



COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF PSYCHIATRY

GRADUATE PROGRAM IN CLINICAL PSYCHOLOGY

MENTAL DISTRESS AND ASSOCIATED FACTORS AMONG

ORPHAN CHILDREN: CASE OF KECHENE AND KOLFE

GOVERNMENTAL CHILD CARE AND REHABILITATION

CENTER

By

ASSAYE TILAHUN

JANUARY, 2018

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Abbreviations and Acronyms

AIDS: Acquired Immunodeficiency Syndrome

BDI: Beck Depression Inventory

CMD: Common mental disorders

CSA: Central Statistical Agency

CBO: Congressional Budget Office

CIF: Children Investment Fund

CSA: Central Statics Agency

EHAPCO: Ethiopia HIV ADIS Prevention and Control

HIV/Aids: human immunodeficiency virus/acquired syndrome

HADS; Hospital Anxiety and Depression Scale

IEMF: International Encyclopedia of Marriage and Family,

IOC: Institutionalized Orphan Children

MOH: Ministry of Health

MIGFPROF: Ministry of Gender and Family Promotion, Republic of Rwanda

MOLSA: Ministry of Labor and Social Affairs

MOWCYA: Ministry of Women, Children & Youth Affairs

PTSD :Post-traumatic stress Disorder

NGAC: National Guidelines for Alternative Care for Children

NIOC: Non-Institutionalized Orphan Children

NYOL: Number of Years of Living

NGO: Nongovernmental organization

NPA: National Plan of Action

OVC: Orphan and Violated Children

PTE: Posttraumatic Experience

UN: United Nations

UK: United Kingdom

UNAIDS: The Joint United Nations Program on HIV/AIDS

UNICEF: United Nations Children's Fund

WHO: World Health Organization

WV: World Vision

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Abstract

Research in the developed world has explored effects of bereavement on children, and has showed differing mental health effects of parental loss. In our country, however, the relationship between mental distress of orphan who live in child care and rehabilitation center and associated factors has received little attention. To assess the mental distress and associated factors among orphan children in children's care and rehabilitation center in Addis Ababa. Cross sectional quantitative study was conduct on two purposively selected governmental child care and rehabilitation center, namely Kechene and Kolfe in Addis Ababa, from January to December, 2017. All Children who were in the age group of 11 - 18 years residing in child care and rehabilitation center orphan were included in the study. A structured questionnaire from Hospital Anxiety and Depression Scale (HADS) were translated into Amharic language and used to collect data; EPI info version 7 and STATA version 12 were used to data entry and analysis. Multivariate analysis was applied to identify correlates of mental distress and independent variables. More than half (51.81%) of children who were included in the study experience mental distress; the most prevalent type of mental distress was Depression (52.9%) followed by anxiety (51.1%). On the other hand, 31.9% of respondents were experienced abnormal Anxiety and Depression Symptoms. Both children's educational status ($P < 0.037$) and quality of relationship with worker ($P < 0.004$) had significantly associated with depression, while quality of relationship with worker ($P < 0.004$) had significantly associated with Anxiety. This study finding indicate depression and anxiety among child care and rehabilitation center orphan hood were common, especially children who had poor relationship with care providers and lower educational status were the most vulnerable; suggested that they may be in need of support. So, early identification and intervention is necessary for the children living care and rehabilitation center to prevent further consequences.

KEY WORD:- *Mental distress, orphan, children, care and rehabilitation center.*

Chapter One

Introduction

1.1 Background

Mental disorders are a global public health agenda and about 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression, other common mental disorders and substance use disorders (WHO, 2001).

Orphaned and Vulnerable Children are caused socio-economic and developmental problem for all developing countries in the world. Orphan-hood is frequently accompanied with multidimensional problems. Most of the time children loss their parent faced by adverse reactions such as anxiety, hopelessness, suicidal ideation, loneliness, anger, confusion, helplessness, and fear of being alone that can further jeopardize children's prospect (Cluver,2008) .Orphan children have shows feeling more depression, personality disorder, and anxiety/insomnia tendencies than do non-orphans (Tweed ,1989) . Orphanage children can be distress luck of financial difficulties which is associated with parental illness and death (Silverman, 2000).Based on the joint report of UNICEF (United Nations Children's Fund), about 153 million children are orphans worldwide, 17.8 million of them have lost double parents and also recent report shows that there are approximately 145 million children worldwide who have lost at least one parent as because of different causes (W HO, 2008).

Research in the developed world has explored effects of bereavement on children, and shows differing mental health effects of parental death from causes such as homicide (Black, 1992). Because of HIV/AIDS in the recent years, police makers are challenging to support for children. HIV/AIDS orphan children are higher than children orphaned by all causes and those affected by the socioeconomic. High support focused on the physical well-being rather than psychosocial for orphans and vulnerable children (OVC); but it need focused like physical wellbeing as soon as possible. As countries create and revise their National Plan of Action for OVC (NPA) in coming years, they need investigation and policy guidance to answer the lack of support for the mental and emotional needs of orphans (Baaroy, 2008).

Large and growing numbers of OVC children are a worldwide concern; whereas sub-Saharan Africa including Ethiopia has the highest proportion (one in seven) of children are orphaned (UNAIDS, 2004). Orphan children may face many hardships during childhood including a decline in health, nutrition, and psychological problem (Laura, 2008).

Like adults, children are grieved by the loss of their parents. However, unlike adults children often do not feel the full impact of the loss simply because they may not immediately understand the finality of death. This prevents them from going through the grieving process which is necessary to recover therefore are at risk of growing up with unresolved negative emotions which are often expressed with anger and depression. Unfortunately, adults do not seem to appreciate that children are also adversely affected by bereavement even though they may not

have an adult's understanding of death. Little attention is therefore given to children's emotions. Children are not given the required support and encouragement to express their emotions nor are they guided to deal with them (Cluver, 2007).

Population based surveys in Africa generally showed higher prevalence of common mental disorder among the community from 10.8% in Kenya to 34.9% in South Africa. Whereas, a 12.1% of life time prevalence and 5.8% of 12 month prevalence of common mental disorders (CMDs) was shown in Nigeria. Available community based studies in Ethiopia conducted in Butajira, Addis Ababa and Kombolcha town indicated that, common mental disorders are the highest ranging from 17%-32.4% (Alem,1999).

Around 5.4 million orphans in Ethiopia as a result of lost one or both parents, around 15% children orphaned by because of HIV/AIDS (EMOH, 2007). Mental illness is the leading non communicable disorder in Ethiopia and this disorder predominantly affect rural area of Ethiopia and it accounts 11% of the total burden of diseases, with schizophrenia and depression (FMOH, n.d.). Other recent study conducted revealed that the prevalence of mental distress is high and accounts 17.7% (Gelaye, 2012). Cross sectional base study at orphanage, 74 (25.3%) of orphan adolescents were depressed and 52 (17.7%) were anxious (Gelaye, 2012). A study in Uganda showed that orphans had higher impacts of anxiety, depression and anger than non orphans.

Furthermore, orphans had significantly higher scores than non-orphans on self administered items in the Beck Youth Depression Inventory that are indicate the symptoms of depression disorder (Atwin,2005). Likewise, kebede's and Gelaye's studies School based orphanage facility has higher prevalence of mental distress among medical students than the general population.

This research tries to show mental distress of child care and rehabilitation center of two purposively selective center and associated factors of their distress. And recommended the solution of their problem based on the result.

1.2 Statement of the problem

'Orphans' as a category of vulnerable children are at the forefront in the context of the global AIDS crisis. Orphans and vulnerable children (OVC) continue to maintain a spot at the forefront of the international agenda with millions of children worldwide being orphaned or made vulnerable by HIV/AIDS (UNAIDS, 2004). Currently the notion of 'Orphans and Vulnerable Children' (OVCs) dominates much of the child protection debates across sub-Saharan Africa. Data from Young Lives in Ethiopia challenges the assumption that parental death alone results in poorer life chances for children. While orphan hood can impact on children's psychosocial well-being, socio-economic deprivation needs to be considered as well (UNAIDS, 2004).

Many Researches has been carried out on orphan and vulnerable children. A lot has been mentioned about this orphan and vulnerable children (OVC) worldwide at large. Nevertheless, there is limitation on the existing knowledge in our continent and country because they concentrate only on certain dimension of OVC (Tatek, 2008).

Psychosocial distress mainly associated with anxiety, loss of parental love and nurture, burden of caring for the sick, impact of family dissolution, stigma, discrimination, grief and frustration seriously affect adolescents (Mums for Mums, 2011).

From the existing studies in Ethiopia, psychological wellbeing of OVC at orphanages found that the majority of the participants felt sad, and in stress due to lack of good relationship with service providers and the community, and due to grief and bereavement of their parental loss(Sebsibe, Fekad,2014). Research was done on Psychological distress and its predictors in AIDS orphan adolescents shows that a large proportion of orphan adolescents are having psychological problems that can affect their present and future life. Thus, a more focused and concerted effort is needed to improve their mental health (Getachew .2011).

Addis Ababa women, Children and Youth Affairs Bureau and the Ministry of Women, Children and Youth Affairs and others indicate that OVC are suffering from psychological problems, like anxiety, distress and emotional disturbance (W.V, 2011).

In Ethiopia, the metal health of children in orphanage is less studied. The limited research that gives emphasis on HIV orphans who suffer from particular social and economic disadvantages and mental health problems. Particularly, in this area there is lack of research concerning about

mental distress. In light of this, this study generally assessed mental distress of orphan children in these child care and rehabilitation centers and identified factors associated with distress. Specifically, the study assessed mental distress like depression and anxiety and their predictors.

Even if mental problem was included in the national health policy of Ethiopia, interventions against the problem are very limited and lack of information about the problem is a contributory factor for poor mental health services. Hence, Epidemiological data which shows the burden of mental health problems in students over time is mandatory. Therefore, this study was aimed to determine the prevalence of mental distress and identify the associated factors for mental distress among orphan children. Results from this study will help in developing evidence based mental health promotion and disease prevention programs.

1. 3 Significance of the study

The study assesses the level of mental distress of orphan children. The findings of this research could be used by those involved in therapy and in counseling to identify children who are at high level of psychological distress and to develop and improve prevention and intervention methods for orphans. The findings could also be used by policy makers and help in providing important direction for conducting further research in the areas of mental distress and mental health of orphans those has been lived in child care and rehabilitation center.

Chapter Two

Review of Related Literature

2.1 Concepts of Psychological Distress

Psychological distress has been recognized for thousands of years. Psychological distress is broadly explain as a state of emotional difficulty characterized by symptoms of depression (e.g., lost interest; sadness; hopelessness) and anxiety (e.g., restlessness; feeling tense) .People with mentally abnormal can have distorted in their think, feel or behave. In other words, their thinking, feeling and behavior is abnormal (Mirowsky, 2002).

In Ethiopia orphan children are called in different phrases by differences Peoples based on their understanding and commonly used in their area. such as, welagi alba hitsanat (ወላጅ አልባ ህፃናት) in media to mean that children who have no true parents, they are also called, Asadagi yelalachew hitsanat“ (አሳዳጊ የሊላቸው ህፃናት) to mean that children who have no care and support providers like guardian, as well as they are represented by welajochachewin bemot yatu hitsanat (ወላጅ ጅቻቸው በ ሞት ያ ጡህ ፃ ና ት) meaning that children’s parents not alive in life (Tatek, 2009).

