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LEVEL OF DEPRESSION AMONG INSTITUTIONALIZED
ORPHAN CHILDREN: SOS CHILDREN'S VILLAGE

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LEVEL OF DEPRESSION AMONG INSTITUTIONALIZED ORPHAN CHILDREN: SOS CHILDREN'S VILLAGE

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List of Abbreviations

CDI	Children's Depression Inventory
FHAPCO	Federal HIV/AIDS Prevention and Control Office
OFFBC	Other Forms of Family Based Care
OVC	Orphans and/or Vulnerable Children
UNICEF	United Nations Children's Fund

Abstract

The aim of this study was to examine the level of depression among institutionalized orphan children. Participants of this study were 80 children aged between 13-17 and both sexes. Interview was held with 3 children and 2 caregivers selected purposively. Totally, the study has 82 participants. All children were subjected to psychiatric assessment for depression by Children's Depression Inventory (CDI). Data about the institutional facilities were collected through interview. Quantitative data were analyzed using both descriptive (percentage, mean and SD) and inferential statistical methods such as independent-samples t- test and correlation. The prevalence rate of depression was 23.6% with a CDI cut-off score of 17. This study concluded that depression is highly prevalent among institutionalized children; there is no statistical difference in means among selected pairs of categories of children, and no statistically significant relationship between admission age and level of depression.

CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

Orphan is any child between the ages of 0 and 17 who has lost one or both parents (United Nations Children's Fund (UNICEF), 2015). Losing a biological father, mother or both make children to become orphan. Because of different conditions like malaria, pregnancy complications, HIV/AIDS, tuberculosis, and natural disaster there is high mortality among young adults which is a reason for the large and increasing number of orphans globally. Children who lost their parent need to make a new living adjustment. They may be compelled to live with the extended family if there is a room or else on the street. Orphaned children are one of the most serious socio-economic and developmental challenges affecting developing countries worldwide. The number of orphans from all causes has risen by more than 50% in sub-Saharan Africa (Cluver & Fincham, 2009). An estimated 5, 459, 139 orphans existed in Ethiopia in 2008 (Federal HIV/AIDS Prevention and Control Office (FHAPCO), 2007).

Recognizing the need to support the growing orphan population, many non-governmental and faith-based organizations have founded orphanages to care for these children. Lack of consistent caregivers, inspiration and standard care are believed to contribute to the negative outcomes among institutionalized children. Long term institutionalization may increase the risk of impoverished children growing into psychiatric impairment and unproductive economic status during adulthood. Nagy and Amira (2010) found that although the basic material needs could be met, orphans in orphanages were almost totally separated from the outside world and could not access normal families and society relations.

Mental health problems continued to increase within the orphanage sample, even among internationally adopted children; those who had previously lived in orphanages were more likely to have developmental and mental health problems, at least in the short and medium term, than those previously in foster care. Orphan-hood has an overall serious negative impact and 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 (Shekmnesh, Alemseged &Hailemariam, 2013).

According to World Health Organization, depression is the number one cause of disability, and will be the second in rank disorder by 2020 in terms of burden of disease (e.g., disability and mortality) (Murray and Lopez, 1996).

Children under stress and who experience loss are at a higher risk for depression. In a review of literature Ahmad et al.(2005),have found that orphans were more likely to be anxious, depressed and to display anger and showed significantly higher feelings of hopelessness and suicidal ideation. A study by Birmaheret al. (1996) has found early-onset depression due to any factor often persists recurs and continues into adulthood and indicates that depression in youth may also predict more severe illness in adult life. According to the most recent data, depression in young people commonly co-occurs with other mental disorders, anxiety, disruptive behavior, or substance abuse disorders and with physical illnesses, such as diabetes (Shaffer et al., 1996).

A study performed on Children admitted to orphanages reported high rates of major psychiatric disorders such as depression (41.5%) and post-traumatic stress disorder (39.3%) (Thabet, Mousa,

Abdul, & Vostanis, 2007). A study in Uganda showed that orphans had greater risk of anxiety, depression and anger than non-orphans. Furthermore, orphans had significantly higher scores than non-orphans on individual items in the Beck Youth Depression Inventory that are regarded as particularly “sensitive” to the possible presence of a depressive disorder, i.e. vegetative symptoms, feelings of hopelessness, and suicidal ideation (Atwin & Cantor, 2005). Similarly, according to quantitative and qualitative study conducted in Eastern Zimbabwe orphans were found to suffer greater psychological distress than non-orphans (Nyamukapaab et.al. 2010).

The extent of suffering is not the same for every child who is institutionalized because the effects of institutionalization are not uniform and are dependent on different factors. The differential effects are due to child characteristics (genetic predisposition, basic personality, attractiveness, prenatal risk factors), caregiver characteristics (training, motivation & attitude), institutional characteristics (child-to-caregiver ratio, quality and degree of programming), and the child's history (the age of the child when he/she entered the institution and the length of time in the institution (Victor, 1996).

1.2. Statements of the Problem

The prevalence of orphaned children has been increasing in every part of the world. There were over 132 million orphans in sub-Saharan Africa, Asia, Latin America and the Caribbean in 2005 (UNICEF, 2015). In Ethiopia there are 5.5 million children, around 6% of the total population, are categorized as orphans or vulnerable children (OVC). OVC comprise almost 12% of Ethiopian's total child population (Save the Children UK, 2008). Because of parental death and poverty young children are frequently placed in the institutional care throughout the world. This occurs despite wide recognition that institutional care is associated with negative consequences for children's health and emotion.

Children are not able to bear up the outside environment because for them every movement and interaction outside their natural residence are becoming difficult to practice (Donahue, 1998). Many orphaned children continue to experience emotional problems and there are several reasons. First, there is a cultural belief that, children do not have emotional problems and therefore there is a lack of attention from adults. Secondly, psychological problems are not always easily detected and identified by elders. In many cases children are punished while showing or displaying their negative emotions, thereby elders are adding children's pain. In community-based orphan support programs, volunteers often assess children's needs in terms of material goods, neglecting their psychosocial needs (Lee, 2000). Children in orphanages are sad, depressed, and under stress due to bereavement of their parental loss and lack of good relationship with service providers, (Sebsibe, Fekadu, & Molalign, 2014). Orphans have psychological problems and may be particularly vulnerable group in their present and future life, (Shekmnesh et al., 2013). Thus, this study is intended to answer the following research question:

What is the level of depression among institutionalized children?

Is there statistical difference in the level of depression between male and female institutionalized orphan children?

Is there a relationship between admission age and level of depression?

Is there statistical difference in the level of depression between institutionalized orphan children who stayed for short period of time and who stayed for lengthy period of time?

1.3. Objectives of the study

1.3.1. General objective:

The general objective of this study is to assess the level of depression among institutionalized children.

1.3.2. Specific objectives

The specific objectives are:

- To examine if there is statistical difference in the level of depression between male and female institutionalized orphan children
- To examine if there is a relationship between admission age and level of depression
- To examine if there is statistical difference in the level of depression between institutionalized orphan children who stayed for relatively short period of time and who stayed for lengthy period of time in the institution
- To examine if there is statistical difference in the level of depression between male and female institutionalized orphan children

1.4. Significance of the study

The study will provide significant information about the prevalence of depression among institutionalized children and the institution can benefit from this study as it contains evidence-based information about children's emotional situation.

Health centers, hospitals, schools, institutions, health professionals and researchers may use the results of this study as a means of understanding and helping children.

The government would benefit from the study by using the information as an input in designing and implementing programs to ensure quality services in the institution and in the community.

