an outcome of the parent-child relation. To satelizing children, group members provide derived status and constitute ego support. They experience a certain spontaneous joy and enthusiasm in-group activity that follows from the 'we feeling' associated with group relatedness (Ausbel & Edmund, 1980)

Baumman (2002) explored the behavioral problems of school aged children with mothers infected with HIV. He observes that children of such mothers were more likely to experience both behavioral and emotional problems presenting with such things as aggressive behavior, and a depressed mood. This intensified if the mother experienced greater psychological distress. Target (2004) underscores that developmental delays and psychological vulnerabilities in later life are strongly associated with maternal neglect in earlier years. Early loss of parents threatens the child's ability to develop age appropriate activities that nurture psychological, developmental and acquisition of cognitive skills.

Monasch and Boerma (2004) observe that students who loose parents earlier in life lose the basic parent child bonding and may go through a lot of deprivation in terms of access to basic

necessities that may make them grow up to be bitter and suspicious. Mishra and Arnold (2005) outline that they may tend to be very independent and may find it difficult to get into strong relationships due to the mistrust developed earlier. Mwaniki (2007) concludes that death or incapacitation of the parent robs them of the opportunity to grow up in a stable family setting which is essential for every child.

Anywar (2010) indicates that orphans who loose parents later in life tend to take longer to adjust since they may have got used to a particular lifestyle that is likely to change with the demise of the parents. Those who are adopted by relatives and other caregivers ted to find it more difficult to adjust as they may find themselves having to endure different rules and regulations or having to make do with less than they had before. The pain of watching the parents through their final stage of the disease and the stigma of the disease is also likely to be more pronounced Njagi (2004)

2.9 The Role of Guidance and Counseling Programme in Schools in Kenya

Guidance is the process through which a counselor directs or guides his/her clients to make choices in life. It is counselor centered and the client listens to the counselor. Pupils have problems related to themselves, their parents and family, their friends and teachers. Some may have disappointing memories related to home or family like death of a parent. Parents could leave their children with a feeling of insecurity and incompetence, when they fail to live up to their expectations. In case of HIV/AIDS orphaned pupils unhappy relationships at home with relatives and maltreatment, lack of sense of belonging and mental disturbances require expert guidance. Pupils also face difficulties when changing schools and when getting involved in new social situations that require guidance so as to adjust properly (Ndambuki &Mutie, 2006). Counseling on the other hand is the process where a client is helped by the counselee to make the right choice out of the many options available. It is client centered and he/she pours out his/her problems while the counselor listens and empathizes. However, the two processes are interrelated and both help the clients to make right decisions in life. Counseling may be more concerned with addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflicts or improving relationships with others (Ndambuki & Mutie, 2006)

According to Salvina (1984), most of the traditional African customs have been done away with and the youth spend most of the time at school. U.N.E.S.C.O, (1988) noted that changes have been experienced which has resulted to the weakening of the structures of society. Mugambi (1989) summaries the role of the community as an agent which prepared the youth socially, psychologically, emotionally, physically and religiously for the next stage in the community. According to Mutie and Ndambuki (1999), guidance and counseling help the pupils perform in their academic work. Siezer (1999) also feels that the young have emotional problems and need help. Effective therapy relationship requires respect and trust between the therapist and the client which is ideal in a teacher student relationship. The teacher fits in very well as a counselor or a helping person.

The government has declared HIV/AIDS a national disaster. For the youth to be safe from this scourge the teacher in school must guide them safely. This calls for a functional guidance and Counseling department in school which can guide students and help the affected. Some students have lost parents and relatives through HIV/AIDS and it is very hard to live with this problem. Currently, there are cases of pupils infected with HIV/AIDS in schools (Muraah & Kiarie, 2001). All these students require appropriate help in order for them to perform well and grow up to face adulthood. Such help cannot be given by an ordinary teacher but requires skilled personnel (Seizer, 1999).

In order to help children cope wit academic pressure, teachers need to notice and assist pupils with each of the following or any combination of the following which could exert pressure on children; a demanding educational system and school, pressure from parents/guardians and other peers and stressful family situations in case of HIV/AIDS orphans. A society that over emphasizes academic excellence puts a great deal of pressure on weak pupils. This pressure could lead to anxiety, depression, nervousness or mental breakdown. A child who is under pressure may exhibit these symptoms sadness, hopelessness, moodiness for a long period, eating and sleeping disorders, physical problems, suicidal thoughts and actions and social change (Tumuti, 1995), This influences on The HIV/AIDS orphan’s academic performance and self-esteem.

A famous study carried out by Professor Michael of institute of psychiatry in London, this that 2% of school children and 5% of adolescents suffer depression most of them neglected orphaned pupils (Dabson 1992). He found that in a primary school with 500 pupils, 10 will suffer from depressive illnesses requiring medical attention. Some younger children suffering from depression are dismissed by teachers and parents as simply odd or silly. Stress not only affects emotional development but has also shown to impair Physical growth. Gichinga (1995), in his study noted, children who experience stressful life events stated in this case include parental separation, serious illness or injury of the parent, hospitalization, death of a parent or frequent move of the home. Since HIV/AIDS are in this category, their academic performance and self-esteem is affected. Therefore, teachers and guardians should identify such children and offer guidance and counseling services in order to cope with their state of orphan hood.

Harold, (1995) observes that children need parents who can be trusted and whom they will share their problems of growing up. HIV/AIDS orphans do not get any parent closer to share their problems with hence they behave abnormally. Knox, (1895) explains that children need an authority who will teach them the social skills and work habits needed to survive in society when there is intimate bond between parents and child benefits accrue.

The school is important not only because of education information provided, but it is a social setting where individuals can share common experiences and interests. Mullis (1992) views a school as a way of shaping personality and social development of children including levels of self-esteem. It offers a lasting ground for ideas and discussions along with the opportunity to engage in decision-making strategies. This was the related literature that was reviewed and it was of great relevance to this study.

2.9.1 Role of Guidance and Counseling in Building Self-esteem

Mosta (2010) observes that due to the upheaval that orphans go through from the time their parents get infected to the time they die, a new need arises, that of counseling them. It is apparent that most organizations have concentrated on offering the orphans material assistance and ignored their psychological needs. This is a group of children who have had to endure more than

they can handle, and every effort needs to be made to help them cope with the challenges of life, Mwaniki (2007).

According to Atwine et al. (2005), the community needs to be supportive of children when they are orphaned, making sure that they are accepted and have access to essential services such as health care and education. This means improving existing services and reducing the stigma surrounding children affected by HIV/AIDS so that they do not face discrimination when trying to access these services. IRIN News (2004) indicates that it is crucial that orphans be kept in school. Education can act as a safety net in the child's life. A good school education can give children a higher self-esteem, better job prospects and economic independence. As well as lift children out of poverty, such an education can also give children a better understanding of HIV and AIDS, decreasing the risk that they will become infected. Schools can also offer emotional support and care for AIDS orphans through counseling, Onyango (2004).

According to Ayier (2013) counseling pupils who are infected and affected by HIV/AIDS requires the caregivers to observe good ways (principles) when providing counseling. The counselor should establish a helping relationship with pupils so that they can gain their confidence. They should also help them tell their stories and listen to them attentively. The counselor should be in a position to give tem correct and appropriate information and also guide them to make informed decisions. The counseling process should help them identify and build upon their strengths and also to develop a positive attitude to life, Mutie and Ndambuki (2001).

Fox (2001) notes that this may help orphaned pupils cope with the challenges and emotions that they experience when they discover that they are either infected or affected by HIV/AIDS. Counselors should have accurate information about HIV/AIDS so as to be able to pass it on to the pupils. Fear and uncertainty regards to HIV/AIDS is rampant and there is a lot of negativity in attitudes, cultural beliefs and practices. Some people still believe that one can get AIDS by shaking hands or sharing beds with infected people including children and these results in stigmatization. These misconceptions and fallacies about HIV/AIDS sometimes isolate pupils. Counselors should deal with these misconceptions and false beliefs about HIV/AIDS.

According to Dooley (2004) counselors need to be aware of some of the commonly asked questions about HIV/AIDS. It is important to clearly outline modes of transmission, what cannot cause it and preventive measures recommended for pupils. Different cultures and societies have different views, beliefs around HIV/AIDS and sex. These cultural factors affect the way people will act on issues surrounding HIV/AIDS and those affected or infected. Some of the factors are harmful while others are helpful. A counselor should be aware of the factors and be able to identify harmful and helpful factors and how to influence harmful beliefs and practices to make positive changes.

According to Ayier (2013) some communities believe that initiation ceremonies for girls who have come of age should involve having sexual intercourse with selected men from the community. These are people who believe that condoms reduce sexual satisfaction or that they can cause cancer of the cervix or that a man should have unprotected sex with his pregnant wife too allow for normal gestation and smooth delivery. There are also beliefs that when one spouse dies, the surviving partner should be forced to have unprotected sex with a relative of the diseased spouse for sexual cleansing or that when a spouse dies, the surviving spouse should marry the relative of the diseased. All these have negative or positive effects on the fight against HIV/AIDS.

Ayier (2013) some beliefs on HIV/AIDS infections border on absurd; like, one can get cured from HIV/AIDS by sleeping with a young boy or girl; or that one cannot get AIDS from circumcision or genital mutilation using one blade among many people, or the practice by many traditional healers of tattooing many clients using the same razor blade cannot cause HIV/AIDS; that children infected and suffering from HIV/AIDS can easily spread it to family members, that sexually transmitted diseases cannot affect nice women or that HIV positive people are promiscuous. Some of the above beliefs promote HIV/AIDS infection and others encourage isolation of those infected or affected.

Ayier (2013) pupils who hold harmful beliefs and follow harmful practices need help to change their attitude and beliefs so that they are more positive and helpful. The counselor should promote open discussion between adults and children. Fox (2001) gives different ways by which

orphaned pupils can be helped. There should be an open discussion between adults and pupils about matters related to HIV/AIDS. In this way correct information on HIV/AIDS can be disseminated to pupils so that they can make informed decisions. Pupils should be listened to and involved in decisions that affect them. It is also important to involve the entire pupil's community to provide emotional support to those infected or affected by giving all of them adequate information to clear the misconceptions.

According to Demo (2001), it is important that the entire pupil's body is mobilized to provide emotional support for those infected or affected to reduce the stigma and discrimination. The counselor should share information and clarify issues about HIV/AIDS and its impact on the school community should openly discuss events around AIDS and its effects and should also be involved in planning how they could provide support for those infected and affected pupils.

