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The Prevalence and Socio-Demographic Correlates of Mental Distress in Children: The Case of Guenet Church Child Sponsorship Project, Addis Ketema Sub city, Addis Ababa

By

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Addis Ababa

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Acronyms and Abbreviations

AACAHB	Addis Ababa City Administration Health Bureau
AIDS	Acquired ImmunoDeficiency Syndrome
CRC	Convention on the Rights of the Child
CSA	Central Statistics Authority
df.	Degrees of freedom
DHS	Demographic and Health Survey
fhi	Family Health International
F-TEST	Fisher test
HIV	Human Immunodeficiency Virus
LSD	List Significant Difference
MoLSA	Ministry of Labour and Social Affair
PLWHA	People Living With HIV/AIDS
SRQ	Self Reporting Questionnaire
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	Unite States Agency for International Development
WHO	World Health Organization

Abstract

The study was conducted in Addis Ababa, Addis Ketema subcity, Kebele 06/07, with the objective of showing the prevalence of mental distress in sponsored children, aged between 15 to 18 years, in Guenet Church Child Sponsorship project during April 2008. The self-reporting questionnaire combined with socio-demographic questionnaire items were administered to 270 beneficiaries selected through systematic random sampling technique. The questionnaire was completed, filtered and the data of 248 children were analysed through percentage and analysis of variance, and reported in this study. As a result, 48.8% of the participants had scored above the cut off point and showed symptoms of mental distress. The prevalence of mental distress was also assessed in relation to socio-demographic variables and it was notified that the mental distress was higher in female than male respondents, in orphaned than non-orphaned children as well as in respondents from large family sizes and with hearing and mobility problems. Moreover, the prevalence of mental distress was found highest among children who never attend religious services and whose educational level was lowest. The mean score obtained across selected socio-demographic variables were analysed and significant differences were observed across all variables. Based on the findings of this study, project holders and staff are suggested to study the impact of mental distress, work on the underlying causes of mental distress with health professionals and counsellors, and give special attention and psychosocial support to orphaned children, children with large family size, children with visible physical impairment/disability and lowest level of education and revise a strategy to utilize religious services as resources to support children with mental distress.

CHAPTER ONE

1. Introduction

1.1. Background of The Problem

Historically, large-scale orphaning has been a sporadic, short-term problem associated with war, famine, or disease. Orphaning caused by HIV/AIDS is and increasingly will be a long-term, chronic problem, affecting developing countries throughout the world (Rose, 2003). Worldwide, an estimated 15 million children under the age of 18 have been orphaned as a result of AIDS – more than 12 million in sub-Saharan Africa, where an estimated 9 percent of all children have lost at least one parent to AIDS (Tiaji, 2005).

In Africa, two million children lost their parents due to AIDS in 2000, orphaning a child every 14 seconds that year (Tiaji, 2004). The U.S. Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), and the Joint United Nations Program on HIV/AIDS (UNAIDS) have estimated that at the end of 2001, 13.4 million children under the age of 15 had lost one or both parents to AIDS, with the majority (82%) in sub-Saharan Africa (Tiaji, 2005). It was estimated that by 2010, there will be over 25 million orphans of AIDS in Africa (USAID/UNICEF/UNAIDS, 2003), and 15.7 million were estimated in sub-Saharan Africa (UNICEF, 2006).

According to Ethiopian Ministry of Health (2002), huge numbers of families are affected and the HIV/AIDS epidemic poses a significant threat to socio-economic development of the country (MoH, 2002). With population growth, Ministry of Health (2002) estimated that, the number would grow to 4.6 million by 2005.

In 2005, there were approximately 5 million orphaned and vulnerable children in Ethiopia, of which a significant proportion can be causally attributed to HIV and AIDS (CSA, 2006). The estimated percentage of children orphaned by AIDS, as opposed to other causes, increased from 9.6 percent of all orphans in 1995 to 25.8 percent in 2001 and

was estimated to increase to 43 percent of all orphans by the end of 2010 (USAID, 2003).

A joint report of AIDS by UNICEF and UNAIDS estimated that, the number of orphans in Ethiopia is likely to increase throughout the decade and surpass 5 million by 2010 (Children on the Brink, 2002). Due to the 10-year time lag between HIV-infection and death, officials predict that orphan populations will continue to rise for a similar period, even after the HIV rate begins to decline (UNICEF, 2006). Report from UNICEF (2007), disclosed that the number of orphans and vulnerable children has approximated 6 million. This number is expected to rise exponentially over the next decade to as many as 25 million by 2014 (UNICEF, 2007).

In Addis Ababa, the capital city of Ethiopia, the number of HIV /AIDS Orphans was estimated 55,000 as compared to 27,000 non HIV/AIDS Orphans in 2003 (MoLSA, 2003). According to the report, this number was expected to grow by the end of 2010.

Following more than a decade of silence and inadequate action for such loses; there is now an absolute imperative that the global community and every individual nation urgently mount large-scale, multifaceted responses to secure the future of orphans and vulnerable children.

Early intervention for psychosocial development of infants and young children in Ethiopia was initiated in 1989 (Pnina et al., 2004). Thereafter, on December 9, 1991, the Ethiopia government has ratified the UN Convention on the rights of the child (CRC), which spells out broad principles to protect all children's physical, mental, spiritual, moral and social developments as the most widely endorsed human rights treaty in history. The convention, together with its optional protocols, lays out in specific terms the legal duties of government to children. However, due to the magnitude of the problem, I believe that the intervention is still below expectation and has not yet addressed the holistic development need of these children.

1.2. Statement Of The Problem

The Addis Ababa City Administration Health Bureau (AACAHB) has developed a guideline and coordinates services provided to orphans and vulnerable children in Addis (AACAHB, 2002). As of the FHI Assessment Report (2002), over 71% of the organizations in Addis were providing food support, financial support, and medical support to orphans and vulnerable children and about 42% of the organizations were providing legal and spiritual supports, but the findings revealed that, the psychological supports were not well recognized and were planned as essential program component. Fore instance, In seven kebeles of Kolfe-Keranyo sub-city, Save the Children was supporting more than 8,000 orphans and vulnerable children, similarly, in Addis Ketema sub city, Ethiopian Guenet Church Development and Welfare Organization is providing care and support to 468 orphaned children and non orphaned children that are vulnerable. These orphaned and non-orphaned children have been receiving educational, medical, nutritional, social, and moral education supports since 1994. Nevertheless, none of these children have received psychological or emotional supports through professionals. A study done by Assefach (2006) in Kolfe Sub city reveals that psychosocial supports have still remained the needs of Orphan and Vulnerable Children.

It seems that the psychological and emotional aspects are overlooked and not included as component of the holistic development program. Part of the explanation could be, firstly, absence of trained staff or professional counsellors, who provide psychological and emotional supports to children in those projects and secondly, the fact that psychological impacts are often not visible, and are difficult to assess. Pre study conversation held with project employees, and informal discussion conducted with youth leaders showed that, beneficiary children had emotional and/ or psychological problems, but they had

Not given explanation if these problems were related to some traumatic experiences or associated with physical injuries, social evils, and mental distress or developed as result of least recognition and early intervention during on set or other causes. It was also worst to learn during those conversations that even their presence and prevalence were unknown and not well recognized as development menaces of these children.

Therefore, it is sensible to say that even if there is intention to provide comprehensive service for children, at least due to less recognition of psychological and/or emotional problems and inputs, the intention to provide holistic service to children has not yet been fully realized. The conversation held with the beneficiary children as well revealed that emotional related problems and their aftermath effects are least recognized and even accepted as normal feelings to live with. The zeal to reveal the prevalence of emotional related problems fuelled by lack of studies looking into the feelings of these children had initiated me to investigate the prevalence of mental distress and its association with selected socio-demographic variable of project beneficiaries' children in Addis Ketema Sub city, Kebele 06/07, Guenet Church Child Sponsorship Project.

1.3. Research Questions

1.3.1. What is the prevalence of mental distress in children, aged between 15 to 18 years?

1.3.2. What is the prevalence of mental distress across the socio-demographic variables of children, aged between 15 to 18 years?

1.3.3. What is the significance of socio-demographic variables of children, aged between 15 to 18 years, on the score of SRQ-20, or prevalence of mental distress?

1.4. Objective Of The Study

1.4.1. General Objective of the Study

This study is designed to contribute to the assessment of psychological and/or emotional problems of children by showing the prevalence and socio-demographic correlates of mental distress among children, aged between 15 to18 years.

1.4.2. Specific Objectives of the Study

The specific objectives of this study are:

1. To show the prevalence of mental distress among sponsored children aged between 15 to 18 years.
2. To show the prevalence of mental distress across the socio-demographic variables of sponsored children, aged between 15 to 18 years,
3. To show the significance of socio-demographic variables of children aged between 15 to 18 years, on the score of SRQ-20, or mental distress.

1.5. Significance Of Study

This study is expected to,

1. Shed light on the prevalence of mental distress in children, , aged between 15 to 18 years.
2. Open new insight for further investigation of mental distress across physical and social characteristics of children, aged between 15 to 18 years.
3. Contributes to the fulfilment of holistic ministry to children, by showing the psychological and/or emotional needs of children.

1.6. Limitation Of The Study

Although the evidence generally supports the notion that socio-demographic variables correlates mental distress, the research does have limitations on getting relevant literature appropriate to all socio demographic variables discussed in this study. One of the key shortcomings in this study is that some of the reports in the literature are relied on larger population than specific groups like orphaned and non-orphaned children.

1.7. Definition of Terms

For the purpose of this study,

1. **Orphan-** A child between the age of 15 and 18 years, whose mother, father or both parents have died from any cause.

2. **Single Orphan-** A child between the age of 15 and 18 years and has lost one parent.

3. **Double Orphan-** A child between the age of 15 and 18 years and has lost both parents.

4. **Maternal orphan-** A child whose mother has died.

