ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF PSYCHOLOGY

CARE AND SUPPORT OF ORPHANED CHILDREN WITH ADERA, NON-ADERA AND INSTITUTIONAL CARE ARRANGEMENTS AT DEBRE MARKOS AND BAHIR DAR TOWNS

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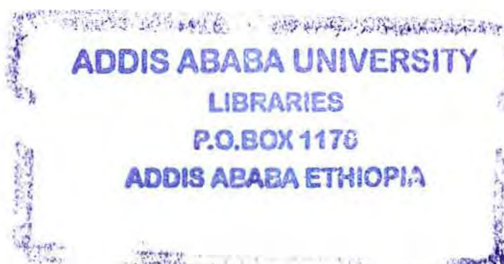

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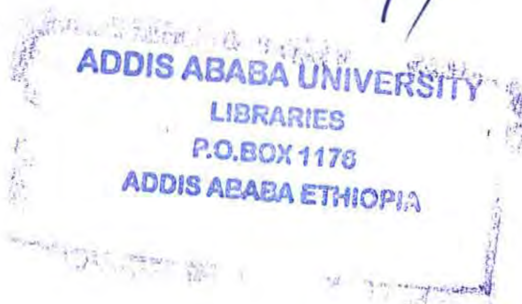
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Table of Contents

Acknowledgements i
List of Tables ii
List of Figures iv
Abstract v

I. INTRODUCTION

1.1. Background 1
1.2. Problem Statement 3
1.3. Operational Definitions 5

II. LITERATURE REVIEW

2.1. The Construct of Orphaned and Vulnerable Children 6
2.2. Conceptual Overview of Childcare 8
2.3. Childcare and Support Practices in Ethiopia 12
2.4. Alternative Care Arrangements for Orphaned Children 13
2.4.1. Adera Care Arrangement 14
2.4.2. Children's Village Care Arrangement 18
2.5. Some Process and Outcomes of Childcare and Support 22

III. METHODS

3.1. Study Design 27
3.2. Study Sites 28
3.3. Participants 28
3.4. Instruments 32
3.4.1. Construction 34
3.4.2. Pilot Study 35
3.4.3. Administration 36
3.5. Data Scoring and Analysis Techniques 37

IV. RESULTS

4.1. Characteristics of Participants 40
4.2. Provisions of Care and Support 44
4.3. Commitment of Guardians to Care and Support 54
4.4. Attachment Styles of the Children 55
4.5. Academic Performances of the Children 58
4.6. Resilience of the Children 61

V. DISCUSSIONS AND SUMMARY
5.1. Provisions of Care and Support 64
5.2. Process of Care and Support 66
5.3. Child-behavior Outcomes of Care and Support 67
VI. CONCLUSION AND RECOMMENDATIONS
6.1. Conclusion 70
6.2. Recommendations 72
REFERENCES 73
APPENDICES
Appendix - A: Questionnaire for Children (English and Amharic Versions)
Appendix - B: Observation Checklist (English and Amharic Versions)
Appendix - C: Semi-structured Interview Schedule for Guardians (English and Amharic Versions)
Appendix - D: Academic Record Format (English and Amharic Versions)
Appendix - E: Item Classification Schemes
Appendix - F: Household Background Record Format

List of Tables

Table 2.1: Policy definitions of an orphan in five African countries 6

Table 3.1: The number of households and children involved in the identification and selection of participants of the study 30

Table 3.2: Actions taken on some items of the Questionnaire after the pilot study 36

Table 4.1: Personal and demographic characteristics of children 41

Table 4.2: Personal and demographic characteristics of guardians 43

Table 4.3: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of *material* care to children 45

Table 4.4: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *material* care to children 46

Table 4.5: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of *psychological* care to children 47

Table 4.6: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *psychological* care to children 47

Table 4.7: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of negative treatments to children 49

Table 4.8: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *negative treatments* to children 50

Table 4.9: Average number of days children of the three groups have become late from school in a week 51

Table 4.10: Number of days children of the three groups become absent from their schools in second semester of 2009 academic year 51

Table 4.11: Physical cleanliness of children in the three groups 52

Table 4.12: Chi-square test results for the three groups on the levels of commitment of guardians to care and support 54

Table 4.13: Chi-square test results for the three groups on attachment styles of the children..56

Table 4.14: Number of children under primary school first cycle, primary school second cycle and secondary school grade categories 58

Table 4.15: Mean scores and Kruskal Wallis H - test values for the three groups on academic performances of children 59
Table 4.16: The Mann-Whitney U - test multiple comparisons of the three groups on academic performances of children under primary school first and second cycle grade categories 60
Table 4.17: Mean scores and Kruskal Wallis H - test values for the three groups on resilience of the children 62
Table 4.18: The Mann-Whitney U - test multiple comparisons of the three groups on resilience of the children 63

List of Figures

Figure 2.1: Interplaying components in the provisions of childcare 10

Figure 3.1: General approach of care and support 28

Figure 3.2: Steps in selecting Adera and Non-Adera participants 31

Abstract

Identifying the strengths and limitations of the existing orphaned children care arrangements in caring and supporting of the children could be the optimal approach for accommodating the increasing number of orphans in Ethiopia for quality care services. To this end, this study attempted to describe and compare the provisions (positive and negative), the process (level of guardian's commitment), and outcome behaviors (child's attachment style, educational performance and resilience) of care and support of orphans in three types of care arrangements: a reconstructed family-type institutional arrangement (SOS Village), Adera-based family support system, and a Non-Adera family-based care and support. Data sources included a questionnaire administered to 180 orphaned children (60 in each care arrangement) with ages 7 to 17 years, interview conducted with a sample of 30 guardians, school records to secure data about educational profiles, and a checklist for physical observation of the children. Having analyzed the data using relevant statistical techniques, it was found that children in SOS Village were provided more material care but lesser psychological care and lesser negative treatments than children in the other two care arrangements. On the other hand, it was found out that while children in Adera care arrangement appeared to secure more psychological care than the rest, the Non-Adera group was, however, the most in terms of negative treatments. Concerning the process of care and support, it was found out that the Adera receiving guardians felt more honored in caring the children and also reported to invest more effort to meeting needs of the children and helping them develop desirable behaviors than the other groups. Finally, regarding child-behavior outcomes, it was found out that the Adera children were more securely attached, resilient, and educationally performing than children of the two care arrangements.

I. INTRODUCTION

1.1. Background

The number of orphaned children in Ethiopia, as in other Sub-Sahara African Countries, is high and increasing alarmingly. The report of UNAIDS and UNICEF (2002), for instance, reveals that the number of orphaned children (below 14) was estimated over 4.4 million (13.8% of the total number of children) in 2005 and increased to 5.1 million in 2010 in the Country. This high and staggering number of orphans coupled with the widely prevalent chronic food-insecurity and poverty of the Country (Bulti, 2007) creates major challenges in caring and supporting of those children to the family, community and the government.

As caring and supporting of orphans is a cooperative exercise involving an interplay of different parties (Belay & Belay, 2010), different governmental, non-governmental and community responses are playing their roles in caring and supporting, and absorbing the increasing numbers of orphans in Ethiopia. Dictated by the cultural orientations, religious practices and family lineage systems of the society, the community responds to the care and support of orphaned children through its different family-based care arrangement systems (Varnis, 2001). Adera giving of children is one of such care arrangement systems established based upon the cultural practices and religious beliefs of the society where parents in their terminal illness (or at the verge of their death) transfer the responsibilities of their children's care and support to another committed and trusted caregiver (Belay, 2007).

Studies conducted on the care and support, and practices of Adera as an alternative care arrangement for orphaned children indicated that it has contributed to the provisions of basic material needs (e.g., food, shelter, health services), psychological needs (e.g., love, attention, parental guidance, supervision) and educational needs of the children (Belay, 2007; Kassa, 2006; Yigzaw, 2009). However, since Adera care arrangement is found within the care and support systems of the community, it is challenged by the routine child-rearing practices of the Country and the low socio-economic conditions of Adera recipients (Belay, 2007), which could not make it able to fulfill the unique psychosocial needs of orphaned children.

On the other hand, relaying on the philosophies of modern nuclear family systems, orphans in Ethiopia are also cared and supported within institutional care arrangements (Bulti, 2007). The level and quality of care provided in institutions differ from one institution to another depending on the type of internal organization (family-based or conventional dormitories), the size of the family or other internal unit, internal equipment, the number of qualified staff, the type of relationship between the caregivers and children, management style, and the overall atmosphere within the institution (Abebe, 2009). Children's Village is one form of institutional care arrangements for orphaned children, which tried to *reconstruct* or *simulate* the 'naturally' occurring family system in caring and supporting of orphaned children. It was established based on the major premises that (a) the community care arrangement systems are not able to absorb the increasing numbers of orphaned children (Abebe, 2009) and (b) the 'formal' institutional care arrangements do not provide opportunities to the proper development of the children (Macarov, 2009).

Research reports on the provisions and outcomes of care and support to orphans in Children's Villages showed that whereas children in this care arrangement are relatively provided stable shelter, basic care and educational facilities for the children (Macarov, 2009), they are far less in terms major developmental outcomes such as emotional interactions and sociability (Abebe cited in Abebe, 2009, p. 87).

These indicate that the community care arrangements such as Adera and the institutional care arrangements such as Children's Village systems for orphans are not likely to fulfill all the basic and developmental needs of the children at one and the same time. On the one hand, they could not address the basic material and emotional needs of the children (Abebe, 2009; Ayalew, 2007; Bulti, 2007). In another hand, they could not be cost-effective (Varnis, 2001), or could alginate the children from their natural milieus (Kebede, 2002).

Thus, identifying the limitations and strengths of the existing orphan care arrangement systems in caring and supporting of orphans could be the optimal approach for (a) accommodating the increasing numbers of orphans in the Country; (b) providing quality care and support services to them; and (c) devising packages of culture-sensitive and child-

friendly orphaned children care and support alternatives. This study, therefore, has been conceived in the mind of the researcher (I) based on these major rationales.

Benchmarking on these rationales, this study was meant for describing and comparing the *provisions* of care and support to orphans in a *reconstructed* institution (SOS Village), Non-Adera and Adera care arrangements at Debre Markos and Bahir Dar Towns. It attempted to compare the provisions of positive and negative forms of care to the children in these care arrangements. Furthermore, the study tried to compare the major childcare giving *process* (commitment of guardians in caring and supporting of the children) and *child-behavior outcomes* of care and support (attachment styles, academic performances and resilience of the children) in SOS Village, Non-Adera and Adera care arrangements.

1.2. Problem Statement

Ethiopia is characterized by more of a collectivist socio-cultural orientation (Belay, 2008), where extensive traditional forms of social supports are highly prevalent (TGE, 1994). Staking on these mutual interdependences among the community, different community care arrangement systems of orphans exist in the Country. Giving children Adera to another person when parents are in their terminal illness (or at the verge of their death) is one common cultural and religious-based care arrangement of orphans in Ethiopia (Belay & Belay, 2010).

Social folklores and religious Holy Books indicate that giving children Adera to another person has existed for generations in the Country (see ASTER 2:6 on the Holy Bible; and Sûrah 4: 6, 7 on the Noble Qur'an). Despite this, studies were not conducted until recently on Adera childcare-giving systems. The few studies (e.g., Belay, 2007; Kassa, 2006; Yigzaw, 2009) conducted on the care and support, and practices of Adera as an alternative orphaned children care arrangement indicated that it has contributed to the provisions of care and support to orphaned children.

Generally, the studies (Belay, 2007; Kassa, 2006; Yigzaw, 2009) conducted so far on the care and support of orphans in Adera care arrangement did not focus on how its care and support

is different from other care arrangement systems providing care and support to orphaned children. Yigzaw (2009), in his study on the 'Practice and Contributions of Adera in Caring and Supporting of Orphaned and Vulnerable Children', for instance, has compared the care and support of Adera and Non-Adera given children. Even though this study was substantial in identifying the contributions of Adera care arrangement in caring and supporting of orphans, the author did not consider the care and support of other orphans who were cared and supported within other care arrangement systems.

This study has, therefore, attempted to fill, or otherwise, to minimize these gaps by comparing the care and support of Adera given orphans with others who were not given Adera but living within the community and were living in a *reconstructed* family-type institutional (SOS Village) care arrangements. In doing so, this study has tried to describe and compare the *provisions*, *process* and *child-behavior outcomes* of care and support among these care arrangements.

This study has described and compared the *provisions* of care and support to orphans in SOS Village, Non-Adera and Adera care arrangements. Besides, it attempted to compare the *process* of care and support (guardians' commitment in caring and supporting of the children) in SOS Village, Non-Adera, and Adera care arrangements. Furthermore, the study tried to compare the major *child-functioning outcomes* (such as attachment style, academic performances and resilience) of the children in SOS Village, Non-Adera, Adera care arrangements. Hence, this study attempted (or aimed) to address the following basic research questions.

i. Are there significant differences among children of the three care arrangements in the *provisions* of care and support they received?
ii. Are there significant differences among guardians of the three care arrangements in their *levels of commitment* in caring and supporting of the children?
iii. Are there significant differences among children of the three care arrangements in their:
    - Attachment style?
    - Academic performance?
    - Resilience?

1.3. Operational Definitions

Guardians: persons who substitute the parental care and support of the children in SOS Village, Non-Adera and Adera care arrangements. These included siblings, grandparents, aunts/uncles and non-relatives of the children.

Orphaned children: children between seven and 17 years old who have lost both of their parents (regardless of how they were died) and who were living either in SOS Village, Non-Adera or Adera care arrangements. It is used *interchangeably* with 'orphans' or 'children'.

Adera care arrangement: a family care system within the community where the Adera given children were living.

Non-Adera care arrangement: a family care system within the community where the children who were not given Adera by their parents were living.

SOS Village care arrangement: an international reconstructed institution that practices a family-like approach for caring and supporting of orphaned children.

Positive care and support: actions which foster the survival, growth and development of the children. These included the provisions of material care (e.g., food, cloth, educational facilities and medical services) and psychological care (e.g., emotional support, advice and supervision) to children.

Negative care and support: actions which deter the survival, growth and development of the children. These included unwanted actions (e.g., spanking and pinching, property grabbing, heavy physical work, delayed medical treatments, discrimination, and scolding) committed on the children.

Commitment of guardians: the efforts made by guardians in discharging the care and support responsibilities of the children. These included the guardians' efforts to meet needs of the children, feeling of honor and delight in caring of the children, and dedication in helping children to have good conduct.

Attachment styles: the dominant patterns of interaction between the child and guardian. These included secure, anxious and avoidant styles of attachment.

Resilience: the degree of recovery of the children from parental grief and mourning, or showing positive outcomes and competence under threat situations.

II. LITERATURE REVIEW

The care and support of orphans in Ethiopia could be understood into three spectrums: (a) with the 'commonness virtue' of human development, they have certain common aspects of care shard with other children of the world; (b) being an 'Ethiopian Child', they share the major socio-cultural and economic experiences of the Country, and are raised within the childcare practices of the Country; and (3) being an 'Orphaned Child', they lost their parents and are cared and supported within different alternative care arrangements. With these backgrounds of the care and support of Ethiopian orphans, this part first describes the construction of OVC for providing some glimpse about the views of orphaned children. In addition, it tried to review literature about the general overview of childcare and childcare practices of Ethiopia. Then, alternative care arrangements for orphaned are described. Finally, some process and outcomes of childcare are briefly described under this part.

2.1. The Construct of Orphaned and Vulnerable Children

A striking issue in caring and supporting of orphaned children is the definition and identification of 'who is an Orphaned and Vulnerable Child (OVC)?' This, according to Abebe (2009), stems from the use different definitions and terminologies to label orphaned children across different countries and societies. The policy definitions of an orphan in different countries (see Table 2.1, for instance) indicate that an orphan is a child below the age of 18 years who has lost its parents.

Table 2.1: Policy definitions of an orphan in five African countries

Country	Definition
Botswana	A child below 18 years who has lost one (single parents) or two (married couples) biological or adoptive parents.
Ethiopia	A child less than 18 years of age who has lost both parents, regardless of how they died.
Namibia	A child under the age of 18 who has lost a mother, a father, or both – or a primary caregiver – due to death, or a child who is in need of care.
Rwanda	A child who has lost one or both parents.
Uganda	A child below the age of 18 years who has lost one or both parents.

Adapted from FHI (2001a)

The definitions of an orphan on Table 2.1 imply that children above the chronological age of 18 years are not labeled as orphans even their parents have deceased. The definitions also suggest the transition from orphanhood to non-orphanhood at the attainment of age 18 years. Chirwa (2002), however, argues that the use of such chronological age ignores; (1) many young persons above 18 years whose parents are deceased from family care and support; and (2) the socio-cultural categories of age. Regarding the latter, the author indicated that an early-married young person or one with the age below of 17 may not be regarded as a child in many African societies. Chirwa (2002) further stated that orphaned children do not cease to have needs upon reaching the age of 18, nor do they necessarily become socially and economically independent of their caregivers in many African societies.

Central to the variations in the socio-cultural constructions of a child or an orphan among different societies of Africa, different terminologies are being used to represent an orphaned child in many African languages (see Bray, 2003 for overview). Likewise, orphaned children in Ethiopia are named by different phrases with slight differences in their terminologies. Sometimes, they are given the phrase 'welagi alba hitsanat' (ወላጅ አልባ ህጻናት) in public printed media (e.g., Feteha Hitsan, 1995; Yehistanat Dimits, 1999) to mean that 'children who have no any biological parents at all'. Other times, they are represented by a phrase 'asadagi yelelacew hitsanat' (አሳዳጊ የሌላቸው ህጻናት) (Addis Lisan, 2002) to mean that 'children who have no any primary guardian'. Even in other times, they are represented by 'welajocacwen bemot yatu hitsanat' (ወላጆቻቸውን በሞት ያጡ ህጻናት) (Yehistanat Dehinint Tekelakay, 1995) meaning that 'children who lost their parents to death'.

The other important point in the construction of OVC is the concept of *vulnerable child*, which is not only restricted to children, but also used to refer to households (Chirwa, 2002). This conception of vulnerability moves our understanding forward to another argument that the socio-economic conditions such as poverty and war (not the mere death of parents) are the central factors for identifying orphans as vulnerable children. Bray (2003) suggested that severe poverty is a more appropriate indicator of vulnerability in a child than the status of parental death alone. Chirwa (2002) also indicated that since many non-orphans in resource-

poor community are equally vulnerable children, the category of OVC should include other non-orphaned destitute children.

In general, different societies have different conceptions about orphans and understanding of orphanhood as a phenomenon and mode of life of children is culture-specific. Taking these views in mind, orphaned children in this study are children below the age of 17 years old who lost their parents due to various hassles and are living with other guardians in different alternative care arrangements. Thus, since they are children in themselves, the care and support of children in general is described next.

2.2. Conceptual Overview of Childcare

The meanings attached to childcare are different for different groups involved in it (Corby, 2003). In health community, for instance, childcare is linked to care for the mother in maternal and child health programs. When associated with 'working mothers', it refers to the arrangement made to another person or institution for assuring that the child has shelter, clothing, food and attention to health needs. In general terms, Myers (1992) stated that caring for a child means responding to the needs of a child.

A child could have many needs for its proper survival, development and growth. Based on their nature, the needs of a child could be roughly classified into the categories of *material needs* (e.g., food, health care, cloth, shelter, educational facilities, etc.) and *psychological needs* (e.g., affection, supervising, bonding, socializing, etc.), which both of them are equally crucial for the child (Myers, 1992). These categories might also involve different aspects or dimensions of needs. Horwath (2007, p. 34) summarized the different needs of children and classified them into five dimensions. These are:

- ***Health needs:*** include proper sanitation, physical care, shelter, nutritious diet, medical services, etc of the children.
- ***Educational needs:*** cover all needs of the children's cognitive development such as appropriate stimulation, guidance and support of school activities, provision of educational materials, and attendance of school.

- ***Emotional and behavioral development needs:*** include adequate nurturance and affection such as promoting attachment to carer, consistent feelings and behaviors, and promotion of appropriate behavioral expressions.
- ***Family and social relationship needs:*** include needs for the development of empathy and social relationship skills, for example, need for guidance regarding social or anti-social interactions, need for opportunities to interact with peers.
- ***Physical activity needs*:** include the need for physical exercises and movements.

Responding to the fulfillment of above needs of the children involve certain childcare activities on the parts of the carer. According to Corby (2003), the activities of caring for a child at a minimum include:

- Providing security,
- Sheltering,
- Clothing,
- Feeding,
- Bathing,
- Supervising and follow-up,
- Preventing and attending to sickness,
- Nurturing and showing affection,
- Interacting with and stimulating a child,
- Playing, and
- Socializing the child to its culture.

The tasks of such childcare activities, however, are "taking place through the processes of progressively more complex interaction between a child and the persons, objects, and symbols in its immediate environment" (Bronfenbrenner cited in Myers, 1992, p. 14). Thus, the interactions between or among the child, carer and the context where the care is taking place play significant roles in the fulfillments of needs of the child (Horwath, 2007). This indicates that while it is possible to identify certain aspects of childcare activities, the *provisions* and *processes* of allocating them vary among *characteristics of the child* and *carer* and *care-giving contexts* (Corby, 2003; Horwath, 2007; Howe, 2005). These interplays among the characteristics of the child, carer and care-giving context in the provisions of childcare is illustrated on Figure 2.1.