Salaam (2005) recommends that pupils should be encouraged to discuss the fears and issues that worry them with their relatives, family, friends, and church groups among others with whom they feel secure. Pupils should be made to understand that enough rest, sleep, prayers and simple exercises like jogging and dancing are helpful when dealing with trauma and emotions. More care need be taken when counseling pupils because they find it more difficult to understand their fears and emotions. Pupils at their adolescent age also generally feel embarrassed when talking about HIV/AIDS because it is generally linked to sex, a subject that is culturally sensitive and that children are not supposed to talk about.

Hussein (2008) points that, once a pupil has opened up and disclosed a sick parent, the counselor can discuss the issue of writing a will with them to hear their views and then encourage them to discuss with their parents. The counselor may also find a way of discussing the same with the parents to prepare a will which leaves assets to their children. The counselor can also find out the organizations that exist for protection of children in the community so that they can be approached for assistance. The counselor may use available referral systems and care networks to cater for ill pupils and parents, the NGOS and church groups that can help with fees.

Ayier (2013) school counselors should adopt certain approaches to enable them deal effectively with challenges facing orphaned pupils. They should begin by coming down to the level of the pupils and establish a good relationship. In starting the counseling session, they should start with something easy to talk about or find a relaxing activity to do with them, like sports or drama, stories or games creativity is necessary to assist in keeping and maintaining their interest and threats should not be used under any circumstances. The counselor needs to gain acceptance of the pupils seeking counseling. According to Jackson (2002) in some cultures where children are not allowed to reply to adults. Pupils tend to react with suspicion or resent an adult who may be trying to talk or listen to them. In this case, the counselor should engage the pupil in action oriented techniques like play, drama, drawing, song, story telling. All this time the counselor should observe the pupil for non-verbal signs in order to determine how they are feeling.

Kweyu (2009) postulates that in Anhui province central China, a group of community based counselors have been trained to provide group counseling sessions focusing on self awareness and communication to provide basic therapeutic approach for depression and anxiety. The author conducted a baseline and two follow up surveys of 36 children who met clinical diagnostic criteria for depression. There was a statistically significant improvement on depression, with greater gains immediately following the intervention. The author demonstrated the feasibility of task shifting for mental health services in this setting.

Hussein (2008) cites several strategies for counseling youth orphaned by AIDS. He feels that other family members, friends and neighbors should be incorporated to help the orphaned pupils deal with the emotions and challenges they face. They also need help when dealing illnesses of parents or relatives, and coping mechanisms to deal with the stigma and discrimination. This should prepare them well for death so that when it is an eventuality they can learn to accept it. The counseling session can also help orphaned pupils to cope with issues of livelihood to enable them meet basic needs.

According to Zivor (2007), from a humanistic perspective, everyone is entitled to a positive self regard, it is the natural birthright of all humans, a gift, and it is from this standpoint that the view is held that respect, nurturance and trust are seen as key to self-esteem enhancement. Increasing

self regard also greatly depends on achieving goals and developing a sense of competence. Self-esteem enhancement should therefore include giving praise where it is due, encouraging the creation of meaningful activities and setting challenges for learning and growth. Pupils should be encouraged to set goals and to take responsibilities for attaining them. Enhancement programs should aim at guiding children through failures and to persevere despite these setbacks. Zivor (2007) maintains that self-esteem enhancement that is based on these outlines will help establish health, stable self-esteem which is built on both competence and positive self regard.

2.10 Theoretical Framework

The researcher employed two theories in the study namely, Information processing theory and Abraham Maslow hierarchy of needs theory.

2.10.1 Information Processing Theory

This study was based on information processing theory that view the processing of memories as involving encoding, storage and retrieval of information like that of the computer. Information processing theory was developed by Schifrin and Atkinson (1969).This theory assumes that, memory involves the processing of information in three successive stages. Sensory memory is the first stage of memory that briefly, for at most a few seconds, stores exact replicas of sensations. This is adoptive because it allow us hold information for long enough to attend to it for further processing.

When the information in sensory memory is attended, it is transferred to short-term memory. This stores it for only twenty seconds unless it is rehearsed. Then the information is transferred to the log-term memory, which is durable and can be stored for lifetime. This explains why a child can be able to recall early childhood memories following loss of parents. Encoding is the conversion of information into a form that can be stored in memory. Information in ones memory is stored in codes that one's brain can process. Storage is the retention of information in memory, whereby in humans, information is stored in the brain. Retrieval is the recovery of information from the memory. We rely on cues to retrieve memories that have been stored in the brain.

HIV/AIDS orphan hood therefore, means a child underwent the three stages of memory processing. According to Turner (1995), the deepest felt and most irreplaceable loss experienced

by any orphaned child, is the loss of parental love. Although it is often thought that children recover easily from bereavement where they start to play and smile again, these appearances are deceiving. Grief and depression are hidden, and often remain unrecognized, leading to expression through behavioral disturbance since they store it in the long-term memory. This is because it influences the child's academic performance and self-esteem. Such children have flush bulb memories.

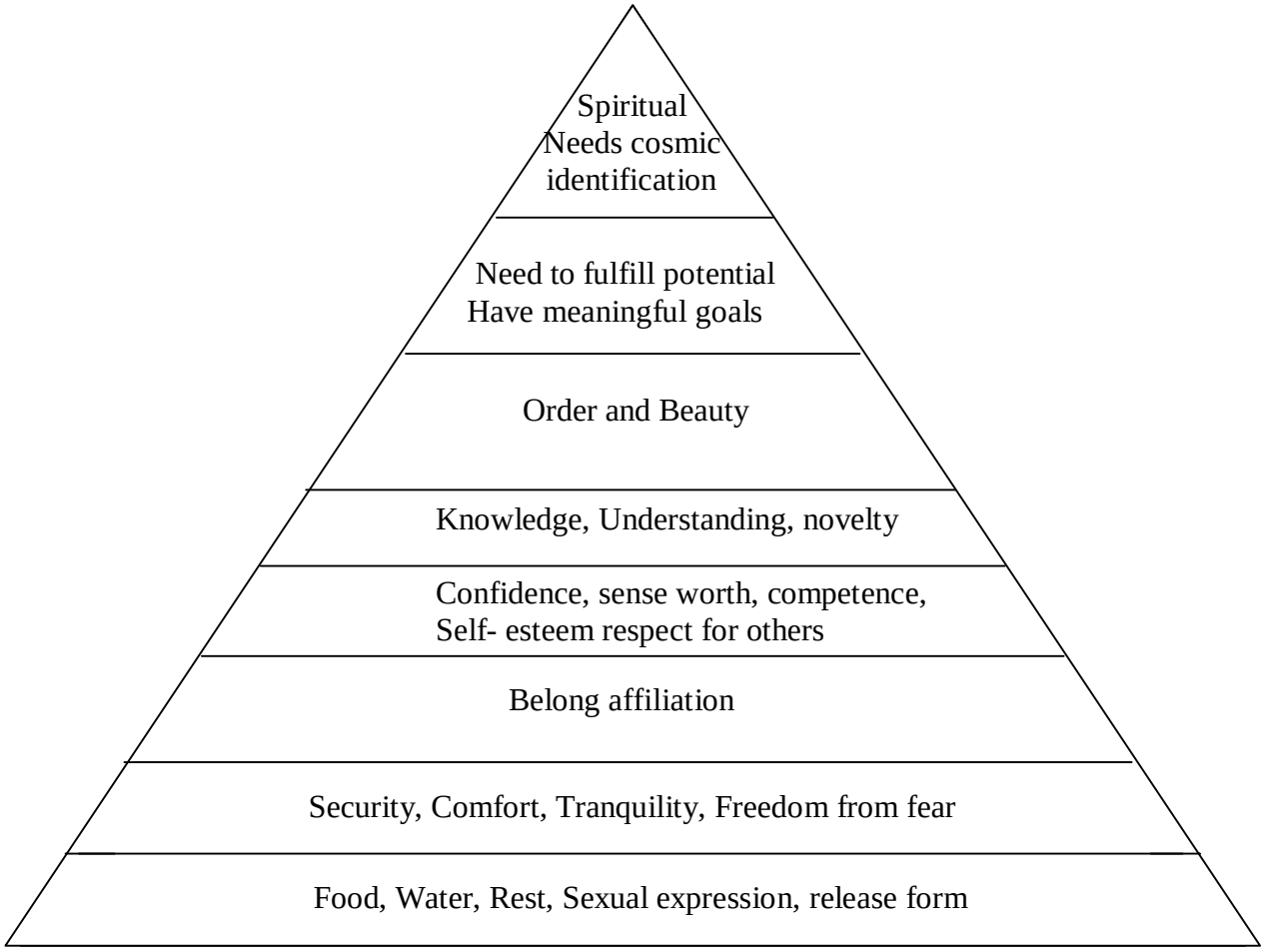
Brown and Kulik (1977) as cited by Sdorrow (2005), define flush memories as a vivid, long lasting memory of surprising, important, emotionally arousing event. People with flush bulb memories of events may recall where they were, what they were doing, how they were told, how they felt about it and even trivial things that occurred shortly afterwards. This applies to orphaned children who recall the traumatic death of their parents if at all they witnessed or were told.

2.10.2 Abraham Maslow's Hierarchy of Needs Theory

Maslow (1954) did a study on human nature and came up with the conclusion that human beings have an innate tendency to move towards higher levels of health, creativity and self-fulfillment. Maslow's theory holds that basic needs form what he called a hierarchy of needs. It stipulates that basic needs are arranged in a sequence, basic ones are biological needs also known as physiological needs such as hunger, shelter and thirst. According to Maslow, needs at the lower level of the hierarchy dominates an individual's motivation as long as they are unsatisfied. Once these needs are adequately satisfied, the high needs occupy the individual's attention. When we have enough safety and are no longer concerned, we become motivated by attachment, the need to be loved and to love also to belong. If satisfied, then go to esteem needs namely confidence, sense of worth, competence and the need to be appreciated. On satisfying the esteem needs, we pay attention to cognitive needs, the aesthetic needs which give rise to the creative aspect of human beings. At the top of the hierarchy, are people who are nourished, loved, loving, secure, thinking and creative and their quest is self-actualization or the need to develop to the fullest ability. According to Maslow, the needs are the major motivating factor in life and every individual experience the needs at a certain level. Those whose basic needs are not met are never

able to move up to higher needs. In Maslow's hierarchy of needs, human beings move from physiological needs towards psychological needs.

In relation to the researcher's study, the researcher found the theory relevant in inclusive education. HIV/AIDS orphaned children may not have enough physiological needs and this is likely to affect their self-esteem and also their academic performance. At an early age, children are dependent on adults that are parents and guardians to meet their needs. HIV/AIDS orphaned children who lose their parents at an early age may not be able to meet even the most basic of the needs and these may stop them from developing to the next level unlike children with both parents who may be able to move to higher levels of Maslow' hierarchy. This can be illustrated using figure 1.



