

CHAPTER I

THE PROBLEM AND ITS BACKGROUND

Introduction

On July 20, 2010 Fozia, a 14-year-old orphaned girl committed suicide. She had been living with her grandmother in Zeway community, Ethiopia. Fozia had recently been registered for sponsorship under Food for the Hungry Child Development Program. A year earlier, a close family member came to Fozia's grandmother and reported that the granddaughter was having an affair with a young man. As a compensation for the loss of virginity, the boyfriend or his family was ordered by the village elders to pay compensation to the girls' family. Thereafter the grandmother impressed on the girl that she was useless, unwanted, with no prospects of a bride price or a future. A year later, she hung herself in a room. This tragedy opens up several questions. How should an adult as a grandmother deal with a hopeless young girl? How effective and relational was the involvement of secondary caregiver who was closely working with the primary caregiver and deceased girl? What other factors affected the granddaughter to commit suicide? Is it enough to give educational and material assistance for the orphan child? Alternatively, should there be a greater emphasis on the wellbeing of the caregiver and how the caregiver perceives the responsibility? Is such a duty perceived as a tiresome burden or a source of joy? Such perceptions in turn can affect the wellbeing and self-esteem of the

orphaned child. This research is an attempt to examine and answer some of these questions. This tragic story is real, but the name of the girl “Fozia” is not her real name.

There are many factors that contribute towards the vulnerability of children such as poverty, HIV/AIDS, various kinds of abuse, violence, drugs, exposure to pornography and so on. “HIV/AIDS is hollowing out whole communities in Africa, affecting vast numbers of the most vulnerable of all people, widows and orphans” (Wright 2006, 434). As a result of the complicated effects of poverty, today most orphan and vulnerable children and their caregivers are “a silent emergency; they are a secondary group, and overlooked with no means to raise their voice” (Kilbourn 1996, 87).

Ethiopia is on an upward route in terms of development. The economy has been on an upward trajectory in recent years. According to 2012/13 estimates, Ethiopia’s Gross Domestic Product (GDP) grew by 9.7%. With a total population of approximately 99 million—80% of those is based in rural areas—Ethiopia is in the midst of a demographic transition that will have a bearing on its future development (CSA 2015, 1-5; EDHS 2014, 29). According to the National Ministry of Finance and Economic Development (NMFE) 2014 report, the structure of the national economy is also changing. Industrial and service sectors are slowly growing, although agriculture remains a central pillar of Ethiopia’s economy, accounting for 43% of GDP (NMFE 2014, 2). For instance, the country has introduced a Community-Based Health Insurance scheme in approximately 200 districts, covering almost 20 million Ethiopians (CSA 2015, 9).

Nonetheless, the United Nation Development Program Report (UNDP), 2015, indicated that with an estimated 26% of the population currently living below the national poverty line (USD 0.60 per day), poverty is still a reality for many Ethiopians. With a

poverty headcount of 32.4%, of the population children are in a more-precarious situation than the population as a whole. Many poor households and their children are vulnerable to adverse effects from external shocks and stressors (UNDP 2015, 3-4). How to deal with the orphan and vulnerable children is one of the challenging issue faced by developing countries especially in sub Saharan Africa. UNAIDS, the Joint United Nation Program on HIV/AIDS (2010) estimated that of the 16.6 million children (aged 0–17) who have lost one or both parents to AIDS, 14.8 million are in sub-Saharan Africa (UNAIDS 2010, 19).

The Ethiopian Bureau of Labor and Social Affairs (BOLAS) indicated that Ethiopia has the second largest population in Africa with the second highest population of orphans. According to the BOLAS 2008 report the country situational analysis on OVC in developing countries like Ethiopia, children constitute more than 50% of the population. Moreover, the analysis pointed out that “most OVC (Orphans or Vulnerable Children) under a family environment were residing with primary caregivers that had a large family size (more than four members of household), were in poor households about 69%, were in female headed households 68% and were in households headed by children 3% or aged persons 14%” (BOLAS 2008, xiii).

Within Ethiopia, 5.5 million children, around 6% of the total population, are categorized as orphans and vulnerable children (OVC). OVC comprise almost 12% of Ethiopia’s total child population. Over 83% of these OVC are living in rural settings of which 855,720 are orphaned children because of the death of one or both parents due to HIV/AIDS (Save the Children UK, 2008). The Ethiopian Demographic and Health Survey (EDHS) estimated that 72% of children in the country live with both parents, 14%

with mothers only, 3% with fathers only and 11% live with neither of their natural parents (EDHS 2011, 257). The same survey indicated that 18% of Ethiopian households are caring for orphans while 0.6% or 11, 577 households were estimated to be child headed.

Poverty, the deaths of parents due to HIV/AIDS, war, recurrent drought and its subsequent food shortages of famine are the major factors that made a number of children become vulnerable in Ethiopia (MOWA and FHAPCO 2010, 1). However, vulnerability might be caused by other additional factors that include severe chronic illness of a parent or caregiver, poverty, hunger, lack of access to services, inadequate clothing or shelter, overcrowding, deficient caretakers, and factors specific to the child, including disability, direct experience of physical or sexual violence, or severe chronic illness (Skinner 2006, 619-626).

Orphans and vulnerable children have been suffering from many problems associated with these factors. Some of the problems they face include hunger, lack of access to health and education, physical and psychological abuse, lack of love and affection and the negative attitudes of their communities towards them (Gudina and Nega 2014, 247). Because of these issues, orphans and vulnerable children have urgent basic needs that require a system of services and support that can be provided either within the community or through institutionalized care.

In Ethiopia, there is a strong culture of caring for orphans, the elderly, the sick, and disabled and other needy members of the society as in the past. Most of this care and protections of children was carried out by the extended family members, such as uncles, aunts, and grandparents (in Gudina and Nega 2014, 247-248).

The Ethiopian Bureau of Labor and Social Affairs indicated that “the extent, severity and magnitude of the vulnerability of children depends upon the socio-economic status of their parents and their countries; the problem exists almost in every country” (BOLAS 2008, 7). The study by Steven R. Schwind on Orphans and Vulnerable Children (OVC) in Ethiopia indicated that the country had one of the largest orphan populations in the world and that thirteen percent of the children throughout the country were missing one or both parents. In the past, the major causes for the increase of OVC, which directly affects the wellbeing of primary caregivers (PCG), were famine, conflict and disease. These days, however, HIV/AIDS has become the leading cause of the vulnerability of orphans. Steven also indicated that most PCGs of OVC children do not have access to the provision of basic needs and rights, such as proper physical care, education, psychological support and supervision.

The 2008 country analysis on OVC stated that more than 82% of OVC were living with illiterate and poor caregivers and household (BOLAS 2008, xi). Due to the lack of care, support and proper guidance from primary interventionists or caregivers, these children have also been exposed to various forms of exploitation. In his study, Zelalem mentioned:

Many of the OVC in Ethiopia are living with female-headed household, surviving parents or extended families who are cared for by the remaining parent who is sick or at the verge of death. As a result of this, elderly grandparents who themselves are often in need of care and support, or impoverished relatives struggling to meet the needs of their own children, are at increased risk of losing opportunities for food, shelter, medical care, school, and so on. Understanding these challenges, some communities have made attempts to address the needs of OVC and their primary caregivers or family (Zelalem 2011, 3).

When the caregivers’ wellbeing is in poor condition and they lack the capacity to care, the supportive community and the institutions are expected to play their role.

According to the African Charter on the Rights of the Child, the state has a responsibility to provide assistance to caregivers and ensure the following measures: first, “to assist parents and other persons responsible for the child and in case of need to provide material assistance and support programs’ assistance, particularly with regard to nutrition, health, education, clothing and housing.” Second, “to assist parents and other persons responsible for the child in the performance of child rearing and to ensure the development of institutions responsible for providing for the care of children” (BOLAS 2008, 17).

A common goal of humanitarian organizations that are dedicated to serve children and to improve their wellbeing worldwide is that of improving the wellbeing and quality of life of the OVC, which depends on a number of wellbeing variables that mainly focus on the physical and psychological needs of the OVC. As a result, many OVC programs focus on measuring the quality and quantity of service rendered to the child and his caregiver in the household setting. In the context of community development programs, ensuring the wellbeing of OVC and the primary interventionist is a collective result caused through an integrated effort from their own community, faith community, school system, the health sector and protection from the legal entities (Senefeld and Strasser 2009, 10).

Due to the growing and consuming challenges that caregivers are facing, there is need for significant, intentional attention focusing on their needs. They need a supportive community to share their burden and to maintain the safety of primary care givers and orphan and vulnerable children. This is also a fundamental issue in that the Bible calls the

faith community to defend the cause of the powerless, and be father to the fatherless. Such an act is presented as “pure and undefiled religion” (James 1:27).

Food for the Hungry International (FHI) is an organization of Christian motivation which responds to this injunction by a commitment to work with poor people to overcome hunger and poverty through integrated self-development, and where necessary, relief programming. It seeks to help those in need regardless of race, religion, or political persuasion. Having the same focus and commitment, Food for the Hungry Ethiopia’s (FHE) programs have evolved since late 1980s. They have shifted from relief and rehabilitation programs to development organization through implementing long-term sustainable development strategies (FHI/E OVCDP 2006, 7). Field based staff work with communities to improve their overall living standard by designing and implementing such programs as food security, integrated community development, HIV/AIDS prevention, care and support, and child development programs. “In all the projects, Food for the Hungry Ethiopia (FHE) strives to work closely with local church, communities and government bodies to effectively address the priority needs of the communities, with significant emphasis and focus toward “the most vulnerable people group” (FHE, OCHH 2009, 4).

Food for the Hungry International/Ethiopia has a long-term commitment to help orphans and the most vulnerable children in all areas of their lives (i.e., physical, intellectual, social and spiritual), so as to make them more productive citizens. The organization approach calls the church, families and leaders as key partners in the process of ensuring a sustainable intervention. The empowerment of people and the integration of

locally available resources are the key elements in the area-specific implementation strategy.

In the Child Focused Community Transformation (CFCT) program implementation approach and philosophy, at the field level, the organization follows the “small input, and high impact” approach in resource and expertise management and utilization. This means that this approach considers and invites the church, families and leaders as key partners in the process of ensuring a sustainable development program that emphasizes the empowerment of people and the integration of locally available resources as the key elements in the area-specific strategy. To ensure the integration these three key partners, the community-level staff and the volunteers play a significant role. The selection of field personnel is based on their Christian values and church witness, on their life testimony and connection with the local church, as well as a healthy connection with the community, particularly with children. Food for the Hungry assumes that the integration of the three local partners and the committed staff creates a child-friendly community or environment that helps children to grow holistically and cultivate their God-given lives and potential properly (1 Peter 4:10).

As the organization walks with the vulnerable sector of the community, in order to safeguard and secure its safety and protection, FH believes in and promotes a biblical world view and values in addition to abiding by international protection and human rights policies. The promotion of creating and maintaining a healthy relationship with God, others, self and creation is the key aspect of the staff and church leaders’ spiritual formation which, in turn, the church members extend and model to the rest of the community and their children. For this reason all FH personnel are encouraged to

participate actively in their local church and to live an exemplary and healthy lifestyle.

For example, in the Zeway area, most of the community-level workers who work closely with OVCs and caregivers are also active members of the church.

The underlying values and focus of the organization which is serving and empowering the most vulnerable sector of the community is derived and integrated from the biblical passages such as Genesis 1: 26-27, Isaiah 61: 1-3, Psalm 145: 15-16, Matthew 13-16, Philippians 2: 1-7, Colossians 1:19, James 1: 27. The theological and biblical meaning and implication of these texts and other related verses have a strong influence in linking and bringing FH as a Christian organization and the church together in serving and empowering the poor holistically. FH is not a church but shares the church's values and supports its ministry and empowerment of the leaders through this partnership. Through such engagement FH contends that the church is a unique partner and body that can help the community to maintain a sustainable development process in a particular community when, at the completion of the program, FH leaves the area to move on to the next geographical location (Kim and Davis 2012, 32).

The theological implication of the belief that sees God as the author of development and sees sin as the origin of the cultural lies and belief systems that suppress the freedom, justice and holistic development of people and also as the root problem of poverty, links and ties FH and the body of Christ as long-term partners in an unconditional common cause, purpose and values. For instance, just as many Christian church members believe and practice through their prayer and teachings, FH uses the term "transformation" to refer to the Spirit-driven process of radical change in the behaviors, attitudes, beliefs, and worldviews of individuals, communities or cultures

towards living in a healthy relationship with God, others, and God's creation.(Kim and Davis 2012, 31) Moreover the major Child Focused Community Transformation (CFCT) program model is designed to support the same transformation: the model is designed after considering questions like, how does God view the child? What is God's intention for each child? What are the critical issues and opportunities that affect their development? How can FH best support, equip, and enable the community to address these issues? (Kim and Davis 2012, 31).

Geographic and Socio-Economic Background

The Child Development Program (CDP) of Food for the Hungry Ethiopia which has been selected for this research project is located in Oromia National Regional State, East Showa Zone, Adami Tulu Jido-Kombolcha (AJIK) District Woreda in Zeway town, the capital of the district. Zeway is found in the Great Rift Valley and surrounded by a number of lakes. According to the 2007 national census, the total population for Ziway was 43,660, of whom 22,956 were men and 20,704 were women (FHI/E OVCDP 2006, 5-6).

According to the district agriculture office, the altitude of the area ranges from 1500 to 2500 meters above sea level. The district is mainly a plain with a few ragged lands. The average temperature in the district is about 20⁰ centigrade. The average annual rainfall is estimated 760 mm and mainly characterized by its erratic type in terms of amount (torrential type), timeliness (late start, early cessation or vice versa) and irregular distribution that has resulted in the disturbance of the conventional crop calendar and in a

serious recurrent drought and food shortages (FHI/E OVCDP 2006, 6). This also make the area one of the most critical in the country in terms of food insecurity.

Private investment, particularly in horticulture (flower farming) has attracted a number of unskilled job seekers to the area. This also causes the existence of a number of migrant laborers, who establish a temporary relationship locally while they may already have family in their places of origin which in turn has contributed to the high possibility of HIV/AIDS transmission and other social problems such as childbirth outside wedlock. These social problems and the impact of food insecurity demand the intervention of FHE not only in short- term relief programs, but also in the implementation of long- term programs, such the Orphan and Vulnerable Child Development Programs (FHI/E OVCDP 2006, 8).

Currently, there are considerable number of orphans and vulnerable children who critically need intentional follow up and care from their primary caregivers (PCGs).

FHE/E, OCHH document stated that:

Orphan and vulnerable children are usually suffering from loneliness due to the absence of a family who can provide them with family love and security. The lack of someone to care for children's future development creates serious psychological and emotional problems. Guardians and caretakers of orphan children are doing all they can do with their limited time and resource though it is difficult to substitute for mother and father. Local leaders are also making efforts in looking for guardians for the orphans. On the other hand, local churches are also found to be cooperative and willing to support the needy children with their limited capacity to accommodate some orphans in the area (FHE, OCHH 2009, 5).

Children living with an HIV-infected caregiver or in a family passing through a complicated critical crisis are commonly under developed and suffering from the lack of

good wellbeing, “either due to being HIV infected themselves, or being exposed to the opportunistic diseases of other infected household members, or aggravated poverty” (Zelalem 2011, 22).

Personal Background and Motivation

I was born and grew up in Bale region, Ethiopia. Just as if yesterday, my childhood memory is bright enough to take me back and explore the experiences of that colorful life. The boundless carefree world, the beauty and aroma of nature, the caring love of my family and my community are still fresh and shining in my consciousness. The annual festivals and family parties, the religious traditions and practices in our home, words of blessings from my parents and neighboring elderly people, the rituals and the songs have been so strong as to create spiritual hunger during my teenage life.

After my college education and several years of ministry in the Christian mission field, I joined Food for the Hungry Ethiopia Orphan and Child Development Program (OVCDP) in 2007. The experience gave me a tremendous opportunity to identify with orphan and vulnerable children and their primary caregivers. Until 2016 where I was serving as an international staff member of the Food for the Hungry in Mozambique Child Development Program operations. It was part of my daily routines to visit the primary caregivers’ home, and involve in the physical, economical and psychosocial part of their life, which are directly related with the wellbeing of their orphan and vulnerable child.

My field involvement serving orphans and the most vulnerable children and caregivers compelled and motivated me to do further study mainly on holistic child development. I lived in the community in which the rate of children’s vulnerability to

poverty and HIV/AIDS coupled with an alarmingly increasing rate of unemployment, lack of good governance, the traditional world view, harmful traditional practices and the like have attracted global attention.

I believe that the failure to raise godly and productive children poses a potential risk towards promoting poverty and ungodly practices. Moreover, the reality is we (the poor community) in Ethiopia are living and facing overwhelming competing rapid changes, and the challenge which in turn significantly affects the livelihood of OVC primary caregivers in particular, and the parenting care and nurture practices in general.

After realizing that working and walking with the most vulnerable people, specifically with OVC children and their caregivers, is my long-term burning vision and potential professional career goal, I looked for avenues of further study. As a result, at this moment of my life and academic career, I can say emphatically that this particular research study is born out of my passion, and extension of my commitment and vision to serve the most vulnerable people group and contribute to their wellbeing development as citizens.

Theoretical Framework

The theoretical framework introduces causalities for the research issue and describes the problem under the study exists. The theoretical and conceptual frameworks to provide the rationale and logical connection or coherence between the research problems in the context, the literature reviews and the research methodology (Rocca, Tonette S. and Plakhotnik, Maria 2009, 127-128). In this particular research context there is a strong causal connection between the OVC primary caregiver wellbeing conditions,

joy and burden, and carrying the nurturing role, which can also in turn affect the OVC's growth in many aspects of life.

Several studies have shown that in spite of all the difficulties associated with caring, vulnerable children caregivers felt a sense of satisfaction and accomplishment. Caregivers found the act of caring for others brought meaning to their lives. Clipp found that most caregivers appraise their caregiving experiences positively and most of these positive experiences came from caregivers of the sickest patients (Clipp 1995, 11). Wrubel says that feelings of having made a difference are very reinforcing for the caregivers (Wrubel 1997, 6-7).

The caregiver's burden as cited by Vachon is described as "the emotional and physical demands and responsibilities of one's illness that are placed on family members, friends, or other individuals involved with the patient outside of the health care system" (Vachon 1998, 49-50). Due to several limitations such as finance, understanding, skill, and assistance to cope with the frequent changes, needs and challenges of children, caregivers often burn out, and end up with other related problems, which then will affect the development of the child directly. In turn, it implies that, particularly in a vulnerable community and family situation, the wellbeing and development of an OVC demands ensuring the wellbeing of the caregiver as well.

According to the OVC wellbeing guide, developed by Senefeld and Strasser, there are ten key variables, which enable the measurement of the wellbeing of OVC, given through the caring and nurturing practice of the caregiver. These variables are "Food and Nutrition, Shelter, Protection, Family, Health, Spirituality, Mental Health, Education, Economic opportunities, and Community Cohesion" (Senefeld and Strasser

2009, 11). Figure 1 depicts the relationship between the variables and it is also designed in such a way that it validates the logical coherence of the literature review section with the research issues. Further details of the design are discussed in chapter III of this dissertation.

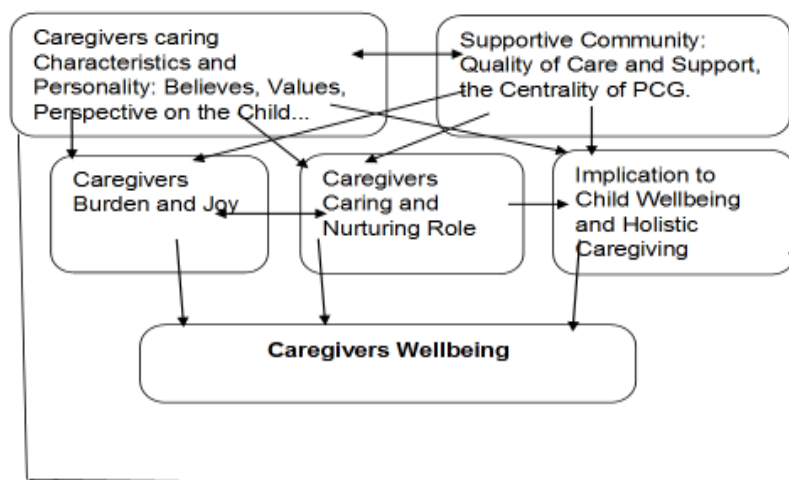


Figure 1: Theoretical Framework: Description of the Relationship of the Variables Influencing Caregivers Wellbeing

Figure 1 shows the cause and effect relationship between the dependent and independent variables. The direction of the arrows indicates the flow of the effect, which mostly comes from the independent variables. The two independent variables, which are the caregivers' caring characteristics and personality and the supportive community, have a direct relationship and impact on one another and also affect the three dependent variables and these are the caregiver's burden and joy, caregiver's caring and nurturing role, and all of which have an impact on the wellbeing and holistic growth of the child. The caregiver's wellbeing, as the major dependent variable, results from these other

dependent variables. The Caregivers' burden and joy affects the caring and nurturing role of the primary caregiver and have a direct effect on the wellbeing of the child.

Conceptual Framework

In the context of the Food for the Hungry Ethiopia child development program, the care for OVC's falls primarily on their extended family or the community, yet grandparents and other extended family members often lack the capacity to care for these children. When children lose their primary caregivers, they immediately become vulnerable. They are then exposed to abuse, exploitation, discrimination and deprivation. Many boys and girls drop out of school or attend inconsistently and become prey to increased levels of physical, verbal, emotional, and sexual abuse and as well as child labor. Therefore, it is necessary to assess the wellbeing conditions and need involved with the caregiver's role and burden, and to provide care and support that impacts their intervention role directly. Such provision and the need for a supportive community also becomes an integral part of this study, in which the writer argues that OVC programs should include such needs. In other words, the program ought to take into consideration the significance of the substantial role played by the primary interventionist (caregiver). The reason behind this assumption is that, particularly in a vulnerable context, the wellbeing development of an OVC has direct effect on the wellbeing of the primary caregivers.

Primary caregiving is an important component in the nurture and overall care and support of OVC children. Becoming the primary caregiver in the Ethiopian context usually involves the parent or grandparents, a biological relative, or it can also be non-biological guardians, particularly in the case of double orphan and abandoned children.

Generally, this study proposes to understand and analyze the major elements or characteristics associated with the caring and role and practice of primary caregivers. This is to be achieved by measuring the overall wellbeing of PCG through purposive cases sampling. These measurements will enable a description of their burden and joy in the light of cultural, scientific and religious perspectives, and it will also provide information on their perception and practice of the caring and nurturing role of caregivers. To address the specific objectives of the study, the research approach aims at enabling the researcher to describe and analyze the wellbeing, burden and joy of PCG, in the light of selected variables or key domains.

Figure 2 below shows the details of the conceptual design of the flow of the research process. Further details of the design are discussed in chapter 3 of this proposal.

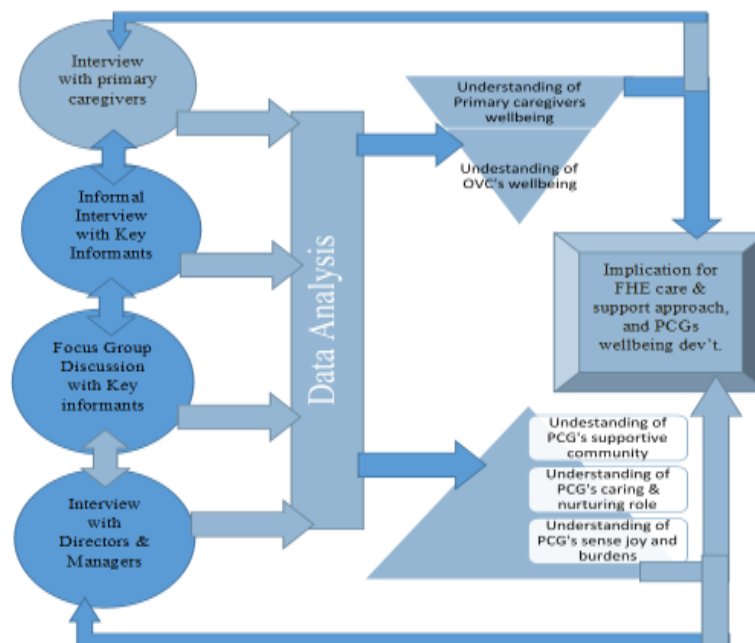


Figure 2: Conceptual Design of the Research Process

Statement of the Problem

This study explores the question: what are the factors that affect the wellbeing of OVC primary caregivers, their caring and nurturing role towards the OVC, in Food for the Hungry Zeway Child Development project?

There has been a considerable emphasis on the immediate losses and material needs of the OVC and yet the wellbeing, caring and parental role and burden of their immediate interventionist or primary caregivers are often significantly overlooked. The effectiveness and sustainable nature of child development programs are directly related to the quality of support provided to primary caregivers, which in turn are passed on to growth in the wellbeing of the OVC. There is a direct relation between the quality of care and support provided to primary caregivers and maintaining healthy and quality care and support to the vulnerable child. Relating to this relationship one of the studies on OVC and caregivers vividly stated:

Illness and death of parents exposed children to severe socio-economic problems such as psychological problem (67%), food shortage (more than 58%), shouldering the responsibility of caring for bedridden parents (39%), forced to work on the streets (more than 22%) and school dropping out (more than 29%) and forced to leave rented houses (25%). As a result, a greater part of orphans faced serious psychological problems, which are reflected in the form of grief loneliness, disturbance, hopelessness, distress and nightmare... Orphans under a family environment were exposed to financial constraint to pay house rent (54%), forced to leave kebele (government) houses (12%) and private rented houses (16%) and difficulty of inheriting their deceased parents' houses (25%), following the death of their parents" (Save the Children 2008, xiv, xv).

On the issue of care for caregivers, Zelalem indicated that caregivers, who are ill or grieving, and who then have to take care of OVC children and other ill family members are not always able to provide good care for children (Zelalem 2011, 27).

Hence, the well-being development of OVC requires an integrated intervention strategy that potentially provides care and support for the primary caregivers as well.

The sustainability and holistic development program of the orphan child involves the dynamic role, and intentional dedication of primary caregivers as well as a back-up means which enables sharing of the burden and maintaining the joy of the caregiver. Particularly in food insecure areas and poor family settings, addressing the demands of children and assisting them to cope with various challenges, and feeling pressured to address the situation are often critical and urgent. It needs due attention to make a comprehensive and deep assessment which will enable a fair analysis about the wellbeing, characteristics, burden and joy of those caregivers who are involved in caring and playing the leading role as they live with orphaned and vulnerable children.

The researcher has a deep concern in such a paradigm in which there is a rapidly escalating vulnerability of the OVC caregivers while they are walking with the most vulnerable community, particularly in a country like Ethiopia. There is a desperate need for a workable strategy that could solve their problems and enable them to share their burden, and maintain the joy of those who are sacrificially walking closely with OVC. The study therefore aims at identifying the major problems, and ensuring the way out from all these difficulties. In taking these steps, the researcher measures PCG, wellbeing, and deals with the burden and joy of caregivers, which is associated with their caring and leading role as a primary interventionist. The study answered the following questions:

1. What are the key wellbeing needs of the primary caregivers?
2. What are the perceptions of primary caregivers on holistic child nurture and learning?

3. What are the caregivers' understandings of their parental and caring role?
4. What are the key wellbeing factors that affect the sense of joy and burdens of primary caregivers?
5. What are the caregivers' understandings and implementation of aspects of child moral development, relational development, and identity formation in the light of scientific perception?
6. What recommendations can be offered to the organization to improve the caring and support provided by the caregivers?

Statement of Purpose

The purpose of this study is to understand the wellbeing status of the primary caregivers, the extent of the burden and joy that the caregivers experience as they care and nurture the OVC. It is hoped that this understanding will lead to the identification of implications and recommendations for care and support approaches, which in turn benefit or contribute to the process of the OVC holistic care and growth. The wellbeing status can be seen as a sense of satisfaction, happiness and overall wellness of the OVC primary caregiver.

As orphan and vulnerable children (OVC) primary caregivers are the main respondents of this research, they will be the direct beneficiaries of the research. I am considering discussing the findings with the leadership of Food for the Hungry Ethiopia, particularly with the Child Development and OVC Care and Support Program Directors and Managers and helping them understand how to be more effective in their care and support approach and how to develop a supportive community for the most vulnerable OVC primary caregivers.

Research Objectives

The study aims to determine the wellbeing status and the joy and burden of caring for orphans and vulnerable children among the primary caregivers of Food for the Hungry Ethiopia Child Development Program. The specific objectives of the study are:

1. To describe primary caregivers' critical wellbeing needs as listed by Senefeld and Susana in Catholic Relief Service Wellbeing measuring Guide (Senefeld and Susana 2009).
2. To identify caregivers' perception on holistic child nurture and learning.
3. To analyze the caregiver's understanding of their parental and caring role.
4. To describe and measure the key wellbeing variables of primary caregivers (listed according to the variables listed in Catholic Relief Wellbeing Measuring Tool (Senefeld and Susana 2009) that affect their sense of joy and burden?
5. To analyze caregivers understanding and implementation of aspects of child moral development, relational development, and identity formation in the light of scientific perception.
6. To provide recommendations for improvements in the Food for the Hungry Ethiopia program and for further scholastic research directions.

The study will help in designing an approach that will enable the caregivers to address three major factors: first, to enable the primary caregivers to maintain and maximize their level of joy and commitment; second, to minimize the level of their burden, facilitate, and initiate a productive caregiving and leadership role for them in such a way that facilitates the holistic implementation for the current FH Ethiopia, child development program; and lastly, to provide a strategic model, guiding and capacity

building tool to be used by the secondary caregivers (professionals), in the process of reinforcing and implementing a dynamic care and support program.

Significance of the Study

This research is significant in six major ways. First, the well-being values (characteristics), joy and burden of primary caregivers were identified, measured and analyzed. Second, in accordance with the caregiver's status of wellbeing, the quality of caring and leading (parenting) role were carefully sorted out and analyzed. Third, based on the research analytical and descriptive results short-and long-term intervention areas were identified. Fourth, as a result of the study an approach were recommended to enable Food for the Hungry Ethiopia OVC program managers and secondary caregivers (community level workers) to ensure dynamic care for primary caregivers and an increase in the performance and the overall quality of the program. Fifth, the study findings will also enable the organization to design strategic evaluation and monitoring tools for the child development program. Finally, the study has identified and recommend further research directions and their analytical rationale. Besides, it will also enable the program to maintain its dynamism and reinforce the values of program sustainability and the wellbeing of both OVC and the primary interventionist.

After the researcher has carried out a brief assessment on the Food for the Hungry Ethiopia Child development programs in different regions, the significance of the study caught the attention of the program, director, program managers, country director and other technical staff including the country and the program monitoring and evaluation managers. The leadership and key professionals have expressed their support. The findings of this research work will hopefully lead to a more in-depth understanding on the

exclusive nature of the program, which will also inspire improved program quality that will directly impact the role of primary caregivers and the wellbeing of the OVC. The result of the study will lead to improvements in short-term intervention procedures which could consequently contribute to the long-term program strategy design. Moreover, at the grassroots level, the secondary caregivers or the community level workers will also be enlightened and be exposed to various views, tools and strategic approaches that will enable them to facilitate dynamic care and support to the primary caregiver and OVC as they do their day-to-day home visits and mobilize the neighborhood and the bigger local supportive community.

Assumptions

This study proceeds on the following assumptions: Food for the Hungry Ethiopia Integrated Child Development Program operations desires result indicators focused on the wellbeing development of the orphan and vulnerable children, primary caregivers and communities. However, for the following three reasons the extent of long-term impact is not clear enough to ensure the key wellbeing variables of orphan and vulnerable children caregivers are intentionally addressed and the sustainable change momentum mode and process is maintained. These three major reasons are: first, the lack of research on the wellbeing status of the caregivers using a more intensive case study method in addition to statistical analyses of aid package distribution. The second reason is the underestimation of the complexity and critical nature of the caring and parenting role of primary caregiver. The third reason is the lack of a supportive community to foster the overall wellbeing of the caregiver and OVC child.

A further basic assumption is that a purposive case study facilitates the investigation of the key wellbeing variables; the burdens of caregivers, the standard and perceptions of their caring and parenting /leading role, the quality of the relationship they have with the OVC and with the rest of the community, and other concerns related with their existing and future life. The critical analysis of such case investigation and observations can be used as leading factors in the design of a strategic intervention strategic tool that can help to minimize the burden of caregivers and improve the wellbeing of the primary givers and ultimately their children because there is a direct relationship between the wellbeing of primary caregivers and children under their care.

It is assumed that the research findings will in turn lead to the development of a workable strategy and approach to minimize the diverse and complex burdens of caregivers that directly affect the wellbeing of the child. Such recommendations could be carried out through the day to day home visit by the FH staff and mobilization of the neighborhood and the bigger supportive of the community.

Definition of Terms

Caregiver refers mostly to heads of the households including parents, relatives, legal guardians, neighbors, friends, employers (in the case of housemaids and baby-sitters) and other persons who provide some economic and psychosocial support and care to orphan and vulnerable children.

Care for a child refers to addressing the basic necessities and protecting a child from harm.

Caregiver Characteristics refer to attitudes towards the caregiving role and responsibilities.

Caregiver Sense of Burden is identifiable attitude which is interwoven with in the caregiving role, as well as the physical, financial, and spiritual stresses of the primary caregiver.

Caregiver Joy is a hidden and an expressible personality attitude of happiness and satisfaction interwoven in the cultural values, physical, financial and spiritual wellness of the caregiver.

Caregiver Wellbeing refers to the overall wellness of the OVC primary interventionist, which is indicated through the extent of a sense of joy and burden that physically, emotionally, physiologically, economically, and socially exists in the caring and leading role and practices.

Child refers to a person who is below 18 years (taken from the United Nations Convention on the Rights of the Child).

Children under a family environment refers to vulnerable children who are supported by caregivers at a household level, but who did not join street life and commercial sex work during the survey period.

Community Level workers refers to Food for the Hungry Zeway community level staff who are selected from the community and closely working with OVC and their family.

Double orphan refers to a child who has lost both of his or her parents.

Nurturing a child refers to developing and modeling a child in holistic ways that address the whole person.

Orphan refers to a child, less than 18 years of age who has lost either one or both parents due to various man made or natural incidents.

Orphan and vulnerable children refer to all children who have lost one or both of their parents, and other groups of children who live under especially difficult circumstances and who face severe social, economic and psychological problems because of poor living condition and illness of their parents and other reasons that are beyond their control.

Primary Caregivers are parents, any family members or any other persons who live with the OVC and provide care and support or acts as a primary interventionist.

Secondary Caregiver is a community level staff member who is assigned to assist an OVC and closely work with the primary caregiver. In FH Zeway they are also called social workers but they are not licensed or social work degree holders.

Single orphan refers to a child who has lost one of his or her parents.

Vulnerable refers to a child is who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights.

Wellbeing Status refers to the condition of the positive sense of wellness, happiness, comfort and satisfaction of the OVC primary caregivers.

Scope and Delimitations of the Study

As a result of the case study design, the findings and the scope of the results are limited in their generalization. The study cases are limited to OVC primary caregivers in the Food for the Hungry Zeway child development program. Due to time and financial limitations, the researcher does not intend to include sample cases from the northern and west project areas, which are considerably distant from Zeway.

Although the Food for the Hungry Ethiopia Child Development Program is involved, this study does not necessarily discuss the nature, existing challenges and success of the program and the details of and the size and quality of the benefit packages that children are getting. Instead, in relation to the wellbeing of primary caregivers, the effect or the impact level of care and support will be investigated.

Six sample cases were selected from the total OVC caregiver population reflecting the different types of caregiver who have been supported by Food for the Hungry project for at least for three years. The scope of the study encompasses the following; the primary caregiver's wellbeing; the sense of burden and joy of the primary caregiver; the caring and nurturing role of the primary caregiver and the existence and nature of a supportive community.

The investigation was carried out by means questionnaires and interviews with primary caregivers, group discussion with secondary social workers, managers and directors, informal interviews with secondary caregivers and archival studies. Data were collected from multiple sources and were analyzed using a triangulation approach. It is hoped that the findings of the study will have a direct impact and influence on the quality of service that the program offers, and will renovate the focus of the intervention by the professionals and secondary caregivers towards the targeted orphan and vulnerable population and beyond.

Overview of the Dissertation

This chapter described the background of the study, the theoretical framework and the statement of the problem among others. The next chapter discusses the review of related literature and studies. Chapter III contains the methodologies and procedures that

were used to conduct the study. Chapter IV presents the analysis and interpretation of the data. Finally, Chapter V provides the summary of findings, conclusions, and recommendations.

