Psychosocial experiences of children aged 6-12 years old, who are affected by HIV & AIDS: An application of Action Learning Model.

JESCA K. KOLA [1], **ASSANI WAKENGE Bonny** [2,3]

1. Great Lakes University of Kisumu (GLUK), Department of Community Health and Development;
2. Provincial Health Division of Maniema, Public Hygiene and Sanitation Office ;

3. Kindu Higher Institute of Medical Technic, Department of Public Health .

Corresponding author : JESCA K. KOLA, PhD, P. O. Box 7088, 40100 Tel: +254 714 977137.
E-MAIL: jescakola6@gmail.com

ABSTRACT

Children aged 6-12years, who are affected by HIV/AIDS struggle with traumatizing psychosocial experiences stemming from loss of their parent(s) then moving in with already burdened caregivers. Lack of basic needs, neglect, abuse and minimal communication form adults resulted in children making bad unguided decisions. Unable to express their feelings, silence left them fearful and untrusting. They missed school often, were sick on and off and poorly took their ARVs. Lack of national interventional policies targeting 6-12year olds created a gap and impacted them negatively. Action learning theory was applied to the children to promote their resilience. **Methods:** Both qualitative and quantitative designs were applied using a phenomenological approach throughout the research to collect data. Sixteen children were purposively sampled following the results of children's health as determined by the Child Status Index tool. Over a period of three months, action learning strategies were applied to them during the weekly meetings and follow-ups at home. Key Informant interviews were conducted with policy holders, administration officers, opinion leaders and caregivers. Focused discussions were held with community health leaders. Inductive qualitative approach was used on content analysis of data and Statistical Package for the Social Sciences was used to analyze quantitative data. **Results:** No previous action learning Model studies on this age group were found. Weekly interactions eased the impact and helped children to unreservedly share their traumatizing experiences. School attendance improved, frequent sicknesses lessened and ART intake was improved. **Conclusions:** Applying action learning Model on children experiencing traumatic psychosocial difficulties improves their coping mechanisms and promotes their resilience.

Keywords: psychosocial- experiences-Children -HIV/AIDS

INTRODUCTION

Long before the parent(s) dies, the child is exposed to hunger, fear, worry and anger leading to traumatizing psychosocial experiences[1]. Reviewed literature confirmed that following this loss, these children suffered exploitation, abuse, stigma and discrimination. They lacked love, care and attention where, even those who appeared to be coping needed support in fitting into formal systems and community safety nets[2]. Moving them away from their school, friends and neighborhood into unfamiliar environment increases their complications. Separating them from their siblings contributed to their problems of not being able to cope. This resulted in recurrent sicknesses, poor performance in school or complete drop out entirely to care for siblings and/or engage in child labour to contribute to the over burdened guardian's income. It also led to poor anti-retroviral therapy (ART) adherence for those infected.[3]

Age 6 to 12 years placed these children in a most exploratory phase of cognitive development whereby they explored their bodies as to what they see and hear from their peers. More often they got initiated in sexual activities very early (37% for girls and 44% for boys*) exposing them to HIV and other ills. If infected with HIV, they are likely to turn symptomatic 5 to 10 years later (resulting in HIV prevalence being highest in 15 to 25 year olds) and yet specific interventions to help them avoid the ordeal with this catastrophe are minimal.

The culture of silence where children are taught from childhood not to express their feelings before adults complicates communication rendering them misfits of the community. Traditionally, the psychosocial support, care, and love would be found within their family. Many children are left without this traditional support system and must cope with the added stress of moving away from home. Social and cultural barriers complicated by outdated traditional practices also contribute to their susceptibility. Decisions made in the new family about issues that affect them such as whether they continue with school or go to work to contribute to the household income sideline them and they have no say*.

Whereas 2.5 million children in Kenya are orphans, nearly half of these are orphaned as a result of HIV. PEPFAR initiative, through the government, Civil Societies and faith based organizations supported 596,616 of these children with services, basic needs and psychosocial support leaving out close to 2 million

---

[1] *McTavish 2012, WHO/UNAIDS/UNICEF 2011; NCP: Kenya Children ACT, 2010*

[2] *KAE Updates 2011;*

[3] *IHAA 2003, KAE Updates 2011*

[4] *KNASP (2009)*

children.   In spite of the fact that in 2010, the National Policy for children was endorsed by the cabinet, only a minimal number of deserving children affected by HIV and AIDS are receiving some kind of support[5].