5. **Paternal orphan-** A child whose father has died.

6. **Non-Orphan-** A child between the age of 15 and 18 years, whose parents' are alive.

7. **Child with mental distress-** A child, between the age of 15 and 18 years, whose score is above the cut off point in this Self Reporting Questionnaire (SRQ-20).

8. **Socio-Demographic-** The following physical and social features of children: Age, Sex, physical disability, Ethnic background, Religion, Attending religious services, Level of Education, Family size, Family income, Child living condition, parent life status and orphan hood status.

CHAPTER TWO

2. Review of Related Literature

2.1 Introduction

Frequently, the word mental disorder and distress are used interchangeably, however, they are different. Mental disorder is undesirable conditions caused by internal (presumably mental) states and processes, i.e. that a plausible analysis of the concept includes both an evaluative component and a factual component. Mental disorder is related to psychoneurotic or personality disorder. The definition of mental disorder usually excludes senility, retardation or other developmental disabilities, and substance addiction (Meltzer et al., 2004), where as; mental distress is a disturbing or miserable mental or emotional condition, other than physical pain, such as: fear, anxiety, depression or grief and is related to neurotic disorder (Rupp's Insurance and Risk Management Glossary, 2002).

Research indicates that some people may have a genetic predisposition to develop mental distress, but it is not like a cold or the measles, it is not contagious (WHO, 2004). According to health policy and planning manual (2003), it is sometimes believed that mental distress is caused by bad blood, punishment or the evil eye. On the other hand, doctors believe that there are a number of factors, which may lead to mental distress such as chemical imbalance in the brain, stress and everyday problems and exposure to severely distressing experiences.

According to Norman (1993), moving to new places, separation or divorce, death of parents and rejection by friends caused children to be in crises. This crisis is manifested with symptoms of mental distress such as lose of appetite, sleep, and a poor performance. He added that, one of the most frequent distressful situations that will occur with children is separation from parents due to death or divorce of parents. When there is the loss of a parent, there also may be a loss

of hope for greater extent than ever before. However, it is still difficult to be absolutely sure about the causes of mental distress in all situations.

2.2 Over view of Mental Distress among OVC's in Africa

Sengendo and Nambi reported in 1997 that in Uganda many orphans were showing signs of stress and Trauma. They reported that, the death of a parent leaves children in a state of trauma (Sengendo and Nambi 1997, cited by Foster and Williamson 2000). Indeed, orphans may become withdrawn and passive or develop sadness, anger, fear, and antisocial behaviours and become violent or depressed. Orphans may experience additional trauma from lack of nurturance, guidance, and a sense of attachment, which may impede their socialization process (through damaged self-confidence, social competencies, motivation, and so forth). Children often find it difficult to express their fear, grievance, and anger effectively. In addition, when willing to express their feelings, they may find it difficult to find a sensitive ear (UNAIDS 2001).

Evidence has shown that sick parents are often not able to talk about their disease with their children for fear of causing distress. Yet, by not including the child in their confidence, parents do indeed cause more distress (Poulter 1997).

A study done in Dar-es-salaam reveals that compared with non-orphans, orphans had more psychosocial distress for both genders: boys and girls, and at younger and older ages. Orphans whose fathers or mothers had died within the previous study year had showed signs of more-severe psychosocial distress than did those whose parents had died further into the past. However, the difference was not statistically significant at ($P>.05$) (Makame and et al., 2002). They reported that, for both genders, each type of orphan exhibited more-severe distress than did non-orphaned, non-vulnerable children. Non-

orphaned, vulnerable boys, but not girls, have also showed evidence of more psychosocial distress compared with non-orphaned, non-vulnerable children.

Another comparative study done in rural Uganda showed that Orphans had greater risk for higher levels of anxiety (odds ratios (OR) =6.4), depression (OR=6.6), and anger (OR=5.1) compared with non-orphaned (Atwine and et al., 2005). Furthermore, orphans had significantly higher scores than non-orphans on individual items in the Beck Youth Depression Inventory that are regarded as particularly "sensitive" to the possible presence of a depressive disorder, i.e. vegetative symptoms, feelings of hopelessness, and suicidal ideation (Atwine and et al., 2005)

Similar study done in Zimbabwe confirms that, orphaned adolescents in Zimbabwe do suffer greater psychosocial distress than do non-orphaned and non-vulnerable children. Their findings did also show that, for both genders, paternal, maternal, and double orphans exhibited more severe distress than did non-orphaned children (Constance, 2007).

In the neighbouring country, South Africa, a study done targeting one thousand and twenty-five children and adolescents (aged 10–19) using socio-demographic questionnaires, interview and standardized scales for assessing depression, anxiety, post-traumatic stress, peer problems, delinquency and conduct problems, revealed that children orphaned by AIDS were more likely to report symptoms of depression, peer relationship problems, post-traumatic stress, delinquency and conduct problems than both children orphaned by other causes, and non-orphaned children. Anxiety showed no differences, but the orphans were more likely to have constant nightmares ($p = .01$), and 73% scored above the cut-off for Post-Traumatic Stress Disorder (Lucie, 2006).

Compared to Western norms, AIDS-orphaned children showed higher levels of internalising problems and delinquency, but lower levels of

conduct problems. Over all, death of parents, economic problems, becoming care provider for ill parents, are causing psychosocial distress among orphaned and vulnerable children (Rose, 2003).

2.3 Mental Distress in Ethiopia

It was estimated that at least 500 million people in the world suffer from mental distress, and that only a small proportion of them receive appropriate care (Beisenberg, 1994), since in many developing countries, in particular, trained staffs are few, and specialized psychiatric facilities are limited to large urban centres. (Beusenberg and Orley, 1994).

From what has been reported in studies done in the country and from worldwide statistics, it is conservatively estimated that 12% of Ethiopians suffer from mental disorders (Alem and et al, 1999). Of these, one million or 2% of the total population are suffering from the severest form of mental illness or psychosis whereas; five million or 10% are suffering from milder disorders or neurotic conditions. Beusenberg and Orley argued that, probably, the figures could be higher for Ethiopia if studies covered wider areas and larger samples.
A cross-sectional survey conducted on 10,468 rural and semi-urban adults in Butajira district, Ethiopian using the Self Reporting Questionnaire (SRQ) reveals that 17% of the study population was experiencing mental distress (Alem et al, 1999). Likewise, a study done in Addis revealed that out of 10,203 study populations, 1.7% of the respondents were categorized as having mental distress (Kebede et al., 1999). In their findings, they reported that some physical, psychological (personal), familial, social and other environmental factors are contributing either to the occurrence or perpetuation or both of certain mental disorders and distress. Some of such factors like malnutrition, chronic illnesses, separation, death, migration, natural disasters, unstable social situations, overpopulation, etc., have been very common in Ethiopia, and these factors are

predominantly affecting the mental status of people in general, and risk groups in Particularly.

2.4 Socio-demographic variables as related to Mental distress

A cross-sectional survey done among 1500 orphans in Catalonia, Spain reveals that socio-demographic and health-related variables were significantly associated with increased psychiatric distress (Steinke, 2003); similarly, a study done among orphans in UK showed that socio-demographic factors included age, gender, and family sizes were associated with most of the psychological distress outcomes. More over, Blazer (2003) reported that poor socio-economic status is causing distress among orphans in Brazil. A study done among low income status women in Syria showed that mental distress is common in the studied population and that it is strongly associated with few, possibly modifiable, socio-demographic factors. (Wasim & et al., 2002)

2.4.1 Mental Distress as related to Orphans and vulnerable Children

Studies done in Sub-Saharan Africa including Ethiopia have shown that orphans and vulnerable children are suffering from anxiety and depression (Atwine, 2005; Makame, 2003). They are also at higher risk of exposure to HIV (Greg son et al., 2005) and missing out on schooling (Christina et al., 2005; Bicego et al., 2003), and live in households with less food security (Yamano et al., 2004; Makame, 2003). These challenges are likely to contribute to the perpetuation or occurrences of mental distress among the orphaned and vulnerable children.

2.4.2 Mental Distress as related to Sex

Dozens of studies have examined gender differences in mental health by focusing on self-reports of emotional problems in the non-treated i.e., the general population. Most of these studies are based on cross-

sectional data from community samples of individuals who report the frequency or intensity in which they experience psychological symptoms such as distress, anxiety, and depression (Robin, 2002). A self reported study conducted among reproductive-age women showed that women of reproductive age experience substantial amounts of physical and mental distress, depression, stress and anxiety, and a high proportion do not get enough rest or sleep compared to men (Indu and et al., 2004). Likewise, comparative analysis of empirical studies of mental disorder reveals a consistency across diverse societies and social contexts: symptoms of depression and anxiety as well as unspecified psychiatric disorder and psychological distress are more prevalent among women, whereas substance disorders are more prevalent among men (Melzer, 2004). These patterns for depression and general psychological distress and substance disorders are consistently documented in many quantitative studies carried out in societies across the world. For instance, a study done in Iran showed that the probability of mental disorder was 19.4% in women and 8.59% in men (Al Jamal and et al, 2007).

The overall prevalence of psychiatric disorders was 14.4%. The fact that women in Iran are more at risk of mental disorders due to the robust effect of biological factors or to social inconveniences experienced more by women than men (Al Jamal and et al, 2007). This finding is supported by Epidemiological and anthropological data that pointed to different patterns and clusters of psychiatric disorders and psychological distress among women than among men. The origins of much of the pain and suffering particular to women can be traced to the social circumstances of many women's lives. Depression, hopelessness, exhaustion, anger and fear grow out of hunger, overwork, domestic and civil violence, entrapment and economic dependence. In another study, it is reported that, women consuming cigarettes and alcohol are experiencing mental and physical distress than their counterparts (Odd and et al, 2007).