The word 'distress' is repeatedly used in nursing literature to explain emotional problem of clients associated to symptoms of mild up to sever psychological disorder. Psychological distresses may more accurately describe the patient condition to which nurses respond than does the term 'distress'. Sometimes psychological distress is defined as a unique way and is often embedded in the context of strain, stress and distress. This is a challenge for nurses try to help attempting to manage the care of people experiencing psychological distress peoples (Nurs,2004).

2.2 Orphanage

“Orphanage” is used to refer to facilities for the short- or long-term care of a child other than in a family setting. Children living in orphanages are one of the most vulnerable groups in a society; many of them have to live with repeated neglect, abuse or fear (Rutter, 1989). Orphans frequently lack sufficient food, shelter; schooling and medical care and are at risk of abuse and economic exploitation (Berry, 2003). Most research work on orphan concentrates on basic need. There is little available research, but increasing concern, regarding the psychological well-being of orphans in Africa (Cluver, 2006).

2.3 Causes of being placed in orphanages

UNICEF report shown that approximately 2.2 million children live at institutions in the worldwide (USG, 2010).Orphanages provide basic support and care for orphan in different level mean small up to large-scale institutions. The number of Children is not clearly counted and registered even if they live at orphanage because of this the number is significant underestimate (Faith to Action, 2014).

The majority of children in orphanage globally are single orphans (Abdullah, 2013). Depending on the region, increases of 50-90% of children living in orphanages at least has one parent alive (Williamson, 2010). In Africa new born child became as an orphan every 15 seconds cause of AIDS, more than 5,760 children become orphans per day and more than 2,102,400 children

become orphans (in Africa alone). Every 2.2 seconds, another orphan child ages out with no family to belong to and no place to call home (Faith to Action, 2014).

Most of the time Children are lost their parental care because of different reason like Poverty, lack of access to basic services, abuse, neglect, disease, disabilities, and emergencies. In parts of Africa and Asia, Because of poverty children are inability to get access of education (supplies, transport, clothing, etc.) and parental illness is a driving force for families to place a child in orphanages (TFTAI, 2014). Poverty is often mentioned in different studies as the reason for placing children in orphanages (Bilson, 2007) .Parents and other caregivers struggling to provide for their children may feel compelled to use orphanages to address an immediate problem. In many regions where material poverty is prevalent, evidence demonstrates the “pull factor” of residential care as the means of meeting such basic needs as food, access to education, and other services for children (MIGEPROF, 2013).A recent study in Europe more than 90% of cases for child abandonment the reasons of poverty and homelessness were (and subsequent placement in orphanages).Luck of nutrition affects children’s attention span and memories, more isolation and fewer positive peer relationships.

A dose–response relationship has also been reported between degrees of malnutrition and externalizing behavior at ages 8–17 years (Liu .J, 2004). A similar study has been found in Karachi orphanage, conduct problems was about more than twice in malnourished compare to well-nourished children (Zohra,2010). Stress thus leads to a disturbance in the organism’s internal equilibrium, and when it is it excessive it can cause damage, like the appearance of organic and behavioral responses (Masci, 1997).

Chronic diseases such as AIDS and lack of necessary medical treatment are frequently correlated with poverty. A recently published study of Rwandan orphanages found that poverty, together with death of a parent or abandonment by a parent, was the reason for placement in an orphanage in 40% of all cases (MIGEPROF, 2012). Studies at orphanages in Ethiopia shown that the most commonly noted reasons for children being placed in orphanages were parental HIV and AIDS status or other chronic illness and poverty (UNICEF, 2010).

2.4 Psychosocial support of children

Psychosocial support describes a continuum of care and support and aims at ensuring the social, emotional and psychological wellbeing of individuals, their families and communities. The provision of psychosocial support services is aimed at enhancing the social, spiritual and emotional wellbeing of orphaned and vulnerable children and youth and may be preventative or curative in nature.

Psychosocial support may include a range of actions along the continuum: Love and affirmation, Ensuring that the child's basic rights are realized (for example protection, nutrition, development, health care, and participation), Listening and responding to the child in order to assist him or her to cope in times of difficulties such as coping with loss or exposure to frightening experiences. Ensuring that the child is well connected socially to others, strengthen the life skills of the child.

Findings underscored the urgency and essentiality of culturally and developmentally appropriate intervention efforts targeting psychosocial problems among children affected by AIDS and call for more explanation of risk and resilience factors, both individual and contextual, affecting the psychosocial wellbeing of these children. U.N Global AIDS Report, (2006), showed three of four children who came to the attention of the child welfare system because of a child abuse and neglect investigation and who had clear clinical impairment had not received any mental health care within 12 months after the investigation (Stanton ,2009). The psychosocial services for OVCs include counseling (individual and group). Life skills training, community support and integration, rehabilitation, apprenticeship and HIV/AIDS services are needed like that of basic necessities and mentioned effective for the health development of orphan and vulnerable children. Similarly the caregiver- child relationship is central to a child's development (UNICEF, 2009).

2.5 The importance of psychosocial support services for caregivers of OVC

Caregivers of OVC are themselves vulnerable in terms of poverty, burden of care and mental health problems, especially depression (Kasese,2012). Large number of families is often already stretched by existing loads of caregiving, poverty and other social problems. Relatives who accept orphans are often elderly and/or poor, and therefore in need of support themselves. Caregivers may also experience stress from the psychological needs of OVC, and their health and wellbeing may be overlooked (Kasese, 2012). As caregivers often face their own challenges,

it is difficult to provide adequate support to OVC without also supporting their caregivers. Thus, there is a need to enhance the psychosocial wellbeing and caring capacity of OVC guardians. By attending to the needs of caregivers a more nurturing environment can be fostered for children's development (Thurman, 2012).

2.6 Theoretical Perspective

Erik Erikson (1963) developed a theoretical framework aimed at establishing connections between various stages of human development and the relationship between the individual and society. He maintains that as each stage changes with time, the family, school, peer group and society affects the difficulty of a person's behavior (Batra, 2013). Unable to achieve the expected virtue in a given stage of development may amount to emotional discomfort, leading to the inability to cope with the challenge of the current and later stages of development (Batra, 2013). Postulates that successfully dealing with the failure in each stage could enable effective management of the challenges during development to improve a healthy progress of the child's ego (self) (Tchombe, 2011). Other researchers agree with Erikson's that managing the crisis effectively at each stage of development is key to socializing children in most African cultures (Tchome, 2011).

Based on the "problem-behavior-theory" (Jessor, 2007) risk-behaviors are defined as behaviors that may compromise the physical or psychosocial adolescent development, and include a broad range of behaviors that often accompany adolescent development including substance abuse, withdrawal from school or unprotected sexual intercourse as a few examples (Jessor, 2007).

A strong correlation between adolescent risk-behaviors and psychological problems has previously been reported; for example, adolescents presenting depressive symptoms are more likely to be involved in several risk-behaviors (Katon,2010).

This perspective theories highlight is important to focus our attention on the orphan vulnerable childhood stage of 8-18 years f age and these insights are applicable to adolescent orphans.

2.7 Risks, Protection Factors and Resilience among Orphan and Vulnerable Children

Review of the general literature suggests that possible factors such as social and psychological difficulties observed in children argued that food insecurity, stigma and bullying increase psychological symptoms among children in South Africa (Cluver,2009). In addition, Factors that have been identified in the general childhood literature as risks and protective factors for the situation of orphaned children (Cluver, 2009).

Several risk factors have been causes of mental disorders, among which social risk factors clearly Known as a sources of this disorders and their extension into adulthood (Rutter, 1989). In addition to this factors ,quality of parental relationship, parent's mental health, education, occupation and broader environmental circumstances such as adequacy of housing (Goodman , 2005).

Orphan children faced different problems when living at orphanage. From the negative effects, Poor caregiver responsiveness, lack of stimulation, and the absence of a consistent caregiver are all elements of institutional rearing (Rutter, 1979). These negative effects leads to delays in physical growth, with approximately 1 month of linear growth lost for every 3 months in an institution (Albers, 1997). However, recent studies shown institutionalized children have behavioral problem but not have unique behavior problems when compared with either home-reared non adopted children or within country-adoptees (IEMF, 2014).

Resilience does not only based on personal performance, but it needs other persons support when cope up from emotional problem. Considering protective factors to reduce risks, more than half (69.2%) had social skills to communicate with others. Similarly, 65.4% had good relationship with their family or care givers where as 34.6% did not have this close bond with their family or care givers (Belay, 2014).

2.8 Component of psychological distress

Orphaned and vulnerable children are among the most serious socio-economic and developmental challenges affecting developing countries worldwide. Orphan-hood is frequently accompanied with multidimensional problems. Common reactions of children to the death of a parent include: depression, hopelessness, suicidal ideation, loneliness, anger, confusion, helplessness, anxiety and fear of being alone that can further jeopardize children's prospect (Cluver, 2009).

2.8.1 Anxiety

Anxiety is an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth, somatic complaints, and rumination (Seligman, 2002). It is the subjectively unpleasant feelings of dread over anticipated events, such as feeling of imminent death (Bower,1981) .Anxiety is not the same as fear, which is a response to a real or perceived immediate threat(APA,2013), whereas anxiety is the expectation of future threat(APA,2013). People usually experience anxiety about events they cannot control or predict about events that seem threatening or dangerous. Anxiety can appear, as the fear losing another loved one or as a concern with the child's own safety. A moderate amount of anxiety motivates people and adds enthusiasm to one's life. When anxiety is intense, prolonged, or uncontrolled, people begin to experience physical, psychological and defensive reactions. On psychological functioning, anxiety can hinder interpersonal relations, unexciting; reduce work effectiveness, and thinking ability. In extreme case, anxiety halts an individual functionality (Collins, 1988). Trait anxiety is defined as the tendency one perceives in several situations as threatening or dangerous. As noted in depression and self esteem models that have found a strong relationship between these two constructs, anxiety and depression have been found to have equally a strong correlation. This was established in a test of the tripartite model of anxiety and depression in elementary and high school of boys and girls(Spielberger ,1985),.

2.8.2 Depression

Depression is a mental illness in which a person experiences deep, unshakable sadness and diminished interest in nearly all activities (Gelder, 1999). Even a competent and decent person may feel deficient, cruel, stupid or guilty. Some depressed people may be, engaging in fidgety

movements and pacing. Depressed people may also have thinking difficulty, poor concentration, and problems with memory (champion & power, 2000). Further cognitive models of depression emphasize that negative cognition or maladaptive believe system as diathesis in the initiation and continuation of depressive symptoms (Tarekegn, 2014).

Cross sectional study done in India showed 53% were age group of 12-14 years and 46% were 15-17 years, 52% females and 48% males, 35% had depression, most of them who had depression were in the age group of 15-17 years and majority were females. According to severity of depression 52% had mild depression, 23% had moderate depression, 14% had severe depression, 9% had very severe depression and 38% of depressed children had suicidal intentions (Ganavi, 2016)

Based on age categories the level of depression were significant difference among children age between (10-14) and (15-18) with the mean of (M=122.32) and (M=79.63) respectively. Male children's were scored high on depression scale than female non institutionalized children counterparts. With regarding self- esteem of respondents , children's of age categories found between (10-14) score high on self -esteem scale than their counterparts of children found between (15-18) age categories with the mean of (M=34.55) and (M=20.34) respectively (Eyerusalem,2015).