The Child Health Strategy in Kenya has national interventions which include a range of neonatal healthcare, early childhood, school and adolescent health services targeting children 0 to 5 years then 13 to 18 years and nothing for 6 to12 year olds. Chalk boards maintained at the community level by community health workers and overseen by Ministry of Health staff, MOH monitoring and evaluation tools, all do not have a provision for collecting health indicators' data from children aged 6 to 12 year olds. There are neither specific interventions nor projections for the age group in the National focus in the control of the spread of HIV and AIDS, creating a big gap.

HIV and AIDS continue to devastate people as a major development issue given that it has reversed all the gains made during the pre-epidemic period. Despite global commitments to combat HIV infection to reduce child mortality, over a thousand children continue to be infected daily[6].   In Sub-Sahara Africa, due to lack of youth empowerment close to half of all new HIV infections occur among young people aged 15 to 25 years.   In Kenya, whereas 83.1% of the eligible adult population needing the life-saving antiretroviral treatment got it, in children it remained inaccessible or poorly administered with only 31.1% eligible children getting it[7]. Nyanza Province has the highest HIV infections placed at 13.9% representing 417,000 people due to wife inheritance, refusal to go for circumcision and practicing sex for survival among women especially young widows, compared with the National figure of 6.2%.   In Rarieda district, HIV prevalence stood at 23.6%.   The population of Omia Mwalo sub-location, among which the study was conducted, is surrounded with three beaches along the shores of Lake Victoria. Young widowed mothers go to the beaches to trade in fish and sex for survival.

Main objective is
To explore psychosocial experiences of HIV/AIDS affected children aged 6-12 years using Action Learning Model (ALM) in Rarieda.

Specific Objectives
a.   To operationalize the ALM as an appropriate tool to study the psychosocial experiences of these children.
b.   To determine the psychosocial experiences of these children and identify possible solutions for them to thrive.

METHODOLOGY

1.   Ethical considerations

This study was conducted on children called by pseudonyms[8]. Approval was sought and received from the Institutional Review Board of the Ethical Committee of the Great Lakes University of Kisumu to ensure that their rights were not violated and the research did not pose any danger to them.   For transparency, consent approval was obtained also from the policy holders: Ministry of Health Officer (MOH), Children Department Officer (CDO), local Administration (Chief), Opinion leaders, CHWs, Officer in charge of health facility and guardians prior to data collection.   The context of research could become manipulative if I ignored the potential for harm to vulnerable research study subjects like the children[9].   Since the study was planned for 6 months of which 3 would be with children, clear engagement and disengagement processes were explained. Children were informed of phasing out which was then done gradually.

2.   Research Methods used

The study settled on purely qualitative design to collect the primary descriptive data, from the children rather than the secondary design as this would collect quantitative data which would not ethically be suitable here.   Out of the five approaches of the qualitative design namely Ethnography; Narrative Research; Phenomenology; Grounded Theory, and Case Study, only phenomenology was suited for this study as it is done by interviewing the subjects to learn their impressions and attain descriptions of the inner being of the interviewee in order to understand the meaning of the described occurrence or phenomenon. This study aimed at understanding the lived experiences, perceptions, views, struggles and understandings of the sampled children as a specific phenomenon. Discussions followed reactions observed including crying leading to first hand data

---

[5] *Fraser et al., (2010); KAE Updates (2011);*

[6] *UNICEF, (2013) ; NASCOP, 2012, p.16*

[7]*KNPA on OVC, 2011*; *The Kenya AIDS Updates 2011*

[8] *Kothari, 2011 Cohen, et al 2000*

[9] *Crane S., 2017*

collection eliminating contamination. Secondly observation describes phenomena as it occurs in its natural settings thereby reducing biases. Thirdly unlike in interviewing where one interview face to face and so increases the respondents' behaving in uncharacteristic manner; observation reduces such artificiality especially if the respondent is unaware that they are being observed. When children became accustomed to my assistants and me, they did not regard us as outsiders and so they behaved naturally. Using this descriptive approach helped follow up the child, observe then work through some exercise which would help the child bring out their true concern[10].