1.5. Delimitation of the study

The scope of this study was limited to examine the level of depression among institutionalized orphan children in SOS Children's Village, Addis Ababa. Additionally this study was also delimited to the variable such as depression and age range of orphan children between 13-17. Both sexes have participated.

1.6. Limitation of the study

The selection of the institution in the study was purposive and was not an arbitrary random selection. This would create selection bias and may affect the representativeness of the study subjects.

1.7. Operational Definition of Terms

Institutionalized orphan children: - children at the age range of between 13 to 17 years old who lost single or both parents and reside in SOS Children's Village.

Orphan:-Child who has no biological parents or parent and below 18 years old.

Depression:-A long-term deep sadness accompanied by feelings of hopelessness, inadequacy, disappointment, and with harmful effects on health and development of the individual.

Age of admission:- an age of a child when he/she was admitted into the SOS children's village

Duration of stay:- a period of time for how long a child stayed in the SOS children's village

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1. The Concept of Orphan

The United Nations Children's Fund (UNICEF) defines an orphan as any "child under 18 years of age who has lost one or both parents" though there is no generally accepted definition of orphan and vulnerable children (OVC) across the world. Children who lost one parent are known as a "single orphan" and those who lost both parents as a "double orphan." In several cases an orphan may still live with primary or extended family. There are millions of children living in institutions worldwide. One estimate puts the total at up to 8 million though, given gaps in global statistics and indications that there are many unregistered children's homes, the true figure may well be much higher.

Because of not all nations have precise census information across the world exact global figures are not available but there is an estimation reported in the joint report, *Children on the Brink* (2004) claim there are approximately 143 million children worldwide who have lost a mother or a father; 16.2 million are "double orphans" who have lost both parents.

2.1.1. Factors Contributing to Orphan-hood

The HIV/AIDS pandemic is not the only contributing factor in the rapidly increasing numbers of orphans and vulnerable children. There are different causes which compels children to become an orphan. The high number of orphans is also attributed to other diseases such as tuberculosis and malaria, high maternal mortality rate, extreme poverty, armed conflict, natural calamities like cyclones, earthquake floods, fire and road accidents, war, famine, drought, political instability and child labor practice (Gulaid, 2008).

Historically, being an orphan was resulted from high mortality rates, and it remains common in areas devastated by war or disease. There are also cases when young ladies making a wrong decision in life they get pregnant unprepared for the responsibility and they either leave the baby in the hospitals or run away. In some cases, the parent of a child may be alive, but is either unable or unwilling to care for the child. Other reasons are factors specific to the child, including disability, direct experience of physical or sexual violence, or severe chronic illness causing the child to become an orphan and vulnerable (Skinner, 2006).

It is really difficult to calculate the number of children in residential institutions country wide because there are almost no trustworthy figures existing. Given that there are lack of reliable statistics and inconsistent data collection, the number of children in institutional care around the world is unknown and is difficult to determine due to inadequate monitoring by governments. Based on the limited existing data, UNICEF estimates that at least 2.2 million children in the world live in orphanages acknowledging that this is probably a significant underestimate (UNICEF, 2009). Orphanages in this case include all types of residential care, from small (15 or fewer children) to large-scale institutions. This number is considered by many to be a significant underestimate, because many orphanages around the world are unregistered and the children living within them are not officially counted (Save the Children, 2001).

2.2. Orphans and Orphanages in Ethiopia

The United Nations Children's Fund- Ethiopia (2007) estimated that there are 4.6 million orphaned children in the country, of these 200,000 children supposedly living on the streets of Addis Ababa. A different source tells that in Ethiopia, like in many other African countries, there will be an increasing numbers of children orphaned in the future. Ethiopia is now the fourth most popular nation for American adoption next to China, Guatemala and Russia (Bauer, 2008).

In a literature review, Tsegaye, mentions that an assessment made in 1988 by National Children's Commission (NCC), indicated there were 106 orphanages in Ethiopia operated by government, nongovernment organizations and city councils caring for 21,318 children (Tsegaye, 2001). Now there are nongovernmental and public orphanages providing service for the OVCs and according to UNICEF (2013) report there are about 225 orphanages found in Ethiopia in the year 2013.

Study of orphanages in Ethiopia has found poverty, deaths of parents due to HIV/AIDS, war, recurrent drought and its subsequent food shortage/famine are the major factors that made a number of children become orphans and vulnerable in Ethiopia (Tsegaye, 2001).

2.3 Concept and Theory of Depression

Cognitive theories of depression have been one way to understand the developmental etiology and maintenance of depression. These theories share the general hypothesis that the ways in which individuals attend to, interpret, and remember negative life events contribute to the likelihood that they will experience depression.

2.3.1 Beck's Cognitive Theory

Depression is quite complex in its symptomatology and etiology. Manifestations of depression includes overt behavior (e.g., sad demeanor, slowed activity, lack of responsiveness), cognition (e.g., low self-esteem, hopelessness, helplessness, negative view of the world), and somatic symptoms (e.g., loss of weight, disturbed sleep, physical complaints) that extend to almost all domains of functioning.

In Beck's cognitive theory of depression (Beck, 1967, 1987), maladaptive self-schemata that include dysfunctional attitudes, involving themes of loss, inadequacy, failure, and worthlessness,

constitute the cognitive vulnerability. These schemata consist of stored bodies of knowledge that affect encoding, comprehension, and retrieval of information. These dysfunctional attitudes are to become activated following the occurrence of a negative life event, generating specific negative cognitions (e.g., negative thoughts about the self, world, and future), and lead to elevations of depressive symptoms. Depression arises as a result of inferences derived from distorted cognitions. The depressed person views the world through an organized set of depressive schemata that distort experience about self, the world, and the future in a negative direction. This negative way of thinking guides one's perception, interpretation, and memory of personally relevant experiences, thereby resulting in a negatively biased understanding of one's personal world, and ultimately, the development of depressive symptoms. For example, the depression-prone individuals are more likely to notice and remember situations in which they have failed or did not live up to some personal standard and discount or ignore successful situations. As a result, they maintain their negative sense of self, leading to depression (Lata, 2000).

In addition, Beck posits that these self-schemata are typically latent in individuals vulnerable to depression and will be activated by a relevant stressor to trigger biased information-processing tendencies. The activation of the schema subsequently influences how the individual perceives, encodes, and retrieves information regarding the negative life event. Conversely, in the absence of stressful events, depressogenic self-schemata are to remain inactive and not exert significant influence on cognitive processing (Beck, 1972).

2.3.2. Hopelessness Theory of Depression

Hopelessness theory (Abramson et al., 1989), posits that some individuals exhibit a more depressogenic inferential style, and when confronted with a negative life event, are likely to develop symptoms of depression. The theory postulates three types of negative inferences that individuals can make given the occurrence of negative events: causal inferences (inferences about why the event occurred including stable and global attributions), inferred consequences (inferences about what will result from the occurrence of the event), and inferences about the self (inferences about the self with respect to the event that occurred). Further, making such inferences increases the likelihood of developing hopelessness, and in turn, depression because hopelessness is posited to be a proximal sufficient cause of hopelessness depression, a theory-based subtype of depression.