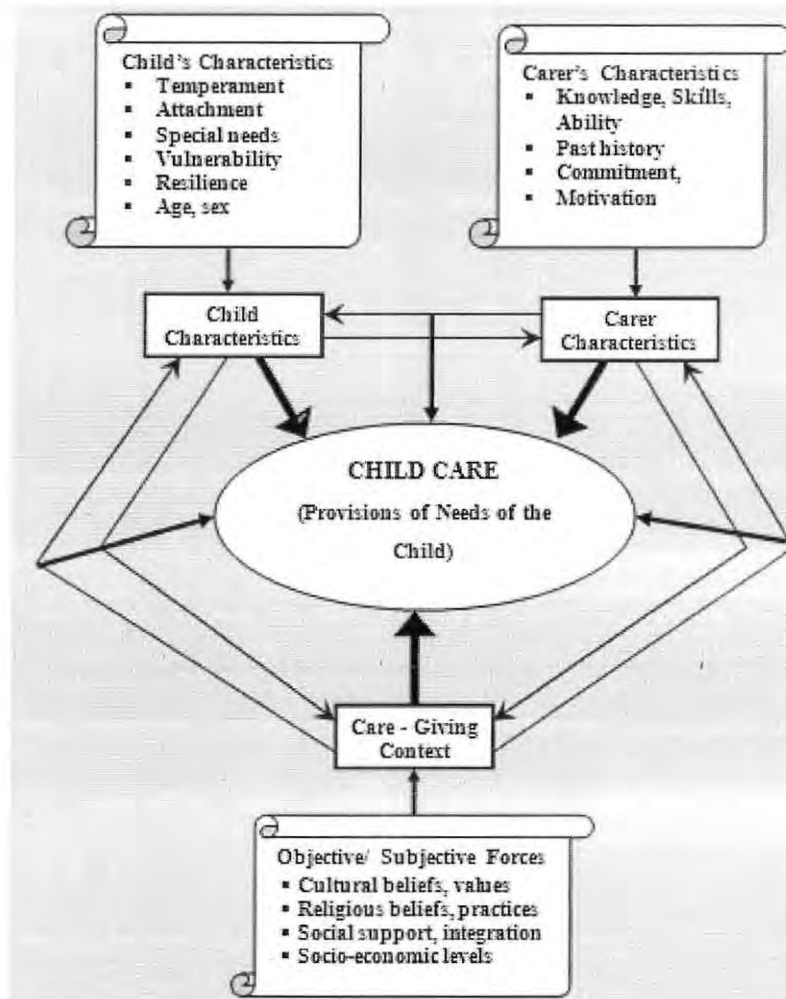

Figure 2.1: Interplaying components in the provisions of childcare

Figure 2.1 illustrates that the carer's major characteristics such as its knowledge, skill and ability of childcare, the past history about its childcare, and the motivation and commitment in providing care to the child convey influences on the attainment of needs of the child (Horwath, 2007). The patterns of temperament and attachment, the special needs, vulnerability, resilience, age and sex, etc. of the child are also crucial factors in the provisions of childcare (Horwath, 2007; Howe, 2005). The characteristics objective (economy, education) and subjective (culture, belief, norms) forces (Belay, 2007) of the care-giving contexts are the opportunities and/or challenges to the carer in fulfilling needs of the child (Corby, 2003). Besides, the figure shows that characteristics of the child, parent and care-giving context continuously interact each other in providing needs of the child (Howe, 2005).

The provisions of needs to children have increasing or limiting *consequences* on their immediate and long-term physical, cognitive and psychosocial development (Howe, 2005). This is to mean that:

> although all children have certain basic [and developmental] needs, each child will have a set of individual needs, determined by its own genetic makeup, by the immediate conditions in the family that satisfy (or do not satisfy) some of the basic needs, by the conditions in the community and larger society, both of which sets goals and impose limits on the child affecting its development. (Myers, 1992, p. 44)

Children in one way or another might not fulfill their basic needs (e.g., not provided adequate food, clothing, shelter, etc.) or might be provided negative forms of care (e.g., battering, sever punishments, etc). Giovannoni (1971) call these experiences of children as *child neglect* and *abuse*. This author in distinguishing between abuse and neglect; defined abuse as 'acts of commission', which result in harm, and neglect as 'acts of mission', which have negative effects. Abuse might be taken as an exploitation of the rights of the parents to control, discipline and punish their children, and neglect represents the failure to perform parental duties, including supervision, nurturance and protection (Howe, 2005).

From the discussions under this section, childcare refers to the actions necessary to fulfill certain *aspects* of a child's needs. It is also indicated that the *processes* of fulfilling such needs to a child are interplays of the characteristics of the carer, child and care-giving conditions. Finally, it is indicated that the actions of childcare could have certain encouraging or deterring consequences on the survival, growth and development of a child. Gloving these general discussions about the care of children in hand, the next section describes childcare practices of Ethiopia.

2.3. Childcare and Support Practices in Ethiopia

Since Ethiopian orphans are the microcosms of the larger group of children in the Country and are reared in the sphere of Ethiopian Childcare and support systems, this section highlights some childcare and support practices of Ethiopia.

Ethiopia is characterized by more of a collectivist socio-cultural orientation (Belay, 2008), where extensive traditional forms of social supports such as the extended family are highly prevalent (TGE, 1994). This cultural orientation appears to be reflected in its childcare and support practices. In Ethiopian society, a child can have more than two parents. All individuals connected through blood ties are responsible in caring and supporting of the child based on the order of their family lineage (Feteha Negest, 1962). According to this customary law of the Government, siblings, brothers/or sisters and mothers/or fathers of the child's biological parents have moral and legal responsibilities of parental roles in fulfilling all needs of the child.

Children in Ethiopia are considered as sources of happiness, love and stability of the family. Due to the high value given to children, if a wife in a family, for instance, unable to bear a child, she is labeled as 'mule' by the neighbors and the community, and the husband is expected to divorce her and marry another woman (Kebebew cited in Mihiret, 2007, p. 41). In addition, children in Ethiopia are considered as assets of their family (Eshetu cited in Belay, 2007, p. 67) and God given creatures (Abebaw, 2007).

Generally, rearing of children include, inter alia, the availability of opportunities for children to raise questions to their parents, to do certain things on their own, to discuss matters with their parents and to express their views (Maltin cited in Abraham, 1996, p. 137). In this regard, some literatures (e.g., Belay, 2007; Melaku, 2007; Ringness & Gander, 1974) in Ethiopia indicate that adult-centered childcare, harsh and authoritarian type of child disciplining are widely prevalent in most rural parts of Country. Besides, a study conducted on 243 parents and their 237 children in Siltigna-Speaking community indicates that parents do not permit their children to ask questions, to participate in a family discussion and to do things on their own (Abraham, 1996). The responses of the children participated in this study

also demonstrated that they do not have the freedom to raise questions to their parents, to discuss matters with their parents and to express their views.

Domestic child labor work is highly prevalent in most rural households of Ethiopia (Abebaw, 2007). Children in rural areas of the Country help their parents by fetching water, preparing food and collecting fire wood (for female children), looking for cattle and plowing farmlands, etc (for male child) (Ringness & Gander, 1974). Besides, corporal physical punishment is used as a method of child disciplining. A review of studies (e.g., Daniel & Gobena, 1997; Dessalegn, 1998; Seleshi, 2001; Yoseph et al., 2006) conducted in home and school settings indicate that the prevalence of harsh physical punishment as method of disciplining children in these settings by parents and teachers.

2.4. Alternative Care Arrangements for Orphaned Children

Placing orphaned children into different care arrangement alternatives is not a new practice in Ethiopia. There were cultural and legal institutions, which provide care and support to children who were orphaned and abandoned due to civil wars, famine and malaria (Abebe, 2009). The capacity of the present practices of care and support of orphans in Ethiopia, however, is frayed by the newly occurred epidemic, HIV/AIDS. Belay (2007), in his model, called "Ambivalent Model of AIDS Orphan Care and Support", has characterized the existing orphan care and support practices of Ethiopia. He stated that:

> the past, present, and future of AIDS orphan care is structured by an interplay of the objective (economy, education…) and subjective (culture, beliefs, norms, values…) forces in Ethiopia, which at one and the same time, are redefined and restructured by the third new force in recent years; HIV/AIDS-induced orphanhood" (p. 60).

Belay signified that the existing alternative arrangements for orphan care and support are the reflections of the socio-economic, political, cultural and traditional setups of the Country. Further, he stated that due to the unprecedented growth of orphans in the Country, the practices neither accommodate the children nor do they fulfill the newly produced social and psychological needs of these children.

In Ethiopia, five alternate childcare programs, namely, Residential Childcare, Child Adoption, Community-Based Support, Child Fostering and Child-Family Reunification are being implemented by different NGO's, GO's, Associations and Community members (MOLSA & Italian Cooperation cited in Belay, 2002, p. 45).

In addition, other cultural and religious-based care and support arrangements of orphaned children such as Adera childcare system (Belay, 2007) and Child Guddifachaa (or 'customary' adoption) (Beckstrom, 1972; Dessalegn, 2006) are practiced in Ethiopia. For the purpose of this study, the practices and care and support of Adera childcare system and Children's Village (particularly, the SOS Children's Village) care arrangements are described next.

2.4.1. Adera Care Arrangement

A. Meaning and Essence

According to Amsalu Aklilu's (1996) Amharic-English Dictionary, the term "Adera" has two meanings with high and low level of intonations. Adera, spelt with low intonation, (*አደራ - adàra*) in noun form, mean that "s/t [some thing] entrusted to s/b [some body]"; and spelt with high intonation, (*አደራ - adàrra*) in verb form, mean that "form web" (Amsalu, 1996, p. 196). In the former case, it is the process of transferring one's own possession or property to another person to be responsible for it. In their definition of Adera, Belay and Belay (2010) stated that "it is usually made when we request others to carryout an assignment in our absence or on behalf of us" (p. xvii). In the latter case, Adera, literally, mean that the formation of complex structure, network or design among things or people.

The meaning attached to Adera has wide spread applications in ones day-to-day life. In the Ethiopian Civil Code (1960, Article-2779), for instance, Adera is given an English translation, 'bailment' to mean that "... a contract where by one person, the bailee, undertakes to receive a chattel [movable property] from another, bailor, to keep it on the latter's behalf". In the context of orphan care and support, Adera (*in noun form*) is the

transference or giving of a child/ren to other person to be responsible in the care and support of the child/ren (Belay, 2007).

Children in Ethiopia are considered as means for the survival and continuation of parental gene (Abebaw, 2007). Parents, perhaps for the continuation of their gene, bestow their children Adera to another person at their terminal illness. Adera giving of children is a culture and religion - based practice of transferring parental childcare responsibilities to another person (Belay, 2007). The socio-cultural and religious implications of the practices and processes of giving children Adera to another person are elaborated next.

B. Practices and Processes

Adera giving of children to another person has cultural and social values. Given the socio-cultural "we-ness" and social interdependence among the Ethiopian society (Belay, 2008), the practice of bestowing children Adera to another person is valued by the deceased parents of the children in the society (Belay, 2007). The social values attached to Adera are shown in the sayings of the society, which often reflect a society's thinking and practice about it (Ethiopian Language Academy, 1982). Consider the following maxim:

አደራ ጥብቅ ሰማይ ሩቅ (*Adera tibk semay ruk*)

This social saying indicates that Adera is much stronger and farther as the distance to the horizon and shows that taking and giving Adera by someone is highly valued practice.

Social labelings for individual who respect the Adera responsibility to the end as "Adera Ketachi" (***አደራ ከታች***) (Ethiopian Language Academy, 1982) and for individual who failed to do so as "Aderawin Yebela" (***አደራውን የበላ***) (Belay, 2007) are given by the society to lay influences on the practitioners of Adera. These and other social labelings given to Adera receivers can serve as sources social benefits or sanctions in their interrelationship in the various forms of traditional social welfare gatherings, associations, and institutions (such as mahiber, senbete, idir, etc.) (Belay, 2008).

The practice of Adera has also implications in religious beliefs, which the Ethiopian culture gives high value (Abebaw, 2007). In Biblical or Qur'anic belief, the Almighty Lord/ Allah entrust children for parents to care and raise them in the recognitions of His Kingdom and Holiness (see GENESIS 4:1; GENESIS 17:16; JOHN 126:3 in the Christian Holy Bible; and Sûrah 2: 233; in the Islam Noble Qur'an). Taking the Lord/Allah as a model, believers of different Personalities at the brink of their death transfer their children in the name of Holy Spirit to another person for taking care of the children (see ASTER 2;6 on the Christian Holy Bible; and Sûrah 4: 6, 7; Sûrah 107: 2, 3 on the Islam Noble Qur'an). In the Christian and Muslim religions, the death of an individual is considered as passing away of one's flesh not the end of life or soul and thus Adera endowed to someone in this World will be returned to the original person in the other World. Individual believer taking the responsibilities of caring and supporting the Adera child will receive the outcomes of its doings at the Doomsday from the Holy Lord/ Allah.

As indicated above, Adera giving of children is a childcare and support responsibility transference by deceased parents to another caregiver. In the transference of the child, at least, two parties: one, the individual who bestow the child (Adera donor) and the other the individual who received the child (Adera recipient) are involved. Adera donors are parents of the children who are found at the verge of their death (Belay, 2007; Kassa, 2006; Yigzaw, 2009). Adera recipients are guardians and could be elder siblings, aunts, uncles, grandmothers/fathers, neighbors, or other non-relative adult acquaintances (Yigzaw, 2009), the survived biological mother or father of the child (Gebreyesus, 1987) who are trusted and loved by the Adera donors and by the community members (Yigzaw, 2009). In some cases, the children given Adera are participated in or informed the transference process (Belay, 2007).

Consensual agreements between Adera donors and Adera recipients take place during the transference of the child. Adera donors entrust Nuzazie (word of promise) in front of witnesses (e.g., Religious Priests and Sheiks, and Community elders) to the Adera recipient for protecting and nurturing the child to be self - reliant, and to utilize child's parental estate

properly (Gebreyesus, 1987; Kassa, 2006). Adera recipient, in turn, received all the responsibilities given from the donor (Belay, 2007).

After taking the Adera child, Adera recipient carryout all the responsibilities of care and support laid on its shoulder and tried every walk of life to implement the Nuzazie entrusted by the donor (Kassa, 2006) and "feels the failure to observe the promise has social, cultural, and religious costs to incur" (Belay, 2007, p. 75).

C. Care and Support

Cross sectional and longitudinal studies on the immediate and long-term impacts of Adera care and support on the development of the children were unavailable. But, the studies (Belay, 2007; Kassa, 2006; Yigzaw, 2009) conducted on the care and support of Adera care arrangement documented that Adera recipients provide the following services to the children.

- clothing, shelter, food and medical services;
- protecting from harmful things, street life and abuse;
- provision of educational materials (e.g., pens, books, exercise books, pencils);
- mediating when the child is quarreled with others;
- establishing emotional closeness, provide advice, supervision.

D. Challenges and Problems

The practice of Adera childcare system is surrounded by different challenges and problems. These challenges and problems could stem either from the Country's existing social, cultural, economic and political setups, in particular childcare systems, or from the inherent limitations of the practice itself. Thus, it is important to delineate the challenges from the inherent limitations of Adera childcare and support system. Although there is no thorough study on this particular aspect, Belay (2007) and Yigzaw (2009) reported the following as the major challenges and inherent limitations of Adera care and support arrangement for orphans.

- **Challenges:**
  - low socio-economic status of Adera recipient families;
  - adult - centered childcare of the guardians;

- inadequate provision of the psychosocial needs of the children; and
- prevalence of different forms of abuse and neglect in the Country.

- **Inherent Limitations:**
  - the large number of children bestowed to an Adera recipient by the donor;
  - donors' ill preparation in the arrangements of their children;
  - Adera receipts' conformity to bestow the child or lack of assertiveness while taking the child; and
  - low support from other relatives or acquaintances who did not received the child.

2.4.2. Children's Village Care Arrangement

A. Rationale for Establishment

Traditionally and particularly in Africa, orphans are taken care of by nuclear family members, by extended families, or even by distant relatives (Varnis, 2001). Granted the social strains caused by the effects of HIV/AIDS and other pandemic, families and social support systems of the community in Africa are developing adaptive capabilities with varying degrees of success and failure (Chirwa, 2002). Some professionals on the area (e.g., Harber, 1999; Varnis, 2001), however, argue that this 'traditional' care arrangement of orphans is collapsing and is not able to absorb the staggering numbers of orphans in Africa. They noted that other family-type care arrangements, which can substitute the collapsing 'traditional' family-care arrangements for orphaned children should be established. In line with this argument, a 'globalised' *simulated* family model, as in Children's Villages, was reconstructed for orphaned care arrangement (Abebe, 2009).

Children's Village care arrangement for orphans has a long history. Boys Town in Nebraska was opened in 1917 and has now grown to 72 homes throughout the World. SOS-Kinderhof operates in 440 Children's Villages since it was founded in 1949. Others like, the Pestolozzi Children's Home in Trogue and Switzerland are some of the Children's Villages established for orphaned and destitute children (Macarov, 2009).

The philosophy of almost all these organizations is similar in that they try to reconstruct a nuclear family for orphans with pseudo-parents and siblings within residential settings (Macarov, 2009). In most cases, the number houses in a Village is limited to ten or less. Here the goal is to make each Village feel like a 'naturally' occurring community and each home feel like a family. For the purpose of this study, orphan care and support and practices of SOS Children's Village are described next.

B. SOS Children's Village

SOS Children's Village is an international, non-profit organization, with independent funding from charitable donations. The first SOS Children's Village was built in Austria, Imst (Macarov, 2009). Hermann Geminer, the founder, established the Village based on his major belief that the traditional orphanages did not provide opportunities for the proper care and development of orphaned and homeless European children (Abebe, 2009).

The SOS Children's Village pioneered a long-term family childcare approach where orphaned and abandoned children are grown-up together as healthy individuals in every aspect (SOS International, 2009). The underlying principles of the Village are conceptualized as the 'four pillars of the organization' that (a) the 'Village' in which orphaned boys and girls can live together as (b) 'brothers and sisters' in (c) a 'family-like environment' with the care of (4) a 'mother' (Abebe, 2009). The families in SOS Village simulate the 'naturally' occurring social environment in which they consist of the Mother, Brothers and Sisters, House and Village (SOS International, 2009).

- **Mother:** the SOS mother acts as a substitute for the children's natural parents and who is supported by another woman called the 'auntie'. She builds close relationships with every child entrusted to her and provides the security, love and stability that each child needs. As a childcare professional, she lives together with children, guides their development and runs her household independently. She recognizes and respects each child's family background, cultural roots and religion.

- **Brothers and Sisters**: boys and girls live together as brothers and sisters, with biological brothers and sisters always staying within the same family. These children and their SOS mother build emotional ties that last a life time.
- **House**: the house is the family's home with its own unique filling, rhythm and routine. Under its roof, children enjoy a real sense of security and belonging. They grow and learn together, and share all the joy and sorrow of daily life.
- **Village**: a cluster of SOS families (usually 10 to 15 families) together form a supportive environment where children enjoy a happy childhood. The families share experiences and offer one another a helping hand. They also live as integrated and contributing members of the local community.

Services and Facilities in SOS Children's Village

Children in SOS Village are provided the following services and facilities (SOS International, 2009).

- ***Food Service***: SOS Village provides four meals per day (breakfast, lunch, supper and dinner) to children above the age of seven. Special care and food items are provided to children below age of six. The mother is provided food menu, which children are supposed to get. The Village nurses check the quantity and quality of food provided to the children.
- ***Housing Service***: Children in SOS Village have clean and furnished houses. A typical SOS Village house consists of dining room, salon, bed rooms, facilitated kitchen, bath room and mini-store for food stuff.
- ***Clothing Service***: Children are provided neat cloths. Children have enough extra cloth for change including school and night uniforms. The cloth can be allocated from the budget of the Village or they can be gifts from individual sponsors. The mother is responsible to purchase the cloths according to the choices of the children.
- ***Health Service***: Medical care is provided for the children and community in the Village. All SOS Villages have clinics and necessary medical equipments. If children are seriously sick they are taken to any higher hospital. Children get health education on how to keep personal hygiene and environment clean.

- ***Educational Service***: The Village covers all educational charges of the children. The children are provided all the necessary educational materials. There are (usually more than two) educators who assist and follow education of the children. If a child refuses or unable to learn, it is provided vocational trainings.
- ***Counseling Service***: The Village has counseling rooms with professional psychologist and/or social worker. The counseling office provides services on psychological, social, academic, personal and economic problems to the children.

Macarov (2009) noted that children in SOS Village get a relatively stable shelter, good basic care and educational facilities than other orphans living in the 'formal' residential arrangements. Despite these services and facilities, some research reports indicated that children in the SOS Village experience different psychosocial and educational problems and difficulties.

Tsige (2007) has conducted a research on the psychosocial experiences and academic achievements of children in SOS Village. She collected qualitative data from the children by making them to write what they like and dislike about the provision of care and support in the Village. In addition, she collected quantitative data from the academic records of the children. Based on analyses of these data, Tsige reported that:

- Many children were not trusted by their guardians;
- Some SOS mothers were not as loving as they were expected by the Village;
- Children experience harsh insult, cursing and hatred from guardians, siblings and other community members of the Village;
- Children experience some corporal punishment and heavy physical work;
- Some SOS mothers work for their salary that they do not have the readiness and psychological makeup to function as a 'mother';
- Some SOS mothers were more distant to their children in that they do no treat and accept the children as their own;
- Children in SOS Village were overburdened as they were always made to study without break; and
- The academic achievements of SOS children were lesser than the home-reared children.