A cross sectional study done in Ethiopia, Butajira, showed that mental distress was more prevalent among women than men. Part of the explanation was that women in the study population were older and most of them were more often widowed or divorced, which were factors associated with mental distress (Alem et al, 1999), and similar study done in Addis Ababa showed that women had a statistically significant: 62% increased risk of having mental distress than men (Kebede et al, 1999). Another study done among Ethiopian orphans revealed that girls were more affected than boys by the emotional loss (Alok, 2005). In their study, Atwine and et al (2005), reported that girls were found to have more psychosocial distress than did boys (B=0.30; 95% confidence interval [CI] =0.21, 0.40). However, no difference was found between younger (aged 12–14 years) and older (aged 15–17 years) children (P=.6).

2.4.3 Mental Distress as related to Age

Young people, who experience excessive fear, worry, or uneasiness may have an anxiety disorder. Anxiety disorders are among the most common of childhood disorders. According to US department of health and human Service (1999), young people, who experience excessive fear, worry, or uneasiness may have an anxiety disorder. The same study done on 9 to 17-year-olds, showed that as many as 13 of every 100 young children have an anxiety disorder (Howard, 1999).

A study done by Richard (2007), among children aged 5 -15 years, 5% had clinically significant conduct disorders; 4% were assessed as having emotional disorders - anxiety and depression and 1% were rated as hyperactive. As their name suggests, autistic disorders, tics and eating disorders are the less common disorders children experience.

2.4.4 Mental Distress as related to Level of Education

Higher rates of psychological distress in people with little education have been reported in several studies (Rognerud et al., 1998). Likewise, there are various mechanisms, which might explain the

Summary of related literature

Mental distress is resulted from the interaction of social, psychological and biological factors and is characterized by fear, anxiety, depression, grief and post-traumatic disorder. Both, disorder and distress are prevalent in Ethiopia.

It is investigated that distress is associated with Socio-demographic variables, such as being an orphan, sex, age, religion, religious practices, family size, educational level, and disability status, and varies across socio-demographic variables of the study population. However, as far as my knowledge, findings and the aforementioned reviewed literatures have not yet reported on the prevalence and socio-demographic association of mental distress in children aged between 15 to 18 years. Therefore, this study is expected to contribute to bridge the gap of literature on mental distress among children, aged between 15 to 18 years in Ethiopia.

CHAPTER THREE

3. Methodology

3.1 Study Area

This study was conducted in Addis Ketema Sub city, Kebel 06/07 where the number of project beneficiary children is highest from the five community based sponsorship projects of Ethiopian Guenet Church in Addis Ababa.

3.2 Participants of the Study

A total of 248 respondents, composed of 124 orphaned [F=64, M=60] and 124 non-orphaned children [F=61 M=63], A total of 123 males and 125 females, aged between 15 to 18 years, were selected based on the sampling procedure mentioned below.

3.3 Sampling Procedure

With the help of project workers, all project beneficiaries [468] were listed out from project database, and stratified by their status as orphaned [258] and non-orphaned [210]. Further classification was done on orphans and 94 paternal, 83 maternal and 81 double orphans were listed out. They were assigned with numbers and through systematic random sampling technique, a total of 135 children, 45 from each category were selected. Similarly, out of 210 non-orphaned children, 168 children aged between 15 to 18 years, were identified. Then, out of 168 children, 135 were selected through systematic random sampling. For sampling frame, *please see Appendix C.*

3.4 Method of Data Collection

The purpose of the study and the instruction for completing the questionnaire was explained to 270 children and to 3 project staffs and then, questionnaires were distributed. All the respondents had completed the questionnaire with in 27 minutes, except 22 respondents who did not complete their questionnaires. All the questionnaires were returned to data collectors.

3.5 Instrument for Data Collection

3.5.1 Questionnaire

To investigate the prevalence of mental distress, a questionnaire that collects data on the socio-demographic variable of respondents was prepared and administered together with a special questionnaire, known by the name Self Reporting Questionnaire (SRQ-20). This self-reporting Questionnaire was developed and published by (WHO) in 1994, as an instrument to screen for mental distress, especially in developing countries. It consists of 20 questions, which have to be answered by yes or no. It may be used either as a self-administered or as an interviewer-administered questionnaire.

- **Applicability Of Self Reported Questionnaire**

The SRQ-20 has been translated from English into Afrikaans, Amharic, Arabic, Bahasa Malaysia, Bengali, Filipino, French, Italian, Hindi, Kashmiri, Kiswahili, Marathi, Njanja Lusaka, Portuguese, Shona, Siswati, Somali, South Sotho, Spanish, Urdu, Vietnamese and Zulu, and has been widely employed (Beusenberg, and Orley, 1994).

- **Validity of Self Reported Questionnaire**

The convergent validity of SRQ-20 was analysed in different countries and moderately high correlation was obtained. Chan and Chan (1983), Mari, J.J and Williams, P. (1985); Araya et al., (1992). Likewise, the translated Amharic version was validated, accepted and employed by different researchers (Kortmann, 1987, 1990, Kortmann and Ten

Horn, 1998,). It was also widely employed by the medical faculty staff and student of Addis Ababa University (Ataly et al., 1999; Kebede et al., 1999 and Leekassa, et al., 2004).

- **Reliability of the instrument**

The translated Amharic version of SRQ-20 was administered to 2000 respondents in Ethiopia and highly acceptable degree of internal consistency was obtained (Solomon & et al., 1991). Likewise, in this study, the reliability was analysed using the statistical package for the social sciences [SPSS] Version 13 for windows, and a Cronbach Alpha of 0.812 was obtained.

Cronbach's Alpha	No of Items
.812	20

3.6 Method of Data Analysis and Interpretation

3.6.1 Screening

The questionnaire was administered to 270 respondents. Of which, 22 questionnaires had been found incomplete and were discarded from the analysis. As a result, the data of 248 children were analysed for the purpose of this study.

3.6.1 Quantitative Analysis

Each of the 20 items is scored 0 [No] or 1[yes]. A score of **1** indicates that neurotic symptom was present during the past month, and score of **0** indicates that the neurotic symptoms were absent. The maximum score is therefore 20. Likewise, in this study, the score of each respondent was summed up, and a score of 7 or more out of 20 items indicates that the respondent has a symptom of mental distress. Accordingly, the prevalence of mental distress was calculated by the percentage of respondents who scored 7 and above in SRQ-20.

The statistical significance of the Socio-demographic variables was computed using independent t-test and Analysis of variance (ANOVA), at a confidence level of 95% and were computed in reference to the Mean plot, standard error plots, and homogeneity tests. *See the homogeneity tests in Appendix B.*

Cut off Point for SRQ-20

Self Reporting Questionnaire is employed in different countries and a cut off 7/8 was used in Rio De Janeiro, Bombay, Lahore, Lusaka, Durban, and Cali with a sample size of greater than 250, however, in some settings where chronic infections (for example, a parasitic infection) is rampant, the number of positive responses is boosted. For example, in rural Ethiopia, Solomon & et al. (1991) has used a cut-off of point 10. However, Ataly Alem and et al has used a cut off point 4/5 in their study. In another study, they have used a cut off point 6/7 (Alem et al., 1999).

In this study, for two reasons, a cut off point 7 was used. Firstly, the mean and the median scores are above 6, and secondly, 6/7 was used as a cut off point in Addis Ababa, urban setting by Ataly and et al. (1999).

3.7 Pilot Results Section

The pilot study

The self-reported questionnaire, with the socio-demographic questionnaire was piloted on 27 children in Gulele project, which is being implemented under the umbrella of Guenet church, child sponsorship program. A reliability of Chronbach's Alpha 0.78 was obtained. Then, the questionnaire was adopted as it was found reliable to apply to the study population.

CHAPTER FOUR

4. Data Presentation, Analysis and Interpretation

In this study, the prevalence of mental distress in children, aged between 15 to 18 years, the prevalence across socio-demographic variables of children, and significance of the variables on mental distress were analysed and presented as follows.

4.1 Prevalence of mental distress in children

The prevalence of mental distress in the study group was estimated by answering yes to 7 and more items, out of 20 questions. Accordingly, the row scores, frequencies, the percentages and cumulative frequencies are summarized as follows.

Table-4.1 Prevalence of Mental Distress

Row Score of the Study Group			
Score out of 20	Frequency	Percent	Cumulative Percent
17	2	0.8%	0.8%
15	4	1.6%	2.4%
14	7	2.8%	5.2%
13	6	2.4%	7.6%
12	7	2.8%	10.5%
11	10	4%	14.5%
10	12	4.8%	19.3%
9	17	7%	26.2%
8	28	11.3%	37.5%
7	28	11.3%	48.8%
6	53	21%	69.8%
5	27	10.9%	80.7%
4	20	8.1%	88.8%
3	17	6.9%	95.7%
2	10	4.0%	99.7%
Total	248	100	

According to table 4.1, 10 respondents or 4% of the respondents were answered yes to 2 items out of twenty (20), and 2 or 0.8% of respondents were answered yes to 17 items. The remaining 236 respondents had scored between 2 and 17.

According to table 4.1, 48.8% respondents had answered yes to 7 and more items and obviously, 51.2% of the respondents had scored below seven. Therefore, the prevalence of mental distress in the study group, aged between 15 to 18 years was 48.8%.

4.2 Prevalence of Mental Distress across Socio-demographic variables of targeted Children

The row scores obtained across selected socio-demographic characteristics of respondents were transformed in to Z-score. It is known that a value of Zero in (Z-score) is equivalent to the mean score. This means, respondents who scored above the mean score in SRQ-20 had scored above Zero in the transformed Z score. Therefore, in this study, the prevalence of mental distress across selected socio-demographic variables such as age, sex, attendance of religious services, disability status, educational level, parents life status, child orphan-hood status, family size and family/guardians' source of income, was determined by the percentage of respondents who scored above Zero in the transformed Z score. The prevalence of mental distress across selected socio-demographic variables of respondents is summarized from Table 4.2 to 4.6 as follows.