2.9 Reviewed studies on orphans and vulnerable children in different countries of the world

Different study result on the psychological distress of orphan children are reviewed and summarized in the following way:

Studies shows that orphaned children are more likely to suffer from Internalizing problems, such as depression and anxiety. Researcher also had found orphans to be more depressed, more anxious, less optimistic about the future, and more likely to express anger feelings and have more disruptive behaviors compared to non-orphans. Response of 169 orphans under the education sponsorship of World Vision in Uganda, and a comparison group of 24 non-orphans. They used systematic random sampling and a non-standardized 25-item depression scale and interviews with orphans, teachers and some guardians. They found that orphans had significantly higher depression scores ($p < .05$) and lower optimism about the future than non-orphans ($p < .05$) (Cluver, 2007).

Makame,(2002) in urban Tanzania, interviewed 41 orphans and 41 non-orphaned controls, using a non-standardized internalizing problems scale based on the Rand Mental Health Inventory

(Veit-Wilson, 1998) and items from the Beck Depression Inventory (Beck, 1961). They found that orphans had increased internalizing problems compared with non-orphans ($p < .0001$) and 34% reported that they had contemplated suicide in the past year, compared to 12% of non-orphans ($p < .016$) (Cluver, 2007).

Report in Zimbabwe had found on psychological distress more in girls than boys (Coeff: 0.22; 95% CI 0.15_0.31). Regarding age categories, Older children reported less psychological distress than younger children, but only statistically significant for boys (Coeff: $-.027$; 95% CI $-.050$ _ $-.005$) (C.A. Nyamukapa, 2010). Psychological distress was seen more in parental orphans without considering the time of loss their parent. Maternal orphans who lost their parents reported less psychological distress than those whose mothers were still alive, suggesting high levels of resilience (Nyamukapa, 2010).

Most of studies revealed that orphans suffer high level of psychosocial problems. Specially, maternal and double orphans are more suspected to behavioral and emotional difficulties, suffer abuse and low rate of trusting relationships (Baaroy, 2008). It has also been reported that orphans are more likely to suffer from behavioral or conduct problems and report suicidal thoughts (Cluver, 2006).

Study done at Mekelle, the prevalence of depression and anxiety was high in High school student's age categories 16-19 than elementary students age 10-15. Females develop depression and anxiety in 40 (54.1%), 28 (53.8%) where as males develop depression and anxiety 34 (45.9%), 24 (46.2%) respectively (Shekmnesh, 2013).

A comparative study in Addis Ababa analyzed that 39.1% of AIDS orphan adolescents were having psychological problems where as 30.3% non- AIDS orphan adolescents also having psychological problems during the week prior to the survey (Getachew, 2011).

2.10 Ethiopia Development of National OVC policy

In the present Mental health is the main area to address in the national health policy. Mental health interventions is one program of the third five-year National Health Sector Development Program that started in 2005 (M.HE, 2005). In this plan, the Ministry of Health has set a schedule to mainstream mental health in 80% of the public health care institutions and assign frontline train health workers for this program.

According to Ethiopian Ministry of Health, over 5.5 million orphans are in the country, 855,000 of orphans lost their parents to the HIV/AIDS pandemic. Despite having one of the largest OVC populations in Africa, and Ethiopia lacks a comprehensive national plan of action to achieve the needs of orphan and vulnerable children. Nevertheless, as a signatory of the UN Child Rights Convention and the African Charter on Rights and Welfare of Children, Ethiopia is start foundation to actualize and to prioritize the development of national OVC policies.

The services offered by network members were not standardized or made uniform in terms of quality and size. To address this issue, the Ministry of Women's Affairs and the Federal HIV/AIDS Prevention and Control Office developed the Standard Service Delivery Guidelines for OVC Care and Support Programs (MoWAF, 2010).

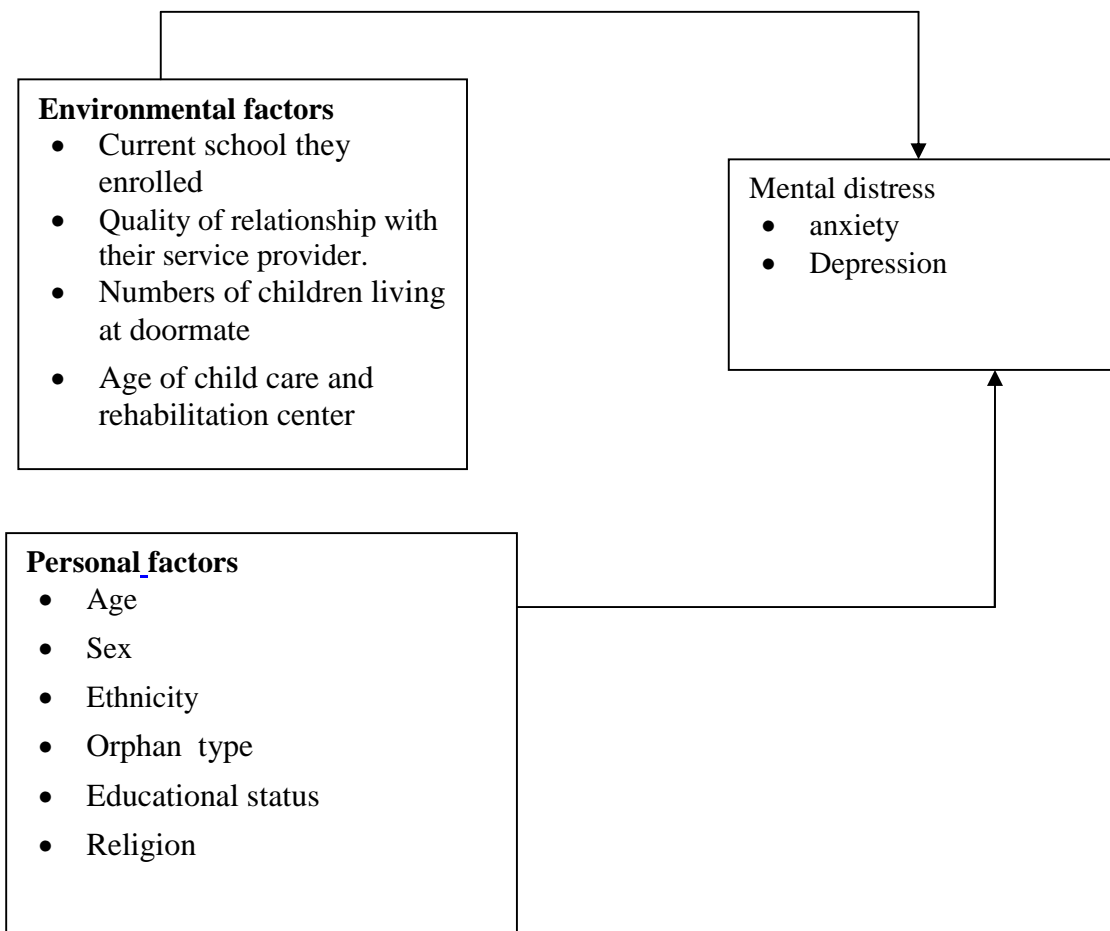
The Standard Service Delivery Guidelines document includes seven core service areas for care and support provides OVC: shelter and care, economic support of families, health care, psychosocial support, education, and food and nutrition. In addition, the guidelines specify "critical minimum activities" which are supposedly "doable by all service partners irrespective of financial and human resources" (2010, p.34). Finally, the document delineates the application of each core service at the child-level, community-level, and policy-level. Continuing with the psychosocial services example, the guidelines needs workers to examine the psychosocial well being of individual children, provide caregivers with guidance on how to counsel children, establish community support groups, and use the local education system to identify and counsel OVC (2010, p. 39).

2.11 Conceptual frame work

Theoretical framework on the causes and consequences of psychological distress amongst orphans adapted from Nyamukapa et al. (2008). The effect of orphan hood on psychological distress depends on the social context. Within a given social context, children may be more or less likely to suffer from psychological distress (or to develop resilience) depending on "moderating" factors such as their sex, age, nature, social background, and form and timing of

parental loss. Orphan hood can result in immediate, possibly short-term, effects (e.g., trauma) as well as intermediate effects that develop over time and have a more gradual effect on psychological well-being (e.g., poor clothing). These “mediating” factors can cause psychological distress and are more common in orphaned children. Psychological distress, in turn, can have a number of consequences including a greater propensity to engage in risky sexual behavior.

A number of different forms of psychological distress can result from losing a parent. However, in the current study, we focus on depression and anxiety.



2.12 Objectives

2.12.1 General objective

- To assess the level of mental distress and associated factors among orphan children in governmental child care and rehabilitation center.

2.12.2 Specific objective

- To assess the level of mental distress among orphan children in governmental child care and rehabilitation center.
- To identify factors associated with mental distress among orphan children in governmental child care and rehabilitation center.

2.13 Research questions and hypotheses

1. What is the level of mental distress among orphan children in Kechene and Kolefe governmental child care and rehabilitation centers?
2. Does mental distress differ by age, gender, educational status and other demographic status?

Hypothes1: Mental distress differs by age, gender, educational status and other demographic status.

3. Does mental distress differ by length of stay in the orphanage and relationship with care givers?

Hypothesis 2: Mental distress differs by length of stay in the orphanage and relationship with care givers.

Chapter Three

Methodology

This chapter deals with the description of the research design, Study area and study period population and sample, research instruments, the procedure of data collection, and statistical methods. The data were collected from 276 orphans of age 11-18 years who were resident in two child care and rehabilitation center. They were taken different component of mental distress (Anxiety and Depression) scales designated according to their age.

3.1 Study design

The research design is a quantitative cross sectional research design with descriptive and explanatory function. Independent variables include demographic variables and environmental variables. The demographic variables are sex, age, orphan types, region, educational status and religion, whereas, environmental variables such as age of child care and rehabilitation center, number of children at a doormat ,current school they enrolled and quality of relationship with their service provider. The dependent variable is mental distress (depression and Anxiety).

A descriptive study design was employed to assess a mental health distress of orphan children in child care and rehabilitation center. A structured questionnaire which asks about level mental distress and factors associated were used to obtain the intended data. A correlation analysis was run to identify the relationship between outcome variable and explanatory variables.

3.2 Study area and study period

The study was conducted in orphanages of 'Kolfe child Care and Rehabilitation Center' Kechene Child Care and Rehabilitation center ' in ' Addis Ketema,' 'Gulele' sub-cities respectively. As we reviewed documents prepared by staff and which contain the history of both centers, Kechene Child care and rehabilitation Center was established in 1944 to provide services for orphans, abandoned and abused children. Whereas, Kolfe Child care and rehabilitation center is established in 1963 to provide services for orphans and vulnerable children, abandoned and abused children. Currently, 197 female and 164 male vulnerable orphan children (OVC) have been living in the kechene child care and rehabilitation center and kolfe child care and rehabilitation center respectively whose age ranges from 8-18 years of age that came from different corners of the country. The center provides basic services for children including counseling service as well as working on reunification and reintegration of children. The overall goal of the institution is to contribute to the ongoing efforts of improving the general wellbeing of OVC.

The study was conducted on two governmental child care and rehabilitation center, namely Kechene and Kolfe in Addis Ababa, the capital city of Ethiopia; from January to December, 2017.