### 3.	Children identification and engagement

To rule out biasness and ensure rigour and validity of selection of participants, children were assessed three times using the Child Status Index (CSI) Tool (Appendix 1a&b). The third time was done by independent researchers who were new in the area and had no direct benefit in the study. 17 CHWs administered the CSI tool to all the 772[11] children from the thirteen villages aged 6 to 18 years. 374 out of 772, children were found to be affected by HIV/AIDS and so became my sampling frame. Using the SPSS to analyze data from the 374, 75 children were identified as being in a poor state of health, (*those that scored 1 – very poor and 2 - poor, see Appendix 1a&b).*   Out of the 75 children, 51 were aged 6 to 12 years old. Out of 51, 16 resided in the village and had no plans to move out for the next 6 months. So the 16 were recruited into the study. One of my inspiring convictions about engaging with children was to be able to listen to their voices, thoughts, fears and inspirations as I engaged with them using ALM.   To avoid biases, I deliberately left out the voices of Guardians, and other significant adults in the children's lives during these engagement processes.

### 4.	Interventions

First was the CSI Tool[12] – it was used in identifying deserving children.   Second   was   a researcher-created questionnaire validating the correctness of the interview protocol[13].   This was a pre-determined set of questions based on the primary research questions, that every participant (Guardians and key informants) were asked. For credibility of the study, I sought consent of the Guardians, policy holders and opinion leaders to ensure children are not abused. Thirdly a checklist for focus group discussion was done and administered to CHWs. So questionnaires, checklist and Consent Forms were developed tested and used.   The fourth tool used was the Action Learning Model originating from the renowned Action Learning Approach[14] traditionally used on adults to address their collaborative and team management skills.   Action Learning Model was theorized into a model comprising three strategies:

Strategy 1(ST1):	**Promotion of Self Esteem**
ST2:	**Promotion of Socializing**
ST3:	**Promotion of Resilience**

ST1: Promoting Self esteem: involved children's initial engagement through talking, storytelling, singing and dancing, reciting poems, riddles, proverbs and general interaction with each other followed by one on one discussion and/or group or team discussion.   Often researchers interact with children directly in their homes[15] but adults can easily influence children and children react differently in adult presence in different settings[16]. Venues away from adult interference were used for interviews, plays and counseling sessions. I agree with Noble-Carr where he states that, "...*it is frequently desirable to interview children in their own home but away from adult's hearing. This often provides important observational data...*"for me, and that engaging children in their own setting made them comfortable and less anxious.

ST2: Promoting Socialization: involved outdoor play and games simulation. Action oriented activities that brought the children together in teams followed by one on one and joint group discussions. Different types of games were engaged in at different times. Some were individual plays while others needed a group or a team. During play sessions, children were observed very closely on how they reacted and responded to the engagement.

ST3: Promoting Resilience involved deeper engagement with the children through drawing and painting followed with discussions individually or group leading to their resilience[17].   Children, who loved drawing, expressed their very deep feelings and experiences in it.   Often the drawing did not make much sense to the

---

[10] *Noble-Carr D,2006, Frankfort-Nachmias C, 2009, Creswell JW,2013*

[11] *DSO, Bondo, 2008*

[12] *O'Donnell K, 2008- (App. 1a&b)*

[13] *Gorard, 2013*

[14] *Revans R 1982, Pedler M,2011*

[15] *Merriam, 1998 p5*

[16] *Noble-Carr D, 2006*

[17] *Frankfort-Nachmias 2009 5th (ed) p.19-2, 180-182;*

observer till the child explains it like Apple (7years old) here. He drew 2 houses – a small leaking grass thatched one without a window. The bigger house was iron roofed, had doors and windows and cemented floors. Beside the smaller house was an anthill surrounded by water where a small child with raised hands was seated. Sadly, Apple explained that, "*the big house is my grandparents'*; *the smaller one is their kitchen where I sleep alone since my mother died when I was 4 years. Seated on the anthill which is my mother's grave, is me calling her to come for me! I am rained on at night, but when I run out to my grandmother in her big house, she shouts at me to find a dry corner that is not leaking in the kitchen and stand there. She tells me that if I go to her I will infect them like my mother infected me with HIV!*