Table 4.2 Prevalence of mental distress in relation to age and sex

Age of Respondents In relation to Prevalence of Mental Distress			
15	16	17	18
48.70%	38.10%	39%	69.50%

Male	Female
45.84%	51.76%

As of table 4.2, the prevalence of mental distress among children aged 15 years was 48.7%, where as the prevalence was least, 38.1%, among respondents aged 16 years. It slightly increased among respondents aged 17, and reached highest prevalence, 69.5 % among children aged 18 years. The adjutant table also shows the prevalence of mental

distress in male and female respondents. It was 45.84% and 51.76%, respectively.

Table 4.3 Prevalence of mental distress in relation to attendance of religious services:

Prevalence in relation to religious Services attendance			
Frequently	Some times	Rarely	Never attend
34 %	**44 %**	**50.78%**	**67%**

As indicated in table 4.3, the prevalence of mental distress was highest, 67%, among children who never attend religious services, and 34 % among those who attend frequently and this was relatively lowest compare to the rest. It was also 44% among respondents who attend religious services sometimes, but the prevalence increased or raised to 67%, among respondents who attend rarely.

Table 4.4 Prevalence of mental distress in relation to physical disability

Do you have physical impairment/ Disability?	Prevalence
Percentage of non-impaired respondents who had showed distress	**51.85%**
Percentage of visually impaired respondents who had showed distress	**55.56 %**
Percentage of respondents with hearing impairment and had showed distress	**80%**
Percentage of respondents with mobility problem and had showed distress	**100%** [All]

Prevalence of mental distress in relation to level of education

Grade 1-4	Grade 5-8	Grade 9-10	Grade 11-12
Prevalence 54.67%	**Prevalence 68.49%**	**Prevalence 27.71%**	**Prevalence 44.10%**

As it is shown in table 4.4, all respondents with mobility problem had shown symptoms of mental distress. The prevalence was also higher-80% among respondents with hearing impairment. The prevalence among children with visual impairment and No impairment was 55.56 % and 51.85%, respectively.

The prevalence was highest- 68.49% among those respondents whose educational level was from grade 5 to 8 and lowest or 27.71% among those respondents whose educational level was either grade 9 or 10. The prevalence was high- 54.67% and 44.10% among respondents whose educational level was 1 to 4 and Grade 11-12, respectively.

Table 4.5 Prevalence of mental distress in relation to parents life status and living condition of children

Prevalence in relation to parents life status			
Both Alive	Only Mother is a live	Only Father is A live	Both are not a live
36.1%	48%	61.54%	75%

Prevalence in relation to living condition of children				
Alone	With my mother	With my father	With Both parents	With Guardians
66.67%	46.27%	33.33%	56.36	72.22

Table 4.5 shows, the prevalence of mental distress in relation to children's parent life status and children's living condition. The prevalence of mental distress was highest-75% among children who lost both parents (double orphans). It was also higher 61.54% among maternal orphaned children. When compared to paternal orphaned children, whose prevalence was 48%, the prevalence of non-orphaned children was significantly lower-36.1%. Despite their orphan-hood status, children who were leaving with guardians and those who were alone had showed highest prevalence of mental distress, 72.22% and 66.67%, respectively. The prevalence was least-33.33% among children who live with their father and children who live with their mother-46.27%

Table 4.6 Prevalence of mental distress in relation to family size and family/guardians' sources of income

What is your Family Size?					
1-2	3-4	5-6	7-8	9-11	Greater than 11
Prevalence 46.6%	**Prevalence 58%**	**Prevalence 56 %**	**Prevalence 53.7%**	**Prevalence 71.4%**	**Prevalence 33.3%**

Respondents' Family/ guardians Sources of Income?				
Daily labour	Self Employment	Gov. Employment	Pension	Other
Prevalence 50%	**Prevalence 55.4%**	**Prevalence 67.7%**	**Prevalence 45.4%**	**Prevalence 87.5%**

According to the findings showed in Table 4.6, prevalence of mental distress was highest among children whose family size was large: between 9 to 11, and low among children whose family size was lower: 1 to 2. The prevalence was least- 33.3% among children whose families sizes were greater than 11, but it was increased and the prevalence gap was narrowed among children from average /medium/ family size (E.g. 3-4, and 5-6).

The table also reveals that, mental distress was lowest among children whose family source of income was pension, followed by children whose family source of income was daily labor. The prevalence was 55.4% among children whose family/guardians'/ source of income was self-employment, and highest among children whose family source of income was unspecified followed by children whose family or guardians' source of income was government employment.

Table 4.7 Prevalence of mental distress in relation to Child status

Status of Respondents	
Orphan	Non-Orphan
Prevalence **61.5%**	Prevalence **36.1%**

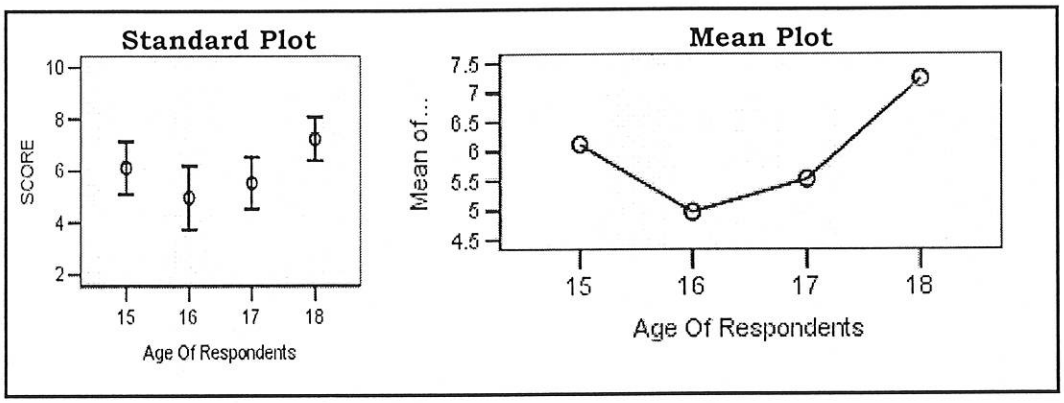
As of the finding in Table 4.7, the prevalence of mental distress in Orphaned and Non-Orphaned children was 61.5% and 36.1%, respectively.

4.3 Significance of Socio-demographic variables on Prevalence of mental distress

Mean scores related to the following socio-demographic variables: age, sex, education level, attendance of religious services, family size, family/guardians sources of income, respondent's parent life status and child life status were analyzed and presented as follows:

Socio demographic variable: Age

Figure 1: Mean and Standard Error Plot in relation to respondents' age



From the above two figures, the first figure in the left side shows the range of respondents score on SRQ-20, whilst the second figure shows the mean score of respondents in relation to different age groups.

According to the second figure, which is the mean plot, the mean score first declines from those respondents, aged 15, and then starts to rise steadily from the age of 16 to 18.

This standard error plot shows the range of mean score in some way. However, the degree of variance with in and between the groups is difficult to estimate just by looking at the standard error plot. As a result, Levene Test of homogeneity of variance was computed to test the equality of variance. *See the table (5.1) in Appendix-B*

The homogeneity test in *Table 5.1 appendix B* had accepted the assumption of equal variance at a significance level of α 0.05. This finding laid ground to compare the mean scores in relation to age groups.

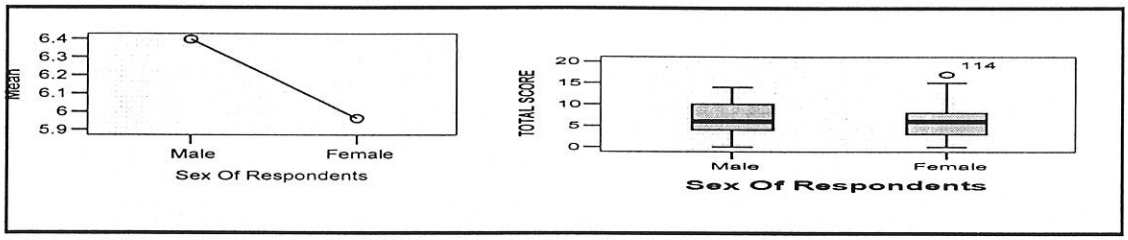
Table-4.8 Comparing means scores in relation to age groups

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	150.995	3	50.332	4.112	0.007
Within Groups	2362.304	245	12.240		
Total	2513.299	248			

Table 4.8 primarily shows the significance value of the F test, which is 0.007. Since the degree of confidence is 0.05, the assumption that the mean score of all respondents, on SRQ-20, is equal across all age groups was rejected.

Socio demographic variable: Sex

Figure 2: Mean and Standard Error Plot in relation to respondents' Sex



The mean plot in Figure 2 shows that, the mean score of male respondents was higher than female respondents. Accordingly, the mean difference was tested using t-test. See Table 4.9

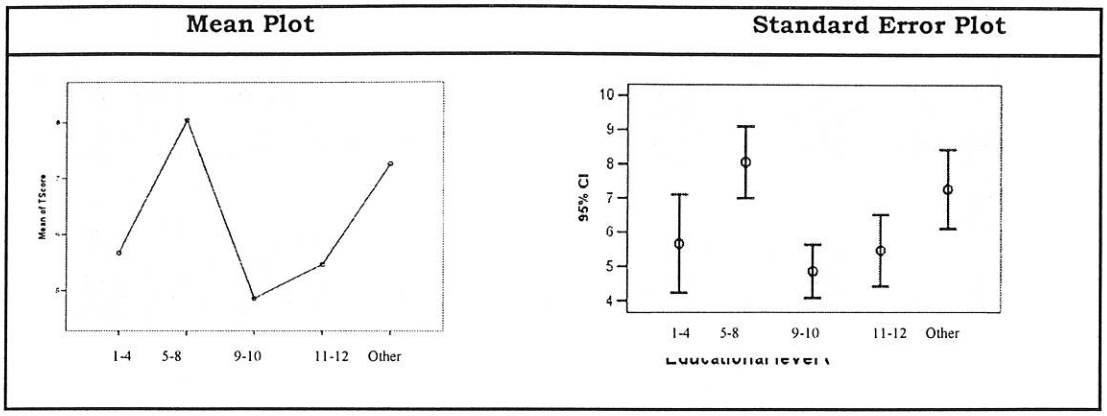
Table-4.9 Comparing means scores in relation to sex of respondents

T-test									
Levene's Test For Equality Of Variances	F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal variances Assumed	.353	0.000	.209	246	0.0005	0.38	0.125	0.19	0.68
Equal variances Not assumed			.209	244.295	0.00051	0.38	0.125	0.189	0.68

As of the above table, mean equality between female and male respondents was rejected at a significance level of α 0.05.