Source: Adopted from Abraham Maslow, (1970) Motivation and Personality, end ed. (New York: Harper Row.

Figure 1: Maslow's Hierarchy of Human Needs

In addition to the theoretical framework, the relationship of the variables in this study can be shown using a conceptual framework as shown in figure 2.

2.11 Conceptual Framework

The variables of the study can be conceptualized through figure 2.

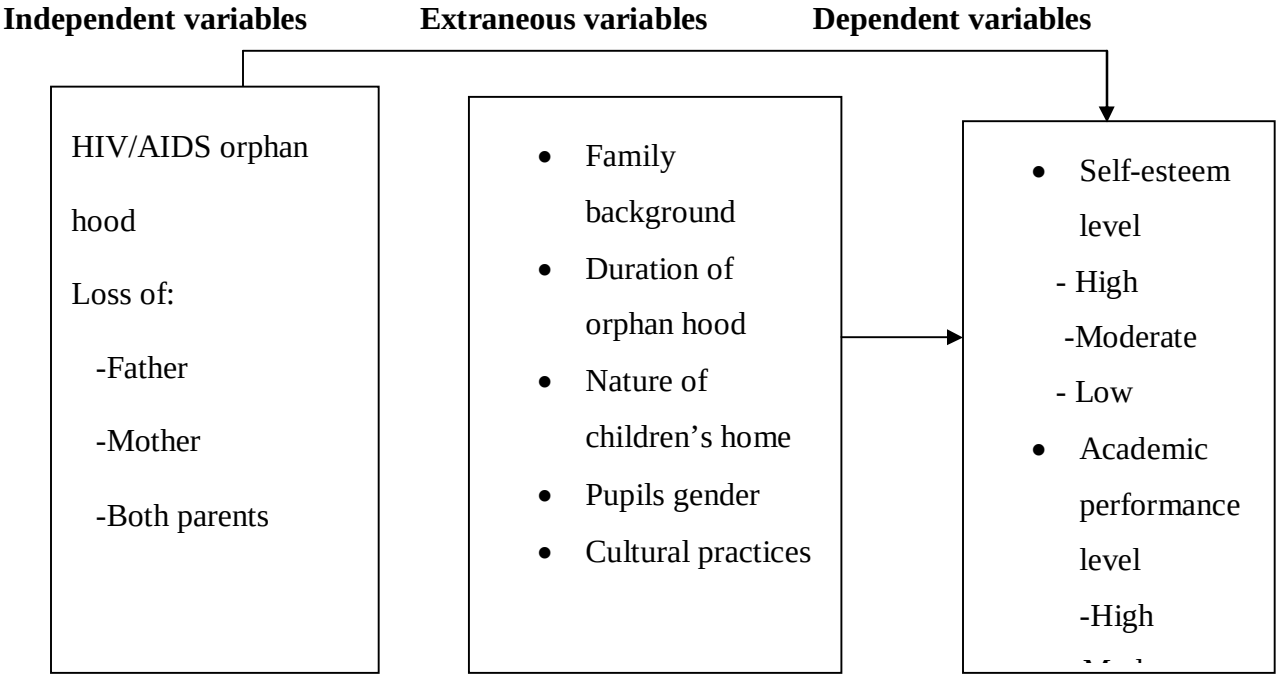


Figure 2: HIV/AIDS Orphan hood, Self-esteem and Academic Performance.

The independent variable is HIV/AIDS orphan hood which was expected to have a direct impact on self-esteem and academic performance. Therefore, HIV/AIDS orphan hood was the independent variable while self-esteem and academic performance were the dependent variables. However, there were extraneous variables that may also affect self-esteem and academic performance which includes family background, duration of orphan hood, nature of the children's home, pupils' gender and cultural practices.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section presents research design, the target population, sample of the study, research instruments, the validity and reliability, data collection, analysis procedure and summary of data analysis.

3.2 Research Design

The study utilized the descriptive research design. The researcher collected a set of data regarding the students' self-esteem and academic performance levels. Again, in this research design no treatment was given to the respondents before collecting data from them. The data that was collected was already in existence. It had occurred naturally, thus the variables of the study were not controlled as their manifestation had already occurred (Gall, Borg & Gall, 1996; Mugenda & Mugenda, 1999).

3.3 Location of the Study

The study was carried out in Nyeri South Sub-county of Nyeri County, Kenya. The location was chosen because it was convenient in terms of available resources. The district had ten children's homes: Africa Inland Church Mahiga, Kenya Red Cross Center, Karatina, KENWA and Tumaini (Riamukurwe), Positive Living, Bewomi, Mumbu-ini, Ebenezer and Wamagana. Some Homes are caring for HIV/AIDS orphans which the study was interested in.

3.4 Population of the Study

The population of the study was 190 HIV/AIDS orphaned primary school pupils in the children's homes in Nyeri South Sub-county in class six to eight. The District had 10 children's homes out of which five of them had HIV/AIDS orphaned pupils as shown in Table 4.

Table 4

Population of all HIV/AIDS Orphaned Pupils and other orphans in Ten Children's Homes in Nyeri South Sub-county

Name of home	Caretakers	HIV/AIDS orphans	other orphans
A.I.C. Mahiga	1	53	73
Kenya Red Cross Center	1	11	33
Karatina	1	25	80
KENWA	1	59	0
Tumaini (Riamukurwe)	1	42	52
Ebenezer	1	0	50
Positive living	1	0	23
Bewomi	1	0	42
Mumbu-ini	1	0	20
Wamagana	1	0	98
Total	**10**	**190**	**471**

Source: Children's homes coordinator's office (January 22, 2013)

The accessible population of the study was 53 HIV/AIDS orphaned pupils in standard six up to standard eight in five children's homes as shown in Table 4.

Table 5

Accessible Population of the HIV/AIDS Orphaned Pupils in five children's homes and Caretakers in the Five Selected Children's Homes in Standard 6-8, in Nyeri South Sub-county

Children's Homes	**HIV/AIDS Orphaned pupils**	**Caretakers**
A.I.C. Mahiga	12	1
Kenya Red Cross	4	1
Karatina	7	1
KENWA	19	1
Tumaini	11	1
Total	**53**	**5**

Source: Children's homes coordinator's office (January 22, 2013)

3.5 Sampling Procedures and Sample Size

Since the accessible population of the study was small, all the 53 HIV/AIDS orphaned primary school pupils in class six to eight from five children's homes were selected because they could understand the items. Also, the researcher purposively selected five care takers, one from each of the five children's homes as shown in Table 6.

Table 6

Sample Population of the HIV/AIDS Orphaned Primary school pupils and Caretakers in five Children's Homes in Standard 6-8, in Nyeri South Sub-county

Children's Homes	**HIV/AIDS Orphaned pupils**	**care takers**
A.I.C. Mahiga	12	1
Kenya Red Cross	4	1
Karatina	7	1
KENWA	19	1
Tumaini	11	1
Total	**53**	**5**

Source: Children's homes coordinator's office (January 22, 2013)

3.6 Instrumentation

The researcher used two questionnaires; one for HIV/AIDS orphaned pupils and the other one for the caretakers. The questionnaire for HIV/AIDS orphaned pupils had four parts: Section A, B, C and D. Section A had items that sought the orphan's biographic data. Section B had items that sought the respondent's information such as academic performance and section C had a self-esteem inventory and section D an academic performance scale. The questionnaire for the care takers had one part with items on the name of the children's home the orphans' self-esteem and academic performance. Mugenda and Mugenda (1999) say that questionnaires are suitable in obtaining important information about the population. The researcher used questionnaires since they were suitable to collect information from a large number of respondents. According to Kahn (1992), questionnaires enable the person administering them to explain the purpose of the research and give the meaning of the items that may not be clear.

3.6.1 Validity of the Research Instrument

According to Orodho (2004), validity refers to the extent to which an instrument measures what it is supposed to measure. The research developed the instruments in line with the objectives of the study. After developing, adopting and modifying the research instruments, the content of the instruments was validated by supervisors and research experts in the Faculty of Education and Community Studies of Egerton University.

3.6.2. Reliability of the Research Instruments

According to Orodho (2004), reliability is the consistency of an instrument to yield the same results at different times. The researcher subjected the instruments to piloting before the actual study commenced. The pilot study was done in two children's homes in Nyeri North Sub-county Piloting was aimed at estimating the reliability coefficient of the research instrument. In determining the internal consistency of the item, Cronbach's coefficient alpha which is a general form of Kuder-Richardson (K-R) 20 formula, was used. The piloting results indicated that the items on the instrument about orphans, academic performance and self-esteem yielded 0.86 and 0.82 respectively. These coefficients were considered acceptable and reflecting the consistency levels with an overall reliability of 0.84. The researcher used Cronbach's Coefficient to estimate the reliability since it can asses multiple response items (Kathuri & Pals, 1993). A reliability coefficient of at least 0.7 is considered acceptable (Fraenkel& Wallen, 2000). The higher coefficients implied that the items correlated highly among themselves and that there was consistency among the items in measuring the pupils' orphan hood, academic performance and self-esteem relationships. Thus the instrument was considered reliable.

3.7 Data Collection Procedure

Before the start of the research, the researcher sought research permit from the then National Council for Science and Technology which is currently the National Commission for Science, Technology and Innovations. Once the permission was given, the researcher visited the five children's homes with a letter of introduction and explanation for the purpose of the study. The researcher in conjunction with the care takers of all the participating children's homes set the date for collecting data. On the set date for each home, the researcher took the questionnaires to the pupils with the help of the care takers in the children's homes for the purpose of identifying the HIV/AIDS orphaned pupils. The five caretakers were also given their questionnaires. The

questionnaires were collected immediately after the pupils and the caretakers filled them. The questionnaires were given serial numbers for the purpose of identification and follow-up.

3.8 Data Analysis

According to Kerlinger (1973), data analysis is categorization, ordering, manipulation and summarizing of data to obtain answers in research questions. In this study, data was analyzed using both inferential and descriptive statistics. The reason for using descriptive statistics was because the scale used in this study is ordinal. Observations were ranked in order of academic performance and the levels of self-esteem that is low, average, and high. In this case, data analysis used means, standard deviation and percentages. The reason for using inferential statistics was because the study involved estimation sampling. T-test were used to analyze the data. Hypothesis were tested at α=0.05. A computer programme, which is the Statistical Package for Social Sciences (SPSS) version 18.0 for windows, was used in analyzing the data.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This chapter gives the outcome and discussions on self-esteem and academic performance levels of HIV/AIDS orphaned primary school pupils in children's homes of Nyeri South Sub-county, Kenya. Descriptive statistics that included percentages, means and frequencies were used to analyze the data with the help of Statistical Package for Social Sciences (SPSS version 18.0 for windows. Data analyses were guided by the following research objectives.

i) To establish the self-esteem levels of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county.
ii) To establish the academic performance levels of HIV/AIDS orphan pupils in children's homes in Nyeri South Sub-county
iii) To determine whether gender differences exist in self-esteem and academic performance levels of HIV/AIDS orphan pupils in children's homes in Nyeri South Sub-county
iv) To determine the influence of guidance and counseling on self-esteem and academic performance of HIV/AIDS orphaned primary school pupils in Nyeri South Sub-county.