Guardian's commitment to care for the child has an important function in the care-giving process; it develops the child's confidence on the caregiver that he or she is committed to him or her (Bowlby, 1973). In this care-giving function, commitment seems to be the *same* with child-caregiver attachment security. Dozier and Lindhiem argue, however, that while child-caregiver attachment security exclusively focuses on individual differences in child's expectation of the caregiver's availability when he or she is distressed, caregiver's commitment to childcare emphasizes on the extent to which the child feels confident that the parent is committed to him or her, or the caregivers' sense of reassurance of the distressed child.

There are a number of factors that affect caregiver's level of commitment to the provision of care to children. Lindhiem and Dozier (2007) have studied the commitment levels of 102 foster caregiver-child dyads using "This is My Baby" Interview guide. They have found out that caregivers exhibit higher levels of commitment to children who were placed at younger age than to children who were placed at older age. The study also indicated that caregivers who had cared for many foster children in the past exhibited lower levels of commitment than caregivers who had cared for fewer foster children. Most importantly, the study shows that caregiver's commitment was found to predict placement stability. Specifically, for every unit increase in commitment, as assessed in the "This is My Baby" Interview, caregivers were almost twice as likely to keep their infant or child in placement for two years or longer.

B. Child-Caregiver Attachment Styles

In the field of child development, attachment is the enduring *reciprocal* (or *bi-directional*) emotional interactions between the child and caregiver(s) (Ainsworth, 1973). Like, traits such as height or weight, a child's attachment capabilities are continuous (Cole, 1989). In an attempt to study these range of attachments, Ainsworth (1973) has classified the continuum into three categories, namely, *secure*, *insecure/anxious*, and *insecure/avoidant* attachment styles using the "Strange Situation Procedures". Later on using the same procedures, Main and Solomon (cited in Green & Piel, 2002, p. 102) added a fourth category of attachment style, *disorganized/disoriented* attachment style. These four attachment styles are briefly described below.

attachment behavior in order to feel safe and cared for (Howe, 2005). Some authors (e.g., Gray, 2002; Green & Piel, 2002; Howe, 2005; Randolph, 2002) indicate that this attachment style is not yet clearly stated and researched.

C. Child Resilience

Apfel and Simon (1995) define resilience as the "capacity to bounce back from traumatic childhood events and develop into a sane, an integrated and socially responsible adult" (p. 4). Apfel and Simon describe resilient children according to their resourcefulness, curiosity, intellectual mastery (ability to conceptualize) and flexibility in emotional experience. In addition, Masten and Coatsworth (1998) defined resilience as the "manifested competence in the context of significant challenges to adaptation or development" (p. 212). According to Masten and Coatsworth, these individual attributes of 'resilient' children must also be combined with protective child care-giving environment in order to help them overcome adversity and proceed on a positive life course.

Cognizant of the different definitions of child resilience provided by different authorities, consensuses on the concepts of child-resilience are emerging in that it encompasses (a) good outcomes despite high-risk status, (b) sustained competence under threat and (c) recovery from trauma (Apfel & Simon, 1995; Boyden & Cooper, 2007). And also resilient children are those who master normative developmental tasks despite their experiences of significant adversity (Masten & Coatsworth, 1998).

Central to the objectives of researches on child-resilience, a number of vulnerable factors (indices that exacerbate the negative effects of risk condition) and protective factors (factors that modify the effects of risk in a positive direction) were identified (Smith & Carlson, 1997). Rutter (cited in Smith & Carlson, 1997, p. 19) categorized these protective and vulnerable factors of child-resilience in to child, family and social environment related factors. These are described below.

- **Child Related Vulnerable and Protective Factors**

Resilient children tend to be characterized by high ego-control, self-esteem and average intelligence, and tend to attribute successes to their own efforts (Boyden & Cooper, 2007). These children have some genotypes and some profiles of physiological stress reactivity confer protection against the adverse effects of maltreatment (Gunnar, 2000).

- **Family Related Vulnerable and Protective Factors**

Children's relationships with family members have been found to promote or demote their resilience to adverse conditions. Of the many factors that affect the trajectories of at-risk individuals, the most potent is maltreatment by caregivers. Maltreating families are more likely to neglect children's needs for physical sustenance and protection, emotional security, and social interaction (Eckenrode et al., 2000). On the contrary, children's positive relationships with the family can do much to promote resilience in children who have faced with challenging circumstances. A research by Gunnar (2000) shows that strong secure attachments to caregivers can buffer or prevent elevations of stress hormones in situations that usually elicit distress in children.

- **Extra-familial Factors**

With respect to children's broader social networks, those who experience a structured school environment, or who form supportive relationships with teachers and peers or other adults in their neighbors and communities tend to have better outcomes (Smith & Carlson, 1997). Children who are grown up in multi-problem families and poverty tend to be more vulnerable to adverse situations.

III. METHODS

This part consists of the design, sites, participants and instruments of the study. In addition, it presents the procedures followed in the construction, piloting and administration of the instruments, and the data scoring and analysis techniques of the study.

3.1. Study Design

The study was conducted to describe and compare the care and support of orphans in SOS Village, Non-Adera and Adera care arrangements. To this end, quantitative and qualitative approaches of research were employed. These research approaches were followed for (a) triangulating methods of the study and (b) employing multiple data collection instruments to combine the strengths and to mitigate the inadequacies of each data collection instrument of the study.

Besides, the study described and compared the care and support of the children in the three care arrangements from an approach of it as the *provisions*, *process* and *child-behavior outcomes*. Thus, the provision of positive and negative forms of care and support to the children in the three care arrangements were described and compared in the study. In addition, levels of commitment of guardians in caring and supporting of the children in the three care arrangements were compared as the process of care and support. Furthermore, the study compared the major child-functioning outcomes of care and support (such as attachment style, educational performance and resilience of the children) in SOS Village, Non-Adera, Adera care arrangements. Figure 3.1 illustrates the general approach of care and support in the study.

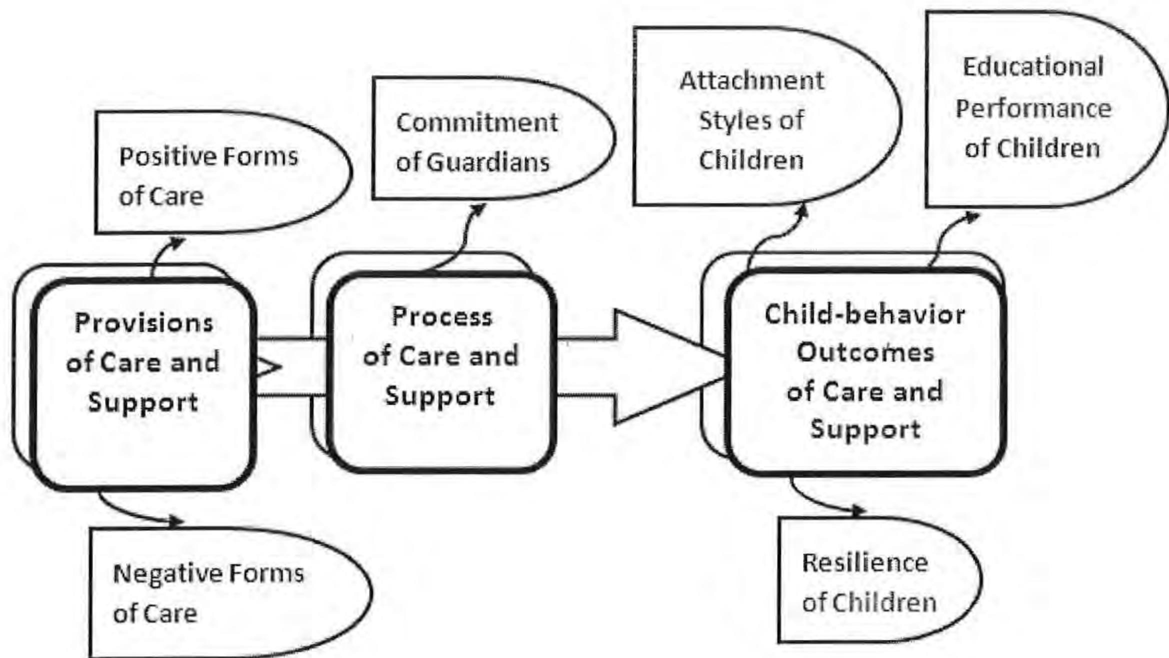

Figure 3.1: General approach of care and support

3.2. Study Sites

The study was conducted at Debre Markos and Bahir Dar Towns. Debre Markos and Bahir Dar Towns with seven and 11 Kebele Administrations, respectively, are found in the Amhara Regional State at the Northwest of Addis Ababa. The two Towns were selected as sites of the study for (a) the researcher is familiar with these areas, which helped him to grasp the socio-cultural networks of inhabitants easily, and (b) as far as experiences of the researcher are concerned the practice of Adera childcare and support system is common in these areas, which helped him to achieve the purposes of the study.

3.3. Participants

Participants of the study were orphaned children and guardians living in Adera and Non-Adera care arrangements with the community and in SOS Village care arrangement. A total of 180 orphans with ages seven to 17 years and 30 guardians were involved in the study.

A comprehensive list containing households of orphans who were cared and supported in Adera and Non-Adera care arrangements was unavailable. These households rather were dispersed across all the Kebeles of Debre Markos and Bahir Dar Towns. The selections of and access to Adera and Non-Adera care arrangement participants, thus, follow *multi-stage* sampling technique.

First, *snowball* sampling technique was employed to identify and create a list of households containing orphans from the two Towns. To do this, funeral association (Idir) leaders, priests, sheiks, school directors and teachers, and Labor and Social Affair Offices of the Kebeles in Debre Markos and Bahir Dar Towns were consulted to identify the households containing orphaned children. Four assistants were participated in consulting these key informants, identifying the households and to gather background information of the households based on the form prepared for this purpose *(refer Appendix - F for the Household Background Record Format*). Accordingly, a list of 136 households (containing 242 children) from Debre Markos and 154 households (containing 240 children) from Bahir Dar Towns were identified. This list has contained orphaned children between two and 20 years old.

Second, households of 103 from Debre Markos and 98 from Bahir Dar Towns, which contained orphaned children with seven and 17 years old, were selected from the established list. By giving due considerations to the children's age, sex and residing Kebeles, these selected households were contacted in-person to ask for their consent to provide information and how they received the children from their parents. Based on this, 38 Adera recipient households (containing 71 children) and 53 Non-Adera recipient households (containing 82 children) from Debre Markos, and 47 Adera recipient households (containing 96 children) and 40 Non-Adera recipient households (containing 86 children) from Bahir Dar Towns gave their consent and therefore, were selected purposively as *potential participants* of the study. The remaining 12 households from Debre Markos and 11 from Bahir Dar Towns were not included due to their refusal to provide the information. Some household heads, for instance, mentioned that:

- They were much bored in the repeated registrations as 'households of orphaned children' by different bodies of government and non-government organizations.
- Their orphaned children were annoyed in the social labeling of them as 'orphaned child'.

Finally, from these purposively selected potential participants, 22 Adera recipient households (containing 30 children) and 25 Non-Adera recipient households (containing 30 children) from Debre Markos, and 19 Adera recipient households (containing 30 children) and 23 Non-Adera recipient households (containing 30 children) from Bahir Dar Towns were selected using *simple random* sampling technique, which was used primarily to make the selection procedures less biased (Shaughnessy & Zechmeister, 1994). Table 3.1 shows the number of Adera and Non-Adera recipient households and children included in the established list, potential participants and actual participants of the study.

Table 3.1: The number of households and children involved in the identification and selection of participants of the study

	List of orphans identified		**Potential participants**				**Actual participants**			
	Debre Markos	Bahir Dar	Debre Markos		Bahir Dar		Debre Markos		Bahir Dar	
			Adera	Non-Adera	Adera	Non-Adera	Adera	Non-Adera	Adera	Non-Adera
Households	136	154	38	53	47	40	22	25	19	23
Children	242	240	71	82	96	86	30	30	30	30

As shown on Table 3.1, a list of 290 households containing 482 orphans between two and 20 years old was formulated from Debre Markos and Bahir Dar Towns. From this list, 85 Adera recipient households (containing 167 children) and 93 Non-Adera recipient households (containing 168 children) were taken as potential participants of the study from the two Towns. Finally, a total of 41 Adera recipient households (containing 60 children) and 48 Non-Adera recipient households (containing 60 children) were selected as sample of the study from the two Towns. The steps followed in selecting the Adera and Non-Adera participants of the study are illustrated on Figure 3.2.

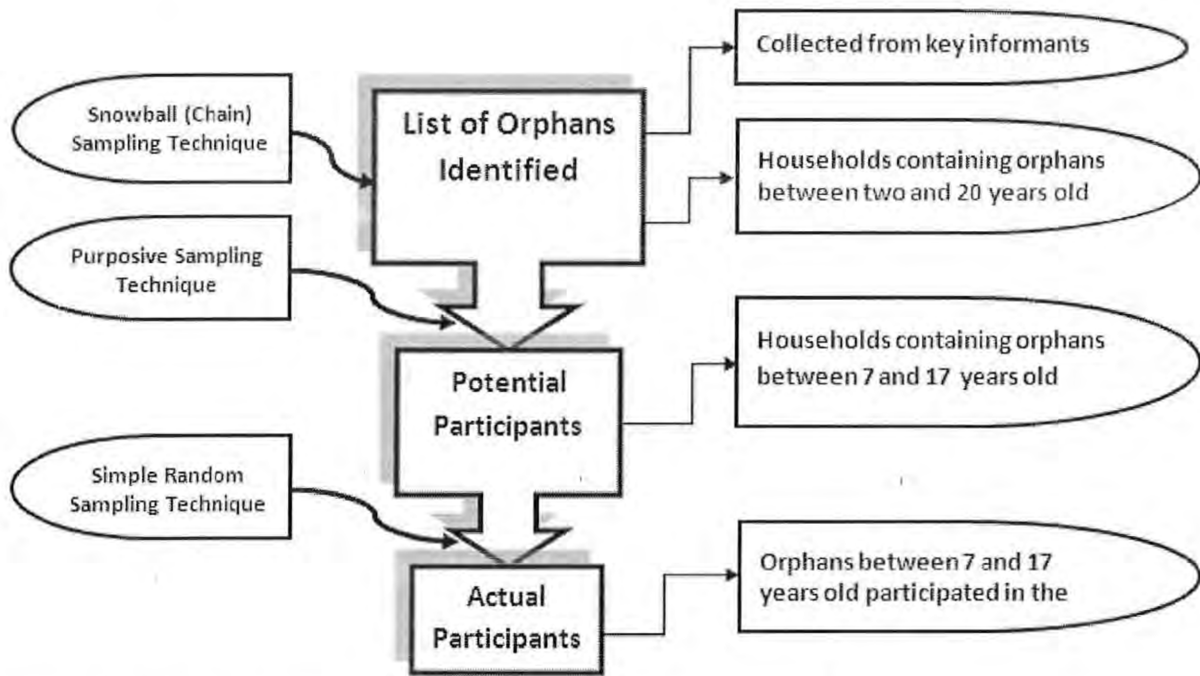

Figure 3.2: Steps in selecting Adera and Non-Adera participants

Guardians of Adera and Non-Adera participants were selected from households in the actual participants using *convenience sampling* technique. Accordingly, five Adera recipient households (containing five guardians) and five Non-Adera recipient households (containing five guardians) from Debre Markos, and five Adera recipient households (containing five guardians) and five Non-Adera recipient households (containing five guardians) from Bahir Dar Towns who can provide data and were willing to be interviewed were involved in the study.

On the other hand, participant children from SOS Village were found in three groups, which were classified based on their chronological ages. The first group was children of both sexes between one and 13 years old who were living in the families of the Village with a family containing six to 10 children and a guardian. The second group was children between 14 and 17 years old who were living in the 'Youth Hostels' of the Village with male and female children separately. The third group was children above the age of 18 years old who were living outside of the Village by renting their own houses with the financial aid of the Village.

Children below seven years old in the first group and above 17 years old in the third group were excluded *purposely* from the sample selection since their ages were out of the ranges of seven and 17 years. Thus, samples were drawn from children between seven and 17 years old in the first and second groups. Accordingly, by giving due considerations to the numbers of children in a family, sex and age, 60 children were selected for the study using simple random sampling technique. Besides, 10 guardians were selected from the families of the children involved in the study using convenience sampling technique.

3.4. Instruments

Data collection instruments such as Questionnaire, Observation Checklist and Semi-structured Interview Schedule for collecting *primary* data from the children and guardians, and Academic Record Format for collecting *secondary* data from the children's academic performance records were employed in the study. These instruments are described below.

A. **Questionnaire**: it consists of five parts intending to gather data about background information of the children and guardians, and the *provisions* (positive and negative), *process* (commitment of guardians) and *outcome behaviors* (children's attachment style and resilience) of care and support.

- **Background Information about Participants (Part-1)**: in this part of the Questionnaire, 12 open and close-ended questions related to the personal and demographic characteristics of the children and their guardians are included.
- **Provisions of Care and Support (Part-2)**: this part having 32 items intends to collect data about the provisions of positive material care (e.g., fulfilling food, cloth, educational materials, health services, etc.), positive psychological care (e.g., emotional support, supervision, guidance, etc.) and negative treatments (e.g., spanking, school dropout, property grabbing, discrimination, scolding, etc.) to the children.
- **Commitment of Guardians to Care and Support (Part-3)**: this part of the Questionnaire has six items, which intends to collect data about the level of guardians' commitment in caring and supporting of the children.

- **Child's Attachment Styles (Part-4)**: this part consists of 15 items used to identify the three attachment styles – secure, anxious and avoidant – that the children have with their guardians.
- **Resilience of the Children (Part-5)**: this part has nine items, which intends to collect data about resilience of the children.

Items from part two to five of the Questionnaire were responded based on a-three-point scale (Agree = 3, Sometimes Agree/Disagree = 2 and Disagree = 1) for the highest number indicating the highest level of agreement on the item *(refer Appendix - A for the Questionnaire)*.

B. Observation Checklist: this checklist having five questions was employed to gather data about the physical cleanliness and status of the children *(refer Appendix - B for the Observation Checklist)*.

C. Semi-structured Interview Schedule: in supplementing the data from the Questionnaire, this schedule was used to collect data from guardians about the provisions of care and support to the children, their interactions with the children, resilience of the children, and their commitment in caring and supporting of the children *(refer Appendix - C for the Semi-structured Interview Schedule)*.

D. Academic Record Format: this format was prepared for collecting the educational profiles of the children such as their grade level, the number of days they become absent in a semester, their total and average results and their class rank *(refer Appendix - D for the Academic Record Format)*.

Certain procedures were followed in the construction, piloting and administration of the instruments. The succeeding sub-sections describe these procedures.

3.4.1. Construction

The data collection instruments were constructed from relevant literature and were adapted from other instruments on similar areas. The following were the procedures followed in the construction of the instruments.

- **Provisions of Care and Support Scale**: based on the categorization schema of Horwath (2007), seven *aspects* of childcare and support (physical, emotional, educational, supervisory, verbal, labor and health) were identified in the initial steps of constructing this scale. In addition, another eighth aspect, 'property', was added since it is the other major concern of orphaned children (Bulti, 2007). Based on these aspects of care and support, 52 items were pooled from research reports and relevant literature (e.g., Ayalew, 2007; Belay H., 2007; Belay, 2007; Bulti, 2007; Chirwa, 2002; Horwath, 2007) on the different issues of care and support of orphans (or children in general). Then these items were prepared in a Likert-scale type with five-point scale (from Strongly Agree to Strongly Disagree), and were shown to the Advisor and other professionals in the Institute of Psychology, Addis Ababa University for discussions of the proper coverage of the contents and comprehension level of the children regarding the content of the statements and responses. After receiving relevant feedback and rigorous discussions with the Advisor, seven items from the 52 items were discarded, some others were modified, and the five-point scale was changed into a four-point scale.
- **Commitment of Guardians to Care and Support Scale**: this scale was adapted from a standardized semi-structured interview known as "This Is My Baby" (TIMB) interview developed to study foster parents' level of commitment in raising their foster children (Dozier & Lindhiem, 2006). Based on this interview and other research reports, it was constructed into a Likert-scale type for making it suitable to participants of the study.
- **Child's Attachment Style Scale**: this scale was developed inline with the Finzi and others (1996) Attachment Styles Questionnaire (ASQ) and from other empirical research reports.
- **Resilience Scale**: it was adapted from Yigzaw (2009) who develop it from Davidson (2003) and Bisrat (2005) who administered it to AIDS orphans.

- **Semi-structured Interview Schedule**: this schedule, as intending to collect supplementary data, was constructed in relation to the Questionnaire prepared for the children.

Initially, the instruments were prepared in English language and then they were translated into participants' mother tongue (i.e., Amharic language). The researcher first made the English to Amharic language translation. The Amharic and English versions of the instruments were shown to two Applied Linguistics and two Developmental Psychology PhD students at Addis Ababa University for examining the clarity and appropriateness of the word usages via the children's comprehension levels and cultural schemas, and for rewriting them in Amharic language. The researcher reconstructed items that failed to provide common understanding by those professionals. Then, the instruments were pilot tested.

3.4.2. Pilot Study

Pilot study was conducted for checking the appropriateness and clarity, and for evaluating the proper ways of administering the instruments.

Thirty children (15 from Adera and 15 from SOS Village care arrangements) were participated in the pilot study for responding the Questionnaire. Besides, interviews were conducted with five guardians in Debre Markos Town. The background information of the children and guardians participated in the pilot study was recorded carefully for excluding them in the main study.

