Care and Support of Orphaned Children with *Adera*, *Non - Adera* and *Institutional Arrangements* in Debre Markos and Bahir Dar Towns

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Abstract: *Examining the strengths and limitations of the existing practices of care and support would help suggesting strategies that accommodate the rising number of orphans for quality care services. To this end, this study attempted to describe and compare the provisions (positive and negative), processes (level of guardian's commitment and child's attachment styles), and child behavior outcomes (resilience and educational performance) 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 gathering instruments included a questionnaire administered to a sample of 180 orphaned children (60 in each care arrangement) with ages 7 to 17 years, an interview conducted with 30 guardians, and school records to secure data on educational profiles of the children. Having analyzed the data using relevant statistical techniques, it was found that children in SOS Village were provided with more material care, lesser negative treatments and psychological support than children in the other two care arrangements. On the other hand, while children in the Adera care arrangement appeared to secure more psychological care than the rest, the Non-Adera group was exposed to the highest negative treatments. Concerning the processes of care and support, it was reported that the Adera guardians felt honored to be given the Adera responsibility that they invested more efforts meeting the needs of the children and guided them to develop desirable behaviors. Hence, the guardians were more committed and their Adera children were more securely attached than the other two groups. Regarding child-behavior outcomes, it was found out that the Adera children were more resilient and this has also unfolded itself in educational terms because this group appeared to significantly outperform the other groups particularly in the first and second cycles of primary school. Based on the findings, conclusions have been drawn and recommendations have been forwarded.*

Key words: Adera**,** Orphan Care, Alternative Care, Institutional Childcare, SOS Village, Resilience, Academic Performance, Attachment, Commitment of guardians

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Introduction

Orphaned children in Ethiopia seem to retain three major concerns in one: (1) that they are children and naturally contain the developmental needs characteristics of this stage, (2) that they are rooted in Ethiopia and are to go through an upbringing that is structured by the objective and subjective realities of this country, and (3) that they are orphans and are likely to develop concerns, needs, and problems that accompany parental loss (Belay, T., 2007).

The concerns associated with these triple phenomena have been appreciated by individuals, communities and organizations. Dictated by the cultural orientations, religious practices, family lineage systems and different philosophical outlooks, society members, governmental organizations and non-governmental organizations in Ethiopia have been responding to the care and support of orphaned children, and the absorption of orphaned children through different care arrangement systems (Varnis, 2001). Some of these care arrangements include, but not limited to, '*Adera* Orphan Care', '*Non-Adera* Family - Based Orphan Care,' and 'Institutional Orphan Care'. None of these care and support arrangement systems are, however, unequivocally complete in the optimal development of orphaned children (Abebe, 2009). Examining the limitations and strengths of these systems would capacitate in identifying care arrangements that need to be scaled-up and scaled-out for (a) accommodating the increasing number 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 childcare and support alternatives. Hence, this study intends to describe and compare the three care arrangement systems (viz. *Adera*, *Non-Adera* and *Institutional*) for the care and support of orphaned children.

Childcare and Support: Nature and Provisions of Alternative Childcare Arrangements

***Adera* Orphan Care Arrangement:** A commonly used Amharic word, '*Adera*', has two meanings. *Adera*, when spelt with low intonation, (አደራ - *adàrra*) in a noun form, refers to "s/t [something] entrusted to s/b [somebody]"; and when spelt with high intonation, (*adàrra*) in a verb form, refers to the act of "forming a web" (Amsalu, 1996, p.196) as in spiders. In the former case, *Adera* is the process of transferring responsibility over one's own possession or property to another person. "It is usually made when we request others to carry out an assignment in our absence or on behalf of us" (Belay and Belay, 2010, p. xvii) with diligence. It is this noun form that is used to refer to the kind of care and support provided to children at a time parents are unable to deliver their parental mandate for various reasons. For example, when parents are terminally ill, it is common in Ethiopia for them to bestow their children's care and responsibility to

another person in anticipation that chances of recovery from the illness are slim and that the children need a substitute caregiver to support them with their education and development. Such a process of entrusting someone to another is locally called '*Adera*'. *Adera* recipients can be elder siblings, aunts, uncles, grandmothers/fathers, neighbors, or other non-relative adult acquaintances (Belay and Belay, 2010; Yigzaw, 2009). In some cases, the children given *Adera* are informed about whom they were given *Adera* to; but in most cases the transfer process is not communicated to the children (Belay, T., 2007).

The *Adera* arrangement is sometimes made in a relatively formal procedure. The *Adera* donor makes 'Nuzazie' (will) about her/his possessions and properties in front of witnesses (e.g., priests and sheiks, and community elders). The donor informs her/his decisions as to which property is to be given to whom and when. Included in this list is also the parent's request of the *Adera* recipient for protecting and nurturing the child/children considering her/him/them as own child (ren) (Gebreyesus, 1987; Kassa, 2006).

In many cases, the *Adera* arrangement is, however, less formal, simple, or may even be indirect. No matter how varied the procedures are, the purpose remains to be the same: impose social, cultural, and spiritual pressures upon the recipient so that s/he may not withdraw from the relationship prematurely (Belay, T., 2007). Social values, beliefs, and practices seem to suggest that *Adera* is more likely to induce compliance to the promises entered. It is said in Amharic - 'አደራ ጥብቅ ሰማይ ሩቅ (*Adera tibk semay ruk*)' (Ethiopian Language Academy, 1982) - that an issue received as 'Adera' is a very serious matter to be observed. A person who respects the *Adera* responsibilities to the end is labeled as "አደራ ከታች (Adera ketach)" (Ethiopian Language Academy, 1982) to mean that s/he is trustworthy, credible, and a person of integrity while, on the other, an individual who fails to do so is labeled as a "person who sucked the *Adera*" ("Aderawin yebela" or አደራውን የበላ) (Belay, T., 2007). These and related other negative social labeling would uplift or depress social status in the community and within the various social groups, gatherings, associations, and institutions to which the *Adera* recipients may subscribe membership to (such as 'mahiber', 'senbete', 'idir', 'ekub', etc.).

The practice of *Adera* still has important religious implications for the recipient. In scriptural writings, the Almighty God/Allah is said to entrust children for parents to care and raise them in recognition of His Kingdom and Holiness. Taking the Lord/Allah as a model, believers are, at the brink of their death, to transfer their children in the name of God/Allah to another person to take care of their needs (see Aster 2:6 in the Bible; and Sûrah 4:6, 7; Sûrah 107: 2, 3in the Qur'an). In the Christian and Muslim religions, the death of an individual is considered as passing away

of one's flesh, not just the end of life or soul, and thus *Adera* endowed to someone in this world is expected to be returned to the giver in the other world, "Bemider yesetehuhin besemay ekebelehalehu" (በምድር የሰጠሁህን በሰማይ እቀበልሃለሁ).