4.2 Demographic Data of Participants

This section focuses on the demographic characteristics of the respondents in the study location. The study sought views from 53 respondents on demographic characteristics. Such background information was important in understanding the respondents of the study and also helps in analyzing the study findings. Analysis of the respondents was done on the basis of their gender and age. The findings were as shown in Tables 5 and 6.

Table 7

Distribution of Pupils by Gender

Pupils status	**Gender**	**Frequency (f)**	**Percentage (%)**
HIV/AIDS orphans	Girls	21	40
	Boys	32	60
Total		**5 3**	**100**

According to Table 7, the percentage of HIV/AIDS orphaned girls was 40% while that of HIV/AIDS orphaned boys was 60 %. This shows that in the area of the study there were more

HIV/AIDS orphaned boys than girls. This is because, when children are orphaned, they are supposed to stay with relatives, however, girls are able to adapt to their new families than boys hence more boys are taken to the children's home (Ruto, 2006).

Table 8

Age Distribution of Pupils in Years

HIV/AIDS orphans age	**Frequency (f)**	**Percentage (%)**
10-12	10	19
13-14	15	28
15-16	22	42
17-18	6	11
Total	**5 3**	**100**

In Table 8, most HIV/AIDS orphaned pupils (42%) were between 15-16 years. The result also indicates that HIV/AIDS orphaned pupils aged between 17-18 years (11%) were still in primary school. This may be because the orphaned pupils absent themselves from school forcing them to repeat some classes or it could be because of neglect from their guardians, relatives, sponsors and the community. The academic performance of the HIV/AIDS orphans may deteriorate due to unresolved psychological trauma and self-esteem may be lowered (Ritcher, 2004) as cited by Sdorrow (2005).

4.3 Levels of Self-esteem of HIV/AIDS Orphaned Pupils

The first objective of the study was to establish the self-esteem levels of HIV/AIDS orphaned primary school pupils in Nyeri South Sub-county. In order to determine this, the percentages of the self-esteem levels of HIV/AIDS orphaned pupils were computed as shown in Table 7.

Table 9

HIV/AIDS orphans' Responses on Levels of Self-esteem

	HIV/AIDS Orphans				
S.E	High	Moderate	Fairly Moderate	Low	Total
HIV/AIDS orphans (f)	6	5	25	7	53
(%)	11.3	9.4	47.1	13.2	100

There were 23 items for measuring self-esteem level given to the HIV/AIDS orphans. Levels were categorized into four categories: high, moderate, fairly moderate and low for example 92 to 115 measured high levels, 69 to 92 measured moderate levels, 46 to 69 measured fairly moderate and 23 to 46 measured low. The percentages were computed as shown in Table 8. Those with high were 11.3 %, moderate 9.4 %, fairly moderate 47.1 % and low 13.2 %. These results indicate that HIV/AIDS orphaned pupils had fairly moderate self-esteem levels.

These results agree with the findings of the previous researches. According to Rainey and Rainey (1986), parents are probably the greatest influence on the development of a person's self-esteem as they are the children's primary advocates and provide the first psychological situation in which the child must survive and thrive. In addition to this, Bornstein (1998), noted that childhood is the stage of life cycle when parents provide experiences that are believed to exert significant and salient influences because the parent's attitudes, feelings and actions are always recorded in the child's mind and form a basis of his or her self-image (Mruk, 1983). The level of self-esteem is a product of the extent to which the child was praised, encouraged or relentlessly criticized (Rainey & Rainey, 1986).

Moreover, children who are emotionally secure tend to exhibit a high self-esteem and vice versa (Mruk, 1983). The parents who withhold unconditional love and acceptance create a child who must perform to be accepted, and looks to others for the missing approval. According to Newman (1993), parents impact on the child's self-esteem in that any negative communication lowers their self-esteem. Those children who have experienced a lot of love and fair discipline have a high self-esteem. They accept themselves because they have been accepted as cherished beings by parents. Conversely, children who have been pushed around, ignored, physically abused, live in uncertainty and fear, as well as those separated from their parents for long periods, develop a low self-esteem. Parents who are permissive, over protective, or label the children as 'stupid', dummies, who cannot do anything right, lead children to develop low self-esteem.

Parents are also important in influencing career choices, which are products of self-esteem. If they encourage independence and provide emotional support, this makes the child more likely to make use of available information for good career choices (Gichuru, 2005).

Ambron (1986) examined the characteristic behavior of the parents of the boys in his study. He found that certain child rearing practices of the boys were related to high self-esteem in their parents. Such parents were more accepting and affectionate toward their children; they took an interest in their children's activities and friends and were generally more attentive to their children (Ambron, 1986). However, these characteristics are lacking in HIV/AIDS orphaned children whereby the parent is absent, thus does not influence the self-esteem of the children positively.

Zivor (2007) indicates that most people see themselves as belonging to one or more social groups based on such things as age, social class, gender, race, sexual orientation, marital status and occupation and membership to these groups make up the individual's collective identity. She observes that membership to a devalued group such as those infected and affected by HIV/AIDS may result in negative self appraisal as the orphan begins to internalize the negative light which may impact their behavior and motivation and diminish their self-esteem.

This is further supported by Salaam (2006), Stein (2003), Atwine et al (2005) and Ljungvist (2003) who observed that orphaned children suffer distress and social isolation before and after the death of their parents. This is strongly exacerbated by the shame, fear, and rejection that often surround people affected by HIV/AIDS. They point out that secondary school students whose parents are living with HIV/AIDS often experience many negative changes in their lives and can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually they suffer the death of the parent(s) and suffer the emotional trauma that results. These are all factors that culminate into a low self-esteem and development of deviant behavior (Harter, 2006).

Zivor (2007) asserts that high self-esteem has been found to be positively correlated with a number of desirable outcomes, as well as with positive emotional experience and positive self appraisal. She confirms that high self-esteem people have been found to experience more positive effect, more life satisfaction, less anxiety, less hopelessness and fewer depressive symptoms than those with lower self-esteem. She concludes that overall, high self-esteem people are happier and more satisfied with life than low self-esteem people. High self-esteem therefore

serves as a buffer against negative outcomes. She observes that people with low self-esteem tend to be more sensitive to criticism and tend to interpret these events as signs of inadequacy and rejection. Orphaned pupils are exposed to so many stressors and possibly criticism that may lead them to start thinking less of themselves, expect negative outcomes out of different life challenges and this may predispose them to low self-esteem.

4.3.1 Caretakers' responses on HIV/AIDS orphaned pupils' self-esteem levels

To shed more light on objective one, care takers' observations were computed as shown in Table 10.

Table 10

Care takers' Responses on HIV/AIDS Orphaned Pupils Levels of Self-esteem

		HIV/AIDS Orphans				
S.E		High	Moderate	Fairly Moderate	Low	Total
Caretakers	(f)	1	1	2	1	5
	(%)	20	20	40	20	100

There were 14 items for measuring self-esteem level given to the care takers. Levels were categorized into four categories: high, moderate, fairly moderate and low. The percentages were computed as shown in Table 10. Those with high were 20%, moderate 20 %, fairly moderate 40 % and low 20 %.These results indicate that HIV/AIDS orphaned pupils had fairy moderate self-esteem levels according to the caretakers.

4.4 Academic performance levels of HIV/AIDS Orphaned Pupils

The second objective of the study was to establish the academic performance levels of HIV/AIDS orphaned pupils in Nyeri South Sub-county. In order to determine this, the means of HIV/AIDS orphaned pupils' academic performance was computed as shown in Table 11.

Table 11

Mean of HIV/AIDS orphaned Pupils' Academic performance

Variable	N	Mean	Required total marks
HIV/AIDS Orphans	53	261.36	500

According to the requirement of the Ministry of Education, Science and Technology, a pupil is supposed to be examined in five subjects which totals to 500 marks. Therefore in this study, any marks above 250 were considered to be above average, 250 was average and below 250 was below average. Though the mean was 260, which was above average, it was still very low marks as per the Kenya Certificate of Primary Education performance. This implies that HIV/AIDS orphaned pupils perform poorly academically. These results agree with other researches done before. Richer, (2004) as cited by Sdorrow (2005), postulates that the school performance of the HIV/AIDS orphans may deteriorate due to unresolved psychological trauma, low self-esteem and acute absenteeism. The challenges they face in school such as lack of uniforms, discrimination, trauma and rejection may also account for their poor performance academically.

In addition to this, the nature of the disease causing the death can also result in children experiencing multiple losses, as well as considerable uncertainty, stigma, secrecy and isolation. Children of parents who have died from HIV/AIDS are at greater risk for emotional and psychological problems than children whose parents have died from other causes and problems are more likely to manifest as internalizing behavior such as depression than externalizing behavior such as aggression (USAID, 2013). Moreover, these children may also under-report their symptoms and problems so that they remain masked from the attention of significant others in their environment. Mureah and Kiarie (2005) also state that the HIV/AIDS orphans were likely to grow up lacking suitable guardians and mentors and thus hinder general development. If children lacked mentors, they were unlikely to achieve high goals in education and in life. Thus, the death of parents almost always had a long-term impact on the orphan's lives.

According to USAID (2013), World Education Forum in Dakar Senegal, listed six goals of education For All (EFA). One of the goals was to expand and improve comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. Among vulnerable are the HIV/AIDS orphans in primary schools. In Kenya, Primary Education is free in terms of tuition, but other learning materials and development project are still left under the parents. Those orphans who have no one to care for them may absent themselves from school due to this factor. This may end up affecting their academic performance, social life and discipline.

4.5. Academic Performance and Self-esteem levels by Gender

The third objective of the study was to determine whether gender differences exist in academic performance and self-esteem levels of HIV/AIDS orphaned primary school pupils in children's homes in Nyeri South Sub-county. In order to effectively assess the academic performance and self-esteem levels, the analysis were done by help of t-test.

4.5.1 Academic Performance and Self-esteem levels of HIV/AIDS orphaned primary school Pupils by Gender

In order to determine whether academic performance and self-esteem differences existed between HIV/AIDS orphaned primary school pupils who were boys and girls, pupils mean scores of academic performance and self-esteem and standard deviations were computed. However, t-test analysis was also performed to test the significance of any existing differences. The results were as shown in table 12 and 13respectively.