CHAPTER II

REVIEW OF RELATED LITERATURE AND STUDIES

The literature review is partly designed and structured to validate the significance of the research problem, and the purpose statement and objective from several dimensions, such as scientific, theological, and cultural, and the existing systems and thought. The section is also structured with the flow of thought that corresponds with the research scope and purpose and the central problem. In this section, related literature overviews will be presented in six major categories. First is an overview of the theoretical framework of family-based care and an assessment of its significance for child care. This section describes the theories that directly contribute and relate to the wellbeing of OVC primary caregivers, and projects the logical thoughts that direct how to improve and secure the wellbeing status of the family. Within the family, shared responsibilities have a potentially key role to provide stability and security for survival and wellbeing. Shared communality in the family setting requires mutuality and emotional oneness with trust as a binding element.

Second, a basic scientific framework for child character development and the role of primary caregivers will be examined. This section gives a brief description of the scientific character and identity formation of children, and the place of the caregiver or parental role in the process. The descriptions include specifics on the connection between the mental development (thinking facilities) and character, identity, and social

development. Moral judgment depends on the ability of reasoning intentions and values. In the mental development of a child, caregivers play a key role by assisting and guiding the mental processing skill (Bee and Boyd 2010, 325).

Third, an overview of holistic learning theories and effective child care implementation will be described. This section follows the education and thinking development described in the preceding section and deals with the need of holistic learning theories and dynamics. Holistic learning is a scientific art of cultivating a child as a whole person, and it happens through a meaningful connection with primary caregivers, peers, community and the natural world (Loreman and Earle 2007, 150-152). In this framework and philosophy, teaching is more of a collaborative caring process, instead of a competitive mental exercise. The interactive skill-based learning approach has the potential to sharpen the child's mind, and thought processes in dealing with practical life experiences.

Fourth, an overview of the value of care and support for primary caregivers will be presented. In this section, the caring role, the burden of primary caregivers, and the place of a supportive community will be analyzed. The section describes the role and responsibility of primary caregivers in the light of their wellbeing and vulnerability. In addition, the section provides logical premises that justify why OVC caregivers need a caring and supportive community (Miller 1996, 39-51). Ongoing environmental, economic, political, social and other global and local changes and challenges can be factors that worsen the wellbeing of OVC caregivers.

Fifth, this section provides an overview of the some of the biblical precepts for parents and the faith community on the care and nurture of children. The section includes

instances and views from early church tradition as well. The God who brought the family and community into existence also set a design as to how the system connects and functions best, based on the condition of following His counsel and intentions. Diverting from the biblical truth and God's intention of purpose always results in complexity, injustice, disorder and unfairness within the system, culture and values of the society, where the family is the nucleus.

The final overview will be of various family-based care therapies and theories. The focus will be the key elements that bind the family system together and highlights attachment as a functional entity, based on the placement and attainment of some fundamental elements, such as communication, shared values, norms, and responsibilities. Ensuring the wellbeing and holistic development of a child is also the partnership of the community, appropriate religious entities, educational and other government structures and policies.

Family Based Care Theoretical Framework for Child Care

Each member in the family contributes to the wellbeing system. Particularly within the family, survival and special care are issues, of real concern. Individuals within the unity of the family are expected to play their roles effectively and sensitively depending on their developmental stage. When opportunities, responsibilities and values are intentionally shared, good communication, growth and positive change will be the outcomes of those positive practices. In contrast, if roles are rejected and underestimated within the family, such neglected burdens affect the others and the family dynamics start to wear out. In this case, the possibility of concern for the children's needs will be

minimal. Furthermore, the children and their concerned caregivers will be the ones who will be affected the most in the process (Phipps 1990, 32).

Three family based theories and their implications will be reviewed in this section, which provide evidence that family caregivers need advice, information assistance, and support from the community and professionals so as to successfully meet caregiving demands.

General System Theory

This theory proposes that power, mutual expectations, roles, rules, communication, patterns of behavior and boundaries are essential components that maintain the family system. Shared communalities are able to keep the balance that provides stability, consistency and security for survival (Phipps 1990, 48). According to this theory, communication in the family and commonly accepted roles are rules vital. Roles activate the family members to function and rules remind them of the standard and expected values in the family system.

Phipps reflected that within family based caring practice where roles, rules and communication are underestimated, the possibility exists for children to be neglected. On the contrary, when roles and rules are actively carried out, depressed orphan children, particularly, can experience a home environment that enable them to recover more easily. Identifying the rules, roles, communication, culture, values and practices in a family can be a strategy to enhance the caring practice where the orphaned and other children in crisis are part of the family (Phipps 1990).

Developmental Theory

This theoretical framework is based on the idea that people are not static, instead, they are becoming and always in a dynamic responding process (Erickson 1963, in Roehlkepartain and King 2006, 141). This theory perceives the family as constantly changing as it goes through different processes from one chronological stage to the next; each stage presents unique tasks for the family members who attempt to resolve the tasks with varying degrees of success as time goes by (Phipps 1990, 47-48). Frequently, the results and products of each successive stage and the tasks carried out by each of the family members influence the next stage.

A central part of this theoretical framework is the premise that developmental tasks must be completed within a critical period of time if the successive proceeding stage is to be favorably negotiated. In this case, family developmental patterns, including those of child growth and maturation, build the quality and achievement of each stage.

According to Erickson, when a healthy person is dealing with certain challenges, developing new capabilities and a new sense of values and moving in to the developmental stage depends on the quality of the relationship with the family members and other people. By describing crises in each stage, Erickson implied that normal development does not proceed smoothly and painlessly. Crisis is to be expected. Stress will be experienced at each stage because the skills one brings from the last stage are not adequate for the demands of the new stage. Growth, with its pains, is needed to meet the new expectations. In fact, not only crisis but also joy, wonder, and excitement can be transferred as a person moves from one stage to another (Erickson 1963, in Roehlkepartain and King 2006, 141).

According to Erickson, the idea of mutuality or functioning interdependency is essential for relationships and builds trust between a child and the caregiving adult. Often adults operate as if they are solely in charge of relationships, and they are the ones who change and shape the child. The problem is that some caregivers are not intentional regarding the mutual nature of the relationship and the extent it affects the growth of the child.

The existence of trust between a child and the caregiver is fundamental to the health, wholeness, psychological makeup, faith, and maturity in all aspects of life and relationship. Particularly, in a child's life the moment mistrust distractively happens, wholeness and maturity cannot come until someone or some community gives the opportunity to experience love, acceptance, and care in a way that fosters trust.

This framework implies that children who are given intentional and timely support and are effectively nurtured in one stage potentially have the appropriate foundation to effectively proceed to the next developmental stage. On the contrary, children who are neglected and lack support on the previous stage suffer continually since the following stage is dependent on the acquired strength, values, learned behaviors and patterns of the first one (Erickson 1963).

Bowen's Theory

The emotional oneness of the family system is a vital element for this theoretical framework (Bowen 1976; Kerr and Bowen 1988, 97-98). The lifestyle and level of behaviors and patterns that individuals introduce to the family affects their sustainability and survival. According to Phipps, Bowen conceptualizes the family as an automatic emotional system, which establishes, maintains, and balances the members' relationships.

The response to emotional stimuli within the family system determines the degree to which members are able to function.

The ability to distinguish between a subjective feeling response and an objective thinking response allows the individual to develop a sense of identity and greater flexibility in coping with life's stresses. If one member learns to respond with objectivity, this will encourage changes in the significant other's response due to the reciprocal nature of family interaction. Based on defined rationales and values, movement towards integrated relations provides an opportunity for improving the states of connectedness and function of the family as a whole (Phipps 1990, 47-49). Due to several personal interests, environmental events, natural events and community pressures, sharing and adapting to new ways of dealing with emotions and experiences seems normal; however, the degree of acceptance and the constructiveness of the new pattern within the family determines the developmental integration as the family strives to meet the requirements of survival (Kerr and Bowen 1988, 272-273).

Basic Scientific Framework for Child Character Development and the Role of Primary Caregivers

Human development scientists and researchers have shown that childhood is a series of stages of learning, development and identity formation, which are based on genetic and environmental factors. Moral or character development is influenced by the mental learning level. A clear understanding of the development stage enables the caregivers or parents to sensitively respond to the needs of the child and facilitate the change and development process. However, being ignorant or naïve about this natural growth momentum affects children and undermines the roles of caregivers or parents.

Moral Development

Thomas Lickona's research suggested that when character education is implemented in a school, the frequency of undesirable behaviors declines. As a developmental scientist Lickona argues that character education, like any other kind of education, whether it occurs in one's family home or in school with hundreds of pupils, begins with an understanding of how individuals think about relationships (the process called social cognition); it is the key for character formation or moral development (Lickona 2004, 3-30).

Lickona claims that although maturational and developmental processes play important roles in character development, for the most part, it must be deliberately and systematically transmitted to children by caring adults. He advocates an approach to character education based on the assumption of ten essential virtues that comprise character. These virtues are wisdom, justice, fortitude, self-control, love, a positive attitude, hard work, integrity, gratitude and humility (Bee and Boyd 2010, 312).

One of the caregivers', parents' and teachers' greatest concerns is helping children learn to be morally good people, to do the right thing according to the standards and values of their culture. In the process of making moral judgments of what is right and wrong, the mind pattern and process of mental reasoning is a key part. Piaget claimed that the ability to use reasoning about intentions and to make judgments about moral dimensions of behavior appears to emerge along with concrete operational thinking (in, Bee and Boyd 2010, 325).

According to Piaget, in the first child's moral development process, children believe that rules are inflexible. Including the most influential cognitive developmental

theories such as those of Lawrence Kohlberg, many scholars agree on the complex nature of moral development; it is not caused by a single unity. It has been explained in terms of psychoanalytic learning and cognitive development theories, and each of these focuses on different aspects (Bee and Boyd 2010, 322).

Frequently, we observe that younger children connect moral feelings with adult observations. They seem to think that they should feel guilty or ashamed only if a parent or teacher sees them violate moral rules. “A seven-year-old candy thief is unlikely to feel guilty unless he is caught in the act. Later, after 9 or 10, when children better understand moral feelings, they are more likely to make a behavioral choice based on how guilty, ashamed, or proud they think they will feel; they understand resisting temptation will make one feel proud of self” (Bee and Boyd 2010, 323).

The social-learning theorist Albert Bandura claims that children learn more from observing others than from either reward or punishment. His theory states that, “when a child sees someone rewarded for behavior, he believes that he will also be rewarded if he behaves in the same way. Similarly, when he sees a model punished, he assumes that he will also experience punishment if he imitates the model’s behavior (Bandura 1989). On the other hand, Kohlberg suggests that there are three progressive levels of moral development: level I, pre-conventional morality, level II, conventional morality, and level III, principled or post conventional morality (Kohlberg 1964).

During the first level of moral development (pre-conventional morality) the child’s judgments of right and wrong are based on the source of authority that is close by and physically superior—usually the parent. This implies that the pattern of learning moral qualities depends on the moral boundaries and disciplines that the parent makes for the

child and for themselves. At this level, the child relies on the physical consequence of some action to decide whether it is right or wrong. At the end of this level the child develops a perspective that what the chosen reference group defines as right or good is right or good in his or her own view; the child follows rules when it is in her or his immediate interest: what is good is what brings a pleasant result. Hence, the meaning that the caring parent gives for what is pleasant, and the conviction level of the child, empowers the keeping of the rules (Bandura 1989, 167-174; Kohlberg 1964).

Level II, (conventional morality): during this level the young person shifts from judgments based on external consequence and personal gain to judgments based on rules or norms of a group to which he or she belongs, whether the group is the family, the peer group, a church, or the nation. During this level children believe that good behavior is what pleases other people. They value trust, loyalty, respect, gratitude and the maintenance of mutual relationships. Andy, a boy Kohlberg interviewed who was at level II, said “I try to do things for my parents; they’ve always done things for you. I try to do everything my mother says, I try to please her. Like she wants me to be a doctor and I want to, and she’s helping me get up there” (in Bee and Boyd 2010, 327).

During level II, the child turns to larger social groups for his or her norms; Kohlberg labeled this stage as “social system consciousness”. Children’s reasoning at this stage focuses on doing their duty, respecting authority, following rules and laws. The emphasis is less on what is pleasing to particular people and more on adhering to a complex set of regulations.

Level III is a social bond orientation stage. At the beginning of Level III, rules, laws and regulations are still seen as important because they ensure fairness, and they are

seen as logically necessary for society to function. In this, there is the notion of trying to achieve the greatest good for the greatest number. The Level embraces concern and emotions of others for the sake of unity for unity. This Level holds the transition stage from adolescence to adulthood; at the end of the transition the young people start to develop self-chosen ethical principles in determining what is good and right. These ethical principles are part of an articulated, integrated, and carefully thought-out and consistently followed system of values and principles. According to this Level, people maturing in Level III, who reason in this way, assume personal responsibility for their own actions on the bases of fundamental and universal principles and cultural norms, such as justice, truth and basic respect for others (Levine 1990, 51-67).

Kohlberg argues that this sequence of moral development is both universal and hierarchically organized, just as Piaget thought his proposed stages of cognitive development are universal and hierarchical. That is, each stage or Level follows and grows from the preceding one and has some internal consistency. Many other researchers (in Bee and Boyd 2010) have confirmed these research findings. The social bond orientation and moral reasoning behaviors are dominant in the elementary school and early adolescent season. John Snarey, who has reviewed and analyzed these studies, notes several things in support of Kohlberg's claim that the levels are universal; studies of children consistently find an increase in the level of reasoning with age (Snarey 1985, 215). Thus, Kohlberg and his supporters agree with the advocacy of character education, so that moral development must be intentionally and systematically encouraged by parents, teachers and religious institutions

The changes in cognitive development during adolescence have the potential to provide a greater capacity for critical thinking, which involves not merely memorization, but analyzing, making logical and integrated judgments based on the awareness of validity and invalidity in accordance with norms and values. According to the cognitive physiologist Daniel Keating (Keating 2004, 45-84), cognitive development adolescence provides the potential for critical thinking in several ways. First, a wide range of knowledge is available in the long-term memory across a variety of domains; thus, the ability to analyze and make judgment about new information is enhanced because more previous knowledge is available for comparison. Second, the ability to consider different kinds of knowledge simultaneously is increased, which makes it possible to think of new combinations of knowledge. Third, more metacognitive strategies are available for applying or gaining knowledge (Jeffrey 2010, 74).

However, Keating and others stress that critical thinking skills do not develop automatically; they require a foundation of skills and knowledge obtained in childhood, along with educational reinforcement and a sustained environment. Small class or group-based settings can be used to promote critical thinking and the one-to-one method is also dynamic.

Identity Formation

Jean Phinney and Jeffrey Arnett provide a detailed discussion on the identity formation of children, particularly the adolescent, in accordance with cultural values and placement. One part of their identity rooted in their local culture while another part stems from an awareness of their relation to the global culture.

There is no doubt that many cultures are being modified by the introduction of global media, free market economics, democratic institutions, and the increased length of formal schooling (Arnett 2010, 167). These changes often alter traditional cultural practices and beliefs, and may lead less to a bicultural identity than to a hybrid identity, integrating local culture with the elements of the global culture. This hybrid pattern of identity is interwoven into the young person's philosophy of life, relationships, values and dreams of opportunities. At the same time, the global culture to some extent seems far off to them, and feels foreign to everything they know from their direct experience. This identity confusion in young people may be reflected and result in problems such as depression, suicide, and substance abuse. Serious conflict with their parents can also be a result (Jeffrey 2010, 168).

Relational Development

The child's understanding of relational development or the development of interpersonal relationships is based on the level of social cognition or understanding of self and others (Selman 1980, in Roehlkepartain 2006, 313). Generally, the research suggests that there is a shift from observation (what children see) to inference (how they interpret what they see) in children's descriptions of others, as well as a clear change in focus from the outer to internal characteristics (Bee and Boyd 2010, 314). Children begin to develop a global sense of self-esteem at the age of about seven or eight, which is shown in a dramatic shift, occurs in their description of others. They begin to focus more on the inner traits or qualities of another person and to assume that those traits will be apparent in many situations.

Barriers against Affectional Attachment

The term attachment relationship does not refer to all types of relationship, but exclusively to relationships that meet three criteria: proximity, maintenance, safe haven and secure base (Hazan and Zeifman 1999, 336-355). Attachment behaviors are activated particularly during situations that are threatening to the child. The way the caregiver responds to the child's needs and behavior signals affects the quality of attachment and the child's progress-through the various developmental stages. Bowlby argued that the caregiver's response to the child in attachment-activating situations determines the nature of the child's internal working models. In time of distress and fear, securely, attached children typically turn to their caregivers who help them in a sensitive way to handle the distressing situation and its effects, by giving them increased confidence (Cassidy 1994, 228-249). Insecurity, on the other hand, is characterized either by a defensive exploration at the expense of the attachment or in rejecting of the caregiving.

Generally, the level, the frequency of expression and the quality of the child-parent bond is the base for the development of effective and affective attachment. In this process the caregivers' awareness of the value of attachment, availability, sensitivity, and the ability of the child to listen as well as realizing and maintaining the patterns and other cultural family norms can be factors that enrich or hinder the attachment values that lead toward the healthy development of a child and a continuous relationship with primary caregivers and others. The following are among the common cultural and environmental attachment barriers:

Lack of awareness and intentional development of interactive skills

The formation of early bonds is essential and the basis for the development of the next level of attachment or relationship layer. How many caregivers, particularly, know much about the need for affectional attachment and response? Although there are universal, common and cultural ways of responding, the level of understanding, identification and interpretation of the need, determines the significance and level of intentionality of the attachment and relational mutuality. Children have different signals for expressing need or calling for attachment (Bowlby 1980; George 1999, 649-670). Bee and Boyd explained:

. . . for a caregiver the critical ingredient for the formation of a bond seems to be the opportunity to develop real synchrony (response to need signals)-to practice the dance until the partners follow one another's leads smoothly and pleurably. Some caregivers become more skillful at it than others do. In general, the smoother and more predictable the process becomes, the more satisfying it seems to be to . . . the stronger their bond to the child becomes (Bee and Boyd 2010, 285).

Availability

Caregivers could be more concerned for what they think their child needs, rather than for the concern and need signals of the child. However, the more the child's needs are addressed, and responded to in a timely manner, the better the child becomes settled psychologically, mentally and physically. Availability refers not only to the physical presence, but also to providing the right response to the specific need of the child in such a way that facilitates and contributes to the ongoing process of the development of the child-parent or caregiver attachment. Availability optimally involves embracing the expectations of the child and taking the relationship to the next level constructively. This idea also helps us to answer why children, especially during the early developmental

stages become scared, and resist different and unfamiliar personalities and forms of approach (Bee and Boyd 2010; Roehlkepartain 2006, 207).

Family structural setting, norms and distribution of responsibilities

According to the general system theory as expounded by Phipps, the sharing of responsibilities, the establishment of mutual expectation and norms are the key to maintaining family balance, survival, stability and security. However, in the family where mutual norms and values, and functional responsibilities are not defined, the mutual caring practice and the attachment bond is not strong; there is room to neglect children's needs. According to Bowen's theory of family development the interplay between family "emotional oneness" and the degree of survival has a direct relationship and effect, the degree to which members are mutually convicted to do something affects the emotions involved in individual or group based functions and activities (Bowen 1976, Phipps 1990, 48). In Ethiopian parenting perception and practice, these theories demand placing the child in the midst of the family and all the family members should realize that the responsibility of developing a child is the duty of everyone. It is not restricted to the mother or the caregiver alone.

Economic factors and the living situation

Rapid global changes and challenges affect every society similarly and differently. In a developing country like Ethiopia, the global market competition and the decline in the living standard of the community significantly affects people's living conditions, and worsens the magnitude and degree of the poverty. The challenge is shocking and frustrating both for the urban and non-urban community. Multifaceted life

challenges or the seriousness of vulnerability sometimes detach child-parent bond and affect the rest of the family (Bee and Boyd 2010, Roehlkepartain 2006).

Cultural Practices and Traditional Beliefs

Even today, in traditional Ethiopia, it would appear that the father-child bond is not strong in the parenting style and practice in the early childhood; the father's touch is minimal. Though the child shows a signal for help, it is a common practice to call the mother, particularly when he or she cries out for some reason, and is in need of a diaper change. Mothers are expected to be with babies, to prepare additional food, and to wash the baby's clothes. Traditionally many parents believe that it is healthy to let the child cry and not to respond, because the more the child cries the more the chest expands, gets wider and stronger. These kinds of practice could weaken the degree of the parent and affect the child's growth when it could be addressed and facilitated through a ready and active parental or caregiver's response (Bee and Boyd 2010; George 1999).

In a collective culture characterized by the extended family, which is wide spread in Ethiopia, each member is expected to contribute to the wellbeing of the family. Unless, the nonproductive members such as the single parent or caregiver and the orphan dependent are seen as burdens and just consumers. Each member in the family should contribute to the wellbeing of the system. Particularly within the family where survival is an issue and special care is needed, the extended family members are expected to exercise responsibilities and make contributions to the dependents. When opportunities, responsibilities and values are shared intentionally, good communication, growth and positive change can be expected as an outcome. In contrast, if the responsibilities are underestimated among the family members, the burden can affect and overwhelm some

members, and then the family dynamics starts to wear out. Such deleterious trends can affect the family bond, and make the family based care giving difficult. The children can easily be neglected, and caregivers can face burden (Bowen 1976, Phipps 1990).

According to Erickson, when a healthy person deals with challenges, the development of new capabilities and a new sense of values depends on the quality of his or her relationship with others. Healthy development of a child from one stage to the other, depends on the family's intentional connections and fair responsible distribution which work together to enhance and sustain family based caring practices (Erickson 1963). Children who are given intentional and timely support and are effectively nurtured at one stage potentially have the appropriate base to effectively proceed to the next life developmental stage. "The impacts of the family on children's mental programming is extremely strong and programs set at this stage are very difficult to change" (Hofstede 1991, 33).

On the contrary, since the following stage is dependent on the acquired strength, values, learned behaviors and patterns of the first one, children who are neglected and lack the necessary support in the previous stage suffer continually. In a collective family setting, the ability to distinguish between a subjective feeling response and an objective thinking response allows the individual to develop a sense of identity and greater flexibility in coping with life's stresses.

Child Focused Holistic Learning Theories and Implication for Effective Child Care Implementation

Many educational scholars insist that education should be understood as the art of cultivating the moral, emotional, physical, psychological and spiritual dimensions of the

developing child. During the 1970s, an emerging body of literature in science, philosophy and cultural history provided an overarching concept to describe this way of understanding learning a perspective known as *holism*. A holistic way of thinking seeks to encompass and integrate multiple layers of meaning and experience rather than defining them narrowly. Every child is more than a future employee. Every person's intelligence and talents are far more complex than his or her scores on standardized tests (Meizrow 2000, 18-20).

Holistic learning is based on the premise that each person finds identity, meaning, and purpose in life through connections to the family, the community, to the natural world, and to spiritual values. There is no one best way to accomplish this goal. What is appropriate for some children and adults, in some situations, in some historical and social contexts, may not fit for others.

The art of holistic education lies in its responsiveness to the diverse learning styles and needs of evolving human beings. For instance, the inclusive educational approach has significant effect on the holistic development of learner-children. It involves children from a wide range of diverse backgrounds and abilities in learning with their peers in such a way that they might address their needs through shared and adaptive learning behaviors and experiences (Loreman and Earle 2007, 150-152).

By fostering collaboration rather than competition in the teaching and caring process, teachers and caregivers help children feel connected and they freely participate and express themselves. By using real-life experiences, current events, the dramatic arts and other lively sources of knowledge, the caregiver-teacher can kindle the love of learning through effective listening.

By encouraging reflection and questioning rather than passive memorization (rote: memorizing without realizing the meaning) caregivers keep alive the "flame of intelligence" that is so much more than an abstract problem solving skill. By accommodating differences and refusing to label children, for example as poor orphan, learning disabled, or hyperactive, caregivers bring out the unique gifts contained within each child's spirit. There are two basic theories that may possibly apply to holistic child development: The Gestalt and the Progressive theory of learning.

Gestalt Child Learning Theory

The origin of Gestalt psychology was outlined by the German, Max Wertheimer in 1912. Gestalt means, pattern, shape, form, or configuration. According to the hypothesis of Gestalt psychology the mind tends to form patterns of meaning from the seemingly chaotic phenomena and stimuli it encounters. It implies that a set of stimulating circumstances takes place according to the relative value of various stimuli acting at the same time (Gregorio 1974, 42). The central theme of this theory is that the concept of experience at any given moment is determined by the totality of its related phases, which constitute an integrated pattern or configuration.

In other words, learning is considered as an acquisition of knowledge, habits, abilities, and skills through the interaction of the whole individual and his or her total environment. Based on this concept the theory assumes that in a child's learning habit response is an integral part. This concept regards learning as essentially experiencing, reacting, doing, understanding, and habit formation: learning is concerned with the whole individual.

The learning view of Gestalt has some key implications for holistic caregiving practice. First, the child is considered as a whole: this implies that, the learner must be developed as a whole- mentally, physically, emotionally, socially, and spiritually. In this case, the aim of caring is to produce an integrated personality. Second, learning as a perceptual process is the process of developing insight or understanding. For learning to be effective within the child, perception analysis and synthesis or generalization is required, which is the expected role of the caregiver. Third, learning is a process of directing activities toward some end or goal. In this process, the essential process is to combine the elements involved in the teaching-learning situation. In this case the caregivers are expected to have a clear direction as to the future of the child (i.e., given the present life orientations, the caregiver needs to know where she or he would take the child). Fourth, learning is transferable and it is strongly connected to the experience of the learner. Learning is easier if one starts with what he or she already knows. Believers are encouraged and ordered to keep in practice what they have already taught. The concept of transferable learning and developmental theory reflects a similar theme when Erickson suggests that the preceding stage has an impact on the following developmental stage. Fifth, practice and effect are an integral part of the caring process: the effectiveness of teaching is evaluated in terms of the total growth (Gregorio 1974).

The Progressivist Child Learning Theory

This theory was formulated in the 1920s, by outstanding leaders of the school which included Horace Mann, Francis Parker, Stanley Hall, John Dewey and William Kilpatrick. It grew from the belief that schools had failed to keep pace with the rapid changes in people's lives. Progressive education tried to reform child learning methods in

several ways. It also stressed the need to design educational activity that promote greater freedom to peruse their own interest and solve their own problems according to their own internal structure of meaning there by allowing greater informality in the teaching and caring setting. This progressivist theory of learning can be seen as a reaction against formalism (Gregorio 1974).

To the Progressivist, learning is a process in which a child becomes more proactive and self-determining in the learning process. It is a process of acquiring useful responses and the control of responses through experiencing them. Unless the child can be involved in the situation, unless he or she can be guided to think, to feel, and to act in the ways appropriate to each situation, it is not possible for him or her to learn. This also means that the child learns what he or she believes or to the degree, that he or she understands and accepts (Gregorio 1974, 51-52).

Related Implications for Holistic Child Caregiving Practices

The Progressivist view of learning has implications for holistic child caregiving practice. First, in the process of teaching and caring, the child is made the center but not the subject matter of the program packages. The growth and development of the child is the target; nothing less and nothing more. Second, learning by doing (self-activity) is emphasized; this concept is based on the principle that learning is an active process. Third, thinking and reasoning are stressed; analysis and synthesis are utilized to stimulate thinking and reasoning: good caring and teaching stimulate thinking, reasoning and the addition of values and experiences (Gregorio 1974).

Parenting in an African Cultural Context: The Village as a Nurturing Environment

Parenting is the process of raising and educating a child from birth or before until adulthood (Self Growth 2012; cited in Amos 2013, 67). Parenting is an enormous task that demands tremendous financial investment, time and emotional commitments. Synonymously, parenting refers to carrying out the responsibilities of raising and relating to children in such a manner that the child is well prepared to realize his or her full potential as a human being. This implies that parenting is the process of taking care or supporting a child from birth to adulthood involving the physical, emotional, social and intellectual capabilities (Amos 2013, 66-67).

Most parents learn parenting practices from their own parents. When parenting methods are passed on from one generation to the next, both desirable and undesirable practices are preserved (in Lucia, 2013:66). A feature of parenting with regards to traditional African communities is in many cases that the responsibility of taking care of the child is not confined to the biological parents in leading the development of the child to be a responsible adult but is shared by the community members as well.

The Parenting Culture

The promotion of different values in different cultures can affect parenting outcomes; because each culture would have different goals and expectations of their members, children in such cultures would be nurtured and socialized under different influences. Amos elucidated:

Culture on the other hand is a way of life of a group of people- the behaviors, symbols, values, beliefs that people accept, not really thinking about them and are passed by mostly communication and imitation from one generation to another. With regards to African culture, people

perceive most of its practices as something which is devilish in the sense that a lot of its practices are attributed to gods. Some people especially Africans, who have not fully experienced the indigenous culture believe that to be too culturally aware makes one backward and or ancient. This is as a result of lack of knowledge of our cultural values and principles (Amos 2013, 66).

According to Tylor, culture is the collection of people who live and learned a particular human behavioral pattern (Tylor 1958, 1). A culture is normally passed from one generation to another, from the knowledgeable adult to learning child. Since the adult has imbibed the norms and practices of the culture from older acculturated adults, this transmission is often simply through exposure and through example (Amos 2013, 68). Parenting forms, norms and practices may differ from one culture to another. Depending on this factor the outcomes may differ in varies cultures.

Within African context, Baumrind, describes parenting according to three types; authoritarian, authoritative, and permissive parenting styles. She described:

... authoritarian parenting as restrictive and punitive, placing firm limit and control on children with little or no verbal exchange, and is said to be associated with social incompetence and poor communication skills. Authoritative parents put some limits and controls on their children's actions, but they allow verbal dialogue which promotes parental responsiveness, encourages independence, social and cognitive competence, self-reliance and social responsibility in the children. In permissive parenting few or no rules and little or no controls are exerted over the children. The children under this parenting style are given complete freedom to make their life decisions and behave autonomously and independently. This type of parenting style is also presumed to be associated with social incompetence and lack of self-control (Baumrind 1971, 4).

According to Cherry (2012), parenting styles differ widely in Africa as a result of certain factors. These factors include culture, personality, parental background, educational level, socio-economic status, family size and religion. According to Cherry

the authoritarian parenting style expects the child to adhere to or follow strict rules established by the parents. Failure to follow the rules will result in punishment. Usually, whatever the parents order, must be done without explanations or questions. On the other hand, authoritative parents establish rules and guidelines that their children are expected to follow (Cherry 2012, in Lucia 2013, 67).

Cherry, reported that authoritarian parenting styles tend to result in children who are obedient and proficient but who rank lower in happiness, social competence and self-esteem as compared to children raised with authoritative or permissive style. By contrast, Maccoby (1992) holds that authoritative parenting styles lead to children who are happy, capable and successful (Maccoby 1992; in Lucia 2013, 67).

Parenting and the Extended Family

In many traditional African cultures such as those in the Zeway area parenting is carried within an extended family. In it the child is encouraged to develop a strong sense of social responsibility from early childhood and learns to be a respectful, responsible and supportive member of the extended family and society. Another feature of this extended family system is that young adults live within the family homestead until they are ready for marriage. Even after marriage the parents would still want to be on hand to offer advice and guidance since they believe they themselves have richer experience than their children at any age (Lucia 2013, 68-69).

It is basically accepted that there are two types of family. These are the nuclear and the extended family. The nuclear family is made up of both parents and the children. The extended family consists of not only nuclear family but it can include uncles, aunts,

grandparents and cousins. In the African context, it is commonly accepted that when one speaks of the family it is the extended family that is referred to (Gyekye 1996).

Similarly, Adinlofu (2009) states that the extended family is composed of a number of joint, compound, elementary and nuclear families occupying separate but nearby homesteads. Adinlofu further noted that the extended family makes provision for the emotional needs of all involved. It is a cohesive unit, which ideally provides economic, social and psychological security to all its members (Adinlofu 2009; in Lucia 2013, 69).

Traditionally in Africa, it is the family system that defines the social and moral norms and that safeguards both the practical and spiritual customs and traditions. The family also provides a variety of role models preparing the way for adulthood. Degbey emphasized that the dominance of the elders or the aged exercises a relatively high degree of social control on the individuals, especially the youth. These extended family involvements in the parenting system and nurturing home can be illustrated by the following widely known African proverbs. “A single hand cannot nurse a child” (Unknown author); “It takes a village to raise a child” (Unknown author).

Although the mother has the responsibility of taking care of the child, the responsibility is shared by the extended family. Referring to the above proverbs in light of her own childhood in Kenya, J. C. Niala states that “Most of us went to school on the strength of this system; otherwise we would have been stark illiterate and walking about aimlessly. This is why it is even said that even when parents are dead, a child would always have ‘parents.’ This is because the extended family is there to take care or parent the child” (Niala 2011, 1).

Niala states further that in this extended family system if anyone sees the child doing something wrong it is not just relatives and friends but anyone who interacts with a child has a responsibility for them. What this practically means is that in public spaces if someone sees a child doing something wrong or getting into danger they will step in even before asking the parent if they can intervene. The intervention can take the form an elderly person appearing in the midst to admonish and share a story (Niala 2011, 1).

In a traditional African cultural setting such as those in Zeway, children learn a great deal from narrations of folk tales by their elders. “A folktale may be described as a story handed down by oral tradition from mouth to ear among people general” (Dawkins 1951, 417). During storytelling, the older ones tell the younger ones’ stories, which depict practical attributes and the socio-cultural values of the community. In Zeway, this can be even been seen in traditional songs and dances as well.

According to Martin (2000), such stories were often told by the light of the moon around a village fire after the completion of a long day of work. It is believed that at such times children and the youth will have a good listening ear for advice and for what is ahead of them as they climb the ladder to adulthood. Any adult who is regarded as responsive and who can impart good morals to the children can tell these stories (in Lucia 2013, 69-71).

A Paradigm Shift in African Traditional Parenting

As the result of the wide range of global change, traditional African cultural systems and practices are increasingly been impacted by external systems and forces. The extended family system in particular, is under pressure and is rapidly eroding and failing

to fulfil its primary role of socialization and coping with the changes and growing modern life changes and challenges.

The resultant paradigm shift is evident in several aspects of the parenting system. The day-to-day lives of many parents and extended families are overstretched, and parenting becomes overwhelming and more demanding, and as result children are being neglected and given to house helpers. Some of these challenges like migrant labor are weakening family ties and tearing unity apart. Simultaneously they are also destroying the cultural values, the unity and the system of helping each other within the village.

Lucia explained:

Again, the media has taken precedence in our families that children no longer listen to folk stories anymore; they are rather with the television, internet, foreign books and computers. These modernization gadgets have limited information with regards to African cultural values and proper traditional parenting which can easily be assessed by all. In view of that a lot of young people have lost touch of the rich cultural values we have as Africans. A lot of young people presently no longer give a helping hand to the adult and do not offer their seat to the elderly whether in public or private (Lucia 2013, 74).

Through all these changes, the primary caregivers must learn to cope with these challenges in such a way that meets the child's specific needs while also preserving the well-being of the entire family unit. Primary caregivers must not only manage the individual child's needs, but must simultaneously address these challenges while working to provide the best quality of life possible for the entire family system. In OVC parenting and nurturing responsibilities, the significant demands of the role lead to a high degree of stress and burden (Fidler, Bailey, and Smalley 2000, 737-740).

There are three basic transitions happening globally, which dramatically affect Ethiopian community. These are the breakdown of beliefs, the birth of global culture and

conflict over the nature of social truth (Veith 1994, 47). These breakdowns influence the whole system of parenting exercised through the nuclear and extended families in Ethiopia. This is what Tsegaye discussed:

In Ethiopia, as in most traditional societies, there has been a strong culture of caring for orphans, the sick, and disabled and other needy members of the society by the nuclear and extended family members, communities and churches. However, the advent of urbanization exacerbated by the recurrent drought and the resultant famine coupled with the internal and external wars that took place in the couple of last decades have claimed a heavy toll of human life. Millions of people were forced to migrate to centers where food was distributed. Consequently, thousands of children were left unaccompanied as neither family nor communities and religious organizations were able to discharge their traditional roles and functions (Tsegaye 2011, 4).

Changes in Traditional Parenting in Ethiopia

Global change and all its new challenges demands a new mindset that results in the weakening of the traditional culture and values especially with regard to parenting. This is very evident in the local community context particularly when the generation gap is getting wider, and tensions are increasing in the family system. The receptiveness of the younger generation to change impacts their personalities, values, attitudes, which can then frustrate many families and religious entities.