Addis Ababa is the capital and largest city of Ethiopia. It has a population of 3,384,569 according to the 2007 population census, with annual growth rate of 3.8%. This number has been increased from the originally published 2,738,248 figure and appears to be still largely underestimated (CSA, 2007).

Addis Ababa has a subtropical highland climate. The city has a complex mix of highland climate zones, with temperature differences of up to 10 °C (18 °F), depending on elevation and prevailing wind patterns. The high elevation moderates temperatures year-round, and the city's position near the equator means that temperatures are very constant from month to month. As such the climate would be maritime if not its elevation was taken into account, as no month is above 22 °C (72 °F) in mean temperatures. Since the last decade, there has been a rapid population movement from the surrounding areas to the city in search of jobs.

3.3 Population

3.3.1 Source population: The source population was orphan children at Addis Ababa city which governed or administered by women and children affair bureau. These organizations have long time experiences in providing care and rehabilitation services for orphan and vulnerable children.

3.3.1 Study population: The study population was orphan children age from 11-18 who were resides in Kechene and Kolfe child care and rehabilitation center. These child care and rehabilitation center were selected based on the fact that there is large number of orphan children in governmental child care and rehabilitation centers.

Inclusion criteria: children in the age group of 11 - 18 years residing in child care and rehabilitation center and, also include orphans whose age is not known clearly by themselves but have police evidence which is indicate their age above 11 and the child care and rehabilitation center classify children by their age to live together in different home based on this reason incorporate as participant to this research.

Exclusion criteria: children with mental retardation identified by counselor who were worked at each center, with chronic medical illness, children who live temporarily and screened for reunification because they were join to center recently and back to their relatives or home within one year ,whereas children who were not willing to participate in the study was excluded from the study.

3.4 Sampling method

There were 4 child care and rehabilitation center in Addis Ababa under Women and child affair bureau which provide different service for children in different age level. From these child care and rehabilitation centers, two centers were selected purposively by different reason such as children live permanently means up to 18 years old and their age were relevant to gain essential data. Whereas, children who has been lived out of selected child care and rehabilitation centers not live permanently and also they may not be exact orphan because it establish for other purpose. For instance, juvenile delinquency children and their age was under 11. For this study the sampling frame was the center's record of orphan children who were in the age between 11 and 18. We made the age 11 as the lower age limit because, children below age 11 are unable to analyze and express their experience which is supported by different researcher in our country and at age 18, because orphan children were out of the center's after this age.

3.5 Sampling size

All children from Kechene and Kolfe child care and rehabilitation center who fulfilled the inclusion criteria were included as a sample from the total study population. The sample size becomes 285 was proposed but the respondent rate was 276(96.84) and non respondent rate has 9 (3.15%).

3.6 Data collection procedures

The data collectors administered questioner was used as a data collection technique and structured questionnaire was designed from Hospital Anxiety and Depression scale consisting variables that can meet the objective of the study, and was translated in to Amharic language. Prior to data collection permission was obtained from the concerned care giver. The data collection was fulfilled by the principal investigator, 2 of them grades ten completed and now learn preparatory school and two of them data collector was college and university level student. During data collection the investigator regularly discussed with the data collectors on issues of concern that they had encountered. There was no major challenge faced during data collection.

3.6.1 Data collection instruments

Mental health problems were measured using a range of standardized scales, all previously used with children in Ethiopia. Depression and Anxiety is measured using the Hospital Anxiety and Depression Scale (HADS). It has been used in Ethiopia and also widely used in Africa

(Getachew, 2011), shows good psychometric properties, and has comparable results with the full CDI (Kovacs, 1992). The scale was tested for its validity and Reliability by previous researchers (Fentie, 2011). The Amharic-HADS had Cronbach's alpha of 0.81 and 0.76 in the whole sample for the anxiety and depression sub-scales, respectively. In the 11-15 years sub-sample the corresponding alpha values for anxiety and depression scales were 0.80 and 0.77, respectively. The correlation between the anxiety and the depression subscales were 0.66 ($p < 0.001$) and 0.67 ($p < 0.001$) for the whole sample and for the 11-15 years group, respectively (Fentie, 2011). In addition, other researcher used this scale to measure anxiety and depression in our country. This gives confidence to us to use it in this particular research. Administering the Amharic version of the Hospital Anxiety and Depression Scale by interviewers gave meaningful data starting from the age of 11 suggesting successful applicability of the scale with further validation (Fentie, 2011).

Structured questionnaire was adapted from Hospital Anxiety and Depression Scale (HADS) to the children consisting variables that can meet the objective of the study. Each item score ranged from zero to three. Scores of 0-7 in respective subscales are considered normal symptoms, with 8-10 borderline and 11 or over indicating or abnormal symptoms were classified as having depression or anxiety and we used to measure feelings of depression and anxiety levels in the week prior to the survey by HADS.

3.7 Research Variables

3.7.1 Dependent variable

- **Depression:** this category had respective verification criteria measured using seven likert scale HADS items which are (wake early and then sleep badly for the rest of the night, I

feel miserable and sad, lost interest in things, have a good appetite, I feel life is not worth living, still enjoy the things I used to, and feel as if I have slowed down).

- **Anxiety:** this category had respective verification criteria measured using seven likert scale HADS items which are (very frightened or have panic feelings for apparently no reason at all, feel anxious when I go out of the house on my own, get palpitations, or sensations of ‘butterflies’ in my stomach or chest, feel scared or frightened, restless and can’t keep still, more irritable than usual, and Worrying thoughts constantly go through my mind).

3.7.2 Independent variable

- Sex
- Age
- Religion
- Region
- Orphan types
- Educational status,
- Number of children at doormats
- Current school they enrolled
- Age of child care and rehabilitation center
- Quality of relationship with care and support provider

Two days training for data collectors was given and Amharic version of the questionnaire was revised after pretested on 5% of child care and rehabilitation center. Actual data collection was carried out by them using a structured questionnaire administered.

After obtaining informed consent from the institutions principals, prior to data collection, permission were obtaining from the concerned care giver mothers and children. The data collection were fulfill by, one supervisors and 4 data collectors. The overall activity was strictly followed by the principal investigator daily to ensure the completeness of questionnaire, to give further clarification and support for data collectors.

3.8 Quality control

To assure the quality of data, the questionnaires were adopted from well known standardized scale and used in previous study in our country. We were preparing in English then translated to Amharic. Questionnaire was Pre-tested in orphanage children similar to the study population, a two days training with practical exercise were give to data collectors and supervisors before the actual data collection regarding the aim of the study.

3.9 Data analysis

Data entry was done by EPINFO and processing was done using STATA version 12. During the process of analysis, frequencies of different variables were determined. Descriptive statistics was used for describing the socio-demographic factors. Descriptive statistics, Chi-square and a

multivariate regression analysis were used. Chi-square tests were used when testing independence between two categorical variables.

Odds ratios with 95% confidence interval were used to assess significance of associations between outcome variables and certain independent variables. Multivariate was done to assess presence of associations as well as to identify and control for confounding variables. The results of the analysis are presented in tables.

3.10 Operational definition

An orphan: is defined as a child that has lost one or both parents and lives at child care and rehabilitation center.

Single orphan: - A child who has lost one parent and live at child care and rehabilitation center.

Double orphan: - A child who has lost both parents and lives at child care and rehabilitation center.

Maternal orphan: - A child whose mother has died.

Paternal orphan: - A child whose father has died.

Length of stay: the maximum duration that the child spent in the child care and rehabilitation center.

Care and rehabilitation center: is the placement of children in institutions, such as orphanages

Education status; The maximum grade the child has achieved

Orphanages: child care and rehabilitation centers where OVC get care and support.

Mental distress: In this study, orphans who were found to have their score 11 or over indicating mental distress according to HADS subscale items.

Depression - Despondency and dejection, typically felt over a period of time accompanied by feelings of hopelessness, inadequacy, disappointment and regret.

Anxiety: Feeling of worry, nervousness, about something with an uncertain outcome.

3.11 Ethical consideration

Ethical approval was obtained from College of psychiatry of Addis Ababa University. Women and children affair office given permission and write a support letter to the respective institutions. Permission to conduct the study was also obtained from each of the institutions namely, Kechene and Kolfe child care and rehabilitation center. Informed verbal consent was taken from each study participant and written consent was obtained from their assigned guardians prior to the response of the questions. Data was collect anonymously to ensure confidentiality. Informants were assured that only the investigators were access to the data and no third party have access to their individual information and recognize.

The objective of the study was clearly communicated in a language the study participants can understand. In addition, the right of the study participants to withdraw from the study at any time was safeguarded. At the same time the potential benefits and risks from participating in the study was explained for the research participants. In addition to this, the data collector inform immediately to the principal investigator when the participants having severe symptoms, suicidal thought or plan and after compelled the scale and the researcher identified those orphans by their code and link with their counselors to provide different psychological interventions.

Chapter Four

Results

This chapter is the presentation of the findings of the study. First, the results of the descriptive analysis for all the variables (independent and dependent variables) are presented. Following the descriptive analyses, the results of multivariate analysis are presented containing the analysis of mental distress with demographic factors, length of stay in the orphanage and answers for the research questions and the accompanied hypotheses of the study.

4.1 Socio demographic characteristics of orphanage children

In this section, the socio-demographic characteristics of the participants were presented. The socio-demographic characteristics analyzed include the age, gender, and educational status, types of orphan and length of stay at child care and rehabilitation center and quality of relationship with their care providers. Table 1 below summarizes this socio-demographic information about the study respondents.

Table 1: Personal characteristics of study participants

Variable	orphans	
	No(276)	percent (100)
Sex		
Female	155	56.16
male	121	43.84
Total	276	100.00
Age		
11-15	91	32.97

16-18	168	60.87
unknown	17	6.16
Total	276	100.00
Educational status		
Never attended school	6	2.17
Primary(1-4)	39	14.13
Primary(5-8)	159	57.61
Secondary (9-10)	51	18.48
Preparatory(11-12)	13	4.71
technical/vocational (10+)	7	2.54
Higher education (university level)	1	0.36
Total	276	100.00
Orphan type		
Maternal	33	11.96
paternal	36	13.04
Both/double	207	75
Total	276	100.00

This research was studied to assess mental distress in child care and rehabilitation center in Addis Ababa. Of 285 children asked for their permission to participate on the study, 276 participants were interviewed making the response rate 96.84% and non respondent rate 9 (3.15 %) because of they were not voluntary to participate on the study.

As it is shown in Table 1 above, out of 276,155(56.14%) and 121(43.84%) female and male respectively. The percentage of study participants belonging to the age group of 11-15 years were 91 (32.36%), in the age group of 16-18 years old 168 (60.87%) with mean age of 15.44 with standard deviation of 2.017.

185 (67.03%) of study participants were Orthodox Christians by religion. More than half of respondents 159 (57.61%) were educated at primary second cycle (5-8). Regarding the type of orphan, it was found that majority 207(75.00%) of the children were double orphans,

36(13.04%) of children were paternal orphan where as 33(11.9%) were maternal orphan of the study participants.