2.4 Age and Sex Difference in Depression

It has been estimated that between 5 and 25% of the population will experience depression at some point in their life, and up to 15% of severely depressed individuals will commit suicide (Gotlib and Hammen, 2002). These inescapable facts are especially true for young people because depression rises dramatically with the transition from childhood through adolescence and then remains at high prevalence levels throughout much of adulthood. For example, a 10-year prospective longitudinal study showed that rates of depression rise six fold during adolescence (Hankin et al., 1998): approximately 2% of 13 year olds are depressed, and these rates sky rocket to 17% at age 18 (Angold et al., 2002; Hankin et al., 1998; Lewinsohn et al., 1994; Wade et al., 2002). In addition, sex differences in depression begin to emerge and expand throughout this time. Researchers from many camps have conducted studies and proposed theories to explain and predict depression; however, much of the knowledge on vulnerability to depression has

utilized adult theories of depression without a consideration of developmental differences. The developmental nature of depression highlights the importance of identifying the factors that confer vulnerability to depression in childhood through adolescence.

Empirical support in laboratory, clinical, or epidemiologic studies, the mechanism underlying the gender difference in depression remains unclear (Nolen-Hoeksema, 2002). There are several possibilities for the reason why women are more depressed than men. An amazing thing happens at puberty. Before developing sexually, boys are more likely to be depressed than girls, but afterwards girls become twice as likely to be depressed and boys turn to delinquency. Despite a number of biological, psychological, and social theoretical explanations that have been formulated in attempts to account for the gender differences in depression, the mechanism underlying this association remains unclear (Ormel, Oldehinkel & Brilman, 2001).

Thus, maturing young girls may get distressed *when* interacting with desirable but sexually aggressive young males, *when* they dislike or don't know how to handle their own bodily changes (breasts, pimples, over or under-weight, no butt, etc., etc.), *when* sexually teased, used, or abused, *when* their social activities are restricted more than boys, *when* peers, culture, and parents start to emphasize attractiveness, sexiness, and friendships more than intelligence, genuine caring, and preparing for one's life work (Robins & Trzesniewski, 2005).

In our today's modern world we are gradually finding more and more childhood factors related to teenage depression. A frequently cited statistic is that women are twice as likely to become depressed as men (and two or three times more likely than men to *attempt* suicide). It is an interesting coincidence that women are also about twice as likely as men to "over-think," which is ruminating mostly about unhappy events in the past (in contrast to worry which often focuses

on bad things that might happen in the future). This could be another bit of evidence that negative thoughts produce negative emotions although the above observation that females dramatically increase their negative thoughts at the time of puberty also suggests something else may be an underlying cause of both negative thoughts and depressed feelings (Nolen-Hoeksema, 2002) and Cyranowski et al., 2000).

2.5. Difference of Early Age Admission and Duration in the Institution

According to attachment theory, for the child to have appropriate emotional development and long-term mental health, early experience with a few warm, caring, and emotionally responsive adults who are relatively stable in the child's life is foundational (e.g., Ainsworth, 1979; Ainsworth, Bell, & Stayton, 1974; Ainsworth, Blehar, Waters, & Wall, 1978; Bornstein & Tamis-LeMonda, 1989; Bowlby, 1958, 1969; Grusec & Lytton, 1988; Spitz, 1946; Sroufe, 1983; Sroufe, Carlson, Levy, & Egeland, 1999).

Theoretically, an infant with a warm, responsive caregiver develops an internal working model of expectations for nurturing, supportive reactions from that caregiver, whom the infant comes to trust and use as a secure base from which to explore the social and physical world. Such experiences in turn promote the development of a sense of worthiness and self-esteem and appropriate long term social-emotional development and mental health. Without the early experience of a few warm, caring, emotionally responsive adults, long-term development may be compromised. The specific ages of approximately 6–18 months may be especially sensitive to deficiencies in orphanage environments (Gunnar, 2001; MacLean, 2003; Merz & McCall, 2007, 2008; Rutter, Beckett et al., 2007).

The evidence strongly suggests that the experience of orphanage care is most damaging for children under the age of five, and especially so for children under the age of three, since it is during these critical years that children need to develop the physical, cognitive, psychological and social foundation for the rest of their lives (Tolfree, 2003).

According to United Nations report on violence against children, extensive research in child development has shown that living in an orphanage from an early age can result in potentially irreversible psychological damage and the negative effects are more severe the longer a child remains in an orphanage.

Placement of children in the institutions during early critical developmental periods, and for lengthy periods of time, is often associated with developmental delays due to environmental deprivation, poor staff to child ratios, and/or lack of early childhood stimulation (Twenge, 2009). A child should grow up in a family. Permanent parental care is the ideal situation for every child. Every child has a right to be permanently placed in a family (Boswell, 1988). However, this is not always possible. There have been decades of research on the topic of institutionalization and the extreme negative effects it has on children. Caring for orphaned, abandoned, and maltreated children through informal care and adoption has a long history (Boswell, 1988).

Anna Freud concluded from several case studies that institutionalized children are fated to fail psychologically because of maternal deprivation. This was despite good physical and social care. Another psychologically trained psychiatrist John Bowlby also reported that maternal deprivation was the central issue causing psychological damage to orphanage children. Goodwin argues that any amount of orphanage experience is harmful; the damage is greatest during the first year of life and increases dramatically with length of stay in an institution. Children in the

institutional care are extremely vulnerable to psychological problem and institutionalization in long term and in early childhood increases the likelihood that they will grow into psychologically impaired and economically unproductive adult (Flank, Klass, Earls, & Eisenburg, 1997). Significant association between child psychopathology and long duration of stay in the orphanage and loss of parents before age of four years was found in a study carried out in a conventional orphanage in Dhaka city (Shaheed, 2004).

2.6. Nature of Institutional Care

Though not all institutions are harmful to children, however, institutional care in general is rarely provided appropriately, to a high enough standard and in the best interests of the individual child (Save the Children, 2001). Institutional care is often examined through the problematic psychosocial functioning of children (Hersor, 1980). For the last half century, child development specialists have recognized that residential institutions consistently fail to meet children's developmental needs for attachment, acculturation and social integration. Institutional care is inadequate particularly that young children typically do not experience the permanent care that they need to form a lasting attachment with an adult caregiver.

Living in an orphanage has been associated with delays in all areas of development including growth, language, social and emotional, and behavioral among others (Ainsworth, 1965; Ames et al., 1997; Ahmad & Mohamad, 1996; Johnson, 2000; Miller, Chan, Comfort, & Tirella, 2005; Rutter, 1998). Children living in orphanages are more likely to be deprived of touching, smiling, laughing, and exploring with a primary caregiver, and institutionalization has been linked to a high rate of disorganized attachment and difficulties in developing healthy interpersonal relationships (Johnson, Browne, & Hamilton-Giachritsis, 2006; Rutter, Kreppner, & O'Connor, 2001; Vorria et al., 2003).

Poor care giving, lack of stimulation and the absence of a consistent caregiver have been implicated in the negative outcomes among institutionalized children. Because of the high ratio of children to staff, the high frequency of staff turnover and the nature of shift work, ongoing and meaningful contact between a child and an individual care provider are almost always impossible to maintain in a residential institution. One of the most common characteristics of institutional life is the lack of stable, long-term relationships between a child and a caregiver (ObrovaKrol et al., 2008).

Although institutions provide for practical needs, they can also lead to stigmatization and separation from family and community (Freidus, 2010). Many children in large-scale institutions face additional problems of neglect caused by poor quality standards. This includes life-threateningly poor nutrition, hygiene and healthcare, lack of access to education, and a chronic lack of physical and emotional attention. In a literature review, D Tobis, (2000) mentions data from Russia indicating that one in three residential care leavers become homeless, one in five ends up with a criminal record, and as many as one in ten commits suicide.