Furthermore, traditional family cultural patterns are also undergoing dramatic and profound change. Change in thinking and breakdown of beliefs is creating a global culture with tensions over social truth (Veith 1994, 47). The goals of self-fulfilling and self-realization are overtaking the primacy of the traditional family and its authority and its values. One example of this breakdown in the traditional cultural family values can be seen in the attitude towards sexuality. For instance, regardless of nationalities, ages, professions and so, on, buying Ethiopian women for sex is becoming a common practice

in Ethiopia. The Addis Admas' report (2010) referred to the following as common examples:

Foreign men visit bars or discos to pick up prostitutes. I enjoy going out for dancing or drinking at night, but there are few places where I could truly enjoy without disturbed by the scenes of foreign men standing on the floor to assess which woman to buy for the night or very beautiful Ethiopian women waiting to be purchased; Cars of Foreigners, sometimes with their diplomatic or international organization license numbers, stopping on the streets to negotiate the price for street prostitutes; Foreign men visiting massage place and ask for sexual favors. One massage owner, who never let their massage workers to engage in sexual activities complained about this situation. The reason for such requests is because there are some massage places that seems normal and decent from outside are also giving sexual service that some farenji men (white people) wrongly think every massage place in Ethiopia is giving sexual service; To entertain Foreign men to achieve the deal that could be a business transaction or even NGOs trying to get the project, Ethiopian side organizes the dinner and also arrange Ethiopian women called "secret weapons" after the dinner" (Addis Admas, July 3, 2010).

The result of such practices exposes women and their partners to HIV/AIDS which has contributed tragically to the OVC problem. Furthermore, this commerce is compounded by other forms of prurient activity. "AIDS is an imminently postmodern disease, not only as a sort of macabre self-deconstruction, but because it is caused by the legacy of the '60s- the sexual revolution, gay rights, and drug abuse. While many are turning back to sexual morality, others are fleeing from AIDS in to brand form of sex not only detached from the family but from human being altogether. Pornography, phone sex, and ultimately and the technological promise of 'virtual sex' in which people will be able to strap themselves in to a body condom and plug in to a 3-D sexual fantasy, threaten the ultimate dehumanization of sexuality" (Veith 1994, 196).

The effect of global changes such as accelerated urbanization and migration has had an impact on the extended family and its traditional cultural values of which current practices in the sex industry are one example. These two factors have led to the further

disintegration of the family and a resultant increase in the vulnerability of children and places them at risk for of abuse (Addis Admass, July 3, 2010).

The Effects of Urbanization and Migration on Parenting in Ethiopia

Urbanization has been the dominant demographic trend in Ethiopia. Unprecedented advance in the economic development during the past decade has resulted in massive growth of towns and city populations with housing shortages, environmental degradation, and lack of infrastructure. The implications of rapid urban growth include increasing unemployment, lack of urban services, overburdening of existing infrastructure and lack of access to land, finance and adequate shelter, increasing violent crime and sexually transmitted diseases. Urbanization has contributed significantly to a decline in the quality of life for the majority of the population. This decline is multi-faceted and embraces social, physical, emotional, economic and spiritual problems and unsettlement (Marina 2006, 37-38; Kebede 2001, 4-5).

The Effects of Internal and External Migration

Ethiopia is one of the countries in Africa with a relatively high level of internal migration and population redistribution. This is associated with the country's economic transition from a socialist to a market-oriented economy, with political changes and famine (Berhanu and White 2000, 91-113). Under these circumstances, migration has become not only an individual or family response to an adverse socioeconomic, physical and political environment, but also the subject of government policy and intervention (Gebre 2001). The overflow of internal migration in most of the big cities in the country and the limited employment opportunities have resulted in external migration.

Ethiopia has become one of the main labor sending countries to the Gulf region following the change of government in 1991 (Regt 2010, 242). Several studies show that there are various categories of migrants constituting postmodern migration, including “permanent settlers, seasonal and temporary workers, refugees and asylum seekers, legal and illegal migrants . . . skilled and unskilled persons” (Shuval 2001, 128).

Even a poor country such as Yemen attracts many female Ethiopian migrants who take up paid domestic work. Lebanon is also one of the most popular destinations but the growing number of human rights violations coupled with stricter migration policies of the Ethiopian government, and sometimes even bans (Beyene 2005, 61), affects the migration to Lebanon. “Some women use the *umra* and the *hajj* as a pretext to go to Saudi Arabia and move from there to other Arab countries, even when they are not Muslim” (Kebede 2001, 4; and Moors 2003, 386-395).

Some argue that the reasons in contracting Ethiopian women are not only for labor, but also for sexual trafficking or for forced prostitution. “Ethiopian women and children are sent to the Middle East as domestic laborers and often end up in prostitution. The victims are often physically and psychologically abused. Some of them have also been trafficked to wealthy Arab states to work as domestic servants” (Marina 2006, 37-38). Women who migrate through illegal employment agencies as temporary labor migrants are at greater risk in facing such problems. In Lebanon, it is often heard that employers call their housemaids *Hmara*, which means donkey in Arabic (Jureidini and Nayala 2004, 6-7). Because of abuse by employers or agencies, there have been records of many Ethiopian and other housemaids in Lebanon committing suicides (IOM 2006, 28).

When mothers returned from domestic work abroad some face suspicious husband who doubt their faithfulness. Many displayed dysfunctional behaviors such as alcoholism and unwillingness to work. Divorce and remarriage are the common outcomes of women who return from work in an Arab country. Such disintegration of families can also expose children to physical, physiological, mental, spiritual and social problems.

The Value of Care and Support for Primary Caregivers: The Place of a Supportive Community in the Caring Role

According to Welch, caregiving entails two aspects: responsibility and ability (Miller 1996, 31-37). Kilbourn, emphasises that due to various limitations and incapability caregivers may be vulnerable for every kind of victimization caused by the lack of assistance, frustration, hopelessness, fear and confusion which they face in the care of orphaned and vulnerable children (Kilbourn 2002). Kilbourn also suggested that unless there is compassionate care provided to primary caregivers it is hard to imagine their compassionate care for their children; when day after day everything turns out to be hard and complex assignments and unmanageable overwhelming routines.

In the context of the care of sick children, Kilbourn pointed out that the demands of caring causes caregivers to underestimate their own needs and those of others in the household (Kilbourn 2002, 133). The burdens of primary caregivers are deep and complicated. Due to this, she emphasised the need for research and serious investigation to identify the characteristics, related challenges, and the extent of the joy of caring .

James Miller suggests a supportive community to help maintain and keep alive families and guardians who are struggling with children's needs (Miller 1996, 51). However, often the truth and the reality is the opposite; instead of being supportive it is

easy and normal to stigmatize the suffering poor family and their children. In any religion, culture or society, a supportive community may not be a reality; rather it may be something which has to be created intentionally.

The character and quality of a supportive community is not measured by a one time compassionate act, like providing food and some kind of donation and then disappearing forever. Never! Rather, it is seen as long-term sustained psychological and social support for the caregivers and their children. Both Kilbourn and Miller agree that failure to make such provision for caregivers can result in burnout and can make tremendous and costly demands and can require a re-orientation process (Miller 1996).

Sharp and Howe's "community based care" includes family based caring particularly in mixed religious and ethnic background settings (Sharp 2001, 245-251). A community based care strategy is created by mobilizing, capacitating and designing a workable network within the community as a means of providing holistic assistance and care for the primary orphan caregivers.

Maintaining a caring heart is not merely a natural birthright, nor does it happen as an extension of another character, but it arises from the quality of understanding and analyzing the "why" of identifying self with the poor ones. The quality of action is identified by the clarity of understanding and involved motivation. Due to wrong motivation and hidden agendas, there are many families and children who have been torn apart and abused in the name of an act of compassionate love.

Downs provides a picture of the primary caregiver as a primary interventionist based on the condition that there must be a holistic approach and compassionate action (Downs 1996, 189). Being holistic is having the potential to read and understand the

totality of a child and is the attempt to address it coordinately, being compassionate as a caregiver lies in putting self in the situation of the orphan child.

“Compassion is the all-encompassing garment which we must wear to minister effectively to hurting children” (Kilbourn 2002, 25). It is tending to the greatest vulnerability and pain of the poor and caring for their whole being. It is also a willful surrender of self to walk the nurturing journey together. Developing such caregivers is also demanding, rather, at any rate, it is not a natural happening, nor is it mere academic practice; it is a day to day talk and walk with sacrifices along the journey with orphan and vulnerable children. It is not a process of strategic program implementation, instead it is a genuine and dynamic selfgiving friendship with the marginalized and frustrated ones.

Kilbourn suggests four characteristics of caregivers that may be applicable in a primary caregiver’s (family-based) setting caring for orphans: learning from each other, serving and being a model, passing on a skill, and teaching them how to protect themselves (Kilbourn 2002, 138-139). In a real sense, caregiving is not only something that one can spiritualize, instead it is what one can humanize and act out in the daily situation. Good humanized actions may be turned to “spiritualized” or religious action. Caregivers need someone who can identify with them intentionally and mentor them in the process of transformation (Kilbourn 2002, 171).

According to Cynthia Blomquist, giving a chance to the depressed child to express his or her feelings is a priority in the restoration (Kilbourn 1995, 226). Caregivers may need advice in the different ways of helping children to express themselves, their deepest feelings, perceptions, character, and self-esteem. This may require that they know

the different developmental stages of children in the light of environmental and cultural factors. Caregivers who understand the basic developmental stage of their child can be more sensitive and accurate in their caring implementation and thereby address the holistic need.

Caretakers who experience chronic stress or feel overloaded are at risk of becoming emotionally traumatized (Kilbourn 1995, 226). Since they cannot meet and yet are expected to address all the children's needs, caregivers should know their own limitations and avoid unrealistic assumptions.

Many western child development program specialists suggest that relevant training would benefit caregivers. This can also be effective for professional caregivers. However, in situations where caregivers are illiterate, informal training should be prepared in an oral-based way that fits their needs. It would be unwise to disregard such groups of uneducated caregivers. In addition, counseling skills should be developed among all caregivers. Welch suggests three questions to be asked and understood by the counselor in the caregiving context: Who is the child? What does the child need; and what are some of the methods for counseling the child? (Welch 1996, 180). In order to guide children in crisis, caregivers as counselors are expected to explore and differentiate the unique influences that have been shaping the child.

Welch suggests a creative counseling approach as a strategy for creating a workable and situational method that may grasp the attention of a child positively and constructively in the midst of unpleasant emotions and decisions. For instance, telling an interesting story may relate with the situation and provide some kind of positive

reflection which may address the child's emotional needs, and propose solutions for various needs.

The role and burden of caregivers is directly related to cultural, economic, religious and social issues in the society; sometimes it also varies based on ethnic and religious differences. At any level and circumstance the effectiveness of care-givers requires intentional and coordinated back-up care. If this is not available, it is inevitable that stressed, confused and hopeless caregivers will affect themselves and the children, including the rest of the household.

Patrick McDonald said, "if we miss the centrality of children in everything we do we have missed it . . . they create sanity in a mad world and they draw us back from ourselves, our destructive habits . . . and can make our community different" (cited in McConnell 2007, ix-x). He underlines how easily parents, the religious community and the rest of the community miss, and neglect children from their priority list of importance. The child's intrinsic worth and value should be an uncompromisable reason to embrace and provide them with opportunities for community participation, language development, and to allow them to exercise their special aptitudes and potentials (Stonehouse 2010, 44-45; Copsy 2005, 140).

Caregivers need to make some boundaries and to set limits in order to maintain the long and tiresome walk with their children. During the day, they sometimes need to distance themselves from their burden and to be connected with a "healthy family" for interaction and genuine fellowship (Kilbourn 2002, 189). They also need to delegate and to learn to share their responsibilities with others in the family, or even with their neighbors. However, this may not be easy, particularly if the child is affected by

HIV/AIDS or other chronic illness. Not only the care-givers' children need caring peers or friends, but also the primary caregivers themselves, too. This implies that the basic perception of Kilbourn's care-giving strategies relies on the quality and strength of networking designed within the community, family and caregivers (both primary and secondary).

The book, *Healing Children of War*, edited by Kilbourn, Josephine Wright states that "children who have been given a firm caring home with acceptance and love, and who have been helped to deal well with past distressing experiences, tend to cope better. The frequency, severity and consequence of these experiences, impact how well a child copes" (cited in Kilbourn 1995, 43).

In the process of holistic nurture, being sensitive about children's dignity and entering into a relationship that possibly generates a genuine love can provide positive qualities that enable caregivers to implement a holistic approach. In Ethiopia children are traditionally viewed as insignificant which contrasts significantly with the holistic view of a child as a dignified person who needs an intentional relationship.

Around the age of 15, adolescents begin to include more comparisons of one's traits with another or one person with another, with some inconsistencies. Research on children's understanding of others' emotions suggests that they acquire these various forms of knowledge gradually over the years from about age one to adolescence. By age 10, the child understands and can read some emotional blends, even expressions of ambivalence. Research by Paul Harris and his associates (1981) in England showed that not until adolescence do young people become fully aware that other people may hide

their emotions or act differently from the way they feel “inside” (Bee and Boyd 2010, 316- 319).

Friendship is one of the key relationship elements and settings in the child’s development process. Preschool children seem to understand friendships mostly in terms of common activities, like playing together. Children at this age think of friendship as something that involves sharing toys or giving things to one another. Gradually, this view of friendship begins to shift away from an emphasis on activities (Dunn 1999). Studies by Thomas Berdt show that the key ingredient of friendships for elementary school children seems to be reciprocal trust: friends are seen as special people with desired qualities other than mere proximity, as people who are generous with one another, who help and trust one another (Berd 1989).

Similarly, children at this age also understand that friendship has temporal dimensions: friends are people with whom one has a history of connection and interaction, rather than people one has just met or played with once. Likewise, over the elementary school years, children develop an understanding of gradation in friendships. That is, they understand the difference between best friends and other kinds of friends (Bee and Boyd 2010, 316-325).

By about age 11 or 12 children begin to talk about intimacy as an important ingredient in friendship; by middle adolescence, they expect a friend to be a confidant and to be supportive and trustworthy. Research suggests that in late adolescence, young people understand that even very close friendships cannot fill every need and that friendships are not static: they change, grow, or dissolve as each member of the pair changes (Bee and Boyd 2010, 316-325).

The study of parent-child relationships, especially in the work of John Bowlby, demonstrate the importance and strength of attachment as strongest relationship (Bowlby 1980). It is an important and long enduring tie that exists mutually and interchangeably important between child-parent. A sense of comfort, security, hope, enjoyment and happiness are the results of a healthy attachment and affectional bond. In turn, this kind of attachment encourages the child to explore his world creatively and progressively. Attachment, acceptance and relationship are important aspects of child development strategy, particularly in restoring children in crisis. Lacking these factors during childhood can potentially cause hopelessness and crisis (Roehlkepartain 2006, 202-205).

Caregiving Practices

The care that primary caregivers and children receive has a powerful effect on their wellbeing, survival, growth and development. Care refers to the behaviors and practices of caregivers to provide the food, health care, stimulation, and emotional support necessary for the wellbeing of the caregiver and the child. Practical efforts to support caregivers in their role should ideally lessen the burden as well as the negative physical and mental effects that caring can cause on their wellbeing. Depending on the culture, in addition to the material support itself, the manner of approach and delivery can lead to a healthy relationship with the care recipient which in turn can create inspiration and joy (Engle 1999, 133).

Essential carrying support, such as food, sharing the work load, physiological and community support are vital for optimal caregiving practices. Engle indicated that in Asian development contexts, “care practices cannot occur without resources to provide care. Focusing on care practices without a concern for resources may lead to the

unfortunate result of blaming the caregivers for inadequate care, rather than recognizing a lack of resources” (Engle 1999, 134). According to the Engle review, the absence of the above essential caring supplies such as, food, sharing work load, parental care, educational support, and community support are often the result of lack of financial provision and other practices.

Depending on the case history, which should include an assessment of the existing level of joy and sense burden carrying, provision should include improving the knowledge, beliefs, and the physical and mental readiness which can back up the caregiver’s constant and intentional caregiving practices (Jonsson 1995, 293-298). The provision of proper or adequate care and resources depends on the entail assessment of the caregiver sense of burden and source of joy.

In challenging caring practice where such resources are overwhelmingly limited, the caregiving motivation, commitment, confidence and joy must be rooted deeply in the value and belief of the primary caregivers. For example, in Africa in an extended family setting, the joy of caring for orphans and children in crisis comes from the socio-cultural values of relationships which also have a spiritual element. Particularly, in the modern changing and challenging world, the engagement with the burden and joy of OVC primary caregivers is not only a cultural and social issue, but is also influenced by the economic conditions, and government human rights and protection policies (Haddad 1999).

The caring therapies and practices vary not only according to culture, but also within families in the same culture, and depend on the family norms, values, behaviors, nature of the relationship, the extent of exposure to modern media and the response for

varies vulnerability. In family setting, the behavior of the OVC primary caregiver and the child, but also of every other member of the household can affect the caring practices and the utilization of resources which can in turn impact the survival and wellbeing characteristics of all and particularly the OVC primary caregiver (Engle 1999, 138).

In the caring practices the nature of attention, responsiveness, affection and involvement are the key behavior qualities which impact growth and development. The care and assistance of backup help the caregiver to develop and maintain positive behaviors. Lack of consistency in affirming and maintaining positive behaviors can create frustration and other negative outcomes (Engle 1999, 147). An overwhelming sense of burden can affect the caregiver's behavior and cause emotional instability which directly affects the emotional attachment with the child and other areas of the caring role and practices.

Vulnerable caregivers who are assisted in the physical and emotional burden and challenges they face and who maintain a healthy and responsive relationship with their OVC can powerfully affect and enhance the growth and development of the child in addition to sensing the joy of their role in the daily caring practices. In an experiment, Dennis observed a difference in physical and mental growth difference between the child who is living in an orphanage and who has little contact with child-care workers (secondary caregivers) and the child who is cared for by a single primary caregiver. For the experiment, “. . . he selected a group of children for special treatment and assigned each child to one particular caregiver, who was asked to pick the child up and hug and talk to the child in daily basis. Children with treatment changed radically; they developed

rapidly in terms of motor behavior and grew well. The treatment was carrying” (Dennis in Engle 1999, 133).

In his evaluation of caring practices in Asia, Engle held that the home visit based interactive training of caregivers was effective (Engle 1999, 148). Kagitcibasi identified the main reason this effectiveness is that “in family or collectively oriented cultures, which are common in many part of the developing world, a program that improves home interaction is likely to be relatively more significant than the one which provides service directly to children” (Engle 1999, 148). For example, in the case of the 14-year-old girl, Fozia, who was living with her grandmother and committed suicide, the program approach that FH Ethiopia was implementing was not family focused, but instead child focused. In a family -focused strategy, particularly the primary caregiver is at the center, whereas in the child-focused program, the OVC is the focus. In a child –focused approach a weaker primary and secondary (care-workers) connection and relationship is likely, which in turn results less effective and more outdated intervention in solve problems between the OVC, primary caregiver and the rest of family members.

The provision of intentional and timely care for the primary caregiver is a critical aspect in the quality of care provided to the OVC. Strategy should be in place which progressively shift from a handout care pattern to a more self-reliant one through self-motivated initiatives, such us income generation activities, group savings, and other opportunities which are visible in the context and can be manageable by the caregiver to obviate long-term dependency and move to sustainable program. UNICEF has made significant efforts to incorporate caregivers care issues into programming and “develop training manuals for teaching program planners and managers how to use the concept of

care in programming.” And these manuals were field-tested in a number of countries (Engle 1999, 159). According to the field tests, caring program strategies that relied on the secondary caregiver or social workers who were expected to incorporate the care messages into the daily work of the primary caregivers through trainings and other formal approaches were much less effective than those which took the message into the homes, either through home visits, parent support group or other community actions and demonstrations (Engle 1999, 159).

Generally, home based care interventions and interactions have a long term effect and create an environment conducive to sharing adaptable, visible and manageable caring practices and lessons in the given cultural and homebased caregiver context. In the child-focused program that FH Ethiopia is implementing, the caregiver’s caring practices and effect on children are most likely to be seen with high intensity interventions directly with children. “However, in developing countries with more collective cultures, the effectiveness of interventions directly with caregivers is likely to be greater” (Engle 1999, 161).

Caregiving Impact

Research has shown how the exercise of the caring role can have a negative impact on the caregiver’s mental, emotional health and other aspect of their life. In Australia, Savage and Bailey found some caregivers experience an extensive negative impact while others are less affected by the caring role (Savage and Bailey 2004, 103). This variation in the impact experienced is not simply related to the extent of caregiving provided; it can be depending on the individual personality, social and religious values

and coping experience (Folkman et al. 1997, 256-298). In their research, Savage and Bailey found that:

The negative impact of caregiving on the mental health of caregivers is substantiated in the literature. For example, the Victorian Carers Program conducted a population-based study in which differences in well-being between caregivers, as a group, and non-caregivers were demonstrated (Schofield et al. 1998). The researchers found less life satisfaction, less positive affect, and more negative affect among caregivers compared with non-caregivers, regardless of age or marital status. In data collected by the Australian Bureau of Statistics (ABS), approximately 30% of caregivers reported that their well-being had been affected by caregiving, and that they were often worried or depressed (ABS, 1998). In a review of 41 studies published between 1990 and 1995 on the effects on caregivers of care recipients with dementia, it was reported that increased levels of psychiatric morbidity were generally found, with elevated levels of depression being a consistent finding (Savage and Bailey 2004, 104).

However, some researchers such as Nolan, Grant and Keady have investigated the positive aspects of caring, such as the joy and satisfaction experienced by caregivers in performing their caring role (in Savage and Bailey 2004, 104). According to the Savage and Bailey review on their research work, “important positive aspects of the caregiving role include giving pleasure to the care recipient, maintaining the dignity and maximizing the potential of the care recipient, experiencing enhanced relationships, meeting perceived responsibilities, sharing mutual love and support, and developing personally. In the Victorian Carers Program research, 84% of caregivers indicated that they receive a great deal of satisfaction from caring” (Savage and Bailey 2004, 104).

According to Ashworth and Baker research caregivers in other countries also described some benefits of caring, such as a sense of closeness to the care recipient, and enhanced self-esteem (Ashworth and Baker 2000, 50-56). In the Australian Bureau of Statistics data, for 1998, 33% of caregivers indicated that their relationship with the care recipient was closer as a result of their caregiving role (ABS 1998). It is likely that these

positive aspects of caring could generate a power and inspiration to maintain the role and impact positively on the caregiver's overall health condition.

The relationship of the care with the recipient can affect the sense of satisfaction in caregiving. This is shown in the Victorian Carers Program research:

Spouse caregivers experienced lower positive affect than did parents and adult offspring (Schofield et al. 1998). Parents reported more satisfaction with the caring role than did spouses, and spouses reported more satisfaction than did adult offspring. Also, parents and spouses reported more closeness in their family than did adult offspring. In the review of research on dementia caregivers, being the patient's spouse was associated with increased depression (Schultz et al. 1995). Further, Nolan et al. (1996) noted differences in the perceived satisfaction of caregivers who were spouses of the care recipient compared with those who were children of the care recipient (Savage and Bailey 2004, 105).

According to the review of research on dementia caregivers, the key variables that were associated with increased depression include the caregiver's low income or low financial adequacy (Schultz et al. 1995, 771-791). The research further indicated that the amount and quality of informal social support (from the supportive community, such as family, friends, neighbors, social groups) and the formal support from agencies is an important factor in ameliorating the negative impact and stressful burden, and could relatively contribute to the joy and satisfaction.

Data from the Victorian Carers' Program research indicate that caregivers who reported having larger informal support networks reported greater life satisfaction, greater perceived support from family and friends, and less resentment and anger than did caregivers reporting smaller informal support networks (Savage and Bailey 2004, 106). As a result of this research, Savage and Bailey make several recommendations in respect of the caring role, practices and intervention. First, factors associated with the negative impact and specific context should be examined. Second, the type, nature and overall

behavior of both the caregiver and the care recipient should, be understood. Third, the positive aspect of the carrying role, such as of joy, and satisfaction should be acknowledged. Fourth, financial service or other visible support should not be overlooked. The means should be provided to ensure long-term sustainable coping mechanism by enhancing feelings and initiatives of self-sufficiency (Savage and Bailey 2004, 107).

Parenting as a Caring Call: Some Theological Foundations and Implications for Parenting

The typical understanding and implication of God-given dignity, that of being created in His image, of being called to “rule over, have dominion, govern and administer” the whole of creation, and being made “fearfully and wonderfully,” moves on to one of the dignified callings: parenting. It is being entrusted with the precious ones, children who are the growing hope of the generation. Parenting is both a divine opportunity and a calling that matters significantly for the progressive mission and redemptive plan of God. It is the highest calling of all.

The family does not come into existence simply for a decorative purpose or some cultural reasons; instead, it is a purposeful constitution, and artistically following God’s creation order. It is true to view the wellbeing of a family, as the well-being of society, and of history. Both famous people, and notorious leaders who have affected the global or the local system have emanated from families.

Childhood behavior has a long-term effect on the life of a person. Every form of abnormal condition and happening, irregularity, complex, disorder, damage, or abuse in our local or global context may have some kind of direct or indirect theological reference

to a certain community, family and childhood background or identity. Since for every single person, personality is also the product of the collective community, it is hard to deny such facts. Personality holds both otherness (our exceptionality and uniqueness) and sameness (shared identity caused through environmental and genetic connection).

Hence, the divine institution called the family is designed to maintain and promote the theologically unique identity of its members and beyond, after the likeness of the Godhead. Such an assumption often begs the theological reflection on the following questions: do we still bear “the likeness of the Godhead” while we are still embracing a character against God? On the other hand, do we still reflect the statement that says: “we are fearfully and wonderfully made,” while we are good at abusing the purpose we are created for? Of course, it is only the new person in Christ who is able to live up to the standard, and overcome any form of corruption (Colossians 1:19-20).

The Bible stays, “Train the child in the way he should go, and when he is old, he will not turn from it” (Proverbs 22:6). It is not a fallible human opinion; rather it is a plain and infallible timeless truth. Such a biblical assumption entails godly child raising and nurturing which mainly involves both the parents and the community. It is an intentional act, and if you like, it is a divine call to live for children. In other words, all marginalized children who are labeled as “evil or bad” are also a mirror to show the values and impact they adopt or share from their families and society around them. The converse is true for their “good” behavior and acts while they are living among the community, which they are a part of. Every child not only belongs to his immediate family, but also, he is a child of the surrounding community.

A Biblical and Theological-Based Understanding of Children and the Parental Role

In the light of the ever-increasing challenge that the contemporary churches, Christian parents, and child focused faith based programs are facing, it is important that Christian parents, care-givers, including pastors and Sunday school teachers, develop a coherent understanding of the biblical insight that shows the depth of God's clear concern for children and the parental (immediate caregiver's) role.

Biblical Reflections

Genesis: The Placement of a Child in the Family (Genesis 1:26-27)

Being an image bearer makes human beings God's representatives on earth. This shared unique identity gives us the capacity and the extra-ordinary opportunity to relate to the creator. Possessing a divine image means that God can enter in to personal relationship with human beings. They can speak to Him and make a covenant with him (Bunge 2008, 9). The "image is not something that Adam and Eve grew up into; instead, it is given as a supernatural grace that qualifies and makes humanity resemble God's likeness. The newborn and growing children are no exception for God's promises are for them as well (Wenham 1996, 29-32).

Some great promises of God depend upon the birth and continuing life of children (Genesis 15:3-5; 22:17; 28:14). For Abraham, the meaning of his life and existence were strongly tied up with his having children and that is also, where God's promises of blessing are centered. God not only kept His part, fulfilling the promises to give children to Abraham, but He also gave a responsibility and command to teach his children (18:19). The promise of Abraham's great blessings does not end up with getting a child at an

advanced age, but also extends to the character development education of the children and the implication for their daily work. The “way of the Lord” that Abraham is called to teach the children includes the matter of righteousness, justice, public matters and relationships with each other (Wenham 1996, 29-32).

In Genesis (21:20) God’s presence and voice is clearly with Hagar and Ishmael, the rejected boy in the wilderness reflect God’s perception of children. God is involved in the life of every child despite the cultural, economic and religious orientation explanation and patterns. God also has a concern for the health and welfare of children, particularly when things seem very tough and unmanageable for parents and caregivers. Again, the case of Hagar gives a good biblical example for this, God coming to the neglected single caregiver in a seemingly impossible situation. There are also other women like this who care for the most vulnerable children all around the globe (Bunge 2001, 12-13; Wenham 1987, 29-32). God was there to encourage Hagar and open her eyes to see how she could care for, and meet the need of her son (Genesis 21:19).

Examples of Moses: Exodus

Moses, during his childhood, was the concern of God and of Pharaoh. Moses was thrown in a basket in a river; however, God controlled the crisis and cared for the boy through his caregiving families. God inspire his mother to trust him to God and the watchful eye of his sister, in that hope that God would provide a way for his life to be saved. God is the one who dealt with the midwives, the family, Pharaoh’s daughter who chose to become the caregiver (Bunge 2008, 29). Particularly, in the beginning of the child’s life the issue of caring for Moses is the key concern. No matter how painful the situation in the early life of the child, it does not determine and necessarily limit the

future. Nevertheless, it is an undoubted fact that every child needs a caregiver, who takes care of and follows her or him seriously as had been done for Moses.

Deuteronomy: Family Worship and the Place for Child Participation

God is not only showing the original parental delegation of responsibility as an extension of His care for children, but also the collective role of the faith community in representing God in welcoming children as participant in worship. God wants parents to embrace His love and teach it to their children (6:1-9). The Book of Deuteronomy depicts this from both the short- and long-term views by referring to the existing children in the midst of the future generation. Miller describes two key responsibilities urged upon the faith community: to explain to the children how God had appeared on the mountain and God gave them the Ten Commandments (4: 9-10), and to recite and know them, so that future generations of children would in turn come to know God's story together (31:12-13). In the teaching-learning fellowship children learn not only the regulations and traditions, but also the profound and big stories (metanarratives) which have the power to keep them in a continual relationship with God and with their fathers (6: 20-25).

The commandment of "teaching your children" was to be the focus of constant discussion inside and outside homes (6:20-25). The continuity of the covenant depends on the transmission of understanding of their special relationship to each new generation. This relationship imposes the responsibility on God's people to honor and obey Him, so that they might continue to experience His presence in history and continue to hear His word. The result of such action keeps them in a right relationship with God. In this context, righteousness means a right personal relationship with the covenant God that will lead to right conduct. The answer to the child's question thus ultimately focuses attention

on the proper relationship of a person to God, and the fruit of that relationship in daily life (Christensen 1991, 142).

The continuity of faith within the context of a religious community depends on maintaining the faith within individual families, where the child is placed at the center. In ancient Israel, the parents carried a great responsibility in educating their children. They focused mainly on teaching their children the story of what God had done for them and about the fear of the Lord as the beginning of wisdom. If parents cannot transmit their faith and inculcate it responsibly to their children, the very existence of that faith community is in jeopardy.

Proverbs: Teachings on Morals and Values

The book of Proverbs often focuses on children, parents and the parental role. Using different wisdom sayings and metaphors, the book depicts the issues of life in a daily practical manner, and as a whole. It deals with identity and value formation. Proverbs defines what it means to live a righteous life, ascertains by intentionally repeating the cause and effect patterns for the sake of special emphasis (22:6; 23:15-26).

The phrase “teach and train,” in the following text of Proverbs, refers to continuous religious and moral training, not to professional activities: “Train a child in the way he should go, and when he is old he will not depart from it.” The nature of the moral content of the phrase gives a sense of the basis of understanding this instruction and the methods of transferring the same instructions. The dynamics of relational life, the day-to-day practical life and structured and intentional correction, confirmation and empowerment and close follow up from the caregiver are also very crucial for her or his moral development. Although persuasion and instruction are important through all the ongoing

caring and parenting process, but the book of Proverbs goes further and stresses that modeling, showing a practical God-fearing lifestyle is also a key factor (1:8-10; 2:1-11; 3:1-12; 4:1-27).

According to the book of Proverbs, successful inheritance and hand-over from father to son could mean successful rearing and caring of a son (13:22; 20:21-22). This inheritance is the key variable of life and the child's destiny. It actually depends on the quality of parental nurturing which can determine the choice and the patterns of life the child selects in the process of value, worldview and identity formation (Walter 2005, 206-208). Ideally, this does not mean that the parents, caregivers or teachers are in a position to override and ultimately determine the child's life. Instead, both parenting and instructing are in their hands in the process in which the child's listening and participation is also a key factor. On the contrary, the moment the child lacks the right instructions and parental responsibilities are miscalculated and underestimated (due to various cultural, economic, social and other personal reasons) the child tends to be "a foolish son who destroys the father's inheritance". Eventually, his continuous deterioration from static laziness to deep sleep shows an approaching hunger and death (19:13-16). In these verses the dysfunctional and functional home relationship are contrasted. Moreover, in the functional family wisdom comes to the house, as the parent maintain good relationships.

At the end of the collection, the wise dear "old father" is closely admonishing and mentoring, the youth in the way of "the wisdom of the Lord which results in the fear of the Lord". This includes educational guidance that will lead the young people away from the folly of endemic selfishness and to stay clear from the sinister road the perverts travel

and from indulgence with the evil (23:15-27; 24:1-2). This is the area of responsibility that parents, caregivers and teachers currently underestimate, and, as a result, they can cause a negative impact on the life of the youth, the family members, the peer group and to the larger community.

Luke's Narrative: Children in the Kingdom Mission

In the progressive kingdom mission, God has a profound place for children. The child, Christ, is presented as the foundational fact of God's gospel who draws people into the eschatological community of faith. Luke presents the child as the main focus of the story and subject of the Gospel as he provides evidence from eye witnesses to draw the attention of Theophilus, using a historical researcher approach. Luke describes God's affirmation of Christ's Sonship by God (3:22) and the manifestation of His messianic role in His early childhood (2: 30-38) and describes His holistic growth (2:52).

Luke 2:46-47 indicates that at the age of twelve Jesus had a good grasp of scripture and was asking important questions; this possibly come from His home and the synagogue school (Nolland 1989, 19). For instance, the religious faithfulness of his parents included the annual trip to Jerusalem for the Passover, which counts for a significant part in Jesus' holistic learning and growth (2:39-42).

Until the age of twelve, his parental attachment also assumed a culturally strong role and smoothly guided and controlled Him to the level of accepted and expected humanistic Jewish tradition. However, at the age of twelve, He begins to make the transition to adult responsibility and action. According to the law, at this age, vows become obligatory and parental discipline and control gets more serious. Before Jesus was recognized as God and man, He kept on learning in various ways: listening, through

dialogue with elites, and by asking questions. Luke pictured Jesus as the student who was eager to learn (Nolland 1989, 132-135).

Nevertheless, Christ made the choice to abide with kingdom rules and principles rather than to follow his Jewish religious traditions. He chose to abide by and declare the kingdom principles and to live for the affairs of His Father. Before that, Jesus had been identified as a fully-grown boy. The development of such a unique identity (personality: thinking and action) created some confusion, misunderstanding and amazement in the minds of His parents.

The concern of the “teaching” we see described in scripture is far more than keeping a religious pattern and culture; instead, it is leading children to a personal attachment with the covenant of God (Bunge 2008, 48). As leader, the role of Moses was to extend the intention of God’s concern and instructions by teaching them to parents to pass on to their children, and to their children. The book of Deuteronomy and Proverbs for instance have clear guidelines on teaching children. In addition, they delegate to parents the responsibility leading children where God sees and expects: parents should talk to children, and share life experiences in the process of instruction.

Theological Reflections from Christian Tradition

In the Christian tradition, there are prominent theologians who significantly contribute to and shape contemporary thinking about children and the parental role. Bunge holds that the convictions and the movements launched by these theologians produced a rich theological heritage concerning children in the history of Christianity and that they continue to influence Christian culture, belief and practices (Bunge 2001, 8-9). This section briefly describes the theological convictions of three selected theologians

concerning children and the parental role; John Calvin, John Wesley, and Horace Bushnell.

John Calvin's Views on Children and the Parental Role

The prominent systematic theologian John Calvin (1509-1564) was interested in Christian education, particularly in children and child rearing in the Christian home and church. He strongly believed in an investment in children and participated in the implementation of public policies that had importance for children (Bunge 2001, 161).

Calvin views children as a heritage from the Lord (Psalm 127:3), and in the home, they radiate God's grace. In his view whenever parents have a new baby, it is not a result of chance or of high probability: rather, each and every child is a gift from God. Parents are expected to continually work out the act of caring for their children in the light of this belief. Parenting is not a mere humanistic act and set of techniques. In the child's mind and character formation parents must consider and seek for God's special favor.

According to Calvin, instructing children is a serious parental obligation. The family is the primary context for moral, social, intellectual, spiritual and physical nurture. The authentic mark of good parenting is instructing children in godliness. This includes baptizing the infant as a reinforcing base to enhance continual instruction, believing that the baptized one is in the caring hands of God (Bunge 2001, 183-185).

Children have to honor, obey, love and care for their parents. It is a parental obligation to apply discipline whenever children fail to do their duties, but it must be done with love and gentleness. Calvin holds that the task of rearing children is not only for individual desires, but also for the family and the common good. This also implies that the role of child care and nurture is an inclusive responsibility where the community

and government take part. One of the main purposes of catechism in the early tradition, was its value for the instruction of children by the faith community. Bushnell, also has even strong views and expectations for the parental role in the process of faith development of children.