Table 4.2 Environmental characteristics of study participants

Variables	orphans	
	No(276)	percent (100)
Duration of living within in child care rehabilitation center		
from 1-5 years	96	34.78
from 6-8 years	142	51.45
> 8 years	38	13.77
total	276	100
Numbers of children living at doormate		
1-5	26	9.42
6-10	76	27.54
>10	174	63.04
Total	276	100
Quality of Relationship with care providers		
Very Good	47	17.03
Good	90	32.61
Neutral	69	25
Bad	34	12.32
Very Bad	36	13.04
Total	276	100

Regarding the duration of living in orphanage center more 142 (51.45%) of respondents has been stay between 6-8 years residency at child care and rehabilitation center, from those 68(22.82%) respondents fall under mental distress. The minimum waiting time is one year where as 16 years was high duration of the children with the mean waiting time was 6.42 ± 2.808 and one fourth of children live at 8 (19.93%) years. and the 174(63.04 %) of children living together at one doormat more than 10 children. The range of children at doormat was 2 to 20 and the mean number 10.34 ± 3.566 . Regarding their quality of relationship with the whole worker in the compound the data shows that 90(32.61%) of them are good relationship with their servants,

69(25.00%) were neutral, 47(17.03%) were have very good relationship with, 36(13.04%) were very bad relationship with their servants, and 34(12.04%) were bad relationship with their servants.

4.3 Severity of Anxiety and depression among orphans

Table 3: Severity of Anxiety and depression among orphans

Severity	Anxiety		depression		Face both	
	Freq	Percent	Freq	Percent	freq	percent
Non case	93	33.7	57	20.65	38	13.77
Borderline symptoms	62	22.46	73	26.45	19	6.88
Abnormal symptoms	121	43.84	146	52.9	88	31.88
Face anxiety and depression Differently					131	47.46
Total					276	100

Almost half 146(52.90) of the respondents fell under category abnormal symptoms of depression and about 121(43.84) of the respondents have abnormal symptoms of anxiety while 62 (22.46%) are on borderline, see table 3. When compare the prevalence rate of each distress, depression showed the highest prevalence rate (52.90%), followed by Anxiety disorders (43.84%). Concerning the mental distress severity, 88 (31.88 %) respondents result indicated that they were experienced both depression and anxiety abnormal symptoms.

4.4 Distribution of Depression scale among participant orphans

Table 4: Distribution of Depression scale among orphans

No	Item	Yes definitely		Yes sometimes		No, not much		No, not at all	
		F	p	f	p	f	p	f	p
1	I wake early and then sleep badly for the rest of the night	81	29.4	70	25.4	44	15.9	81	29.4
2	I feel miserable and sad	87	31.5	79	28.6	39	14.1	71	25.7
3	I have lost interest in things	68	24.6	56	20.3	50	18.1	102	37
4	I have a good appetite.	102	37	50	18.1	56	20.3	126	45.7
5	I feel life is not worth living.	75	27.2	48	17.4	48	17.4	54	19.6
6	I still enjoy the things I used to.	78	28.3	50	18.1	65	23.6	83	30.1
7	I feel as if I have slowed down.	78	28.3	46	16.7	42	15.2	110	39.9

As shown in the above table more than one fourth of the respondents wake early and sleep badly (their sleep pattern is not good) for the rest of the night 81(29.35%). More than one third of respondents told that they feel slowed down 110(39.86%). From total respondents one third has a good appetite and interest in things 102 (36.96%). Above one fourth of the respondent feels miserable and sad , not still enjoy the things I used to and feels life is not worth living 87 (31.52%), 78(28.267%) and 5(27.17%) respectively.

4.5 Distribution of Anxiety scale among participant orphans

Table 5: Distribution of Anxiety scale among orphans

no	Item	Yes definitely		Yes sometimes		No, not much		No, not at all	
1	I get very frightened or have panic feelings for apparently no reason at all.	72	26.1	72	26.1	52	18.8	80	29
2	I feel anxious when I go out of the house on my own	58	21	67	24.3	43	15.6	102	37
3	I get palpitations, or sensations of 'butterflies' in my stomach or chest	44	15.9	53	19.2	46	16.7	133	48.2
4	I feel scared or frightened	66	23.9	73	26.5	51	18.5	86	31.2
5	I am restless and can't keep still.	62	22.5	47	17	12.3	60.5	133	48.2
6	I am more irritable than usual.	74	26.8	45	16.3	20.3	56.9	101	36.6
7	Worrying thoughts constantly go through my mind.	116	42	54	19.6	22	7.97	84	30.4

As shown in the above table, Only 44(15.94%) of the respondents had got palpitation, or sensations of 'butterflies' in their stomach or chest, but majority 133(48.19) of the respondents totally didn't get this kind of feeling of attack (problem) and 72(26.09%) of the respondents get very frightened or have panic feelings for apparently no reason at all. 116(42.03%) then respondents suffering by worrying thoughts constantly go through my mind, Around one fourth of the respondent suffering from scared frightened 66(23.91), 74(26.81%) Of respondent more irritable than usual. Majority 102(36.96%) of respondents not feel anxious when they go out of the house on my own, 62(22.46%) of the respondents were restless and couldn't keep still but majority 133(48.19%) of respondents normal.

4.6 Chi square results for Depression among orphans

Table 6: Chi square results for Depression among orphans

variable		Normal symptoms/non case		Borderline symptoms		Abnormal symptoms/case		Total	2 value (df)	Sig.
		N	%	N	%	N	%			
Educational status	Illiterate	2	0.72	2	0.72	2	0.72	6	Pearson chi2(12) = 18.1987 Pr = 0.110	P<0.037
	Primary first cycle	9	3.26	14	5.07	16	5.79	39		
	Primary second cycle	27	9.78	47	17.1	35	12.68	109		
	High school	15	5.43	7	2.53	29	10.5	51		
	Preparatory	3	1.08	2	0.72	8	2.89	13		
	10 +	0	0	1	0.36	6	2.17	7		
	Higher education	1	0.36	0	0	0	0	1		
Total	93	33.69	121	43.8	62	22.46	176			
Quality of relationship	Very good	16	5.79	11	3.98	20	7.24	47	Pearson chi2(8) = 15.8434 Pr = 0.045	P < 0.004
	Good	17	6.15	30	10.9	43	15.57	90		
	Undecided	14	5.07	20	7.24	35	12.68	69		
	Bad	3	1.08	7	2.53	24	8.69	34		
	Very bad	7	2.53	5	1.81	24	8.69	36		
	Total	57	20.65	73	26.4	146	52.89	276		

The relationship between the children's educational status and the depression symptom categories was statistically significant at a Pearson 2 value of 18.19 at P<0.037.

Primary second cycle (12.68 %) scored in the range of abnormal symptoms compared to their lower grade level (5.79%) who were under abnormal symptom.

Table 6 shows that 7.24. % of orphanage children reported had very well their quality of relationship with worker and abnormal symptoms of total on depression while 8.69.% showed abnormal symptoms of them had very bad relationship of total on depression scale at a Pearson's 2 value of 15.8434 at P<0.004.

On the other hand, the table shows that the majority of children 15.57 % of the respondents had under normal symptoms score and their quality of relationship with the whole care providers was good relationship on depression at a Pearson's χ^2 value of 15.8434 at $P < 0.004$.

4.7 Chi square results for anxiety symptoms among orphans

Table 7: Chi square results for anxiety symptoms among orphans

The quality of relationship of children was associated with the scores on the total anxiety scale at a Pearson's χ^2 value of 26.77. The following table shows the chi square results for the severity of anxiety.

variable		Non case		Border line		case		Total	2 value	Sig.
		N	%	N	%	N	%			
Quality of relationship	Very good	21	7.6	17	6.15	9	3.26	47	Pearson chi2(8) = 26.7795 Pr = 0.001	p<0.001
	Good	34	12.3	28	10.1	28	10.1	90		
	Undecided	24	8.69	34	12.3	11	3.98	69		
	Bad	4	1.44	26	9.42	4	1.44	34		
	Very bad	10	3.62	16	5.79	10	3.62	36		
	Total	93	33.7	121	43.8	62	22.5	276		

As presented on table 7, among those who reported having a good quality of relationship with their care providers, 12.31 % scored under normal symptoms, while among those who answered having poor quality of relationships with their care providers relatively higher proportion of them (9.42%) reported borderline symptoms.

Likewise, among those who reported having a very good quality of relationship with their care and support providers, a great deal of them (7.6%) showed normal symptoms on anxiety scale.

On the other hand, those children who reported having a very bad (3.62%) and poor (1.44%) quality of relationship with their care and support providers registered abnormal scores in their total anxiety.

4.8 Multiple regression analysis for factors and mental distress

Table 8: Multiple regression analysis for predictors and mental distress

Independent Variable	Coef./ odd ratio	Std. Err.	t	P<t	[95% Conf. Interval	
Sex	-0.0417	0.0838	-0.5	0.62	-0.206744	0.123426
Age	0.0072	0.0547	0.13	0.9	-0.100553	0.11496
Religion	0.0039	0.0294	0.13	0.9	-0.054018	0.061724
Ethnicity	0.0202	0.0152	1.33	0.19	-0.009758	0.050252
Educational Status	0.0514	0.0384	1.34	0.18	-0.024295	0.127055
Current school they enrolled	-0.0054	0.0188	-0.3	0.78	-0.042455	0.031666
Waiting time at care and rehabilitation center	0.0191	0.0477	0.4	0.69	-0.074769	0.112912
Number of children at a doormat	-0.0293	0.0498	-0.6	0.56	-0.127323	0.068672
Type of Parent they was Died	-0.0109	0.0449	-0.2	0.81	-0.099361	0.07762
Relationship with care providers	0.0586	0.0249	2.35	0.02	0.0095962	0.107517

The above table shows that on multivariate analysis, Keeping other factors constant, children who had positive relationship with care providers were 42% less likely (OR=.0585 ; & CI:0.00959 - .1075) to have mental distress as compared to had poor relationship and the association was statistically significant (P<0.0249). Both children's educational status (P<0.037)

and quality of relationship with worker ($P < 0.004$) had significantly associated with depression, while quality of relationship with worker ($P < 0.004$) had significantly associated with Anxiety.

On the other demographic characteristics, there were no significantly higher prevalence of mental distress ($P < 0.08$) 95%CI =1.45–5.68) in male than in female. And also there is no significant relationship on age categories. No significant differences were observed between children living together with one or more children.

The multivariate analysis result showed that quality of relationship with their care and support provider had statistically significant association with mental distress in orphan children at kechene and kolefe child care and rehabilitation center.

Half of the orphans are depressed with no significant difference with age, number of child at doormat, sex, and duration of stay in orphanage. Depression is significant positive relation with orphans in different educational level and quality of relationship with their provider.

Chapter Five

Discussion

This study attempted to determine the level of mental distress among children at child care and rehabilitation center. In addition, the study aimed at identifying factors that correlate with mental distress specifically anxiety and depression using quantitative cross sectional methods. The result showed that more than one third of (31.88) respondents experienced Anxiety and Depression (mental distress) at a time.

In current study the most prevalent type of mental distress was Depression (52.9%) followed by anxiety (43.84%). On the other hand, 31.88% of respondents were experienced abnormal Anxiety and Depression Symptoms at a time. Cross sectional based at Mekele ,74 (25.3%) orphan adolescents were depressed in the week before the survey. Moreover, 52(17.7%) orphan adolescents were anxious in the week before the survey. The main predictor variables of anxiety were their score of self esteem and employment opportunity (Berhe, 2013).