5.   Data storing methods

Audio taping could interfere with children focusing their attention to it and behaving unnaturally so I used "Memoing"[18] or Field notes taking which is a secondary data storage method in which a researcher records daily all that transpires[19]. Four types of field notes were made: Observational notes (ON) – for all observed using of all senses. It is the "what happened notes": Theoretical notes (TN) that expressed my thoughts, or reflections on the experiences of the children; Methodological Notes (MN) covered a critique to the process, I undertook, reminders and instructions; Analytical memos (AM) – I analytically summarised the proceedings of the day and filed all the progress reviews. I maintained a balance between descriptive notes and reflective ones such as hunches, impressions and feelings. These were typed and stored in a soft copy apart from children's drawings and paintings, which were stored as they were.

6.   Analyzing data collected

For the purpose of data reduction and generation of themes from the collected information, data were subjected to content analysis. The first step of the data analysis consisted of the coding process in which open coding was used. This involved a literal line-by-line reading and interpretation of the data to identify a wide range of categories from the identified relationships between codes and the grouping of codes into coherent categories. The final level of analysis involved the iterative mapping of codes and the identification of their relationships and interactions forming themes[20].

RESULTS

Two objectives of exploring and determining the psychosocial experiences of these children and operationalizing the ALM as an appropriate tool to study the phenomenon are reported as follows:

1.   Exploring psychosocial experiences

a.   **Separation of children:**

45% of the children were separated with their siblings at the death of their parent(s) or guardians. These children expressed a lot of fear and concern as to how their siblings were doing. They said that every time they got beaten they wondered whether their siblings were suffering the same. Some even worried that if they went without food so often what could be happening to their siblings? It was quiet traumatizing for the children to remain separated for whatever reasons.

b.   **Poverty:**

Minimal resources in the family accelerated suffering among children. Guardians who had taken in an orphan on their meagre resources reported a lot of frustrations to both them and to the child. Some of the contributing factors were:

> ➢ **Poor or no harvest** – Due to prolonged drought and outdated farming practices harvest was poor and communities depended on buying cereals resulting in severe hunger – very few families could afford one meal in a day.
> ➢ **No source of income** – little cash was in circulation and no capital to boost income generating activities. The local market nearby served as the source of livelihood to the women for trading in anything available including prostitution and local brew.
> ➢ **Parents dying, leaving no savings for their children:** Grandparents expressed concern that when their departed children were brought home for burial, there were always no savings left for their children leading to a real burden added on an already loaded family system.
> ➢ **Illiteracy** – those assessed, 12% never went to school at all. 44% had only lower primary education; 38% had upper primary and 6% dropped out of secondary school.

---

[18] *Miles & Huberman, 1984, pg 69*

[19] *Lofland & Lofland, 1999*

[20] *Kothari CR, 2011*

> **Ignorance** – Asked on knowledge about effects of HIV among children, 25% correctly expressed themselves. 75% mixed it up with strong traditional beliefs and practices.

c.   Culture of silence, negative traditional practices & religion:

Children said they are told to remain silent or get caned if they talk.   Talking back to an adult, they were told was very rude. So they leant to remain silent in everything. In the traditional practices, children said that they were not allowed to share sleeping spaces with adults especially if the adults were in sexual relations with their partners.   A woman would rather have children sleep in a dilapidated kitchen or send them to a neighbour's house to sleep even as she had a good spacious house to herself with her spouse or male friend - the wife inheritor.

Some said their religion forbade them from taking conventional medicine but holy water.

d.   No attention and love, Rejection:

Children expressed feelings of rejection from guardians who were not their real mothers like Sandhra said that, *"they send me to the river to collect water only to return and find when they have eaten the only pawpaw we were to eat so I remained hungry"*.   Jamna said, *"Clothes are bought for their children alone and none for me yet I am beaten because I went to borrow a dress to wear as my only one was torn and dirty"*. Children expressed a lot of unfulfilled desires in their live resulting in trauma and stress.