Horace Bushnell's Views on Children and the Parental Role

In the nurture of children, Horace Bushnell (1802-1876) advocates a strong parental role, and views the family as a primary agent of grace. In the gradual development of childhood faith and the process of enlightenment, the home environment and the family relationships are a facilitating influence. The daily family life routines and modeling are important for a child's conversion. In a truly godly parent, the gospel beams out as a living episode before it is taught in words.

Bushnell also gives special emphasis on family intimacy and holds that dysfunctional family relationships negatively affect the growth and happiness of children. Children realize the feelings of the loving God more through parental love and teaching. Training in doctrine and scripture should be sensitive to the child's needs and understanding. Bushnell believed that for parents to ignore their importance roles as the moral interventionist for children was "virtual abuse and cruelty" (Bushnell 1876, 48).

Bushnell saw child conversion as an intergenerational process, involving both the parent and child transmitted through human interaction within the family. Conversion in the life of children is a process, rather than a sudden action; it comes through a gradual awakening of the soul to God. This happens when a child and parent have a strong attachment (Bushnell 1876, 49-50).

John Wesley's Views on Children and Parental Role

Wesley (1703-1791) strongly believes in the early learning capacity of the child and the parental role. One of his convictions and frequent questions probably for parents “why did not you break the will of children from their infancy? He emphasizes the authority of the parent over the child, “keeping a strict hand over them beginning at the early stage” (starting at the age of two)?” (Heitzenrater, in Bunge 2001, 285).

Wesley views early parental instruction and discipline as a source of generating awe and respect in children minds, which would then hopefully grow into love and an effective child-parent attachment. He suggests that the aim of child rearing and education should ultimately be spiritual growth of the child, although he is committed to the design of an inclusive curriculum, promoting instructions in several subjects and teaching children several subjects (Bunge 2001, 286-288).

On his view of education for children, Wesley sees the parental and teacher's role as that of instruments of imprinting God's will in the minds and lives of children. In this respect, he also expects parents and teachers to be the persons of compassion and to be knowledgeable. He viewed the teaching and learning process a means of grace to restore and transform children (Bunge 2001, 292-293).

Orphans and Vulnerable Child Care

Richard D. Patterson has shown that care for the widow, orphan and the poor is a recurrent theme, not only in the Old Testament but also in the literature and legal codes of the Ancient Near East, such as the code of Hammurabi in the 18th century BC Mesopotamia (Patterson 19973, 223-34). God's concern for widows and orphans is a consistent theme throughout the Bible. This concern was enshrined in the covenant law

God gave to the nation of Israel in the Old Testament and a remarkable instance is the provision for the care of widows, orphans and poor in the covenant made between God and the people of Israel in the code of Sinai (Exodus 22:21-24; 23:6). These are also held to be under the protection of God Himself (Bromiley et al. 1986, 616). These injunctions are repeated later in Deuteronomy as well as other books in the Bible.

The Israelites were also instructed to make regular provisions for widows and orphans through tithes and offerings (Deut. 14:28, 29; 26:12). Moreover, prophets also urged God's people to demonstrate their righteousness through the care of widows and orphans, and warned them of God's impending judgment if they did not do so: Isa. 10:1–3; Jer. 7:5–7, 22:2–5; Zech. 7:9–11; Mal. 3:5 (Mclemore 2001, 616).

Caring for the physical and spiritual needs of widows and orphans has always been an integral part of worshiping God. The New Testament describes the essence of “pure religion” as caring for widows and orphans (James 1:27). Particularly, as the result of the neglect of children in Jewish religious practice and the Hellenistic and Romans view on the image and social status of children as “not yet human in the full sense” during that time, Jesus demonstrated a strong child acceptance and eschatological perspective of children as a way of instructing and warning the disciples to welcome and care for children in order to break the cultural the cultural against children(Luke, 6:20-23, Mark 3:5, 10: 15, Matthew 18:1-5), (Volf 2001, 29-46).

In his sermon from Joshua 24:15, *On Family Religion*, John Wesley expounded principles for caring in godly households. In his exposition of the text, “As for me and my house, we will serve the Lord.” This commitment to serving the Lord included the entire social unit living together in the same dwelling, from the wife to the children,

servants, and even the strangers at the gate. The principle that Wesley derived from Joshua's exhortation to all the elders and leaders of Israel was to serve and care for a house hold wider than the biological family unit, which probably includes children of the servants, and of the strangers (Wesley 1872).

In Africa, as a result of adversity the family unity is breaking down and the number of widows and orphans steadily grows as a result of wars, natural disasters, and displacement. Particularly in Africa, unemployment, urbanization, internal and external migration have rapidly increased the number of orphan and vulnerable children bereft of parental care and at the mercy of the availability of alternative care arrangements (Herzog 2005, 91-93). The massive increase in world population and the HIV/AIDS pandemic has led to an accelerated number of orphans and vulnerable children and a concomitant demand for substitute caregiver (Miller 1996, 8, 51; UNAIDS 2009, 19).

Childcare through caregivers is not a new phenomenon or there is no a specific revolutionary instant or transition that changed the parental role to caregivers. Instead, it is as old as human history for wherever there has been conflict, famine, slavery, disaster, war and disease, children have been left orphaned. Institutional care of orphans has been one solution to this problem. For instance, the Romans stablished an orphanage in 400 AD. In the nineteenth century institutions such as orphanages and work houses were seen to be the answer in Britain. However, since the 1950s there has been a shift from the institutional care of orphans as a result of exposures of abuses in the system (Kershaw, and Sacks, retrieved, 2018). Even in Africa there has been move towards the care of orphan children in a small family type unit headed by a caregiver.

The 2011 Ethiopian Demographic and Health Survey (EDHS) indicated that 18% of Ethiopian households are caring for orphans (EDHS 2011, 257). “Many of the OVC in Ethiopia are living with female-headed household, surviving parents or extended families” (Zelalem 2011, 3). UNICEF estimates that there are a hundred million street children worldwide. Some live alternately in a home and in the streets often expected by their parents to bring in some money. Other never return home because of broken families. . . .” (Herzog 2005, 92).

A Summary of the Literature Review

The literature review has been organized within the scope of the research problem in such a way that it also validates the significance of the study from various aspects, such as scientific, theological, social, economic and cultural perspectives. The flow, relationship and the pattern of thought has had a central focus on the research issue, which emphasizes the wellbeing domains and the nature of the burden of the primary caregivers as interventionist in the lives of OVC children.

The theories that directly relate to the wellbeing of OVC primary caregivers, also project logical thoughts on how to improve and secure the wellbeing status of the caregiving family. For example, shared communalities, values, roles and responsibilities are shown as the factors that provide stability and security for survival and wellbeing. Mutuality, emotional oneness and trust are also pointed out as the key elements that bind the family ties in such a way that minimizes the burden of the OVC primary caregiver and maintains the dynamic relationship between the caregiver and the child.

The child identity formation has a direct relation to the wellbeing level of the primary caregivers. For instance, identity formation and the thinking faculty have a direct

cause and effect connection, which also influences to the wellbeing domains of the caregiver and the child (Arnett 2002, 167). The primary interventionist has to play a significant part in facilitating the child's cognitive growth to the next development stage, which also in turn affects the change and maturity in moral judgment. Behavior and identity emerge along with mental reasoning which results from dynamic education (Piaget 1976, in Bee and Boyd 2010, 325; Roehlkepartain 2006, 95-96).

Holistic learning is a scientific art aimed at cultivating a child as a whole person, and it happens through a meaningful connection with the parents or primary caregivers, peers, the community and natural world. As Loreman and Earle indicated, the holistic and scientific child development process, which involves child participation and the inclusive educational approach has a significant impact for the growth of a child as a holistic practical learner (Loreman and Earle 2007, 150-152). According to Hudson, because of the magnitude of the holistic caring role, primary caregivers need a supportive community (Miller 1996, 51) who will walk with them and help them to establish sustainable wellbeing grounded in the complex and rapidly changing environment they are living in.

The biblical and theological views describe the fundamental truths that deal with the intention and concern of God that defines the caregiving role, and the placement and value of a child, before God and within the family and existing community. It also provides the spiritual and social underlying causes that affirm the decisiveness of the OVC caregiver's roles, joy and the burdens they are facing physically and emotionally as they act out the caring and leading role.

The biblical view shapes and gives an objective and personal level motivation and meaning on how the caregivers should view themselves, the orphan child, and their role as a primary interventionist. The parenting or caregiver's role which is seen as a caregiving call implies not only the joy and reward aspect of their role, but also the extended outcome of caring and raising godly children. This also has a positive reinforcement and connection with the scientific child-caregiver attachment, identity and character formation of OVC. The biblical and traditional understanding of the caregiver's nurturing and caring role also gives a deeper meaning to the importance of a mutual community as the challenges and vulnerability of OVC families escalate.

In summary, though, there is a shortage of literary publications in relation to the research specific topics that directly relate to the primary caregiver's burden, joy, wellbeing, caregiving role and practices, this review of related literature will embrace and reflect on the implications of the major sections and theories as they apply to OVC primary caregivers. Analyzing and integrating the available related literature enables an understanding of the extent of the actual research study in context.

This chapter presented the review of related literature and studies that are crucial to the discussion of the current research. The next chapter identifies the research methodology and procedures.

CHAPTER III

RESEARCH METHODOLOGY AND PROCEDURES

This chapter presents the research design and the methods in data collection. The specific purpose of this section is to describe the research procedure used to investigate the primary caregiver's wellbeing, joy and burden in carrying out their caring and nurturing responsibilities in Food for the Hungry Ethiopia, Child Development Program in Zeway area.

Description of the Research Methodology

This investigation used a case study method in which the data were collected using qualitative and quantitative tools in the form of structured and semi-structured questionnaires. It started probing by means of a structured questionnaire aimed at measuring the well-being of caregivers and identifying issues that need to be given more attention. A questionnaire (Appendix A) was used to gather quantitative data.

Qualitative data was collected from focus group interviews (Appendix C), individual interviews (Appendix B), and informal individual interviews. According to John Gerring, “case studies may employ a great variety of techniques—both quantitative and qualitative—for the gathering and analysis of evidence. This is one of the intriguing qualities of case study research and lends that research its characteristic flexibility” (Gerring 2007, 32).

The quantitative assessment followed by the qualitative investigation can be seen as a sequential approach which researchers find useful for case study research (Ersulo

2009, 126). The reason and the assumption behind this is that by moving from the general or quantitative aspects to the more specific details of the research facilitates a greater understanding of the cause-effect relationships between the independent variables such as the existence of supportive community and the dependent variables such as the sense of joy and burden of primary caregivers.

In a vulnerable community situation, the wellbeing of OVC primary caregivers is at risk. In the community like Zeway, where productivity is low and food supplies are insecure the adequate livelihood of OVC family is an ongoing source of stress and a burden (District Agricultural Office/DAO 2004). There is a direct relationship between the wellbeing of the OVC primary caregiver and the quality of the care and nurture of the child. This research aims at investigating and measuring the variables that impact this wellbeing, and which can affect the attitude of the primary caregiver towards the burden of responsibility and the sense of joy.

Research Design

The research design for this research is case study using purposive sampling. According to Yin “case studies are the preferred strategy when ‘how’ or ‘why’ questions are being posed and when the focus is on a contemporary phenomenon within some real-life context” (Yin 1994, 1). The case is specific, a complex, functioning thing . . . the case is an integrated system” (Stake 1995, 2-3). The two case study approaches of intrinsic study and instrumental study were used. In intrinsic study, the focus is on particular case itself, but not on other cases or general, related problems. In instrumental study, the focus is on what the case study subjects are doing, rather than proceeding to understand or get insight on other aspect of the case. Stake explained:

It may be useful to try to select cases which are typical or representative of other cases, but a sample of one or a sample of just a few is unlikely to be a strong representation of others. Case study research is not sampling research. We do not study a case primarily to understand other cases. Our first obligation is to understand this one case. In intrinsic case study the case is pre-selected, in instrumental case study, some case would do better a job than others (Stake 1995, 3-4).

Rationale for Mixed Data Collection Methodology

Traditionally, the case study research design has been associated with qualitative methods of analysis. However, some researchers such as John Gerring argue that to study a single case or a few cases intensively does not need to limit an investigator to qualitative techniques. A case study research may be either quantitative or qualitative, or some combination of both (Gerring 2007, 10). Moreover, he states that “There is no reason that case study work cannot accommodate formal mathematical analysis. Indeed, virtually all case studies produced in the social sciences today include some quantitative and qualitative components” (Gerring 2007, 10).

Mixed method data collection is a research strategy designed to combine two or more research methods in either a sequential or a simultaneous manner. Despite the different assumptions and criticisms underlying qualitative and quantitative research methods, there is now a growing consensus among research scholars about the advantage of mixed methodology that is built on their strengths (Creswell and Plano Clark 2007, 6). Some researchers hold that the use of mixed methods enriches the information and the understanding about the researcher’s topic of interest and increase the effectiveness, validity and reliability of the data (Golafshani 2003, 579-607).

The use of a mixed approach also helps to produce a comprehensive and realistic record of the study. In a mixed approach, the quantitative research helps to explore the major issues and concerns while the qualitative research facilitates deeper investigation and discovery of the problem. Currently the key question has become not whether it is acceptable or valid to employ a mixed data collection method, but how two or more methods will be mutually supportive and how the data gathered through different methods will be integrated (Christ 2007, 228-239).

By using the mixed data collection methodology, I was able to collect and compare data from different sources in a structured fashion. Specifically, the quantitative data generated helped me to identify major issues of the primary caregivers' wellbeing in accordance with the ten wellbeing variables and to understand the wellbeing status and major concerns for both the caregiver and the OVC. According to sequential data collection methods, such understanding can be an eye opener and create a vivid road map for the qualitative detailed investigation. The qualitative research which included the focus group, interviews and archival study (Appendices B and C) helped in investigating more deeply and discover the underlying cause and effects of the caregiver's burden and joy in relation to their caring and nurturing role towards the orphan and vulnerable child.

In order to cross check and integrate multiple data sources and collection, a triangulation method was applied. This method helps in evaluating the extent to which all evidence or findings converge and gives a common meaning. Simultaneously, this also increases the trust in the validity of the study's interpretation and conclusions.

Quantitative and Qualitative Methods Using Case Studies

In this study, a questionnaire was administered to the six caregivers who served as cases for the study to get preliminary data about the wellbeing variables of primary caregivers. This data helped in identifying major areas of concern that need to be given more attention during the successive and different qualitative research inquiries. The six research respondents were drawn from OVC primary caregivers from the major caregivers group within the FHE child development program in Zeway. In the context of the Food for the Hungry Ethiopian Child Development Program in Zeway area, primary caregivers of orphaned children are usually the single parents, grandparents, biological family members, or guardians who have no blood relationship. These families are identified as the poorest of the poor among the community. These six primary caregivers selected on purpose are:

Case one: Double orphan primary caregiver;

Case two: Sisters or brothers as primary caregiver or children as primary caregivers;

Case three: Grandparents as primary caregiver (large family size);

Case four: Non-blood relationship primary caregivers (guardian as primary caregiver);

Case five: HIV patient or disabled as primary caregiver;

Case six: Primary caregivers leading a large family.

Selection Criteria for Caregivers

Pre-selection and a purposive-sampling data collection method was employed in this case study research. The selection was carried out using the following criteria: First,

one of the most vulnerable families living with orphan and vulnerable child/children as identified by Food for the Hungry Zeway Project. Second, there is registration or acknowledgement as the parent or primary caregiver in the orphan and vulnerable child/children (OVC) as recognized or registered by the Food for the Hungry (FH) Zeway Child Development Program database/World Link. Third, supported by Food for the Hungry for the last three years. Fourth, the availability of initial personal case history documentation in FH archives. Fifth, residence in Zeway township or area at least for the last three years and speaking the local or national language. Sixth, has been visited during the last three years by a Food for the Hungry community level worker or volunteers. Lastly, seventh, living with an OVC over 10 years of age and the child has been supported by FH at least for the last three years and has been attending school. Appendix D contains the Primary Givers' Consent for Research Participation.

Data Gathering Using Qualitative Methods

According to John Creswell, qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. Creswell notes, "The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (Creswell 1998, 15). Shank defines qualitative research as "a form of systematic empirical inquiry into meaning" (Shank 2002, 5).

The advantages of conducting qualitative research include the flexibility to follow unexpected ideas during the research and to explore processes effectively. It helps to generate new theories about the issue studied, enhances sensitivity to contextual factors, promotes the ability to study symbolic dimensions and social meaning, and can increase

opportunities to develop new empirically supported ideas and theories for in-depth and longitudinal explorations of social phenomena (Ersulo 2009, 136).

The key reason for using a variety of qualitative research methods in this study is to help the researcher engage in a deeper investigation and understanding of issues that quantitative research cannot carry out. The investigative nature of qualitative data collection methods helps in understanding the factors that contribute to the wellbeing, burden and joy of the primary caregivers in light of their caring and nurturing role towards the OVC.

There are four qualitative data collection processes used for this study: focus group discussions, individual interviews, informal interviews, and document or archival studies. These methods of data gathering are considered appropriate to address the central research issue and answer the research questions. The program director, managers and secondary social workers were key informants in the identification and selection of preferred cases from the specific target population (see Appendix E for Letters to Various Directors). Figure 3 presents the research design and sequence of data collection.

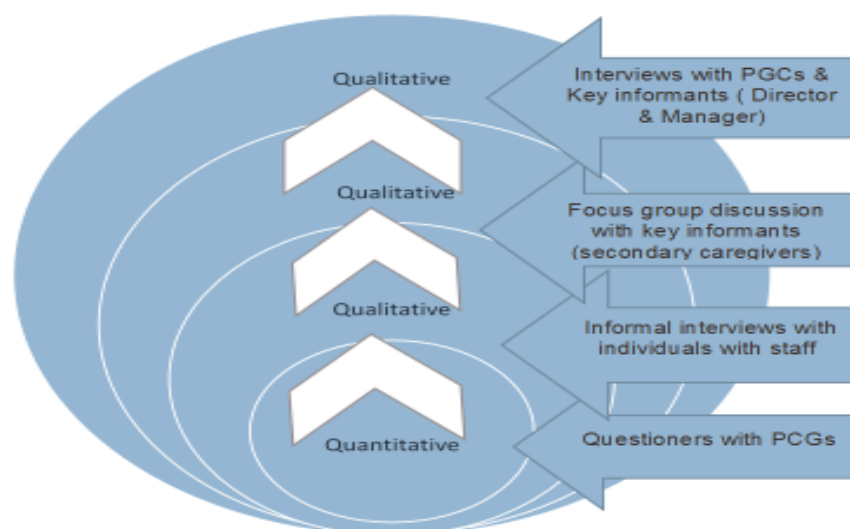


Figure 3: Summary of Research Design and Sequence of Data Collection

Pilot Study

A pilot study served as a pretest or a trial for the actual research, and it also clarified the feasibility of the study (Baker 1994, 182). According to Polit and Beck, “the pilot study can be used as a small-scale version or trial run in preparation for a major study” (Polit and Beck 2001, 467). Baker suggested that a sample size of 10-20% of the actual study can be a reasonable number of participants or cases to carry out the pilot study (Baker 1994, 183). The Pilot study also gives an advance alarm or warning for any procedural weaknesses or ambiguities reflected by the questionnaires and the corresponding respondents (DeVause 1993, 45). A well-conducted pilot study gives a green light for a researcher to go ahead on the research process to reach the outcomes.

For this particular study, I conducted a pilot case study with a primary caregiver and used the three major data collection tools and sources: a survey questionnaire carried out with a primary caregiver, interviews with the primary caregivers and focus group discussions with key informants. This was conducted immediately before the actual study, with persons who did not participate in the actual research. Detailed reports on the findings and all the changes and recommendations made for the improvement of the actual research study was documented and reported on as part of this study. The successful pilot case study validated the feasibility of this study.

I conducted two pilot case studies with primary caregivers by using two major data collection tools and data sources: an oral survey questionnaire carried out with a primary caregiver and interviews with a primary caregiver. They were conducted a week before the actual study, with persons who did not participate in the actual research.

The pilot study helped improve four different areas of the data collection process. The first was to improve the semi-structured question number 26. Initially, it was the last question and structured in such a way that it asked the question with the expectation that the respondent knew the word “holistic” which in the local Amharic language is *hulentenawie*. During the pilot study, I realized that the word *hulentenawie* is not a common or colloquial word, particularly for older people like the OVC caregivers who are not well educated. As a result, the question was simplified into five different questions each specifying one of the following specific holistic components: economic, social, spiritual, health and educational. The second was the improvement in time management: I realized that for both the oral structured questionnaires and the semi-structured interviews, the respondents (the primary caregivers) wanted to say a lot about each of the ten wellbeing domains, their burdens, the supportive community/friendship and their worries about the future. This gave me a concrete warning signal that it was not possible to listen and at the same time to take proper and extensive notes during the interview. There was a need to help the respondents wisely, to guide them to stick to the question and to respond precisely. To solve this, I purchased a voice recorder that can record for over eight hours without any interruption of power and then shortened the time allocated to the interview and oral questionnaire by ten minutes. The major techniques used to keep the respondent on track was to be by repeating the specific question, softly, listening to the answers attentively, drawing or joining them emotionally through different gestures, and appreciating what they were saying and sharing. Lastly, there was a need to control one’s emotions: through the pilot study one realized that most of the semi-structured interview questions were framed in such a way as to raise and investigate

the respondents' deep emotions, reactions and opinions. The pilot test had not only helped and directed the respondents to control their emotions but mine as well. As I listened, I understood and observed them as social beings. As a local researcher who understood their language, as well as the socio-economic and political context, there was a need to draw meaning to the interactions without cultural and social biases.

As a summary, the pilot case study helped to validate the feasibility of the study and manage the data collection process efficiently by providing me warning signals that potentially helped me to be more prepared physically, mentally, emotionally or socially and materially.

Data Collection Process

In academic research, data are collected to ensure or establish realistic decisions based on the raw material from which information is obtained. Data are “facts or figures from which conclusions can be drawn” (Powell 2000, 183). The research data for this study were collected in two different trips made to the research context, Ethiopia. The first trip was made between August 2016 and October 2016. Initial meetings with key Food for the Hungry leadership, key informants, and a brief presentation of the research issue and significance, as well as the request for permission for data collection were carried out during this trip. The second data collection trip were conducted between February-April 2017. This time, the questionnaire was administered, as well as the interviews, the focus group discussions and the archival study. The quantitative data were collected by using a wellbeing measuring tool instrument.

Wellbeing Measuring Tool (WMT)

A scientific wellbeing-measuring tool, developed by the Catholic Relief Services, was adapted with their permission to measure the wellbeing of primary caregivers for this research. This tool measures the wellbeing variables (the domains) of the PCG's. The ten key domains are the following: food and nutrition, shelter, protection, family spirituality, mental health, education, the economy and community cohesion (Senefeld and Strasser 2009, 11).

This tool has been applied in several parts of the world and in African countries where the CRC OVC program has been implemented, including Kenya, Rwanda and Ethiopia. The tool consists of 36 questions and takes approximately 20 minutes to administer. The advantage of this tool is that the scoring can be done immediately in the field or via a computer program. Ultimately, the results are used to determine the wellbeing of the PCG through the quality of care status score derived from the respondent (Senefeld and Strasser 2009, 9).

Focus Group Discussion

Krueger defines a focus group as a “carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, nonthreatening environment” (Krueger 1988, 26). The open and free group interaction among the participants is the greatest advantage of this method. Focus groups carry the elements of both interviewing and participant observation. Some people feel greater confidence in a group setting and are willing to discuss sensitive topics and offer comments that would be unlikely in a one-on-one interview.

As a researcher and participant observer, the open and free group discussion not only helped me to follow the content of the conversation, but also the emotions and the patterns of the participant engagement which also enable me to learn and confirm the exploration and presence of hidden facts and to engage with the initial spark of interpretation which could be developed through the rest of the process. The focus group was made up of secondary caregivers (community level workers) assigned to work closely with the OVC and their primary caregivers. Using semi-structured questions data was collected on 11 May 2017 morning from 9:00 am -12: pm at in Zeway FHE project office and seven respondents (community level workers) participated. The major themes discussed during the discussion were caregiver's burden and sense of joy, caregiver's caring and nurturing role, caregiver's friends and supportive community, caregiver's worries for the future and ways or solutions to improve the livelihood of the primary caregivers.

Individual Interviews

Individual interviews are also ideal means to explore detailed personal experiences of respondents about the issue to be discussed (Ersulo 2009, 138). It is suited to stimulating discussion of personal or sensitive information. Topics that may not arise in a group situation can also be addressed in individual interviews. Through this method, the researcher "can gain access to, and subsequently understand, the private interpretations of social reality that individuals hold" (Minichiello et al. 1990, 87).

The individual interviews for this study were conducted with two different groups: with selected cases (six primary caregivers) and with program owners or professionals (key informants: program directors and managers). For these two groups

different lines of questioning were used. However, the ultimate aim of the questions was the same in both groups which was understanding and investigating details about primary caregivers, their burden and joy, caring and nurturing role, and their supportive community. Semi-structured protocols was used to guide face-to-face interviews. All interviews were conducted in Amharic, the local language, and informants were encouraged to be frank and comment on the questions as much as they can.

During the in-depth individual interviews with secondary caregivers, program managers and directors were asked to share details of their personal relationships and experiences with the primary caregivers and their OVCs. As a participant and researcher, I took the detailed notes during the interviews and expanded the incomplete responses from memory immediately after the interview. Altogether, apart from the informal interviews, nine individual interviews were conducted during this study. Data was collected on May 12-14, 2017 in three different locations and three different dates. On May 12, 2017 morning from 8: 00 am-10: 00 am, data was collected from two respondents living in Bullbulla area at FH sub office. On the next day, May13, data was collected from two respondents living Abossa area. The meeting was held at the individual's home. On the 14th, from 4:00 pm-12:00 pm data was collected from two respondents living in Zeway. The meeting was done at the individuals' home. Zeway in six different caregiver's houses. Six primary caregivers and four secondary social workers (informants) participated. The interview was focused in the following five major themes: caregiver's burden and sense of joy, caregiver's caring and nurturing role, caregiver's friends and supportive community, caregiver's worries for the future and caregiver's understanding on child holistic growth and nurture.

Informal Interviews

The informal interview was the third qualitative tool which took place immediately after the focus group discussion and was carried out with the secondary caregivers. This method was used to gather information from the key informant participants who were included in the focus group discussion. Because of their organizational duties, their close relationship with the primary caregivers and OVCs and their long experience, this group was a potential source of information. These informal interviews took place during coffee time to provide an open environment for those individuals who were not comfortable in more formal contexts to share information during the group discussion and also to talk further with focus group members. This method helped me to investigate in greater depth and to probe specific questions and to learn and discover more. Informal individual interviews were conducted as a source of invaluable learning opportunity that could enrich the data triangulation analysis method.

The data were collected on May 15-16, 2017 in Zeway at Right Coffee shop from 4:00 pm to 6:00 pm. Five informants (community level workers) participated. The interview carried the same focus and theme with the focus group discussion, however, some details were given which were not mentioned during the focus group discussion session.

Documentary/Archival Studies

This tool enables an investigation of data or documents associated with the research project and other specific research issues and cases. Using this method, I accessed the initial written case records and program documents on FH project files. During this time, ultimately, supplementary data and information were retrieved from the

child's personal case history which also briefly described the economic, educational, type of religion religious and family size.

Data Analysis and Methodological Assumptions

Basically, the research data were analyzed using logical methodology. Logical analytical methods were first formulated in 1979 by Joseph Wholey. He used program intervention result evaluation logic involving the cause-effect connection between the intermediate and final outcomes (Yin 2003, 127). According to Robert Yin, the logical method becomes increasingly useful especially in doing case study research and the techniques integrate empirically or factually observed events into theoretical prediction. Yin, further explained that “the events are staged repeated cause– effect-cause –effect patterns whereby a dependent variable (events) at an earlier stage becomes the independent variables (casual effect) for the next stage” (Yin 2003, 127). This description can also give the validity of the construal design of this study and the logical coherence between the data collection tools and data analysis method of this this study.

A sample case Wellbeing Measuring Tool (WMT) developed by Senefeld and Strasser for the Catholic Relief Service (CRS) was applied to measure the wellbeing variables of OVC primary caregivers and these questionnaires were analyzed on a score-based scale. A triangulation approach was used to analyze and study each case from all aspects using the data collected from primary caregivers: OVC's and key informants through questionnaires, interviews, and focus group discussion.

Reliability and Validity of the Study

In the process of academic research, maintaining the credibility of a study is of great importance. Lincoln and Guba (1985) claim that, sustaining the trustworthiness of a

research report depends on the reliability and validity of data and appropriateness of methods used in carrying a research project (cited in Ersulo 2009, 144). According to Lincoln and Guba, four factors need to be considered in establishing the trustworthiness of findings from qualitative research: credibility, transferability, dependability, and confirmability.

D. Warwick and C. Lininger claim that there are two basic goals in designing a research project: obtaining information relevant to the purposes of the study and collecting this information with maximal reliability and validity (cited in Ersulo 2009, 145). Although several different standards have been suggested by different scholars, the one presented by Lincoln and Guba (1985) and J. Kirk and M. Miller (1986) is the key for collecting and analyzing qualitative and quantitative data with maximal reliability and validity. Relatively, the most manageable and easiest way to set the credibility and validity of a research is through a process of triangulation (Creswell and Miller 2007, 126). Data triangulation is very useful in validating multiple responses and in reaching the same or similar conclusions (Ersulo 2009, 145). This study applied data triangulation techniques throughout the data collection and analysis process (see Figure 4 below).

Data Triangulation Process



Figure 4: Data Triangulation Process

Limitations

There were five issues that challenged the process of data collection and analysis. First, some key informants were not willing to make themselves available for the interviews. These individuals mentioned busy work schedules and other priorities as excuses to avoid the interview meetings. Second, although they had a lot to say about the challenges of the OVC primary caregivers and gave their opinions freely, some informants, especially the community level workers (secondary caregivers), were somewhat restricted in openly discussing sensitive issues that could connect them with the organization directly or indirectly. Regardless of my assertions that their real names and identities would be kept anonymous, a few were afraid that their comments might be taken out of context or the outcome could hurt or affect their careers and relationships with the organization and the project. The third challenge faced was translating the data (transcription) from Amharic (local language) into English, particularly the cultural proverbs and metaphoric sayings which are powerful and profound in illustrating the socio-economic, spiritual and cultural life of the OVC caregivers. As a non-native English speaker, I made every effort to ensure that the translated data would express the same information as communicated by informants by listening to the recordings repeatedly and referring to the notes I had taken. The fourth challenge was that the archival or documentary records of the OVC primary caregivers were not updated and sufficiently informative. The case history records of the OVC, the family and the caregiver, regardless of the years of connection with the organization, did not show any updated records relating to the wellbeing changes and challenges in the family or the impact of the organizational support. Even though there is a file under each OVC

caregiver there is no record tracing the wellbeing or a periodic update of the initial records of the OVC and the family. As a result, the contribution from documentary data is limited. Lastly, I experienced some financial stress in covering all the expenses in traveling from Mozambique to Ethiopia and staying for an extended period to complete the data collection process.

Summary

Appropriate research methods as well as research protocols and activities and procedures are key factors in undertaking a research project. For this particular study the use of the mixed data collection methodology enabled me to compare data from different sources in a structured and sequential pattern. The quantitative method helped to identify the major dependent variables (effects) and the general causes, whereas the qualitative research helped to investigate more deeply and discover the underlying cause and effects in a sequential way.

The goal of the analysis is to arrange the collected material in such a way as to answer and to address the initial problem of the study and the central research issue. Based on the findings and premises from the Wellbeing Measuring Tool and the ensuing triangulation, predictions were made. In order to understand the information obtained, a qualitative summary chart was designed. By arranging information in a chart, case cause-effect trends were observed and implications and solutions can be considered. Detailed description of the data analysis are articulated in the following chapter.

CHAPTER IV

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

This chapter analyzes the field research data on the understanding of the wellbeing status and the joy and burden of caring for orphans and vulnerable children among the primary caregivers of Food for the Hungry Ethiopia Child Development Program. The same understanding led to the identification of recommendations for the improvement of the care and support approach which in turn would benefit the process of the OVC holistic care and growth provided to the direct beneficiaries. The chapter also presents the demographic characteristics of the study and the treatment of the problems referred to in the study. Data were gathered from multiple sources to help understand the wellbeing status, burden and sense of joy of OVC primary caregivers. The data collected from the quantitative and qualitative sources were analyzed and summarized separately under ten themes which appear in different sections.

Demographic Characteristics of Respondents

The respondent profile summary includes gender, age, family size, living means, the relationship with the OVC, and how long they have been assisted under the FHE support program. It has to be noted that the names identified here are not the actual names of the respondents. I have used pseudonyms to protect their privacy. They qualified for the support because the community and FHE identified them as the poorest of the poor or the most vulnerable families caring for school age children. The respondents involved in this survey research were six OVC primary caregivers in Zeway are who have been

receiving support from FHE program for two years or more. Among the six, three of them are grandmothers, two are parents (mother and father), and one is a guardian. In terms of age composition, four of them are above 60, and the parents and the guardians are in the late forties. The six cases are the following:

Case 1. A grandmother taking care of 3 single orphan children whose mother is a chronic HIV Patient;

Case 2. A sick father who is raising an 11- year-old boy;

Case 3. A grandmother taking care of eight children, six abandoned by their parents and two of her own;

Case 4. An HIV-infected guardian caring for a 12-year-old HIV infected OVC;

Case 5. A grandmother caring for eight OVCs of which three are HIV infected;

Case 6. A young mother caring for six children of her own, two of whom, aged 13 and 15, are not living with her.

Regarding the respondents' range of age, cases 2 and 6 are between 45 to 50; all the rest fall between 65 to 70. Gender-wise, except in the two cases where there is a father, all of the respondents are female.

Table 1: Personal Information of the Respondent

Case Code	Sex	Age	Family Size	Religion	Location	Means of Livelihood
C-1	Female	67	5	Muslim	Bulbula	Selling Charcoal, sick most of the time
C-2	Male	49	2	Muslim	Bulbula	Daily laborer
C-3	Female	61	4	Muslim	Zeway Center	Selling Vegetables
C-4	Female	55	3	Protestant	Zeway Center	No work, sick most of the time
C-5	Female	66	6	Orthodox	Abossa	Farming
C- 6	Female	46	8	Orthodox	Abossa	Occasional work as a house maid

Table 2: Number of OVC living with the Respondent and Relationship with the OVC

Case Code	Number of children living with	Relationship to OVC
C-1	3	Grandmother
C-2	1	Biological Father
C-3	4	Grandmother
C-4	2	Guardian
C-5	4	Grandmother
C-6	4	Biological Mother

Caregivers' Case Profile: Case Stories

This section gives brief narrative summary of the wellbeing status of each caregiver and the impression on what they feel and practice as they care for and nurture the OVC. The stories in this section came out directly from the quantitative and qualitative responses they have shared; the research logical opinion is also reflected. The section does not intended to replace the quantitative detail measurement and the qualitative thematic analysis. Instead the narration gives light on where and how each caregiver stands in the care and nurturing role and practices. At the same time the stories signify the caregivers' wellbeing status, their burden and sense joy, the level of care and support they are receiving and the worries that concerns them and affecting their caring and nurturing role.

Following each caregiver case narrative, each case wellbeing domain score is presented. The wellbeing domain scores range between 10 and 30. The desirable score is 25; the average score is 23. Scores below 22 indicate some defects experienced within the domain, and a score below 15 indicates that immediate action is needed to determine if there is a problem affecting the caregiver. Score details on each wellbeing domain will be described under quantitative data analysis session (Senefeld and Strasser 2009, 9).

Case 1: A Grandmother Named Meyemuna, Taking Care of Three
Single Orphan Children who mothered a Chronic HIV Patient

Meyemuna is a 67-year-old slim and attractive woman living with her daughter, two grandsons and a granddaughter. She is tall with a wrinkled face that gives the impression that, particularly from the cultural point of view, she is a woman facing a life of challenges or excessive burdens. Her voice is not clear enough when she speaks; it sounds as though she has some sort of vocal cord problem. Meyemuna is from Arusie and has lived in the Zeway Bullbual area for over 15 years. She has only one daughter who is currently a chronic HIV patient undergoing on bed treatment. Because of HIV/AIDS the daughter's husband died six years ago and she then moved to live with her mother. Selling charcoal is their main source of income, which is insufficient to cover their basic needs. As the result Meyemuna approached the Food for the hungry sponsorship program, to get some support for her grandchildren's schooling, and two of her grandchildren were registered and qualified for basic educational material support.