The contribution of this (*Adera*) kind of care arrangement is, of course, not very well researched. Some small scale investigations were, in fact, carried out to examine the practices and impacts of *Adera* as an alternative care arrangement particularly for orphaned children (Belay, T., 2007; Kassa, 2006; Yigzaw, 2009). These studies indicated that *Adera* would demand the provisions of materials to meet the children's basic needs (food, clothing, shelter, health services, etc.), psychological needs (love, attention, parental guidance, supervision, protection, etc.) and educational needs (books, pens, pencils, exercise books, etc.). On the other hand, evidences still suggest that the traditional role of *Adera* has been under siege (Belay and Belay, 2010) as a result of, among others, the expansion of HIV/AIDS eroding values and African traditions of cooperation and interdependence and undermining the capacities and roles of extended family care (Chirwa, 2002). HIV/AIDS appears to have led to scores of children living without parents, thus making substitute parenting (through *Adera*) less feasible. In addition, *Adera* care arrangement would be less efficacious if all orphaned children are to be given *Adera* only to one person, if all responsibilities of caring (psychological, material, educational, social…etc.), even for a single child, are given only to one person (Belay, T., 2007), and if *Adera* recipients accept the request to bestow the child mainly to please the dying parent rather than out of personal conviction.

Institutional Orphan Care Arrangement: The rising number of orphans, the decline in the capacities of extended families and communities to care for them, and the emergence of modern nuclear family systems have led many orphans in Ethiopia to be cared for and supported within institutional care arrangements (Bulti, 2007). Institutional or residential care arrangement has, in fact, been historically the most seriously critiqued approach of childcare. Bowlby (1965) was the first person to investigate the nature and effects of childcare institutions. According to him and many other subsequent researchers, institutional childcare was found to be severely depressing the emotional, social and cognitive development of the children and, therefore, was recommended to be abolished altogether or get substituted by other community-based arrangements. A number of local investigations have also documented that children reared in institutions had internalizing and externalizing disorders (Abdinasir, 1995) including bedwetting and aggressive behaviors (Mekdes, 1986; Belay, H., 2002), retarded cognitive, moral and physical development (Gobena, 1994 cited in Belay and Teka, 2008), academic problems including underachievement (Tsige, 2007) and

repetition of classes (Belay, H., 2002), and dependency syndrome among the youth (Belay, H., 2002) or a common tendency to seek lasting support and to continue to live in the same way for long. Social responsibility (interpersonal and group) behavior was the only exception in which these children were found to fare better than their home-reared counterparts (Firew, 1994).

Evidences suggest that institutional children who are more vulnerable as a group are those who were admitted because of complete parental absence (orphan) compared with those joining for parental destitution (Belay, H., 2002). Children who maintained contact with parents while in the institutions were found to make easy adjustments during the community reintegration efforts initiated in one project (of Ethiopian Orthodox Church) aimed at de-institutionalizing childcare programs (Belay, H., 2002).

Realizing the risks of residential care and the protective role of social/family support for children, some innovative practices were introduced into the system of care arrangement in more recent years. One such arrangement is that of creating Children's Village for orphaned children within the institutional setting. This is an approach that tries to *reconstruct* or *simulate* the 'naturally' occurring nuclear family system in caring for and supporting of orphaned children with pseudo-parents (called auntie) and siblings within the residential settings. The number of houses in a village, in most cases, is limited to ten or less to make each village feel like a 'naturally' occurring community and each home feels like a family (Macarov, 2009). SOS Village is one such organization in Ethiopia.

Research reports on the provisions and outcomes of care and support to orphans in children's villages have shown that these villages tend to provide relatively stable shelter, clothing, health services, counseling services and basic educational facilities for the children (Macarov, 2009). They are better off compared to working street children (living with their parents) in terms of housing, nutrition and access to education (Abebe, 2009). However, they are much worse in terms of interrelationship with peers and sociability compared to their counterpart on the streets (Abebe, 2009). Children in the SOS Villages are isolated, have fewer social skills and seem unprepared to cope with life when they come of age and leave the Villages as adults (Abebe, 2009).

Childcare and Support: The Process that Makes the Difference

Caring for a child is a process of interaction that takes meaning and structure as a result of interplay of the characteristics of the caregiver, the child and the care-giving conditions. Experiences in this process of interaction are believed to be the ones making differences in the possible contributions of the various alternative care arrangements. Some of the major

defining forces of the process of interaction and its possible outcome are, among others, *caregiver's commitment* in the provision of care and support and *attachment styles* of the children with caregivers.

Commitment of Caregivers: Commitment of caregiver is the degree to which the caregiver is motivated in meeting the needs of the child. It refers to the extent to which the caregiver invests his/her effort in caring for the child (Dozier and Lindhiem, 2006). Furthermore, commitment of caregiver to childcare consists of parental delight in the child, sensitivity to the child's needs and cues, acceptance of the parenting role, and sense of distress at separation from the child (Dozier and Lindhiem, 2006). Some of the factors that affect caregiver's level of commitment to care include age of the child at the time of placement for care and the number of children to be cared for and supported (Lindhiem and Dozier, 2007).

Child-Caregiver Attachment Styles: Child-caregiver attachment is the enduring reciprocal emotional interactions between the child and the caregiver/s (Ainsworth, 1973). In her classic work, Ainsworth has classified attachment into three categories (*secure*, *insecure/anxious*, and *insecure/avoidant*) that are still widely accepted.

Secure attachment style is a "... relationship involving intimacy, exclusivity, mutual enjoyment, acceptance and recognition of feelings between the child and caregiver" (Gray, 2002, p.67). Gray stated that a securely attached child will recover quickly from minor hurts and insults of its caregiver. A child with this attachment style spontaneously hugs or puts its arm around the caregiver and demonstrates confidence in the caregiver.

Anxious attachment style involves the children exhibiting mixed feelings of alternately ignoring the caregivers and clinging to them (Gray, 2002). They get through their caregivers' emotional neglect, unavailability and lack of responsiveness in order to increase their chances of getting noticed. In this attachment style, care tends to be inconsistent, unreliable and unpredictable (Howe, 2005). Caregivers are not necessarily unloving, but are erratic and insensitive in their care of the children.

In avoidant attachment style, children feel connected to the caregivers, but they do not trust caregivers to meet their needs in a reliable, pain-free or sensitive manner (Gray, 2002). These children show little apparent signs of distress when separated from their caregivers and will either ignore or avoid their caregivers upon reunion. Avoidant attachment arises when caregivers are indifferent towards or even rejecting the children. Caregivers show a lack of interest in the children's needs and emotional state (Howe, 2005).

Guardians' level of commitment and the associated child-guardian attachment style, will definitely unfold its impact on

children's wellbeing and performance in life.

Childcare and Support: Child Behavior Outcomes

From the perspective of a growing orphaned child, the contributions of care arrangements need to be gauged against issues of resilience and academic learning.

Resilience has been a developmental construct that has been closely tied up reviewing life experiences of children exposed to different kinds of vulnerabilities. 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). Child-resilience encompasses (a) good outcomes despite high-risk status, (b) sustained competence under threat and (c) recovery from trauma (Apfel and Simon, 1995). Further, resilient children are those who master normative developmental tasks despite their experiences of significant adversity.