e.   Severe punishment, over working, and child labour

38% of the children reported being beaten severely for different reasons, like, Pawpaw said, *"While grazing, one cow strayed into a neighbour's garden but did not destroy anything, I was caned thoroughly and denied food till the next day"*. Avocado said he refused to go back to fetch water the 6th time and, *"I refused because I was very hungry, and while I was collecting water those five times their children were given food. I was beaten till I started bleeding from the nostrils"*. Recalling this ordeal, the child burst into tears and said he desires to follow his parents. Jamna said, *"When I returned from school I started doing all the household chores no one had done. I finished and started preparing supper. When it was ready, every one sat down to eat as I was asked to sort out maize and beans and put on fire for next day. When they finished eating then I was given the remaining little food. I quickly ate it and washed plates. Since I had homework, I sat on the table with other children who were finishing their work. When done my guardian came and blew out the lamp saying I am finishing paraffin for her children. They will use it the next day. When I got to school the teacher caned me severely for not finishing homework…!"* Lemon stated in between tears, *"When you sit down a bit to rest from hard work you have been doing since morning, with no food, you are beaten severely"*.   These are some of the sentiments given by the children during ALM exercises, sometimes in play, in drawing, or direct in a counseling session.

f.   Rape, Incest, Child Abuse and Exploitation:

Children reported neglect; inappropriate work for age, abuse both physical and sexual, child labour and exploitation. Rape and incest was reported as if it was a normal occurrence, mostly committed by people well known to the child with promises of being given food or school requirements. As reported, often the child saw nothing wrong with it like the case here (even her pseudo name left out for her safety) *"my auntie's man friend would wait when she has gone to the market, he takes the baby from me and goes into our one roomed house. He then calls me inside the house to take the baby. When I enter, he locks the door. He talks to me nicely and gives me a small packet of milk and biscuits which he would have hidden from my auntie. Since I am very hungry, I eat very quickly. He promises to bring for me every day and warns me not to tell my auntie. After eating we would play some games he taught me. He would tell me to allow him to touch my private parts gently. He assured me that he would not hurt me and that I should touch his also. Then we suck each other's private parts. One day my auntie came back early and found us playing that game. She beat me up badly and chased him away. Now I go without food and I am suffering a lot!*

2.   **Operationalizing the Action Learning Model**

It helped children to avoid engaging in risky and aggressive behaviours by developing self respect. It encouraged teamwork and increased tolerance towards others and also improved their supportive behaviours towards their peers. It promoted self discovery leading to positive change. It enabled children to open up, arise, isolate issues affecting them and finding solutions.   It taught them how to speak for themselves to reach out to others and share instead of remaining silent with disturbing issues. Role-playing and drama helped children to act out situations or re-enact their experiences. Puppets and models were especially useful for working with children who had been sexually or physically abused, because they found it easier to describe or show what had happened to the puppet rather than to themselves.

DISCUSSION

The Action Learning Model addressing self esteem, socialization and resilience strategies were applied over a period of three months. The study applied all methods of gathering data namely interviewing, observation, focus group discussion and exploring existing records through the phenomenological approach of the qualitative research design in an empirical primary paradigm. Inductive qualitative design was used on content analysis of data and SPSS was used to analyze quantitative data.

Objective 1:   To operationalize the Action Learning Model as an appropriate tool for the study

Policy implication of the study

To address children's issues, the study revealed that the Children's Department needs to involve all other policy holders such as MOH, Ministry of Agriculture, administration, spiritual leaders and other stakeholders and Guardians.

Study findings

Children in distress, who have minimal external support, can identify each other and help each other to rise up from their challenges and move on.

Objective 2:   To explore and determine the psychosocial experiences of these children.

Policy implication of the study

The first gap was lack of recognition by the Ministry of Health in the National Strategic plans[21] of age group 6 to 12 years and their unique problems and experiences. The second gap was lack of adult support and direction leading to harming the children. Third gap was guardians burdened with caring for the orphans with no coping mechanism especially knowledge and resources to support the children.

Study findings

a)   Challenges that put children at risk

Lack of basic needs got children lured into compromising into risky actions. Child abuse and neglect threatened a child's life and their total well being. Being overworked yet being given little or no food at all leads a child to poor health, resulting in poor school performance or even dropping out of school entirely.

b)   Low self esteem and poor socialization

These children face multiple HIV related stressors including illness and death of guardians, lack of adult guidance, stigma and discrimination, disclosure of the HIV status, loneliness, isolation, family conflicts and no involvement in decision making on matters affecting them[22]

c)   Children's silence, disclosure, stigma, discrimination, death and bereavement