2.7. Emotional problem of institutionalized children

Death of parents introduces a major change in the life of a vulnerable child and the change may involve moving from a middle or upper-class urban home to a poor rural relative's home. It may again involve separation from siblings, which is often done arbitrarily when orphaned children are divided among relatives without their needs being taken into consideration. It may also mean the end of a child's opportunity for education because of lack of school fees. Those children who refuses to move or who may not have any other relative to go to may be forced to live on their own, constituting child-headed families. Therefore, all these changes can easily affect not only

the physical, but also the psychological well-being of a vulnerable child. They can be very stressful as they pose new demands and constraints to children's life. It is feared that many children may fail to adapt to the new changes. Minde (1988) makes it clear that it is not the social change itself that may cause psychological problems; rather it is the failure of the individual to adapt to it. Like bereavement the process of trying to adapt to the social change create stress.

Existing literature indicates that orphans in general and those brought to institutions in particular suffer from many social, psychological and economic problems (Gilborn, 2006; Boris, 2012; Dabla, 2010; Bhargava, 2005). Psychological wellbeing scores are significantly lower among orphans than non-orphans (Delva et al 2009). Majority of orphans have low psychological wellbeing and majority of non-orphans have high psychological wellbeing (Tsegaye, 2013). Children in institution care who are exposed to neglect and physical abuse have many problems internalizing (anxiety, depression) and externalizing (aggression, impulsivity) behavior problems (Brendgen, 2002).

In a cross sectional study conducted in Dhaka, Bangladesh the result revealed a significant number of cases with emotional disorder and researchers indicated that emotional and behavioral disorders are highly prevalent among orphaned children (Rehman, et. al 2012). Bhat, (2014) conducted a study on emotional stability and depression in secondary school orphans and non-orphans, result revealed significant difference in emotional stability and depression levels between the two groups, orphans were found to experience lower side of emotional stability and higher level of depression than non-orphans.

Behrendt, and Serigne, (2008) investigated the psychosocial impact of parental loss and orphanhood on children and certain mental disorders such as post-traumatic stress disorder (28%) and depression (45%) were highly prevalent in the total sample. In a 2011 study of 60 Pakistani children, single and double orphans living in institutional care and those living at home with their parents were included. Using the Child Depression Inventory researchers found that children in institutional care had significantly higher levels of depression than those living with their parents. Those who had lost both parents had the highest levels of depression (Um-e-kalsoom and Waheed). Peter, Eunice & Sarah (2004) conducted a study to identify the psychosocial problems of orphans and non-orphans. Findings showed that prevalence and seriousness of psychosocial problems (negative emotion, stigma, depression and behavioral problems) were higher among orphans than non-orphans.

Depression is a deep sadness with long-term, harmful effects on the health and development of the individual. In spite of different efforts made by different agencies like UNICEF, World Vision, and Save the Children, many number of orphans still experience emotional problems. The absence of sufficient information about the nature and magnitude of the problem, culturally formed belief that children do not experience emotional problems, and the difficulty to identify psychological problems, as they are not always obvious, are some of the reasons why adults doesn't pay much attention.

In most cases children are not given the chance to talk and they are not listened to and because of this their emotion is not understood. Even when children show their negative emotions like when they fail to do house chores, when they have decreased appetite for food, when they get inattentive in a class or when they lack the strength to attend a class they will be punished for it

because there is lack of knowledge about how to handle the identified problems. This is the crux of the matter, which needs empirical scrutiny (Smart, 2008).

When a parent dies children are adversely affected by bereavement like adults but they usually do not feel the loss with its magnitude simply because they may not understand what it means to lose a parent to death and this prevents them from going through the grieving process, which is the necessary to gain recovery from the loss. Therefore, children will be at risk to grow up with unresolved negative emotions expressed with anger and depression (Brodzinsky, Gormly and Ambron, 1986).

2.8. The Situation of Children in Institutional Facilities

Compared to international standards and guidelines many orphanages fall short of the standard. With regards to children's welfare, development and protection, the provision of health services is seriously lacking, and there is not sufficient provision of basic necessities such as clothing and bedding. Furthermore, not all children are getting three meals a day. Children in just about all facilities are expected to partake in regular chores and duties that contribute to the running and upkeep of the facility, and failure to do so may result in the child being punished – sometimes physically.

Just about all facilities allow children to attend school – though not all children do so – but many lack sufficient education materials. In general, children are not given the opportunity to play, and have access to recreation. The time and access to materials varies greatly across facilities, but it often involves interacting with children from the local community. However, religious freedom is not respected at the majority of facilities, although speaking one's ethnic language is allowed.

Premises and buildings vary greatly in terms of standards, upkeep and appearance: some have insufficient sleeping space, some dormitories cannot be locked, and only half of the facilities provide a separate locker, drawer or box for children to keep their personal belongings.

Even where facilities have a Code of Conduct or child protection guidelines, they are not clearly displayed and many staff lack knowledge of them. Less than half of the caregivers have ever received training on child care and development; they work on average 60 hours a week, and are responsible for 48 children on average. The ratio of children to staff in an orphanage is nearly always higher than to adult careers in a home setting and the continuity and dependability of relationships is lacking. Admission and record-keeping is particularly weak, with approximately half of the facilities making and maintaining a case record. Information collected is not thorough, and children – or their next caregiver – rarely receive a copy of the child's file upon departure. Little effort is made to promote contact with family and relatives.

2.9. Locus of Control

The concept of locus of control refers to the relationship between the environment and the individual's assessment of his or her ability to deal with it and to adjust behavior accordingly. Locus of control has two dimensions: the external and internal. The external locus of control assumes that a person's life is controlled by external factors, such as luck, fate and nature (Lefcourt, 2009).

Externally oriented individuals (externals) do not see themselves as responsible for what happens to their lives but merely accept what happens. From this perspective, a person is helpless and is at the mercy of the environment. The internal locus of control assumes that a person has the ability to predict environmental events and be able to respond appropriately. Internally oriented

individuals (internals) feel they have the ability to control events and the resultant behavior. Therefore, they are in control of their own fate. It is this perception of the ability “to do something” that gives rise to the concept of perceived control (Lefcourt, 2009).

Locus of control is important for effective coping behavior in the case of stress. When faced with stress, internals tend to adopt a problem-solving strategy while the externals tend to react emotionally, for example by being angry (Sarason and Sarason, 1989). Consequently, internals are able to leave their disappointments behind them and live happily. Externals, on the other hand, continue to carry their burdens into their future and hence are often depressed. Our theoretical expectation is that depression is positively correlated with external locus of control and negatively correlated with internal locus of control. This means that those who scored high on the depression scale also scored high on the locus of control scale. Likewise, those who scored low on depression also scored low on the locus of control (Sarason, 1989).

2.10. Laws concerning orphans and vulnerable children

Under the regime of the Government of Federal Republic of Ethiopia there are various laws which enacted to address the matter. The main policies, plan of actions and guidelines available in Ethiopia regarding OVC are: Child Right Convention adopted by Ethiopian government, Developmental Social Welfare Policy, National Plan of Action for Children, National OVC Plan of Action and Guideline on Alternative Child Care program. These policies, plan of actions and guidelines are meant to create favorable and supportive environment for orphans and vulnerable children to develop and grow properly. To this end, the policies, the strategies and the guidelines have paid attention to the need for psychosocial support, education and vocational training, health support, shelter, economic strengthening, social protection of the children (Save the Children UK, 2007).