Resiliency being multidimensional, an indispensable dimension of functioning in the life of children is experience in schooling. Like resilience, school learning is a developmentally salient area of child functioning where the different care arrangements would trigger impact of one kind or another. Children under different care arrangements would develop different kinds of concerns that would eventually compromise their learning.

Conceptual Map

The ongoing discussion would preferably unfold itself in the following simplified schematic presentation that still guides subsequent activities of this research.

Figure 1 presents care and support of the children: possible *provisions* (positive and negative forms of care and support), *processes* (levels of guardians' commitment in care and support and child attachment styles) and *child-behavior outcomes* (resilience and educational performance of the children).

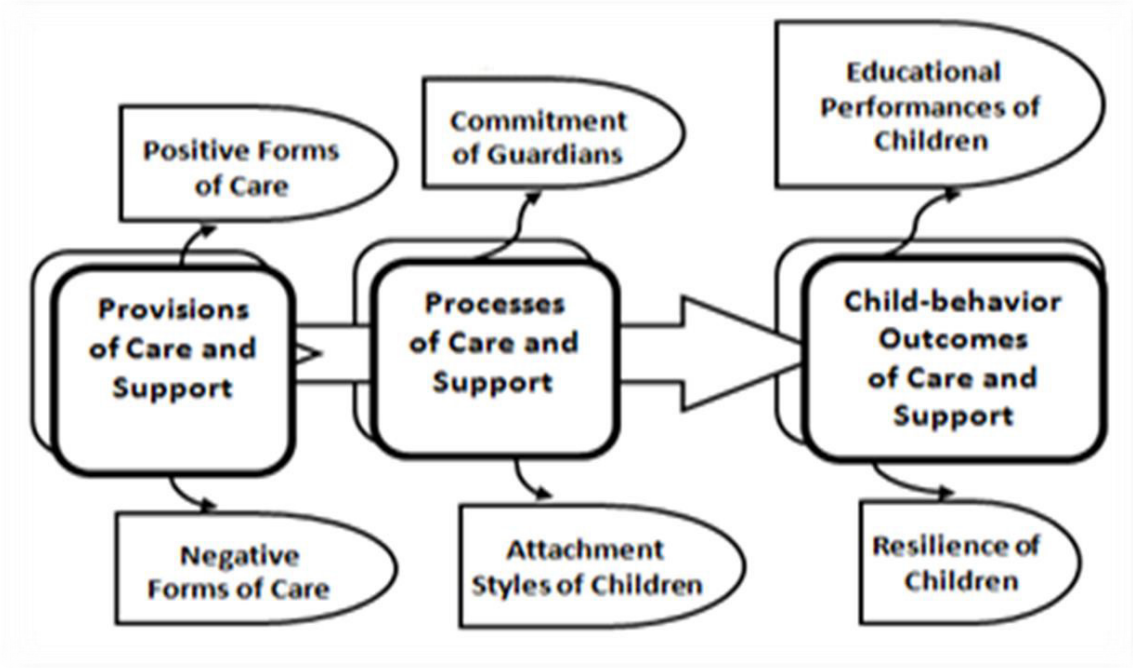

Figure 1: Conceptualization of childcare and support

Objectives

Generally, this study aimed to describe and compare the *provisions*, *processes* (guardian's commitment in care and support and child attachment styles) and *child-behavior outcomes* (resilience and academic learning) of care and support of orphaned children in *Adera*, *Non-Adera*, and SOS Village care arrangements. In more specific terms, it attempts to examine possible differences among the three forms of care arrangements in the:

- provisions of care and support (provisions),
- levels of commitment of caregivers and attachment styles of children (processes), and
- resilience and academic performances of the children (outcomes, impacts).

Methods

Study Design: The current study employed 'mixed methods concurrent explanatory' research design (Creswell, 2009). Pertinent to this design, both quantitative and qualitative datasets were used and collected in a similar period. The qualitative data were used to supplement or to provide explanations about the quantitative results. Besides, the qualitative data were embedded within the themes and categories formed for the quantitative data that had been established for addressing the basic research questions of the study.

Data Sources

Study Sites: The study was conducted in Debre Markos and Bahir Dar Towns of the Amhara Regional State, Ethiopia. These sites were selected mainly because

of the researchers' familiarity with these areas. Given very limited budget put at the disposal of the research, this familiarity has facilitated the data collection processes. More importantly, these areas were selected because it was possible to access children and guardians in all the three care arrangements. In fact, experience of the present researchers is informative of the fact that the practice of *Adera* childcare and support system, which is becoming less visible in recent times in other areas, appears more common in these areas.

Population: The target populations of the study were orphaned children and their guardians living in *Adera* and *Non-Adera* care arrangements within the community of Debre Markos and Bahir Dar Towns and in SOS Village of Bahir Dar. Currently, it is estimated that there are 2154 and 4773 orphaned and vulnerable children in Debre Markos and Bahir Dar, respectively (Labor and Social Affairs Offices of Debre Markos and Bahir Dar Towns, unpublished sources). Besides, there are a total of 113 children in 14 families each containing one auntie (guardian) in the SOS Village of Bahir Dar Town.

Participants: A total of 180 orphaned children (aged between 7 and 17 years) and 30 guardians were sampled to participate in the study from the *Adera*, *Non-Adera* and SOS Village care arrangements.

The selection of and access to *Adera* and *Non-Adera* participants followed a *multi-stage* sampling technique. First, *snowball* sampling technique was employed to identify and create a list of households containing orphans in the two towns. To do this, *Idir* (funeral association) leaders, priests, sheiks, school directors, and Labor and Social Affair Offices of the *Kebele*s were consulted. Accordingly, a list of 136 households (containing 242 children) from Debre Markos and 154 households (containing 240 children) from Bahir Dar were identified to serve as a sampling frame. This list was found to contain orphaned children aged 2 to 20.

Second, once the sampling frame was identified, 103 households from Debre Markos and 98 from Bahir Dar were found to have orphans between 7 and 17 years of age and hence selected for inclusion in the sample. These selected households were contacted door-to-door to check their consent to participate in the study. Finally, 38 *Adera* recipients with 71 children and 53 *Non-Adera* recipients with 82 children from Debre Markos, and 47 *Adera* recipients with 96 children and 40 *Non-Adera* recipients with 86 children from Bahir Dar gave their consents to become participants. The remaining 12 households from Debre Markos and 11 from Bahir Dar were left out due to their refusal. Some of the heads of the households that declined the request said that they, on the one hand, were bored of being repeatedly tagged as *households with orphaned children* by different agents, and on the other, their orphaned children were annoyed with being

socially labeled as *orphaned children,* anytime such registrations take place.

Finally, from the refined final list of potential participants, 22 *Adera* and 25 *Non-Adera* recipient households from Debre Markos with 30 children each, and 19 *Adera* and 23 *Non-Adera* recipient households from Bahir Dar with 30 children each were selected using *simple random* sampling. The steps followed in selecting the *Adera and Non-Adera* participants are illustrated in Figure 2 below.