Socio demographic variable: Education level

Figure 3: Mean and Standard Error Plot in relation to respondents' Educational Level



The mean plot in figure 3 shows that, the mean score was raised from respondents whose grade level was 1 to 4 to 5 to 8 graders and then dropped down among respondents in grade 9 to 10. Gradually, the score raised along 11th and12th graders and other levels.

Since the Standard error plot showed range and variance of scores between and with in respondents, Levene test of homogeneity of variance was run to check the assumption that the variance of the groups was equal. *See table 5.10 in Appendix-B.*

Since Levene statistic test accepted the equality of group variances, F test was employed to see the mean significance in relation to respondents' educational level. The equality of Mean scores in relation to educational level was rejected at a confidence level of 95%. See table 4.10

Table-4.10 Comparing means scores in relation to Educational level

ANOVA					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	333.591	4	83.398	7.346	0.000
Within Groups	2179.709	243	11.353		
Total	2513.299	247			

Since equality of the means was rejected, Post Hoc Multiple Comparison, which assumes equal variance, was computed to learn more about the real differences among respondents in different levels of education. See table 4.11

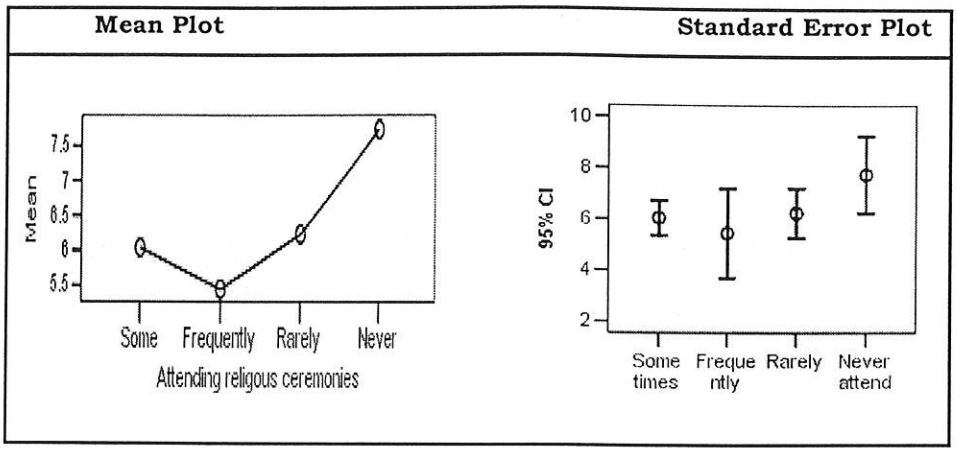
Table-4.11 Multiple Comparisons In relation to Educational Level

	Educational level	Educational level	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
LSD	Grade 1-4	Grade 5-8	-2.38	2.02	0.24	-6.36	1.59
		Grade 9-10	0.81	1.99	0.68	-3.11	4.73
		Grade 11-12	0.20	2.01	0.92	-3.76	4.16
		Other	-1.60	2.02	0.43	-5.58	2.39
	Grade 5-8	Grade 1-4	2.38	2.02	0.24	-1.59	6.36
		Grade 9-10	3.19	0.66	0.00	1.88	4.50
		Grade 11-12	2.58	0.73	0.00	1.15	4.02
		Other	0.79	0.76	0.30	-0.71	2.28
	Grade 9-10	Grade 1-4	-0.81	1.99	0.68	-4.73	3.11
		Grade 5-8	-3.19	0.66	0.00	-4.50	-1.88
		Grade 11-12	-0.61	0.64	0.34	-1.88	0.66
		Other	-2.41	0.68	0.00	-3.75	-1.07
	Grade 11-12	Grade 1-4	-0.20	2.01	0.92	-4.16	3.76
		Grade 5-8	-2.58	0.73	0.00	-4.02	-1.15
		Grade 9-10	0.61	0.64	0.34	-0.66	1.88
		Other	-1.80	0.74	0.02	-3.26	-0.33
	Other	Grade 1-4	1.60	2.02	0.43	-2.39	5.58
		Grade 5-8	-0.79	0.76	0.30	-2.28	0.71
		Grade 9-10	2.41	0.68	0.00	1.07	3.75
		Grade 11-12	1.80	0.74	0.02	0.33	3.26
○	The mean difference is significant at the .05 level of confidence.						

Like F-test, LSD test in table 4.11 rejected the equality of mean scores in relation to all educational level, however, unlike the F test, LSD test showed non statistically significant mean difference between respondents in the first cycle (grade 1- 4) and others, between respondents in grade 5-8 and others, and between respondents in grade 9-10 and grade 11-12.

Socio demographic variable: Attending religious Services

Figure 4: Mean and Standard Error Plot in relation to respondents' attendance of Religious Services



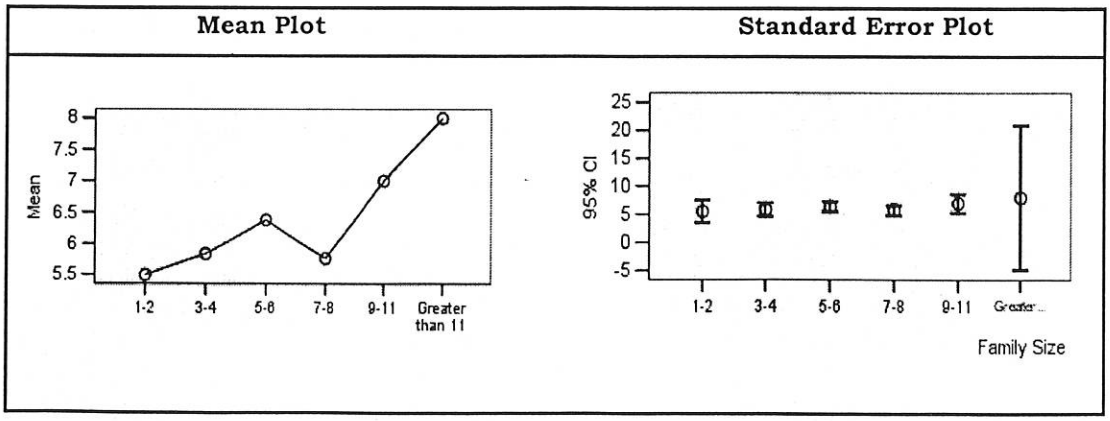
In Figure 4, the mean score of respondents, who attend their religious services on frequent bases was less than the grand mean, but the mean score starts to rise among respondents who attend religious services at times, seldom and not at all, respectively.

To study the significance of the differences, Least Significance difference (LCD) test was computed. At a confidence level of α 0.05, the equality of mean scores between the groups was rejected.

There was statistically significant difference between the mean score of those frequently attend and never attend religious services. Which means, the prevalence of mental distress was lowest among children who attend religious services frequently.

Socio demographic variable: Family Size

Figure 5: Mean and Standard Error Plot in relation to respondents' family size



In Figure 5, the mean plot across respondents' family size was relatively increased except between respondents whose family size was 7 or 8. The standard error also shows variation in scores across family sizes of respondents. Following the findings from the mean and standard error plots, test of homogeneity was run using Levene statistic test. *See table 5.19 in Appendix B*

At a significance level of α 0.05, the test accepted the assumption of equal group variances. Thereafter, F statistics was analyzed to test the assumption of equal group means. See table 4.12

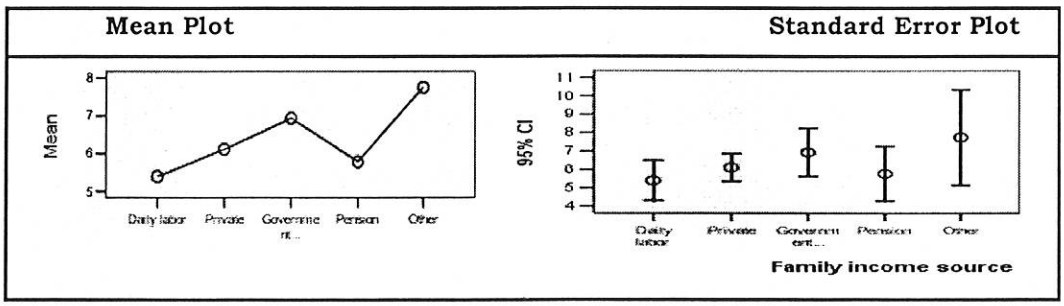
Table-4.12 comparing mean scores in relation to family sizes

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	49.093	5	9.819	.761	.00
Within Groups	2464.206	242	12.902		
Total	2513.299	247			

The F- test as well as the post hoc multiple comparisons that assume equal variance had rejected the equality of all means in relation to respondent's family size.