CHAPTER THREE: METHODOLOGY

3.1. Research Design

To address the designed objectives, the researcher used a cross-sectional design. As explained by Bryman (2004), unlike a longitudinal design, cross sectional research design involves the collection of data at a single point in time. Therefore, in this study, a cross-sectional research design was deployed since the data regarding the level of depression among institutionalized orphan children was collected at one point in time from the target population, taking into account the time and cost of undertaking the study. Quantitative research method was employed.

3.2 Description of Study Site

The study was carried out in SOS Children's Village, Addis Ababa. Both genders within age range of 13-17 years were included in the study.

The institution has a quality service that children are provided with sufficient basic necessities like clothing, housing, and bedding. The institution has buildings which are greatly similar in terms of standards, upkeep and appearance with sufficient sleeping space. Each child has his/her own bed. The institution allows children to attend in a private school and they have sufficient education materials. Children are given the opportunity to play and have access to recreation. They all get three meals a day. They have house chores to do but at the same time they all have a maidservant to make Enjera and do laundry. Their religious freedom is respected if the child has one during admission time but if not, since they are little kids, they will have religion of their caregiver (SOS mother). The caregivers are always receiving training on child care and development; they work on six days a week, and are responsible for only 10 children on average which enables them to give appropriate attention and quality care. The caregivers have worked

for more than 10 years and are dedicated to their responsibility being motivated by their belief that those children are gifts from God. They have a good attachment which supports the children to have healthy emotional development.

SOS Children's Village Program Addis Ababa is led by a Program Director. Under which four major units: Family based care and Other Alternative child care unit, Family strengthening unit, Day Care Centre and Kindergarten are working towards the accomplishment of the organization's mission.

The Family based care and Other Alternative child care unit has the care and development units. While the Village Director take the leading role in the unit, SOS mothers and youth care co-workers take the front line share in the care system of the children and the youth. Alternative child care model which is named other forms of family based care (OFFBC) is an area that the organization is working for expansion in its future direction. The development co-workers including the social workers, educators, youth affairs officers play important role in the holistic development of children and youth.

The Family Strengthening unit has the Family Strengthening Coordinator and Community Development Officers. The Junior Accountant and a Driver will support the realization of the project activities. The Daycare Centre under this unit has nannies and daycare supervisors supported by a matron and a gardener. The kindergarten has also kindergarten educators and cleaner under the supervision of the Kindergarten leader.

Under the overall supervision and support of the National Office, SOS Children's Village Addis Ababa Program has been running Family based care and other forms of family based care program, Family Strengthening Program, Vocational Training College, Medical Centre, Day

Care Centre and the Kindergarten to achieve the organization's strategic objective, mission and vision.

3.3. Sample and Sampling Techniques

Institutionalized orphan children within an age range of 13-17 years and both sexes were the intended target population but fortunately, the researcher found the whole population size to be small. Therefore, the researcher chose to study the entire population because the size of the population is manageable. Therefore, there were around 80 institutionalized orphan children who are within age range of 13-17 and they all have been included to participate in the study. After the collection of distributed questionnaires, around eight were discarded because they were returned with unchecked boxes, empty answer on the blank space, and/or answer boxes are cancelled more than two times. Three orphan children and two caregivers (SOS mothers) were interviewed.

3.4. Instruments of Data Collection

Structured questionnaire was designed by the researcher to collect information related to socio-demographic data of the participants. Children's background information includes age, sex, educational status, admission age, duration of stay in the institution, and family status (double orphans, single orphans, both alive and unknown).

In order to secure data from participants Children's Depression Inventory which consists of 27 items was used for assessing depression level of respondents.

Interpretive Guidelines for CDI *T*-scores

<i>T</i>-score	Overall symptoms/complaints
Above 70	Very much above average
66 to 70	Much above average
61 to 65	Above average
56 to 60	Slightly above average
45 to 55	Average
40 to 44	Slightly below average
35 to 39	Below average
30 to 34	Much below average
Below 30	Very much below average

CDI Cut-points

T-scores at or above 65 (1.5 standard deviations above the mean) are generally considered clinically significant. Using the former approach, a CDI cut-point of 20 was identified in the original manual (Kovacs, 1992) as most appropriate in general screening. Elsewhere in the literature, cut-points of 19 have been suggested. Some researchers have proposed CDI cut-points of 12 or 13 for use with clinical samples in which a higher depression incidence is expected. Other studies, which examined clinically referred samples, have reported reasonably good classification rates for CDI score cut-points ranging from 13 to 16 or 17.

Age Range and Administration Time

The CDI self-report is suitable for administration to youths aged 7 to 17, and it can be completed in 15 minutes or less.

3.5 .Pilot test

The researcher did not conduct a pilot study since the English version of the CDI was available in Amharic version all validated.

The reliability of the original CDI has been examined in terms of internal consistency. Cronbach's alpha for the 27-item CDI in the normative sample was .86, indicating good internal consistency. In various samples the total score alpha coefficient was found to be .86 with a heterogeneous, psychiatric referred sample of children, .71 with a pediatric-medical outpatient group, and .87 with a large sample of public school students (n=860), indicating good to excellent internal consistency.

The CDI has been utilized in hundreds of clinical and experimental research studies and its validity has been well established using a variety of techniques. Overall, the weight of the evidence indicates that the CDI assesses constructs that have strong explanatory and predictive utility in the characterization of depressive symptoms in children and adolescents. The discriminative validity of the CDI has been investigated in terms of sensitivity and specificity. CDI factor scores have been shown to classify participants as depressed versus not depressed with a high degree of accuracy. Sensitivity of 80% and specificity of 84% also were found for a CDI total cut-off score of 17. What does the cut-off mean?

3.6 .Procedure of data gathering

Following the selection of the institution, the Program Director was asked for permission to conduct the study and permission to conduct the study was granted. Participants were informed about the purpose of the study. Following this, orientation on how to respond to the questions was provided by the researcher for participants. In addition, the respondents were informed to

respond honestly to all items as the personal information they provided will going to be used only for the purpose of this study. Accordingly, the questionnaires were distributed to respondents to be filled individually. The questionnaires were administered to the respondents during their meeting for game by the researcher. During data collection, the researcher was personally available in each classroom and clarified the purpose and instructions of the questionnaire. Finally, the filled data was collected and organized to make it appropriate for analysis.

3.7 Methods of data analysis

The collected quantitative data were analyzed using SPSS version 23 software package. Following this, the responses of the participants of the study were coded and interpreted using descriptive statistical methods. The first part involves description of the characteristics and background of participants in the study followed by a descriptive statistical presentation summarizing the data with means and standard deviation of the scores on the variable of the study. A t-test was carried out for the purpose of establishing whether there was any statistical difference in means among selected pairs of categories of children. Correlation was carried out for the examination of relationship between admission age and level of depression.

3.8. Variables

Dependent variable

- Depression

Independent variables

- Gender of institutionalized orphan children
- Admission age into institution
- Duration of stay in the institution

CHAPTER FOUR: RESULT

Introduction

In this section description of findings are presented. The analysis involves three parts. The first part involves description of the characteristics and background of participants in the study followed by a descriptive statistical presentation summarizing the data with means and standard deviation of the scores on the variable in the study.

The second part presents a T-test that was carried out for the purpose of establishing whether there was any statistical difference in means among selected pairs of categories of children.

SPSS was used to compute and test for difference in variances and means of selected pairs of independent categories. For the test on means, the value of test statistics and the p-value were provided. The third part presents the summary of an interview result both with the children and the caregivers.