Guardians of the *Adera* and *Non-Adera* participants were selected from households of the sampled children using *convenience sampling.* Accordingly, five guardians *from Adera* and another five from *Non-Adera* recipient households from each of Debre Markos and Bahir Dar were selected for inclusion. On the other hand, child participants from SOS Village were classified into two based on their chronological ages. The first group consisted of male and female children between 6 and 13 years of age living with the families of the village containing six to 10 children per guardian. The second group contained children with ages between 14 and 17 years living in the 'Youth Hostels' of the village with males and females separately. Children between 7 and 17 years old were selected *purposely* from the two groups. Accordingly, 60 SOS Village children were selected giving considerations to the number of children in a family, sex and age of the children. In the same way, 10 guardians were selected from the families of the children in the SOS Village using *convenience* sampling.

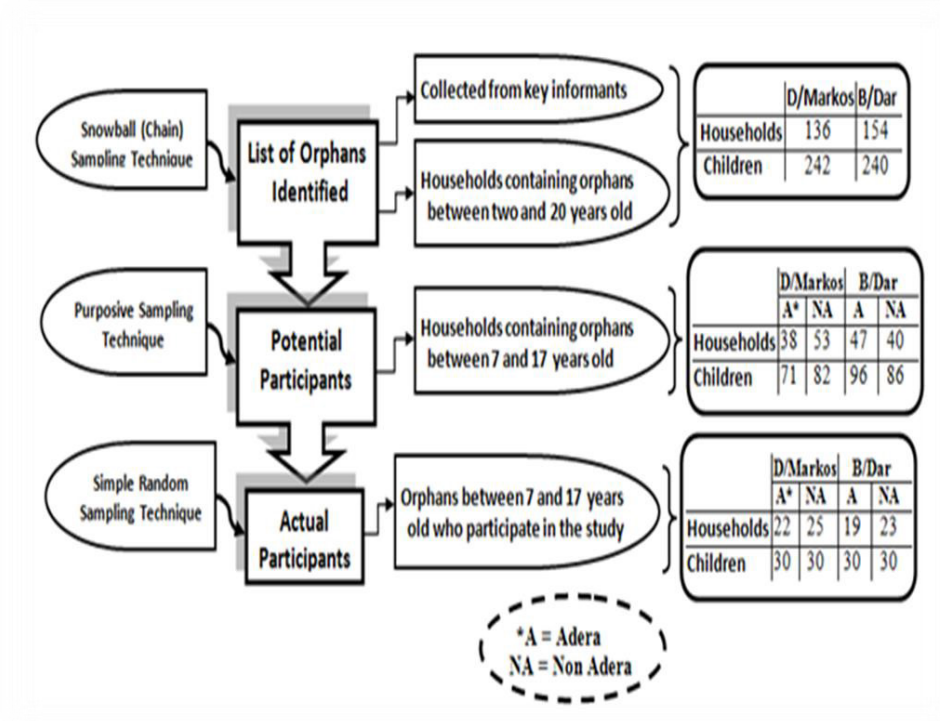

Figure 2: Steps in selecting Adera and Non-Adera participants

Instruments

Questionnaire: Consisted of a set of piloted items to be rated on a-three-point scale (Agree = 3, Sometimes Agree/Disagree = 2 and Disagree = 1) regarding four themes. The first is on the provision of care and support and contains 32 items of positive material support (like, for example, fulfilling needs for food, cloth, educational materials, health services, etc.), positive psychological care (e.g., emotional support, supervision, guidance, etc.) and negative treatments (e.g., spanking, property grabbing, discrimination, scolding, etc.) to the children. The second part consists of six items on the commitment of the guardians in relation to providing care and support. The third part is on the child's attachment style (secure, anxious and avoidant) to her/his guardian and contains 15 items. The fourth part deals with resilience of the children measured with nine items. Generally, the questionnaire was administered in or around the residences of the children. Items were read aloud to the children one at a time and responses were recorded by the assistants. These sub-scales were constructed partly from a review of relevant literature and partly from other existing instruments in similar areas as follows:

Provisions of Care and Support Scale was developed based on Horwath's (2007) approach of categorization of care and support in which seven *aspects* of childcare and support - viz, physical, emotional, educational, supervisory, verbal, labor and health - were identified in the initial steps of constructing this scale. Later on, an eighth aspect, 'property grabbing', was added since it was found to be repeatedly mentioned in literature as a major concern of orphaned children (Belay and Belay, 2010; Belay, T., 2007; Bulti, 2007). Using these eight dimensions of care and support, a total of 52 items were pooled from research reports and literature (e.g., Ayalew, 2007; Belay, H., 2007; Belay, T., 2007; Bulti, 2007; Chirwa, 2002; Horwath, 2007).

Commitment of Guardians to Care and Support Scale was adapted from a standardized semi-structured interview known as "This Is My Baby" (TIMB) interview schedule developed to study foster parents' level of commitment in raising their foster children (Dozier and Lindhiem, 2006). Items of this instrument and some additional items borrowed from literature were assembled together and developed into a Likert-type scale for making it more convenient for participants to respond to.

Child's Attachment Style Scale was adapted from Finzi and colleagues' (1996) Attachment Styles Questionnaire (ASQ) as well as from other empirical research reports.

Resilience Scale was adapted from Yigzaw's (2009) measure of resiliency, that in turn, was developed from Davidson (2003 cited in Yigzaw, 2009), and Bisrat's (2005) resilience scales that were developed to measure AIDS-orphaned children's resilience.

Semi-Structured Interview Schedule: It was used to collect data from guardians about their interactions with and provisions of care and support to the children, resilience of the children, and their commitment in caring and supporting of the children. Such data were mainly used to triangulate the quantitative data. Interview with the guardians was conducted exclusively by the researchers. It followed immediately after the completion of the administration of the questionnaire to the child of each sampled guardian. This Semi-Structured Interview Schedule was constructed paralleling the Questionnaire prepared for the children and tried out on five guardians to check and improve clarity, usefulness and feasibility of conducting the interview. Adjustments were made following the lessons learned from this experience. Audio recordings of interviews were made with the consent of the interviewees and these records were listened to repeatedly and then transcribed verbatim for analysis.

Academic Record was referred to for the children's average scores and their class rank. The educational profiles of the children were collected from school records. To keep the anonymity of the questionnaire, each child's questionnaire was coded and referent names were recorded in a separate paper for accessing corresponding academic scores in the records of the children.

Validation of the questionnaire

The pool of items of the questionnaire was originally prepared in a five-point Likert scale (ranging from Strongly Agree to Strongly Disagree) in English language and then translated into participants' mother tongue (i.e., Amharic). The Amharic and English versions of the instruments were shown to two (English and Amharic) language experts for checking clarity and appropriateness of expressions for children. Comments were incorporated and then subjected again to expert critique for feedback on relevance of contents of the items, adequacy of coverage, clarity of expressions and feasibility for children's level of understanding. After receiving relevant feedback from three experts, seven of the items were discarded, some were modified, and the five-point rating scale was reduced to a four-point scale to make it more feasible for the children (see table 1 for more details).

The last phase of refinement was pilot-testing of the questionnaire. This was conducted to check, once again, the appropriateness and clarity of items from the participants' perspective and also to see if there are better ways of administering the questionnaire to the children. Thirty children (15 from *Adera* and 15 from SOS Village care arrangements) were selected to participate in the pilot study.