The pilot responses obtained through the Questionnaire were analyzed statistically to see the reliability of items under *each* part of the Questionnaire. Cronbach (Coefficient) alpha, which was used to judge the internal consistency of the items in each part of the Questionnaire, was generated and alpha values between 0.59 and 0.84 were obtained for the five parts of the Questionnaire.

Based on the results of the pilot study and further discussions with the Advisor, some items were discarded, some others were modified, few were added and the four-point scale of the

Questionnaire was changed into a three-point scale. Table 3.2 summarized the actions taken on some items of the Questionnaire after the pilot study.

Table 3.2: Actions taken on some items of the Questionnaire after the pilot study

Type of problem observed	No. of items with such problem	Example of item with such problem	Measures taken	Example of the item modified/added
Redundancy	5	My guardians give importance to my opinion	Discarded	-
Ambiguity	4	My guardians tell me that they love me	Modified	I am informed that I should consider the home as my own house
Inappropriate for orphaned children	7	My guardians make me to get enough sleep	Discarded	-
Inappropriately stated	6	My guardians do not cloth me properly	Modified	I have no problem in cloth
Inadequate coverage	3	-	Addition	Did you receive aid from relatives or Organizations?

Finally, after passing all these major procedures, the Questionnaire was administered to the children in the main study and found in its present form *(refer Appendix - A for the Questionnaire)*. Besides, the audio records of interviews were listened repeatedly with the Advisor and independently to judge the clarity and usefulness of the questions to the study.

3.4.3. Administration

Eight research assistants (four in each Town) were involved in administering the Questionnaire, conducting the Observation and filling the educational profiles of the children. The four assistants in Debre Markos Town had taken a short-term training on "Survey Data Collection", which was organized by OSSA (Organization for Social Services for AIDS) before this study was conducted. The three assistants in Bahir Dar Town were recruited from Bahir Dar University (Poly-Technique Campus) and the other one was a resident in Bahir Dar Town who has been working as Home-Based caretaker for five years in Mekdim Ethiopia. All the assistants were given training on how to administer and record the Questionnaire and conduct the Observation to the children for one day in each Town.

Before administering the instruments, permission letters were received from the respective Kebele Administrations of the participants. The Questionnaire and Observation Checklist were administered in the houses of the children. After briefing about the objectives, the Questionnaire was read to the children and their responses were recorded by the assistants and/or the researcher on the appropriate spaces of the Questionnaire. Simultaneously, Observation of children's physical cleanliness was conducted during the interactions with the individual child in filling the Questionnaire.

Interviews with the guardians were conducted *exclusively* by the researcher. After their children had responded to the Questionnaire, the Interview was followed. This helped the researcher to establish rapport easily with the interviewees.

The educational profiles of the children were collected from their schools by the assistants and researcher. The Directors in the children's schools were informed about the purposes of collecting the educational profiles of the children and shown the official letters received from the residing Kebele Administrations. Then, the second semester (2009 academic year) educational profiles of the children were observed carefully and recorded in the form prepared for such purpose *(refer Appendix - D for the Academic Record Format)*. To keep the confidentiality of the data, code numbers were given to the names of the children in the separate sheet papers.

3.5. Data Scoring and Analysis Techniques

For simplifying the data scoring and analyses tasks, the data gathered through the Questionnaire, Observation Checklist and Academic Record Format were screened and given code numbers. All the scorings and analyses were done with the help of Microsoft Office Excel and SPSS (Statistical Package for Social Sciences) programs, and the significant levels were tested at the probability level of 0.05. The different scoring procedures and analysis techniques followed for each part of the Questionnaire and the Observation are described next.

A. Provisions of care and support: First, the 32 items included in this part of the Questionnaire were classified under three categories: material care, psychological care and negative treatments *(refer Appendix - E for the Item Classification Schemes)*. Second, each item under the three categories were scored in a three-point scale (i.e., Agree = 3, Sometimes Agree/Disagree = 2 and Disagree = 1) *without* reversing any of the items. Finally, based on the total mean rank scores, the significant differences among the three groups in the provisions of material and psychological cares, and negative treatments to children were analyzed and compared using Kruskal Wallis H - test, a *non-parametric* equivalent of one-way ANOVA commonly used when the major assumptions such as normality, homogeneity, randomness, etc. of ANOVA test are not met (Pagano, 1998; Yalew, 1998).

B. Commitment of Guardians to care and support: the six items included in this part of the Questionnaire were scored in a three-point scale by *reversing* the four negatively keyed items (i.e., 3 become 1and 1 become 3). The scores of the six items were categorized into three levels – lower, moderate and higher – to identify the level of guardians' commitment to care and support. The 25th, 50th and 75th percentile scores and one standard deviation above and below the mean of the total score of all the children in the three care arrangement was used to classify the children under each level of guardians' commitment. Finally, Chi-square (χ^2) test was computed to analyze the significant differences among the three care arrangements in the levels of commitment of guardians.

C. Attachment styles of the children: the 15 items in this part of Questionnaire were categorized into the three attachment styles: secure, anxious and avoidant attachment styles *(refer Appendix - E for the Item Classification Schemes)*. Accordingly, five items are found under each attachment style with the total score for a child between the ranges of five to 15. The total score of each attachment style was grouped into two levels – low and high – to identify the dominant attachment style of the children in each care arrangement. The score of the children in each attachment style below and above the median point was used to categorize these levels. Finally, Chi-square (χ^2) test was generated to analyze the significant differences among the three care arrangements in the attachment styles of the children with guardian.

D. Resilience of the children: the nine items in this part of the Questionnaire were scored with a three-point scale to the children in the three care arrangements. Then, the mean rank scores of the children in the three care arrangements were analyzed by using Kruskal Wallis H - test for their significant differences in resilience of the children.

E. Academic performance of the children: the *average* academic performance scores of the children collected through the Record Format were categorized into three grade cycles: primary school first cycle (grade 1-4), primary school second cycle (grade 5-8) and secondary school. Then, the academic performance scores of the children in the three care arrangements were added under these grade cycles. On the basis of the total mean rank scores, the significant differences among the three care arrangements in the children's academic performance were tested using Kruskal Wallis H - test.

Regarding the analyses of guardians' interviews, comparative and thematic analyses techniques were utilized. To do these, the audio records were listened repeatedly and transcribed as they were spoken in the words of the interviewees. Finally, major themes were identified and compared across the three care arrangements.

IV. RESULTS

The main objectives of this study were to describe and compare the Adera, Non-Adera and SOS Village care arrangements in caring and supporting orphaned children at Debre Markos and Bahir Dar Towns. Thus, the data collected from 180 orphans and 30 guardians in SOS Village, Non-Adera and Adera care arrangements are presented and analyzed systematically in this part for achieving these objectives. As a result, this part consists of major topics such as the characteristics of participants, provisions of care and support to children, commitment of guardians to care and support, attachment styles, academic performances, and resilience of the children.

4.1. Characteristics of Participants

A. Characteristics of the Children

Participant children were orphans who were living in SOS Village, Non-Adera and Adera care arrangements (*hereafter called groups*). Sixty children from each group were participated in the study. These children were asked to describe their personal and demographic characteristics such as their current age, age when the mother and father were died, year of stay in the present and another care arrangement, relation with guardian, and whether they get aid from organizations or relatives. The responses of the children about their characteristics are summarized on Table 4.1.

Table 4.1 depicts that from the 60 children in each of the three groups, 36 (60 %) in SOS, 39 (65 %) in Non-Adera and 45 (75 %) in Adera groups were males. The remaining 24 (40 %) in SOS, 21 (35 %) in Non-Adera and 15 (25 %) in Adera groups were females. In addition, the age of the children in the three groups were found between the ranges of seven and 17 years old with the mean and standard deviation of 12.2 and 3.13 in SOS, 11.85 and 3.2 in Non-Adera, and 12.67 and 3.25 in Adera groups, respectively.

Table 4.1 shows that children were found between the ranges of one and 12 years old when their *mothers* were died. The mean and standard deviations of the children's age in SOS group were 3.62 and 2.42, in Non-Adera group were 3.23 and 1.89, and in Adera group were

4.63 and 2.74, respectively, when they lost their *mothers*. Likewise, children were between the ranges of one and 14 years old when they lost their *fathers.* Regarding the mean and standard deviations of ages of the children when their fathers were died, the SOS group was 4.62 and 2.73, the Non-Adera group was 4.84 and 2.86, and the Adera group was 5.3 and 2.96, respectively. Relative to the death of fathers, mothers were died at the earlier ages of the children in the three groups.

Table 4.1: Personal and demographic characteristics of children

Variable	Category	Group		
		SOS Village	**Non-Adera**	**Adera**
Sex (n = 180)	Male	36 (60 %)	39 (65 %)	45 (75 %)
	Female	24 (40 %)	21 (35 %)	15 (25 %)
Present age	Minimum	7	7	7
	Maximum	17	17	17
	Mean	12.2	11.85	12.67
	Standard Deviation	3.13	3.2	3.25
Age when the *mother* was died	Minimum	1	1	2
	Maximum	10	9	12
	Mean	3.62	3.23	4.63
	Standard Deviation	2.42	1.89	2.74
Age when the *father* was died	Minimum	1	1	1
	Maximum	9	13	14
	Mean	4.62	4.84	5.3
	Standard Deviation	2.73	2.86	2.96
Year of stay in the *present* care arrangement (n = 173)	Between 1-5 years	28 (50 %)	23 (39.7 %)	25 (42.4 %)
	Between 6-10 years	25 (44.6 %)	21 (36.2 %)	30 (50.8 %)
	Between 11-17 years	3 (5.4 %)	14 (24.1 %)	4 (6.8 %)
Year of stay in *another* care arrangement (n = 179)	Less than 1 year	42 (71.2 %)	46 (76.7 %)	58 (96.7 %)
	Between 2-4 years	14 (23.7 %)	10 (16.7 %)	2 (3.3 %)
	Between 5-7 years	3 (5.1%)	3 (5.0 %)	0 (0 %)
	Between 8-10 years	0 (0 %)	1 (1.7 %)	0 (0 %)
Relation with guardian (n = 180)	Sister/Brother	0 (0 %)	28 (46.7 %)	20 (33.3 %)
	Aunt/Uncle	0 (0 %)	12 (20 %)	14 (23.3 %)
	Grandmother/father	0 (0 %)	15 (25 %)	18 (30 %)
	Neighbor	0 (0 %)	4 (6.7 %)	8 (13.3 %)
	No relationship	60 (100 %)	1 (1.7 %)	0 (0 %)
Aid received (n = 179)	Yes	Not Applicable	19 (32.2 %)	24 (43.3 %)
	No	Not Applicable	40 (67.8 %)	36 (56.7 %)

Table 4.1 reveals that 28 (50 %) children in SOS, 23 (39.7 %) children in Non-Adera and 25 (42.4 %) children in Adera groups stayed for one to five years in the *present* care arrangement. Similarly, 25 (44.6 %) children in SOS, 21 (36.2 %) children in Non-Adera and 30 (50.8 %) children in Adera groups stayed for six to 10 years in the *present* care arrangement. Just a few, 3 (5.4 %), children in SOS, 14 (24.1 %) in Non-Adera and 4 (6.8 %) in Adera groups were lived for 11 to 17 years in the *present* care arrangement. The majority, 58 (96.7 %) in Adera, 46 (76.7 %) in Non-Adera and 42 (71.2 %) in SOS groups have experiences of *another* care arrangement for less than a year.

Table 4.1 depicts that from the 60 children in Non-Adera group, 28 (46.7 %) were living with their sisters or brothers, 12 (20 %) were living with their aunts or uncles, 15 (25 %) were living with their grandmothers or fathers, 4 (6.7 %) were living with their parents' neighbors, and only one (1.7 %) was living with non-relative guardian. Likewise, from the 60 children in Adera group, 20 (33.3 %), 14 (23.3 %), 18 (30 %) and 8 (13.3 %) were living with sisters or brothers, aunts or uncles, grandmothers or fathers, and parents' neighbors, respectively. The majority of Non-Adera and Adera children were living with sibling household heads. On the other hand, all the children in SOS Village were living with remunerated adult guardians of the Village.

As indicated on Table 4.1, 19 (32.2 %) children in Non-Adera and 24 (43.3 %) children reported that they get aid from different Organizations and relatives. In addition, they specified that they received educational materials (e.g., exercise books, pen, pencil, bag and uniform) in every semester from UNICEF, and three liters of food oil and 15 kilogram rice in every 15 days from Mother Teresa's Foundation.

B. Characteristics of the Guardians

A total of 30 guardians from SOS, Non-Adera and Adera groups were participated in the Semi-structured Interview. Their sex, age, year of stay with child/ren, educational level, job and number of orphans raised are summarized on Table 4.2.

Table 4.2: Personal and demographic characteristics of guardians

Variable (n = 30)	**Category**	**Group**		
		SOS Village	**Non-Adera**	**Adera**
Sex	Male	0	2	2
	Female	10	8	8
Present age	Minimum	29	21	26
	Maximum	41	48	65
	Mean	34	31.1	43.1
	Standard deviation	5.14	8.43	14.96
Year of stay with the child	Between 2-5 years	5	6	4
	Between 6-10 years	3	2	5
	Between 11-15 years	2	2	1
Educational level	Illiterate	0	1	6
	Basic/primary school	6	3	2
	Secondary school	4	5	1
	College	0	1	1
Job	No work	0	0	1
	Daily laborers	0	6	7
	Businessman/ women	0	3	1
	Civil servant	0	1	1
	Remunerated guardian	10	0	0
Number of orphaned children raised	One child	0	3	4
	Two children	5	5	5
	Three children	5	2	1

Table 4.2 depicts that all SOS guardians participated in the study were females. On the other hand, two male and eight female guardians were found in each Non-Adera and Adera group. The age of guardians in the three groups were found between the ranges of 21 and 65 years old with the mean and standard deviations of 34 and 5.14 in SOS, 31.1 and 8.43 in Non-Adera, and 43.1, and 14.96 in Adera groups, respectively.

Table 4.2 shows that five guardians in SOS, six guardians in Non-Adera and four guardians in Adera groups stayed with their orphaned children for two to five years. Likewise, three guardians in SOS, two guardians in Non-Adera and five guardians in Adera guardians stayed for six to ten years with the orphaned children.

Table 4.2 reveals that while all SOS group guardians and most of the Non-Adera group guardians have reached in primary and secondary schools, most of the Adera group guardians were illiterate. In addition, all 10 guardians in SOS group were remunerated or they were hired by the Village. From the Non-Adera guardians, six were daily laborers, three were businesswomen and one was civil servant. Similarly, from the Adera guardians, one has no work, seven were daily laborers, one was businesswomen, and the other one was civil servant.

Finally, Table 4.2 indicates that guardians in the three care arrangements raised one to three orphaned children. Specifically, three guardians in Non-Adera and four guardians in Adera groups raised only one child. Five guardians in each group raised two children. Five guardians in SOS Village, two guardians in Non-Adera and one guardian in Adera groups raised three children.

4.2. Provisions of Care and Support

The care and support provided to children could be either positive or negative in its form for their development. Accordingly, the data collected using the different types of instruments about the provisions of care and support to children were analyzed for the intent of comparing the three groups on the provisions positive and negative forms of care to children. Thus, under this section, the positive and negative forms care provided to children in the three groups are described and compared.

A. Provision of Positive Care

The provision of positive care and support to children involves material and psychological aspects, which both of them are equally crucial for their proper survival, growth and development. With this background, children were asked to respond to 16 items about the positive care provided to them in their care arrangements. The responses of children to these items were classified under material and psychological aspects of care and their scores were analyzed using Kruskal Wallis H - Test. Thus, analyses results for the provision of material care is presented first on Table 4.3 and followed by the provision of psychological care to children on Table 4.5.

Table 4.3: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of *material* care to children

It. No.	Item Ψ	SOS Village (n=60)		Non- Adera (n=60)		Adera (n=60)		H -test Value*
		Mean	Mean rank	Mean	Mean rank	Mean	Mean rank	
1	Most of the time I am not starved	2.62	115.24	2.27	91.64	1.87	64.62	33.56**
2	I have no problem in clothes	2.58	103.64	2.38	91.75	2.15	76.11	10.27**
3	Someone encourages and assists me to perform better in my education	2.12	98.11	1.83	76.57	2.1	96.83	9.81**
4	I have school materials (e.g., pen, pencil, exercise book, uniform, etc.)	2.7	128.95	1.62	58.74	2.02	83.81	64.01**
5	I am allowed to know my parents' estates or the aids received from organization	1.88	86.93	1.93	90.5	1.98	94.08	0.71
6	My parents' estates or the aids received from organization are utilized properly in the home	2.05	90.65	1.98	85.23,	2.12	95.63	1.78
7	I carryout activities which I can do (e.g., washing plates in home)	1.57	71.08	1.85	93.09	2.05	107.33	19.7**
8	Someone encourages me to know and observe about how to perform important activities	2.03	94.97	1.8	77.95	2.08	98.58	7.14**
9	Someone advised (or kept) me to be clean	2.7	121.53	1.92	66.53	2.2	83.44	41.76**
10	I get advice on how to care for my health	2.43	90.5	2.38	89.05	2.48	91.95	0.12
H - test Value*	**Mean**	**22.68**		**19.97**		**21.05**		**31.37****
	Mean rank	**118.58**		**65.98**		**86.94**		

*$df = 2$
** $p < 0.05$ (two-tailed)

Ψ Range of scores for each item = 1-3 and for all items = 10-30
Ψ High score indicates high level of agreement on the item

As shown on Table 4.3, the *overall* mean rank differences among SOS (M=22.68, Mean rank=118.58), Non-Adera (M =19.97, Mean rank= 65.98) and Adera (M=21.05, Mean rank =86.94) groups in the provision of *material* care to the children were significant (*H =31.37, df = 2, p < 0.05, two- tailed*). Since Kruskal Wallis H -Test does not tell us how the three groups were different, the Mann-Whitney U - test of Two-Independent-Samples Test procedure need to be generated for pair-wise comparisons of the three groups. Thus, the post-hoc analyses using the Mann-Whitney U - test on Table 4.4 reveals which of the three groups was significantly different from the other in the provision of *material* care to children.

Table 4.4: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *material* care to children

Comparison	Groups	Mean rank	Sum of Ranks	U - test Value
Between SOS Village and Non-Adera	SOS Village (n=60)	77.67	4660	770*
	Non-Adera (n=60)	43.33	2600	
Between SOS Village and Adera	SOS Village (n=60)	71.41	4284.5	1145.5*
	Adera (n=60)	49.59	2975.5	
Between Non-Adera and Adera	Non-Adera (n=60)	53.15	3189	1359
	Adera (n=60)	67.85	4071	

* $p < 0.05$ *(two-tailed)*

Table 4.4 indicates that:

- there was significant ($U = 770$, $p < 0.05$, *two- tailed)* mean rank difference between SOS and Non-Adera groups. The SOS Village (M=22.68, Mean rank=77.67) has provided more *material* care to children than Non-Adera (M=19.97, Mean rank=43.33) care arrangement.
- there was significant ($U = 1145.5$, $p < 0.05$, *two- tailed)* mean rank difference between SOS and Adera groups. The SOS Village (M=22.68, Mean rank=71.41) has provided more *material* care to the children than Adera (M=21.05, Mean rank=49.59) care arrangement.
- significant difference was *not* found between Non-Adera (M=19.97, Mean rank=53.15) and Adera (M=21.05, Mean rank=67.85) care arrangements in the provision of *material* care to children.

Besides, the analyses results of *psychological* care provided to children in the three groups is presented on Table 4.5.

Table 4.5: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of *psychological* care to children

It. No.	Item $^{\Psi}$		SOS Village (n=60)		Non- Adera (n=60)		Adera (n=60)		H - test Value*
			Mean	Mean rank	Mean	Mean rank	Mean	Mean rank	
1	I am allowed to know and interact with my relatives		1.68	69.16	2	92.13	2.25	110.21	24.72**
2	Someone treats me when I feel sad		1.67	64.72	2.15	96.21	2.37	110.58	28.09**
3	I get advice about where and with whom I should spend my spare time		1.87	86.6	1.93	91.93	1.95	92.98	0.72
4	Someone follows me if I am studying my education		1.93	80.07	2.02	85.48	2.3	105.95	10.3**
5	I have person whom I discuss my day-to-day experiences (e.g., my school activities)		1.65	70.32	1.8	80.88	2.38	120.3	36.99**
6	I am informed to consider the home that I am living in as my own house		1.82	80.1	2.02	93.95	2.07	97.45	4.67
H – test Value*		**Mean**	**10.62**		**11.92**		**13.32**		**41.07****
		Mean rank	**60.05**		**90.9**		**120.55**		

*$df = 2$
** $p < 0.05$ *(two-tailed)*

$^{\Psi}$ Range of the scores for each item = 1-3 and for all the items = 6-18
$^{\Psi}$ High score indicates high level of agreement on the item

The Kruskal Wallis H - Test on Table 4.5 indicates that there were *overall* significant ($H = 41.067$, $df=2$, $p<0.05$, *two-tailed*) mean rank differences among SOS (M=10.62, Mean rank=60.05), Non-Adera (M=11.92, Mean rank=90.9) and Adera (M=13.32, Mean rank=120.55) groups in the provision of *psychological* care to children. Based on these differences, the Mann-Whitney U - test was generated to compare the three groups on the provision of *psychological* care to the children. Table 4.6 presents the comparison results of the three groups on the provision of *psychological* care to children.