Table 12

Comparison of HIV/AIDS orphaned pupils Academic Performance level per gender

Variable	N	Mean	class mean	S.D	t-value	Df	P value
HIV/AIDS Orphans boys A.P	32	274.76	250	24.76	16.03*	106	0.026
HIV/AIDS Orphans girls A.P	21	248.36	250	-1.7			

*denotes significance at $\alpha = 0.05$

A.P-Academic performance

Table 13

Comparison of HIV/AIDS orphaned primary school pupils' self-esteem levels per gender

Variable	N	Mean	S.D	t-value	Df	P value
HIV/AIDS Orphaned boys S.E	32	50.05	23.35	2.768*	54	0.047
HIV/AIDS Orphaned girls S.E	21	56.97	24.69			

*denotes significance at $\alpha = 0.05$

S.E-Self-esteem

An inspection of the results in Table 12 indicates that some academic performance differences existed between HIV/AIDS orphaned boys and girls. The academic performance, mean score for HIV/AIDS orphaned boys was 274.76 whereas that for HIV/AIDS orphaned girls was 248.36. This shows that HIV/AIDS orphaned girls have lower academic performance level than HIV/AIDS orphaned boys. This implies that HIV/AIDS orphaned boys academic performance is significantly higher than the HIV/AIDS orphaned girls since girls play a bigger role in the household chores such as cooking, fetching water and firewood and taking care of other siblings unlike HIV/AIDS orphaned boys. According to UNAIDS (2013), the girl child education was the most affected by the HIV/AIDS orphan hood because they were prevented to go to school and instead asked to remain at home to nurse their other younger siblings and sometimes had to forego schooling completely as their male counterparts continued their learning in schools.

An inspection of the results in Table 13 indicates that mean differences existed in self-esteem between HIV/AIDS orphaned boys and girls. The mean for HIV/AIDS orphaned boys was 50.05 whereas that for HIV/AIDS orphaned girls was 56.97. The deviation from the means for boys was 24.69 and for the girls 23.35. In effect then, mean differences were 1.24 points higher in favor of HIV/AIDS orphaned boys. However, this mean difference was found to be statistically significant, ($t=2.768$, $p<0.05$). This shows that HIV/AIDS orphaned boys have lower self-esteem level than HIV/AIDS orphaned girls. These results agree with other researches done before.

This could be due to the fact that girls being generally more emotional tend to grieve during loss of parents and get people to comfort them and counsel them even at the point of loss whereas boys tend to want to look strong and keep everything to themselves so they do not benefit from the counseling that takes place during funerals. Thus they carry the baggage with them and suppress their grief to put up a brave face and to look strong for the family. Any public display of grief for boys is frowned upon in certain communities or cultures and a boy who breaks down during the funeral of a parent feel like a failure.

One is looked down upon as a failure when they mourn their loved ones. They may start developing feelings of inadequacy because indeed grief occasionally overwhelms them. This predisposes them to low self-esteem as they do not develop proper coping mechanisms to deal with the loss. Atwine et al (2005) seem to confirm this when they observe that some boys resort

to drinking, drug abuse and crime to counter the effects of depression after loss of parents. This is because traditionally boys are supposed to be air of their parents after death and hence are expected to take over the mantle of which could lead to antisocial behavior. The story of Ray (Chirwa, 2002) the eighteen year old Malawian orphan who had to drop out of school to fend for the family is an indication of what pressure orphaned boys have to go through which could lead to low self-esteem.

The findings also indicate that more girls who are orphaned in this study have high self-esteem compared to boys. Generally society expects boys to get over loss faster than girls without an explicit display of grief. While a girl can grieve long after the death of a parent, a boy may not. While a girl may talk about their pain and grief and even discuss their needs with a confidant or a caregiver, probably boys want to pretend that they can cope and that all is well. This places a bigger psychological burden on boys as compared to girls predisposing them to low self-esteem

The findings that gender differences exist in self-esteem of orphaned pupils agrees with earlier observations and expectations of different scholars and researchers who have studied orphans, Onyango (2005), Njagi (2004), Mwanzia (2009, Kokul (2005) and Atwine Et al (2005). However, the findings seem to contradict earlier observations by Mwazia (2009) and Stein (2003) who felt that given the great responsibility left to girls during and after the death of their parents, they would be more predisposed to low self-esteem. The researcher would therefore have expected girls to have lower self-esteem than boys contrary to the findings in this study. It is also possible that as girls take care of ailing parents, when death finally comes, they learn to come to terms with it, they grieve with fewer reservations than boys and they learn to let go. This prepares them faster for the healing process as they will not take a long time in denial.

According to Odiwour (2006), although the majority of orphans of HIV/AIDS stayed with their close relatives, the environment did not provide conducive atmosphere similar to when their parents were still alive. This is worse for boys who are discriminated because of the fear of competition for inheritance. This in return greatly affects their self-esteem (Gichuru, 2005).
Ambron (1986) examined the behavior of the parents of the boys in his study and found that certain child rearing practices of the boys were related to high self-esteem in their parents. Such

parents were more accepting and affectionate toward their children; they took an interest in their children's activities and friends and were generally more attentive tot heir children (Ambron, 1986). However, these characteristics are lacking in HIV/AIDS orphaned children whereby the parent is absent, thus does not influence the self-esteem of the children positively.

4.5.2 Caretakers responses on academic performance and self-esteem by gender

To shed more light on objective three, caretakers' observations about pupils' academic performance and self-esteem differences were awarded points depending on their answers from the five point Likert scale. As a result, total points were classified into three categories of low, moderate and high academic performance and self-esteem. Those who said strongly disagree and disagree had low, undecided group had moderate and those who agreed and strongly agreed had high levels of academic performance and self-esteem. The results were as shown in Table 14 and Table 15 respectively.

Table 13

Caretakers' Responses on HIV/AIDS Orphaned primary school pupils Academic performance levels

		HIV/AIDS Orphans			
A.P		High	Moderate	Low	Total
Boys (f)		1	3	1	5
	(%)	20	60	20	100
Girls (f)		1	1	3	5
	(%)	20	20	60	100

Table 12,depicts that majority of the caretakers supports the fact that HIV/AIDS orphaned boys had moderate (60%) academic performance. Most of the caretakers said that HIV/AIDS orphaned girls had low academic performance (60%). 20% had moderate and 20% high academic performance.

Table 15

Caretakers' Responses on HIV/AIDS Orphaned primary school pupils Self-esteem levels

		HIV/AIDS Orphans			
S.E		High	Moderate	Low	Total
Boys (f)		1	2	2	5
	(%)	20	40	40	100
Girls (f)		2	2	1	5
	(%)	40	40	20	100

4.6 Guidance and Counseling , Self-Esteem and academic performance

The fourth objective of the study was to investigate the effects of guidance and counseling in self-esteem and academic performance in HIV/AIDS orphan hood performance in HIV/AIDS orphan hood in Nyeri South Sub-county. Caretakers' observations about pupils' academic performance and self-esteem were awarded points depending on their answers from Likert scale. As a result, total points were classified into three categories of low, moderate and high level of academic performance. Those who said strongly disagree and disagree had low, undecided group had moderate and those who agreed and strongly agreed had high levels of performance respectively as shown in Table 16 and 17 respectively.

Table 16

Caretakers' Responses on HIV/AIDS Orphaned Pupils Levels of Self-esteem after Guidance and Counseling

	HIV/AIDS Orphans			
S.E	High	Moderate	Low	Total
Frequency (f)	2	2	1	5
Percentages (%)	40	40	20	100

Table 17

Caretakers' Responses on HIV/AIDS Orphaned Pupils Levels of Academic Performance after Guidance and Counseling

	HIV/AIDS Orphans			
A.P	High	Moderate	Low	Total
Frequency	2	2	1	5
Percentage	40%	40%	20%	100%

According to the results of Table 16, most caretakers (40%) pointed out that self-esteem level of HIV/AIDS orphaned pupils was high after guidance and counseling, moderate (40%) and low (20%).This shows that guidance and counseling enhances the self-esteem level of HIV/AIDS orphaned pupils.

This agrees with the findings of other studies done in the past. According to Salvina (1984), most of the traditional African customs have been done away with and the youth spend most of the time at school. UNESCO (1988) noted that changes have been experienced which has resulted to the community as an agent which prepared the youth socially, psychologically, emotionally, physically and religiously for the next stage in the community.

According to the results of Table 17, most caretakers said that guidance and counseling affects academic performance. Those who said that academic performance becomes high were 40 % followed by moderate 40% and low 20 %. This shows that there is a relationship between academic performance and guidance and counseling. These results, agrees with the findings of other studies carried out in the past. Siezer (1999) feels that the young have emotional problems and need help. Effective therapy relationship requires respect and trust between the therapist and the client which is ideal in a teacher student relationship. The teacher fits in very well as a counselor or a helping person.

UNESCO (1988) noted that changes have been experienced which has resulted to the weakening of the structures of society. Mugambi, (1989) summarizes the role of the community as agent which prepared the youth socially, psychologically, emotionally, physically and religiously for

the next stage in the community. This agrees with Mutie and Ndambuki (1999) that guidance and counseling help the pupils perform in their academic work.

According to Atwine et al. (2005), the community needs to be supportive of children when they are orphaned, making sure that they are accepted and have access to essential services such as health care and education. This means improving existing services and reducing the stigma surrounding children affected by HIV/AIDS so that they do not face discrimination when trying to access these services. IRIN News (2004) indicates that it is crucial that orphans be kept in school. Education can act as a safety net in the child's life. A good school education can give children a higher self-esteem, better job prospects and economic independence. As well as lift children out of poverty, such an education can also give children a better understanding of HIV and AIDS, decreasing the risk that they will become infected. Schools can also offer emotional support and care for AIDS orphans through counseling, Onyango (2004).

According to Ayier (2013) counseling pupils who are infected and affected by HIV/AIDS requires the caregivers to observe good ways (principles) when providing counseling. The counselor should establish a helping relationship with pupils so that they can gain their confidence. They should also help them tell their stories and listen to them attentively. The counselor should be in a position to give tem correct and appropriate information and also guide them to make informed decisions. The counseling process should help them identify and build upon their strengths and also to develop a positive attitude to life, Mutie and Ndambuki (2001).

Fox (2001) notes that this may help orphaned pupils cope with the challenges and emotions that they experience when they discover that they are either infected or affected by HIV/AIDS. Counselors should have accurate information about HIV/AIDS so as to be able to pass it on to the pupils. Fear and uncertainty regards to HIV/AIDS is rampant and there is a lot of negativity in attitudes, cultural beliefs and practices. Some people still believe that one can get AIDS by shaking hands or sharing beds with infected people including children and these results in stigmatization. These misconceptions and fallacies about HIV/AIDS sometimes isolate pupils. Counselors should deal with these misconceptions and false beliefs about HIV/AIDS.