The responses obtained from the questionnaire were statistically analyzed

before the above revision to check the reliability coefficients of the scales. A Cronbach Alpha coefficient of 0.89 was found for the total scale. Indices for the sub-scales ranged between a minimum of 0.59 for 'Commitment of Guardians for Care and Support Scale' to a maximum of 0.84 for "Provision of Care and Support to the Children". The other two sub-scales (Child Attachment Style and Child Resilience) had Cronbach Alpha coefficients of 0.67 and 0.74 respectively.

Attempts were also made to make some revisions based on the responses of the pilot study to address the concerns noted during administration and it was hoped that it would boost the reliability of the scales further. Accordingly, some items were discarded, others were modified, few were added and the four-point scale of the Questionnaire was again reduced further into a three-point scale. Generally, some of the actions taken on some items of the Questionnaire after the pilot study are summarized in Table 1 below

Table 1: Actions taken on some items of the questionnaire after the pilot study

Types of problems observed	***№ of items***	***Example of items with the problem***	***Measures taken***	***Example of the item modified/added***
Redundancy	*5*	*My guardians gives importance to my opinion*	*Discarded*	**-**
Ambiguity	*4*	*I am advised that I should consider the home as my own house*	*Modified*	*My guardians tell me that they love me*
Inappropriateness for orphaned children	*7*	*My guardians make me get enough sleep*	*Discarded*	**-**
Inappropriately stated	*6*	*My guardians do not cloth me properly*	*Modified*	*I have no problem in clothing*
Inadequate coverage	*3*	**-**	*Addition*	*Did you receive aid from relatives or organizations?*
Ambiguity	*1*	*My needs are prioritized by my guardians than themselves*	*Modified*	*Most of the time, my guardians prioritize their own needs than my need.*

Having gone through all these refinement procedures, the Questionnaire was finally administered to the children to generate data for the main study.

Analysis

Despite the fact that interval data were generated in this research, non-parametric statistical techniques were employed for analysis mainly because the major assumptions that parametric tests commonly require (normality, homogeneity, and randomness) were not met in the present data. To be more specific, the Kruskal Wallis H - test was employed supplanting One Way ANOVA for parametric data. The model requires converting the interval data into ordinal ones and then it compares the summed ranks of two or more independent groups. This test was followed by a further Post Hoc comparison Mann-Whitney U-test to locate the sources of significant H-test. On the other hand, when data on dependent measures were conveniently collapsed into two or more categories (e.g. attachment styles and guardians' commitment levels) an r x c contingency (χ^2) test was applied to check if there are differences among the three groups of children in their attachment styles as well as in their guardians' commitment levels (Bisrat, 2005). Table 2 presents the approaches and models of the analysis in a better detail.

Table 2: The types of statistical analysis techniques employed for the study

Variables of the study	***Purpose of analysis***	***The type of statistical technique employed***
Provisions of care and support	*Differences in the provisions of care and support among the three groups*	*Kruskal Wallis H - test*
	Post Hoc Comparison of these differences	*Mann-Whitney U-test*
Commitment of guardians	*Differences among the three groups in the level of commitment of guardians (Low, Moderate or high) to the children's care and support*	*Chi-square (χ^2) test*
Attachment styles	*Differences among the three groups of children in their attachment (secured, anxious, or avoidant) styles*	*Chi-square (χ^2) test*
Children's resilience	*Differences in resilience of children of the three groups*	*Kruskal Wallis H - test*
	Post Hoc Comparison of these differences	*Mann-Whitney U-test*
Academic performance	*Differences in academic performance of children in the three groups*	*Kruskal Wallis H - test*
	Post Hoc Comparison of these differences	*Mann-Whitney U-test*

Regarding the analyses of guardians' interviews, the audio records were listened repeatedly and then transcribed as they were spoken in the words of the interviewees. Finally, major themes were identified and compared across the three care arrangements.

Results

Provisions of Care and Support

Provision of Positive Care: The provision of positive care and support involves ensuring the survival, growth and development of children by attending to their material and psychological needs. Accordingly, children were presented with 16 items so that they can rate the extent to which they were assisted to meet these needs. Their responses were analyzed using Kruskal Wallis H-Test. This analysis (Table 3) revealed that there are overall mean rank differences (*H=31.37, df = 2, p < 0.05*) among SOS (M=22.68, MR = 118.58), *Non-Adera* (M =19.97, MR = 65.98) and *Adera* (M=21.05, MR = 86.94) groups.

Table 3: The Mean scores and Kruskal Wallis H-test values for the three groups on the provision of material care to children

	SOS Village (n=60)	*Non-Adera (n=60)*	*Adera (n=60)*	*H-test Value*
Mean (M)	*22.68*	*19.97*	*21.05*	*31.37**
Mean Rank (MR)	*118.58*	*65.98*	*86.94*	

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

Mann-Whitney U-test of two independent samples was computed (Table 4) to identify the group that made significant contributions for the Kruskal Wallis H-test result.

Table 4: The Mann-Whitney U-test multiple comparisons of the three groups on the provision of material careto children

Comparison	*Groups*	*MR*	*SR*	*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); MR = Mean rank, SR = Sum of Ranks*

Table 4 indicates that there was:

- a significant (*U=770, p < 0.05, two-tailed)* mean rank difference between SOS and *Non-Adera* groups. The SOS Village (M=22.68, MR=77.67) has provided more *material* care to children than the *Non-Adera* (M=19.97, MR= 43.33) group.
- a significant (*U=1145.5, p < 0.05, two-tailed)* mean rank difference between SOS and *Adera* groups. The SOS Village (M = 22.68, MR = 71.41) has provided more *material* care to the

children than the *Adera* (M=21.05, MR=49.59) group.

- no significant difference between *Non-Adera* (M=19.97, MR=53.15) and *Adera* (M=21.05, MR = 67.85) care arrangements in the provision of *material* care to children.

Analyses on *psychological* care (Table 5) showed that there was an *overall* significant (*H= 41.07, df =2, p < 0.05, two-tailed*) mean rank difference among SOS (M=10.62, MR = 60.05), *Non-Adera* (M=11.92, MR = 90.9) and *Adera* (M=13.32, MR = 120.55) groups.

Table 5: The Mean scores and Kruskal Wallis H-test values for the three groups on the provision of psychological care to children

	SOS Village (n=60)	*Non - Adera (n=60)*	*Adera (n=60)*	*H - test Value*
Mean (M)	*10.62*	*11.92*	*13.32*	*41.07**
Mean Rank (MR)	*60.05*	*90.9*	*120.55*	
** p < 0.05 (two-tailed), df = 2*				

The Mann-Whitney U-test of comparison of rank differences among the three groups yielded (Table 6) that there was a significant mean rank difference between the:

- SOS and *Non-Adera* groups *(U=114, p < 0.05, two-tailed)*. The *Non-Adera* group (M = 11.92, MR = 71.5) has provided more *psychological* care than the SOS group (M=10.62, MR = 49.5).
- SOS and Adera groups (U=633, p < 0.05, two-tailed). The Adera group (M=13.32, MR = 79.95) has exceeded the SOS group (M=10.62, MR = 41.05).
- Non-Adera and Adera groups (U=1164, p < 0.05, two-tailed). The Non-Adera group has secured (M=11.92, MR = 49.9) less psychological care than the Adera group (M=13.32, MR =71.1).