Table 4.6: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *psychological* care to children

Comparison	Groups	Mean rank	Sum of Ranks	U - test value
Between SOS Village and Non-Adera	SOS Village (n=60)	49.5	2970	114*
	Non-Adera (n=60)	71.5	4290	
Between SOS Village and Adera	SOS Village (n=60)	41.05	2463	633*
	Adera (n=60)	79.95	4797	
Between Non-Adera and Adera	Non-Adera (n=60)	49.9	2994	1164*
	Adera (n=60)	71.1	4266	

* $p < 0.05$ *(two-tailed)*

Caparisons of the three groups on Table 4.6 depict that:

- there was significant (*$U = 114$, $p < 0.05$, two- tailed*) mean rank difference between SOS and Non-Adera groups. The Non-Adera group (M=11.92, Mean rank=71.5) has provided more *psychological* care to children than SOS group (M=10.62, Mean rank=49.5).
- significant (*$U = 633$, $p < 0.05$, two- tailed*) mean rank difference was found between SOS and Adera groups. The Adera group (M=13.32, Mean rank=79.95) has exceeded the SOS group (M=10.62, Mean rank=41.05) in providing *psychological* care to children.
- there was significant (*$U = 1164$, $p < 0.05$, two- tailed*) difference between Non-Adera and Adera groups. More than the Non-Adera (M=11.92, Mean rank=49.9), Adera group (M=13.32, Mean rank=71.1) has provided more *psychological* care to children.

B. Provision of Negative Treatments

Negative treatments of children have adverse impact on their proper survival, growth and development. Sixteen items related to the provision of negative treatments were responded by children in the three groups. The responses of the children to these items were analyzed using Kruskal Wallis H -Test to compare the three groups on the provision of negative treatments to children. The analyses results for the three groups on the provision of negative treatments are presented on Table 4.7.

Table 4.7 shows that there were *overall* significant ($H = 70.406$, *$p<0.05$, two-tailed*) mean rank differences among SOS (M=29.97, Mean rank=48.44), Non-Adera (M=35.35, Mean rank=127.48) and Adera (M=33.18, Mean rank=95.58) groups in the provision of *negative treatments* to the children. Accordingly, the Mann-Whitney U - test comparisons of each group on the provision of *negative treatment* to children is presented on Table 4.8.

Table 4.7: Mean scores and Kruskal Wallis H - test values for the three groups on the provision of negative treatments to children

It. No.	Item [Ψ]	SOS Village (n=60)		Non- Adera (n=60)		Adera (n=60)		H - test Value*
		Mean	Mean rank	Mean	Mean rank	Mean	Mean rank	
1	Most of the time I am not allowed to go to bed or obliged to wake up while I am asleep	1.95	78.63	2.18	95.43	2.22	97.45	6.06**
2	Most of the time I am spanked and pinched	1.95	73.51	2.32	100.96	2.27	97.03	12.37**
3	Most of the time I am discriminated in the home	1.88	75.78	2.33	107.25	2.07	88.47	13.13**
4	Most of the time when a property is lost in the home, it is considered that I am responsible for it	1.97	80.47	2.23	99.62	2.12	91.42	4.92
5	Most of the time I am going to school without doing my school homework	1.77	58.53	2.52	111.88	2.37	101.08	43.41**
6	I repeatedly become absent from school	1.37	54.02	2.3	113.33	2.15	104.16	51.24**
7	No one cares for me if I quarrel or fight with others	1.9	103.4	1.82	95.22	1.48	72.88	13.41**
8	No one prohibits me if I drink alcohol or smoke cigarette	1.53	80.01	1.88	103.91	1.63	87.58	8.06**
9	Most of the time I am scolded in the home	2.13	86.17	2.33	100.35	2.1	84.98	4.03
10	There are persons who speak that I am the cause for my parents' death	2.17	82.97	2.18	85.82	2.42	102.72	6.15**
11	The estates inherited from my parents are found in the hands of different individuals	2.27	107.97	1.9	81.68	1.9	81.85	12.99**
12	Different individuals steal my parents' estates	1.95	89.13	2.22	107.25	1.75	75.13	13.88**
13	I am ordered to carryout heavy physical work at home, farming and business places	1.75	63.19	2.32	99.29	2.45	109.02	29.7**
14	I am obliged to serve passerby through my labor	1.78	76.14	2.23	107.63	1.95	87.73	13.9**
15	Whenever I get sick, it is taken as a lame excuse on my part	2.07	84.67	2.32	101.72	2.06	85.12	5.01
16	Most of the time I am obliged to eat spoiled food	1.53	58.02	2.27	107.26	2.25	106.23	41.32**
H – test Value*	**Mean**	**29.97**		**35.35**		**33.18**		**70.41****
	Mean rank	**48.44**		**127.48**		**95.58**		

*$df = 2$
** $p < 0.05$ (two-tailed)

[Ψ] Range of the scores for each item = 1-3 and for all the items = 16-48
[Ψ] High score indicates high level of agreement on the item

Table 4.8: The Mann-Whitney U - test multiple comparisons of the three groups on the provision of *negative treatments* to children

Comparison	Groups	Mean rank	Sum of Ranks	U - test Value
Between SOS Village and Non-Adera	SOS Village (n=60)	34.34	2060.5	230.5*
	Non-Adera (n=60)	86.66	5199.5	
Between SOS Village and Adera	SOS Village (n=60)	44.6	2676	846*
	Adera (n=60)	76.4	4584	
Between Non-Adera and Adera	Non-Adera (n=60)	71.33	4279.5	1150.5*
	Adera (n=60)	49.68	2980.5	

* $p < 0.05$ *(two-tailed)*

The pair-wise comparisons of the three groups in providing *negative treatment* to children on Table 4.8 indicate that:

- significant ($U = 230.5$, $p < 0.05$, *two- tailed)* mean rank difference was found between SOS and Non-Adera groups. The Non-Adera group (M=35.35, Mean rank=86.66) has provided more *negative treatment* to children than SOS Village (M=29.97, Mean rank=34.34).
- there was significant ($U = 846$, $p < 0.05$, *two- tailed)* mean rank difference between SOS and Adera groups. More than SOS Village (M=29.97, Mean rank=44.6), Adera group (M=33.18, Mean rank=76.4) has provided more *negative treatment* to children.
- there was significant ($U = 1150.5$, $p < 0.05$, *two- tailed)* mean rank difference between Non-Adera and Adera groups. The Non-Adera group (M=35.35, Mean rank=71.33) has provided more *negative treatment* to children than that of the Adera group (M=33.18, Mean rank=49.68).

Consolidating these results, the number of days children of the three groups have become late and absent from school as provisions of care and support to children indicates that children in Non-Adera and Adera groups become late and absent from school more days than children in SOS group. Children were asked a close-ended question to state the average number of days they have become late from school in a week. The responses of the children to this question are summarized on Table 4.9.

Table 4.9: Average number of days children of the three groups have become late from school in a week

Average no. of days children become late in a week from school	Group		
	SOS Village (n=60)	**Non-Adera** (n=60)	**Adera** (n=60)
None of the days	50	28	36
One day	8	16	11
Two days	2	10	9
Three and above days	0	6	4

As indicated on Table 4.9, from the 60 children in each group, 50 children in SOS, 28 children in Non-Adera and 36 children in Adera groups have become late *none* of the days in a week from their schools. Eight children in SOS, 16 children in Non-Adera and 11 children in Adera groups have become late *one* day in a week. Besides, two children in SOS, 10 children in Non-Adera and nine children in Adera groups have become late *two* days in a week. Finally, six children in Non-Adera and four children in Adera groups have become late *three and above* days in a week. These imply that more children in Non-Adera and Adera groups have become late from their school than children in SOS group, which shows the provision of *negative* educational treatment to children.

In addition, the number of days children of the three groups become absent from their schools in a semester also shows similar trend. Data on the number of days children have become absent from their schools in a semester were gathered from their second semester (2009 academic year) records. These data are summarized on Table 4.10.

Table 4.10: Number of days children of the three groups become absent from their schools in second semester of 2009 academic year

Category	Group		
	SOS Village (n= 59)	**Non-Adera** (n=57)	**Adera** (n=58)
Minimum	0	0	0
Maximum	3	15	11
Mean	0.41	2.77	2.31
Standard deviation	0.79	3.01	2.44

As indicated on Table 4.10, children in Non-Adera and Adera groups become absent more days from their schools in the semester than children in SOS group, which also indicates the provision of *negative* educational treatment to children.

The data collected through Observation Checklist of the physical cleanliness of children in the three groups supplement the above results that children in SOS group were relatively cleaner in their physique than children in Non-Adera and Adera groups. Results of the physical cleanliness observation of children in the three groups are presented on Table 4.11.

Table 4.11: Physical cleanliness of children in the three groups

It. No.	Item	SOS Village (n=60)		Non-Adera (n=60)		Adera (n=60)	
		Yes	No	Yes	No	Yes	No
1	Does the child's hair has pest or grime?	0	60	8	52	6	54
2	Does the child has cut fingernails?	0	60	5	55	1	59
3	Does the child has untreated body scare or fracture?	0	60	4	56	1	59
4	Does the child has unrepaired shoe or unprotected foot?	0	60	7	53	3	57
5	Does the child has tattered or dirty cloths?	0	60	4	56	5	55
Total		**0**	**300**	**28**	**272**	**16**	**284**

The observation results of some indicators of the children's physical cleanliness on Table 4.11 entails that all the 60 children in SOS group have relatively clean hair, properly handled fingernails, physical body, shoe and cloth. From the 60 children in Non-Adera and Adera groups, eight children in Non-Adera and six children in Adera groups have pest or grimy hair; five children in Non-Adera and one child in Adera groups have improper (or uncut) fingernails; four children in Non-Adera and one child in Adera groups have untreated body fracture or scare; seven children in Non-Adera and three Adera groups have unprotected foot, and four children in Non-Adera and five children in Adera groups have tattered or dirty cloth. Based on these indicators, children in SOS Village were physically cleaner than children in Non-Adera and Adera groups. This supports the above results that children in Non-Adera and Adera groups were provided more *negative treatment* than children in SOS group.

Furthermore, the interviews with guardians pointed that children in Non-Adera and Adera groups were not provided adequate food, clothes and educational materials than children in SOS Village. These were illustrated below by the Non-Adera, Adera and SOS group interviewees:

> *I was providing food and clothes, and buying exercise books, pen and pencil to her [the child] from the income I get by baking bread and selling tella [local drink] and enjera [local food] ... Sometimes when the market of tella and enjera is low and when I become ill, I asked relatives to provide food to her for some days. ...but now she dropped out from grade seven due to the problem of school uniform.*
>
> (Interview, Non-Adera guardian, Kebele 01, Debre Markos Town)

> *...they [children] are provided clothes, shoe and educational materials from their bank saving account, which their father has been saving with their name when he was alive. Now the Birr is becoming low, I do not know what I shall do after the money is finished.*
>
> (Interview, Adera guardian, Kebele 03, Debre Markos Town)

> *...they [children] are provided breakfast, lunch, snack and dinner in a day, as per the food menu of the week. They have two school uniforms and bedclothes and provided clothes twice a year. They have school assistant teachers in the Village. They get medical and health care services from the Village's nurses.*
>
> (Interview, SOS Village guardian, Bahir Dar Town)

These and most other interviews imply that children in SOS group were provided relatively adequate food, cloth, and educational materials and assistances than children in Non-Adera and Adera groups.

The above analyses on the provisions of positive care and negative treatment to children imply that children in SOS group were provided more *material* care (e.g., fulfillment of food, clothes, educational materials, medical care services, etc.) than children of the Adera group; and children of the Adera group were provided more *material* care than children of the Non-Adera group. In the other aspect, children in Adera and Non-Adera groups were provided more *psychological* care (e.g., emotional support, advising, supervision, etc.) than children in SOS group. Regarding the provision of *negative treatments*, children in Non-Adera group

were provided more *negative treatments* (e.g., spanking, school dropout, property grabbing, discrimination, scolding, etc.) than children in Adera group; and children in Adera group were provided more of such treatments than children in SOS Village.

4.3. Commitment of Guardians to Care and Support

The other intent of the study was to compare the three groups on the commitment of guardians in caring and supporting of the children. To achieve this, the guardians' efforts in meeting needs of the children, feeling of honor and delight in caring of the children, and dedication in helping the children to have good conduct were rated by children of the three groups. The responses of the children were categorized under three levels (low, medium and high) of guardians' commitment. Then, the levels of commitment of guardians for the three groups were analyzed using Chi-square test and are presented on Table 4.12.

Table 4.12: Chi-square test results for the three groups on the levels of commitment of guardians to care and support

Levels of commitment	**SOS Village** (n=60)			**Non-Adera** (n=60)			**Adera** (n=60)			*df*	x^2 - *test Value*
	Obs*	%	Exp	Obs*	%	Exp	Obs*	%	Exp		
Lower	**17**	28.3	10.3	**10**	16.7	10.3	**4**	6.7	10.3	4	*60.48***
Moderate	**40**	66.7	33	**41**	68.3	33	**18**	30	33		
Higher	**3**	5	16.7	**9**	15	16.7	**38**	63.3	16.7		

* 'Obs' and 'Exp' represent 'Observed' and 'Expected' frequencies, respectively
**$p < 0.05$ *(two-tailed)*

The Chi-square test on Table 4.12 indicates that the differences among number of children in the three groups in the levels of commitment of guardians to care and support were significant ($x^2 = 60.48$, $df = 4$, $p < 0.05$, *two-tailed*). Based on this, 17 (28.3 %) children in SOS, 10 (16.7%) children in Non-Adera and four (6.7 %) children in Adera groups were found in the *lower level* of guardians' commitment. Similarly, 40 (66.7 %) children in SOS, 41 (68.3%) children in Non-Adera and 18 (30 %) children in Adera groups were found in the *moderate level* of guardians' commitment. Finally, three (5 %) children in SOS, nine (15 %) children in Non-Adera and 38 (63.3 %) children in Adera groups were found in the *higher level* of guardians' commitment. These imply that children in SOS, Non-Adera and Adera

groups found lower, moderate and higher levels of commitment of in their guardians, respectively.

Besides, some guardians of the children in the three groups were interviewed about the extent to which they invest their effort in correcting the children's misconduct or how much they would permit children to live with them if the children repeatedly show misconduct. The responses of guardians in Adera and SOS groups clearly explicate the above results that guardians in Adera and SOS groups have higher and lower levels of commitment, respectively, in caring and supporting of the children. Consider the following interviews:

> *I will not abandon her [the child] until I am deceased even her conduct is not good for me. I will invest all my efforts to make her successful in her education and life, because she is the reminiscence of my deceased son.*
>
> (Interview, Adera guardian, Kebele 07, Debre Markos Town)

> *I plea them [the children] to properly manage their conduct as far as I am their guardian, but... if they do not recognize my advice I make them to be given warning that they might leave me, again, if they do not manage their conduct after they have given warnings, I make them to be substituted by other family children.*
>
> (Interview, SOS guardian, Bahir Dar Town)

These interview transcriptions signify that the guardian in Adera group can pay scarifications to help the child to be self-reliant even when the she behaved misconduct. On the other hand, the guardian in SOS group was not in a position to do so rather it transferred the children to another body in correcting their misconduct.

4.4. Attachment Styles of the Children

Fifteen attachment related behaviors were presented to children to rate whether the behaviors are found in their interactions with the guardians. The responses of the children to these items were classified under the three styles of attachment (secure, anxious and avoidant). Based on the scores of the children in the three groups, each attachment style was labeled under 'high' and 'low' categories for identifying the styles of attachment that children in three groups have exhibited. Table 4.13 presents the Chi-square test analyses results for the three groups on the attachment styles of the children.

Table 4.13: Chi-square test results for the three groups on attachment styles of the children

Group	Statistics	Secure Attachment		Anxious Attachment		Avoidant Attachment	
		Low	High	Low	High	Low	High
SOS Village (n=60)	**Observed**	**31**	**29**	**18**	**42**	**9**	**51**
	%	51.7	48.3	30	70	15	85
	Expected	19.3	40.7	14.3	45.7	18.3	41.7
Non-Adera (n=60)	**Observed**	**17**	**43**	**9**	**51**	**23**	**37**
	%	28.3	71.7	15	85	38.3	61.7
	Expected	19.3	40.7	14.3	45.7	18.3	41.7
Adera (n=60)	**Observed**	**10**	**50**	**16**	**44**	**23**	**37**
	%	16.7	83.3	26.7	73.3	38.3	61.7
	Expected	19.3	40.7	14.3	45.7	18.3	41.7
x^2- test Value*		***17.45****		***4.09***		***10.26****	

$*p < 0.05$ (two-tailed) ** *df = 2*

Table 4.13 depicts that there were significant (χ^2 = *17.45, df = 2, p < 0.05, two-tailed)* differences among the numbers of children in the three groups in *secure* child-guardian attachment style. This indicates that more children in Adera group (50, 83.3 %) exhibited high secure attachment than children in SOS (29, 48.3 %) and Non-Adera (43, 71.7%) groups. Besides, significant (χ^2 = *10.26, df = 2, p < 0.05, two-tailed)* differences among SOS, Non-Adera and Adera groups were found in the *avoidant* attachment style. More than the number children in Adera (37, 61.7 %) and Non-Adera (37, 61.7 %) groups, many children in SOS group (51, 85 %) exhibited high avoidant attachment style. These imply that more than children of the other groups, SOS group children were avoidantly attached with their guardians. No significant difference, however, was found in the *anxious* attachment style of the children.

Additionally, guardians in the three groups were asked to describe their interactions with the children. They were asked, for example, to describe or show the level of their agreement to the statements: '*When the child feels hungry or sick he/she does not inform me*'; and '*When the child commit mistake, I inform other people to advice him or her*'. The responses of guardians to these statements showed mixed patterns in that there were guardians in SOS, Non-Adera and Adera groups who described that they have both distant and close forms

relationships with their children. Consider the following two interview transcriptions in each group.

He [child] feels ease to talk to me when he become hungry and quarreled with his friends; he considers me as his mother in every respect.

(Interview, SOS guardian, Bahir Dar Town)

Sometimes, I gave advice to the 7th grader through other guardians in the Village, because he [child] does not respect me.

(Interview, SOS guardian, Bahir Dar Town)

He [child] is free to talk with me but, when I talk angrily, he cried and feels sad easily. Even though he is sad, he does not give-up food and with this, I am much happy.

(Interview, Non-Adera guardian, Kebele 03, Debre Markos Town)

He [child] does not directly tell his hunger and sadness to me. But, I know his feelings from his physical acts and facial expressions (for instance, when he is hungry he bends his head and shows sad feeling).

(Interview, Non-Adera guardian, Kebele 02, Bahir Dar Town)

They [children] are free to disclose their problems for me; they are free to ask me to eat enjera [local food]. After their school, they became irritated when they do not found me in the home ....

(Interview, Adera guardian, Kebele 02, Debre Markos Town)

She [child] is reserved to talk her illness for me. I initiate her to tell her feelings to me; I think this is because of her nobility to the home.

(Interview, Adera guardian, Kebele 04, Bahir Dar Town)

These two interviews in each group and most others showed mixed patterns in that some children feel ease and some others feel uncomfortable to relate or tell their feelings to their guardians. Thus, no particular relationship pattern was identified among the interviews of guardians in the three groups.

4.5. Academic Performances of the Children

The provisions of educational care and support to the children in the three groups were described and compared earlier in section 4.2 of the paper. It was indicated that children in SOS group seems to be provided more educational facilities and assistances than children in Adera and Non-Adera groups. Now in this section, the academic performances of the children in the three groups are analyzed and compared as the *child-behavior outcomes* of care and support.

The 2009 (second semester) academic scores of the children were collected from their school records for comparing the three groups on the academic performances of children. The academic scores of 174 children who were found between grade one and 10 were collected. The academic performances of children in the three groups were categorized into three grade cycles: primary school first cycle (grade 1-4), primary school second cycle (grade 5-8) and secondary school (grade 9-10). Table 4.14 summarized the number of children found under the categories of the three grade cycles.

Table 4.14: Number of children under primary school first cycle, primary school second cycle and secondary school grade categories

Grade Cycle	SOS Village (n=59)	Non-Adera (n= 57)	Adera (n= 58)	Total
Primary school first cycle (grade 1-4)	27 (34.6%)	28 (35.9%)	23 (29.5%)	78 (100%)
Primary school second cycle (grade 5-8)	24 (33.8%)	22 (31%)	25 (35.2%)	71 (100%)
Secondary school (grade 9-10)	8 (32%)	7 (28%)	10 (40%)	25 (100%)

Table 4.14 reveals that 27 (34.6 %) children in SOS, 28 (35.9 %) children in Non-Adera and 23 (29.5 %) children in Adera groups were found between grade one and four. Likewise, 24 (33.8 %) children in SOS, 22 (31 %) children in Non-Adera and 25 (35.2%) children in Adera groups were found between grade nine and ten. Finally, there were 8 (32 %) children in SOS, 7 (28 %) children in Non-Adera and 10 (40 %) children in Adera groups in grade nine and 10. Based on these categories of grade cycles, the differences of the three groups in

the academic performances of the children were analyzed by using Kruskal Wallis H - Test and the results of the analyses are presented on Table 4.15.