4.1. Socio-background characteristics of Respondents

Table 1: Background of participants

Categories		Frequency	Percent
Admission age	from birth_2 years	6	8.3
	3 years and above	66	91.7
	Total	72	100.0
Sex	Male	34	47.2
	Female	38	52.8
	Total	72	100.0
Duration of stay	3-5 years	11	15.3
	8-15 years	61	84.7
	Total	72	100.0

As can be seen in the above Table 1, 91.7% of respondents' admission age into SOS institution falls on 3 years and above while only 8.3% of them were admitted from birth-2 years old.

Pertaining to sexes of respondents 52.8% of them are Females and 47.2 are Males.

Relating to participants duration of stay in SOS institution 15.3% of them have stayed for 3-5 years and 84.7% of them have stayed for 8-15 years.

4.2. T-score Frequencies of Participants on level of depression

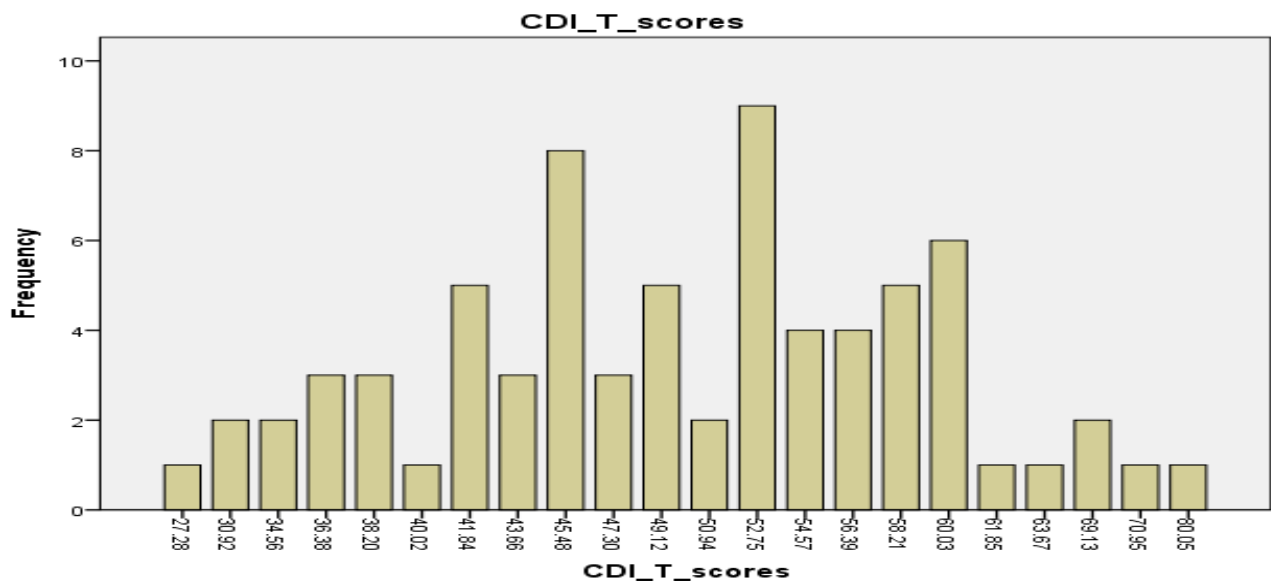


Figure 1: Participants T-score frequencies

As can be seen in the above figure 1, of all the participants five and six of them have a t-score of 58.21 and 60.03, respectively, which is slightly above average, two of them have a t-score of 61.85 and 63.67 which is above average, another two of participants have a t-score of 69.13 which is much above average, and the last two participants have a t-score of 70.95 and 80.05 which is very much above average. Precious

4.3 Sum total score frequencies of participants on level of depression

Table 2: total score frequencies of participants on level of depression

Total score	Frequency	Cumulative percentage
Below 17	55	76.4
17 and above	17	23.6

Generally, 23.6% of the participants are found to be from slightly above average to very much above average with cut-off score of 17, which is classification criterion in this study.

4.4. Descriptive summaries of variables of the study

Table 3: Means and standard deviation of the study variable by gender, admission age and duration of stay on Children's Depression Inventory

Study variables			
Depression			
Admission age	No	Mean	SD
Birth-2 years old	6	52.7549	8.29946
3 years and above	66	49.7496	10.15716
Total	72		
Sex			
Male	34	50.7211	11.37567
Female	38	49.3548	8.69314
Total	72		
Duration of stay			
3-5 years	11	51.7623	12.24437

8-15 years	61	49.6822	9.62672
Total	72		

As can be seen from Table 2, institutionalized children who were admitted in their early age which is from birth to 2 years have scored a bit higher on CDI than those institutionalized children who were admitted from 3 years and above with the mean of (M=52.7549) and (M=49.7496) respectively.

Male institutionalized orphan children scored almost as the same as female institutionalized orphan children on CDI with the mean of (M=50.7211) and (M=49.3548) respectively.

Institutionalized orphan children who stayed for relatively short period of time in the institution which is 3-5 years scored a bit more on CDI than those who stayed for relatively lengthy period of time which is 8-15 years with the mean of (M=51.7623) and (M=49.6822) respectively.

4.5. Sex difference between institutionalized orphan children in their level of depression

Table 2: Independent T-test Results on the difference between male and female institutionalized orphan children in their level of depression

<i>DV</i>	<i>IV</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Df</i>	<i>T</i>	<i>P</i>
Level of Gender depression	Male	34	50.7211	11.37567	70	.576	.566
	Female	38	49.3548	8.69314			

Using an alpha level of .05, an independent-samples *t*-test was conducted to evaluate whether males and females institutionalized orphan children differed significantly on the level of depression.

Table 4 illustrates the test was not significant, $t(70) = .576$, $p > .05$. An examination of the group means indicate that males institutionalized children ($M = 50.7211$, $SD = 11.37567$) and females institutionalized children ($M = 49.3548$, $SD = 8.69314$) do not differ significantly in their level of depression.

4.6. Duration of stay difference between institutionalized orphan children in their level of depression

Table 3: Independent T-test Results on duration of stay difference between institutionalized orphan children in their level of depression

<i>DV</i>			<i>IV</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Df</i>	<i>T</i>	<i>P</i>
Level of depression	of stay	Duration of	3-5 years	11	51.7623	12.24437	70	.632	.529
			8-15 years	61	49.6822	9.62672			

Using an alpha level of .05, an independent-samples t -test was conducted to evaluate whether institutionalized children who stayed in the institution for 3-5 years and institutionalized children who stayed for 8-15 years in the institution differed significantly on the level of depression.

Table 5 illustrates the test was not significant, $t(70) = .632$, $p > .05$. An examination of the group means indicate that institutionalized children who stayed in the institution for 3-5 years ($M = 51.7623$, $SD = 12.24437$) and institutionalized children who stayed for 8-15 years in the institution ($M = 49.6822$, $SD = 9.62672$) do not differ significantly in their level of depression.

4.7. Pearson correlation of admission age and level of depression

Table 6: Pearson correlation of admission age and level of depression

	N	R	P
Admission age	72	-.024	.840
Level of depression	72	-.024	.840

Using an alpha level of .05, Pearson correlation was conducted to test the relationship between admission age and level of depression.

The table indicates, Pearson $r = -0.024$, $p > .05$, that there is no statistically significant relationship between admission age and level of depression.

CHAPTER FIVE: DISCUSSION

In this section, the results presented in the previous section are discussed. Possible explanations and potential reasons for obtained results are forwarded. In addition, the results are compared with similar previous research findings.

5.1. Prevalence of depression among institutionalized orphan children

As can be seen in the result section of the study 23.6% of participants have depression with 5.6% of the case being clinically significant, that are four children out of seventy two with a t-score above 65. This shows that depression is highly prevalent among institutionalized orphan children.