Table 6: The Mann-Whitney U-test of comparisons of the three groups on the provision of psychological care to children

Comparison	***Groups***	***MR***	***SR***	***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); MR = Mean rank, SR = Sum of Ranks*				

The vignettes drawn from interviews, presented briefly below, still support the observation above that the material home environment of the SOS group was much better:

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

> *...they [children] are provided with clothes, shoes and educational materials from their saving bank account their father had opened for them while alive. Now the money is draining and I am worried about what to do with the Adera given to me. For sure, I can't afford abandoning the children. I may need to engage in all possible activities that help care for my kids (Interview with an Adera guardian, Kebele 03, Debre Markos Town).*

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

Provision of Negative Treatment: Negative treatment of children has an adverse effect on their proper survival, growth and development. The analyses on exposure to negative treatments (Table 7) showed that there was an *overall* significant mean rank difference ($H = 70.41$, $p < 0.05$, *two-tailed*) among SOS (M = 29.97, MR = 48.44), *Non - Adera* (M=35.35, MR = 127. 48) and *Adera* (M = 33.18, MR = 95.58) groups.

Table 7: The Kruskal Wallis H-test of group differences on exposure to negative treatments to children

	SOS Village (n=60)	*Non- Adera (n=60)*	*Adera (n=60)*	*H –test Value*
Mean (M)	*29.97*	*35.35*	*33.18*	*70.41**
Mean Rank (MR)	*48.44*	*127.48*	*95.58*	

** P < 0.05 (two-tailed), df = 2*

The Mann-Whitney U-test pair-wise comparisons (Table 8) of *negative treatment* of children indicated that there was a significant mean rank difference between the:

- SOS and *Non-Adera* groups (*U=230.5, p < 0.05)*. The *Non - Adera* group (M = 35.35, MR = 86.66) had experienced more *negative treatment* than the SOS Village (M = 29.97, MR = 34.34).
- SOS and *Adera* groups (*U = 846, p <0.05)*. The SOS Village (M = 29.97, MR= 44.6) were more exposed to negative treatments than the *Adera* group (M = 33.18, MR = 76.4).
- *Non - Adera* and *Adera* groups (*U=1150.5, p < 0.05)*. The *Non - Adera* group (M = 35.35, MR = 71.33) are treated *more negatively than* the *Adera* group (M = 33.18, MR = 49.68).

Table 8: The Mann-Whitney U-test multiple comparisons of the three groups on the provision of negative treatments to children

Comparison	*Groups*	*MR*	*SR*	*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.*
	Adera (n=60)	*49.68*	*2980.5*	*5**

** p < 0.05 (two-tailed); MR = Mean rank, SR = Sum of Ranks*

Analysis of number of days in which children were made to be late and/ or absent from school (a form of negative treatment of children) indicated that, alike the above case, those in the *Non-Adera* and *Adera* groups were the ones being more vulnerable to delays and absenteeism (Table 9).

Table 9: The average number of day's children of the three groups have become late and absent from school

Average nº. of days of being late from school in a week	*Groups*		
	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 more days	*0*	*6*	*4*

Groups	*Nº. of children being absent from the school in a year*
SOS Village (n= 59)	*3*
Non-Adera (n=57)	*15*
Adera (n=58)	*11*

Commitment of Guardians to Care and Support

The scores of the six items, which intend to measure guardians' commitment to care and support were categorized into three levels -low, moderate and high - 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. The Chi-square test in Table 10 indicates that guardians' level of commitment to care and support was significantly different among the three groups *(x^2 =60.48, df = 4, p < 0.05, two-tailed)*. Based on this, 17 (28.3%) children in SOS, 10 (16.7%) in *Non-Adera* and 4 (6.7%) children in *Adera* groups were found in the *low 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 *high level* of guardians' commitment. These implies that children in SOS, *Non-Adera* and *Adera* groups enjoy low, moderate and high levels of guardians' commitment, respectively.

Table 10: The Chi-square test results for the three groups on the levels of guardians' commitment

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

**p < 0.05 (two-tailed)*

Note:- Ob = observed frequency, Ex. = expected frequency

Besides, the responses of guardians on the extent to which they make efforts in correcting the children's misconduct indicates that guardians in *Adera* and SOS groups really had high and low levels of commitment, respectively, in caring and supporting of the children:

> *I will not abandon her [the child] until I am deceased even if her conduct is not good for me. I will take whatever it takes to make*
>
> *her successful in her education and life, because she is my Adera child (Interview with an Adera guardian, Kebele 07, Debre Markos Town).*

I try to properly manage their [the children] conduct as far as I am their guardian, but… if they do not recognize my advice, I warn them so that they may change. If they do not behave after that, I request that they be removed and substituted by other children (Interview with an SOS guardian, Bahir Dar Town).

Attachment Styles of Children

Children were presented with fifteen attachment-related items so that they rate their interaction patterns with their guardians. The responses of the children to these items were classified under the three styles of attachment (secure, anxious and avoidant). The total score of each attachment style was classified 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 was used to categorize these levels. As it is shown in Table 11, there were significant differences among the three groups in *secure* ($x^2 = 17.45$, $df = 2$, $p < 0.05$) and *avoidant* attachment styles ($x^2 = 10.26$, $df = 2$, $p < 0.05$) compared to the *anxious* attachment style ($x^2 = 4.09$, $df = 2$, $p > 0.05$). This indicates that more children in the *Adera* group (50, 83.3%) exhibited secured attachment style than children in SOS (29, 48.3%) and *Non-Adera* (43, 71.7%) groups. In contrast, the avoidant attachment style was exhibited more in the SOS group (51, 85%) than in the Adera (37, 61.7%) and *Non-Adera* (37, 61.7%) groups.