Socio demographic variable: Family/Guardians Sources of Income

Figure 6: Mean and Standard Error Plot in relation to respondents' family / guardian sources of income



The mean plot in Figure-6 shows the mean score that started to ascend from respondents, whose family source of income was daily laborers, to those respondents whose families or guardians' source of

income was private/self employment/ until it culminates with respondents whose family source of income was government employment. Then, the mean score dropped down among respondents whose family means of income was pension and again started to hike among respondents whose family source of income was unknown or not-specified. Similarly, the standard error plot in Figure-6 indicates variance with in and between guardians or families' sources of incomes. However, this variance was checked through test of homogeneity. *See table 5.22 in Appendix-B*

Since the assumption of equal variance was accepted *in table 5.22,* F test was computed (Table-4.13) and at a significance level of α 0.05, the equality of all means scores was rejected. See the table below

Table-4.13 Comparing of mean scores in relation to respondents' family/guardians sources of income

ANOVA					
TOTAL SCORE IN RELATION TO ITEMS					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	65.19	4.00	16.30	1.28	0.28
Within Groups	2448.11	243.00	12.75		
Total	2513.30	247.00			

Socio demographic variable: Parent Life Status

Table-4.14 Mean and standard deviation of respondents' in relation to Parent life status

Parent Life Status	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Mini	Max
					Lower Bound	Upper Bound		
Both Alive	124	4.64	2.01	.363	4.48	4.92	3	15
Only Mother is a live	41	5.15	2.88	.401	4.02	5.63	3	13
Only Father is A live	41	7.13	3.46	.962	4.14	7.33	4	14
Both are not a live	42	7.64	4.15	.661	6.68	8.38	1	15
Total	248	6.14	3.581	.255	5.63	6.64	4	16

Table 4.14 shows that, 124 children had both parents and were non-orphans. For the non-orphans, a mean of 4.64, a standard deviation of 2.01, and standard error of 0.36 was obtained from SRQ-20. For paternal orphans or children only their mother was alive, a mean score of 5.15, a standard deviation of 2.88, and standard error of .401 was obtained. Similarly, for maternal orphans, i.e. father was alive; a mean score of 7.13, a standard deviation of 3.46, and standard error of .962 was computed

Table 4.14 clearly shows that, the mean score was quite high among double orphaned children and maternal orphans, and the score was least in non-orphaned children, followed by paternal orphans.

To see the significance of these mean differences, Levene test of homogeneity was calculated, *(Table 5-25 in Appendix-B)*, and the equality of the group variances was rejected.

Due to difference in sample size and significant difference in variance, (Table 4.14 & *Table 5.25 in Appendix B)*, Welch and Brown-Forsythe tests (Table 4.15) were employed for testing mean differences, and the equality of all mean scores across respondents' parent life status was rejected at α 0.05. See the table below

Table-4.15 Comparing means scores in relation to respondents' Parent life status

	Statistic (a)	Df1	Df2	Sig.
Welch	.218	2.00	245.104	0.02
Brown-Forsythe	.210	2.00	245.104	0.02
a	Asymptotically F distributed.			

Socio demographic variable: Status of Children

Table-4.16 Mean and Standard deviation in relation to Status of children

Respondents Status	N	Mean	Std. Deviation
Non-orphan	124	4.64	2.01
Orphaned	124	7.64	4.15

Table 4.16 shows that, the mean score and standard deviations of 124 orphaned and 124 non-orphan children. A two-tailed t-test was run to see the equality of the means (Table 4.17). The test has rejected the equality of the means at a significance level of α 0.05. See Table 4.17

Table-4.17 Comparing means scores in relation to status of respondents

Total Score Across Items	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Dif	95% Confidence Interval of the Difference	
								Lower	Upper
Equal variances assumed	0.46	0.00	-2.66	245.00	0.01	-2.48	0.55	-1.57	-0.38
Equal variances not assumed			-2.86	83.62	0.01	-2.48	0.52	-1.50	-0.45

CHAPTER FIVE

Discussion

One of the objectives of this study was to show the prevalence of mental distress in children aged between 15 to 18 years that are sponsored by Guenet project. Accordingly, 48.8% of the respondents had showed symptoms of mental distress during the previous month and this prevalence was significantly higher compared to community surveys done in Addis Ababa and Butajira by Alem and et al., [1999]; and Kebede and et al., [1999). Possible statement of explanation, for getting higher score among the study group, could be their vulnerability status. Most of these children were from poor socio-economic status and they are vulnerable.

The other explanation could be their age. Respondents were in the age of adolescence where they experience excessive fear, worry or uneasiness and may have anxiety disorder.' US health and human resource department (1999): Moreover, the age of this study groups was fallen in the period where suicidal behaviour, one of the symptoms of mental distress, is escalated among adolescents (US National Center of Health Statistics, 2004).

Literature also shows that, rapid physical changes are resulted in emotional and behavioural changes among adolescents. (Jenkins & Astington (1996]. These descriptions are consistent with the findings of Howard (1999), done among children aged 9 to17, and could be an explanation for getting higher scores among study groups compared to community surveys done in Ethiopia.

In this study, the prevalence of mental distress in female respondents was found slightly higher than male respondents (Table-4.2) and the mean difference was statistically significant. In a matter of fact, dozens of studies reported that distress is higher among females than males (Melzer, 2004; Alok, 2005; Atwine and et al., 2005; Al Jamal and et al., 2007). Similarly studies done by (Gregson and et al, 2005)

mental distress (8%) compared with those who were part of four-and five children households (Howard, 1999). In support of Howard's finding, in this study, the prevalence of mental distress between two children households was found lowest compared with those who had 5 to 11 family sizes (Table 4.6) and was consistent with the studies done by Solomon and et al, (1999), but inconsistent with studies done by Kebede, and et al, (1999); Alem and et al., (1999). In addition, the Post hoc analysis had showed significant mean score differs in relation to respondents' family size, and part of the explanation might be, children from poor but large family size are more likely to compute for scare resource. For instance, my long experience in project supervision testifies that most sponsored children share their clothes, hygienic materials, food ration to their siblings' with or without their consent. If the sharing was not on consent, it is more likely to create tension and conflict among the siblings and even with parents or guardians.

In table 4.6 of this study, guardians or family's source of income was analysed in relation to the prevalence of mental distress. It was found that, level of children's distress was varied in relation to their guardians or family's sources of incomes and had association with mental distress. The mean scores were computed and their differences were statistically significant. It seemed that, the mean scores had some kind of pattern along guardians' sources of income (Figure 6).

Last but not least, in this study, the prevalence of mental distress was analysed in relation to child status. As it was showed in table 4.7, the prevalence of mental distress was higher in orphaned children than non-orphaned children (Table-4.7). The mean score of orphaned and non-orphaned children were also compared and their difference was found significant (Table-4.17). This finding is consistent with several comparative studies that showed higher mental distress in orphaned than non-orphaned children (Makame and et al., 2002; Atwine and et al., 2005; Constance, 2007). Norman (1993) states that, separation

from parents due to death or divorce of parents is one of the most frequent distressful situations that will occur with children. When there is the loss of a parent, there also may be a loss of hope for greater extent than ever before and this could be possible reason for getting higher scores.

CHAPTER SIX

Summary, Conclusion and Recommendation

6.1 Summary

The purpose of this study was to investigate the prevalence of mental distress in sponsored children aged between 15 to 18 years in Addis Ketema sub city Kebele 06/07. Accordingly, 248 children were systematically sampled and a special questionnaire was administered; accordingly, 48.8% of children had showed symptoms of mental distress.

The other objective of this study was to show the prevalence of mental distress in relation to socio-demographic variables: sex, age, attendance of religious services, educational level, disability status, family size, respondent's family or guardians source of income, respondent's parent life status and status of children, and in relation to each of the variable, the detail finding's was presented in chapter four. However, it was notified that the prevalence of mental distress was higher in female than male respondents, in orphaned than non-orphaned children as well as in respondents from large family sizes and with hearing and mobility problems. Moreover, the prevalence of mental distress was found highest among children who never attend religious services and whose educational level was lowest.

Besides, in this study the tests of significance of means were analyzed, through analysis of variance, t-tests and post hoc multiple comparison tests based on mean plot, standard plots and test of homogeneity, to see the significance of selected socio-demographic variables on scores of mental distress and each of the results were presented in Chapter four and discussed in Chapter five. It was also notified that mental distress is varied across the selected variables.

6.2 Conclusion

The prevalence of mental distress in the targeted children was significantly higher compared to the findings obtained from community surveys done in Ethiopia by Atalay and et al. Moreover, the prevalence of mental distress among orphaned children was higher than non-orphaned children aged between 15 to 18 years. Prevalence of mental distress was also varied in relation to respondents' age category, sex, physical impairment or disability, attendance of religious services, level of education, family size, family or guardians sources of income, children parent life status and orphan-ness.

Therefore, from this study, it is more likely to conclude that, mental distress is prevalent in sponsored children, aged between 15 to 18 years and is varied with selected socio-demographic variables of respondents.

6.3 Recommendations

Based on the experiences and the findings of this study, the following recommendations and suggestions are forwarded:

6.3.1 Mental distress was prevalent among those targeted children sponsored by Guenet Church Project. Therefore, the project staff and the project holders are suggested to study its impact and work on the underlying causes of mental distress with health professionals and counselors.

6.3.2 Mental distress was highly prevalent among orphaned children, and children with visible physical impairment, lowest level of education and those whose family size was large; therefore, special attention and psychosocial support should be offered to those groups.

6.3.3 Compare to non-attendants, those children who attend religious services frequently had less distress; thus, project holders should revise a strategy to utilize religious services as resources to support children with mental distress.