The Severity of depression among orphans was found to be 52.90% in the current study. This finding is higher as compared to studies in Mekele (25.3%) (Berhe, 2013) and in the week before the survey. And also This prevalence is relatively higher than the prevalence of depression study done (2010) in Addis Ababa as that of 157(39.1%) depressed (Getachew, 2011). The difference could be attributed to the socio, cultural and environmental factor. From

these factors quality of relationship with care provider and educational level significantly associated with depression.

The severity of this research result indicates of anxiety 33.7 % normal symptom, 22.46 % borderline symptoms and 43.84 % abnormal symptoms and of depression 20.65 % non case, 26.45% Borderline symptoms, 52.9 abnormal symptoms of orphan children. According to severity of depression 52% had mild depression, 23% had moderate depression, 14% had severe depression, 9% had very severe depression and 38% of depressed children had suicidal intentions (Ganavi, 2016) .On the other hand, According to the severity of depression 52% had mild depression, 23% had moderate depression, 14% had severe depression, 9% had very severe depression and 38% of depressed children had suicidal intentions (Ganavi, 2016).

The current findings indicate that child care and rehabilitation center orphans had higher levels of psychological distress when other factors were controlled. This is consistent with previous studies using other methods of measurement (Makame, 2002). Orphans had higher levels of anxiety and depression symptoms and more frequently endorsed those BYI items that are considered to be especially sensitive for the detection of depressive disorder in children (Beck et al., 2001).

According to this study the prevalence of mental distress symptoms was higher for female (26.8%) than male (21.4 %). Similarly, study in Brazil, Prevalence of stress according to gender was higher for girls (20.9%) than for boys (15.4%). Bivariate analysis showed that girls had 1.35 times the prevalence of stress as compared to boys. Children over 10 years showed a significantly higher prevalence of stress (27.2%) than younger children, with 1.67 times the prevalence of stress(Sbaraini ,2008). In India, A cross sectional descriptive study, involving

Among orphanage showed that depression was prevalent among 35% of children living in orphanage, most of them were females, age group of 15-17 years and mean duration of stay was 5.2 years and majority of them had single parent especially mother with father being expired due to medical illness or accident. Likewise in the study from Bulawayo, Zimbabwe females were reported markedly higher levels of psychosocial distress than males, similarly in this study the number of depression is higher in females than in males (Horizons, 2006). Differently, there is no gender influence on mental health outcomes. Male and female children scored similar levels of distress/positive mental health outcomes in the study and control groups (Francis, 2010).

However ,the prevalence depression and anxiety in the current study was high in child care and rehabilitation center orphans age categories 16 -18 than 11-15,like wise, studies in Mekelle , the prevalence of depression and anxiety was high in High school student's age catigores16-19 than elementary students age 10-15. Females develop depression and anxiety in 40 (54.1%), 28 (53.8%) where as males develop depression and anxiety 34 (45.9%), 24 (46.2%) respectively (Shekmnesh, 2013).

Depression and anxiety or over all mental distress of children in child care and rehabilitation center is a prevalent and serious issue in many countries. The overall level of mental distress reported by the study participants in our study was high compared to what was reported by other studies. The overall level of mental distress participants was 48.19 % in this study.Whereas, previous studies in Ethiopia at Mekele, the magnitude of depression was 74(25.3%) in the week before the survey (Asefawesen, 2013). This prevalence is relatively lower than the prevalence of depression study done (2010) in Addis Ababa as that of 157(39.1%)

depressed.(Getachew,2010).The prevalence of depression and anxiety was high in high school students age 16-19 than elementary students age 10-15. Females develop depression and anxiety in 40 (54.1%), 28 (53.8%) while males develop depression and anxiety 34 (45.9%), 24 (46.2%) when this survey was conducted of the study participants, 274 (93.5%) have access to health care, 252 (86%) counseling service, 130 (44.4%) psychosocial participation, 97 (33.1%) sociopolitical involvement, and 192 (65.5%), have employment opportunity (Shekmnesh,2012) The present study indicates that was higher of the studied orphans have mental distress. This high prevalence may be related to many factors such as quality of relationship with their service providers statistically significant association with mental distress in orphan children at kechene and kolfe child care and rehabilitation center. Other studies result shows that after admission to orphanages; separation from his/her family, psychological trauma, related to the environment of the orphanages itself like: mistrust, insecurity, maltreatment by their foster family, and risk of neglect, abuse, and exploitation. Also children in foster care were using denial as a coping mechanism to handle depression (Azza,2012). Inadequate care, in the form of basic needs not being met, was also associated with greater psychological distress; a finding which is consistent with data from a national survey in Zimbabwe showing a positive association between extreme poverty and psychological distress (Nyamukapa et al., 2008).Inverse association of natural mentoring with mental distress in children orphaned by AIDS (Francis, 2010).

And also result indicates that the association of different level of education status had significant positively with mental distress. Likewise, Being out of school was associated with greater psychological distress in childhood and was more common in orphans, as has been found in

Zimbabwe nationally (Nyamukapa et al.,2008).orphan adolescents that were not enrolled in school were more likely to be depressed and anxious in South Africa(Cluver,2007).

From the existing studies of Ethiopia, psychological wellbeing of orphan and vulnerable children at orphanages .They found that the majority of the participants felt sad, depressed, and in stress due to lack of good relationship with service providers and the community, and due to grief and bereavement of their parental loss (Sebsibe,2014). Other factors include quality of parental relationship, parent's mental health, education, occupation and broader environmental circumstances such as adequacy of housing (Goodman, 2005).

The current study showed an association between mental distress and quality of relationship with service provider. Orphan with bad relationship with service provider(caregiver ,social worker, counselor and guard) odd ratio 0.058 time the prevalence of stress as compared to those with excellent relationship. Children with fair/bad family relations (with the father or mother, between sibs, or between parents) had 1.49 times the prevalence of stress as compared to children with excellent/good family relations. Children with fair/bad social contact showed 1.85 times the prevalence of stress as compared to those who enjoyed excellent/good social contact(Sbaraini , 2008).

In the family where a guardian was physically hurt by another family member, both boys and girls had a significantly higher level of depressive symptoms. However, a different study in Cambodia reported that no significant association was detected between family violence witnessing and depressive symptoms among boys and girls (Poudel, 2016).

Strengths of the study

The instrument was used widely in our country on the same age.

The study is one of the new data to contribute in the area of investigations assessing the level of mental distress at governmental care and rehabilitation center children.

Limitation of the study

This study has some;

- orphans not registered by the governmental institutions were not included, resulted the study finding could not be generalized to all orphans in Addis Ababa
- Children who were age less than 11 were not included in the study. Therefore, it's difficult to conclude the stress suffered by the all orphaned children

Chapter Six

Conclusion and Recommendations

The level of mental distress among orphan children was found to be high. The prevalence of mental distress was relatively high among female children.

Anxiety and Depression were prevalent mental illnesses among children living in orphanages, especially governmental care and rehabilitation centers. Level of education and their quality of relationship with care providers were the main determinants of their experience.

The researcher recommends the following elements based on the findings of this research.

- The intervention modalities which are planned to bring change in the life of orphan children have to consider their level of education and their quality of relationship.
- Counseling or psychological service is essential so as to alleviate their mental distress and the counselor follows their changes.
- The existing life skill training in the institution should be strengthening in order to maintain and improve children current mental distress.
- Strength and follow children school enrolment and their progress in academic performance

- There is also a need for future in-depth qualitative studies to gain detailed and rich understanding in answering the “how” and “why” of the distress and experiences of orphans in their real world.
- They (caregivers) need to be trained on childcare issues to prevent them from bad relationship children in their care.
- Therefore, it is recommended that mental distress needs due attention and remedial action from policy makers, college officials, non-governmental organizations, parents, students and other concerned bodies. Programs aimed at preventing mental distress need to address these identified factors of mental distress.

Reference

- Abdulahi H., Hailemariam D., Kebede D. (2001). Burden of disease analysis in rural Ethiopia. *Ethiopian Medical journal*, 39, 271–281.
- Albers L., Johnson D., Hostetter M., Iverson S., Miller L. (1997). Health of children adopted from the former Soviet Union and Eastern Europe, *comparison with preadoptive records*. 278, 922–924.
- Alem A., Kebede D., Woldesemiati G., Jacobsson L., Kullgren G. (1999) .The prevalence and socio-demographic correlates of mental distress, Ethiopia. *Acta psychiatrica Scandinavica*, 397, 48-55.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Publishing. 189. ISBN 978-0-89042-555-8.
- Atwin B., Cantor-Graae E. (2005). Psychological distress among AIDS orphans in rural Uganda. *Social science & Medicine*.
- Azza I. (2012). Prevalence and predictors of depression among orphans. *International Journal of Collaborative Research on Internal Medicine & Public Health*.
- Baaroy J., & Webb, D. (2008). Who are the most vulnerable? Disaggregating orphan categories and identifying child outcome status. *Vulnerable Children and Youth Studies*, 3, 92-101.

- Batra S. (2013).The psychological development of children implications for education and society .*Contemporary Education Dialogue, 10, 249-278.*
- Beck J., Beck A.,&JollyB.(2001).Manual for the back Youth Inventories of emotional and social adjustment ,*San San Antonio .*
- Belay T., & Missaye M. (2014).Risks, protection factors and resilience among orphan and vulnerable children, Ethiopia, *Implications for intervention.*
- Berhe H. (2013). Prevalence and associated factors of anxiety among aids orphan.*College of health sciences, Ethiopia.*
- Berry L., & Guthrie T., (2003). *Rapid assessment the situation of children.*The Children's Institute, *University of Cape Town, Cape Town.*
- Bilson A. & Cox P. (2007). Caring about Poverty supported .*Journal of children and poverty, 13(1), pp. 37-49.*
- Bouras, N.; Holt, G. (2007). *Psychiatric and Behavioral Disorders in Intellectual and Developmental Disabilities , Cambridge University Press, 2.*
- Champion, L. P. (2002). *Adult Psychological problems, An Introduction Hove Psychological Press.*
- Cluver L .(2006). The Psychological well-being of children orphaned by AIDS. *Annals of General Psychiatry, South Africa,*
- Cluver L., Fincham D.(2009). Posttraumatic stress in AIDS orphans Exposed to high level of trauma. *Journal of Traumatic Stress.*

Cluver L., Gardner F.(2008). Effects of Stigma on theMental Health of Adolescents Orphaned by AIDS. *Journal of adolescents health ,42, 410-41.*

Cluver L., Operario L.,& Gardner, F. (2007). Risk and protective factors for psychological well-being of orphaned children. *AIDS Care ,19,318-325.*

Collins .R. (1988). The meaning of Anxiety. Norton council ,New York.

Davison, Gerald C. (2008). Abnormal Psychology. Toronto: *Veronica Visentin. p. 154.*
ISBN 978-0-470-84072-6.

Erikson E.(1968).Childhood and society, *New York,NY,Norton 2.*

Eyerusalem H., (2015).The Level of depression and self esteem among institutionalized and non Institutionalized orphan children. *Child adol psychology.*

Federal ministry of health (FMOH, 2012). National Mental Health Strategy of Ethiopia.