Ayier (2013) pupils who hold harmful beliefs and follow harmful practices need help to change their attitude and beliefs so that they are more positive and helpful. The counselor should promote open discussion between adults and children. Fox (2001) gives different ways by which orphaned pupils can be helped. There should be an open discussion between adults and pupils about matters related to HIV/AIDS. In this way correct information on HIV/AIDS can be disseminated to pupils so that they can make informed decisions. Pupils should be listened to and involved in decisions that affect them. It is also important to involve the entire pupil's community to provide emotional support to those infected or affected by giving all of them adequate information to clear the misconceptions.

According to Demo (2001), it is important that the entire pupil's body is mobilized to provide emotional support for those infected or affected to reduce the stigma and discrimination. The counselor should share information and clarify issues about HIV/AIDS and its impact on the school community should openly discuss events around AIDS and its effects and should also be involved in planning how they could provide support for those infected and affected pupils.

Salaam (2005) recommends that pupils should be encouraged to discuss the fears and issues that worry them with their relatives, family, friends, and church groups among others with whom they feel secure. Pupils should be made to understand that enough rest, sleep, prayers and simple exercises like jogging and dancing are helpful when dealing with trauma and emotions. More care need be taken when counseling pupils because they find it more difficult to understand their fears and emotions. Pupils at their adolescent age also generally feel embarrassed when talking about HIV/AIDS because it is generally linked to sex, a subject that is culturally sensitive and that children are not supposed to talk about.

4.6.Effects of guidance and counseling on academic performance and self-esteem by gender

In order to shed more light on the forth objective, pupils responses were awarded points depending on their answers from the Likert scale. As a result, total points were divided into three categories of low, moderate and high levels of academic performance and self-esteem. Those who strongly disagreed and disagreed had low, undecided group had moderate and those who agreed and strongly agreed had high levels of academic performance and self-esteem respectively as shown in Tables 18 and 19.

Table 18

Influence of Guidance and Counseling on HIV/AIDS on orphaned boys and girls on Self-esteem by gender

	HIV/AIDS orphaned boys			HIV/AIDS orphaned girls		
A.P	High	Moderate	Low	High	Moderate	Low
Frequency	18	9	6	8	10	4
Percentage	54.5%	27.3%	18.1%	36.4 %	45.5%	18.2%

Table 19

Effects of Guidance and Counseling on HIV/AIDS on orphaned boys and girls on Academic Performance by gender

	HIV/AIDS orphaned boys			HIV/AIDS orphaned girls		
S.E	High	Moderate	Low	High	Moderate	Low
Frequency	9	17	7	12	7	3
Percentage	27.3 %	51.5 %	21.2%	54.5%	31.8%	13.6%

From Table 18, it is evident that most HIV/AIDS orphaned primary school boys (54.4%) had high academic performance levels after guidance and counseling was done while most of the HIV/AIDS orphaned girls had moderate academic performance after counseling. This results shows that HIV/AIDS orphaned boys responded better to guidance and counseling as compared to the girls. This may have been as a result of the gender of the caretakers who were females and boys are said to be closer to their mothers than girls. In this case may be, they saw the mother figure in the caretakers (Melgosa, 2000).

The results of Table 19 indicates that most of the HIV/AIDS orphaned boys had moderate self-esteem (51.5%) while most of the HIV/AIDS orphaned girls had high self-esteem (54.5%).It is evident that girls have higher self-esteem after Guidance and Counseling than boys.

In the interview with the caretakers the researcher notes that more girls attend counseling than boys. This means that girls tend to open up more easily and share problems than boys and therefore can more easily get intervention to cope with pressures of HIV/AIDS orphan hood than boys who keep a lot of hurt to themselves. Girls will also find it easier to open up to fellow girls or to a close friend and it is widely believed that a problem shared is a problem half solved. These friends provide a shoulder to lean or cry on when they want to grieve and this gives them an opportunity to heal faster.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings, conclusions and recommendations.

5.2 Summary

Based on the objectives and the analysis of the study in chapter four, the following can be considered as the summary of the findings:

i) Majority of the HIV/AIDS orphaned pupils in Nyeri south sub-county had moderate or low self-esteem with a very small number having high self-esteem. The impact of loss of parents on their self-esteem was negative and tended to make them lose confidence and become very uncertain of their future due to the fear of the unknown.

ii) Most of the HIV/AIDS orphaned pupils in Nyeri south sub-county had average or poor academic performance with a very small number having high academic performance. The impact of loss of parents on their academic performance was negative and tended to make them lose concentration in their academic performance and become very uncertain of their future due to the fear of the unknown.

iii) Gender differences existed in self-esteem and academic performance of HIV/AIDS orphaned pupils in Nyeri south sub-county with the female pupils depicting a higher self-esteem than the male pupils. This could be attributed to the fact that girls tend to share their problems more easily and seek counseling services.

iv) Academic performance level of HIV/AIDS orphaned primary school pupils who were boys was higher than for girls. This could be attributed to the fact that when parents pass on, girls are overburdened with household chores than boys. This makes them not to have enough time to concentrate with their academic work. HIV/AIDS orphans generally felt that orphan hood had a negative effect on their academic performance as they spent a lot of time worrying about their future which was not assured in the absence of their parents. Majority of the HIV/AIDS pupils felt that their academic performance had declined after the loss of their parents.

v) Guidance and counseling enhanced self-esteem and academic performance of HIV/AIDS orphaned primary school pupils. It played a key role in mitigating negative effects and challenges of orphan hood. Majority of the pupils felt that counseling had helped them to a great deal to cope with their situation. The caregivers also reported that those who attended counseling were more disciplined and avoided getting into disciplinary problems unnecessarily. They also reported that girls tended to attend counseling and opened up more easily compared to boys who tended to feel that seeking counseling was a sign of weakness.

5.3 Conclusions

In general then, from the study it can be concluded that:

i) HIV/AIDS orphan hood affects the self-esteem levels of primary school pupils in Nyeri South Sub-county.
ii) HIV/AIDS orphan hood affects the academic performance of the primary school pupils in Nyeri South Sub-county.
iii) The self-esteem levels of HIV/AIDS orphaned primary school was affected by gender in Nyeri South Sub-county.
iv) The academic performance levels of HIV/AIDS orphaned primary school was affected by gender in Nyeri South Sub-county.
v) Guidance and counseling enhanced self-esteem and academic performance of HIV/AIDS orphaned pupils positively in Nyeri South Sub-county.

5.4 Recommendations

From the findings of this study, it is evident that HIV/AIDS orphan hood influences the pupils' self-esteem and academic performance level. Therefore, the following recommendations are made:

i) The Ministry of Education, Science and Technology, Ministry of gender and equality commission, school administrators, teachers, guardians and other stakeholders need to identify and understand the unique needs of orphaned pupils owing to the challenges of HIV/AIDS orphan hood. This may help to boost the orphaned pupils self-esteem and academic performance.

ii) The Ministry of Education, Science and Technology should organize some seminars and workshops which will equip teachers with the necessary skills on the plight of HIV/AIDS orphaned pupils.

iii) The ministry of education should employ enough teachers with skills to handle the HIV/AIDS orphaned pupils.

iv) During the world's orphans day HIV/AIDS issues should be highlighted by the Ministry of Gender and equality commission to make the stakeholders in primary schools to be sensitive as they deal with HIV/AIDS orphans.

v) Teacher counselors should be cautious when dealing with HIV/AIDS orphaned pupils so as to understand their feelings.

vi) HIV/AIDS orphans' caretakers should be equipped with guidance and counseling skills

5.5 Suggestions for Further Research

More research that could be beneficial to HIV/AIDS orphaned pupils includes:

i) There is need to extend the study to a larger population than the sample in this study. This might create a better picture on the influence of HIV/AIDS orphan hood and academic performance in Nyeri South Sub-county.

ii) There is need to further investigate on self-esteem and academic performance levels of HIV/AIDS by age in Nyeri Sub-county.

iii) There is need to investigate the impact of the children's homes on self-esteem and academic performance level in Nyeri South Sub-county.

iv) There is need to investigate whether there is difference in self-esteem and academic performance level of HIV/AIDS orphaned pupils and non-orphans in Nyeri Sub-county.

v) There is need to compare self-esteem and academic performance level of HIV/AIDS orphaned pupils depending on the type of orphan hood, whether orphaned by mother, father or both parents.

REFERENCES

Adain, J. (1990). *Understanding Motivation.* New York: Pewley Hill, Talbot Press.

Adam, G., & Gullalta, T. (1983). *Adolescence and Life Experience.* Monteny: California: Brook Publishing Company.

Ambrom, S.R.A. (1986). *Lifespan on Human Development.* New York: Holt, Rinehart and Winston.

Anywar N. (4th Nov 2010) *Plight of Elderly who Must fend for Grandchildren*. The Standard I & M Bank Tower. Kenyatta Avenue, Likoni Road Nairob, Kenya pp 6.

Appilla, N.M. (2000). *Problems of orphans* cited in Sdorrow, L.W. (2005). *Psychology. (2nd Edition)* Oxford: Brown and Benchmark publishers.

Ascot S. (2012) Retrieved on 16th Jan 2014 from lightbulb.extime.com/2014/1/16/generation-of-orphans-southafricas-children-of aids

Atwine B. Cantor G. & Banjuriwe F. (March 2005) *Psychological Distress among AIDS Orphans in Rural Uganda.* Social Science and Medicine 61-555-564. Retrieved on May 5 from http:www. avert. org/ aidsorphans.htm.

Ausbel P.D. & Edmund V.S. (1980). *Theory and Problem of Child Development 3rd Edition.* Grune and Stratton Inc.

Ayier, E.B. (2013). *Effects of HIV/AIDS Orphan hood on Self-esteem of Secondary Students in Upper Nyakach District, Kenya.* Published. M.Ed. project Egerton University, Njoro campus.

Baguma P., Kyomugisha E. & Kimenze S.N. *Psychological Needs Assessment of AIDS Orphans in Uganda*: A case study in Masaka district. Mental Health and Psychotherapy in Africa, pp 366-418

Barrie L (2011) *Report on HIV/AIDS UNICEF New York.* Senior Communications Advisor on HIV/AIDS (1-212) 326-7593 (1-646). Retrieved on February 15, 2014 from http://www.undp.org/hiv/publications/study/english/sp2each.2htm.

Bauman L.J., Camacho S., Silver E.J. Hudis J. & Draimin B. (2002). *Behavioural Problems in School-aged Children of Mothers with HIV/AIDS.* Clinical Child Psychology 7 pp 39-54.

Bell, J. (1993). *Doing Your Research Project,* Buckinggham Open University.

Boggiano, N. (1992). *Achievements and Motivation: A Social Development Perspective*. NewYork: Cambrige University Press.