Table 4.15: Mean scores and Kruskal Wallis H - test values for the three groups on academic performances of children

Grade Cycle	**SOS Village** (n=59)		**Non-Adera** (n= 57)		**Adera** (n= 58)		**H -test Value***
	Mean	Mean rank	Mean	Mean rank	Mean	Mean rank	
Primary school first cycle (grade 1-4)	65.33	32.57	68.13	36.38	77.14	51.43	9.44**
Primary school second cycle (grade 5-8)	66.58	28.42	70.61	36.11	74.42	43.18	6.27**
Secondary school (grade 9-10)	65.39	10.06	72.79	15.57	71.89	13.55	2.19

**df = 2* ** $p < 0.05$ *(two-tailed)*

Table 4.15 depicts that there were significant ($H = 9.44$, $df = 2$, $p < 0.05$, *two- tailed*) *overall* mean rank differences among the primary school first cycle children of SOS (M =65.33, Mean rank= 32.57), Non-Adera (M=68.13, Mean rank=36.38) and Adera (M =77.14, Mean rank= 51.43) groups. Similarly, the *overall* mean rank differences among primary school second cycle children of SOS (M=66.58, Mean rank=28.42), Non-Adera (M =70.61, Mean rank= 36.11) and Adera (M=74.42, Mean rank =43.18) groups were significant ($H = 6.27$, $df = 2$, $p < 0.05$, *two- tailed*). The H-value indicates, however, that no significant differences among *secondary school* children of the three groups. Accordingly, analyses of pair-wise comparisons of the three groups using the Mann-Whitney U - test on Table 4.16 reveals which of the three groups was significantly different from the other on the academic performances of primary school first and second cycle children.

Table 4.16: The Mann-Whitney U - test multiple comparisons of the three groups on academic performances of children under primary school first and second cycle grade categories

Grade Cycle	Comparison	Groups	Mean rank	Sum of Ranks	U - test Value
Primary school first cycle (grade 1-4)	Between SOS Village and Non-Adera	SOS village (n=27)	26.22	708	330
		Non-Adera (n=28)	29.71	832	
	Between SOS Village and Adera	SOS village (n=27)	20.35	549	171*
		Adera (n=23)	31.54	725	
	Between Non-Adera and Adera	Non-Adera (n=28)	21.16	592.5	186.5*
		Adera (n=23)	31.89	733.5	
Primary school second cycle (grade 5-8)	Between SOS Village and Non-Adera	SOS village (n=24)	20.83	500	200
		Non-Adera(n=22)	26.41	581	
	Between SOS Village and Adera	SOS village (n=24)	20.08	482	182*
		Adera (n=25)	29.72	743	
	Between Non-Adera and Adera	Non-Adera (n=22)	21.2	466.5	213.5
		Adera (n=25)	26.46	661.5	

* *$p < 0.05$ (two-tailed)*

The pair-wise comparisons using the U - test values on Table 4.16 indicate that:

- there was no significant mean rank difference between SOS (M=65.33, Mean rank=26.22) and Non-Adera (M =68.13, Mean rank= 29.71) groups in academic performances of *primary school first cycle* children.
- there was significant *(U =171, $p < 0.05$, two- tailed)* mean rank difference between the *primary school first cycle* children of SOS and Adera groups. The primary school first cycle children in Adera group (M =77.14, Mean rank= 31.89) were better in their academic performance than those children SOS group (M =68.13, Mean rank= 20.35).
- significant difference was not found between SOS (M =68.13, Mean rank= 20.83) and Non-Adera (M =68.13, Mean rank= 26.41) groups in the *primary school second cycle* children's academic performances.
- there was significant (*U =182, $p < 0.05$, two- tailed*) difference between SOS and Adera groups in the academic performances of *primary school second cycle* children. The primary school second cycle children of SOS (M=66.58, Mean rank=20.08) lesser on their academic performance than their counterparts Adera group (M=74.42, Mean rank =29.72).
- no significant difference was found between Non-Adera (M =70.61, Mean rank= 21.2) and Adera (M=74.42, Mean rank =26.46) group *primary school second cycle* children.

These imply that primary school first cycle children of Adera group seem to be better in their academic performance than their counterparts in SOS and Non-Adera groups. Besides, primary school second cycle children in Adera group were better in their academic performance than those children in SOS group. On the other hand, the academic performance of primary school second cycle children in Adera group was not significantly different from the Non-Adera group. Finally, it was found that the academic performances of primary school first and second cycle children in SOS and Non-Adera groups were not different.

4.6. Resilience of the Children

The other valuable intent of the study was comparing the three groups on resilience of the children. To achieve this aim, the degree of children's recovery from parental mourning and grief or manifestation of positive outcomes and competences under adverse situations were assessed through nine items intended to measure resilience of the children. Based on responses of the children, the differences among the three groups in children's resilience were analyzed by using Kruskal Wallis H - Test and are presented on Table 4.17.

Table 4.17 shows that the *overall* mean rank differences among SOS (M=16.73, Mean rank=73.9), Non-Adera (M =17.32, Mean rank= 84.68) and Adera (M=18.72, Mean rank =112.93) groups in resilience of the children were significant ($H = 18.219$, $df = 2$, $p < 0.05$, *two- tailed*). Based on these overall significant differences, the post-hoc analyses using the Mann-Whitney U - test on Table 4.18 reveal which of the three groups was significantly different from the other in resilience of the children.

Table 4.17: Mean scores and Kruskal Wallis H - test values for the three groups on resilience of the children

It. No.	Item Ψ	SOS Village (n=60)		Non-Adera (n=60)		Adera (n=60)		H -test Value*
		Mean	Mean rank	Mean	Mean rank	Mean	Mean rank	
1	I can achieve my goals despite the problem I have faced	1.6	69.77	1.85	86.73	2.28	115.01	27.09**
2	I believe that I can still be successful in my education despite shortage of school materials	1.8	84.06	1.83	86.58	2.05	100.86	4.25
3	I have recovered from my grief and mourning	1.67	76.87	1.87	89.85	2.1	104.78	9.91**
4	I adapt easily to situations in my day-to-day life	1.82	84.83	1.9	90.45	1.98	96.22	1.68
5	I do not cease my activities even when things look hopeless	1.83	82.27	1.83	82.8	2.2	106.43	9.69**
6	I can surpass successfully if I experience stigma and discrimination due to my parents' death	1.87	76.05	2.12	91.78	2.3	103.68	9.71**
7	I have passed different challenges in my life	2.25	102.73	1.85	76.13	2.1	92.65	9.23**
8	If I face problems beyond my capacity, I consult other persons who can assist me	2.02	87.13	2.23	102.74	1.93	81.63	6.55**
9	I can think properly even when I am under pressure and stress situations	1.88	93.74	1.83	91.37	1.77	86.39	0.794
H - test Value*	Mean	16.73		17.32		18.72		18.219**
	Mean rank	73.9		84.68		112.93		

*$df = 2$
** $p < 0.05$ *(two-tailed)*

Ψ Range of the scores for each item = 1-3 and for all the items = 9-27
Ψ High score indicates high level of agreement on the item

The U - test multiple comparisons on Table 4.18 about resilience of the children in the three groups indicate that:

- there was no significant difference between SOS (M=16.73, Mean rank=56.74) and Non-Adera (M =17.32, Mean rank= 64.26) groups in resilience of the children.
- there was significant *(U =1029.5, $p < 0.05$, two- tailed)* difference between the children of SOS and Adera groups. Children in Adera group (M=18.72, Mean rank =73.34) were more resilient than children in SOS group (M=16.73, Mean rank=47.66).
- significant *(U =1225, $p < 0.05$, two- tailed)* difference was found between children of the Non-Adera and Adera groups. Children in Adera group (M=18.72, Mean rank =70.08) were more resilient than children in Non-Adera group (M =17.32, Mean rank= 64.26).

Table 4.18: The Mann-Whitney U - test multiple comparisons of the three groups on resilience of the children

Comparison	Groups	Mean rank	Sum of Ranks	U - test Value
Between SOS Village and Non-Adera	SOS Village (n=60)	56.74	3404.5	1574.5
	Non-Adera (n=60)	64.26	3855.5	
Between SOS Village and Adera	SOS Village (n=60)	47.66	2859.5	1029.5*
	Adera (n=60)	73.34	4400.5	
Between Non-Adera and Adera	Non-Adera (n=60)	50.92	3055	1225*
	Adera (n=60)	70.08	4205	

* $p < 0.05$ *(two-tailed)*

These imply that children in Adera group seem to be advantageous in their resilience than children in Non-Adera and SOS groups. But, the U-test value on Table 4.18 reveals there no significant difference between SOS and Non-Adera groups in resilience of the children.

Evidently the interviews with guardians of SOS, Non-Adera and Adera groups supplement these results. Consider the following interviews:

> *He [the child] remembers his mother more frequently than his father... he become exasperated when he hears his mother's name, 'Ketema'. One day, he angrily crashed the TV when he listen the name 'Ketema' on the TV.*
>
> (Interview, SOS Village guardian, Bahir Dar Town)

> *The fourth grade brother has cried frequently when he wakes-up in every morning. Although we did not tell him about our parents' death, he was found repeatedly in the burial place of our parents.*
>
> (Interview, Non-Adera guardian, Kebele 07, Bahir Dar Town)

> *He [the child] is much stronger... he repeatedly tell me his vision to be a big man. He prepared 'mekerkeria' [a small box made-up of cheap-wood used for putting coins] and saves money from the coins he received from the relatives for buying play materials.*
>
> (Interview, Adera guardian, Kebele 03, Debre Markos Town)

These interviews illustrate that children in Adera group seem to be recovered from their parental grief and manifested positive outcomes than children in SOS and Non-Adera groups.

V. DISCUSSIONS AND SUMMARY

This study was primarily intended to describe and compare the SOS Village, Non-Adera and Adera care arrangements in caring and supporting orphaned children. In accordance with these major goals, five basic research questions related to the *provisions*, *process* and *child-behavior outcomes* of care and support were formulated to be answered by the study. Now, it is time to discuss and summarize the answers to these questions based on the analyses of the data in part four of the paper.

5.1. Provisions of Care and Support

The first basic research question of the study was "are there significant differences among children of the three care arrangements in the *provisions* of care and support they received?". In answering this question, provisions of care and support to children was categorized into positive and negative forms of care and support. Based on this, the study indicated that children in SOS Village were provided more *material* care than children in Non-Adera and Adera care arrangements. The SOS Village children seem to be secured in terms of the provision of their daily foods, cloths, educational materials and medical care services. In line with this finding, Tsige (2007) reported that the living standards of children in SOS Village were high in that they were well fed, clothed and sheltered. Children in SOS Village, for instance, get four meals in a day and adequate medical services (SOS International, 2009).

In addition to the provision of material needs, caring of children consists of the provision of psychological care (Myers, 1992). In relation to the provision of this aspect of care, this study showed that children in Adera care arrangement seem to be provided more *psychological* care than children in SOS Village and Non-Adera care arrangements. Compared to the children in Non-Adera and SOS Village, Adera given children were provided more emotional support, advising and supervision. Belay (2007), Kassa (2006) and Yigzaw (2009) also reported that Adera recipients (guardians) render advising and sympathy, provide follow-up, and reconciling services to the children. On the other hand, compared to the Non-Adera care arrangement, children in SOS Village were provided lesser psychological care. Although SOS Village follows a family care style to provide more individualized emotional support to

children, its children were not actually get adequate psychological care as compared to Adera and Non-Adera care arrangements. Coinciding with this result, SOS Village children in Tsige's (2007) study reported that they were not trusted by their guardians. Tsige also indicated that some SOS mothers were not as loving as they were expected by the Village.

Regarding the provision of negative forms of care and support to children, the study reveals that children in Non-Adera and Adera care arrangements seem to be provided more negative treatments than children in SOS Village. Further, Non-Adera given children were provided more negative treatments than Adera given children. Comparatively, more negative forms of care (e.g., spanking and pinching, repeated school absenteeism, property grabbing, heavy physical work, delayed medical treatments, discrimination, and scolding) were provided in Non-Adera and Adera care arrangements than SOS Village. This indicates that although children in SOS Village have experienced some corporal punishment and heavy physical work (Tsige, 2007), the provision of these and other negative forms of care were pronounced more in children of Non-Adera and Adera care arrangements. In fact, since Adera and Non-Adera care giving systems are found in the childcare systems of the community, the provision of more negative forms of care and support to children in these care arrangements could partly be explained in relation to the routine child rearing practices of the Country where the provision of corporal punishment and heavy physical work are used as methods of disciplining by parents and teachers (Daniel & Gobena, 1997; Dessalegn, 1998; Seleshi, 2001; Yoseph et al., 2006).

More interestingly, the study showed that children in SOS Village were provided more material care than children in Adera and Non-Adera care arrangements. In addition, children in Adera and Non-Adera care arrangements were provided more psychological care than children in SOS Village. Contrary to these results, the study also revealed that children in SOS Village were provided lesser psychological care than children in Adera and Non-Adera care arrangements; and children in Non-Adera and Adera care arrangements were provided more negative forms of care than children in SOS Village. In fact, the two results are not contradictory in their nature as the provisions of positive and negative forms of care to children are *not mutually exclusive*. That is, a caregiver who provides positive care (e.g.,

food, cloth, emotional support, supervision, etc.) to a child does not *necessarily* mean (guarantee) that he or she does (or can) not provide negative care (e.g., physical punishment, pinching, scolding, etc.) to the child, and *vice versa*.

Generally, answers to the above stated basic research question could be summarized as follows.

- In the provision of positive forms of material and psychological care and support:
  - The SOS Village has provided more *material* care to children than Non-Adera and Adera care arrangements.
  - Significant difference was *not* found between Non-Adera and Adera care arrangements in the provision of *material* care to the children.
  - The Non-Adera group has provided more *psychological* care to children than SOS group.
  - The Adera group has exceeded the SOS and Non-Adera groups in providing *psychological* care to children.
- In the provision of negative forms care and support:
  - The Non-Adera group has provided more *negative treatments* to children than SOS Village and Adera groups.
  - More than SOS Village, Adera group has provided more *negative treatments* to children.

5.2. Process of Care and Support

The second major research question of the study, which was considered as the *process* of childcare and support, was "are there significant differences among guardians of the three care arrangements in their *levels of commitment* in caring and supporting of the children?". In this regard, the study revealed that guardians in Adera, Non-Adera and SOS Village care arrangements were in the higher, moderate and lower levels of commitment in caring and supporting of their orphaned children, respectively. The study indicated that guardians in Adera care arrangement felt more honored in caring the children, reported to invest more efforts to meet needs of the children and help the children to have good conduct, and were more delighted by their provision of care to the children.

The higher level of guardians' commitment in Adera care arrangement could be ascribed to the:

- **Socio-cultural values attached to the practice of Adera**: Adera giving of children has high social and cultural values that failure to fulfill the responsibilities on the part of Adera recipient has social sanctions (Belay, 2007) from various forms of 'traditional' social welfare gatherings, associations, and institutions (such as mahiber, senbete, idir, etc.) (Belay, 2008).
- **Religious values attached to the practice of Adera**: As children are God given creatures and as different religious Personalities transfer their children in the name of the Holy Spirit to another person, followers of different religious beliefs (e.g., Christian and Islam) fear the sin of the Lord by not committing themselves to the entrusted responsibilities.

In relation to the lower level of commitment of guardians in SOS Village, children of SOS Village in Tsige's (2007) study reported that their SOS mothers were working for their salary in that they do not have the readiness and psychological makeup to function as a 'mother'.

5.3. Child-behavior Outcomes of Care and Support

A. Attachment Styles of the Children

The third basic research question devised to be answered by the study was "are there significant differences among children of the three care arrangements in their attachment style?". Regarding this question, the study showed that Adera care arrangement children seem to be securely attached with their guardians than children in SOS Village and Non-Adera care arrangements. Adera given children reported that they were happier and more comfortable in their interactions with their guardians than children in Non-Adera and SOS Village care arrangements. In relation to this result, Kassa (2006) has reported that Adera given children felt ease to relate with their guardians and as a result established emotional closeness more easily with their guardians.

On the other hand, the study indicated that children in SOS Village, seem to have *avoidant* attachment with their guardians than children in Adera and Non-Adera care arrangements. Children in SOS Village reported that they found uncomfortable when they met their guardians, felt tight when their guardians want to be very close with them, did not want to stay in home with their guardian and did not trust their guardians. A study conducted on the attachment of children reared in institutional and community home settings in Romania also indicates that children reared in institution exhibited disturbances of attachment with their caregivers (Zeanah et al., 2005). More interestingly, Zeanah and its colleague reported that many children reared in institutional setting have disorganized attachments with their caregivers. Furthermore, Tsige has indicated that mothers in SOS Village were more distant in their feelings to their children in that they do no treat and accept the children as their own.

B. Educational Performances of the Children

The fourth major research question of the study was "are there significant differences among children of the three care arrangements in their academic performance?". To answer this question, the academic performances of the children were categorized into three grade cycles: primary school first cycle (grade 1-4), primary school second cycle (grade 5-8) and secondary school (grade 9-10). Accordingly, this study indicated that primary school *first* cycle children of Adera care arrangement were better in their academic performance than their counterparts in SOS and Non-Adera care arrangements. Besides, primary school *second* cycle children in Adera care arrangement were better in their academic performance than SOS care arrangement. However, the academic performance of primary school *second* cycle children in Adera care arrangement was not different from the Non-Adera arrangement. Furthermore, it was found that the academic performance of primary school *first* and *second* cycle children in SOS and Non-Adera care arrangement were not different. This follows that although children in SOS Village were provided more educational facilities and support than children in Adera and Non-Adera care arrangements, their academic performances were lesser than children in the other two care arrangements. Tsige (2007), in her comparison of the academic achievements of SOS and home reared children, has also reported that SOS children were lesser in their academic achievement than the home reared children.

C. Resilience of the Children

Resilience of children – performance of good outcomes despite high-risk status, sustained competence under threat and recovery from trauma – are important functioning areas to children living in adverse conditions (Boyden & Cooper, 2007). The last but the valuable basic research question, "are there significant differences among children of the three care arrangements in their resilience?", was devised as child-behavior outcomes of care and support in the children. In this regard, this study showed that children in Adera care arrangement seem to be more advantageous in their resilience than children in SOS and Non-Adera care arrangements. Adera given children reported that they have the belief that they can achieve their goals despite the problems they have faced, have recovered from their parental mourning and grief, do not cease from their activities even when things look hopeless to them, and can surpass successfully if they experience stigma and discrimination due to parental death. As these children were reared in the home environment within the community, this result agrees with Abebe's (cited in Abebe, 2009, p. 87) report that street children (living with their parents) were more adjusted and have more coping mechanisms than their counterparts in SOS Village. Bridging Abebe's report with the result of this study, Yigzaw (2009) has compared the resilience of Adera and Non-Adera given children and has reported that Adera given children were more advantageous in terms of their resilience to adverse events than the Non-Adera given children.

VI. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study has described and compared the provisions of care and support to children, the commitment of guardians in caring and supporting of the children, and the attachment styles, academic performances and resilience of the children. As a result, the following conclusions were drawn from the study.

i. **Provisions of Care and Support**: Children in SOS Village seem to be more secured in terms of the provisions of their daily foods, cloth, educational materials and facilities, and medical care services than children in Adera and Non-Adera care arrangements. Children in Adera care arrangement, however, seem to be provided more psychological care such as emotional support, advising and supervision than children in SOS and Non-Adera care arrangements. On the other hand, children in Non-Adera and Adera care arrangements seem to be provided more negative forms of care such as spanking and pinching, repeated school absenteeism, property grabbing, heavy physical work, delayed medical treatments, discrimination, and scolding than children in SOS Village.

ii. **Levels of Commitment of Guardians**: More than guardians of Non-Adera and SOS care arrangements, Adera guardians felt more honored in caring children, reported to invest more efforts to meet needs of the children and help the children to have good conduct, and were more delighted by their provisions of care to the children. More importantly, guardians in Adera, Non-Adera and SOS care arrangements seem to found in the higher, moderate and lower levels of commitment in caring and supporting of their orphaned children, respectively.

iii. **Attachment Styles of the Children**: Adera care arrangement children seem to be securely attached with their guardians than children in the two care arrangements. Adera given children were happier and more comfortable in their relationships with guardians than the other care arrangement children. On the other hand, children in SOS Village seem to be avoidantly attached with their guardians in that they found uncomfortable when they met their guardians, felt tight when their guardians want to be very close with them, did not want to stay in home with their guardian.

iv. **Academic Performances of the Children**: children in Adera care arrangement seem to be better in their academic performance than children in SOS and Non-Adera care arrangements. Besides, children in Non-Adera care arrangement seem to performed lesser in their academic performance than children in SOS Village.

v. **Resilience of the Children**: More than the children in Non-Adera and SOS Village care arrangements, Adera given children seem to have the belief that they can achieve their goals despite the problems they have faced, have recovered from their parental grief and mourning, do not cease from their activities even when things look hopeless to them, and can surpass successfully if they experience stigma and discrimination due to the death of their parents.

More generally and broadly, children in Adera care arrangement seem to be advantageous in their child-behavior outcomes of care and support such as attachment styles, academic performance and resilience than children in other two care arrangements.

The above conclusions about the results of the study, however, were drawn with the following major *limitations*.

- The assessments of care and support in the three care arrangements were conducted at single point of time. But, since childcare and support is a continuous process, it would be more accurate if the data were collected with some time interval.
- The study has focused on the comparison of SOS, Non-Adera and Adera care arrangements in the provisions of care and support to children and the major guardian and child functioning areas. But, other important factors – such as age limit (young and old) and sex of the children, numbers of years children have stayed in the present care arrangement, experiences of children before placement of the present care arrangement – were not considered in the study, which would create variations in the results of the study.
- The data to the study were collected from children and some of their *primary* guardians, but it would be more accurate if the data were also collected from *secondary* and *other* care and support providers of the children such as assistant guardians (aunties), counselors/social workers of the Village, and community associations, and

Governmental/Non-Governmental Organizations of the Adera and Non-Adera care arrangements.