In the past, her daughter also sold charcoal to provide some support for her children while they were living with her mother. But now, sadly, she is at the final chronic stage between life and death and is unable to do so. The burden of caring for the entire family has fallen on the old mother's shoulders, affecting her physical, emotional, mental, social and spiritual wellbeing. The worst aspect is that Meyemuna herself is a cancer patient. When she described her health condition, she said "I have cancer and have undergone radiation 12 times at Tikur Ambessa Hospital. I can't complain. God has given me comfort, poverty and illness respectively. I asked God to lessen the burden and bring conveniences and there's nothing else I can do. I am sad, weak and tired but, the children are my own, I cannot hate my own flesh and blood. We can suffer together and we eat

together when we have food.” Through all this stress, Meyemuna has a sense of joy which comes from the children’s health and educational progress. Of course, she also has a sense of hope in God.

When she described her caring and nurturing role she felt that the community has isolated her and her family as a result her daughter’s condition. When she described the past regarding her “beautiful and special daughter,” she said, “Her life and her beauty which people admired was cut short when she got infected with HIV. When I see her now, I turn away, I wish I had died instead.”

Though Meyemuna does not have a supportive community or extended family members who can assist her in her caring and nurturing role, she is thankful for the support FH gives her. In addition to the educational package, she also receives the Child Headed Household (CHH) support package which is given to extremely vulnerable households. Their survival depends on the monthly ration and other items of support they receive from the organization which includes 15 kg. white flour, ½ liter of oil , ½ kg. beans, 300 birr for rental, as well as casual clothes once a year, and every three years they are issued with a sheet, pillow, and mattress. The daily life of the grandmother is overwhelmed by the different critical survival demands of the household. She has to cook and feed her sick daughter and the three grandchildren, wash their clothes as well as sell charcoal at the community open market area which takes up most of her time.

The economic, social, health and emotional constraints Maymuna faces have a direct impact on her caring and nurturing role. Chief of these limitations is that she is also illiterate with very limited exposure to and knowledge about the current modern world. Moreover, her lack of understanding of the peer pressure and the environment the

children have to deal with limits her in providing the educational assistance and other holistic care and support they need, although the organization and the community level workers try to help her and the children. Because of the her limitations and her sick daughter, the children are under pressure not only to deal with their own education but also to provide some kind of support in the house and outside. Often she gets home late from the marketplace and during her absence the children have taken care of their sick mother. Even though her time with the children is so limited, she tries to advise them to have good behaviour and to study hard.

As Meymuna fights daily for survival and to care for the children, the future remains a serious threat and source of worry. She said, “I always worry about what will happen to the children... I worry that they might run into trouble and be left homeless, what would happen to them if I or my daughter died. Not owning good property, land or good housing makes me doubt the future of the children. I don't have any friends because my husband was a jealous man who didn't let me go anywhere. Besides, the people around here are not friendly towards us: because of our poverty, fear and frustration we are also disconnected from social engagement.”

As Meyemuna admitted her various limitations, she felt that she did have the extent of happiness, health, strength and confidence that most people of her age have. The extent of her financial constraints means that sometimes the children go to sleep without food or they are sent to school without breakfast. Her brokenness and frustration is deep; she does not feel secure or welcomed by the community, including her religious group or her extended family. When she tried to describe her wellbeing situation, she said, “when poverty becomes your enemy, everything around you turn out to be your enemy too, and

you remain like a naked person who is ashamed, confused and powerless. But no one knows what God can do in the middle of all this. Anyway, this world is colorful.”

Table 3: Case 1 Wellbeing Domain Score

Wellbeing Domains	Average Score
Food and Nutrition	2
Education	2.2
Shelter	1
Economy	2
Protection	1.5
Mental Health	1
Family	1
Health	1
Spirituality	2.5
Community Cohesion	2

Case 1 Total score=16.2

Case 2: A Sick Father, Zidan, Who is Raising an 11-Year-old Boy

Zidan is a 49-year-old man living in the Zeway Bullbulla area with his 11-year-old son. He is raising his son alone. His wife passed away four years ago but he is still dealing with the emotion, grief and sadness of the bereavement. Zidan does not have a proper job or constant income. His means of living is based on the daily work he can get around the Mosque area. This is insufficient to address his basic needs and those of his son. Zidan is furthermore, living with a chronic goiter problem in his neck which also affects his breathing.

Zidan and his son survive on the support they are receiving from FH and their neighbor, Birtukan. It was right before his wife’s death that FH identified the family’s extreme vulnerability and included their son in their programs. In addition to the basic educational package, Zidan also receives the CHH food package which includes the

monthly ration of 15 kg. white flour, ½ liter oil , ½ kg. beans, 300 birr for rental, as well as casual clothes once a year, and every three years they are issued with a sheet, pillow, and mattress. The other support, particularly for his son, comes from the lady whom Zidan's wife asked to take care of her son just before her last breath. Zidan is so thankful for the support he gets from FH as well as that of his neighbour. He expressed that by saying, "God doesn't quarrel and discard us without celebrating with us first. He made me happy before taking my 'mother.'"

Zidan's biggest joy comes from his son whom he feels is a gift from God and whom he is extremely grateful to have. He said, "I see him and it makes me feel happy and I forget all the shortcomings and challenges I am passing through." He feels God gave him both a son and a friend who constantly comforts him. He adds, "I can't provide him with what he wants to help him feel the same as some of his school friends; however, our neighbor is his mother who is always there to support him. She feeds him and takes care of him."

Sometimes Zidan and his boy Ramadan take time to walk and talk together. They play and have fun together. However, whenever Ramadan asks why he does not have some of the things that other children play with or bring to school, his father tries to understand him and show him the hope he has in the future. There have been times that Zidan's son has promised to build his father a house and hire a maid for him when he grows up and gets money. His boy loves to tell his father about his activities in school and about his friends. Zidan also admits that there are some people who isolate and reject his son and make him feel bad and angry as he does not have family members who live

nearby that he can sometimes go and play and stay with. In the last four years after his wife's death it is only his sister and her husband who visited him once.

It was surprising to find that Zidan and his son usually eat three times a day and that they do not go to bed hungry. They also feel secure in the place and the community they live with. However, Zidan admits shortcomings in his ability to provide proper educational material for his son, which in turn to some extent affects the performance and emotions of Ramadan.

Even though Zidan lives with serious financial and health problems, he is a caring and loving father. Where there is a need to correct his child, he prefers not to act in the way many local people do normally do by applying emotional and physical coercion and harm. He said: "Instead of being angry or nagging or hitting my child I guide him with sympathy. That's better for him as he grows he will say that is how my father raised him and he'll follow my example." Nonetheless Zidan admits his fear and worry for the future of his boy. When he describes the main factors that frustrate him about the future, he mentions his condition of health, particularly the goiter in his neck which is increasing in size. He does not have the money to go to a medical center to get treatment. He also worries seriously about what will happen when the support from FH stops while still his son is still at the elementary school; he does not have his own land and house, instead he and his son live in a small house made of mud. In the community where Zidan lives , land, house, cattle, children and extended families are important and a source of hope and respect, which he does not have except for his son.

Table 4: Case 2 Wellbeing Domain Score

Wellbeing Domains	Score
Food and Nutrition	3
Education	2.4
Shelter	2
Economy	1.6
Protection	2.5
Mental Health	2.5
Family	2.5
Health	1
Spirituality	2
Community Cohesion	2.6

Case 2 Total Score=21.1

Case 3: A Grandmother, Masho, Taking Care of Eight Children Abandoned by their Parents. Two of whom are also Her Children

Masho is a 61-year-old lady who lives in Zeway and takes care of four grandchildren whose parents abandoned them and left the area. Even though she was happy when two of her daughters got married and had children, unfortunately, this happiness did not last long. Masho lost two of her sons-in-law through death and divorce. The one who divorced his wife abandoned the children and left the area. As a result, her two daughters also left their children and disappeared to Arab countries to work as housemaids to earn some income. The heartbreaking fact is that after five years Masho still does not know where her older daughter is. Not only Masho but also the two girls who are eight and thirteen do not know where their mother is. As Masho recalls all the anguish she has passed through and is living with, she said: “People say a child is a medicine, but sometimes it is not true: it is useless and the source of endless hardship.”

Masho did not know what to do with her four grandchildren until community level worker approached her and facilitated the educational support and supplementary

provision of monthly rations for the household, which includes basic educational material support, 15 kg. white flour, ½ liter oil , ½ kg. beans, 300 birr for rental, as well as casual clothes once a year, and every three years they are issued with a sheet, pillow, and mattress. This is appreciable support, but for a large family like Masho has, they still have critical basic needs. To get some income and care for the OVCs Masho sells vegetables in the open marketplace which is a mile away from her house. They live in a very small mud rental house. Apart from one small bed, a small television, some plastic items and few other things, there is nothing else to be seen in the small house.

According to Masho, the FH support and the community level worker who visits her is all the assistance she has received. This was the only help she had in the time of her greatest need. She is grateful that she and the children are healthy. Recently, apart from the care and nurturing burden she is dealing with, she has also faced new worries and mixed emotions when her younger daughter came home from abroad for the first time after five years. As a mother, it is always great joy to meet and see a missing daughter. Of course, it also meant a great deal for the children to see their mother again. Masho is so thankful for a new bed and television her daughter brought. She said, “This the first time in my life to see a television in my own home, but, the behaviour of my daughter has changed. She is not interested in living with us or in staying in this town. She wants to go back to a different Arab country.” Masho also observed that her daughter’s religious orientation and practice is no longer the same. Instead, the daughter expressed regret for practising and being part of it. She told her mother that she no longer visits the *Mechjde* or waits for *Zecha*. She says, “I am looking to God who saves my life not for handouts.” As Masho observed, whenever her daughter comes to stay with her, the children,

including her own, are not really friendly and that she also does not treat her children as a mother and the others as an aunt. Masho, as a mother, was not only disappointed and disturbed but she was also confused as to what to do to help her daughter to get settled and live with her at least for some of the time.

Masho's struggle for survival and caring for the children is not only very demanding but also worrying when she looks at the next day and the future beyond. She knows that because of her extreme poverty and severe limitations there is nothing she can offer to these growing children whom she loves as they grow and need support. In the previous year, the 15-year-old girl, Mehret, was sent away from school because of lack of support. It has been almost a year since she dropped out of school and she no longer wants to go back. Mehret was also working at the marketplace and helping herself. As a teenage girl she has needs and faces peer pressure. Although supporting herself and the family is beneficial for the girl, in other aspects it has affected her life. The grandmother is afraid that Mehret could disappear from the area or get married or become pregnant with the wrong person. Most of the day Masho is not available at home, and there is no one else who comes and advises the children in a proper way. People in the area call them "street kids," which also makes the children cry and worries her. Even though Masho believes that training and advising children is very important, she feels that there is no one who can fill that gap and help develop the children in a holistic way. She said, "Advice is necessary, it's useful for the development of a child. Advice makes or breaks a person. Maybe because of our poverty, our dirty area and our house, we don't have anyone and I am the one that gives them advice. I tell them not to go to other people's homes or go downtown but they go to the mosque on Fridays if they can."

Masho does not feel that she has or lives with a supportive community including her religious group. She approached the community leader to get some support such as a better house with at least two rooms but the response she received was negative. Even though she enjoys living with the children and caring for them, she does have a concern for what will happen to them in the future. She admitted that FH used to give them a monthly ration but since last year the support ceased. However, two of the children still get basic educational support. She also admitted that most of the time they do not have enough food and often go to bed hungry. She is not as happy as she feels most people at her age are, however, she feels strong and healthy. Living with the children, sharing what she has, seeing them healthy and pursuing their education counts as her source of joy. She does have hope that as they grow up and become self-supporting they can also support her and improve her livelihood.

Table 5: Case 3 Wellbeing Domain Score

Wellbeing Domains	Score
Food and Nutrition	1.6
Education	1.4
Shelter	2.3
Economy	1.3
Protection	2
Mental Health	1.75
Family	1
Health	3
Spirituality	2.3
Community Cohesion	1.3

Case 3 Total Score=17.95

Case 4: An HIV-infected Guardian, Zeritu, Caring for a
12-year-old HIV-infected OVC

Zeritu is a 55-year-old woman living in Zeway with three children. Currently, a 12-year-old boy, Kamile, is the only one living with her. Her husband died ten years ago. She and her child moved from the central part of the country to Zeway eight years ago. Zeritu and Kamile are both HIV positive. For the last four years, she has been receiving the monthly ration support and basic educational material for Kamile from FH for which she is very thankful. In order to address the basic needs and the demands of survival she used to sell charcoal and other small items at the marketplace to get some income. But these days she does not feel strong enough to stay all day at the marketplace and do the hard work of carrying charcoal from one place to another. However, in spite of her sickness and the fact that the needs of her child are growing, she still has a strong urge to do something at home and get some income. The rest of her children are far from the area and she does not have much contact with them.

Zeritu strongly believes and feels that she is rejected by the community around her, including her neighbors. It is only the FH community level workers that visit and support her in different ways and in the time of need. As a result, she and her son do not feel secure where they are living; however, they do not have the option to move from the area and live in some other place. She stated, "If FH had not been covering the rent we would have been thrown out in the street and died." When they feel lonely, desperate and hungry there is one place they can go to; it is to a, FH community level worker who constantly visits them and opens his home and welcomes them. She further explained, "We do not worry about holiday festivals and their preparation, we just go and enjoy with our God-given family. Sometimes when he comes to visit us, he gives us some money to

buy some bread. Most of the time we do not have enough food to eat three times a day. There are times we go to bed hungry.”

Tearfully, Zeritu admits that her health condition affects her son and his education. However, she does have hope that one day God can heal them and make them free. Softly she told me, “I know about Jesus and I believe it is only a matter of time. Someone also promised me to take us to Awassa (one of the biggest cities in Ethiopia and known for a spiritual revival), where spiritual healings and miracles are happening.” It is her constant dream to think about her children and hope that they will be able to support her in the future. She also prays that God will let her and her son live long enough so they can see that. She said, “Maybe they will get me a house and I will finally get out of rental houses. I'll be happy with a little hut. The boy comforts me. He tells me not to cry, and that he's getting support from other people. I just hope for them to live and grow.”

Just being at home, without doing anything is frustrating her. She believes that she can do something and generate income if there was an opportunity to get some seed money. This is one of the things that could possibly make her happy and lessen the burden and stress she is feeling and which is affecting their livelihood. Repeatedly she explained, “Not working makes me unhappy. Sometimes I am hungry when the FHI food runs out. That makes me sad. It is not easy to see your child going to bed or school hungry.” The advice and encouragement they get from FH community level worker means a lot to them. Weekly, or sometimes twice a month, they have a brief prayer session with FH community level workers, though it is not an open practice.

Socially, Zeritu and her son are lonely; no one comes to their home or invites them for coffee and they do not invite anyone either. Zeritu believes that she is not part of

the community and that people with homes of their own are the ones who are accepted. She worries seriously about not having a one-roomed small house where she and her son can feel free. She also worries about what will happen if her children lose their jobs. She feels that she is not the kind of mother who can provide them with a place to live and can feed them. However, she believes that God is the one who holds the future and controls what is going to happen. She narrated, “I only have God and FH. Who knows in the near future? God will comfort me and give me a house and restore our health. . . . I have heard many testimonies that people with HIV have received healing from God.”

Table 6: Case 4 Wellbeing Domain Score

Wellbeing Domains	Score
Food and Nutrition	2.6
Education	1.8
Shelter	1
Economy	1
Protection	2.75
Mental Health	2.75
Family	1.75
Health	2.75
Spirituality	2
Community Cohesion	2.3

Case 4 Total Score=20.7

Case 5: A Grandmother, Negele, Caring for Eight OVCs of which Three are HIV Infected

Negele is a 66-year-old woman from Aris who has been living in Zeway, Abossa since childhood. She cares for three double-orphaned HIV-patient grandchildren who are 17, 15 and 13 years old. The 13-year-old orphan is a girl and the two others are boys. Her

adult daughter and sick husband are also living with her making it a household of six people. In addition to the monthly ration support she receives from FH, farming is their main source of livelihood. There is no one from her family who can undertake the farming so, instead, she shares the land with others so that they can also work for her and get some production on an annual basis. For the last four years she has been receiving support from FH but caring for the three grandchildren has affected her own social, emotional, economic and emotional wellbeing. The parents of the children died because of HIV AIDS.

Unlike the boys, treating and caring for Beshadu, the 13-year-old girl was stressful for the old grandmother. The main reason was that Beshadu did not want to take the Anti Retro Viral Therapy (ART) treatment. She hated the medicine, which represented her disappointment as a teenager and she wanted to shorten her life. On the day I visited the family, Beshadu was in Zeway hospital, critically ill. The next day when I went to visit her at the hospital she had already passed away. What a day! I felt deeply broken, sad, and emotional. Except for some FH staff, very few people came for the funeral. One could see and feel how miserable and hopeless the life of Negele and the rest of the young boys was. As the boys grew and realized their health condition, even though they were taking the treatment, they too were not happy and wanted to disappear from the area. The FH community level workers tried everything to advise and help them to continue their education. Nonetheless, three years ago the boys dropped out of school and started to look for income. Most of the time they have been going to the nearby towns to look for jobs and opportunities to help themselves. Sometimes they disappear for a week or two. As the result of a high unemployment rate in the area, it is not always easy to find

a job. She said, “I am not strong any more. I am old, it's hard to run around and get money and provide them with all that they need. I wish I could, and could keep them here at home with me. Farming is the only thing I have. I grow corn and cabbages.” Negele worries a lot about the boys in case they forget to take the ART or lose it somewhere. She always wants them to come and eat something at home which makes her feel good. She admits that she does not sleep well and have the mental rest she needs as she always looks back at how her children died and left her in such a tough situation; she feels bad about herself. She explained, “I should have died before of all this despair. As an old person, what is left for me, why sweat for many years in this way to support my family? Look at my husband, he is also unhealthy. We don't really know what kind of bad sin we did against God to be repaid with all this.” Not only the past, but the future of these children she cares for is always an unresolved puzzle and source disappointment, fear and frustration for her. She does not have family members who are willing to support her and share her burden. Instead, a very limited number of people have had the courage to come and visit her. This does not mean that the people around her are deliberately unfriendly towards her, instead, they are not supportive and prefer to keep a distance from her which is a common reaction most people show due to lack of awareness. Whatever the reaction from others, whenever the boys come home and are around, Negele is happy. Lately, the older son, Belay, started to give her some money to buy coffee, which amazed her and sparked a light of hope in her life.

Table 7: Case 5 Wellbeing Domain Score

Wellbeing Domains	Score
Food and Nutrition	1.3
Education	1.8
Shelter	2
Economy	1.6
Protection	1.25
Mental Health	1.25
Family	1.25
Health	1.5
Spirituality	2.3
Community Cohesion	2.3

Case 5 Total score: 16.55

Case 6: A Young Mother, Zewditu, Caring for Six Children of Her Own,
which Two of whom, aged 13 and 15, are not Living with Her

It has been over ten years since Zewditu and her family moved from their origin, the northern part of Ethiopia to the central region, to the Zeway area. Zewditu is 46 years old, young and a very slim and tall woman. She lives in the Zeway, Abossa area with her seven children in small 4-by-4-meter mud house. They moved to Abossa to get land for farming and to raise their children in a better way, since most of the northern part is not favorable for agriculture, and particularly because their area was largely rocky. They moved from their area with three children, two boys and one girl. In the last ten years she has had four more children: a boy and three girls.

For Zewiditu and her large family, the move from their region of origin to improve their chances of survival did not work out as they had dreamed. In fact, initially, they bought a piece of land and started to produce vegetables and corn. But later they

became bankrupt as the weather conditions turned disastrous and damaged their crop production for two consecutive seasons. As their family size increased and demands escalated they were forced to sell their land to feed their children, which also did not last for long. Currently her husband and the two eldest children are not living with her. Because of the stress of living, her husband, Kefle, left her family and the area to search for work. At the age of 15 and 13, the oldest girl and boy also left the area and began work in as domestic assistants. The 11-year-old boy Dawit, who was living with his mother was in grade 3, and his time was divided between helping his mother raise the twin girls and his education. As a result, he is not doing well at school. The six-year-old girl, Mekdes, had not yet started school.

Literally, as a human being and as a citizen, the time I had with Zewidtu was full of mixed emotion. Zewidtu is illiterate: she does not even know how to write her name or read anything. But still she wants Dawit to attend school. In fact, Dawit was receiving basic educational support from FH. To get this support, continuous attendance at school is mandatory. As regards educational care and follow-up, Zewidtu, as the mother, was doing the bare minimum. She declared: “I do not know how to read but I ask my son what he's learned at school. I have to ask him as he doesn't talk much if I don't ask him.” Unlike the other primary caregivers who are living in extreme poverty, Zewidtu does not receive the monthly ration support from FH. The community level worker who knew of another similarly extreme case tried to bring that case to the organization, was informed that as the program is at the last phase, it is difficult to add any new cases or beneficiaries. This does not mean or justify the contention that the only means to facilitate care and support for Zewidtu is through the CHH project benefits.

Leading a large family and raising twins as well as a 3-year-old and another 6-year-old child is not a simple task for Zewditu, living under poverty line; it is also challenging for the relatively well-to-do parents in that area. Zeweditu and her family's wellbeing is at risk. Mostly, she and her children do not eat two times a day, and they usually go to bed hungry. Six of them are living in a small mud one-roomed house. Apart from a few plastic kitchen items and an old mattress made of grass, there is almost nothing else in the house. Physically, emotionally, and mentally Zewditu is very depressed and burdened. Although the twins are a year and 3 months old, they are tiny and are not even able to sit up. As the FH community level worker informed me, the mother and the children are underweight.

Zewditu's caring and nurturing role is not only tiresome because of extreme limitations and unmet needs, but also from the lack of a supportive community and security. She described the environment and community around her by saying:

I know that people who came from another area like me have been killed, unjustly treated and pushed around. This place (Abossa) is a hard place to live in. People here don't like us, they are treating us as mere strangers who do not belong here. People are harsh and nobody has any sympathy. In this place people discriminate on the grounds of how you dress or how clean you seem and on physical appearance. They look at me and say my children will not thrive. Except for FH workers, nobody visits us when we have problems. I have friends to whom I can speak to but I am not getting any support.

There are times that her son comes from school crying and beaten by other children. That particular day she was afraid to send him alone even to the nearest shop to buy some items or to fetch water. As a mother, the level of worry and burden Zewditu is living with is critical. Each day she faces overwhelming demands and concerns, such as what to feed the children, the safety and health of all her children, as well as her own and

her husband's health, the house rental and other social issues. As a researcher, it was hard to believe what I have seen, observed, and heard. It was an impacting and challenging time for reflection, learning, investigation and thinking of possible action plans. Zewditu is living with a wellbeing defect that needs immediate action and intervention. In fact, not only Zewditu but also all the rest living with such critical wellbeing defects that call for intervention. As a researcher I not only found this case to be a substantial source of investigation and learning, but also an overwhelming call to act as human being to save them and the OVCs' lives.

Table 8: Case 6 Wellbeing Domain Score

Wellbeing Domains	Score
Food and Nutrition	1.3
Education	1.8
Shelter	1
Economy	1
Protection	1.75
Mental Health	1
Family	1.5
Health	1
Spirituality	1.6
Community Cohesion	2.3

Case 6 Total=14.25

The Quantitative Data Analysis

The data for this analysis were obtained from the survey questionnaire given by the OVC primary caregivers. Under 10 different wellbeing domains, 36 questionnaires were presented and the questions were fully answered by the selected six primary caregivers. The purpose of administering the questionnaire was to help obtain preliminary

information which would also lead to the identification of the major concerns which are affecting the wellbeing of the respondents. The questionnaires were analyzed under 10 different variables or themes using the wellbeing measuring score sheet. Details with similar themes were sorted out and coded under each respondent or case and score descriptions were also given under each variable summary score. Based on the total score summary, a wellbeing description was given for the six cases. Table 9 shows the general wellbeing score labels.

Table 9 General Score Range Description

Range Description	Label 1	Label 2	Label 3
	None of the time	Sometime	All the time
Single Wellbeing Score Range	Defect : below 1.5	Average:2.3	Equal and above 2.5: desirable
Total Wellbeing Domain Score Range	Defect: below 15	Average:23	Equal and above 25: desirable

This research tool consists of 36 questions which are measured under ten key wellbeing domains. According to CRS wellbeing measuring tool, the ten domain scores range between 10 and 30. The desirable score is 25; the average score is 23. Scores below 22 indicate some defects experienced within the domain, and a score below 15 indicates a problem affecting the caregiver. The ten key domains are the following: food and nutrition, shelter, protection, family spirituality, mental health, education, economic and community cohesion. The respondent score range given as 1, 2, 3 for the three labels, none of the time, sometimes, and all the time respectively. Ultimately, the results were used to determine the wellbeing of the PCG through the quality of care status score

derived from the respondent (Senefeld and Strasser 2009, 9), and the findings were summarized under the ten wellbeing domains in the questionnaires.

The food and nutrition domain is designed to measure directly the primary caregiver's status in relation to food security and nutrition, and indirectly the availability of food for the child.

Table 10: Food and Nutrition Scores

Case Code	Caregiver Name	Food and Nutrition Domains Score
C-1	Meyemuna	2
C-2	Zidan	2.3
C-3	Masho	1.6
C-4	Zeritu	2.6
C-5	Negle	1.3
C-6	Zewditu	1.3

The findings from the food and nutrition-based set of questions indicated that out of the six primary caregivers, four of them have defects in this particular wellbeing domain and are living under stress. The detailed findings indicated that C-1, C-3 and C-5 sometimes get two meals a day and also sometimes go to bed hungry. C-2 and C-4 have food most the time, but C-6 does not have two meals a day. None of them have enough food to feed their child or children. Intervention action is required particularly for C-1, C-3, C-5 and C-6 and in the remaining two cases C-2 and C-4 action is required so that the availability of meals for the family or for the caregiver and the child can be maintained. Table 11 shows the food and nutrition domain score summary.

Table 11: Education Domain Scores

Case Code	Caregiver Name	Education Domain Score
C-1	Meyemuna	2.2
C-2	Zidan	2.4
C-3	Masho	1.4
C-4	Zeritu	1.8
C-5	Negle	1.8
C-6	Zewditu	1.8

The education domain explores the capacity of the primary caregiver in providing school-related support such as accessing to educational materials, and the OVC's emotional satisfaction at the school. The findings from the education-related set of questions indicated that all the six primary caregivers have defects in this particular wellbeing domain score and are living under stress. All of them are unable to provide adequate educational materials for the OVC and sometimes they do not know how to help their children study hard with the result that their children's exam scores are unsatisfactory. This implies that intervention is required to enable the caregivers to provide adequate educational support for the child. Table 12 shows the education domain score summary.

Table 12: Shelter Domain Scores

Case Code	Caregiver Name	Shelter Domain Score
C-1	Meyemuna	1
C-2	Zidan	2
C-3	Masho	2.3
C-4	Zeritu	1
C-5	Negle	2
C-6	Zewditu	1

The shelter domain focuses on physical shelter and the infrastructure of the PC immediate environment. The findings from the shelter set of questions indicated that out of the six primary caregivers, four of them have defects in this particular wellbeing domain and are living under stress. The detailed findings indicated that except C-5 all the rest have defects on this particular domain, which means they do not have their own, the rental is paid by the FH and they do not feel secure where they are living. Besides, they are living in the house with worries that the owner can any time move them out without any condition. Table 13 shows the shelter domain score summary:

Table 13: Economy Domain Scores

Case Code	Caregiver Name	Economy Domain Score
C-1	Meymuna	2
C-2	Zidan	1.6
C-3	Masho	1.3
C-4	Zeritu	1
C-5	Negle	1.6
C-6	Zewditu	1

Economic opportunities domain explores the economic situation of the PC and the household in which the child lives. The findings from the economic opportunity set of questions indicated that all the caregivers are living with economical stress and limitation. As a result, the school attendance and performance of their children are affected by their need to work, they do not have enough money to buy all the basic things they need to survive, to earn money, to care for their children they have to work outside of their house.

Under this particular domain all of them require an intervention action. Table 14 shows the economy domain score summary.

Table 14: Protection Domain Scores

Case Code	Caregiver Name	Protection Domain Score
C-1	Meyemuna	1.5
C-2	Zidan	2.5
C-3	Masho	2
C-4	Zeritu	2.75
C-5	Negle	1.25
C-6	Zewditu	1.75

The protection domain focuses on whether the primary caregiver and the child are treated differently or similarly to other people in their communities, schools, and households. The findings from the protection set of questions indicated that out of the six primary caregivers, four of them have defects in this particular wellbeing domain and are living under stress. C- 1, C-2, C-3, and C-4 indicated that they are treated differently from other people in their family and neighborhood. C-1, C-3 and C-6 felt that they are not treated the same as other people in the community group they are involved with, such as during the meeting time. The survey also indicated that C-1, C-2, C-3, C-4 and C-6 do not get enough sleep and feel tired because of all the work they are doing. Under this particular domain C-1, C-3, C-5 and C-6 required an intervention action. Table 15 shows the protection domain score summary.

Table 15: Mental Health Domain Scores

Case Code	Caregiver Name	Mental Health Domain Score
C-1	Meyemuna	1
C-2	Zidan	2.5
C-3	Masho	1.75
C-4	Zeritu	2.75
C-5	Negle	1.25
C-6	Zewditu	1

The mental health domain examines the primary caregiver's mental health, looking at concepts such as emotional support from others and self-reported happiness. The findings from the mental health set of questions indicated that out of the six primary caregivers, four of them have defects in this particular wellbeing domain and are living under mental health challenges. The data indicated that all of them feel that they are not able to do things as well as most other people. C-1, C-3, C-5 and C-6 do not have people to talk to when they have a problem. C-1, C-2, C-3, C-5 and C-6 feel that they are not as happy as other people of their own community and C-1, C-5 and C-6 do not feel that they are living in a safe place. Based on the mental health domain score, for C-1, C-3, C-5 and C-6, intervention is required. Table 16 shows the mental health domain score summary.

Table 16: Family Domain Scores

Case Code	Caregiver Name	Family Domain Score
C-1	Meyemuna	1
C-2	Zidan	2.5
C-3	Masho	1
C-4	Zeritu	1.75
C-5	Negle	1.25
C-6	Zewditu	1.5

The Family domain measures whether the primary caregivers feel supported by their family members and relatives. The findings from the family set of questions indicated that out of the six primary caregivers, five of them have defects in this particular wellbeing domain score and the support they are getting from others is minimal or none. The data under this particular domain indicated that all them, at home, do not have someone to look after them if they get hurt, sick or feel sad. Except for C-2, all the rest do not get the emotional help or the other support which they need from their family and extended family. The survey also indicated that C-1, C-3, C-5 and C-6 do not have people whom they feel they can trust. This implies that intervention is required. For the C-4 caregiver the status of the family wellbeing domain score is average. Table 17 shows the family domain score summary.

Table 17: Health Domain Scores

Case Code	Caregiver Name	Health Domain Score
C-1	Meyemuna	1
C-2	Zidan	1
C-3	Masho	3
C-4	Zeritu	2.75
C-5	Negle	1.5
C-6	Zewditu	1

The health domain examines whether the primary caregiver believes he or she is healthy and doing as well as others of the same age do. The findings from the health wellbeing domain set of questions indicated that out of the six primary caregivers, four of them have defects in this particular wellbeing domain and are living with personal health problems. The survey indicated that C-1, C-2, C-4, C-5 and C-6 do not feel they are strong and healthy. The health condition of C-1, C-2, C-5 and C-6 is not felt to be good or that they are not healthy and strong enough like other people of their age. According to the health domain score C-1, C-2, C-5, and C-6 require intervention. Table 18 shows the health domain score summary.

Table 18: Spiritual Domain Scores

Case Code	Caregiver Name	Spirituality Domain Score
C-1	Meyemuna	2.5
C-2	Zidan	2
C-3	Masho	2.3
C-4	Zeritu	2
C-5	Negle	2.3
C-6	Zewditu	1.6

The spirituality domain examines whether the primary caregiver draws support from his or her faith community. The findings from the spirituality wellbeing domain set of questions indicated that out of the six primary caregivers, five of them have defects in this particular wellbeing domain and the caregivers feel they are not getting adequate spiritual support. The survey indicated that for all of the respondents, the faith community is not providing important support to them and it is their belief in God that gives them the comfort, reassurance and strength to face difficulties. According to the spirituality domain score, except for C-1, intervention by the faith community is required for all the rest. Table 19 shows the spirituality domain score summary.

Table 19: Community Cohesion Domain Scores

Case Code	Caregiver Name	Community Domain Score
C-1	Meyemuna	2
C-2	Zidan	2.6
C-3	Masho	1.3
C-4	Zeritu	2.3
C-5	Negle	2.3
C-6	Zewditu	2.3

The Community Cohesion domain questions explore community cohesion by asking the primary caregiver how welcome he or she feels in the community and about the availability of support for his or her family. The findings from the health wellbeing domain set of questions indicated that out of the six primary caregivers, five of them feel that they have defects in this particular wellbeing domain and they feel that they are not welcomed by their community and are not getting support from their community or their

family members. The survey indicated that, except for C-2, all the rest said that people in their community are not trying to help them. Except C-3, all the others feel they welcomed by the religious community. Apart from what they are receiving from the FHE they do not receive any other free support in caring for the children who are living with them, but C-3 was not receiving free support. According to the community wellbeing domain score, except for C-2, all of the rest require intervention.

Table 20 presents the summary of the Wellbeing Domains Score (WDS). It shows the ranking among the respondents in terms of the WDS.

Table 20: Wellbeing Domains Score Summary

Case	Domain 1	D 2	D 3	D 4	D 5	D 6	D 7	D 8	D9	D10	Total Score	Rank
1	2	2.2	1	2	1.5	1	1	1	2.5	2	16.2	5-Negle
2	2.3	2.4	2	1.6	2.5	2.5	2.5	1	2	2.6	22.1	1-Zidan
3	1.6	1.4	2.3	1.3	2	1.75	1	3	2.3	1.3	17.95	3-Masho
4	2.6	1.8	1	1	2.75	2.75	1.75	2.75	2	2.3	20.7	2-Zeritu
5	1.3	1.8	2	1.6	1.25	1.25	1.25	1.5	2.3	2.3	16.55	4-Zeritu
6	1.3	1.8	1	1	1.75	1	1.5	1	1.6	2.3	14.25	6-Zewditu

Summary of the Quantitative Data Analyses

As stated earlier, according to the wellbeing measuring tool, the ten domain scores range between 10 and 30. The desirable score is 25; the average score is 23. Scores below 22 indicate some defects experienced within the domain, and a score below 15 indicates that immediate action is needed to determine if there is a problem affecting the caregiver. As in the total wellbeing domains score indicated below, the survey data

results show that the score range for the six cases is between 14.25 and 22.1. None of them reached the desirable score of 25. All of them are below the average score of 23 which, at the same time, shows defects within most of the domains. Defects are indicated within all the domains by C-6 which means that the caregiver requires immediate intervention.

The Qualitative Data Analysis

The qualitative research in this study helped me to engage in a deeper investigation and to acquire a greater understanding of the factors that contribute to the wellbeing, burden and joy of the primary caregivers in the light of their caring and nurturing role towards the OVC. The investigation into the wellbeing factors included different independent and dependent variables and other major aspects which directly connect to the wellbeing of the primary caregiver and the holistic growth of the OVC, or the caring and nurturing role of the PC.

The initial step in interpreting the qualitative data was to transcribe the information from the tapes and the hand-written notes. This was one of the most difficult tasks of the research process I have faced. In order to answer the research question stated in chapter one, the findings from the focus group discussion and the interviews with the informants were related to the five research questions. To ensure and enrich the in-depth study, the data was collected and investigated under the following six aspects which at the same time reflect the research-specific questions, assumptions and contents (literature review).

1. Respondents' reactions regarding the OVC primary caregiver's burden;
2. Respondents' opinions regarding the sense of joy the OVC primary caregivers experience;
3. Respondents' understanding concerning the caring and nurturing role of the OVC primary caregivers;
4. Respondents' reflections on OVC primary caregiver's supportive community and friends;
5. Respondents' reactions regarding the OVC primary caregivers' worries about the future;
6. Respondents' reflections on the OVC primary caregiver's understanding of the holistic growth of the OVC.

Codes Used to Represent Respondents

In order to protect the respondents, the following general codes were given to the respondent as group. Table 21 shows respondents' specific code.

Table 21: Codes Used to Represent Respondents

Code	Meaning	As used in the dissertation
PCG	Primary Caregiver	PCG (numbered 1 to 6, example PCG-1, PCG-2...)
SCG	Secondary Caregiver	SCG (with the addition of a letter at the end, for example, SCG-S, SCG-M...)
PM	Project Manager	PM (numbered 1 to 3, example PM-1, PM-2,
IIV	Informal Individual Interview	IIV (with the addition of a letter at the end, example IIV-R, IIV-A...)

Demographic Summary of the Respondents

The respondents involved in the qualitative research were the six primary caregivers themselves and the key informants who have been connected by serving in the Food for the Hungry Child Development Program and the OVC and family in Zeway area for five to twelve years.