Bornstein, M.H. (1998). *Parents:* Available: (on-line). http:// Parenthood Library. Wise. Ed Bornsrein. Html. Accessed on 12.8.2013

Branden N. (1969). *The Psychology of Self-esteem*. New York Bantein

Byren, B. (1990). *Self concept and Academic Achievement:* investigating their importance as discriminators of academic track membership in high school. Canadian Journal of Education, 15(2) 173-182.

Chirwa C.W. (2002) Social Exclusion and Inclusion Challenges to orphan care in Malawi, University of Malawi, Malawi.

Clemens H. & Bean R. (1981). *Self-esteem*: The Key to Your Child Well Being. New York: Puttman.

Colen, L., & Manion, L. (1994). *Research Methods in Education.* London: Routledge.

Cole, K. (1993). *Crystal Clean Communication*. New York: Prentice Hall Publisher.

Congour, J.J. & Peterson, A.C. (1984). *Adolescence and the Youth*. New York: Harperand Row Publishers.

Coopersmith, S. (1967). *The Antecedents of Self-esteem*. San Francisco: Freeman and Company Publisher.

Csete J. (2006) *Kenya Government Neglects AIDS Orphans.* Human Rights WATCH. Retrieved on February 10th 2014 from http://hrw.org/english/docs.2014/2/10 /kenya96txt.htm

Dainow, S. (1992). *Developing Skills with People.* New York: Wilay Publisher.

Dharani, N. (2002). *Life Little Secret*. Nairobi: Focus Books Publisher.

Dobson, J. (1975). *Man to Man about Women.*USA: Tyndale house publisher.

Emler N. (2001). *Self-esteem*: The Costs and Causes OF Low Self-esteem Worth: New York Joseph Rown tree Foundation.

Erickson, E. (1963). *Childhood and* society (2nd Edition) New York: Norton.

Epstein H. (2012). AIDS orphans in South Africa. Retrieved on July 12th 2013 from w.w.w.ny.books.com/blogs/nyblog/2013/July 12/south Africa-aids orphans-breaking-silence

Brown, H. & Kulik, M. (1977). *The Brain.* Sdorrow, L.M. (2005). *Psychology.* (2nd Edition). Oxford: Brown and Benchmark publishers.

Fraenkel, J.R. & Wallen, N.E. (2000). *How to Design and Evaluate Research in Education:* San Francisco State University.

Frogas, J. & William, K.D. (2002). *The Social Self.* New York: Psychology Press.

Gacheru, F.M. (2005). *Analysis of the Perception of Self-esteem of Secondary School Students: A case of Othaya Division, Nyeri District, Kenya.* Published. M.Ed. project. Egerton University, Njoro campus.

Gall, M., Borg, W. & Gall, J. (1996). *Educational Research*. New York: Longman

Gerald & Gerald. (2005). *Counseling Children*. A Practical Introduction. Second Edition. London. Sage.

Gherman, E.M. (1981). *Stress and the Bottom line.* New York: Amacom Publishing Publishers.

Gichuru, M.C. (2005). *The relationship between self-concept and academic performance among secondary school students in Ol-jororok Division of Nyanarwa District, Kenya.* Published. M.Ed. project Egerton University, Njoro campus.

Glencoe, F. (1990). *Teen Health.* Illinois: McGraw Hill.

Gordon, J.J. (1990). *Children view themselves*: Washington D.C Association for childhood educational international.

Government of Kenya, (2007). *Report on the Rapid Assessment Analyze and Action Planning Process (RAAAPD) for orphans and other vulnerable children in Kenya*. Nairobi: UNICEF.

Harmuth, E.S. (1994). *The Ecology of Self Relocation and Self Concept Change.* New York Chester: Cambridge University Press.

Hornby, A.S. (2000). *Oxford Advanced Learner's Dictionary of Current English 6th Ed*. New York: Oxford University.

Hussein A. (7th May, 2008). *World Orphans day, 7th May 2008*. Daily Nation, Nation Media Group. Nairobi pp 14 IRIN News (Dec 3rd 2004). 'AIDS Prevalence down by half. (Dec 3rd 2004). http:// www.avert.org/aidsorphans.htm.

Ignoffo, N. (1992). *Everything for you need to know about self confidence.* New York: The Publishers Group Inc.

IRIN News (June, 2005) 'Malawi; New Child Welfare Plan gives stakeholders common platform.' Retrieved on My 5th 2010 from http:// www.avert .org/aidsorphans.htm

Joulmes C (2005). Double Jeopardy of AIDS orphans. Nigeria.

Kathuri, N.J. & Pals, D.A. (1993). *Introduction to Education Research.* Egerton University, Kenya: Educational Media Centre.

Kerlinger, F.N. (1973). *Foundation of Behavioral Research* .New York: Holt, Renehart and Winston.

Kiirya, A.S. (2003) *AIDS-related parental death and its effects on orphaned children's self-esteem and sociability at school. Makerere University, Kampala.*

Kweyu D. (March 11th 2012). Self-esteem. Daily Nation. Nation Media group, Nairobi pp15

Lewis S. (21st Sept 2003) An extract of speech of U.N. Secretary General's Special Envoy for HIV/AIDS in Africa- Official opening of the 13th ICASA in Nairobi Kenya. Retrieved on June 4th 2013 from http: www.avert.org/aidsorphans.htm.

Ljungvist B. (April 8th 2003) *Orphans Survey Finding Confidence*. UNICEF Representative: Retrieved on July 9th 2010 from http:// www.avert.org/aidsorphans.htm.

Lindsey D.S (1994).The Welfare of Children. Oxford University Press.

Marsh, H.W., & Yeung, A.S. (1997). *Course work selection:* relations to academic self-concept and achievement. American Educational Research Journal 34, p 691.

Maslow, A. (1954). *Motivation and Personality.* New York: Harper and Row.

Mayoyo P. (Feb 8th 2009). *AIDS Indicator Survey*; widows say No to inheritance. Daily Nation. Nation Media Group. Nairobi pp 8.

Mbugua J.C. (2000). *The AIDS Epidemic in South Africa*. South Africa; Sunny Print.

Mercado M. (2010). HIV/AIDS. UNICEF, New York 646) 247-2975. Retrieved on October fromhttp:www.undp.org/hiv/publications/study/English/sp2each.2htm

Ministry of Health Kenya, (2013). *AIDS in Kenya*, 7th edition. National AIDS and STI Control Programme (NASCOP).

Mosota M. (Nov 2nd 2010). *It's Life to the Rescue*. The Standard. I & M Bank Tower. Kenyatta Avenue, Likoni Road Nairobi, Kenya pp 19

Morris S. (2012). *They are our children*. Helping AIDS Orphans in Africa. World Ark.

Moula, J.M. (1990). The effect of academic achievement motivation and home environment on academic performance among standard eight students, Unpublished M.Ed. thesis, Kenyatta University.

Mruk, C. (1983). *Self-esteem research, theory and practice.* Toward a positive psychology of self-esteem (3rd ed.). New York: Springer.

Mugambi, J.N.K. (1989). *African Heritage and Contemporary Christianity.* Nairobi, Kenya: Longman.

Mugenda, O.M. & Mugenda, A.G. (1999). *Research Methods; Quantitative and Qualitative Approaches*. Nairobi: Acts Press.

Mureah,W. & Kiarie, W.(2001). *HIV and AIDS, Facts that could change your life.* London:

Murdovich K. (2013). *AIDS Orphans in Tanzania*. Norvatis Foundation for Sustainable Development.

Musau Z. (Oct 20th 2003) '*Caring for AIDS Orphans'* Sunday Nation. Nation Media Group Nairobi pp 12.

Mussen P. H., Conger J.J & Kagan J. (1969). *Child Development and Personality*. 3rd Edition.

Mwandoto, W. (2008). '2.4 *million orphans risk neglect, Daily Nation.' (May, 9th, 2008).*

Mwaniki M. (Jan 30th 2007) '*Vice President's Presentation on Plight of Orphans*,' Daily Nation. Nation Media Group, Nairobi pp 6

Mwanizia M. (Feb 25th 2009). *AIDS Orphans*. The Standard I & M Bank Tower, Kenyatta Avenue, Likoni Road, Nairobi, Kenya pp 15

National AIDS Control Council (2013). *The Kenya National HIV/AIDS Strategic Plan 2000-2005-popular version:* NACC, Nairobi.

Ndambuki, P.K. and Mutie, E.K. (1999). *Guidance and counseling for schools:* Zima Press.

Newman, F. (1993). *Children in Crisis*. Toronto: Scholatic Canada Ltd.

Njagi D. (23rd Dec 2004) '*No Respite for AIDS Orphans*. New and Views ON Africa From Africa (lastupdate 21st March 2008).Retrieved on May 5th 2008 from http://newsfromafrica.org/newsfromafrica/articles/art-8765.html

Ochieng M. (20th Aug 2008). 'Curse of Orphan hood News and

Views on Africa from Africa. Retrieved on August 4th2012 from http: // newsfromafrica.org/newsfromafrica/articles/art-8765.html.

Onyango J. (Dec 3rd 2004). 'Deafening Silence over Sexual Coercion' The Standard I&M Bank Tower. Kenyatta Avenue. Likoni Road Nairobi Kenya pp 22.

Odiwuor, W.H. (2006). *The Impact of HIV/AIDS on Primary Education: A case study on selected districts of Kenya.* Published M.Ed. Thesis. Nairobi.

Onyango J. (Dec 3rd 2004). '*Deafening Silence over* Sexual *Coercion'* The Standard I & M Bank Tower. Kenyatta Avenue. Likoni Road Nairobi Kenya pp 22.

Opolot J.A. (1997). The Level of Life Skills of Uganda's Secondary School Students. A Baseline Study Report. Ministry of Education and Sports for UNICEF Kampala, Uganda.

Orodho, J. A. (2004) *Elements of Education and Social Science Research Methods.* Nairobi: Masola Publishers.

Pelt, N.V. (1984). *Train up a child.* A Guide to Successful Parenting: Pacific Press Publishing Association. Grantham, England.

Peter, C.B. (1994). *A Guide to Academic Writing:* Zapf Chancery. Eldoret: Kenya.

Rainey, D. & Rainey, B. (1986). *Building Your Mates' Self- esteem*. Here's Life Publishing Inc.

Ritcher, S.H. (2004). Sdorrow, L.M. (2005). *Psychology. (2nd Edition).* Oxford: Brown and Benchmark publishers.

Ruto, J.S. (2006). *Achieving goals through quality EFA Basic Education for O.V.Cs. A study of implementation of HIV/AIDS Education policy in Kenya. M.O.E.S.T, Kenya.*

Salaam T. (2005). '*AIDS Orphans & Vulnerable Children (OVC)*; problems, responses, and issues for congress. congressional research service.