Fentie A. (2011).The structure and reliability of the Amharic version of the hospital anxiety and depression scale in orphan adolescents. *Ethiop J Health Science, 21.*

Francis N., Onuoha(2010). Inverse association of natural mentoring relationship with distress. *Biolgy Medical Center Psychiatry,10, 1471-244.*

Ganavi R., Shobana N., Uma Devi L. (2 016). Prevalence of depression among children living in orphanage. *International Journal of Contemporary Pediatrics, 3, 1326-1328.*

Gelaye B., Lemma S., Deyassa N., Bahretibeb Y., Tesfaye M., Berhane Y., & Williams M. A. (2012). Prevalence and correlates of mental distress among working adults. *Clinical practice and epidemiology in mental health, 8, 126-133.*

- Gelder, M., Gath, D. & Mayou, R. (1999) *The Oxford Textbook of Psychiatry*. 2nd
- Getachew H., Ambaw F., Lakew A., Wondosen K., (2011). Psychological distress and its predictors in AIDS orphan adolescents.
- Goodman R., Slobodskaya H., Knyazev G. (2005). Prevalence and risk factors. *Child, Adolescent Psychiatry, 14*, 28.
- Havenaar JM., Geerlings MI., Vivian L., Collinson M., Robertson B. (2007). Common mental health problems in historically disadvantaged urban and rural communities in . *Soc Psychiatry Epidemiol* ,7 ,294–299.
- Horizons (2006). Psychosocial well being & support program, Washington .
- International Encyclopedia of Marriage and Family(2014). Orphanages retrieved. *International Journal of Social Welfare*, 10.12073.
- Jessor, R. (2007). Risk behavior in adolescence: a psychosocial framework for understanding and action. *Journal of Adolescent Health, 12*(8), 597-605.
- Kasese H., Nduna M., Ndebele M. & Pillay N. (2012). Health and psychological wellbeing of caregivers and households of orphans and vulnerable children . *Journal of Psychology in South Africa, 22*, 435-439.
- Katon W, Richardson L, Russo J, McCarty CA, Rockhill C, McCauley E, Richards J, Grossman DC (2010) Depressive symptoms in adolescence, *Gen Hosp Psychiatry, 32*:233–239
- Kirrily P. (2011). Rethinking orphan hood and vulnerability in Ethiopia. *Young lives policy brief* ,University of Oxford, 16.

- Laura Z.(2008). Nutritional status, psychological well-being and the quality of life of AIDS orphans in rural Henan Province. *Med International Health,China*.
- Liu J., Raine A., Venable P., Mednick S. (2004). Malnutrition at age 3 and externalizing behavioral problems. *Am J Psychiatry.161(11),2005–2013*.
- Makame V., Ani C., Grantham M. (2002). Psychological well-being of orphans. *Acta Paediatric, Tanzania. 91,459-465*.
- Ministry of Gender and Family Promotion, (2012). Republic of Rwanda (MIGEPROF) and Hope and Homes for Children, *Better care network*.
- Ministry of Health (MOH,2007).National HIV and AIDS Prevention Control Office AIDS in Ethiopia, *6th*, Addis Ababa.
- Mirowsky J., & Ross C.(2002.) .Selecting outcomes for the sociology of mental health Issues of measurement and dimensionality. *Journal of Health and Social Behavior ,43*.
- MOLSA, (2003). Ministry of Labour and Social Affairs (MoLSA) and UNICEF. 2005. *African Charter on the Rights and Welfare of the Child*, Addis Ababa: UNICEF
- Mums for Mums,(2011). Report on the situation analysis of orphan and vulnerable child services, Ethiopia.
- Nurs (2014).Psychological distress. concept analysis. 45 (5):536-45
- Nyamukapa, C.A., Gregson S., M., Wambe P., Lopman B., Mupambireyi K. (2010). Causes and consequences of psychological distress among orphans in eastern. *AIDS care psychological and socio-medical Aspects of AIDS/HIV, 22,988-996*.

- Rutter M. (1989). Path way from childhood to adult life. *Journal of Child Psychology and Psychiatry*, 30, 23-51.
- Rutter M. (1979). Maternal deprivation new findings, new concepts, new approaches. *Child Development*, 50, 283–305.
- Sbaraini (2008). Prevalence of childhood stress and associated factors, *Saúde Pública*, 24, 1082-1088.
- Sebsibe T. (2014). Psychosocial wellbeing of orphan and vulnerable children at orphanages. *Institute of Public Health, Ethiopia*.
- Seligman, M.E.P.; Walker, E.F.; Rosenhan, D.L. (2002). *Abnormal psychology (4th ed.)*. New York: W.W. Norton & Company.
- Shekmnesh A., Aregay A., Berhe H. (2013). Prevalence of psychological distress and associated factors among AIDS orphan adolescents, Ethiopia *Greener. Journal of Medical Science*, 3, 260-9.
- Silverman P. (2000). Never too young to know earth in children's lives, *New York*
- Stanton B, Lin X, Zhao G, Li X, Zhang L, & Hong Y. (2010). Perceived HIV stigma among children in a high HIV-prevalence area in central China: beyond the parental HIV-related illness and death. *AIDS Care*. 22, 545–55.
- Tarekegn H. (2014). Psychosocial Problems and Coping Mechanisms of HIV/AIDS Orphans .
- Tatek A. (2009). Orphaned poverty and care dilemma, *Review of global policy*.
- Tatek, A. (2008). Lives of Orphans and Working Children, *Centre for Child Research*.

Tchome T.(2011).Psychological parameters of classroom processes. Hand book of Africa educational theories and practices, Generative teacher education Curriculum. Human development resource centre, 20.

The Faith to Action Initiative,(2014).Children, orphanages, and families: *a summary of research to help guide faith-based action.*

Thurman T., Jarobi, B., & Rice, T. (2012). Caring for the caregiver evaluation of support groups for guardians of orphans and vulnerable children. *AIDS Care, 24, 811-819.*

Thurman, T., Jarobi, B., & Rice, T. (2012). Caring for the caregiver: Evaluation of support groups for guardians of orphans and vulnerable children in Kenya. *AIDS Care, 24(7), 811-819.*

Tsegaye A. (2013). Psychological Wellbeing between Orphan and Non-orphan Children in, Addis Ababa.

Tweed JL., Schoenbach VJ., George LK., Blazer DG.(1989).The effects of childhood parental death and divorce on six-month history of anxiety disorders. *Journal of Psychiatry, 154,823-828.*

UNAIDS, UNICEF, & USAID. (2006). Africa's orphaned and vulnerable generations. Children affected by AIDS. New York.

UNAIDS, USAID & UNICEF.(2002). Children on the brink. A joint report on orphan nestimates and program strategies. New York.

UNAIDS. (2010). *Report on the global AIDS epidemic*,Geneva,UN.

UNICEF, (2006). Psychosocial vulnerability and resilience measures for national level monitoring of orphans and other vulnerable children:

UNICEF, (2007). The state of the world's children. *Women and Children child Survival*. New York.

UNICEF, UNAIDS & PEPFAR (2006). Children affected by AIDS. *Africa's orphaned and vulnerable generations*. New York.

UNICEF. (2005).The State of the World's Children.

http://www.unicef.org/publications/index_24432.html.

United Nations Children's Fund. (2006). Children affected by AIDS. *Africa's Orphaned and Vulnerable Generations*.

United Nations fund (2007).The state of the world's children 2008.Women and children, New York

United States Government (2013.)Fifth Annual Report to Congress on PL 109-95.

World's Vulnerable Children (2010). Retrievable at: Accessed on <http://pdf.usaid.gov/pdf/docs/PDACU307.pdf>. Accessed on 15/06/.

WHO (2013). Investing in mental health. Evidence for Action.

Williamson J. & Greenberg A.(2010). Families, not orphanages, *Better Care Network Working Paper*.

World Health Organization (WHO, 2001). The world health report Mental Health. *New Understanding, New Hope*.

World vision UK.(2011).What difference does a decade make? Action for orphans and vulnerable children.

Yi S., Poudel KC., Yasuoka J., Palmer PH., Jimba M.(2013) .Exposure to violence in relation to depressive symptoms among male and female adolescent students .*Psychiatry Epidemiol*,48,397–405.

Zohra S., Lassi S.,Ehsan U., Naveed Z.(2010).Behavioral problems among children living in orphanage facilities of Karachi, Pakistan: comparison of children in an SOS Village.

Annex-English questionnaire

ADDIS ABABAUNIVERSITY

COLLEGE OF HEALTH SCIENCES

DEPARTMENT OF PSYCHIATRY

I. Information sheet

Good morning /afternoon, my name is_____. I am a part of a team carrying out study on Level of Depression and Anxiety and associated factors at this institution.

The purpose of this study is to assess the Level of Depression and Anxiety and associated factors at this child care and rehabilitation Center. There will not be any an immediate benefit in terms of money; rather you may be morally satisfied for you contribute to the community welfare that may be attained from the result of the study. We believe that the study findings will help in order to improve their mental health care service.

If you participate in the study, it will not take us more than 15-20 minutes. Your name will not be written on this form, thus the information you provide will not be known to others. There is no risk involved in participating in the study. Your participation is purely voluntary, and you can withdraw any time after you get involved in the study without compromising the services you ought to get from the care and rehabilitation center. I hope that you will participate in this study since your views are important.

Do you have any questions about the survey? May I begin the interview now?

If you have any question contact the principal investigator at any time convenient for you using the following addresses:

Name of principal Investigator- Assaye Tilahun
Address- Addis Ababa University, collage of health science
Addis Ababa, Ethiopia
Cell phone 0928853220
E-mail sgdayele78@gmail.com

II. Consent form

I selected as a participant, heard the information in the consent sheet and understood what is required from me and what will happen to me if I take part in the study. I understand that all the information regarding me, like name and all answers given by me must not be transferred to the third party. I can also understand that I can withdraw from the study at any time without giving a reason and without me or my families' routine service utilization being affected for my refusal. Therefore, I will on behalf of me my caregiver take this consent as:

1. Agreed
2. Did not agree → End the interview and thank the respondent.

Interviewer Agreement

I certify that I have taken written consent from the respondent that she has agreed to participate in study and I have confirmed the agreement is correct.

Interviewer Name: _____ Signature _____
|_____||_____|| 2017.
Date month

Supervisor Name: _____ Signature _____

|_____|_____| 2017.

Date month

Name of institution: -----

Children's code.....

|_____|_____|_____| Date |_____|_____| 2017

Interviewer's code |_____|_____|

Start Time ____:____

End time ____:____

PART I- BACKGROUND INFORMATION

This part of the questionnaire is presented to assess your personal back ground

No.	Question	Response	Code
1.	Sex	1.Male <input type="checkbox"/> 2.Female <input type="checkbox"/>	
2.	In what month and year were you born?	Month _____ <input type="text"/> <input type="text"/> Don't know month _____ Years _____ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Don't know year _____	
3.	What is your religion?	1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Tradition Others [Specify]_____	
4.	What is your relgion?	1. Amhara 2. Oromo 3. Tigire	

		4. Southnation and nationality peoples 5. Others(specify)-----	
5.	What is your Education level?	1. never attended school 2. primary first cycle (Grade 1-4) 3. primary second cycle (Grade 5-8) 4. Secondary (grade 9-10) 5. preparatory (grade 11-12) 6. technical/vocational (10+) 7. Higher education (University level)	
6.	Name of school where you attend?		
7.	Duration of living within the institution?		
8.	Numbers of children living house?		
9.	Orphan Type	1. Maternal 2. paternal 3. both	
10.	Relationship with care and support providers Individuals (caregiver, guard, social worker and other service providers)	1. Very Good 2. Good 3. Neutral 4. Bad 5. Very Bad	

Part Two: Depression and Anxiety Scale

Instruction 2: Please read each of the following items in detail that best describes the way you have feeling including today and give your response under the column of your chose by using tick mark (



No.	Question	Yes definitely	Yes someti mes	No, not much	No, not at all
1.	I wake early and then sleep badly for the rest of the night				
2.	I get very frightened or have panic feelings for apparently no reason at all.				
3.	I feel miserable and sad				
4.	I feel anxious when I go out of the house on my own.				
5.	I have lost interest in things				
6.	I get palpitations, or sensations of 'butterflies' in my stomach or chest				
7.	I have a good appetite.				
8.	I feel scared or frightened				
9.	I feel life is not worth living.				
10.	I still enjoy the things I used to.				
11.	I am restless and can't keep still.				
12.	I am more irritable than usual.				