The result is consistent with the existing literature that indicates that orphans in general and those brought to institutions in particular suffer from many psychological problems (Gilborn, 2006; Boris, 2012; Dabla, 2010; Bhargava, 2005). This study has found depression to be highly prevalent in agreement with a cross sectional study conducted in Dhaka, Bangladesh, which indicated emotional disorders to be highly prevalent among orphaned children (Rehman, et. al 2012) and similar to Behrendt, and Serigne, (2008) investigation on the psychosocial impact of parental loss and orphan hood on children which stated that depression (45%) was highly prevalent in the total sample.

As can be noted in the result section of the study many children have depression. Since the extent of suffering is not the same for every child who is institutionalized because the effects of institutionalization are not uniform and are dependent on different factor, the observed result might be due to child characteristics like genetic predisposition, basic personality, and prenatal

risk factors, and the child's history like the age of the child when he/she entered the institution and the length of time in the institution (Victor, 1996).

As they lost their parent, those children might have not gained recovery from the loss. They may fail to immediately understand the finality of death which holds them back from going through the grieving process and this could be the reason why those children have depression because it put them at risk to grow up with unresolved negative emotions which are often expressed with anger and depression (Brodzinsky, Gormly and Ambron 1986).

Again, those children were exposed to some social changes because of parental loss and like bereavement the process of trying to adapt to the social change create stress. Therefore, those children might have failed to adapt to it and this might be one of the reasons why they developed psychological problem Minde (1988).

5.2. Sex difference between institutionalized orphan children in their level of depression

As can be seen in the result section of the study no statistical difference between male and female institutionalized orphan children was observed. This indicates that male orphans are as depressed as female orphans regardless of their gender difference.

The result is inconsistent with a frequently cited statistics that women are twice as likely to become depressed as men (and two or three times more likely than men to *attempt* suicide). There are several possibilities for the reason why women are more depressed than men and one of the reasons is the thing that happens at puberty. Before developing sexually, boys are more likely to be depressed than girls, but afterwards girls become twice as likely to be depressed and boys turn to delinquency (Ormel, Oldehinkel & Brilman, 2001).

In opposite to the present finding study conducted stated that the mechanism underlying the gender difference in depression remains unclear (Nolen-Hoeksema, 2002). Despite a number of biological, psychological, and social theoretical explanations that have been formulated in attempts to account for the gender differences in depression, the mechanism underlying this association remains unclear (Ormel, Oldehinkel & Brilman, 2001).

5.3. Duration of stay difference between institutionalized orphan children in their level of depression

As can be depicted in the result section of the study no statistical difference between institutionalized orphan children who stayed in the institution for relatively short period of time and who stayed in the institution for lengthy period of time was observed.

This shows that no matter for how long, orphans whose duration in the institution are for relatively short period of time are as depressed as orphans whose duration in the institution is for a lengthy period of time.

The observed result is may be because the children get high quality service in the institution in terms of nutrition, hygiene, educational access, physical and emotional attention, inconsistent with a study carried out in orphanage in Dhaka city which found out significant association between childhood depression and long duration of stay in the institution as a result of life-threateningly poor nutrition, hygiene and healthcare, lack of access to education, and a chronic lack of physical and emotional attention (Shaheed, 2004).

Children who stayed for a long period of time are as same as those children who stayed for relatively short period of time inconsistent with Goodwin argument that any amount of

orphanage experience is harmful; the damage is greatest during the first year of life and increases dramatically with length of stay in an institution.

5.4. Correlation of admission age and level of depression

As can be noted in the result section of the study there was no statistically significant relationship between admission age and level of depression.

The caregivers have served for at least ten years and above in the institution and one mother with maximum of 10 kids to take care of. Since poor care giving, high ratio of children to staff, high frequency of staff turnover and the nature of shift work, lack of stimulation, lack of stable, long-term relationships between a child and a caregiver (ObrovaKrol et al., 2008) and (Twenge, 2009) have been implicated in the negative outcomes among institutionalized orphan children, the caregivers permanent stay might have helped the orphans to have an ongoing and meaningful contact with them. In addition the caregivers have only one day off in a week and the rest of their time they spend with the children in the institution day and night and the children have an aunty which covers for their mother's day off.

Against previous findings which stated that children living in orphanages are more likely to be deprived of touching, smiling, laughing, and exploring with a primary caregiver (Johnson, Browne, & Hamilton-Giachritsis, 2006; Rutter, Kreppner, & O'Connor, 2001; Vorria et al., 2003), orphans in SOS institution were raised all laughing and smiling, even sucking their SOS mother's breast milk, and sleeping with them as a little babies with the mother telling stories for children which enables them to have a healthy attachment with their caregivers. The small number of children-mother ratio might have also support the mothers to give the necessary attention for the kids since they can afford the time.

The caregivers were trained for six months before they start working as a caregiver in the institution and are still taking important trainings on child care and development. As can be inferred from the interview result the caregivers are attached to their children to the extent that they let little children to share bed with them and do not even care if the kids pee on the bed which shows the extent of the caregivers' acceptance of the children as their own. The children who were interviewed as well speak of their caregiver as their own biological mom.

CHAPTER SIX: CONCLUSION AND RECOMMENDATION

6.1. Conclusion

This study concluded that depression is highly prevalent among institutionalized orphan children. There is no statistical difference between male and female institutionalized orphan children, between orphans who stayed in the institution for relatively short period of time which is 3-5 years and orphans who stayed in the institution for lengthy period of time which is 8-15 years, and there is no statistically significant relationship between admission age and level of depression.

6.2. Recommendation

- The institution, in addition to their quality service in terms of meeting children's physical need, should focus on emotional support for the kids through their caregiver.
- The institution should create awareness about the emotional condition of the children among caregivers, social workers and teachers in the institution.
- Alternatives such as family support services, kinship care, foster care, supporting child-headed household, and domestic adoption should be the care options to consider. These options are not only better for the child's physical and mental well-being but are also a cheaper and more sustainable solution.
- Future research should be carried out with a large number of institutionalized orphans so as to confirm the findings of this study

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Appendices

አዲስ አበባ ዩኒቨርሲቲ የትምህርትና ስነ-ባህሪ ኮሌጅ የስነ-ልቦና ትምህርት ክፍል

በመጠለያ በሚኖሩ ልጆች የሚሞላ መጠይቅ

የኮድ ቁጥር _____

ከሚከተሉት ሶስት ጥምር ዓረፍተ ነገሮች ውስጥ ባለፉት ሁለት ሳምንታት አንተን/አንቺን ይበልጥ የሚገልፀውን አንዱን ብቻ በመምረጥ የ x ምልክት ከጥያቄው በስተግራ ባለው ሳጥን ውስጥ በመፃፍ መልስ/መልሺ፡፡ የምትሰጠው/የምትሰጧው መልስ ስህተት ወይም ትክክል ተብሎ አይታረምም፡፡ የምትሰጠው/የምትሰጧው መልስ አንተን/አንቺን እስከገለፀ ድረስ ተቀባይነት አለው፡፡

ጥያቄ 1.

	አልፎአልፎደስተኛአይደለሁም
	ብዙውንጊዜደስተኛአይደለሁም
	ሁልጊዜደስተኛአይደለሁም

ጥያቄ 2.

	ምንምየሚሳካልኝነገርየለም
	የሚሳካልኝጉዳይስለመኖሩእርግጠኛአይደለሁም
	ሁኔታዎችይሳኩልኛል

ጥያቄ 3.