Death of a parent(s) in some cases violated and/or compromised the child's right to education, good health, play, leisure and to being protected from all forms of abuse and exploitation, resulting in extreme psychosocial suffering This situation is worsened by the persistent stigma and shame attached to HIV/AIDS which the child experiences everywhere they go. The study confirmed reactions from the children that feelings associated with the death of a parent are usually negative and painful to experience. We also agree that grief can be very difficult to deal with, especially in cultures that prevent children from expressing such feelings[23].

d)   Orphan-hood and residing with new Guardians

It emerged that often guardians are totally unaware that the child is suffering from psychosocial challenges. Avocado, a total orphan in the study, held on to the spiritual side of things and in his mourning, he consoled himself that although he failed to see his mother on earth, spiritually, he will see her in heaven. This is a divine way of dealing with this traumatizing situation to enhance resilience[24] and it re-enforces that religion of whatever sort is intertwined with enhanced physical and mental health of a child. Others may look for a reason why a parent died, feeling betrayed by the guardian or fate or God or their ancestors. Some children need meaning to be given to the death of their parent[25].
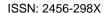
---

[21] (Global Report, (2012) p.11

[22] *Aidstar 2011*

[23] McTavish M, 2012

[24] *Schenk 2005*

[25] *Clarke, 2005 175(6), 489-505*

e)   Posts which offered children strength, power and support

The relationship between the guardian and the child plays a crucial role in cushioning the child from further psychological and emotional hardships Also the child's resilience has been found to pivot closely on the emotionality of the primary guardian.

Promotion of children's resilience – ST3 promoted and encouraged:

behavioral change which entailed basic life skills, communication and negotiation skills; responsible decision-making, following and obeying the set values and norms of a family, a child is fostered into; allowed children to voice their own concerns, ideas and share them with their peers; adults need to acknowledge the fact that young people are able to take responsibility, and create the opportunity for them to do so and support them. It helped affected children to resume normal activities such as going back to school as soon as possible after the demise of a parent; kept siblings together as much as possible and not to separate them if it can be helped;   the child to be part of a group and to spend time with other children; adults especially the guardians to spend time with the child, showing interest in them and having fun together; use of honest language that the child can understand when talking to them and listening to what they say and try to understand what the child is feeling; the child to take part in religious or cultural rituals and a guardian should share positive memories and stories about the deceased parent with the child and what the parent did when he or she was the child's own age.

New knowledge from use of the ALM

This study led the children into understanding and demonstrating things they otherwise had been unable to do. These cutting across situations where they now can talk, make informed decisions as they grow up to reduce the spread of HIV. According to the existing literature no one else had applied ALM directly to the children before.   It is a strategy of involving children to discover themselves and discover what disturbs them in a manner that is child friendly and respecting the rights of a child.   The promotion of well being and resilience enables children to better deal with challenges, and can thus prevent future complications.   Action learning concept has been researched deeply, tested and proved to be robust in that it can operate without failure under a variety of conditions and it can also handle variability and remain effective[26]. Applying ALM on children in this study brings out its robustness. This is a concept that can be applied to different situations, and yet produces the desired results

CONCLUSION

Action Learning Model helped the children to focus first on themselves, discover who they are, their circumstances, difficulties they face and possible ways of overcoming them. It boosted their self-esteem, broke communication barriers encouraging them to speak and put feelings into words and expressions so they can be helped to promote their resilience. It taught children to share and link up in a team for peer support and to realize that they were not alone in this struggle especially where there was no other person willing to listen to them without condemnation. It improved their coping mechanisms and promoted their ability to thrive.

REFERENCES
[1]   McTavish M, Streelasky J, Coles L, Listening to children's voices: Children as Participants in research. International. Journal of Early Childhood Vol. 44,   Issue 3 Nov. 2012 p249-267;
   1.   World Health Organization, United Nations AIDS/United Nations Children Fund 2011;
   1.   National Children Policy: Kenya Children ACT, 2010

---

[26] *Bjorklund & Causey, 2017; Gorard, 2013, Reynolds, M., 2011, p.5, Grotberg EH, 2005*