13.	I feel as if I have slowed down.				
14.	Worrying thoughts constantly go through my mind.				

Annex 2: Amharic Questionnaires

አዲስ አበባ ዩኒቨርሲቲ
የጤና ሳይንስ ኮሌጅ
የአእምሮ ሕክምና ትምህርት ክፍል

በልጆች ክብካቤና ማቋቋሚያ ተቋም በሚኖሩ ታዳጊዎች የሚሞላ የጥናት ቅጽ

ሀ. የጥናቱ መረጃ ቅፅ

ጤና ይስጥልኝ። ስሜ-----ይባላል። ድባቱ (Depression) እና ጭንቀት-(Anxiety) ድርጅቱ ውስጥ ባሉ ልጆች መካከል መኖር አለመኖሩንና ያለበትን ደረጃ እንዲሁም ሰለተለያዩ ተያያዥ ምክንያቶች ጥናት ከሚያደረግ ቡድን ጋር በመተባበር የመረጃ ሰብሳቢ ነኝ።

የዚህ ጥናት አላማም በልጆች ክብካቤና ማቋቋሚያ ተቋም የሚኖሩ ታዳጊዎች ድባቱ (Depression) እና ጭንቀት-(Anxiety) ምን እንደሚመስል እና ተያያዥ ምክንያቶች ላይ ጥናት በማድረግ የማሻሻያ መንገዶችን መጠቀም ነው።

በዚህ ጥናት በመሳተፍዎ ቀጥታ የሆነ ክፍያም ሆነ ጥቅማጥቅም የለውም፤ ነገር ግን እርስዎ ለዚህ ጥናት በሚሰጡት መረጃ የጥናቱ ወጤት በክብካቤና ማቋቋሚያ ተቋም የሚኖሩ ታዳጊዎች ማግኘት ያለባቸውን አገልግሎት በማጠናከር የልጆችን ጤና ለማሻሻል ለህብረተሰቡ በሚያስገኘው ጠቀሜታ የበኩልዎን በመወጣትዎ ከፍተኛ የአእምሮ እርካታ ያገኛሉ ብዬ አምናለሁ።

በጥናቱ ላይ ተሳታፊ ከሆኑ ከ15-20 ደቂቃ ብቻ ይወስድቦታል። የእርስዎ ስም በዚህ መጠይቅ ላይ አይሞላም። ስለዚህ የሚሰጡት መረጃ ሁሉ ሚስጠራዊነቱ እጅግ የተጠበቀ ይሆናል። ተሳትፎዎ ሙሉ በሙሉ በእርሶዎ ፈቃደኝነት ላይ ብቻ የተመሰረተ ይሆናል። እንዲሁም በፈለጉት ጊዜ መረጃ መስጠቱን ማቋረጥ ይችላሉ። ባለመሳተፍዎ ወይም መረጃ መስጠቱን በማቋረጥዎ ምንም አይነት አገልግሎት አይጓደልብዎትም። ይሁን እንጂ የእርስዎ ተሳትፎ በጣም አስፈላጊ በመሆኑ በጥናቱ እንሚዲሳተፉ ተስፋ እናደርጋለን።

ስለጥናቱ ከላይ በተሰጠው ማብራሪያ ጥያቄ አለዎት?

ተጨማሪ ጥያቄ በማኛውም ጊዜ ከኖረዎት፤ ከዚህ በታች በተጠቀሰው አድራሻ ዋና ተመራማሪውን ማግኘት ይቻላል።

ስም	አሳዩ ጥላሁን
አድራሻ	አዲስ አበባ ዩኒቨርሲቲ , አዲስ አበባ
የስልክ ቁጥር	0928853220
E- mail	sgdayele78@gmail.com

በቃለ መጠይቁ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ አይደለሁም

ለ. የፍቃደኝነት ማረጋገጫ ቅፅ

እኔ በጥናቱ ላይ እንድሳተፍ የተጠየቅኩ ከዚህ በላይ በጥናቱ መረጃ ቅፅ ላይ የተቀመጠውን ነገር በአግባቡ በመረዳት ከእኔ የሚጠበቀውን ሁሉ አወቁያለሁ። ከዚህም ሌላ በጥናቱ ላይ ተሳታፊ ብሆን እኔ የምሰጣቸው መረጃዎች ለሶስተኛ አካል ተላልፈው እንደማይታወቁና የግለሰብ ስም እንደማይካተት ተረድቻለሁ። በተጨማሪም መረጃ መስጠቱን የማልፈልገው ከሆነ በማንኛውም ሰዓት ያለምንም ምክንያት ማቆም እንደምችልና በማቆሜም እኔ ከድርጅቱ በማገኘው አገልግሎት ላይ ምንም ዓይነት ተፅዕኖ እንደማይኖረው አወቁያለሁ ። ስለሆነም በአሳዳጊዎ አማካኝነት በጥናቱ ለመሳተፍ

1. ተስማምቻለሁ

2. አልተስማሙሁም →

አመስግነህ/ሽ ጨርስ/ሽ.

የቃለ መጠየቅ አድራጊወ/ዋ ስምምነት

ተሳታፊዎ በጥናቱ ላይ ለመሳተፍ ፍቃደኝነታን የሚገልፅ ስምምነት በዕሉፍ መልክ መወሰዱንና ስምምነቱም ትክክለኛ መሆኑን እገልጻለሁኝ።

የቃለ መጠይቅ አድራጊወ/ዋ ስም ፊርማ

ስም _____ ፊርማ _____ የቃለ መጠይቅ አድራጊወ ኮድ

/ _____ / _____ /2009ዓ.ም

ቀን

ወር

የተጠያቂው ሞግዚት ስም _____ ፊርማ _____

የታዳጊ ኮድ...../-----/-----/

ቃለመጠይቁ የተጀመረበት ሰዓት -----:-----

:-----

ክፍል አንድ : አጠቃላይ መረጃ

መመሪያ: ለሚከተሉት ጥያቄዎች "✓" ምልክት በማድረግ ወይም የተጠየቀውን መረጃ በመጻፍ መልስ ሰጥ/ጭ::

1	ጾታ	ወንድ <input type="checkbox"/> 2. ሴት <input type="checkbox"/>
2	በምን ወርና ዓመተ ምህረት ተወለዱ?	1. ወር <input type="text"/> <input type="text"/> 2. ወሩን አላወቀውም 3. ዓመተ ምህረት <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4. ዓመተ ምህቱን አላስታወስም-----
3.	ሐይማኖትዎ ምንድነው?	1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. ሙስሊም 4. ካቶሊክ 5. ሌላ/ይገለጽ-----
4.	ብሄርዎ ምንድን ነው?	1.አማራ 2.ኦሮሞ 3.ትግይ 4. ደቡብ 5. ሌላ(ይገለጽ)- -----
4	የትምህርት ደረጃ?	1. ያልተማረ /ች 2. የመጀመሪያ ደረጃ 1ኛ ሳይክል (1-4ተኛ) 3. የመጀመሪያ ደረጃ 2ኛ ሳይክል(5-8ኛ) 4. ሁለተኛ ደረጃ (9-10ተኛ) 5. መሰናዶ ትምህርት(11-12ተኛ)

		6. የሙያ ትምህርት(10 ⁺) 7.ከፍተኛ ትምህርት (በዩኒቨርሲቲ ደረጃ)				
5	የሚማሩበት የትምህርት ቤት ስም					
6	በተቋሙ ምን ያክል ጊዜ ቆይተዋል?					
7	በሚኖሩበት የመኝታ ክፍል ውስጥ የሚኖሩ ታዳጊዎች ባዛት?					
8	በህይወት የሌሉ ወላጅ	4. እናት	5. አባት	6. ሁለቱም		
9	እንክብካቤ ከሚያደረጉልዎት ግለሰቦች ጋር ያለዎት ግንኙነት (ከሞግዚት፣ ከጥበቃ፣ ከማህበራዊ ሰራተኞች፣ በአጠቃላይ ከሁሉም ሰራተኞች)	6. በጣም ጥሩ	7. ጥሩ	8. መወሰን አለቸልም	9. ጥሩ ያልሆነ	10.በጣም ጥሩ ያልሆነ
<p>ክፍል ሁለት : የድባቱ (Depression) እና ጭንቀት(Anxiety) ስሜትን የተመለከቱ መጠይቆች</p> <p>መመሪያ: ለሚከተሉት ጥያቄዎች "✓" ምልክት በማድረግ ትክክለኛውን መረጃ ሰጥ/ጭ::</p>						
ተ.ቁ	የጥያቄው አይነት	አዎ በትክክ	አዎ፣ አንዳንዴ	አይደለም	አይደልም	

		ል		በጥቂቱ	በፊትም
1	መንቃት ካለብኝ(ሳይነጋ) ቀደም ብዩ እነቃልሁ፣ ከዚያም በኋላ ቀሪውን የእንቅልፍ ሰዓት በአግባቡ አልተኛም።				
2	በግልጽ ምንም አይነት ነገር ሳይኖር በጣም የፍርሃት ስሜት ወይም ድንገተኛ ድንጋጤ ይሰማኛል።				
3	የብስጭትና የሃዘን ስሜት ይሰማኛል።				
4	ለብቻዬ ከቤት በምወጣበት ጊዜ የመረበሽ ስሜት ይሰማኛል ።				
5	ለምንም ነገር ፍላጎት የለኝም።				
6	ያለምንም ምክንያት ፈጣን የሆነ የልብ ምት ያጋጥመኛል ወይም ደርሶ ልቤ መምታት ይሰማኛል ።				
7	ጥሩ የምግብ ፍላጎት አለኝ				
8	ፍርሃት ፍርሃት የሚል ስሜት ይሰማኛል።				
9	በህይወት መኖር ትርጉም የለውም የሚል ስሜት ይሰማኛል።				
10	ከዚህ በፊት እንደምደሰተው ደስታ በነገሮች እስከ አሁን እደሰታለሁ።				
11	የመቁነጥነጥ ስሜት እየተሰመኝ ተረጋገቶ መቀመጥ ያቅተኛል				

12	ከቀደመው ጊዜ ይልቅ አሁን ትግስት ያጥረኛል።				
13	ፍዝዝ ያልኩ ይመስለኛል ።				
14	አስጨናቂ ሃሳቦች በተደጋጋሚ በአዕምሮዬ ይመላለሱብኛል።				