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Internet Resources

1. www.unicef.org/aids (UNICEF protects the rights of children, with an emphasis on primary health care and nutrition, education, water, sanitation and hygiene education, and child protection)
2. www.unicef.org/crc/crc.htm (CRC, Convention on the Rights of the Child)
3. www.csa.gov.et /orphans and vulnerable children/2006
4. www.childinfo.org/MICS2/Gj99306k.htm, (MICS, Multiple Indicator Cluster Surveys)
5. WHO, Promoting Mental Health, Summary Report, 2004. http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf
6. http://www.pubmedcentral.nih.gov/
7. www.worldbank.org/children/ (orphans and vulnerable children, early child development)

-Appendices-

Appendix - A

Addis Ababa University,
School of Graduate Studies
Department of Psychology

Dear study participants,

This questionnaire is designed to assess certain feelings of those children, in Addis ketema Sub city, kebele 06/07, sponsored by Guenet Church Child Project, in the last 30 days. The data generated from this questionnaire is expected to help stakeholders get better understanding of sponsored children. So, you are kindly requested to provide your genuine responses to part one and part two of the questionnaire.

I would like to ensure you that, the individual scores and data are confidential and shall not be disclosed for the third party, but the data will be analysed, interpreted and presented to Addis Ababa University, department of psychology, for the partial fulfilment of Masters Degree in Counselling.

Thank you in advance for your cooperation!

PART-1

Socio-Demographic Characteristics

Please complete the following information by using a '√' mark on appropriate box

PERSONAL DATA

1. Sex

   M ☐ ☐

2. Age

   15 ☐ 16 ☐ 17 ☐ 18 ☐

3. Do you have any visible impairment?

   Yes, I have visual impairment ☐

   Yes, I have hearing impairment ☐

   Yes, I have mobility problem ☐

   Yes, I have other impartment ☐ Please specify _____

   No, I don't have visible impartment

4. Religion

   Orthodox ☐ Catholic ☐

   Muslim ☐ Protestant ☐

   Other, Please specify _____

5. Ethnicity

   Gurage ☐ Amhara ☐

   Tigre ☐ Oromo ☐

   Other, Please specify _____

6. Educational Level

Illiterate ☐ Grade 1-4 ☐ Grade 5-8 ☐

Grade 9-10 ☐ Grade 11-12 ☐ Other, Please specify ----

7. Family Size

No Family ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9-10 ☐

Greater than 11 ☐

8. Parents Status

Both alive ☐ Mother died ☐ Father died ☐

Both died ☐

9. Family/guardians source of income

Daily labour ☐ Self-employment ☐ Gov.t employment ☐

Pension ☐ Other ☐ Please specify ----------

10. Living Condition

I live alone ☐ I live with my Mother ☐ I live with my father ☐

I live with my step father/ Mother ☐ I live with my parents ☐

I live with my guardian ☐ Please specify your relationship with the guardian _____

11. Do you attend religious services organized by your denomination?

Frequently ☐ Sometimes ☐

Rarely ☐ Never ☐

PART-2

Self-Reporting Questionnaire (SRQ-20)

Instruction:

The following questions are related to certain feelings you felt in the last 30 days, if you think the question applies to you and you had the described problem in the last 30 days, mark tick [√] to yes. On the other hand, if the question does not apply to you and you did not have the problem in the last 30 days, mark tick [√] to no column.

Please do not discuss the questions with anyone while answering the questionnaire. I would like to reassure that the answers you are going to provide here are confidential.

S/No	Questionnaire Items	Yes	No
1.	Do you often have headaches?		
2.	Is your appetite lost?		
3.	Are you easily frightened?		
4.	Do you sleep badly?		
5.	Do your hands shake?		
6.	Do you feel nervous, tense or worried?		
7.	Is your digestion poor?		
8.	Do you have trouble thinking clearly?		
9.	Do you feel unhappy?		
10.	Do you cry more than usual?		
11.	Do you find it difficult to enjoy your daily activities?		
12.	Do you find it difficult to make decisions?		
13.	Is your daily work suffering?		
14.	Are you unable to play a useful part in life?		
15.	Have you lost interest in things?		
16.	Do you feel that you are a worthless person?		
17.	Has the thought of ending your life been in your mind?		
18.	Do you feel tired all the time?		
19.	Do you feel stomach discomfort?		
20.	Do you easily feel tired?		

በአዲስ አበባ ዩኒቨርስቲ የትምህርት ፋኩልቲ
የሳይኮሎጂ ዲፓርትመንት
በድህረ ምረቃ ተማሪ የተዘጋጀ መጠይቅ

የተከበራችሁ የዚህ ጥናት ተሳታፊዎች፡-

ይህ መጠይቅ የተዘጋጀው በአዲስ ከተማ ክ/ከተማ ቀበሌ 06/07 በገነት ቤ/ክ የልጆች ተራድኦ ፕሮግራም የታቀፉትን ታዳጊ ህጻናት ባለፉት 30 ቀናት የተሰማቸውን ስሜት ለማወቅ ሲሆን የጥናቱ ውጤት ባለ ድርሻ አካላት በፕሮጀክቱ የታቀፉትን ህጻናት በተሻለ ሁኔታ እንዲረድዋቸው የሚያግዝ ይሆናል፤ እርስዎ የሚሰጡት የግልዎ መረጃ ሚሥጥራዊና ለሶስተኛ ወገን የማይተላለፍ መሆኑን እገልፃለሁ፡፡ መጠይቁ ሁለት ክፍሎችን የያዘ ሲሆን የርስዎን ማንነት ሳይገልጥ መረጃው በጥቅል እንዲሁም በአሃዛዊ መረጃ በአዲስ አበባ ዩኒቨርስቲ ለሳይኮሎጂ ዲፓርትመንት ለሁለተኛ ዲግሪ ማሟያ የሚቀርብ መሆኑን ተረድተው ያለምንም ማመንታት ትክክለኛውን ምላሽ እንዲሰጡኝ በታላቅ ትህትና እጠይቃለሁ፡፡

ስለ ትብብርዎ በቅድሚያ አመሰግናለሁ!

ክፍል-1

እባክዎትን በተሰጥዎት ሳጥን ውስጥ ይሄን '√' ምልክት በመጠቀም መጠይቁን ይመሉ::

<u>የግል መረጃ</u>

1. ፆታ

   ወ ☐ ሴ ☐

2. ዕድሜ

   15 ☐ 16 ☐ 17 ☐ 18 ☐

3. በአካል ላይ የሚታይ እንከን /ጉዳት/ አለብዎ?

   አዎን የማየት ችግር አለብኝ ☐

   አዎን የመስማት ችግር አለብኝ ☐

   አዎን የመንቀሳቀስ ችግር አለብኝ ☐

   ሌላ ዓይነት እንከን /ጉዳት/ ካለብዎት እባክዎን ይግለፁልኝ_____

   ምንም ዓይነት እንከን /ጉዳት/ የለብኝም ☐

4. ሃይማኖት

   ኦርቶዶክስ ☐ ካቶሊክ ☐

   ፕሮቴስታንት ☐ መስሊም ☐

   ሌላ ☐ እባክዎን ይግለፁልን _____

5. ብሔር

   አማራ ☐ ትግሬ ☐

   ጉራጌ ☐ ኦሮሞ ☐

   ሌላ ☐ እባክዎን ይግለፁልን _____

6. የትምህርት ደረጃ

ያልተማረ ☐ ከ1ኛ- 4ኛ ☐ ከ5ኛ- 8ኛ ☐

ከ9ኛ- 10ኛ ☐ ከ11ኛ- 12ኛ ☐ ሌላ ☐

እባክዎን ይግለፁልን _____

7. የቤተሰብ ብዛት

ከ1- 2 ☐ ከ3- 4 ☐

ከ5-6 ☐ ከ7- 8 ☐

ከ9-11 ☐ ከ11 በላይ ☐

ቤተሰብ የለኝም ☐

8. የወላጆች ሁኔታ

ሁለቱም በሕይወት አሉ ☐ እናቴ ብቻ በሕይወት አለች ☐

አባቴ ብቻ በሕይወት አለ ☐ ሁለቱም በሕይወት የሉም ☐

9. የቤተሰብ/የአሳዳጊ የገቢ ምንጭ

የቀን ሥራ ☐ የግል ሥራ ☐

የመንግስት ሥራ ☐ ጡረተኛ ☐

ሌላ ካለ እባክዎን ይገለጹልን _____

10. በአሁኑ ጊዜ ከማን ጋር ትኖራለህ/ሪያለሽ?

ለብቻዬ ☐ ከእናቴ ጋር ☐

አባቴ ጋር ☐ ከዘመዶቼ ጋር ☐

ከአሳዳጊዬ ጋር ☐ ሌላ ካለ ይገለጽ _____

11. በቤተእምነትዎ/በሃይማኖትዎ/ በሚዘጋጀው መንፈሣዊ አገልግልዎት ምን ያህል ይሳተፋሉ?