[2]   Kenya AIDS Epidemic Updates 2011
[3]   International Health AIDS Alliance , 2003
        3.   Kenya AIDS Epidemic Updates 2011
[4]   Kenya National AIDS Strategic Plan, 2009
[5]   Fraser N, Rapid analysis of HIV epidemiological and response data on vulnerable populations in the Great Lakes Region of Africa, World Bank Global HIV/AIDS Program 2008
        5.   Kenya AIDS Epidemic Updates 2011
[6]   United Nations AIDS Children Education Fund, 2013
        6.   National AIDS Control Council & NASCOP, 2012, p.16
[7]   Kenya National Plan on OVCs, 2011;
        7.   The Kenya AIDS Updates 2011
[8]   Kothari CR, Research Methodology – Methods &Techniques (2nd Ed), New Age International Publication, 2011
        8.   Cohen W, Richard M, Nelson R, Walsh J, Case Studies: Research Methods 2000
[9]   Crane S, Broome ME, Understanding Ethical Issues of Research Participation from the Perspective of Participating Children and Adolescents: a Systematic Review, Wiley Online library, 16 February 2017, DOI: 10.1111/wvn.12209.
[10]   Noble-Carr D, Engaging children in research on sensitive studies, Institute of child protection studies, Australia Catholic University [National Canberra] 2006,
        10.   Frankfort-Nachmias C, Nachmias D, [5thed.], Research Methods in Social Sciences, Hodder Ed, St Martin's Press Inc. 304-316, 2009 p.19-2;
        10.   Creswell JW, [3rd Ed]. Qualitative Inquiry and Research Design Choosing among five Approaches, SAGE Publication Inc. 2013
[11]   District Statistical Office Bondo, 2008
[12]   O'Donnell K, Nyangara F, Murphy R, Nyberg B. (2008), Child Status Index: MEASURE Evaluation. (2014). Child Status Index Tool Kit, Chapel Hill, NC, USA: University of North Carolina.   Retrieved from: https://www.measureevaluation.org/ resources/tools/ovc/child-status-index/child-status-index-tool-kit
[13]   Gorard S, Creating Robust Approaches for Social Sciences, SAGE Publication Feb.2013
[14]   Revans R, The Origins and Growth of Action Learning, Bromley, U.K. Chartwell 1982,
        24.   Pedler M (ed.) Action Learning in Practice, 4th edition; Aldershot, U.K. 2011
[15]   Merriam SB, Qualitative Research in Practice, Oaks SAGE Publication (Pub) (1998
[16]   Noble-Carr D, Engaging children in research on sensitive studies, Institute of child protection studies, Australia Catholic University (National Canberra) 2006,
[17]   Frankfort-Nachmias C, Nachmias D, 5th(ed.), Research Methods in Social Sciences, Hodder Ed, St Martin's Press Inc. 2009 304-316 pg 181/2
[18]   Miles M, Huberman A, Qualitative data analysis: An expanded source book (2nd ed), Thousand Oakes: Sage, pg 69 1994
[19]   Lofland LH, Data logging in observation: Field notes. In Bryman, Burgess RG, (Eds.), Qualitative research (Vol. 3). 1999 London: Sage.
[20]   Kothari CR, Research Methodology – Methods &Techniques (2nd Ed), New Age International Publication, 2011
[21]   Kenya Ministry of Health, Global Report, (2012) p.11
[22]   Aidstar < http://www.aidstar-one.com/focus>, http://www.aidstar-one.com/focus.areas/pmtct> www.unicef.org/.../index prevention you...) , 2011,
[23]   McTavish M, Streelasky J, Coles L, Listening to children's voices: Children as Participants in research. International Journal of Early Childhood Vol. 44,   Issue 3 Nov. 2012: p249-267
[24]   Schenk K, Williamson J, Ethical Approaches to Gathering Information from Children and Adolescents in International Settings: Guidelines and Resources. Washington, DC: Population Council 2005
[25]   Clarke A, Listen to & Involve young children: A review of Research & Practice ECD/Care 2005 175(6) 489-505
[26]   Bjorklund DF, Causey KB, Children's thinking: Cognitive development and individual differences, 2017, SAGE Publications
        26.   Reynolds M., Reflective Practice: Origins and Interpretations; Action Learning: Research and Practice, Vol.8, Iss.1, 2011, Pg 5
        26.   Grotberg, EH, A guide in promoting resilience in children: Strengthening the human spirit. Amsterdam, Bernard Van Leer Foundation. 2005