Personal Information of the Respondents

The following codes were given to protect the identity of the participants, see table 22 below.

Table 22: Participant Codes

Codes	Range of Age	Job Title/ Profession	Number of years of connection with the Food for the Hungry Child Development Program
PCG-1	65-70	Selling Charcoal	10
PCG-2	47-51	Daily laborer	6
PCG-3	59-64	Selling Vegetables	10
PCG-4	52-57	Housemaid	10
PCG-5	63-68	Farming	10
PCG-6	42-48	Housemaid	10
SCG-T	46-50	Community level Worker	7
SCG-S	44-48	Community level Worker	11
SCG-M	35-39	Community level Worker	9
SCG-TS	33-37	Community level Worker	9
SCG-A	36-40	Community level Worker	9
SCG-J	32-36	Community level Worker	8
SCG-R	44-49	Community level Worker	6
IIV-A	37-41	Community level Worker	9
IIV-T	45-50	Community level Worker	9
IIV-J	33-37	Community level Worker	8
IIV-R	41-45	Community level Worker	9
PM-1	52-56	Director	18
PM-2	46-50	Program Manager	7
PM-3	50-55	Project Manager	13

The qualitative findings from the focus group discussions and the interviews are summarized under the following six thematic areas which also reflect and are aligned

with the research questions, the contents and the assumptions of the study. The six themes deal primarily with the caring and nurturing role of primary caregivers which also at the same time affect or contribute towards the wellbeing stability and status of the caregivers and the children they are caring for.

Summary Description of Data Under the Research Questions

The study was guided by the five research questions listed earlier which focused on the investigation of the wellbeing status of OVC primary caregivers and the extent of the sense of burden and joy they experience as they care and nurture the OVC. It is important to notice that the detailed thematic analysis presented above under the six major sections are aligned with the research questions, the literature review and the assumptions of the study. The following data summary description section presents the main findings under five research questions in such a way that they also articulate the findings from qualitative and quantitative data.

Research Question 1: What Are the Key Wellbeing Needs of the Primary Caregivers?

Wellbeing is the condition of a positive sense of wellness, happiness, comfort and satisfaction in the OVC primary caregiver. In the other words, wellbeing is a dependent variable that is affected by other factors or causalities. The data indicated that the vulnerability of the caregivers intensified and became critical as the key wellbeing needs of their own and their OVC failed to be addressed or met. Specifically, the availability of meals for the caregivers and OVC was found to be less than twice a day, they were found to be living with critical health problem, with inadequate shelter or without enough income to cover their own basic needs or those of their OVCs. Furthermore, they did not

feel that they were getting any tenable support from their family members, that the community around was not seen as supportive, and they did not feel secure.

In the caring and nurturing role of the OVC primary caregivers, a supportive community is vital in maintaining and keep alive the caregivers as they struggle with their own limitations and the children's needs (Miller 1996, 51). However, investigations carried out in this study found that, apart from the support of FH and FH community level workers, all the PCGs reported that the truth and the reality they face is the opposite. Instead of being supportive, the community tends to stigmatize them and their children. However, this does not mean that they do not have a friend or a family member who feels empathy and interacts with them, but it is rare and exceptional. PCG-1, PCG-4 and PCG-5 reported that because of HIV/AIDS, they have experienced stigmatization and emotional abuse from the community they live in including their family members. During the interview PCG-5 said emotionally, "For the last two weeks one of my daughters has been in the Zeway Hospital. She is a chronic HIV patient. Apart from an FH community level worker, and the hospital health worker, no one is visiting her. The next day when I called FH worker to take me to the hospital, but the young teenager had sadly passed away. I have also realized that very few people appeared at the funeral."

Similarly, PCG-1 and her family also experienced rejection from the community.

She expressed:

My daughter's illness, weakness and weight loss make me worry. Neighbors gossip and call her '*AIDS-am*' [one with AIDS]. I don't have the money or resources to sue these people. So, I wait for God's judgment. My daughter doesn't go to crowded places like funerals or weddings because she gets anxious and uncomfortable. My daughter is no longer beautiful or youthful. I fear everyone stares at her if she goes to these crowded places.

Maintaining a caring heart towards the OVC particularly while living in a stressful family situation is not simple and automatic. Instead, it demands a supportive community network which serves as springboard and back-up. A genuinely compassionate reaction and a dynamic and selfgiving friendship with the marginalized and frustrated ones arises from the quality of understanding and from analyzing the reasons for identifying oneself with the poor ones (Sharp 2001, 245-251, Kilbourn 2002, 25) . During the interview PCG-2 (a sick father who is raising his own son) said,

After the death of my wife there is a woman, who accepted my child as her own. She and FH are my close neighbors. These women are my neighbors, they are special to us. For the last four years after my wife died, this woman has been feeding me. I told my son to give her his hand even if she wanted to bite him. Sometime my son goes to school with her. She treats him like her own. She calls him her middle child. She gives him snacks after school. She's like his mother. He was sick once and she took him to the clinic before I even knew about it. She said his mother told her to take care of her son and educate him. I have a sister. A year ago, she came with her husband and children. She and her husband are supportive.

Some of the PCGs, particularly PCG-1 , PCG-2 and PCG 3, who are registered under the Child Headed Household (CHH) program, reported that the psychological and material support they receive from FH is important and that their lives depend on the monthly distribution they receive. They have mentioned that the monthly support they receive includes food items such as 15 kg white flour, ½ litter oil , ½ kg beans, 300 birr for rental, as well as casual clothes once a year, and every three years they are issued with a sheet, pillow and mattress. During the in-depth individual interview, the IIV-T reported that even though he has great concerns about the future of OVCs and their caregivers, as a CHH community level worker he is so grateful for what the organization is doing for the beneficiaries under CHH program. He maintained that:

Because of this support, today there are many children attending elementary and high school, college and vocational training centres. Besides, without this support the survival of these beneficiaries and their families their lives would have been very difficult. One of our CHH beneficiaries, Melekete, as a result of the support she has been receiving from FH, is now running her own business, has built her own house and is maintaining a middle class lifestyle.

IIV-A also indicated that in Zeway and another community which is not in the program, teachers and government officials are so grateful and happy with what FH is doing for the poor families.

On the contrary, the lack of a supportive community can cause emotional stress and burnout for the OVC caregivers, particularly in the OVC family that is struggling to survive and live under various limitations. PCG-4 and PCG-5 who are under the sponsorship program complained that they are not satisfied with the support they are receiving from FH. They are receiving only educational material support for their child, but not the other types of monthly distribution. Similar to this, during the in-depth interview, IIV-J stated:

FH has a big name and the picture from outside is good but some of the sponsorship social workers are disappointed because of the insignificant support that the beneficiaries under the sponsorship are receiving unlike the CHH caregivers. As a result, some caregivers left the area and we have many school dropouts. For example, I know a caregiver who is chronically sick and has been in bed for the last two years. I brought the case to the organization for special attention but nothing has happened. Finally I tried to mobilize my friend and do something. Dealing with this kind of family is so stressful; sometimes advice is not enough. For us it is a usual thing to share our salaries with these families.

According to Engle's research review, essential caring support such as food, sharing the work load, psychological and community support are vital for optimal caregiving practices. Caring practices cannot occur without resources. Focusing on care practices without a concern for resources may lead to the unfortunate result of blaming the primary and secondary caregivers for inadequate care, rather than recognizing a lack

of resources (Engle 1999, 134). Other research has also shown that the depression that the OVC caregivers experience is associated with their low income or financial inadequacy (Schultz et al. 1995, 771-791). They were worried for their own and their OVC's future, and they did not have the capacity to provide educational and spiritual assistance to their OVC in order to make them more effective and more self-supportive.

An overwhelming sense of burden can affect the caregiver's wellbeing, behavior and cause emotional instability which directly affects the emotional attachment with the child and other areas of the caring role and practices. The survey demonstrated that as the result of defects in various wellbeing domain, caregivers are under stress or burdened. Defects in their wellbeing condition which resulted from scarcity of food and resultant poor health, poor conditions of shelter, low income, lack of community support, lack of spiritual strength, lack educational capacity to assist their OVC and other unfulfilled basic needs of their OVCs are the source of worries that the caregivers are facing and living with. During the interview with PCG-1, an old grandmother who is caring for 3 grandchildren and her own daughter who is a chronic HIV patient, said, "My concern is very heavy. I worry that the children might run into trouble and be left homeless. What would happen to them if I or my daughter died? Not owning good land or good housing makes me doubt the future of the children. How will the children live their lives when they have no land or home?" Relating to worries about his health PCG-2 explained:

After I lost my wife, I have been passing through hardships and getting worried about my health. I've had this Goiter since 1986. The disease doesn't prevent me from breathing but it is getting bigger right on my neck. I am afraid to remove it out and of course I don't have money for the surgery. Some people advise me to ask the organization to help me for the medication, but some people told me that it is better not to touch unless it will spread to other parts of my body.

On the other hand, as the informants reported that as a result of the struggle for survival and the concern for the development the OVC so that they grow up to be self-supporting adult are the main issues that constantly worry the caregivers. IM-1 alleged:

For the caregivers, I think they are concerned that they continue to support the OVC until the child reaches the stage of becoming a self-supporting adult and that they continue to develop a good relationship and trust to be able to significantly impact the child's life. For OVCs, I think their concern is about the current challenges of survival that force them to focus on immediate needs and to attend less consistently on their education and the need to study hard. Their future perspective is very limited in this regard.

As the informants stated, there are many things that makes the OVC caregiver worry. During the discussion they mentioned the following:

They worry about the children's and their own needs since they have low incomes. If it's a girl, she will want things other than food. She might want lotions and things when she is menstruating. She might have concerns about what to wear or when she looks at her peers. All this might make caregivers worry. Financial concerns may cause stress. Even a rich person will worry about their child's future. There are caregivers that have poor health. They worry about their child's future if they were to die. There are some children that are HIV positive. Caregivers worry about the child's survival and his or her health. They worry about female children running away or quitting school and getting married once they reach puberty. They worry about male children becoming drug or alcohol addicts. They worry because they have regrets. They regret losing a lot of people like the child's biological parents and that kind of history makes them pessimistic. They might worry the child is going to die too.

The survey indicated that insecurity and concerns related with shelter, OVC education and health are the common sources of caregiver's worries. PCG-3, expressed, "I worry about the children. About paying for their school and how their futures will be. I don't have any place to rest. People in the neighborhood call them street children. The children cry and come back home. I worry about that. If I die they have nowhere to go." Similarly, PCG-4 also thought, "I worry that still I don't have even a little hut the children can live in if I die. I have no money. If the children learn, they can support

themselves in the future. I worry about the children getting burnt while working in the kitchen.” PCG-5 said, “The health of the children is my constant worry. The children could easily get sick if they don't take their HIV medication correctly.”

In addition, as mentioned above, the survey showed that, not only because of the various daily challenges they face, the primary caregivers are also worried for themselves and their OVCs' future, but also the secondary caregivers (informants), who are closely working with the OVC and the caregivers on a daily basis are worried for the OVC and caregiver's future conditions. One fact they mentioned was that they have been recently informed that the program will come to an end in the near future and the support packages will also stop. They know many caregivers who are highly dependent on what they receive from the organization and who because of their health condition have no alternative but to generate some income by themselves. As mentioned earlier, the discussion and the in-depth interviews showed that, in the event of the withdrawal of support, the secondary caregivers were afraid that many children would drop out from school, teenage girls could get married early or exposed to or be forced into prostitution, and some boys could also be exposed to street life and drug addiction. Data from the Victorian Carers Program research also indicated that caregivers who reported having larger informal support networks reported greater life satisfaction, greater perceived support from family and friends, and less resentment and anger than did caregivers reporting smaller informal support networks (Savage and Bailey 2004, 106). The following table 23 shows the wellbeing domains score summary and score description for the six cases, C-1 to C-6.

Table 23: Wellbeing Domain Score Description

Case Code	Total Wellbeing Domains Score	Score Description
C-1	16.2	Below the average and defects within nine domains
C-2	22.1	Below the average and defects within four domains
C-3	17.95	Below the average and defects within nine domains
C-4	20.7	Below the average and defects within five domains
C-5	16.55	Below the average and defects within all domains
C-6	14.25	Defects in all domains and requires immediate action

As stated earlier, according to CRS wellbeing measuring tool, the range of the scores of the ten domains is between 10 and 30. The highly desirable score is 25, 23 is the average, while scores below 22 indicate some defect within certain domains, and a score below 15 indicates that immediate action is needed to determine if there is a problem affecting the caregiver. The survey showed that the score range for the selected cases was between 14.85 and 22.2. None of them reached to the averagely desirable score. The scores show that there are defects in all domain for C-6 which means the caregiver requires an immediate intervention.

As shown above, not only the questionnaires, but also the data from the discussions and the interviews showed that caregivers are living with critical problems of basic needs and lack of understanding on the principles of holistic nurture and growth of the OVC. The data indicated that PCG-1, PCG-2, PCG-3, PCG-5 and PCG-6 and their children are affected by food and nutrition availability; they have meals less than twice a day; it is only occasionally that they have two meals a day. Informant PM-1 indicated, “Caregivers are already struggling to meet the needs of their own and are stressed in having to take the additional responsibility of providing support to the OVC. Economically, the family might not be able to meet the needs adequately of both the

OVC and their own children. This can result in disappointment and worsen the situation. All this affects their wellbeing, creates a lot of stress and overwhelms the families.” The defects or limitations and the lack of capacity to solve their own problem not only affects the wellbeing of the caregivers but also affects their fulfilment of the caring role and the holistic growth of the OVC.

Research Question 2: What Are the Perceptions of Primary Caregivers on Holistic Child Nurture and Learning?

Holistic child nurture and learning is based on the premise that each person finds identity, meaning, and purpose in life through connections to the family, the community, the natural world, and to spiritual values. But the study showed that as the result of various limitations and lack of understanding, the OVC caregivers do not maintain the intentional connection or the follow up with their OVC that can possibly enhance the holistic learning and development of the child. In the provision of a good learning and development-facilitating environment the caregivers do not have a relevant connection and dynamic relationship with the community or with the teachers and the peer group of the child. Instead, because of the condition of their health and their social status, some of them feel stigmatized and insecure and also as the result of the community and their neighbors’ reactions.

Healthy and intentional connections and relations can enhance the learning and development stage and process in the life of the child. As shown in the content, in the caring and nurturing role and practice, the nature of attention, responsiveness, affection and involvement from the caregivers’ side is the key range of behavior qualities which impact the growth and development of the OVC. In this process backup care and

assistance helps the caregiver to develop and maintain positive behaviors. Lack of consistency in affirming and maintaining positive behaviors and other personality development in the child's life can create negative outcomes and frustration as the child grows from one stage to the next (Engle 1999, 147). The survey found that caregivers who were assisted in the physical, spiritual and emotional burden and challenges they faced and who maintained a healthy and responsive relationship with their OVC affected and enhanced the growth and development of their child. However, because of financial limitation, lack of knowledge and spiritual understanding or maturity, caregivers were not able to effectively support the OVC's holistic growth and learning. For example, the survey showed that even though the caregivers receive educational support from FH in sending their OVCs to school, they have defects in providing the additional educational support that would make their children successful. During the discussion and in-depth interview, some informants reported that as a result of unfulfilled competing needs, instead of attending their education properly some OVCs are looking for job opportunities at any cost. In turn this has exposed some to street life, prostitution, drug addiction, labor abuse and other bad behaviors. The informants reported that it is not the caregivers who have been exposed to begging, street life or have left the area because of survival challenges, but also there are some OVCs who drop out from school and have become exposed to street life, begging, labor abuse, sexual abuse and other complicated lifestyles. IIV-said, "the young orphan girl, who has been chronically sick for the last two years and who died yesterday was an HIV patient. After she lost her parent she began living with her grandmother (PCG-5) and then later she started working and moving in different places and houses as a house helper."

The survey questionnaires showed that the caregivers did not provide the educational materials that would help the child and they did not know how to help their child study hard. On the other hand, PCG-6 said, “I am not educated and I don’t know how to read and write. I sometimes remind my child to study as his exams approach. The problem is, as you see today, he is the one who is helping me to raise these twins. As his sister told me, and he also showed me, some of his exam scores are OK but some are not.”

Similarly, the community level workers reported that most of their caregivers are not educated and could not assist their children achieve good grades. All the community level workers confirmed that the reaction and the experience of SCG-M was true for all of them. She declared:

Regarding the OVC and in connection with educational matters, most of the teachers prefer to inform and deal with us instead of the caregivers. Most of the caregivers do not check their OVC’s homework, scores and exercise books. It is us who advise the OVC and check their exercise books. It is not simple to do this activity and follow up the over 150 children under each of us, but what can we do? In reality, the OVC and their caregivers are living in two different worlds. Sometimes caregivers do not know what is happening the life of their child, their true character or the challenges they face. For example, as a woman there is something that I know about the OVC that the caregiver doesn’t know. To maintain the relationship between them I have to keep the secret and be wise as to how to solve the problem. Sometime we bring the issue to our supervisors and seek for advice and help because it is overwhelming and stressful.

The developmental scientist Lickona argues that an understanding of how individuals think about relationships is the key for character formation or moral development (Lickona 2004, 3-30). A clear understanding of the development stage of children enables the caregivers or parents to sensitively respond to the needs of the child and facilitate the change and development process (Bee and Boyd 2010, 325). However, as that survey found, being financially in need, socially stigmatized, uneducated or naïve

from the caregivers' side not only affected their caring and nurturing role but also the holistic growth of the OVC too. Even though caregivers have the greatest concern and deep desire to help their children learn to be morally good people, to do the right thing according to the standards and values of their culture, as a result of their educational, economic and spiritual limitations they leave the responsibility to others, such as the supporting organization, the church and school teachers. Besides, because of their social status and health situation, the OVC's opportunities for learning from their peers, neighbors and others OVCs are limited as they are indirectly or directly socially stigmatized. PCG-1, PCG-2, PCG-4 and PCG-5 reported that they have experienced rejection and stigma from their neighbors and other people. PCG-1 said, "I am living with gossiping neighbors. My children and I don't involve ourselves with them. Sometimes they openly despise us." PCG-2 also stated, "I always tell and remind my son to be careful and not to go around troublesome neighborhoods. Each week my son goes to the FH meeting place and learns different things about his future. They also advise the children how to be a good person and study hard." As has been mentioned above, the struggle for survival and other limitation has incapacitated the caregivers from acting out holistic development effectively. PCG-3 disclosed:

I am trying to lead and nurture my children to the best of my ability. One is a good student and he is still attending school, but for the girl I didn't have money for her tuition so they expelled her. The Kebele (the community leaders) wouldn't listen to my appeals. She was supposed to move on to the 4th grade but she sits at home now. I take them to school myself when I suspect they aren't going that day. One day I came home for lunch and found her at home. She tells me she didn't go. I called FH staff (SCG-S) and we went to school and asked why the school refused her and sent her back home? They told us that she was disturbing and didn't have school supplies. She hadn't told me this before.

Relating to the spiritual nurture of the OVCs and the caregivers, the respondents reported that unless they go to their prayer and worship place (Church and Mosques) no one comes to visit or advise them. They are not active participants. They only get spiritual advice from FH staff. PCG-4 said, "I have faith in God. I go to the mosque and pray. No one from the mosque comes to us. From FH, staff comes at least once every two weeks and gives me advice. He tells me about the healing power of God and invites me to accept the Lord. The one who has accepted God will not die twice. My child also goes to the meeting and gets some spiritual advice on how to behave, on his personal hygiene and to study hard."

As a result of receiving support from the Christian Organization (FH) and visits from the Christian staff, caregivers from Muslim background are feeling some challenges and rejection from other Muslim friends. PCG-3 and PCG-4 stated that they love to worship and hear the word of God and realize that Christianity is more meaningful to them. However, if they openly start to go to church they are afraid they would be kicked out from their rental home and something dangerous might happen to their children.

Regarding her spiritual feelings and experience PCG-3 imparted:

Spiritual advice and teaching are necessary. I have realized the change in one of my daughters. Advice makes or breaks a person. FH staff come here to advise us. We don't have anyone from the mosque; I am the one that gives them advice. I tell them to go to the mosque on Fridays. The girl in the 9th grade has changed her religion. She told me that it is over. She mentions Jesus now. She doesn't want money, Jesus is not about money. She said she is not looking to God to receive handouts "*Zika*." I didn't oppose her when she converted. She stated that she wanted to renew her life to save her soul, to live her life and get an education.

Concerning the behavioral and spiritual development and connection of OVCs, PM-1 stated, "The more caregivers develop the right level of trust, the greater the roles caregivers play in developing the right morals and character of the OVC depending on

their religion. In most cases when OVCs learn behavioral and spiritual principles and then compare them with the type of relationship and the abusive nature of their caregivers, they start to resist the right biblical moral behaviors as they are not seeing those qualities in their caregivers.”

As the survey indicated, beside the financial, social, personal health and understanding limitations that debilitate the caregivers from acting out their caring and nurturing role in a holistic manner, the availability of time with the OVC is also one of the factors that directly affects the relationship between the OVCs and their caregivers. Caregivers are more concerned about what they think of their child, rather than having a concern for signals of need from the child. To get some income and support, most of the caregivers in Zeway work outside the house throughout the day outside the house as daily laborers or in selling small items in the market place. As the result, they don't have enough time to spend with their OVC to enable them to understand their emotions, challenges and to respond to their questions in an effective and constructive way.

As discussed in the content, availability refers not only to physical presence, but also to providing the right response to the specific need of the child in such a way that facilitates and contributes to the ongoing process of the development of the child-parent or caregiver attachment. Availability optimally involves embracing the expectations of the child and taking the relationship to the next level constructively. However, the more the child's needs are addressed, and responded to in a timely manner, the better the child becomes settled psychologically, mentally and physically (Bee and Boyd 2010; Roehlkepartain 2006, 207). As indicated earlier, some OVCs prefer to confide their educational, emotional, social, spiritual and physiological challenges to FH staff instead

of to their caregivers. This implies that their relationship and trust level is not secure and mature enough to draw them together to discuss the challenges and find a solution as a family. The existence of trust between a child and the caregiver is fundamental to the health, wholeness, psychological makeup, faith, and maturity in all aspects of life and relationship. Particularly, in a child's life the moment mistrust distractively happens, wholeness and maturity cannot come until someone or some community gives the opportunity to experience love, acceptance, and care in a way that fosters trust.

Children who are given intentional and timely support and who are effectively nurtured at one stage potentially have the appropriate base to effectively proceed to the next life developmental stage. On the contrary, since the following development stage is dependent on the acquired strength, values, learned behaviors and patterns of the preceding one, children who are neglected and who lack the necessary support in the previous development stage suffer continually (Hofstede 1991, 33; Erickson 1963). PCG-6 revealed:

Raising twins is so difficult especially while you do not have money or any people who can help you. After school, my boy is the one who helps me and takes care of one of the babies. Sometimes he cries, the babies cry and then I also cry. If my neighbor next door is around she calls and give him something to eat and embraces him. We don't discuss much about his school and what he is facing. Unless I ask him, he does not tell me about his school experiences. These days he is not interested in attending school, but I don't want him to stay with me at home the whole day and be 'uneducated' like me.

On the other hand, the informant also maintained that transparency between the OVCs and caregivers is only partial and that most of the caregivers are raising their children in the same way that they have been raised in which open discussion and communication is not part of the family culture here. SCG-T conveyed:

I have realized that at the early stage of the child-caregiver relationship, openness and communication is good, but when children reach around the age of 12 and above it became different and more difficult. There are also the issues of modernity and information and technology. Children are exposed to a lot of information and technology but the caretakers are older in age and have been significantly left behind. High schools are banning cell phones in classrooms because the children use them so much. I had a recent case on this. There's an 8th grade boy that missed his matriculation exam because of this. His caretaker bought him a phone and he had pornographic videos on it that he watched. His caretaker was worried he wasn't sleeping. She hadn't recognized the sounds coming from his phone during the night as sex noises. She finally took his phone and gave it to me to keep away from him. I called and spoke to the boy. He missed his national exam because he was watching the videos all night and couldn't wake up in the morning. He told me finally that he didn't want the phone anymore.

As the survey showed, holistic nurture of the OVC is not only affected by the various limitations of the primary caregivers, but also by an intentional and low level of involvement and support from the supporting organization (FH), church and extended family. In the discussion and interviews the informants, particularly the sponsorship social workers and the caregivers maintained that the involvement of the church is unseen. IIV-T felt that because of the lack of supporting materials, such as for Sunday schools and other situations which can deliver advice and guidelines encouraging holistic development principles and messages for children, he doubted that the home visits they are doing are effective enough to guide and assist both the OVCs and the primary caregivers.

As indicated earlier, as a result of the development stage of the OVCs, modernity (technology and media) the old age caregivers and the teenagers are living in different worlds. The SCGs (community level workers) stated that they are dealing with various cases of conflict between the OVC and the caregivers and sometimes within the family. IIV-T, IIV-A and SCG-T reported that during their home visits and counseling sessions

they have faced cases which were beyond their ability to respond to and have had to deal with, and there were times they preferred avoidance. IIV-A voiced out, “I prefer not to visit a family instead of offering nothing while they are suffering and passing through complicated challenges. As community level workers, we ourselves need education on how to deal with some of the cases, like dealing with teenage girls which is so difficult. We don’t have supporting manuals that provide different lessons.” Relating the position and support from the church IIV-T expressed, “I am the church leader and from one of the biggest churches in Zeway. Even though, we tried to mobilize the church for OVC support, it seems that the church has left the OVC and poor families for NGOs, like FH and Compassion. Some churches might try to support a few, but they are limited within their own congregation.”

In this study all the caregivers (PCG 1-PCG-6) similarly perceived and assumed that their OVCs were getting holistic advice, such as in educational, social, health and spiritual spheres, from the FH community level workers who were assigned to assist their OVCs. However, I have realized that as a result of being responsible for other program activity routines, such as translating sponsorship correspondence letters and submitting them on time, none of the community level workers (secondary caregivers) felt that they were providing such holistic assistance intentionally and in an organized manner and were not addressing the felt needs of the child. As stated earlier, as the result of big number of children under their supervision, the community level workers feel that they are stressed and some of the problems that the OVC and their caregivers passing through are beyond their capability to address and the capacity of the organization. During the in-depth interview IIV-T said that “I feel that most of the community level workers here in

Zeway get tired, disappointed or burn out. For example, most of us are not intentional enough to at least provide some spiritual advice. We ourselves need training and motivation.” The SCGs (community level workers) reported that they were dealing with various cases of conflict between the OVCs and the caregivers and sometimes in the family. IIV-T, IIV-A and SCG-T reported that during home visits and counseling sessions they face cases which are beyond their ability to respond to and deal with and that there were times when they preferred avoidance. IIV-A aired, “I prefer not to visit a family instead of offering nothing while they are suffering and passing through complicated challenges.”

As Zelalem indicated in his research, “Many of the OVC in Ethiopia are living with female-headed household, surviving parents or extended families” (Zelalem 2011, 3). However, apart from examining the challenge for church engagement in OVC care and support, there is no further significant description and investigation into how the traditional extended family support and child nurture system is functioning in the current or modern Ethiopian family system and what is missing or of the cause of the breakdown of the system. Similarly, all the respondents of this research reported that for them there is no visible care and support extended to the OVC and caregivers by the church. Nonetheless, in relation to the position and practice of the church in engagement and care and support of the OVCs and their families, Zelalem research findings identified three aspects of this shortcoming, giving recommendations for action which are also directly and indirectly in agreement with findings and recommendation of this particular research. These are, “the need for conceptualizing the mission of the church to include initiatives toward OVC care and support, to undertake practical and holistic planning for OVC care

and support initiatives, and to begin holistic OVC care and support initiatives relying on their own resources”(Zelalem, 2011, 87).

In Ethiopian traditional family culture, the role of child care and nurture is an inclusive responsibility involving the extended family and the community. However, as the survey demonstrated none of the caregivers felt that they have a strong connection with and are getting tangible and constant support from their extended family members and the community in general. This implies that the global cultural, social, and economic changes and challenges are affecting the Ethiopian traditional extended family unit and practices and the community is also getting more and more individualistic. This is very evident in the local community context particularly when the generation gap is getting wider, and tensions are increasing in the family system. Furthermore, these changes also demonstrate that the traditional family cultural patterns are undergoing dramatic and profound change. Change in thinking and the breakdown of belief is creating a global culture with tensions over social truth, values and practices. On the other hand, the passivity of the extended family members, the neighbors and the community in providing some kind support for the OVC caretakers who are critically struggling with challenges of survival and caring suggests that the goals of self-fulfillment and self-realization are overtaking the primacy of the traditional family, its authority and its values (Veith 1994, 47). These breakdowns influence the whole system of parenting exercised through the nuclear and extended families in Ethiopia. I have realized that it is very true what Tsegaye conveyed:

In Ethiopia, as in most traditional societies, there has been a strong culture of caring for orphans, the sick, and disabled and other needy members of the society by the nuclear and extended family members, communities and churches. However, the advent of urbanization

exacerbated by the recurrent drought and the resultant famine coupled with the internal and external wars. . . Millions of people were forced to migrate to centers where food was distributed. Consequently, thousands of children were left unaccompanied as neither family nor communities and religious organizations were able to discharge their traditional roles and functions (Tsegaye 2011, 4).

From the respondent and informant reaction and opinion I have realized that in terms of closeness and providing support for the OVC, generally the level of involvement with OVC caregivers the church or the faith community practice is not different from that of the community. Specifically, the church in Zeway is not active in visiting, encouraging, teaching and supporting the vulnerable in Zeway area. As shown above in the content, caring for the physical and spiritual needs of widows and orphans has always been an integral part of worshiping God. God's concern for widows and orphans is a consistent theme throughout the Bible (Bromiley et al. 1986, 616). The Israelites were also instructed to make regular provisions for widows and orphans through tithes and offerings and prophets also urged God's people to demonstrate their righteousness through the care of widows and orphans (Deut. 14:28, 29; 26:12). The New Testament also describes the essence of "pure religion" as caring for widows and orphans (James 1:27). But the absence of these supportive (the extended family and the churches) community in Zeway has left the OVC primary caregivers being more vulnerable and living with deteriorated wellbeing.

The OVC's holistic nurture is not only affected by the limitations and incapability of the primary caregivers, but also because of lack support from the church, the extended family and the community as the poor and HIV-infected people are often not naturally accepted by others.

Research Question 3: What is the Caregiver's Understanding of their Parental and Caring Role?

Caring and nurturing is an intentional act of developing and molding a child in a holistic way or as a whole person. In other words, the act of parenting is an enormous task that demands tremendous financial investment, time spent in fostering the relationship and emotional commitment. It is the process and responsibility of raising and relating to children in such a manner that the child is well prepared to realize his or her full potential as a human being. The intentional act of nurturing and developing a child in a holistic way or as a whole person, however, is not a serious concern nor is it rooted in the perceptions of Ethiopians parents. The cultural perception is that after birth, children can grow by chance; the attitude that “a child can just grow” is deeply rooted particularly in the traditional parenting values and practices. The study has shown that the OVC primary caregivers typically hold this value and practice (Folkman et al. 1997, 256-298).

It can be held that, naively or because of the lack of understanding, that there are caregivers who are rejected or underestimated in their role as they expected to fulfil their key responsibilities such as educational, behavioral and other emotional and spiritual, and fail to issue follow-up reports on their OVC to the sponsoring organization, particularly to FH community level workers. The rejection of these roles is leading and exposing the caregivers to face extensive stress and to being worn-out. PCG-6 explained that she had sent two of her older children who are under 14 years to work as house helpers in order to support themselves. As she was raising twins, her third boy had also been given the responsibility to raise his younger siblings. As the result of lack of income, support, and the feeling of insecurity and rejection from the community she was frustrated and

depressed and wanted to leave the area, though she did not know where to go (Phipps 1990, 32).

Maintaining a caring heart and being effective involves or demands physical, emotional, social and intellectual capabilities and back-up care (Amos 2013, 66-67). When these capabilities are not available it is inevitable that stress, confusion and hopelessness occur and affect the caregiving and nurturing role, and the wellbeing of the caretaker.

The study indicated that as a result of several limitations such as finance, understanding, skill, and assistance in coping with the frequent changes, needs and challenges of children, caregivers often burn out and end up with other related problems which will affect the development of the child in critical ways. During the in-depth informal interview IIV-A reported that he knew a caregiver who was caring for two OVCs and getting some support from the FH program but was nonetheless begging on the street. He also said, "I also know a 10-year-old girl (OVC) who is begging and whenever she sees me or one of the community level workers she tries to hide from us." It is the informants' consensus that as a result of unfulfilled basic needs there are OVCs who drop out of school, disappear from the area, become exposed to child labor, and become involved in early marriage and sexual practice. IIV-A declared:

I know of a 12-year-old girl from our program, who told me that she was abused by an adult man and when we asked her who the person is she told us that the person had left the area. These days I am deeply disappointed. Many of our young teenage girls have a strong dream to go to Arab lands, live in that area and work in the hotels, maybe as a prostitute. I know of alcoholic young boys who have been supported by the program and are still in the program. Some of the caregivers and the parents don't really know what their child is thinking about and doing. They are afraid to ask and discipline them. Partly because they don't know how to handle the situation; the children and their old caregivers

(grandparents) are living in two different worlds. I am afraid and worried that our effort may end up being in vain. In addition, the program is coming to an end. I am afraid that maybe 40% to 45% of the students who are getting support from the Child Headed Household program may drop out of school.

Maintaining trust, communication and relationship is a key caregiving factor, especially in the OVC family setting where survival is an issue. When responsibilities and values are intentionally shared, good communication, growth and positive change will be the outcomes of those positive practices. In contrast, if these roles are rejected and underestimated within the family, such neglected burdens affect the others and the family dynamics and start to wear out (Phipps 1990, 32). The survey showed that in the family where caregivers are concerned about the daily activities of the OVC like education and their relationship with the OVC, this helped the child to be healthy emotionally and have good conduct, but in those families where caregivers underestimate the importance of intimacy and communication, depression and conflict is an outcome. During the discussion, the informants (community level workers) reported that they knew of many caregivers who frequently appeared at their office just to get some advice regarding their OVCs educational performance and their behavior outside the home. Regarding her OVCs' educational performance, daily activities and her relationship with her OVCs, PCG-1 disclosed:

I have to be strict and make sure they don't hang around with thieves or waste time on idle things. I keep them close and watch what they do. I ask them what they did during the day. The older boy has won many awards and ranks high in his class. I was very happy and went to see him receive an award. They tell me what happens to them at school and that the teachers love them because they are quiet and obedient.

In the same way PCG-2 also reported that sometimes his child complains about some of the things he does not have compared to his school friends and other children in the neighborhood, but...

Instead of being angry or nagging or hitting him, I treat him with sympathy and as far as possible I try to show him the future and help him understand the reality of our life. That's better for him as he grows up. I ask him about his day-to-day things. I have a good relationship with his teachers. I ask about his manners in the classroom and his grades. I want to make sure he has good morals. Mostly he tells me without my having to ask him. He's not afraid to call me by my name. One day we were walking down the road and he said one day he will go to America and build me a house and hire a maid.

To the contrary, there are many OVC caregivers who really do not know their OVCs and how they are performing at school. PCG-6 said, "I do not know how to read but I ask my son what he's learned at school. He doesn't talk much if I don't ask him." Similar to this FGD-A said, "Recently I received a call from the teacher and was told that one of the children had not appeared at the school for three days and that he is frequently absent, but no one knew about this. Then I found out that due to some financial challenges and peer pressure he had started taking a daily job and getting some money." But FGD-T, FGD-M and FGD-S commented on this and reported that in their home visits and school educational supervision responsibilities they were aware of and knew many caregivers who frequently contacted teachers and maintained good relationships with their children. However, on the other hand, SCG-T had shared his childhood struggle and experience and said, "I am handling a case in which, after living together for 12 years, the OVC does not even want his caregiver. This happened because he had recently realized that the caregiver is not his real mother."

As pointed out in the content, some research has shown how the exercise of the caring role can have a negative impact on the caregiver's mental and emotional health and other aspects of their life. Some caregivers experience an extensive negative impact while others are less affected by the caring role (Savage and Bailey 2004, 103). This variation in the impact experienced is not simply related to the extent of caregiving provided, it depends on the individual personality, on social and religious values and on the coping experience (Folkman et al. 1997, 256-298). In the practice of caring, offering intentional attention, responsiveness, affection and involvement are the key behavior qualities which can serve as a strategy to enhance and maintain the caring practice and positive outcomes. Lack of consistency in affirming and maintaining these positive behaviors can create frustration and other negative outcomes (Engle 1999, 147; Phipps 1990, 48). On the other hand, with regard to the caregiver's caring role, trust and relationship with the OVC, PM-1 who has been monitoring and leading the program for many years and is still supervising the overall program quality articulated:

In most cases, yes, they trust each other and the relationship goes very well in building trust among themselves. Sometimes, the relationship might not go well if the caregiver gives priority to his siblings and the OVC feels the he is not treated fairly. This by itself erodes trust and can cause conflict and lead the OVC to go onto the streets to look for his life thus ending up with bad living conditions. I think it depends on the level of trust built. However, OVCs may not be able to share openly as they scavenge for survival and pretend that they are happy and thankful. Deeply they may not be open to share all their positive and negative feelings. In fact, the OVC wants to keep the relationship positive with the caregiver. On the other hand, due to stress and psychological trauma, they can be aggressive and may not want to trust any support from their caregivers or parents which can cause them to develop negative behaviors like alcohol and drug addictions.