ዘወትር/ሁል ጊዜ ☐ አንዳንድ ጊዜ ☐

አልፎ አልፎ ☐ በጭራሽ አልሣተፍም ☐

ክፍል –2

መመሪያ:

ከዚህ በታች የተዘረዘሩት መጠይቆች ባለፉት 30 ቀናት የተሰማዎትን ስሜት ለማወቅ ሲሆን እያንዳንዱ ጥያቄ ባለፉት 30 ቀናት ከተሰማዎት ስሜት ጋር ከተዛመደ አዎን በሚለው ሳጥን ውስጥ ይሄን √ ' ምልክት በመጠቀም ምላሽ እንዲሰጡ አደራ እላለሁ፡፡ ነገር ግን እያንዳንዱ ጥያቄ ባለፉት 30 ቀናት ከተሰማዎት ስሜት ጋር ከልተዛመደ የለም በሚለው ሳጥን ውስጥ ይሄን √ ' ምልክት በመጠቀም ምላሽዎን ይስጡ፡፡ ይህንን ምላሽ ሲሰጡ ከሁለተኛ ወገን ጋር ሳይመካከሩ ይሁን፡፡
የዚህ ጥናት ውጤት ሚሥጥራዊና ለሶስተኛ ወገን የማይተላለፍ መሆኑን በድጋሚ አረጋግጥላችኋለሁ፡፡

1) ራስ ምታት ብዙ ጊዜ ያምዎታል?	አዎን	የለም
2) የምግብ ፍላጎትዎ ጠፍቷል?	አዎን	የለም
3) በቀላሉ ፍርሀት ፍርሀት ይለዎታል?	አዎን	የለም
4) የእንቅልፍ ችግር አለብዎት?	አዎን	የለም
5) እጆችዎ ይንቀጠቀጣሉ?	አዎን	የለም
6) መረበሽ÷ መጠበብ ወይም መጨነቅ ይበዛብዎታል?	አዎን	የለም
7) ምግብ ከበሉ በኋላ ሆድዎን ይከብድዎታል?	አዎን	የለም
8) በትክክል ማሰብ ይቸግርዎታል?	አዎን	የለም
9) የደስታ ማጣት ስሜት ይሰማዎታል?	አዎን	የለም
10) ያለበቂ ምክንያት እምባ እምባ ይልዎታል?	አዎን	የለም
11) በየቀኑ በሚሠሯቸው ሥራዎች መደሰት ይቸግርዎታል?	አዎን	የለም
12) በእለት ተለት ተግባርዎ ውሳኔ መወሰን ይቸገራሉ?	አዎን	የለም
13) የየእለት ተግባርዎን ለመፈጸም ያስቸግርዎታል?	አዎን	የለም
14) በአካባቢዎ ጠቃሚ ተሳትፎ ማድረግ አስቸግርዎታል?	አዎን	የለም
15) በአንዳንድ ነገሮች ላይ የነበረዎት ፍላጐት/ ስሜት/ ጠፍቷል?	አዎን	የለም
16) የማልጠቅም ሰው ነኝ የሚል ስሜት ይሰማዎታል?	አዎን	የለም
17) ሕይወትዎ አስጠልቶዎት ሞቼ ባረፍኩ ያሉበት ጊዜ አለ?	አዎን	የለም
18) ሁል ጊዜ ድካም ይሰማዎታል?	አዎን	የለም
19) ሆድዎ/ ጨጓራዎ በቀላሉ ይረበሻል?	አዎን	የለም
20) በቀላሉ የድካም ስሜት ይሰማዎታል?	አዎን	የለም

Appendix - B

Test of homogeneity of Variance

Table-5.1 Test of homogeneity of Variance

Levene Statistics	df1	df2	Sig.
.199	3	245	.897

Table-5.10 Test of Homogeny of Variances

Levene Statistic	Df1	df2	Sig.
1.320	4	243	0.264

Table-5.19 Test of Homogeneity of Variances

Levene Statistic	Df1	Df2	Sig.
1.133	5	242	.344

Table-5.22 Test of Homogeneity of Variances

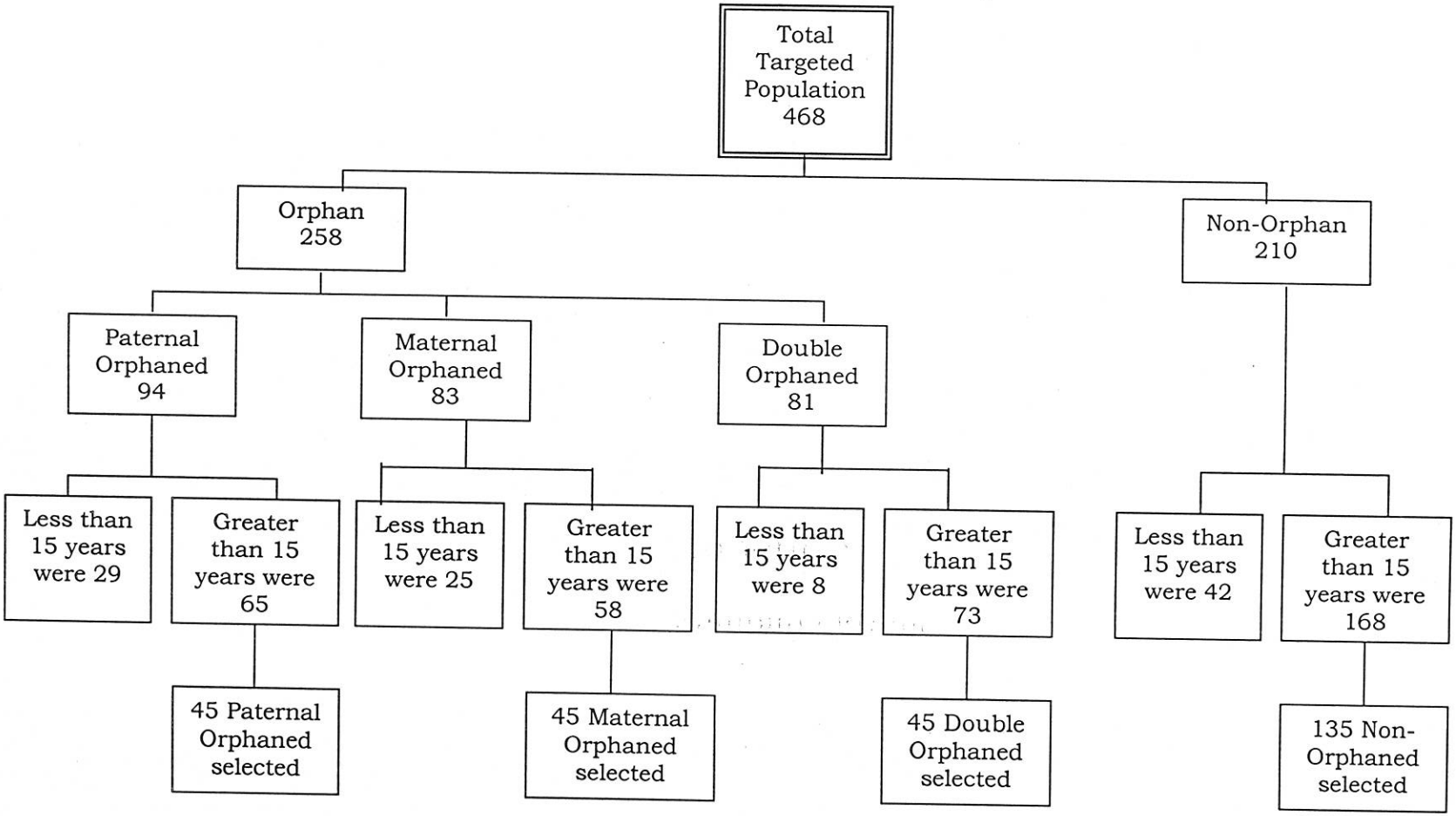
Levene Statistic	Df1	Df2	Sig.
1.168	4	243	.326

Table-5.25 Test of Homogeneity of Variances

Levene Statistic	**Df1**	**Df2**	**Sig.**
2.153	**3**	**244**	**.035**

Appendix – C

Sampling Frame



Appendix – D

Socio-demographic Characteristics of Respondents

Table –1: Age and Sex of Respondents

Age of Respondents	Sex Of Respondents				Total %
	Male		Female		
	N	%	N	%	
15	30	24.4	25	20	22.2
16	26	21.1	19	15.2	18.2
17	27	22.0	39	31.2	26.6
18	40	32.5	42	33.6	33.1
Total	**123**	100	**125**	100	100
% Of Respondents Across Sex	49.6%		50.4%		100 %

Table-2 Religious and Ethnic Background of Respondents

Ethnic Background of Respondents	Religion of respondents						Total %
	Ethiopian Orthodox		Protestant		Muslim		
	Count	%	Count	%	Count	%	
Amhara	43	37.7	9	7.03	1	16.7	20.5
Tigre	19	16.7	26	20.31	1	16.7	17.9
Gurage	27	23.7	64	50.00	2	33.3	35.7
Oromo	25	21.9	22	17.19	1	16.7	18.6
Others	0	0	7	5.47	1	16.7	7.4
Total	114	100	128	100	6	100	
Total % of respondents Across religion		**(46.0%)**		**(51.6%)**		**(2.4%)**	

Table-3 Disability Status of Respondents

Disability Status	Type of impairment	
	Count	%
No impairment	216	87.1%
Visual	10	4.0%
Hearing	5	2.0%
Mobility	7	2.8%
Others	10	4.0%
Total	248	100.0%

Table-4 Educational Level of Respondents

Educational Level	Male	%	Female	%	Total	%
First Cycle	5	4%	0	0%	5	2%
Elementary	14	11%	35	28%	49	20%
High school	41	33%	46	37%	87	35%
Preparatory	33	27%	27	22%	60	24%
Other	30	24%	17	14%	47	19%
Total	123	100%	125	100%	248	100%

Table-5 Guardian's/ parents' life status and child living condition

Children's Parents life status			
Both Parents Alive	Only Mother is alive	Only Father is alive	Both are not alive
50%	**16.5%**	**16.5%**	**17%**

Table-6 Respondents' Guardian or family's sources of income

Guardians or Families Sources of income					
Daily labor	Self-Employment	Government employment	Pension	Other/ Unspecified	Total
20.2%	**50.4%**	**15.3%**	**9.7%**	**4.4%**	**100%**

Table-7 Respondents' family size

Respondents' Family Size					
1-2	3-4	5-6	7-8	9-11	Greater than 11
10%	**16.5%**	**36.3%**	**26.6%**	**9%**	**1%**

Table-8 Respondents' Living condition

Child Living condition					
Alone	With my mother	With my father	With parents	Guardians	Total
3%	**28%**	**18%**	**29%**	**21%**	**100%**

Table-9 Mean and Median of the study group

Mean and Median Of the Study Group		
N	Valid	248
	Missing	0
Mean		6.14
Median		6.00

Declaration

I, the undersigned, declare that this is my original work and has not been presented for a degree in any of other universities.

Name: Ephraim Tsegay

Signature _____

Date of Submission Dec 2008

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

Name: Sentayehu Tadesse, PhD

Signature _____

Date of Submission Dec, 12/08