Table 11: The 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)	*Ob.*	*31*	*29*	*18*	*42*	*9*	*51*
	%	*51.7*	*48.3*	*30*	*70*	*15*	*85*
	Ex.	*19.3*	*40.7*	*14.3*	*45.7*	*18.3*	*41.7*
Non-Adera (n=60)	*Ob.*	*17*	*43*	*9*	*51*	*23*	*37*
	%	*28.3*	*71.7*	*15*	*85*	*38.3*	*61.7*
	Ex.	*19.3*	*40.7*	*14.3*	*45.7*	*18.3*	*41.7*
Adera (n=60)	*Ob.*	*10*	*50*	*16*	*44*	*23*	*37*
	%	*16.7*	*83.3*	*26.7*	*73.3*	*38.3*	*61.7*
	Ex.	*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*

Note :- Ob = observed frequency, Ex.= expected frequency

Guardians, too, were asked to describe their interactions with the children. Responses obtained seem to portray that guardian-child

attachment was more comforting than the other two. Consider the following interview transcriptions:

> *He [the child] feels at ease talking to me when he gets hungry or quarrels with his friends (Interview with an SOS guardian, Bahir Dar Town).*
>
> *Sometimes, I give him advice through other guardians in the Village, because he [the child] does not respect me (Interview with an SOS guardian, Bahir Dar Town).*
>
> *He [the child] is free to talk to me but, when I talk angrily, he cries and feels sad easily. Even though he is sad, he does not give up food and with this, I am very happy (Interview with a Non-Adera guardian, Kebele 03, Debre Markos Town.*
>
> *He [the child] does not directly tell his feelings of hunger and sorrow 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 looks sad). (Interview with a Non-Adera guardian, Kebele 02, Bahir Dar Town).*
>
> *They [the children] are free to disclose their problems to me; they are free to ask me for enjera [local food]. When they get back home from school, they become disappointed if they do not find me in. (Interview with an Adera guardian, Kebele 02, Debre Markos Town).*

Resilience of the Children

Comparison of children's resilience in the three groups (Table 12) indicates that there was a significant *overall* mean rank difference (*H=18.22, df = 2, p < 0.05)* among the SOS (M=16.73, MR=73.9), *Non-Adera* (M =17.32, MR = 84.68) and *Adera* (M=18.72, MR =112.93) groups. The Post-Hoc analysis using the Mann-Whitney U-test (Table 13) reveals that there was:

- no significant difference between SOS (M=16.73, MR=56.74) and *Non-Adera* (M =17.32, MR = 64.26) groups.

Table 12: The mean scores and Kruskal Wallis H-test values for the three groups on resilience of the children

	SOS Village (n=60)	*Non- Adera (n=60)*	*Adera (n=60)*	*H –test Value*
Mean (M)	*16.73*	*17.32*	*18.72*	*18.22**
Mean Rank (MR)	*73.9*	*84.68*	*112.93*	
**** p < 0.05 (two-tailed), df = 2***				

The above table shows:

- a significant (*U=1029.5, p < 0.05)* difference between the SOS and *Adera* groups. Children of the *Adera* group (M=18.72, MR=73.34) were more resilient than children in SOS group (M=16.73, MR= 47.66).
- a significant (*U*=1225*, p < 0.05)* difference between children of the *Non-Adera* and *Adera* groups. Children of the *Adera* group (M=18.72, MR=70.08) were more resilient than children of the *Non-Adera* group (M=17.32, MR = 64.26).

Table 13: The Mann-Whitney U-test multiple comparisons of the three groups on resilience of the children

Comparison	***Groups***	***MR***	***SR***	***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); df =2; MR = Mean rank, SR = Sum of Ranks*				

The interview result with guardians seems to supplement the above findings:

> *He [the child] remembers his mother more frequently than his father, … he becomes saddened when he hears his mother's name, 'Ketema'. One day, he angrily crashed the TV when he heard the name 'Ketema' in the TV. (Interview with an SOS Village guardian, Bahir Dar Town).*
>
> *The child cries when he wakes-up every morning. Although he was not told about the death of his parents, he was repeatedly found in their burial place. (Interview with a Non-Adera guardian, Kebele 07, Bahir Dar Town).*
>
> *He [the child] is very strong… he repeatedly tells me his vision to be a big man. He made 'mekerkeria' [a small box made-up of chipboard used for saving coins in] and saves*

money from the coins he receives from relatives for buying play materials. (Interview with an Adera guardian, Kebele 03, Debre Markos Town).

Academic Performances of the Children

The academic performances of children in the three groups (Table 14) were seen at three grade cycles: primary school first cycle (grade 1-4), primary school second cycle (grade 5-8) and secondary school (grade 9-10).

Table 14: The Number of children under primary school first cycle, primary school second cycle and secondary school grade categories

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

The differences of the three groups in academic performances (Table 15) were found significant at the primary first cycle *(H=9.44, df =2, p < 0.05)* and second cycles *(H=6.27, df =2, p < 0.05)* but not for secondary school *(H=6.27, df =2, p < 0.05)*.

Table 15: The Mean scores and Kruskal Wallis H-test values for the three groups on academic performances of children

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

**p < 0.05 (two-tailed),df = 2; MR = Mean rank*

The Mann-Whitney U-test in Table 16 indicates that there were significant differences between the SOS and *Adera* groups (Adera group performing better), and between the *Non-Adera* and *Adera* groups in the first cycle of primary school and between the SOS Village and *Adera* groups in the second cycle of primary school.

Table 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 Level	*Comparison*	*Groups*	*MR*	*SR*	*U-test Value*
Primary school first cycle	*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	*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); MR = Mean rank ; SR = Sum of Ranks*

Discussions

This study has attempted to compare practices of care and support among three groups of orphaned children, the child-guardian interaction patterns in the process of care and support, and possible impacts of both on children's wellbeing and learning.

Regarding the provisions of care and support, the study indicated that children in SOS Village are provided with better *material* care than children in both *Non-Adera* and *Adera* care arrangements. Given the existing rampant poverty in the country, we can say that the material life conditions of children in *Non-Adera* and *Adera* groups are just reflections of the general scenario in which many families find themselves in today's Ethiopia. The SOS Village children, on the other hand, seem to be more secured in terms of the provisions of their daily food, clothes, educational materials and medical care services. Earlier reports have, in fact, shown that the living standards of children in SOS Village were high (Macarov, 2009) in the sense that they were well fed, clothed and sheltered. Children in SOS Village, for instance, get four meals a day and adequate medical services (SOS International, 2009).

However, SOS children were actually found to be provided with less psychological care than children in the other groups. Although SOS Village follows a family style care and is expected to provide more individualized emotional support to children, this provision, in reality, is not to the satisfaction of the children. Of course, some evidences have indicated that the SOS Village children were not trusted and loved by their guardians (Tsige, 2007). It rather seems that the *Adera* care arrangement provides children with better psychological care (emotional support, advising and supervision) than the SOS Village and *Non-Adera* care arrangements. This appears in agreement with some previous small scale local studies (Belay, T., 2007; Kassa, 2006; Yigzaw, 2009) that unequivocally converge to a portrayal of *Adera* as an important source of social and psychological support (care, protection and security), guidance and sympathy. Taking a sample of orphaned children in streets, Yigzaw (2009) even found out that there were very few orphaned children in streets who were given *Adera* and concluded that *Adera* giving is likely to reduce the incidence of streetism among orphaned children.

Regarding the provisions of negative care and support, although children in the SOS Village were reported in previous research to have experienced some corporal punishment and heavy physical works (Tsige, 2007), it was found in this research, however, that children in *Non-Adera* and *Adera* care arrangements seemed to be more vulnerable to negative treatments (e.g., spanking and pinching, repeated school absenteeism, property grabbing, heavy physical work, delayed medical treatments, discrimination, and scolding) than children in SOS Village. Evidences indicate that childrearing in Ethiopia is replete with authoritarian type of parenting (e.g. Abraham, 1996; Habtamu, 1995; Seleshi, 2001) and that this culture is likely to unfold itself in the family-based childcare. That is, since *Adera* and *Non-Adera* care giving systems are found in the childcare systems of the community (Belay, T., 2007), 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 (Dessalegn, 1998; Seleshi, 2001). But, the SOS Village might have enforced rules that ban different forms of negative treatments; thus reducing the incidence of corporal punishment, verbal abuse and related others.