Research Question 4: What are the Key Wellbeing Factors that Affect the Sense of Joy and Burdens of Primary Caregivers?

As the caregivers explained, their burden is seen as very heavy, deep and complicated (PCG-1, PCG-2, and PCG-6). All the limitations and defects reported and included in the domains are major causes of the sense of burden which caregivers reported as experiencing. These caregivers are very poor parents, non-blood relationship guardians and grandparents who are sick and who are at the same time struggling to meet the needs of their own and the OVC children. They have and lost opportunities and the capacity of providing for basic needs such as food, shelter, medical care, education, and so on (Zelalem 2011, 3). For instance, because of a large chronic goiter on his neck, PCG -2 is living with a breathing problem; PCG-4 is a very poor HIV patient caring for an OVC living with HIV and PCG-6 is raising twins with no means providing for basic necessities like food, shelter and clothing. In addition to this, socially, they are regarded as outcasts and marginalized. In turn, the unavoidable demands of survival and health problems has directly affected the caregivers' wellbeing and their caring and nurturing of the OVCs. As they live with such uncontrolled challenges emotionally they are frustrated and hopeless, particularly as they worried about the future (Kilbourn 1995, 226; 2002, 133). To look for additional income and support some OVCs have left their home, were not performing well at school and were exposed to various abuses. As the community level workers (informants) maintained, some of the OVCs' actions also affected their relationships with their caregivers. Living together and enjoying the relationship with the OVC is one of the key values for the caregivers; to the contrary, the absence of this, in one way of another, is very stressful for the caregiver's life and emotional stability or wellbeing.

During the interview PCG-2, a 49-year-old father who is raising an 11-year-old OVC boy and who is personally living with a goiter problem in his neck and struggling to even breathe properly described his complicated burden by saying:

After I lost my wife four years ago, I am facing many problems. My health is deteriorating and I don't have a proper job. These days I do not have the daily laboring job I had before. However, '*Egziabehare saydegis aytalam*' (God doesn't quarrel and discard us without providing the way out and celebrating with us first); Allah supports us through FH and my neighbor. They are angels sent to us. I cannot imagine living without the support from my neighbor in sending my boy to school, my neighbor is always feeding him.

Caretakers who experience chronic stress or feel overloaded are at risk of becoming emotionally traumatized (Kilbourn 1995, 226). Since they cannot meet, and yet are expected to address, all their children's needs, caregivers should know their own limitations and avoid unrealistic assumptions. According to PCG-1, an old mother who has a large family:

Raising children is hard and the burden is heavy. Being poor makes raising children harder. I gave birth to twins last year. It's made my head hurt. I don't have a source of income. There are two of them so I can't work anymore. They're over 15 months old now but they can't walk, they are also under-weight and are frequently sick. They have just begun to eat food. FH is helping my child with educational materials, but I'm not receiving anything else like some others. Recently I sent (gave) two of my oldest children (a girl at the age of 14 and a boy who is 12) to another place to work as house helpers. And as you have seen my third boy who is 11 is helping me to raise these twins. Life is not as we had expected before we moved to this region. People here don't like us, they are treating us as mere strangers who do not belong here.

On the other side, from an in-depth informal interview, IIV-R said that, for the sake of getting a plot of farming land and a job, PCG-6 and her family migrated from the Northern part of the country. But when their family size increased from four to eight, they sold their land and the husband left the area to look for a job. The archival study also indicated that, initially, farming provided the family's means of living when the family

size was four. As a researcher I observed that PCG-6's family members are living in a 3 by 4 -meter sized mud house and the caregiver herself and her twins are very tiny in their body size. PCG-6 is also one of the critical cases where the study indicated that defects were observed in all the wellbeing domain scores and intervention is required.

As discussed in the literature, the role and burden of caregivers are directly related to cultural, economic, religious and social issues in the society; sometimes they also vary based on ethic and cultural differences. At any level and in all circumstances the effectiveness of caregivers requires intentional and coordinated back-up care. If this is not available, it is inevitable that stressed, confused and hopeless caregivers will affect not only themselves but the children and the rest of the household.

I have realized that the same caregivers who were experiencing tremendous stress and a feeling of burden can also have sense joy. What PCG-1 said during the interview was so profound:

I can't complain. God has given me comfort, poverty and illness respectively. I asked God to lessen the burden and bring conveniences and there is nothing else I can do. However sad or tired I am I cannot hate my own blood. We can suffer together and we eat together when we have food. Even though my little flower has been cut off at such young age, her little one whom I am raising is giving me joy. I am so happy that they are HIV negative. They are brave and loved by everyone and so lovely. I am happy when I see the children. They look like children that come from rich families. They are the ones who pour oil on my broken and wounded heart; I am thankful and proud.

In an extended family setting in Africa, the joy for caring for orphans and children in crisis comes from the socio-cultural values of the relationships which also have a spiritual element. As indicated in the content, the research investigation of Nolan, Grant, and Keady, found that a positive aspect of the caring role was that 84% of the caregivers experienced joy and a great deal satisfaction from caring (Savage and Bailey 2004, 104).

However, in the modern changing and challenging world, the experience of the burden and joy of OVC primary caregivers is not only a cultural and social issue, but is also influenced by the economic conditions and level of protection (Haddad 1999, 102-104). The interviews conducted in this study have shown that, despite the burden and worries, the caregivers experience a sense of joy in caring for the OVC. PCG-1 stated:

Even though my “little flower” has been cut off at such a young age, her little ones whom I am raising, are giving me joy. I am so happy that they are HIV negative. They are brave and loved by everyone and so lovely. I am happy when I see the children. They look like children that come from rich families. They are the ones who pour out oil on my broken and wounded heart; I am thankful and proud.

According to Ashworth and Baker’s research, caregivers in other countries also described some benefits of caring, such as a sense of closeness to the care recipient, and enhanced self-esteem (Ashworth and Baker 2000, 50-56). The survey indicated that the caregiver’s friends, family members and neighbors who accepted and treated their OVCs well are their source of joy and happiness, but those people who mistreat their children are their “enemies” and negatively affect their sense of joy. PCG-2 said that, “the sudden death of my wife was a tragedy that left us in deep sadness and frustration, but God gave us rest and joy through our neighbor whom I believe is my “*ablejie*,” or second mother of my son.

PCG-6 reported that some of the community around her act like enemies and, as a result, she is experiencing a stressful life and is emotionally traumatized. She expressed:

I know that people who came from another area like me have been killed, unjustly treated and pushed around. This place (Abossa) is a hard place to live in. People are harsh and nobody has any sympathy. In this place people discriminate on the grounds of how you dress or how clean you seem and on physical appearance. They look at me and say my children will not thrive. Except for FH workers, nobody visits us when we have

problems. I have friends whom I can speak to but I am not getting any support.

The respondent reported that as a result of the absence of supportive friends, family members and community, OVC caregivers experience stress which in turn affects their wellbeing. This demonstrates that the establishment of a community-based care strategy and supportive or workable networking is vital to assisting and providing holistic care for primary caregivers. As mentioned in the content, the amount and quality of informal social support from the supportive community, such as family, friends, neighbors, social groups as well as the formal support from agencies are important factors in ameliorating the negative impact and stressful burden of caregivers, and could contribute to their sense of joy and satisfaction (Kilbourn 2002, 138-139).

For PCG-3, seeing her children are healthy, attending to their education and living with them is a source of her joy. She said, “These days I am so happy to see how one of my daughters has grown into adulthood and how she is seen as an equal by others. She came from Lebanon, and bought me a television, bed and other household items. I am happy we are living together but still I am worried about my other daughter who is also living in Lebanon.”

On the other hand, the key informants reported that joy was experienced in providing support to the OVC as naturally as supporting others give satisfaction. When OVCs are growing and manifesting hope for their future life, caregivers also become satisfied. PM-1 related, “Playing a parental role towards my OVC is considered as living out the word of God (Bible) and gives satisfaction. Sharing from already limited resources for the family, though stressful, also gives satisfaction in not promoting selfishness.”

It is likely that these positive aspects of caring could generate the power and inspiration to maintain the role and could impact the caregiver's overall condition of health positively. FGD Maid said that as their children attend school their excitement and optimism about their future success gives the caregiver joy, satisfaction and hope. During the interview with PCG-4 she said, "I look at my children and hope they will be able to support me in the future. I just pray that God will let me live long so I can see that. Maybe they will get me a house and I will finally get out of rented houses. I'll be happy with a little hut. The boy comforts me and tells me not to cry. I just hope for them to live and grow."

Feeding and supporting the OVC even when the caregivers themselves are hungry and in need also gives them joy. FGD S added to this by saying, "Not only because of Christianity, but here our culture opens doors for the OVC and the intention and act of helping others is a good value and brings respect to people. Good feedback from the social circle, families and friends also makes caregivers happy and gives them a positive reinforcement."

The study showed that caregivers are so grateful and happy for the relationship and closeness that they and their children have established with FH community level workers (secondary caregivers). The home visits and other informal contact and communication makes the caregivers and their children feel emotionally good and secure. Reporting the sense of joy and comfort that comes from closeness and support, PCG-4 said, "Life is hard, a small amount of coal is 5 birrs. That's very expensive. Whenever community level worker comes to my little house, he gives me 40 or 50 birrs from his

own pocket. His home is open to us. When we are desperate and hungry we can freely go to his house to eat and relax.

The caregiver's joy is an inner and an expressible personality attitude of happiness and satisfaction interwoven into the caregiver's perceptions and caring practices. As the research indicated, the sense of joy and satisfaction which caregivers experience is associated with five main elements or areas which they are concerned and value most in their daily life situation. These are their belief or faith orientation, living together and sharing what they have with the OVC, seeing the health, growth and education of the child, and getting support and acceptance from others. However, the study showed that the sense of joy that caregivers experience is significantly influenced by economic conditions and their protection and safety (Haddad 1999, 102-104; Ashworth and Baker 2000, 50-56; and Savage and Bailey 2004, 104).

Research Question 5: What are the Caregivers' Understanding and Implementation of Aspects of Child Moral Development, Relational Development, and Identity Formation in the Light of Scientific Perception?

Generally, Ethiopia is a religious country where parents and the family are concerned about and wish to have morally behaving children and to maintain the social connection and acceptance of the child. However, because of the poverty level of the country, low income and education and other factors, apart from the traditional way of parenting, the scientific perception of child character development is not rooted and practiced by the majority who have responsibilities for child care and nurture. In particular, in the agricultural community of Zeway, and more specifically among the OVC caregivers who are aged and poor, caring is restricted to the traditional way and

there is not a basic understanding of connecting scientific principles of the natural stages of child development with their caring and nurturing role. On a daily basis they are overwhelmed by the survival needs and struggle to address the child's and their own basic needs. As the result, the series of stages of childhood learning, age related identity formation, moral and relational development, including dealing with the genetic, environmental and other factors of modern life are not considered serious caring issues even though they do worry about the future of their OVC.

As discussed in the literature review, according to human development scientists and researchers, moral or character development is influenced by the mental learning level. A clear understanding of the developmental stage enables the caregivers or parents to sensitively respond to the needs of the child and facilitate the change and development process. However, being ignorant or naïve about this natural growth momentum affects children and undermines the roles of caregivers or parents. For instance, in his research work Thomas Lickona suggested that when character education is implemented in a home or school, the frequency of undesirable behaviors declines and desirable behaviors and personalities are cultivated and emerge (Lickona 2004, 3-30; Bee and Boyd 2010, 312). An understanding of how the individual child thinks about relationships or social cognition is the key for character formation or moral development. In the light of the caregivers' and the informants' reports, I have realized that because of caregivers' limitations and gap in capacity, there is no deliberate and systematic way of influencing the OVC relationship and moral orientation through the caring role. Furthermore, in this regard, the community level workers' understanding and engagement are also limited.

Culturally, in Zeway, children are expected to be morally good and to do the right thing but the aspects of the ability of child mental reasoning or the cognitive development as the key part is not understood or seen by the caregiver. The social-learning theorist Albert Bandura claims that children learn more from observing others. However, as this study indicated earlier, the home and community environment of the OVCs does not facilitate such a learning situation through the opportunity of observing morally, socially and emotionally constructive behaviors (Bandura 1989, 167-174). Instead, what they are hearing and observing from their caregivers is reaction and acceptance. Moreover, the community and some of their neighbors are seen as negative and intimidating. As PCG-1, PCG-4, PCG-5 and PCG -6 reported, as the result of HIV-AIDS and other aspects of critical vulnerability or poverty they experience rejection and stigma. Furthermore, some of them do not feel secure in the place and neighborhood where they live.

According to Kohlberg, when children come to understand that judgments are based on the rules or norms of a group to which he or she belongs, whether the group is the family, the peer group, a church, or the nation, they believe that good behavior is what pleases other people. They value trust, loyalty, respect, gratitude and the maintenance of mutual relationships. But when these elements are not visible or are missing in their family, peer or community connection, it can create a different reaction in children's lives and can lead them to refrain from normal and desirable growth patterns (Kohlberg 2010, 327). It is especially important that when the older children reach the period of transition to adulthood that they have the social bond and orientation to help them see that rules, laws and regulations are the key that ensure fairness, and are logically necessary for society to function. They want to embrace the concern and emotions of

others for the sake of unity for unity (Levine 1990, 51-67). In this study, an informant reported, some the OVCs and their caregivers have instead experienced abuse such as emotional neglect as they live in their critical life situation and are also verbally abused. During the interview PCG-1 emotionally expressed her deep and painful anguish when she said, “My daughter’s illness, weakness and her weight loss make her worry. Neighbors gossip and call her ‘*AIDS-am*’ [one with AIDS]. I don’t have the money or resources to sue these people. So, I wait for God’s judgment.”

Similarly, because of the community reaction, PCG-6 also expressed frustration. She said, “I know that people who came from another areas like me have been killed, unjustly treated and pushed. In this place people discriminate based on how you dress or how clean you seem and what you physically look like. They look at me and say my children will not grow.”

It is not only the caregiver-OVC relationship that affects the identity formation of the OVC but also the community values, practices and culture, as well as the modern and changing culture that influences children. As the informants reported, some children are confused in managing or balancing their values rooted in the community culture with the growing modern global culture which the elderly caregivers (all the caregivers in this study) find strange. IIV-T reported that the OVC who was accessing pornography throughout the night and missed his grade 8 national matriculation exam as a result. This identity confusion in children’s lives is reflected and results in problems such as depression, addiction, and conflict with their caregivers (Jeffrey 2010, 167-168). During the interview the informants (the community level workers) reported that they are dealing

with broken relationships between the OVC and their caregivers and have to deal with the secret problems faced by the OVC of which the caregivers are unaware.

The meaning they draw from what children see and observe from others also affects the development of their interpersonal relationships. The child's understanding of relational development is based on the level of social cognition or understanding of self and others. Their description of the other, which comes from what they see, hear and observe, also affects their interpersonal behavior, identity and sense of national and global self-esteem (Selman 1980; Roehlkepartain 2006, 313; and Bee and Boyd 2010, 314). Negative personal understanding of their family, caregivers, community and others in their area can create frustration that separates them from others while a more positive understanding can be a road map for them to develop inner qualities and behaviors that encourage them to be more open and to develop trust as they relate with others. In the history of the Zeway Child Development Sponsorship project there are cases of OVCs, who, as the result of issues in interpersonal understanding with their family, caregivers and community, have dropped out from school and left or disappeared from the area. As stated in the introduction of this study, there is even a case of suicide. Furthermore, informants reported that young girls dream to leave their area and their country and go to Arab countries or work in the bars where no one knows them.

The relational development of the OVCs is not only affected by the caregivers' level of understanding and knowledge of the OVCs' world and what they are facing in their lives, but also by their perceptions, reactions and level of relationships (Cassidy 1994, 228-249; Hazan and Zeifman 1999, 336-355). During the interview with PCG-6, I realized that she is not happy at all to let her child to play with other children around him.

She said, “We are not from this area, the people here in Abossa are not good. I don’t want to him to relate with these people when I send him to buy something from the nearby *keyosk* (small shop). Sometimes he comes home from school crying. People here are like wild animals. That is why I have sent his older brother and sister away from this area.”

The survey indicated that making time or the availability to talk to the child is also a factor that directly affects the relationship between the OVCs and their caregivers. Caregivers are more concerned with what they themselves think of their child, rather than with the need signals of the child. In order to get some income and support, most of the caregivers in Zeway work outside the house throughout the day as daily laborers or in selling small items in the market place. Moreover, some of the caregivers are constantly sick and old. As the result of these factors caregivers do not have enough time to spend with their OVC, so that they can understand their emotions, challenges and respond to their questions in an effective and constructive way.

As discussed in the literature review, availability refers not only to the physical presence, but also to providing the right response to the specific need of the child in such a way that facilitates and contributes to the ongoing process of the development of the child-parent or caregiver attachment. Availability optimally involves embracing the expectations of the child and taking the relationship to the next level constructively. However, the more the child’s needs are addressed, and responded to in a timely manner, the better the child becomes settled psychologically, mentally and physically (Bee and Boyd 2010; Roehlkepartain 2006, 207). As mentioned earlier, some OVCs prefer to talk about their educational, emotional, educational, social, spiritual and physiological challenges to FH staff instead of their caregivers. This implies that their relationship and

trust level between the OVC and caregiver is not secure and mature enough to draw them together and share the challenges and find a solution as a family.

The absence of trust and constructive interpersonal relations with the neighborhood and with peers is not only affecting the caregivers but also the OVC's psychological makeup, character and relational maturity in all the aspects of life. Particularly, in a child's life, the moment mistrust distractively happens, wholeness and maturity cannot come until someone or some community gives the opportunity to experience love, acceptance, and care in a way that fosters trust.

Children who are given intentional and timely support and who are effectively nurtured at one stage potentially have the appropriate base to effectively proceed to the next life developmental stage. On the contrary, since the following development stage is dependent on the acquired strength, values, learned behaviors and patterns of the previous one, children who are neglected and lack the necessary support in the previous development stage suffer continually (Hofstede 1991, 33; Erickson 1963). PCG-6 said:

Raising twins is so difficult especially when you do not have money or any people who can help you. After school, my boy is the one who is helping me take care of one of the babies. Sometimes he cries, the babies cry, and then I also cry. We don't much discuss about his school and what he is facing... Sometimes he comes home from school crying...I don't know, he may be hungry or has quarreled with others...People here are like wild animals. Unless I ask him, he does not tell me about his school experience. These days I am afraid to send him buy something from the nearby *keyosk* (small shop). After school he is just here with me. These days he is not interested in attending school, but I don't want him to stay with me at home whole day and be like me, uneducated.

One of the main goals of this study has been to understand the wellbeing conditions of the primary caregivers, the extent of their burden and sense of joy they are experiencing as they care and nurture the OVC. The above conclusions or answers to the

research questions are drawn directly from the data reported in the preceding sections. The following recommendations are also inferred from the data or from the understanding, reaction and opinions of the informants and the caregivers themselves.

This chapter presented the data and its interpretation according to the objectives set forth in the study. Chapter V discusses the summary of findings, conclusions, and recommendations.

CHAPTER V

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter aims to provide the summary of the research findings and the conclusions of the study, to offer recommendations for Food for the Hungry Child Development Program implementation, and to make recommendations for further studies.

Summary of Findings

The focus of this study was to draw attention to and to explore the wellbeing status and the joy and burden of caring for orphans and vulnerable children among the primary caregivers of Food for the Hungry Ethiopia Child Development Program. Many of the OVCs in Zeway are living in female-headed households, or with surviving parents or extended family members who are sick and struggling to meet the need of their children. As a result of shortcomings or limitations and incapability in the major wellbeing domains (availability of food, income, shelter, health, education, protection, spirituality, relationship with and assistance from the family members and the community) the wellbeing condition of the caregivers is suboptimal burdened and stressed. The limitaions which affect their caring role and the OVC's holistic development coupled with frustratation and insecurity about the future have placed the wellbeing of the carer and the wellbeing and the holistic growth of the OVC extensively

at risk and on shaky ground. Nonetheless, as the result of their beliefs and values, they were found to be experiencing some sense joy in the care and nurture the OVC.

While serving with Food for the Hungry in Ethiopia and Mozambique I had a chance to serve in the Child Development Sponsorship program there and was closely involved in ministering to the OVCs and their elderly caregivers who were very poor and living with chronic health problems. After dealing with different cases I realized that their burdens and challenges are deep and complicated. Compared with their needs, as an immediate OVC interventionist and caretaker, I felt that the support they were receiving from the organization was not enough. Moreover, although the major focus of the organization is to provide educational assistance for the child, caregivers were not the main focus. As a result, the school dropout rate in the program was quite high and many caregivers were living in an area where they could get some income and food to improve their level of support and save their own lives and that of their children. Caretakers who were experiencing chronic sickness and stress or who were feeling overloaded lost their OVCs as they disappeared from the area and, as a result, became emotionally traumatized. My heart was filled with passion and compassion for these OVC caregivers and the need for the organization to find better ways to support them, to see them at the center of the program and to raise a supportive community that could help improve their wellbeing so that they could be self-reliant and help them solve their urgent and critical needs.

Statement of Purpose

The purpose of this study is to understand the wellbeing status of the primary caregivers, the extent of the burden and joy that the caregivers experience as they care

and nurture the OVC. It is hoped that this understanding will lead to the identification of implications and recommendations for care and support approaches, which in turn will benefit or contribute to the process of the OVC's holistic care and growth. This study was pursued to answer the following guiding questions:

1. What are the key wellbeing needs of the primary caregivers?

Corresponding recommendation: developing a supportive community

2. What are the perceptions of primary caregivers on holistic child nurture and learning?

Corresponding recommendation: home based care therapy and holistic message development

3. What are caregivers' understanding of their parental and caring role?

Corresponding recommendation: holistic message or lesson delivery can help caregivers to understand the need of child holistic growth.

4. What are the key wellbeing factors that affect the sense of joy and burdens of primary caregivers?

Corresponding recommendation: Caregivers saving practice, home based care therapy and other also contribute to solve the cause of wellbeing defects

5. What are caregiver's understanding and implementation of aspects of child moral development, relational development, and identity formation in the light of scientific perception?

Corresponding recommendation: holistic message development and motivating the secondary interventionist can also help caregivers to understand the basics of different aspect of child development.

Research Design

Mixed study (qualitative and quantitative) tools were used in gathering data from case studies (purposive sample cases: caregiver's interviews), questionnaires, informant interviews, focus group discussions and archival studies. The quantitative study was aimed at identifying the issues that needed to be given more attention and which provided general information that focused on the wellbeing status of the caregivers in the major domains or contributing domains. The qualitative investigation moved from the general or quantitative aspects to the more specific details of the research and facilitated a greater understanding of the cause-effect relationships between the independent variables such as the existence of a supportive community and the caregiver's view of OVC holistic growth and care, and the dependent variables such as the sense of joy and burden, and future worries of primary caregivers. The use of this mixed approach helped me to produce a comprehensive and realist record of the study. The quantitative research helped me to explore the wellbeing status of the primary caregivers through measuring the wellbeing domains of families and their problems. Sequentially the qualitative data enabled a deeper investigation and discovery of the problems and causalities through a triangulation data analysis method.

The qualitative data collection process involved four different methods: focus group discussions, individual interviews, informal interviews, and documental or archival studies. The key informants for the study were the program director, managers and secondary community level workers who have been with FH and engaged in the child development program for eight to eighteen years. The interviews and all the transcriptions and data analyses took 11 months, between 11 May 2017 and 15 February

2018. The conclusions and recommendations in the following sections can be applied to the OVC primary caregivers and the Food for the Hungry Ethiopia organization in designing program strategies for supporting the OVC primary caregivers in a more effective way using a holist home-based approach.

Conclusions

The study was guided by the five research questions listed earlier which focused on the investigation of the wellbeing status of OVC primary caregivers and the extent of the sense of burden and joy they experience as they care and nurture the OVC. The findings under the six major sections are aligned with the research questions, the literature review and the assumptions of the study. Investigation on the wellbeing condition of the primary caregivers, the extent of their burden and sense of joy they are experiencing as thy care and nurture for the OVC is the main goal of the study. The data collected under this dissertation using the mixed methodology were conveyed a logical inference that gives meaning to the problem and theoretical assumption of the study.

The data indicated that the vulnerability of the caregivers intensified and became critical as the key wellbeing needs of their own and their OVC failed to be addressed or met. This implies that as a dependent variable the condition of a positive sense of wellness, happiness, comfort and satisfaction in the OVC primary caregiver is affected by other causalities. Caregivers' lack of capacity to solve their own problem not only affected their wellbeing but also affected their fulfilment of the caring role and the holistic growth of the OVC.

The study showed that as the result of various limitations and lack of understanding, the OVC caregivers do not maintain the intentional connection or the

follow up with their OVC that can possibly enhance the holistic learning and development of the child. For instance, in the provision of a good learning and development-facilitating environment the caregivers do not have a relevant connection and dynamic relationship with the community or with the teachers and the peer group of the child. Because of the condition of their health and their social status, some of them feel stigmatized and insecure. Because of the cultural view and lack of understanding, there are caregivers who underestimated their key role and responsibilities such as providing educational, behavioral and other emotional and spiritual support and guidance. Considering the results that came out from this study or the descriptions presented under the research question the following recommendations are also inferred from the data or from the understanding, reaction and opinions of the informants and the caregivers themselves as means and process to tackle the problem and improve the wellbeing of OVC primary caregivers, the intervention action of the FH and the quality of service and support given to the caregivers.

Recommendations

This section is composed of two parts. The first part includes the recommendations and implication for practice. The second part identifies the recommendations for further research.

Recommendations and Implications for Practice

After reviewing the research findings and the relevant literature, it is appropriate to make recommendations that can possibly assist and give direction to and strategies for the wellbeing development and empowerment of OVC primary caregivers in the Zeway

Child Development Project and beyond. At the same time, the recommendations can also assist the community level workers or secondary caregivers in such a way that they can be more effective and supportive as they work closely with the OVC and can also back up the caring and nurturing role of the primary caregivers. If appropriately implemented, these recommendations could help to minimize the caregiver's frustration and worries about the future and also identify possible interventions in the wellbeing domain defects so as to assist the holistic learning and development of the child, to establish and maintain a good relationship and open communication between the caregiver and the OVC, and with the community.

One can ask the question what is the connection between FH and the church on the ground and how the church can benefit from the investigation and recommendation of this particular research. As discussed earlier, according to FH values and its vulnerable community intervention philosophy and policies, there is an ample opening and invitation for the church to come and work together, and of course, to bridge the gap. FH believes that overcoming all forms of human poverty depends on changing the worldview and mindset to one that aligns with the intentions and objective truth of God (Kim and Davis 2012, 32). For the awareness and practice of such foundational principles, FH capacitates the local church leaders and its ministers to share the Biblical world view and messages with community members, families and children. The community-level staff and the volunteers who are from the community and church have a dynamic role to play in working together and leading the partners to achieve the desired outcome.

The biblical roles that God has mandated for families, churches and leaders can be seen as the common cause and ground that links FH and the church and the

recommendation of this particular study. For instance, as discussed in the different literature and data analysis section, FH and the church agree on and clearly promote the principle that parents and guardians are to take an active role in caring for their children. The Bible commands parents and guardians to “train” their children, to “direct” their households and to “bring up” their children. (1 Timothy 5:8) (Kim and Davis 2012, 32). The faith community should be expected naturally to be available and willing to act as a supportive community for the families and OVCs who are vulnerable and struggle with their survival and wellbeing defects. As a supportive community the church has the responsibility to work out what is requested in Micah 6:8 and unconditionally remain being the support of the vulnerable and marginalized people, “God commended you to do justice, love kindness and walk humbly with God.” God’s people are further given the instructions in Mark 12:28-31 to follow the two greatest commandments to, “Love the Lord God with all their heart, soul, mind and strength and love their neighbors as themselves”.

As a researcher and a Christian professional who understands the FH principles and philosophy as well as the theological position of the church as the body of Christ, I strongly claim that most of the recommendations resulting from the research and given to FH can also provide direction and benefit to the church as its members strive to accomplish its mission, particularly the great commandment and as they work out their faith individually, as a group and as the body of Christ. For instance, the church is called to be a supportive community for the marginalized and defenseless as the data demonstrated and which clearly includes OVCs and their primary caregivers. As shown in the literature review, defending and helping the poor is not a recent fashion of the

modern church, but is a commandment and practice that is as old as the people of God. As recommended, not only FH, but also the church can formulate and implement community support actions through the home-based approach with the coordination of FH staff or by identifying and establishing their own vulnerable target and supporting groups. FH and the church can establish an informed group who can design a curriculum and develop a holistic lesson plan that can be used as a tool to assist the caregivers in promoting the holistic growth of the OVC and cultivate the behavior and identity formation of children. In the same way the saving culture and biblical principles can be applied in the church among different groups to support and defend poor families, child-headed households, vulnerable and single caregivers, and others who are both in the church as well as outside the church. As researcher, I realized that FH as organization and the poor OVC caregivers in Zeway expect the church to take the concern for the wellbeing of such people seriously and play a practical part and to take steps to improve their wellbeing and rescue them as they struggle in silence in a situation of emergency or at the verge of death and life. In the light of this, the sustainability of the program and the improvement of the wellbeing of OVC primary caregivers depends on the strength of the bond that connects FH and the church and the viability and adaptability of the models as they are live as Christ's footprint among their community and surviving households. Finally, these inputs can increase the program's effectiveness by implementing and ensuring the relevant mechanisms for coping, by providing adaptable models and sustainable future options that give hope, and improve the means of living and back up the caregiver's caring and nurturing role.

Develop a Supportive Community

As the result of various limitations, incapability and lack of assistance, caregivers are vulnerable to every kind of victimization, frustration, hopelessness, fear and confusion in their day-to-day lives (Miller 1996 31-37, Kilbourn 2002, 133). As the data has shown, the caregivers' role and responsibility to the OVC is far beyond their capacity. They need a supportive community that can be committed to walk with them and provide compassionate care for them and their OVCs. For those caregivers who are in critical wellbeing conditions, overwhelmed by the demands of survival and living with hopelessness, insecurity and fear, a supportive community can serve as a springboard by providing ongoing assistance and by empowering them to be self-sustaining. The study indicated that caregivers feel that, apart from FH and FH community level workers, they do not have a supportive community that can provide them with some kind of support. They feel that they are not welcome and are marginalized by the community they are living with.

The idea of a supportive community is beyond that of living supported by family members and friends. It is not ready-made or natural but it is an intentionally created and developed community or a group of individuals or families who can go beyond a one-time compassionate act and commit themselves to relate to and extend their support to empower and solve the problems and critical challenges the caregivers face both in the short and long term. In reality, the development implementation plan like the Zeway Child Development Program, without the engagement of a gifted and committed community empowering and sustaining the poorest of the poor like the OVC primary caregivers, is not viable. Providing or distributing support does not necessarily mean

taking the poor to the path of empowerment or sustainable development; instead it can be compared to handling the daily fire. The act of sustainability in an environment of poverty demands a community or mutuality of willing cooperation.

The composition of the membership of a supportive community is not restricted by area; it can be people who know each other and who live in close contact with the OVC and the primary caregivers and may be people from another community, region, country and continent who understand the condition of the wellbeing condition and the caring and nurturing role of the the OVC caregivers and who extend their support with good or a healthy intention. However, there must be a person or an agent who can be close enough to capacitate, facilitate, and promote the wellbeing of the caregiver, and connect people for the same purpose and track the progress. My recommendation, in the case of OVC primary caregivers under the FH program, is that a supportive community can be created from individuals from religious entities (protestant, catholic, orthodox churches, and mosques), family members, neighbours, the OVCs' teachers, community leaders, friends and donors from other regions and abroad. As a secondary caregiver, the FH social worker can play the key role in mobilizing, creating, developing and monitoring the supportive actions. Being a development staff member is one thing, but it exists in engaging and being knowledgeable about the development model, as well as in sacrificially and creatively working on a daily basis. It is to dirty the hands while managing self and stress. This is the character and level of the professionalism and the calling.

Home-Based Care Not Home Visits

For a different reason, in the context of the Zeway Child Development Program, the OVC caregivers' availability at home can in most cases be seen in two different extremes, particularly in relation to facilitating and assisting the OVC's holistic development. The elderly and sick caregivers are mostly present at home throughout the day but are not able or capable of monitoring the child's education, peer connections, behaviors and challenges outside the home. However, the other group of caregivers is made up of daily labourers, or vendors of vegetables, charcoal and other small items, who are away from home throughout the day and do not have active and appropriate time to connect with their OVC during day. In the light of this, the routine home visits that FH social workers carry out once a month do not appear to be sufficiently relevant and organized to effectively assist in meeting the demands of caregiver role, such as establishing effective rapport with their OVC and in ensuring a good home environment. The OVCs are the main focus of the community level workers in that their aim is to confirm the presence of the OVC in the area, and to work on the correspondence between the sponsor and child and to submit the routine letters on time. Unless the caregivers and the OVC share their concerns and challenges, there is no visible and strong implementation and strategic reinforcement or guidance that engages the social workers in achieving a deeper understanding of the caregivers' lives or an assessment and identification of their wellbeing status and challenges of survival. Basically, in the routine home visits the caregivers' concerns are not central, instead it is those of the OVC. This does not necessarily mean that the program does not have some other focus and objectives or support package for the OVCs and their families. But home-based care

focuses on distributing a benefit packages and keeping the standared records without entering into the lives of the caregivers, empowering them to solve their problems, or improving their wellbeing as they care for and nurutre the OVC.

Home-based care is not something that only the social workers can do: it involves or requires engagement of the family members, the neighbors and members of the community (Sharp 2001, 245-251). It is more of a communy-based care strategy that can be created by designing, mobilizing, and capacitating a workable network within the community as a means of providing holistic assistance and care for the primary orphan caregivers. In this process, FH personnel can play a key role by strengthening and maintaining the caring netwok and the caring hearts of the individuals in the caring team. The team can share different roles and activites that can be extended to the OVC caregiver in a periodic fashion and in different situations. The home-based care has the potential to assist and provide holistic care, to understand the totality of the OVC and the caregiver's situation and intervene through the supportive community group. The home-care approach can facilitate an enviroment for supportive communy action and help the caregiver to develop friendships, get encouragement and relief from their stress, fear and truama, and to learn different parenting roles and how to solve problems, learn new skills and how to protect themselves and lead their OVC. A home-based care strategy or setting can also faciltate relevant informal training and counseling for caregivers such as those in Zeway who are not educated or literate through different methods like story telling, teaching posters and practical life testimonies.

The home-based care approach and support from other community members and support groups can also help the caregiver to set boundaries and limits in order to

maintain the long and tiresome walk with their OVC children and protect themselves from burnout. During the day, they sometimes need to distance themselves from their burden and to be connected with a healthy family for interaction and genuine fellowship (Kilbourn 2002, 189). They also need to learn to share their responsibilities and deep life concerns with others in the family, or even with their neighbors. The supportive networking and the homecare strategies can possibly help and the caregivers to be empowered to improve their wellbeing defects in the different domains and needs.

The caring therapies and practices should vary not only according to culture, but also within families in the same culture, but should take into account the family norms, values, and behaviors, the nature of the relationship, challenges, roles and vulnerability and other life realities. (Engle 1999, 138).

According to the field tests, home-based care interventions and interactions have a long-term effect and create an environment conducive to sharing adaptable, viable and manageable caring practices and lessons in the given cultural and home-based caregiver context. (Engle 1999, 159-161). Data from the Victorian Carers Program research indicate that caregivers who reported having larger informal support networks reported greater life satisfaction, greater perceived support from family and friends, and less resentment and anger than did caregivers reporting smaller informal support networks (Savage and Bailey 2004, 106-107). Particularly in vulnerable families where survival and special care is an issue, each member in the family should contribute to the wellbeing of the family. Home-based care can be a good strategy when the different members of the family are involved in the process, and mobilized, motivated and capacitated as individuals within the family to play their roles to lessen the burden and

stress of the primary caregiver. This kind of action by the other members provides assistance to the holistic development of the OVC by intentionally establishing functional common norms and values, responsibly, enhancing interpersonal communication, and developing trust and positive changes. The General System theory which proposes that the practice of home-based visits as an enabling strategy to establish mutual expectation, roles, rules, communication, and patterns of behavior and boundaries with the family also helps to maintain the family system and the balance that provide stability, consistency and security for survival (Phipps 1990, 48). Identifying the rules, roles, communication, culture, values and practices in a family can be a strategy to enhance the caring practice where the orphaned and other children in crisis are part of the family. According to Erickson, the idea of mutuality or functioning interdependency is essential for relationships and builds trust between a child and the caregiving adult. Often adults operate as if they are solely in charge of the relationships, and they are the ones who change and shape the child. The problem is that some caregivers are not intentional in regarding the mutual nature of the relationship and the extent it affects the growth of the child (Erickson 1963, in Roehlkepartain and King 2006, 141). The existence of trust between a child and the caregiver is fundamental to the health, wholeness, psychological makeup, faith, and maturity in all aspects of life and the relationship. Particularly, in a child's life the moment mistrust distractively happens, wholeness and maturity cannot come until someone or some community gives the child an opportunity to experience love, acceptance, and care in a way that fosters trust.