	ብዙውንስራበትክክልአከናውናለው
	ብዙውንስራላይስህተትእፈፅማለው
	ሁሉምስራላይስህተትእፈፅማለው

ጥያቄ 4.

	ብዙሃን የሚያስደስቱ ንጉዳዮች አሉ
	አንዳንድ የሚያስደስቱ ንጉዳዮች አሉ
	ምንም የሚያስደስተኝ ንጉዳይ የለም

ጥያቄ 5.

	ሁሌም ቢሆን መጥፎ ሰውነት
	ብዙውን ጊዜ መጥፎ ሰውነት
	አልፎ አልፎ መጥፎ ሰውነት

ጥያቄ 6.

	ከአለታት አንድ ቀን መጥፎ ሁኔታ ይገጥመኛል ብዬ አስባለዉ
	መጥፎ ሁኔታዎች ሊገጥሙኝ ይችላሉ በማለት እጨነቃለዉ
	እርግጠኛ ነኝ አሰቃቂ ሁኔታ ይገጥመኛል

ጥያቄ 7.

	እራሴን በጣም እጠላለዉ
	እራሴን በሚገባ አልወደዉም
	እራሴን እወደዋለዉ

ጥያቄ 8.

	ለሁሉም መጥፎ ክስተቶች ተጠያቂዉ እኔ ነኝ
	ብዙ መጥፎ ክስተቶች የኔ ጥፋት ናቸዉ
	መጥፎ ክስተቶች ብዙውን ጊዜ የኔ ጥፋቶች አይደሉም

ጥያቄ 9.

	እራሴንመግደልአላስብም
	እራሴንመግደልአስባለውግንአላደርገውም
	እራሴንመግደልእፈልጋለው

ጥያቄ 10.

	ሁሌይከፋኛል
	በተደጋጋሚይከፋኛል
	አልፎአልፎይከፋኛል

ጥያቄ 11.

	ሁልጊዜሁኔታዎችያሳስቡኛል
	በተደጋጋሚሁኔታዎችያሳስቡኛል
	አልፎአልፎሁኔታዎችያሳስቡኛል

ጥያቄ 12.

	ሰዎችንመቅረብእወዳለው
	ብዙውንጊዜሰዎችንመቅረብአልወድም
	በጭራሽሰዎችንመቅረብአልወድም

ጥያቄ 13.

	ራሴንማረጋጋትበፍፁምአልችልም
	ራሴንማረጋጋትያዳግተኛል
	በቀላሉራሴንማረጋጋትእችላለሁ

ጥያቄ 14.

	አምራሉሁ
	እንዳላምር የሚያደርጉኝ አንዳንድ እንከኖች አሉብኝ
	አስጠሊታኝ

ጥያቄ 15.

	ሁሌ ትምህርቴን ለመከታተል እቸገራለሁ
	በተደጋጋሚ ትምህርቴን ለመከታተል እቸገራለሁ
	ትምህርቴን ለመከታተል አልቸገርም

ጥያቄ 16.

	ሁሌ የእንቅልፍች ግርዛብ ነኝ
	በተደጋጋሚ የእንቅልፍች ግርዛብ ነኝ
	በቂ እንቅልፍ አገኛለሁ

ጥያቄ 17.

	አልፎ አልፎ ድካም ይሰማኛል
	በተደጋጋሚ የድካም ስሜት ይሰማኛል
	ሁሌ ይደክመኛል

ጥያቄ 18.

	አብዛኛውን ጊዜ የምግብ ፍላጎት የለኝም
	በተደጋጋሚ የምግብ ፍላጎት የለኝም
	ጥሩ የምግብ ፍላጎት አለኝ

ጥያቄ 19.

	ስለህመምተጨንቄአላውቅም
	ብዙጊዜህመምያስጨንቀኛል
	ሁልጊዜህመምያስጨንቀኛል

ጥያቄ 20.

	ብቸኝነትአይሰማኝም
	በተደጋጋሚብቸኝነትይሰማኛል
	ሁልጊዜብቸኝነትይሰማኛል

ጥያቄ 21.

	ትምህርትቤቴውስጥበጭራሽተደሰቼአላውቅም
	አልፎአልፎትምህርትቤቴውስጥየሚያስደስተኝሁኔታአለ
	ብዙጊዜትምህርትቤቴውስጥየሚያስደስተኝሁኔታአለ

ጥያቄ 22.

	ብዙጉአደኞችአሉኝ
	የተወሰኑጉአደኞችአሉኝግንተጨማሪጉአደኞችቢኖሩኝእመኛለው
	ምንምጉአደኛየለኝም

ጥያቄ 23.

	የትምህርትውጤቴጥሩነው
	የትምህርትውጤቴእንደቀድሞውጥሩአይደለም
	ጥሩውጤትአገኝባቸውየነበሩትምህርቶችአሁንዝቅተኛውጤትአምጥቻለው

ጥያቄ 24.

	እንደሌሎችልጆችበፍፁምጥሩልጅመሆንአልችልም
	ከፈለኩእንደሌሎችልጆችጥሩልጅመሆንአችላለሁ
	እንደማንኛውምልጅእኔምጥሩልጅኝኝ

ጥያቄ 25.

	ማንምየሚወደኝሰውየለም
	የሚወደኝሰውሰለመኖሩእርግጠኛመሆንአልችልም
	የሚወደኝሰውእንዳለኝእርግጠኛኝኝ

ጥያቄ 26.

	ብዙውንጊዜየታዘዝኩትንአከናውናለሁ
	ብዙውንጊዜየታዘዝኩትንአከናውንንም
	በጭራሽየታዘዝኩትንአከናውንንም

ጥያቄ 27.

	ከሰዎችጋርእግባባለሁ
	በተደጋጋሚከሰዎችጋርእግባለሁ
	ሁሌከሰዎችጋርእግባለሁ

የግልመረጃ

1. እድሜ: _____
2. ጾታ: 1. ወንድ
 2. ሴት
3. የክፍል ደረጃ: _____
4. የወላጅ ሁኔታ: 1. ሁለቱም በህይወት የሉም
 2. አንዳቸው በህይወት አሉ
5. ወደ ተቁላሙ ከመምጣትህ/ሽ በፊት ከማንኛውም ስትኖር/ሪ ነበር?
 1. ቤተሰብ
 2. ዘመድ
 3. ሌላመልስካለ _____
6. ወደ SOS ተቁላም ስትመጣ/ጪ ስንት አመትህ/ሽ ነበር? _____
7. በ SOS ተቁላሙ ውስጥ ምን ያህል አመት ቆየህ/ሽ? _____

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General Interview Questions for Caregivers

1. Would you please introduce yourself?
2. For how long did you work in SOS Children's Village?
3. How have you been doing working as a mother and what does it feel like becoming a mother for orphans?
4. How attached are you with your kids physically plus emotionally?
5. How do you take care of your kids like feeding, bathing and keep their hygiene, and following their educational activities?
6. Do you think you are doing enough for your kids as a mother?
7. How is the institutional provision for the kids in terms of food, clothing, housing and educational access?

General Interview Questions for Orphan Children

1. Would you please introduce yourself?
2. When did you come to the institution and for how long did you stay in the institution?
3. What does it feel like growing in the institution and how do you describe your stay? Do you have time to play?
4. How is the institution's service in terms of meeting your physical needs like food, clothing, housing..., and educational access?
5. How many caregivers have you had in the institution since you came and how is your relationship with your caregiver?
6. How do you describe the care you have been given from your caregiver?