We may finally need to put a caveat about the apparent contradiction that the *Adera* care arrangement is to predispose both to psychological care and negative treatments. In fact, the two results are not contradicting one another as positive and negative provisions of care are *not mutually exclusive*. That is, a caregiver who provides positive care (e.g., food, clothes, emotional support, supervision, etc.) to a child may practice negative care

(e.g., physical punishment, pinching, scolding, etc.), and *vice versa*. In the Ethiopian context, it is commonly held that if a child is yours and you genuinely love him/her, then the common practice is to punish and put the child in good shape. A child whom you do not punish is only someone who is not yours.

The most important factors in childcare and support that may even put the children out of equation are the happenings in the course of child-guardian relationship. The two core dimensions of this process of child-guardian interaction are commitment of guardians to childcare and support and the ensuing attachment patterns children may develop in due course. Emerging from the relationship, this attachment pattern feeds back and structures the relationship between children and caregivers.

The study revealed that guardians in the *Adera* group are highly committed followed by the *Non-Adera* group, and then the SOS Village. The high level of guardians' commitment in *Adera* care arrangement could be ascribed to the socio-cultural and religious persuasion that accompanies the *Adera* responsibility. Execution of the *Adera* responsibility or failure to do so is likely to evoke serious social, psychological, and spiritual sanctions (Belay, T., 2007) that the *Adera* recipient cannot afford to downplay. The reconstructed family-type care of the SOS Village does not seem to bring about the required commitment among the guardians thus far possibly because the fact that the SOS aunties are working for their salary (Tsige, 2007) might infuse lack of psychological ingredient that attunes the maternity mandate.

The logical extension of these differences would obviously unfold themselves in the child-guardian attachment patterns. Accordingly, the findings of this study favored the *Adera* group in forming secured attachment style. This would mean then that attachment is a function more of psychological rather than material care. It is like the Amharic saying, "kefitfitu fitu" (ከፍትፍቱ ፊቱ) that your smile, attitude or pleasant approach is more satisfying than your food or "fitfit" (ፍት ፍት).In relation to this, Kassa (2006) has also reported that the *Adera* children were feeling at ease to relate with and, as a result, establish emotional closeness more easily with their guardians. On the other hand, the study indicated that children in SOS Village seemed to have *avoidant* attachment with their guardians in the sense that they felt uncomfortable staying with their guardians, felt tight when their guardians wanted to be very close to them, did not want to stay at home with their guardian and had difficulties trusting their guardians' caring intentions. A study conducted on the attachment of children reared in institutional and community or family settings in Romania also indicated that children reared in institution exhibited disturbances of attachment with their caregivers (Zeanah *et al*., 2005). More interestingly, Zeanah and colleagues

reported that many children reared in institutional settings have disorganized attachments with their caregivers. Furthermore, Tsige (2007) reported in her qualitative study that mothers in SOS Village were more distant in their feelings towards their children and that they do no treat and accept the children as their own. According to her, many children in SOS Village were not trusted by their guardians; experience harsh insult, cursing and hatred from guardians, siblings and other community members of the Village; more distant to their guardians; overburdened as they were always made to study without break; and lesser than the home-reared children in their academic achievements.

Given better psychological care, guardians' commitment, and the resulting secured attachment, it is quite telling that the *Adera* orphans are to be more resilient than the other two groups. The study showed indeed that the *Adera* children show the belief that they can achieve their goals despite the problems they encounter, have recovered from their parental mourning and grief, do not give up trying even when circumstances look gloomy, and can cope with experiences of stigma and discrimination due to parental death. As these children are reared in the home environment within the community, this result agrees with Abebe's (2009) report that street children (living with their parents) were more adjusted and have more coping mechanisms than their counterparts in SOS Village. This again suggests that the nutrition for resilience is not basically the nutrients in the food but in the emotional experiences surrounding the life of the child. Yigzaw (2009) has compared the resilience of *Adera* and *Non-Adera* children and concluded again that the former were more advantaged in terms of their resilience to adverse events than the latter.

Last but not least, the resilience of the orphaned children was checked against academic learning. It was found out that despite delays and abseentism seen more among the *Adera* (and of course the *Non-Adera*) group, this study indicated that the *Adera* group performed better in the first cycle of primary school than the other two groups. It seems that this difference is to persist into the second cycle of primary school only for the SOS group, while the *Non-Adera* group seems to catch up. Furthermore, secondary schooling seems to homogenize the performance of the three groups; even the SOS group being able to catch up but so late.

Conclusions

Based on the results of the study, it can be concluded that the reconstructed family type institutional care arrangement tends to provide the material needs to the satisfaction of the children. Furthermore, this arrangement seems to stand fairer in terms of guarding children from negative treatments of one kind or another. However, psychological needs appeared to be minimally addressed implying that the very idea of introducing a reconstructed family care system in the institution is not meeting the intended

goal. Moreover, the study showed that while the *Adera* and *Non-Adera* care arrangements are comparable in terms of making provisions to material needs, which in fact, was felt inferior to the SOS, as well as exposing children to some negative treatments, the psychological care was significantly better particularly for the *Adera* group. The *Adera* group was better in many other measures as well suggesting that this community-based cultural practice is a more promising option for bringing up of orphans. There are significant differences in the level of commitment of guardians of the three groups in caring for the children. While the *Adera* arrangement evokes significantly better guardian commitment, the SOS arrangement was least in terms of ensuring this commitment. In fact, the *Non-Adera* is still better than the institutional one. Compared to the other two groups, the *Adera* children seem to be more securely attached with their guardians and also more resilient. Their resilience was significantly noted in their academic achievements. They were found to achieve better in the lower grades, though the other two groups seemed to have gradually caught up later in secondary school. In general, the *Adera* care arrangement seemed to be better for the children than the other two arrangements in terms of psychological provisions, caregivers' commitments, children's attachment behaviors, and children's resilience and academic achievement.

Recommendations

Intervention practitioners implementing external programs such as placing children in Children's Village without examining the capacities and potentials of the community care arrangement systems such as *Adera* may run the risk of wasting crucial community resources and, even worse, gradually making such practices increasingly invisible, irrelevant, and then extinct. 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 psycho-social 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. It is, therefore, an obvious recommendation of this research that these three types of care arrangements need to evolve as viable sources of care and support to the orphaned children by learning from each other. In addition, we strongly underscore in this regard the need to consider the *Adera* care arrangement with the intent to scale it up for better provisions.

In fact, the findings of this research need to be extended in different ways. For instance, interested researchers may fill in the gaps of knowledge on how factors like age (young and old), sex, numbers of years stayed in the care arrangements,

experiences of children before the placement in the present care arrangement etc. affect the caring processes. It may even be more interesting to explore how the *Adera* experience works when the *Adera* child joins a natural family with its own kids and without.

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