6.2. Recommendations

Based on results of the study, the following recommendations were forwarded for further researches and to intervention practitioners.

- **Recommendations for further researches**

Interested researchers on the area would fill the limitations of this study by incorporating other important factors such as age limit (young and old) and sex of the children, numbers of years children have stayed in their care arrangements, experiences of children before the placement in the present care arrangement. Furthermore, they might also gather data with some time gaps from secondary and other care and support providers of the children.

- **Recommendations for intervention practitioners**

The study showed mixed results in that SOS Village provide relatively adequate material care to the children than Adera and Non-Adera care arrangements. Adera care arrangement, on the other hand, seems to provide more psychological care to the children than SOS Village and Non-Adera care arrangements. More interestingly, children in Adera care arrangement seem to be advantageous in terms of the major child-behavior outcome areas such as children's attachment styles with guardians, academic performances and resilience than other children in Non-Adera and SOS care arrangements. These results highlight intervention practitioners that implementing external programs such as placing children in SOS Village without examining the capacities and potentials of the community care arrangement systems such as Adera can waste crucial resources at the risk of making them socially unsustainable. Likewise, romanticizing the community care arrangement systems without a critical assessment of their constraints may result in the placement of orphans in unprepared families, to the detriment of their physical and psychosocial well-being. With this clue, given the vast and staggering numbers orphaned children in Ethiopia, intervention practitioners should maximize the strengths and replace the substantial deficiencies of the three care arrangements in their care and support.

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Appendix - A: Questionnaire for Children (English and Amharic Versions)

Addis Ababa University
Post-Graduate Program
Institute of Psychology

Dear Children,

First of all, I would like to thank you for your willingness in responding to this questionnaire. The aim of this questionnaire is to collect data about the *care and support* provided for orphan children. Therefore, I would like you to give honest responses to the following questions based on their directions. **Please Note** that your name will not be attached with the questionnaire and your responses will be recorded and kept confidentially.

Code No.:______

1. Background Information about Participants

Direction: Respond the appropriate answers to the following questions.

1. Sex: Male ☐ Female ☐
2. How old are you? ______
3. How old you were when you lost your *mother*? _______
4. How old you were when you lost your *father*? _______

[Ψ]5. What form of relation do you have with your present guardians? _______________

6. For how many *months* or *years* you stayed with the *present guardians*? _________
7. Did you live with *other guardian* before this time? Yes, I did ☐ No, I did not ☐
   8. If you did, for how many *months* or *years*? ______

[Ψ]9. Did you get aid from relatives or organizations? Yes, we did ☐ No, we did not ☐

   If your answer to this question is "Yes",

   10. From whom it was given?_______________
   11. Is the aid present at this time? Yes, it is ☐ No, it is not ☐
   12. If it is present, what is the type of the aid?

2. Provision of Care and Support

[Ψ] Questions raised only to Adera and Non-Adera children.

Direction: Based on the care and support provided to you, state the level of your agreement on each item that I am going to present for you by saying "Agree", "Sometimes Agree/Disagree", or "Disagree".

S. Nº	Item	Agreement Levels		
		Agree	**Sometimes Agree/Disagree**	**Disagree**
13	Most of the time I am not starved	3	2	1
14	I have no problem in clothes	3	2	1
15	Most of the time I am not allowed to go to bed or obliged to wake up while I am asleep	3	2	1
16	Most of the time I am spanked and pinched	3	2	1
17	I am allowed to know and interact with my relatives	3	2	1
18	Someone treats me when I feel sad	3	2	1
19	Most of the time I am discriminated in the home	3	2	1
20	Most of the time when a property is lost in the home, it is considered that I am responsible for it	3	2	1
21	Someone encourages and assists me to perform better in my education	3	2	1
22	I have school materials (e.g., pen, pencil, exercise book, uniform, etc.)	3	2	1
23	Most of the time I am going to school without doing my school homework	3	2	1
24	I repeatedly become absent from school	3	2	1
25	I get advice about where and with whom I should spend my spare time	3	2	1
26	Someone follows me if I am studying my education	3	2	1
27	No one cares for me if I quarrel or fight with others	3	2	1
28	No one prohibits me if I drink alcohol or smoke cigarette	3	2	1
29	I have person whom I discuss my day-to-day experiences (e.g., my school activities)	3	2	1
30	I am informed to consider the home that I am living in as my own house	3	2	1
31	Most of the time I am scolded in the home	3	2	1
32	There are persons who speak that I am the cause for my parents' death	3	2	1
33	I am allowed to know my parents' estates or the aids received from organization	3	2	1
34	My parents' estates or the aids received from organization are utilized properly in the home	3	2	1
35	The estates inherited from my parents are found in the hands of different individuals	3	2	1
36	Different individuals steal my parents' estates	3	2	1
37	I carryout activities which I can do (e.g., washing plates in home)	3	2	1

38	Someone encourages me to know and observe about how to perform important activities	3	2	1
39	I am ordered to carryout heavy physical work at home, farming and business places	3	2	1
40	I am obliged to serve passerby through my labor	3	2	1
41	Someone advised (or kept) me to be clean	3	2	1
42	I get advice on how to care for my health	3	2	1
43	Whenever I get sick, it is taken as a lame excuse on my part	3	2	1
44	Most of the time I am obliged to eat spoiled food	3	2	1

3. Commitment of Guardians to Care and Support

Direction: Based on the care and support behavior of your guardian, state your level of agreement on each item that I am going to present for you by saying "Agree", or "Sometimes Agree/ Disagree", or "Disagree".

S. Nº	Item	Agreement Levels		
		Agree	Sometimes Agree/Disagree	Disagree
45	My guardians repeatedly disgrace their fate as a result of my caring	3	2	1
46	My guardians invest all their efforts to meet my needs	3	2	1
47	Other people repeatedly initiate my guardians what they should provide for me.	3	2	1
48	My guardians notify me that they do not care me if my conduct is not good for them	3	2	1
49	Most of the time my guardians prioritize their needs than mine	3	2	1
50	My guardians speak their delight in their caring of me	3	2	1

4. Child - Guardian Attachment Styles

Direction: Based on the your attachment with your guardians, state your level of agreement on each item that I am going to present for you by saying "Agree", or "Sometimes Agree/ Disagree", or "Disagree".

S. Nº	Item	Agreement Levels		
		Agree	**Sometimes Agree/Disagree**	**Disagree**
51	I am happy while I am with my guardian	3	2	1
52	I feel sad if I do not find my guardian in home when I comeback from school	3	2	1
53	I find it easy to close to my guardian after staying separated for some days	3	2	1
54	I can play with my guardian easily	3	2	1
55	When I face threatening situation, I use my guardian as safe haven	3	2	1
56	Most of the time I worry a lot whether I can stay with my guardian	3	2	1
57	Most of the time I afraid that my guardian may dislike me	3	2	1
58	I often worry that I may loss my guardian's care	3	2	1
59	Sometimes when my guardian leaves me, I think that he/she will not comeback	3	2	1
60	When I want to close my guardian, he/she departs from me	3	2	1
61	When I am distressed or happy, I do not want to tell it to my guardian	3	2	1
62	If I share my idea with my guardian, he or she might disclose it to other individuals	3	2	1
63	I leave the home since I do not want to stay with my guardian	3	2	1
64	I feel tight when my guardian wants to be very close with me	3	2	1
65	I find it uncomfortable when I meet my guardian	3	2	1

5. Resilience of the Children

Direction: State your level of agreement on each item that I am going to present for you by saying "Agree", or "Sometimes Agree/ Disagree", or "Disagree".

S. Nº	Item	Agreement Levels		
		Agree	**Sometimes Agree/Disagree**	**Disagree**
66	I can achieve my goals despite the problem I have faced	3	2	1
67	I believe that I can still be successful in my education despite shortage of school materials	3	2	1
68	I have recovered from my grief and mourning	3	2	1
69	I adapt easily to situations in my day-to-day life	3	2	1
70	I do not cease my activities even when things look hopeless	3	2	1
71	I can surpass successfully if I experience stigma and discrimination due to my parents' death	3	2	1
72	I have passed different challenges in my life	3	2	1
73	If I face problems beyond my capacity, I consult other persons who can assist me	3	2	1
74	I can think properly even when I am under pressure and stress situations	3	2	1

Direction: Choose the correct answer to the following questions.

75. How many days you become late from school in a week?

A) I did not be late B) one day C) two days D) three and above days

አዲስ አበባ ዩኒቨርሲቲ
ድህረ ምረቃ መርሃ - ግብር
የሳይኮሎጂ ኢንስቲትዩት

ለልጆች የቀረበ መጠይቅ

የተወደዳችሁ ልጆች፡-

ከሁሉ አስቀድሜ ይህንን መጠይቅ ለመሙላት ስለተባበራችሁኝ ላመሰግናችሁ እወዳለሁ፡፡ የዚህ መጠይቅ ዋና አላማ ወላጆቻቸውን በሞት ላጡ ልጆች የሚደረግላቸውን *እንክብካቤና ድጋፍ* በተመለከተ መረጃ መሰብሰብና ማጥናት ሲሆን ይህን አላማ ለማሳካት ከዚህ በታች ለማቀርብላችሁ ጥያቄዎች በመመሪያዎቻቸው መሰረት ትክክለኛ ምላሽ እንድትሰጡኝ እጠይቃለሁ፡፡ ምላሽ ስትሰጡ ስማችሁ ተመዝግቦ አይደያዝም እንዲሁም የምትሰጡት መልስ በሚስጥር ተጠብቆ ይቀመጣል፡፡

የመለያ ቁጥር፡- ______

1. የመላሾች ዳራዊ መረጃ

መመሪያ ፡- ለሚከተሉት ጥያቄዎች ትክክለኛ መልስ መልስ/ሽ፡፡

1. *ፆታ፡* ወንድ ☐ ሴት ☐
2. እድሜህ/ሽ ስንት ነው? ______
3. ወላጅ እናትህ/ሽ ስትሞት የስንት ዓመት ልጅ ነበርህ/ሽ?______
4. ወላጅ አባትህ/ሽ ሲሞት የስንት ዓመት ልጅ ነበርህ/ሽ?______

[Ψ]5. ከአሳዳጊዎችህ/ሽ ጋር ያለህ/ሽ ዝምድና (ግንኙነት) ምንድን ነው?______________

6. አሁን በምትኖርበት/ሪበት ቤት (ተቋም) ውስጥ መኖር ከጀመርህ/ሽ ስንት *ወር* ወይም *ዓመት* ሆነህ/ሽ?______
7. ከአሁን በፊት ከሌላ አሳዳጊ ጋር ኑረህ/ሽ ታውቅ/ቂ ነበር? ኑሬ አውቃለሁ ☐ ኑሬ አላውቅም ☐
    8. ኑረህ/ሽ የምታውቅ/ቂ ከሆነ ለስንት *ወራት* ወይም *ዓመታት* ኑረሀል/ሻል?______

[Ψ]9. አሳዳጊዎችህ/ሽ ወይም አንተ/ች ከዘመድ ወይም ከድርጅት እርዳታ ታገኙ ነበር? እናገኝ ነበረ ☐ አናገኝም ነበረ ☐

ለዚህ ጥያቄ መልስህ/ሽ "እናገኝ ነበረ" ከሆነ፡-

10. እርዳታውን ከማን ወይም ከየትኛው ድርጅት ነበር የምታገኙት?______________
11. እርዳታው አሁን አለ? አለ ☐ ተቋርጧል ☐
12. እርዳታው አሁም ካለ፤ የእርዳታው ዓይነት ምን ነው?______________

2. ልጆች የሚደረግላቸው *እንክብካቤና ድጋፍ*

[Ψ] አደራ ለተሰጡና ላልተሰጡ ልጆች የቀረቡ ጥያቄዎች

መመሪያ፡- የሚደረግልህን/ሽን እንክብካቤና ድጋፍ መሰረት አድርገህ/ሽ ከዚህ በታች በምዘረዝርልህ/ሽ ዓረፍተ ነገሮች ላይ የመስማማት ደረጃህን/ሽን "እስማማለሁ"፣ "አንዳንድ ጊዜ እስማማለሁ/ አልስማማም"፣ ወይም "አልስማማም" ከሚሉት አማራጮች መካከል አንዱን ምረጥ/ጭ።

ተ.ቁ	ዓረፍተ ነገር	የመስማማት ደረጃዎች		
		እስማማለሁ	አንዳንድ ጊዜ እስማማለሁ/ አልስማማም	አልስማማም
13	ብዙ ጊዜ አልራብም፣ አልጠማም	3	2	1
14	የልብስ ችግር የለብኝም	3	2	1
15	ብዙ ጊዜ እንቅልፌ ሲመጣ እንዳልተኛ እደረጋለሁ፣ እንቅልፌን ሳልጨርስ እቀሰቀሳለሁ	3	2	1
16	ብዙ ጊዜ እመታለሁ (አገረፋለሁ)	3	2	1
17	ከዘመዶቼ ጋር እንድተዋወቅ (እንድገናኝ) ይፈቀድልኛል	3	2	1
18	ሲከፋኝ የሚያጽናናኝ፣ የሚያበረታታኝ ሰው አለ	3	2	1
19	በቤት ውስጥ ብዙ ጊዜ መገለል ይደርስብኛል	3	2	1
20	በቤት ውስጥ እቃ ሲጠፋ ብዙ ጊዜ እቃውን እኔ እንዳጠፋሁት ተደርጎ ይወሰዳል	3	2	1
21	በትምህርቴ ጥሩ ውጤት እንዳመጣ የሚያበረታታኝና የሚደግፈኝ ሰው አለ	3	2	1
22	የመማሪያ ቁሳቁሶች ተሟልተውልኛል (ለምሳሌ፡- እስክሪፕቶ፣ እርሳስ፣ ደብተር፣ ዩኒፎርም … ወዘተ)	3	2	1
23	ብዙ ጊዜ ከትምህርት ቤት የተሰጠኝን የቤት ስራ ሳልሰራ ትምህርት ቤት እሄዳለሁ	3	2	1
24	ከትምህርት ቤት መቅረት አበዛለሁ	3	2	1
25	የትና ከማን ጋር መዋል እንዳለብኝ ምክር አገኛለሁ	3	2	1
26	ትምህርቴን ማጥናቴን የሚከታተለኝ ሰው አለ	3	2	1
27	ከሰው ጋር ብጣላ፤ ብደባደብ የሚመክረኝ ሰው የለም	3	2	1
28	አልኮል ብጠጣ፣ ሲጋራ ባጨስ የሚከለክለኝ የለም	3	2	1
29	በእየለቱ ስለሚያጋጥሙኝ ነገሮች የማነጋግረው ሰው አለኝ (ለምሳሌ፡- የትምህርት ቤት ውሎየን)	3	2	1
30	የምኖርበትን ቤት እንደራሴ ቤት አድርጌ ማየት እንዳለብኝ ይነገረኛል	3	2	1
31	ብዙ ጊዜ በቤት ውስጥ በስድብ ቅስሜ ይሰበራል	3	2	1
32	በቤት ውስጥ ለወላጆቼ ሞት ምክንያት እኔ እንደሆንሁ የሚናገሩ ሰዎች አሉ	3	2	1
33	በቤት ውስጥ ከወላጆቼ ወይም ከድርጅት ስለተሰጠኝ ንብረት ወይም ቁሳቁስ እንዳውቅ ይፈቀድልኛል	3	2	1
34	ከወላጆቼ ወይም ከድርጅት የተሰጠኝ ንብረትና ቁሳቁስ በቤት ውስጥ በአግባቡ ጥቅም ላይ እየዋሉ ነው	3	2	1
35	ወላጆቼ ለእኔ ያወረሱኝ ንብረት በተለየዩ ሰዎች እጅ ተበታትኖ ይገኛል	3	2	1
36	ከወላጆቼ ወይም ከድርጅት የሰጡኝ ቁሳቁስና ንብረት በሌሎች ሰዎች ይወሰዱብኛል	3	2	1
37	አቅሜን የሚመጥኑ ስራዎችን እሰራለሁ (ለምሳሌ፡- በቤት ውስጥ የምግብ እቃችን ማጠብ)	3	2	1

38	ሰለስራ ክሂሎች እንዳውቅና እንድመለከት በቤት ውስጥ የሚያበረታታኝ ሰው አለ	3	2	1
39	በቤት፣ በእርሻና በንግድ ቦታዎች ከባድ የጉልበት ስራ እንድሰራ እታዘዛለሁ	3	2	1
40	ሌሎች ሰዎችን በጉልበቴ እንዳገለግል እገደዳለሁ	3	2	1
41	ንፅህናዬ ተጠብቆልኛል	3	2	1
42	ጤናየን እንዴት መጠበቅ እንዳለብኝ ምክር አገኛለሁ	3	2	1
43	ሲያመኝ ብዙ ጊዜ እንደምቀልድ ተደርጎ ይወሰድብኛል	3	2	1
44	ተዘጋጅቶ የቆየ (የሻገተ)፣ ፍርፋሪ፣ ሌሎች ያልጣማቸውን ምግብ እንድመገብ ይደረጋል	3	2	1

3 ፡- አሳዳጊዎች ልጆችን ለመንከባከብ ያላቸው ዝግጁነትና ትጋት

መመሪያ ፡- የአሳዳጊዎችህን/ሽን እንክብካቤና ድጋፍ የማድረግ ባህሪ መሰረት አድርገህ/ሽ ከዚህ በታች በምዘረዝርልህ/ሽ ዓረፍተ ነገሮች ላይ የመስማማት ደረጃህን/ሽን "እስማማለሁ"፣ "አንዳንድ ጊዜ እስማማለሁ/ አልስማማም"፣ ወይም "አልስማማም" ከሚሉት አማራጮች መካከል አንዱን ምረጥ/ጭ፡፡

ተ.ቁ	ዓረፍተ ነገር	የመስማማት ደረጃዎች		
		እስማማለሁ	አንዳንድ ጊዜ እስማማለሁ/ አልስማማም	አልስማማም
45	አሳዳጊዎቼ በተደጋጋሚ እድላቸውን ሲያማርሩ እሰማለሁ	3	2	1
46	አሳዳጊዎቼ እንዳይከፋኝ የአቅማቸውን ሁሉ ይጥራሉ	3	2	1
47	አሳዳጊዎቼ ለእኔ ማድረግ ስለሚገባቸው ጉዳይ ሌሎች ሰዎች በተደጋጋሚ ይነግሯቸዋል	3	2	1
48	አሳዳጊዎቼ ጠባዬ ጥሩ ካልሆነ እንደማያሳድጉኝ ይናገራሉ	3	2	1
49	አሳዳጊዎቼ ብዙ ጊዜ ለራሳቸው ችግር ቅድሚያ ይሰጣሉ	3	2	1
50	አሳዳጊዎቼ እኔን በማሳደጋቸው እንደሚደሰቱ ይናገራሉ	3	2	1

4 ፡- በልጆችና በአሳዳጊዎች መካከል ያለው የቅርርብ ሥርዓት

መመሪያ ፡- በአንተ/ች እና በአሳዳጊህ/ሽ መካከል ያለውን ቅርርብ መሰረት አድርገህ/ሽ ከዚህ በታች በምዘረዝርልህ/ሽ ዓረፍተ ነገሮች ላይ የመስማማት ደረጃህን/ሽን "እስማማለሁ"፣ "አንዳንድ ጊዜ እስማማለሁ/ አልስማማም"፣ ወይም "አልስማማም" ከሚሉት አማራጮች መካከል አንዱን ምረጥ/ጭ፡፡

ተ.ቁ	ዓረፍተ ነገር	የመስማማት ደረጃዎች		
		እስማማለሁ	አንዳንድ ጊዜ እስማማለሁ/ አልስማማም	ኣልስማማም
51	ከአሳዳጊዬ ጋር ስሆን ደስ ይለኛል	3	2	1
52	ከትምህርት ቤት ስመለስ አሳዳጊዬን ቤት ውስጥ ካላገኘሁ ቅር ይለኛል	3	2	1
53	ለተወሰኑ ቀናት ከአሳዳጊዬ ተለይቼ ስቆይ ናፍቆት ይይዘኛል	3	2	1

54	ከአሳዳጊዬ ጋር እንደልቤ እጫወታለሁ	3	2	1
55	አሳዳጊዬ ችግር ሲገጥመኝ መጠለያየ (መጠጊየ) ነው/ናት	3	2	1
56	ብዙ ጊዜ ከአሳዳጊዬ ጋር አብሬ መኖሬን ሳስብ እሰጋለሁ	3	2	1
57	ብዙ ጊዜ አሳዳጊዬ ቢጠላኝስ/ብትጠላኝስ ብዬ አስባለሁ	3	2	1
58	የአሳዳጊዬን እንክብካቤ ላጣ እችላለሁ እያልሁኝ እጨነቃለሁ	3	2	1
59	አሳዳጊዬ ሲለየኝ/ስትለየኝ ተመልሶ/ሳ አይመጣም/አትመጣም ብዬ አስባለሁ	3	2	1
60	አሳዳጊዬን ለመቅረብ ስፈልግ እሷ/እሱ ይርቀኛል/ትርቀኛለች	3	2	1
61	ቢከፋኝም ብደሰትም ለአሳዳጊዬ መናገር አልፈልግም	3	2	1
62	ያለኝን ሀሳብ ለአሳዳጊዬ ባጋራ ለሌላ ሰው የሚናገርብኝ/ የምትናገርብኝ ይመስለኛል	3	2	1
63	ብዙ ጊዜ በቤት ውስጥ ከአሳዳጊዬ ጋር መሆን ደስ ስለማይለኝ እቤት ውስጥ መቀመጥ አልፈልግም	3	2	1
64	አሳዳጊዬ በጣም ሲቀርበኝ/ስትቀርበኝ ምቾት አይሰጠኝም	3	2	1
65	ከአሳዳጊዬ ጋር ስገናኝ ጥሩ የሆነ ስሜት አይሰማኝም	3	2	1