Salvina, B. (1984). *The Adolescent*. Nairobi, Kenya: Heinemann Education Books.

Santrock, J.W. (1996). *Adolescence. London*: Brown and Benchmark Publishers.

Santrock, J.W. (1990). *Children*. London: Brown and Benchmark Publishers.

Seizer, W.W. (1999). *Health Making Life Choices*. New York: West Publishing Company.

Sdorrow, L.M. (2005). *Psychology. (2nd Edition.* Oxford: Brown and Benchmark publishers.

Shah K.V. 'Inspiration' The Standard I & M Tower, Kenyatta Avenue, Likoni Road Nairobi, Kenya pp 18.

Solomon S. (2006). *Self-esteem is central to human well being*. New York. Psychology Press.

Stein J. (2003). *Sorrow Makes Children of Us All; A Literature Review of Psychological Impact of HIV/AIDS on Children.* CSSR Working Paper No.47. Retrieved on October 19 2010 from http;//www.undp.org/hiv/publications/study/English/sp2ech.2htm

Susan, S.R. (1991) *Corporal punishment as a form of child abuse cited* in Sdorrow, L.M.

Turner, S.J. (1995) *Lifespan Development* (5th Edition) California, U.S.A: Harcourt Publishers

UNAIDS (2010) *Report on the Global AIDS Epidemic.* WHO Library Cataloguing-in Publication Data, Geneva Switzerland.

UNAIDS/WHO (2012). *Comparing adult antenatal-clinic based HIV prevalence with prevalence from national population based surveys in sub- Sahara Africa. UNAIDS presentation*. accessed 17 November 2012 at http:// data UNAID. Org/pub/presentation/2012/survey

United Nations Educational, Social and Cultural Organizations, (1988). *Regional Training Seminar on Guidance and Counseling Module Z*. Paris, France Ag 21 communication.

United States Aids (1997, December). *Family Health International AIDS control prevention project.*

Weiner, I. (1972). *Reading in Child Development*. New York: Pewley Hill Talbot Press. Winton.

Wittrock, M. C. & Baker, E.L. (1991). *Testing and Cognition*. Englewood: New Jersey. Prentice.

Zivor A.C.J. *Self-esteem of AIDS Orphans-a descriptive study.* Universiry of South Africa.

APPENDIX A

QUESTIONNAIRE FOR HIV/AIDS ORPHANED PUPILS

Dear Respondents,

I am a post-graduate student in Egerton University, pursuing a masters' degree in Guidance and Counseling. I am conducting a research on the influence of HIV/AIDS orphan hood on self-esteem and academic performance in Nyeri South District.

You have been selected to take part in this study. I would appreciate if you would assist me by responding to all items in the attached questionnaire. Your response will be treated with utmost confidentiality. The questionnaires are designed for this research only.

Thank you in advance.

Yours faithfully,

……..,

TABITHA NJAMBI KIRAGU.

INSTRUCTIONS

This questionnaire has four sections: A, B C and D.

In section A B, C and D, please tick the correct answers from the given choices. Where choices are not given, please write down the answers in the space provided.

SECTION A

1. How old are you?.....years old.
2. You are in

   Class 6 [ ]

   Class 7 [ ]

   Class 8 [ ]
3. Sex: Male [ ]

   Female [ ]

SECTION B

Self-esteem is the regard or opinion for oneself. It is the thoughts and feelings you have about yourself.

4. What was your self-esteem level before your parents(s) died?

   High [ ]

moderate [ ]

Low [ ]

5. How do you compare your level of self-esteem now with your self-esteem before your parent(s) died?

High [ ]

moderate [ ]

Low [ ]

6.How was your academic performance before your parent(s) died?

Improving [ ]

Declining [ ]

Stable [ ]

7. How do you compare your current academic performance with your academic performance before your parent(s) death?

Improving [ ]

Declining [ ]

Stable [ ]

8. Do you think your self-esteem level has been affected by your parent(s) death?

Yes [ ]

No [ ]

9. Do you think the death of your parent(s) has any effect on your academic performance?

Yes [ ]

No [ ]

10. Does the value you attach to yourself (self-esteem level) affect your academic performance

Yes [ ]

No [ ]

11. a) I have been given guidance and counseling in the children's home?

Yes [ ]

No [ ]

b) If yes indicate how many times

Once [ ]

Twice [ ]

Many times [ ]

c) If yes in a) has this guidance and counseling helped to change the value that you have about yourself?

Yes [ ]

No [ ]

c) If yes in a) has this helped to change the way you have been performing in school?

Yes [ ]

No [ ]

6. Write you mean score/marks for the last three terms in school.

……

……

……

SECTION C: SELF-ESTEEM SCALE

Karl Perera scale

Instructions

The statements below are about you. Read each statement carefully and decide how it describes the feelings you have towards yourself. Choose the response that you feel shows exactly the way you feel about yourself. Put a tick only where appropriate; either true or false.

1. Other people are not better off or more fortunate than me.
   True [ ]
   False [ ]
2. I accept myself as I am and I am happy with myself.
   True [ ]
   False [ ]

3. I enjoy socializing.
   True [ ]
   False [ ]
4. I deserve love and respect.
   True [ ]
   False [ ]

5. I feel valued and needed.
   True [ ]
   False [ ]
6. Being my self is important.
   True [ ]
   False [ ]
7. I do not need others to tell me I have done a good job.
   True [ ]
   False [ ]

8. I make friends easily.
   True [ ]
   False [ ]
9. I can accept criticism without feeling put down.
   True [ ]
   False [ ]
10. I admit my mistakes openly.
    True [ ]
    False [ ]
11. I never hide my true feelings.
    True [ ]
    False [ ]
12. I always speak up for myself and put my views across.
    True [ ]
    False [ ]

13. I am happy carefree person.
    True [ ]
    False [ ]
14. I do not worry what others think of my views.
    True [ ]
    False [ ]
15. I do not need others approval to feel good.
    True [ ]
    False [ ]
16. I do not feel guilty about doing or saying what I want.
    True [ ]
    False [ ]

SECTION D: ACADEMIC PERFORMANCE SCALE

Statement	**SA**	**A**	**NS**	**D**	**SD**
1. Parents presence influence pupils academic performance					
2. Absence of my parents affects my performance					
3. The way I am treated in this primary school affects my performance					
4. Duration of orphan hood affect pupils academic performance					
5. My gender affects my performance					
6. The way I feel about myself affect my academic performance.					
7. Guidance and counseling has helped to improve pupils self-esteem					
8. Guidance and counseling has helped to improve pupils academic performance					
9. Academic performance and self esteem has been improving in the last one year					

APPENDIX B

QUESTIONNAIRE FOR THE CARE TAKERS

Dear Respondents,

I am a post-graduate student in Egerton University, pursuing a masters' degree in Guidance and Counseling. I am conducting a research on the influence of HIV/AIDS orphan hood on self-esteem and academic performance in Nyeri South District.

You have been selected to take part in this study. I would appreciate if you would assist me by responding to all items in the attached questionnaire. Your response will be treated with utmost confidentiality. The questionnaires are designed for this research only.

Thank you in advance.

Yours faithfully,

……..,

TABITHA NJAMBI KIRAGU.

SECTION A:

Name of the children's home:.....

1. Sex: Male [ ]
   Female [ ]
2. Academic training in guidance and counseling
   Non [ ]
   Certificate [ ]
   Diploma [ ]
   Degree [ ]
   1. Guidance and counseling is offered in this institution
      Yes [ ]
      No [ ]

   4. If yes where?
      Staffroom [ ]
      Guidance and counseling office [ ]
      Anywhere [ ]
5. If yes in 4, when?
   During break time [ ]
   According to the counseling program [ ]
   Any time [ ]

SECTION B

Statement	SA	A	NS	D	SD
1. Guidance and Counseling is given to HIV/AIDS orphaned children					
2. HIV/AIDS orphaned pupils perform better after guidance and counseling .					
3. HIV/AIDS orphaned boys have higher self-esteem level than girls					
4. HIV/AIDS orphaned boys have higher academic performance level than girls.					
5. Parents presence influence pupils' academic performance.					
5. Absence of pupils' parents affects their academic performance level.					
7. The way pupils are treated in this children's home affect their academic performance level.					
8. Duration of orphan hood affect pupils' academic performance level.					
9. HIV/AIDS orphans self-esteem is affected by their academic performance level.					
10. The way pupils feel about them self affect their academic performance level.					
11. Guidance and counseling has helped to improve pupils self-esteem level					
12. Guidance and counseling has helped to improve pupils academic performance level					
13. Guidance and counseling have helped to improve both academic performance level and self-esteem level.					
14. Academic performance level and self esteem level of HIV/AIDS orphans have been improving in the last one year					

APPENDIX C

RESEARCH AUTHORIZATION

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: "SCIENCETECH", Nairobi
Telephone: 254-020-241349, 2213102
254-020-310571, 2213123.
Fax: 254-020-2213215, 318245, 318249
When replying please quote

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref: **NCST/RRI/12/1/SS-011/283/5**

Date: **24th March 2011**

Tabitha Njambi Kiragu
Egerton University
P. O. Box 536
EGERTON

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on **"Influence of HIV/AIDS orphan-hood on self esteem level and academic performance: A comparative study of HIV/AIDS orphans and non-orphans among primary school pupils in Nyeri South District, Kenya"** I am pleased to inform you that you have been authorized to undertake research **in Nyeri South District** for a period ending ***30th June 2011.***

You are advised to report to **the District Commissioner and the District Education Officer, Nyeri South District** before embarking on the research project.

On completion of the research, you are expected to submit **one hard copy and one soft copy** of the research report/thesis to our office.

P. N. NYAKUNDI
FOR: SECRETARY/CEO

Copy to:
The District Commissioner
Nyeri South District

The District Education Officer
Nyeri South District

APPENDIX D

LETTER OF INTRODUCTION

P.O.BOX 557,
OTHAYA.
23/3/11.

THE CORDINATOR,
CHILDRENS' HOME
P.O.BOX ……..
NYERI.

Dear Coordinator,

RE:LETTER OF INTRODUCTION

I am a post-graduate student in Egerton University, pursuing a masters' degree in Guidance and Counseling. I am conducting a research on the influence of HIV/AIDS orphan hood on self-esteem and academic performance in Nyeri South District.

Your children's home has been selected to take part in this study. As the coordinator, I kindly request you to allow me to collect some information from the pupils to enable me complete the study.

I assure you that the information I get from the pupils will be treated as confidential.

Thank you very much for your cooperation.

Yours faithfully,

……..,

TABITHA NJAMBI KIRAGU.

CC

The coordinator
Children's homes
Nyeri South District