5፡- የልጆች ችግር የመቋቋም (በችግር ውስጥ አዎንታዊ ባህርይ ማዳበርን) ችሎታ

መመሪያ፡- የአንተን/ችን ችግር የመቋቋም ወይም በችግር ውስጥ አዎንታዊ ባህርይ የማዳበር ችሎታ መሰረት አድርገህ/ሽ ከዚህ በታች በምዘረዝርልህ/ሽ ዓረፍተ ነገሮች ላይ የመስማማት ደረጃህን/ሽን "እስማማለሁ"፣ "አንዳንድ ጊዜ እስማማለሁ/ አልስማማም"፣ ወይም "አልስማማም" ከሚሉት አማራጮች መካከል አንዱን ምረጥ/ጭ፡፡

ተ.ቁ	ዓረፍተ ነገር	የመስማማት ደረጃዎች		
		እስማማለሁ	አንዳንድ ጊዜ እስማማለሁ/ አልስማማም	አልስማማም
66	ምንም ችግር ቢያጋጥመኝ ያቀድኳቸውን ግቦች ማሳካት እችላለሁ	3	2	1
67	የመማሪያ ቁሳቁሶች እጥረት ቢያጋጥመኝም እንኳ ተደጋጋሚ ጥረቶችን በማድረግ በትምህርቴ እንደሚሳካልኝ አምናለሁ	3	2	1
68	ከነበረብኝ ሀዘን ወይም መከራ ወጥቻለሁ (አገግሜያለሁ)	3	2	1
69	በኑሮዬ ውስጥ በእየለቱ ከሚያጋጥሙኝ ሁኔታዎች ጋር እራሴን አላምዳለሁ	3	2	1
70	የሚያጋጥሙኝ ነገሮች ተስፋ ሰጪ ባይሆኑም እንኳ መስራቴን አላቆምም	3	2	1
71	ወላጆቼን በማጣቴ ምክንያት መገለልና መድሎ ቢያጋጥመኝም እንኳ በጥንካሬዬ በአሸናፊነት እወጣቸዋለሁ	3	2	1
72	የተለያዩ ችግሮችን ተጋፍጬ አልፌያለሁ	3	2	1
73	ከአቅሜ በላይ የሆኑ ችግሮች ሲያጋጥሙኝ ሊረዱኝ የሚችሉ ሰዎችን አማክራለሁ	3	2	1
74	በችግርና በውጥረት ውስጥ እያለሁ እንኳ በአግባቡና በትክክል ማሰብ እችላለሁ	3	2	1

መመሪያ፡- ለሚከተሉት ጥያቄዎች ትክክለኛ የሆነውን መልስ ምረጥ/ጭ፡፡

75. ትምህርት ቤት ከሚሰጡ የቤት ስራዎች መካከል ምን የህሉን ሰርተህ/ሽ ተኼዳለህ/ጃለሽ?

ሀ) ሰርቼ አላውቅም ለ) አንዳንድ ጊዜ እሰራለሁ/ አንዳንድ ጊዜ አልሰራም ሐ) ሁልጊዜ እሰራለሁ

Appendix - B: Observation Checklist (English and Amharic Versions)

Objective: to collect data about the physical cleanliness of the children.

Direction: while you fill the responses of a child to the questionnaire, observe his or her physical cleanliness and respond the following questions.

S.No.	Question	Yes	No
1	Does the child's hair has pest or grime?		
2	Does the child has cut fingernails?		
3	Does the child has untreated body scare or fracture?		
4	Does the child has unrepaired shoe or unprotected foot?		
5	Does the child has tattered or dirty cloths?		

የምልከታ ጥያቄዎች

የምልከታው ዓላማ፡- የጥናቱ ተሳታፊ ልጆችን *አካላዊ ይዘታ* አስመልክቶ መረጃ መሰብሰብ።

መመሪያ፡- መጠይቁ የሚሞላለት/ላላት ልጅ መጠየቁ ሲሞላ ባለው የጊዜ ቆይታ አካላዊ ይዞታውን/ዋን መሰረት ተደርጎ ለሚከተሉት ጥያቄዎች ተገቢ ምላሽ ይሰጥ። ማሳሰቢያ ጥያቄዎቹ ሲመለሱ የአካባቢውን ማህበረሰብ የኑሮ ዘይቤ (ሁኔታ) ግንዛቤ ውስጥ በማስገባት ይሁን።

ተ.ቁ	ጥያቄ	አዎ	አይታይም/ የለም
1	በፀጉሩ/ሯ ላይ ቅጫም፣ የንጽህና ጉድለት ይታያል?		
2	በአግባቡ ያልተቆረጡ የእጅ ጥፍሮች አለው/ላት?		
3	ያልታከመ ቁስል፣ ስብራት በአካሉ/ሏ ላይ ይታያል?		
4	የተቀዳደዱ ጫማዎች (በአግባቡ ያልተያዙ እግሮች) አለው/ላት?		
5	የተቀዳደዱ (የቆሸሹ) ልብሶች ለብሷል/ሳለች?		

Appendix - C: Semi-structured Interview Schedule for Guardians (English and Amharic Versions)

Dear Guardians,

First of all, I would like to thank you for your willingness in conducting this interview. The aim of the interview is to collect data about the *care and support* provided for orphan children. Therefore, I would like you to reply the following questions related to yourself and your orphan child, which I am going to present for you. **Please Note** that your personal profiles will not be attached with the interview and your response will be recorded and kept confidentially.

The child's code No.:______

1. Background Information about Respondents

Direction: Please reply the appropriate answers to the following questions.

1. How old are you?
2. What is your educational level?

[Ψ]3. What is your job?

[Ψ]4. What type of relation do you have with your orphan child?

5. How many orphan children do you raise?
6. For how many months or years the child has been living with you?

2. Provision of Care and Support for Child

Direction: Please elaborate the following questions.

7. Do you know the academic result (rank) of the child? How do you rate the level of his her performance (i.e., is he or she a lower, or medium, or higher level student)?
8. Does the child have educational materials (for example, pen, pencil, exercise book, uniform ...etc.)?
9. How do you know whether the child has done his or her school homework?
10. How do you know where and with whom the child has passed his or her time?
11. Does the child feel novelty in the home?
12. Does the child interact with other relatives?
13. Does the child keep his/her hygiene (shower, clean his / her hair) when he or she is asked to do so?

[Ψ] Questions raised only to Adera and Non-Adera guardians.

3. Patterns Relationship with the Child

Direction: Please state the level of your agreement to the following sentences by saying 'Agree completely', 'Agree partially', or 'Disagree completely'.

14. It is not known what the child thinks in his/her mind; I observe reticence (uncommunicativeness) on him/her.
15. I suspect the child wants to live with another person than me.
16. When the child feels hungry, sick or experiences other problems he/she does not inform me.
17. When the child commit mistake, I inform other people to advice him/her.
18. Since I suspect the child might disclose the information to other people, I do not tell secrets to him/her.

4. Resilience Status of the Child

Direction: Which of the following statements represent the characteristics of your child? Please replay by saying 'correct' or 'incorrect'.

19. The child can achieve my goals despite the problem I have faced.
20. The child believes that I can still be successful in my education despite shortage of school materials that I have.
21. The child has recovered from his/her grief and mourning.
22. The child can able to adapt to the situations in his/her day-to-day life.
23. The child not ceases his/her activities even when things look hopeless.
24. If the child faces problems out of my capacity, he/she consult other persons who can assist him/her.
25. The child can think properly even when he/she is under pressure and stress situations.

5. Commitment of Guardian of to Care and Support

Direction: Please elaboration to the following questions.

Ψ26. Do you raise the child if he/she will have bad conduct, ill health, failed repeatedly in his/ her education?

Ψ27. What you will do if you do not have the capacity to raise the child?

27. If possible, do you want to entrust the child to another guardian?

Ψ Questions raised only to only to Adera and Non-Adera guardians.

ለአሳዳጊዎች የቀረበ ከፊል ነፃ ቃለ-መጠይቅ

የተከበራችሁ አሳዳጊዎች፦

ከሁሉ አስቀድሜ ይህንን ቃለ-ምልልስ እንድናደርግ ስለተባበሩኝ ላመሰግን እወዳለሁ፡፡ የቃለ-ምልልሱ ዋና አላማ ወላጆቻቸውን በሞት ላጡ ልጆች የሚደረግላቸውን *እንክብካቤና ድጋፍ* በተመለከተ መረጃ መሰብሰብና ማጥናት ሲሆን ይህን አላማ ለማሳካት ቀጥዬ የእርስዎንና የሚያሳድጉትን/ጓትን ልጅ አስመልክቶ ለማነሳልዎት ጥያቄዎች ትክክለኛ ምላሽ እንዲሰጡኝ በአክብሮት እጠይቃለሁ፡፡ በቃለ-ምልልሱ ወቅት ስምዎት ተመዝግቦ አይያያዝም እንዲሁም የሚሰጡት መልስ በሚስጥር ተጠብቆ ይቀመጣል፡፡

የሚያሳድጉት/ጓት ልጅ መለያ ቁጥር፦______

1. የመላሾች ዳራዊ መረጃ

መመሪያ፦ እባክዎ የሚከተሉትን ጥያቄዎች ይመልሱልኝ፡፡

1. እድሜዎት ስንት ነው?
2. እስከ ስንተኛ ክፍል ተምረዋል?
3. [Ψ] የመተዳደሪያ ስራዎት ምንድን ነው?
4. [Ψ] ከሚያሳድጉት/ጓት ልጅ ጋር ያለው የዝምድና (የግንኙነት) አይነት ምንድን ነው?
5. በአሁኑ ሰዓት ስንት የራስዎ ያልሆኑ ልጆችን ያሳድጋሉ?
6. የሚያሳድጉት/ጓት ልጅ ከእርስዎ ጋር መኖር ከጀመረ/ች ስንት ወር ወይም ዓመት ሆነው/ናት?

2. ልጆች በአሳዳጊዎቻቸው የሚደረግላቸው እንክብካቤ

መመሪያ፦ እባክዎ ለሚከተሉት ጥያቄዎች ማብራሪያ ይስጡኝ፡፡

7. ልጅዎ በትምህርቱ/ቷ ስንት ማርክ እንዳመጣ/ች (ስንተኛ ደረጃ እንደወጣ/ች) ያውቃሉ? የትምህርት ክትትሉ/ሏስ እንዴት ነው (ማለት ደካማ፣ መካከለኛ፣ ወይስ ጎበዝ ተማሪ ነው/ናት)?
8. ልጅዎ የመማሪያ ቁሳቁሶች (ለምሳሌ፦ እስክሪፕቶ፣ እርሳስ፣ ደብተር፣ ዩኒፎርም ... ወዘተ) አለው/ላት?
9. ልጅዎ ከትምህርት ቤት የተሰጠውን/ችውን የቤት ስራ መስራቱን/ቷን ያውቃሉ?
10. ልጅዎ ከትምህርት ቤት ውጪ የትና ከማን ጋር እንደሚውል/ምትውል ያውቃሉ?
11. ልጅዎ በቤት ውስጥ የባይተዋርነት ስሜት ይሰማዋል/ታል?
12. ልጅዎ ከሌሎች ዘመዶቹ/ቿ ጋር ይገናኛ/ትገናኛለች?
13. ልጅዎ ንጽህናውን/ዋን እንዲጠብቅ/እንድትጠብቅ (ገላውን/ዋን፣ ጠጉሩን/ሯን እንዲታጠብ/እንድትታጠብ) ሲነገረው/ራት እሽ ይላል/ ትላለች?

[Ψ] አደራ ላልተሰጡና ለተሰጡ አሳዳጊዎች ብቻ የቀረቡ ጥያቄዎች

3. በልጆችና በአሳዳጊዎች መካከል ያለው የቅርርብ ሥርዓት

መመሪያ፡- እባክዎ በሚከተሉት ዓረፍተ ነገሮች ላይ የመስማማት ደረጃዎን ሙሉ በሙሉ እስማማለሁ፣ በከፊል እስማማለሁ፣ ወይም ሙሉ በሙሉ አልስማማም እያሉ ይመልሱ፡፡

14. ልጁ/ጇ "በልቡ/ቧ" ምን እንደሚያስብ/ምታስብ አይታወቅም፣ ድብቅነት አይበታለሁ/ባታለሁ፡፡
15. ልጁ/ጇ ከዚህ ቤት ይልቅ "ልቡ/ቧ" ወደ ሌላ ሰው ቤት የሚያስብ ይመስለኛል፡፡
16. ልጁ/ጇ ሲርበው/ባት፣ ሲያመው/ማት ወይም ሌሎች ችግሮች ሲያጋጥሙት ለእኔ አይነግረኝም/አትነግረኝም፡፡
17. ልጁ/ጇ ሲያጠፋ/ስታጠፋ ጠባዬን እንዲያርም/እንድታርም ለሌሎች ሰዎች እናገራለሁ፡፡
18. ለሌሎች ሰዎች ሊናገር/ልትናገር ይችላል/ትችላለች ብዬ ስለማስብ ለልጁ/ጇ ሚስጢር አልነግረውም/ራትም፡፡

4. የልጆች ችግር መቋቋም (በችግር ውስጥ አዎንታዊ ባህርይ ማዳበርን) ችሎታ

መመሪያ፡- እባክዎ ከሚከተሉት ዓረፍተ ነገሮች ውስጥ ስለልጅዎ ባህሪ (ጠባይ) ትክክል የሆነው እና ትክክል ያልሆነው ይለዩልኝ፡፡

19. ምንም ችግር ቢያጋጥመው/ማት ያቀዳቸውን/ደቻቸውን ግቦች ማሳካት ይችላል/ ትችላለች
20. ተደጋጋሚ ጥረቶችን በማድረግ በትምህርቱ/ቷ እንደሚሳካለት/ላት ያምናል/ ታምናለች
21. ከነበረበት/ችበት ሀዘን ወጥቷል/ጣለች (አገግሟል)
22. በእየለቱ ከሚያጋጥሙት/ሚት ሁኔታዎች ጋር እራሱን/ሷን ያላምዳል/ታላምዳለች
23. የሚያጋጥሙት/ሚት ነገሮች ተስፋ ሰጪ ባይሆኑም መስራቱን/ቷን አያቆምም/ አታቆምም
24. ከአቅሙ/ሟ በላይ የሆኑ ችግሮች ሲያጋጥሙት/ሚት ሊረዱት/ዷት የሚችሉ ሰዎችን ያማክራል/ ታማክራለች
25. በችግርና በውጥረት ውስጥ እያለ/ች እንኳ በአግባቡ ማሰብ ይችላል/ ትችላለች

5. አሳዳጊዎች ልጆችን ለመንከባከብ ያላቸው ዝግጁነትና ትጋት

መመሪያ፡- እባክዎ ለሚከተሉት ጥያቄዎች ማብራሪያ ይስጡኝ፡፡

26. [Ψ] አሁን የሚያሳድጉት/ጓት ልጅ ጠባዬ ጥሩ ባይሆን/ባትሆ፣ ህመምተኛ ቢሆን/ብትሆ፣ በትምህርቱ/ቷ በተደጋጋሚ ቢወድቅ/ብትወድቅ ሊያሳድጉት/ጓት ይችላሉ?
27. [Ψ] ልጁን/ጇን ለመንከባከብ የሚያስችል አቅም ባይኖርዎት ምን ያደርጋሉ?
28. አሁን የሚያሳድጉት/ጓት ልጅ ሌላ አሳዳጊ ቢገኝለት/ላት መስጠት ይፈልጋሉ? ለምን?

[Ψ] አደራ ላልተሰጡና ለተሰጡ አሳዳጊዎች ብቻ የቀረቡ ጥያቄዎች

Appendix - D: Academic Record Format (English and Amharic Versions)

Direction: observe the child's academic record from his or her school and fill the following form about the child's school performance. *Note that the child's name, care arrangement and school name are found in the separate sheet prepared for such purpose.*

Code No.	School attendance and performance	The child's living arrangement		
		SOS Village	**Non**-Adera given	Adera given
	Grade level/Section			
	Number of days absented in a semester			
	Number of subjects taken			
	Total result			
	Average result			
	Class rank			
	Grade level/Section			
	Number of days absented in a semester			
	Number of subjects taken			
	Total result			
	Average result			
	Class rank			
	Grade level/Section			
	Number of days absented in a semester			
	Number of subjects taken			
	Total result			
	Average result			
	Class rank			

Co'td.

የትምህርት ሰነድ መሙያ ቅጽ

መመሪያ፡- የጥናቱ ተሳታፊ ልጅ ያለውን/ያላትን አጠቃላይ የትምህርት ክትትል በሚማርበት/በምትማርበት ትምህርት ቤት የሚገኘውን የውጤት መመዝገቢያ ሰነድ መመልከት የሚከተሉት መረጃዎች እንዲሟሉ ይደርግ። ማሳሰቢያ የልጁ/ጇ ስም፣ የሚኖርት/የምትኖርበት ቦታ እና የትምህርት ቤት ስም ለየብቻቸው ተመዝግበው ይገኛሉ።

የመለያ ቁ.	የት/ት ውጤትና ክትትል ጠቋሚ	የጥናቱ ተሳታፊ ልጅ የሚኖርበት/የምትኖርበት ቦታ		
		SOS መንደር	አደራ ያልተሰጠ	አደራ የተሰጠ
	የሚማርበት ክፍል ደረጃ (ሴክሽን)			
	ከት/ት ቤት የቀረባቸው ቀናት ብዛት			
	የተማሩት የት/ት ዓይነት ብዛት			
	ድምር ውጤት			
	አማካይ ውጤት			
	በክፍል ውስጥ የነበረው የት/ት ደረጃ			
	የሚማርበት ክፍል ደረጃ (ሴክሽን)			
	ከት/ት ቤት የቀረባቸው ቀናት ብዛት			
	የተማሩት የት/ት ዓይነት ብዛት			
	ድምር ውጤት			
	አማካይ ውጤት			
	በክፍል ውስጥ የነበረው የት/ት ደረጃ			
	የሚማርበት ክፍል ደረጃ (ሴክሽን)			
	ከት/ት ቤት የቀረባቸው ቀናት ብዛት			
	የተማሩት የት/ት ዓይነት ብዛት			
	ድምር ውጤት			
	አማካይ ውጤት			
	በክፍል ውስጥ የነበረው የት/ት ደረጃ			

ይቀጥላል ...

Appendix - E: Item Classification Schemes

1. Provision of Care and Support

Aspect		Forms	
		Items for Positive Care*	**Items for Negative Treatment***
Material Care	Physical	13,14	15,16
	Educational	21, 22	23, 24
	Property	33, 34	35, 36
	Labor	37, 38	39, 40
	Health	41, 42	43, 44
Psychological Care	Emotional	17, 18	19, 20
	Supervisory	25, 26	27, 28
	Verbal	29, 30	31, 32

* The items numbers are as they are found in the questionnaire in Appendix- A

2. Child-Guardian Attachment Styles

Attachment Styles	Item Numbers*
Secure	51, 52, 53, 54, 55
Anxious	56, 57, 58, 59, 60
Avoidant	61, 62, 63, 64, 65

* The items numbers are as they are found in the questionnaire in Appendix- A

Appendix - F: Household Background Record Format

በ ____________________ ከተማ የተመዘገቡ ወላጅ የሞተባቸው ልጆችና የአሳዳጊዎቻቸው አጠቃላይ መረጃ

ተ.ቁ	የአሳዳጊ መረጃ					መረጃውን የሰጠ አካል	ወላጅ የሞተበት/ባት ልጅ መረጃ									
	ስም	ቀበሌ	ሰፈር	የቤት ቁጥር	የሚያሳድጓቸው ወላጅ የሞተባቸው ልጆች ብዛት		ስም	እድሜ	የሚማርበት ት/ት ቤት ስም	የክፍል ደረጃ	የወላጅ ሁኔታ		አደራ የተሰጠ	አደራ ያልተሰጠ	ምርመራ	የመለያ ቁጥር
											አንዱን ያጣ	ሁለቱን ያጣ				

ይቀጥላል...

በ ____________________ ከተማ SOS ህጻናት ማሳደጊያ መንደር ውስጥ የሚኖሩ ልጆች መረጃ

ተ.ቁ	ስም	እድሜ	የቤተሰብ ብዛት	በማሳደጊያ መንደሩ ውስጥ የቆየው/ችው ጊዜ	የሚማርበት/ የምትማርበት ት/ት ቤት ስም	የክፍል ደረጃ	የመለያ ቁጥር

ይቀጥላል...

DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been duly acknowledged.

Name: Meberate Belachew

Signature: ____________

Date of Submission: 21/ June 2010

Place of Submission: Institute of Psychology, Addis Ababa University

This thesis has been submitted for examination with my approval as University Advisor

Name: Belay Tefera (Ph.D)

Signature: ____________

Date: 21 June 2010

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