Consistent and intentional home-based care can help the caregiver and those family members who are directly or indirectly involved in the caring role to distinguish

between a subjective and an objective feeling and response as they live together. This also allows the individual to develop a sense of identity and greater flexibility in coping with life's stresses and to adopt new ways of dealing with emotions and experiences. The degree of acceptance and the constructiveness of the new pattern within the family determines the developmental integration as the family strives to meet the requirements of survival, and has the potential for improving the quality of care and wellness as a whole-family unit (Kerr and Bowen 1988, 272-273).

Caregivers' Savings Culture

Many of the respondents reported that, as the result of lack of income and gainful employment opportunities, the OVC caregivers are living under considerable limitations and wellbeing defects in their struggle to survive and have worries about their future. None of the respondents, including the caregivers themselves, mentioned either their involvement or the benefit or support they are getting from the savings group or from income-generating activity. The respondents recommended that importance of creating work and small-scale businesses opportunities for OVC caregivers is so crucial. As may often think availing these opportunities may not necessarily require the provision of seed money (fund). As a sustainable development strategy, from the project implementer's point of view the idea and conviction that the poor can save is vital. What matters most is not the amount money but the culture of saving itself which, when embedded, can bind the saving caregivers group together. The recommendation of a savings group culture is based on three objectives that benefit the OVC caregivers, addresses their wellbeing, survival and ability to cope with social challenges, while providing a back-up means for their caring and nurturing role. The saving practice can

increase household income, financially empower women and improve the social network dynamics and relationships among the OVC caregivers and with other community members. FH has well-established savings schemes in Mozambique where many OVC families are empowered financially, while increasing the household income and women's involvement in the social system and decision making. Such schemes address the family's basic needs and create a platform for learning from one another and solving problems thereby increasing their resilience and readiness to mitigate and cope with the seasonal disasters. Here are the key directions or steps for the formation and maintenance of the savings group scheme:

1. Share the idea of saving and its importance describing a success story featuring poor caregivers from a similar community with the community leaders and structures.
2. Involve the leaders in organizing a community meeting and dialogues to share the importance of saving.
3. Select volunteers who can identify positive respondents, organize the saving group's registration and promote it.
4. Explain the different functions and roles in the group, establish the management committee, and elect a group leader, secretary and treasurer for each group.
5. Guide the group to establish internal regulations and norms. The key internal regulations are:
 - a. Establishment of the minimum savings deposit and the savings rate of interest for the group members and outsider. Outsiders can borrow at a different

interest rate which is still better and less complex than the commercial bank rates.

- b. Establishment of the saving interval, date, time, and place
 - c. Based on the law and policies of the country, and the organization's guidelines, set the minimum and maximum group membership size
 - d. Establish controlling and binding rules such as the interest rate and the type of penalty for those who fail to repay the amount borrowed and the interest on time.
 - e. Establish the rate or percentage of the savings and dividend to be shared at the end of each year with the group members and save all money at the local bank.
6. Help the group to be legalized and connect them with a local commercial bank. Provide them with registration books, pass books (control and record books for individual savings) and savings boxes.
 7. Teach and initiate the group into entrepreneurship and small business ventures so that they can borrow money and invest on locally viable businesses.
 8. Keep reminding them of the value of the savings group by sharing success stories, and to facilitate learning and the experience of sharing, organize meetings with other group members.
 9. Advise and encourage members to integrate and reflect on biblical verses that relate to savings and caring for OVCs. Reflecting on biblical values encourages the group to develop trust, faithfulness, right work ethics, social values and other

right personal and social values and principles. The following are the key related topics and Bible verses:

- Saving: Proverbs 6: 6-10, 21: 20, Psalms 37:25, Matthew 6: 19-20.
 - Investment: Psalm 62 10, 127:2, Proverbs 11:28, 21:5, 23:4-5, 28: 20-22, Matthew 25:14-30, Luke 19:12-26.
 - Borrowing: Exodus 22:25-26, Deuteronomy 23:19-20, 24:10 Nehemiah 5:7, 10 Psalm 15:5, 37: 26, Proverbs 28:8, Ezekiel 18:8, Luke 6: 34-35, 7:41.
 - Contentment: Psalm 119:57, 72, Proverbs 8: 18-21, 10:20-22 Matthew 20: 1-16, Philippians 4: 11-14, Colossians 3:2, I Thessalonians 5: 18, I Timothy 3:3, 6:6-9, I John 2:15
 - Trust on the Lord: Psalm 37, Jeremiah 17:7-8, Matthew 10:9, 16: 24, 19:21 Mark: 6:9, 8:34 Luke 9:59-60, 11:13, 14:33, 18:29 22:35-36 Philippians 4:19.
 - Sharing with others: Exodus 16: 18-20, Psalm 72 Proverbs 11:24, 14:21, 21:13, 22:9, 28:27 Matthew 5: 42, 6:3, 13:12, 25:40 Act 2:45, 4:32 Romans 12:13 I Corinthians 9:7-11, 9:14, 16: 1-2 2 Corinthian 8: 8-15, 9: 6-13, Galatian 6:6 I Timothy 5:3, 5:8 I John 3:17, 3 John 6-7.
 - Work: Deuteronomy 24: 14-15 Proverbs 6:6-10, 10: 4-5, 12:11, 24, 14:23, 16:26, 28:19, Ephesian 4:28
10. Assist them to establish a social fund. The purpose of the social fund or savings scheme is to support each other during different social events and issues like weddings, death, sickness and others. The fund is established by equal deposits by

all group members and is collected once a year. Only group members are eligible to borrow from the social savings scheme. They can borrow more than once but the money should be replaced within three months or according to the group norm.

11. Avoid promising or providing seed money to the group. It can easily be mismanaged and can be a reason for weakening group involvement and the social bond.
12. Help them to set a common vision to the future and to think big: for example, to grow into an association on their own or by merging with another group. For example, in Zeway they could create a farming association which could include vegetable farming, fish farming, transportation, milk production and other initiatives based on viability and the market assessment and to liaise with the district agriculture office and city council for support.

Holistic Messages, Lessons and Christian Education Specialist

The respondents in the focus group discussions and individual interviews maintained that the lack of teaching tools aimed at assisting them to deliver messages that enhance the character development and identity formation of the OVC also limit them from understanding the OVCs and their caregivers' problems and from providing them with proper advice, teaching and counsel. Even though they have meeting times with the OVCs, they do not feel that they have the capacity and readiness to organize the group in order to teach them holistic principles and to influence their character formation. From the respondents' reactions, I have realized that the Ziway Holistic Child Development Program or the social workers as a secondary caregiver who assist the OVCs'

development do not have organized lesson materials to share with the school-age OVCs that can lead them to learn and practice right values and principles as they grow. The same is true for caregivers; there are no supporting tools that can assist the social workers to teach the caregivers different lessons in caregiving featuring life stories and principles that can help them to learn new skills to solve their problems. FH is a Christian relief and development organization that is committed to empower people holistically and to deal with the root problems of poverty by enhancing biblical values and principles. In the implementation strategy, this requires a knowledgeable person who has an understanding of the principles of the child's holistic development. Hence, I believe that the recommendation of the preparation and proper delivery of the holistic message by knowledgeable or expert personnel can promote the effectiveness of the caregiving and strengthen the coping mechanisms of the OVC and their caregivers in addition to assisting the caregivers in the process of building the social, mental, social and spiritual life of the OVC. My recommendation includes the provision of a teacher's (community level workers) guide with a brief account of the background, reflections on research findings, a description of holistic education and learning, and a holistic message delivery giving specific directions, objectives and lesson plans including detailed instructions for teenagers. The lessons could also serve as a handbook for the Christian education expert and social workers to help them understand the steps and motivate the practice and preparation of other lessons for groups or individuals for different ages of children in their program and church.

Background: Guidance for the Holistic Message or Educational Development

The holistic message and lesson formation is aimed at capacitating orphaned and vulnerable children (OVC) community level workers (secondary caregivers), tutorial teachers, study club monitors, parents (including all primary caregivers), and church Sunday school teachers to be able to create and facilitate a holistic educational environment for their orphaned and vulnerable children including traumatized and physically disabled children and teenagers. Holistic educational instruction means using different techniques of presentation in order for the students to have a variety of options for taking in information, making sense of the information, and expressing the information they have learned. It allows the teacher (community level workers) to improve the way they meet students' diverse needs. There are three elements that should be differentiated: content, process, and product. When teachers differentiate these three elements, they offer different approaches to what the children learn, how they learn, and how they demonstrate what they have learned. Holistic education instruction is proactive, qualitative rather than quantitative (Miller, 2000). It responds to learners' best ways of learning and allows them to demonstrate for themselves what they have learned in ways that capitalize on their strengths and interests (Heacox 2002, 5).

OVCs in crisis appear in the class and in study group with emotional differences due to their stressful background and the impact of the struggle for survival in the home environment. The holistic message lesson guide is aimed to capacitate orphan and vulnerable children (OVC) community level workers (secondary caregivers), tutorial teachers, study club monitors, parents (including all primary caregivers) and church Sunday school teachers to be able to create and facilitate a holistic education environment

for their orphan and vulnerable children including, traumatized and physically disabled children, and, specifically, teenagers.

Research Reflection

On October and November 2011, I carried out research related to Christian child nurture, targeting 94% of the total number of Christian teenagers in the Food for the Hungry Ethiopia, Zeway project. The teenagers were Christian OVC teenagers supported by the sponsorship program. These teens were between 11- and 20-year-olds, living in different types of households: double orphan, single orphan, child-headed, with grandparent, aunt or uncle, with siblings, and with non-blood relationship guardians. The research assumed, based on the findings, that an approach will be designed to enable the family, care givers and the church to undertake two initiatives: the first was to enable them to provide assistance that may minimize the pressure and level of burden that both the teens and their families and caregivers face; the second was that the survey analysis could be used as a training needs assessment tool for Christian child nurture to train professional caregivers, Sunday school teachers and parents who may lack the knowledge on how to nurture the teen from a Christian world view perspective or holistically. The study objectively addressed and assessed six different and major areas related to the orphaned and vulnerable Christian teen life:

- Educational performance
- Family Relationship
- Relationship with Members of the opposite sex (sexual relationship)
- Daily Challenges
- Belief and perspective about Life

- Christian Faith experience and practical disciplines

Negative peer pressure causes moral dilemmas in the life of the child or teenager, destroys the self- image that the teenager is trying to build, and creates tension in the parent-teenager relationship. Negative peer pressure is a spiritual battle that requires not only parents, but also all the Christian community to fight through prayer and helping the teens to build a God-centered self-image. Since teenagers are imitators, who observe our practical lives more than hearing our words, setting an exemplary life has a significant impact on their lives. As they learn biblical lessons and meanings, helping them to ask good questions that relate to their own situation also helps them to develop responsibility and critical thinking toward their own future.

What is the Holistic Education Message?

Holistic learning is based on the premise that each person finds identity, meaning, and purpose in life through connections to the family, community, to the natural world, and to spiritual values. There is no one best way to accomplish this goal; what is appropriate for some children and adults, in some situations, in some historical and social contexts, may not be best for others. Many educational scholars insisted that education should be understood as the art of cultivating the moral, emotional, physical, psychological and spiritual dimensions of the developing child or learner. A holistic way of thinking seeks to encompass and integrate multiple layers of meaning and experience rather than defining it narrowly (Holistic education@ the encyclopedia of informal education).

The art of holistic education lies in its responsiveness to the diverse learning styles and needs of evolving human beings. For instance, an inclusive educational approach has a significant effect on the holistic development of the learner-children: it involves children

from a wide range of diverse backgrounds and abilities in learning with their peers in such a way that they might address their needs through shared and adaptive learning behaviors and experiences (Loreman and Earle, 2007: 150-152). It also stresses greater freedom, activity and informality in the teaching and caring setting.

In holistic education objectives, a differentiated approach promotes the learning and sense of caring by fostering collaboration rather than competition in the process; teachers and caregivers help children to feel connected and to freely participate and express themselves. By using real-life experiences, current events, the dramatic arts and other lively sources of knowledge, caregiver-teacher can kindle the love of learning through effective listening.

By encouraging reflection and questioning rather than passive memorization or by rote which is memorizing without realizing the meaning, a holistic educational instruction and learning approach inspires caregivers and teachers to keep alive the "flame of intelligence" that is so much more than abstract problem-solving skills as they facilitate learning, particularly in teenage group and family-based care therapy exercise and discussions. By accommodating differences and refusing to label children, for example, as poor orphaned, learning disabled or "hyperactive," caregivers bring out the unique gifts contained within each child's spirit.

Holistic Message Delivery: Specific Directions

1. The child should be considered as a whole, to be developed mentally, physically, emotionally, socially, and spiritually. The aim of the message and education is to produce an integrated personality.

2. Learning is a process of directing activities toward some end or goal: the facilitator or caregiver is expected to have a clear understanding of the future direction and the where and why to lead the child based on the present-life orientations.
3. Learning is transferable and finds integration and interaction with the past experience of the learner or the OVC child. Learning is easier if one begins with what he already knows. As discussed in the content, the concept of transferable learning and developmental theory reflects similar themes as Erickson suggests, the preceding stage has an impact on the following developmental stage.
4. Practice and effect are integral parts of the learning and caring process: teaching learning effectiveness is evaluated in terms of the total or holistic growth.
5. In the process of teaching and caring, the child is made the center but not the subject matter or the program package: the growth and development of the child is the target.
6. Learning by doing should be emphasized. This concept is based on the principles that learning is an active process, and initiating child's participations is one of the significant roles of the facilitator or secondary caregiver.
7. Thinking and reasoning should be well stressed: the message delivery interaction or teaching should stimulate thinking, reasoning, and the addition of values and experiences.

Implications for the Primary Caregivers in Their Role

In relation to the specific objectives of the study, the literature review, the respondents' opinions and the focus of the study implications, I want to reflect on two major concerns which also benefit and assist the primary caregivers in their caring and

nurturing role, and which could possibly enhance the effectiveness the child development program of FH as organization and the secondary caregivers in their engagement with the OVC family:

1. Assist the emotional, mental (educational), physiological and spiritual development of the OVC-teenagers.
2. Bridge the gaps that parents, caregivers and churches fail to address in order to facilitate the holistic growth and maturity of Christian teenagers.
3. Form a team who can develop a contextual curriculum and lessons that can guild the moral development and identity formation of a teenage.

Secondary Interventionist Motivational Revival Strategy: Maintaining the Secondary Caregivers (community level Workers) Service Motivation

The focus group discussions and individual interviews demonstrated the fact that the wellbeing of some OVCs and their primary caregivers showed deterioration and critical vulnerability and as a result, the community level workers in such situations have expressed a sense of burnout, disappointment and frustration. The delay in or lack of response in the critical cases they have reported to the organization and observing for years the growing hopelessness of the primary caregivers and some OVSs has also contributed to their disappointment and frustration about the future lives of the some OVC and their caregivers. As discussed earlier, as the result of the challenges of survival some of the OVCs and their caregivers face, they are begging on the street, they want to disappear from the area, and the teenage girls want to go to Arab countries and work in bars.

As development workers, community level workers should have the passion and commitment to walk with the OVC and their caregivers. Failure to coordinate the organization's input and to motivate the workers to furnish maximum support with deep conviction, intentions and actions in order to improve the future of the growing OVCs and the caregivers' burdens can affect the organization's effectiveness and sustainable impact. Community development work without commitment and passion to improve and defend the livelihood of the vulnerable and the victim group and individuals is not community development work, although still it can be work. In order to solve this problem, periodic individual-based performance evaluations and appraisals, relevant capacity building and other motivational actions can help to restore the project's corporate performance and motivate the community level workers to recover and maintain their community level work passion, strength and excitement. As an organization FH has a defined performance evaluation and appraisal policy and standards; however, it is the establishment of periodic project-specific assessment, analysis and action that can help the project and the staff to maintain active involvement with the OVC family and motivate them to take their child's home visit an opportunity to interact at a deeper level or to provide home-based care assistance. Not only the community level workers, but also the volunteers who are selected from the church and assisting the community level workers and work closely with the OVC and their families also deserve recognition and some kind of motivational trainings and other strategies that help them to maintain their commitment and extend their service to the poor. As the church remains the key partner of FH, and FH community level workers and the

volunteers were chosen from the church, directly or indirectly the church benefits from the recommendations given under this study.

Recommendations for Further Research

The research has confirmed that, as in the case of Fozia, material benefits are not enough. It has highlighted the defects and severe strain caregiver's face, not only materially, but psycho-socially. Caregivers have demonstrated joy in carrying out their responsibilities but in all the cases interviewed they have demonstrated they would urgently benefit from greater community and organizational support. Caregivers shared their desperation and agony in being unable to give adequate support and direction to their OVCs from lack of basic understanding of holistic developmental needs of the child, from the sheer inadequacy of their own means of livelihood to their own severe health problems which are augmented by loneliness from stigma, disinterest, and lack of engagement and support from the extended family and local community.

Further research is recommended on how this support can best be furnished and tracked in a manner that will not perpetuate dependency but lead to greater ability and economic self-sufficiency in caring for the OVCs. Such support is urgently needed, especially in Zeway, where it is likely that even the material benefits afforded by FH are likely to be withdrawn in the near future. This research has highlighted how traumatic such a termination of support could be and how it is likely to affect not only the OVCs but the caregivers and the community level workers and other professionals involved. There is an immediate urgency for research and recommendations as to possible economic and psycho-social measures and intervention that would generate adequate economic self-sufficiency, ongoing psycho-social support interaction networking that

could be implemented by FH and local territorial and faith communities that would stimulate and ensure much greater joy and wellbeing of the caregivers that will in turn ensure the optimal care and wellbeing of the OVCs. To monitor the wellbeing status of caregivers and take the relevant action, further research on the development of a model on how the primary caregiver's and OVC's wellbeing can be tracked periodically can help the caregivers to maintain and improve their wellbeing and the quality of their role.

APPENDIX A

QUESTIONNAIRE PROTOCOL FOR OVC PRIMARY CAREGIVER

The researcher will thank the caregivers for their permission and for offering their time to the study. The researcher will give a self-introduction and explain what the study is about. He will then explain the purpose and the outcome of the research and initiate the structured interview using the following questionnaire, which is adapted from Catholic Relief Services Wellbeing Measuring Tool (Senefeld and Strasser, 2009, 9-11) to measure ten key wellbeing domains.

Name of OVC Primary Caregiver: _____
Caregiver Identification Number: _____
Gender: Male ____ Female ____
Age: _____
Administration: Oral ____ Self-administered ____

Statement	Never	Some times	All the time
1. I eat at least two meals a day			
2. I have enough food to eat			
3. I go to bed hungry			
4. Teachers treat my child like other students			
5. I can provide educational material for my child			
6. My child's exam scores are not satisfactory			
7. I know how to help my child to study hard and like his/her school			
8. My child has enough books and supplies for school			
9. I have a house where I and my child sleep at the night			
10. I feel secure in my neighborhood			
11. I feel safe where I live			
12. The school attendance of my child is affected by my need to work			
13. I have enough money to buy the basic things we need to survive			
14. In order to earn money and care for my child I have to work at a job outside my house			
15. I'm treated differently from other people in my household/in the family village, neighborhood compound			
16. I'm treated the same as other people in the group/e.g. during the meeting time			

17. I'm treated differently from other people in my village, neighbors, and compound, e.g. at the government office			
18. I do not get enough sleep and feel tired because of all the work I do			
19. I have people to talk to when I have a problem			
20. I am able to do things as well as most other people			
21. I am as happy as other people(adult) my age			
22. I feel I live in a safe place			
23. At home I have someone to look after me if I get hurt, sick or feel sad			
24. I have people that I can trust			
25. I get the emotional help and support I need from my family			
26. I feel I am supported by my extended family			
27. I feel strong and healthy			
28. I worry about my health			
29. My health is good			
30. I am healthy and strong enough like other people my age			
31. My belief in God gives me strength to face difficulties			
32. My belief in God gives me comfort and reassurance			
33. My faith community is important to me			
34. People in my community are trying to help me			
35. I feel welcome to take part in religious services			
36. I receive free support to care for the children who live with me			

FIELD SCORING SHEET

	Scoring Template Statement	Never	Sometimes	All	Calculation	Domain Sum
FOOD AND NUTRITION	1. In our-house we eat at least two meals a day				Sum divide by 3	
	2. I have enough food to eat and feed my children					
	3. I go to bed hungry					
	4. Teachers treat my child like other students				Sum divide by 5	

EDUCATION	5. I can provide educational materials for my child					
	6. My child's exam scores are not satisfactory					
	7. I know how to help my child to study hard and like his/her school					
	8. My child has enough books and supplies for school					
SHELTER	9. I have a house where I and my child sleep at the night				Sum divide by 3	
	10. I feel secure in my neighborhood					
	11. I feel safe where I live					
ECONOMIC	12. The school attendance of my child is affected by my need to work 13. I have enough money to buy the basic things we need to survive				Sum divide by 3	
	14. In order to earn money and care for my child I have to work at a job outside of my house					
PROTECTION	15. I'm treated differently from other people in my household/in the family village, neighborhood compound				Sum divide by 4	
	16. I'm treated the same as other people in the group/e.g. during the meeting time					
	17. I'm treated differently from other people in my village, neighborhood and compound e.g. at the government office					
	18. I do not get enough sleep and feel tired because of all the work I do					
MENTAL HEALTH	19. I have people to talk to when I have a problem				Sum divide by 4	
	20. I am able to do things as well as most other people					

	21. I am as happy as other people(adults) my age					
	22. I feel I live in a safe place					
FAMILY	23. At-home I have someone to look after me if I get hurt, sick or feel sad				Sum divide by 4	
	24. I have people that I can trust					
	25. I get the emotional help and support I need from my family					
	26. I feel I am supported by my extended family					
HEALTH	27. I feel strong and healthy				Sum divide by 4	
	28. I worry about my health					
	29. My health is good					
	30. I am healthy and strong enough like other people my age					
SPIRITUALITY	31. My belief in God gives me strength to face difficulties				Sum divide by 3	
	32. My belief in God gives me comfort and reassurance					
	33. My faith community is important to me					
COMMUNITY	34. People in my community are trying to help me				Sum divide by 3	
	35. I feel welcome to take part in religious services					
	36. I receive free support to care for the children who live with me					

APPENDIX B

INTERVIEW PROTOCOL FOR OVC PRIMARY CAREGIVER

The researcher will thank the caregivers for their permission and for offering their time to the study. The researcher will give a self-introduction and explain what the study is about. He will then explain the purpose and the outcome of the research and initiate the semi-structured interview using the following questions.

I. Caregiver's Burden

1. What can you say or feel about being a caregiver?
2. How do you see or feel about the level of your burden? Is it low or medium or high?
3. What are the sources of your burden?
4. During the time of need, who or which group of people do you think is helpful to you?

II. Caregiver's Joy

5. Do you agree that your role as a caregiver gives you joy?
6. How do you see or feel about the level of joy you have? Is it high, or low or you don't feel any at all?
7. If high, what is the source of your Joy?
8. Can you share with us the situations or things that can positively or negatively affect your joy?
9. Positively _____
10. Negatively _____
11. Are you getting any support from another group, institution, or people that may help you to maintain your caring and parental role towards your child? If yes, are you willing to share with us the name of the type of support, and the intervals in which you are getting the support?

Caring and Nurturing Role

12. Do you agree that the way you care for and nurture your child will have either positive or negative impact on the future of your child or children? Can you further describe how this impact happens?
13. What can you say about the caring and nurturing role in relation to a leadership role that may possibly influence the future of your child?
14. Do you have time to ask your child about his/her daily life and experience? What were his/her experiences?
15. How would you describe the child's feeling about sharing personal things and daily experiences with you?

Friends and Supportive Community

Objective: Identify the OVC primary caregiver's close friends and supportive people

16. Do you have close friends or people who are visiting you and your child, and who have tried to help you during times of need?

17. Who is visiting and helping you?
18. Can describe how you makes friends?
19. Which group did not accept you or did not welcome you every time you tried to approach them for help?
20. Do you agree that the following causes may contribute to any form of social rejection you are facing? Food and nutrition, education, shelter, economic, protection, health, spiritual, or specify if any other.
21. If any, what are the causes that may contribute to any form of social rejection you are facing?
22. Do you agree that your child/children are accepted by his/her/their school peers or other friends? Are you willing to share the reason?

The Future

23. What are your worries for your future life?
24. What are the issues that makes you constantly worry about your future life? Can you share with us how or why the issues make you worry?
25. If you rank the issues that make you constantly worry about the future, as little, medium or high?

Holistic Care and Nurture

Objective: to identify whether the OVC primary caregiver and the child are getting spiritual and physical (holistic) assistance

26. Do you agree that you and your child/children is/are needing holistic advice related to your economic, social, spiritual, health, educational situation to help him/her/them improve their wellbeing (livelihood)? Can you share any brief reasons or description for your answer?
27. Is there anyone who can advise you or teach you on these spiritual and physical issues? Can you specify the people or the group?
28. As an example, from the spiritual advice or discussion you have had, can you share with us some of the things you remember?
29. As an example, from other physical aspects of advice or teaching you have received and learned on health, education, the economy, can you share as few things you can remember?
30. As an example, from the social advice or discussion you have had, can you share are few things that you can remember?
31. Do you agree that your child is getting proper spiritual advice and teachings? Why?
32. Do you know about some of the spiritual advice or teachings your child is receiving? If yes, can share us few thoughts or at least the general areas?

APPENDIX C

INFORMANTS FOCUS GROUP DISCUSSION PROTOCOL

Groups: Secondary caregivers (community level workers)

Objective: Understand the observation and feelings of the key informant groups regarding the areas of the carrying and nurturing role of the OVC primary caregiver in Food for the hungry Zeway Child development project.

The researcher will thank the caregivers for their permission and offering their time to the study. The researcher will give a self-introduction and explain what the study is about. Then he will explain the purpose and the outcome of the research and initiate the semi-structured discussion using the following questions.

1. If you agree that OVC primary Caregivers carry an overwhelming burden in their caring and parental role, from your observation what are the key factors or causes?

2. If you agree that OVC primary caregivers also have some joy in life as they care for their children and work out their parental responsibilities, what do you think or observe as the source of their joy?

3. How do you describe the caring and parental role of the OVC primary caregiver?

 - 3.1. Do the caregiver and the child trust each other or have a good relationship (attachment)?
 - 3.2. Do you think that the child is open or willing to share personal feelings and daily experiences with his/her caregiver? Why?
 - 3.3. How do you observe the involvement of the primary caregiver in the child's moral development or character formation?
4. Who do you think are the best friends of the OVC primary caregiver, who are frequently visiting and take the initiative to care and provide some help?
Why _____
5. Do you think that the OVC and primary caregiver are well accepted by different community groups? Why?

6. Based on your observation what are the key concerns that make the primary caregiver and the child worry about their future? Why?

7. Generally, what kind of solutions do you suggest that may help the primary caregiver to improve the existing life situations and assist in the long term?

APPENDIX D

PRIMARY CAREGIVERS' CONSENT FOR RESEARCH PARTICIPATION

Caregiver's Name: _____

I have been told and have understood the description of the doctorate dissertation of Mr. Aweke Solomon Tadesse, and have had the opportunity to ask and receive answers to any questions I have regarding the research and the use of the information to be gathered.

I am willing and agree to participate in the interview, fill in the study questionnaire, and for this information to be used in the dissertation.

(Caregiver's signature)

KEY INFORMANTS CONSENT FOR RESEARCH PARTICIPATION

Part I: Questions About yourself:

1. What is your name? _____
2. What is your gender? _____ male _____ female
3. What is your relationship with the caregiver?
 _____ Staff (social worker)
 _____ Supervisory staff
 _____ Teacher
 _____ Community Adviser

Part II: Consent:

I have understood the purpose of the dissertation research project of Aweke Solomon Tadesse, and have had the opportunity to ask and receive answers to any questions I have regarding the research, and the use of the information to be gathered.

I am willing and agree to participate in the focus group discussions, conduct the questionnaire survey and interviews of the study, and for this information to be used in the dissertation.

(Key informant's signature)

APPENDIX E

LETTERS TO VARIOUS DIRECTORS

LETTER TO THE AFRICA REGIONAL DIRECTOR OF
FOOD FOR THE HUNGRY, NAIROBI, KENYA

December 2016

Dear Mr. Thomas LePage,

Greetings in the name of our Lord Jesus Christ!

I am a student undertaking a Doctor of Philosophy (PhD) degree in Holistic Child Development at the Asia Graduate School of Theology (AGST). As part of my study I am carrying out research on the topic, “The Joy and Burden of Caring for Orphans and Vulnerable Children: A Case Study on the Wellbeing of Primary Caregivers in Food for the Hungry Ethiopia Child Development Program,” to complete my PhD in Holistic Child Development. The purpose of this study is to describe and measure the key wellbeing factors or domains of orphan and vulnerable children (OVC) primary caregivers and to analyze the burden and joy that caregivers experiencing through their caring and nurturing role to the OVC. The key research findings and recommendations will be presented to Food for the Hungry Ethiopia. A quantitative research methodology will be applied and data will be gathered from multiple respondents such as: primary caregivers, children and key informants, which includes the community level workers (secondary caregivers). Archival or supplementary data and information will be retrieved from the child’s personal case history and other up-to-date documents which briefly describe the economic, educational, health, religious background and family size, including success and problem descriptions attached to the caregiver’s and child’s lives. In this light, may I request your favor in granting permission to conduct a survey, interviews and focus group discussions in Food for the Hungry Ethiopia, Zeway Child Development program areas with the selected respondents mentioned above?

I can assure you that I will make every effort to ensure that the study does not disrupt the working environment in any way and that any data collected will remain confidential.

I would greatly appreciate your kind consideration and support of my request. I pray that God richly blesses your ministries.

Gratefully yours,

AWEKE SOLOMON

PhD Candidate

LETTER TO THE COUNTRY DIRECTOR OF FOOD FOR
THE HUNGRY ETHIOPIA

December 2016

Dear Mr. Craig Jagers,

Greetings in the name of our Lord Jesus Christ!

I am a student undertaking a Doctor of Philosophy (PhD) degree in Holistic Child Development at the Asia Graduate School of Theology (AGST). As part of my study I am carrying out research on the topic, "The Joy and Burden of Caring for Orphans and Vulnerable Children: A Case Study on the Wellbeing of Primary Caregivers in Food for the Hungry Ethiopia Child Development Program," to complete a PhD in Holistic Child Development. The purpose of this study is to describe and measure the key wellbeing factors or domains of orphan and vulnerable children (OVC) primary caregivers and analyze the burden and joy that caregivers experience through their caring and nurturing role towards the OVC. The key research findings and recommendations will be presented to Food for the Hungry Ethiopia. A quantitative research methodology will be applied and data will be gathered from multiple respondents such as primary caregivers, children and key informants, which will also include the community level workers (secondary caregivers). Archival or supplementary data and information will be retrieved from the child's personal case history as well as other up-to-date documents which briefly describe the economic, educational, health, and religious background as well as the family size, and including success and problem descriptions attached to the caregiver's and child's lives.

In this light, may I request your favor in granting permission to conduct a survey, interviews and focus group discussions in Food for the Hungry Ethiopia, Zeway Child Development program areas with the selected respondents mentioned above? Just for your information, initially, in 2012 I shared this with the existing country Director, Mr. Thomas LePage who is now Africa Regional Director and received his permission to go ahead and other extended support.

I can assure you that I will make every effort to ensure that the study does not disrupt the working environment in any way and that any data collected will remain confidential.

I would greatly appreciate your kind consideration and support of my request. I pray that God richly blesses your ministries.

Gratefully yours,

AWEKE SOLOMON
PhD Candidate

LETTER TO THE DIRECTOR OF THE CHILD DEVELOPMENT PROGRAM,
FOOD FOR THE HUNGRY ETHIOPIA

December 2016

Dear Mr. Daniel Ashenafi,

Greetings in the name of our Lord Jesus Christ!

I am a student undertaking a Doctor of Philosophy (PhD) degree in Holistic Child Development at the Asia Graduate School of Theology (AGST). As part of my study I am carrying out research on the topic, “The Joy and Burden of Caring for Orphans and Vulnerable Children: A Case Study on the Wellbeing of Primary Caregivers in Food for the Hungry Ethiopia Child Development Program,” to complete a PhD in Holistic Child Development. The purpose of this study is to describe and measure the key wellbeing factors or domains of orphan and vulnerable children (OVC) primary caregivers and analyze the burden and joy that caregivers experience through their caring and nurturing role towards the OVC. The key research findings and recommendations will be presented to Food for the Hungry Ethiopia. A quantitative research methodology will be applied and data will be gathered from multiple respondents such as primary caregivers, children and key informants, which also includes the community level workers (secondary caregivers). Archival or supplementary data and information will be retrieved from the child’s personal case history and other up-to-date documents which briefly describe the economic, educational, health, and religious background as well as the family size, and also including success and problem descriptions attached to the caregiver’s and child’s lives.

In this light, may I request your favor in granting permission to conduct a survey, interviews and focus group discussions in Food for the Hungry Ethiopia, Zeway Child Development program areas with the selected respondents mentioned above? Just for your information, I also discussed these intentions with the existing the Country Director, Craig Jagers and received his permission to go ahead.

I can assure you that I will make every effort to ensure that the study does not disrupt the working environment in any way and that any data collected will remain confidential.

I would greatly appreciate your kind consideration and support of my request. I pray that God richly blesses your ministries.

Gratefully yours,

AWEKE SOLOMON
PhD Candidate

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CURRICULUM VITAE

Name: Aweke Solomon Tadesse
 Nationality: Ethiopian
 Date of Birth: 10th October 1974
 Place of Birth: Bale
 Church: Beira International Community Church
 Address: Beira, Sofala, Mozambique, Ave. Eduardo Mondlane
 E-mail: aweke3@gmail.com

Education

Ph.D. in Holistic Child Development	Asia-Pacific Nazarene Theological Seminary (Pending upon Dissertation Defense)
Master of Management (MCM)	International Institute of Church Management, India (2008)
Bachelor of Theology (Christian Education)	Evangelical Theological Collage (2002)
Diploma in Theological	Dilla Theological College (1996)
Higher Secondary School	Batu Terra, Ethiopia (1990)

Work Experience

Food for the Hungry	Provincial Programs Manager, Mozambique Beira (2014-present)
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Provincial Programs Manager (2014 – present)

Key accomplishments: Program and Performance Growth

- Program funding growth from \$ 800,000 to \$ 2.5 million;
- Number of orphan and vulnerable children growth from 6000 to 16000;
- Number of social workers working for the organization increased 15 to 53
- Performance improvement from 58% to 99%;
- Establishment of dynamic networking and partnership with sponsors, local institutions and provincial and district education, health, infrastructure and women and child affair offices; and
- Development of 5-year program budget plan and proposal.
- Manage over 105 technical and community level staff
- Lead USAID and WFP funded Food for Asset (FFA) and Disaster Risk Reduction Program in three district of Sofala (Dondo, Marromeo and Caia)

Organizational Learning and Knowledge Management Advisor (2012-2013)

Key accomplishments: identification of best practices of the organization

- OVC care and support program implementations;
- Community initiatives in small scale income generation activities;
- Established partnership and facilitate TOT with British Council and Crisis Care Training International (CCTI);
- Designed and conducted TOT for social workers and project coordinators on Cara and Support Strategies for OVC and their Primary Caregivers, and Parenting in Postmodern Context;
- Mobilized Religious Institution for OVC care and Support

Training Coordinator and Academic Initiative Country Assistance (2009-2011)

Key accomplishments:

- Mobilized and capacitated local institute and community leaders in Zeway, Yabello, Yergachefe, and Hosenna area for child protection, and orphan and vulnerable children care and support (establishment of OVC support in many local churches);
- Assisted American University student in their practicum field work; activities with vulnerable communities and developed the evaluation report; and
- Developed organizational capacity need assessment tool, delivered the actual assessment and reported to each department heads, and designed the action plan.

Education and Communication Officer (2007-2008)

Key accomplishments

- Helped the sponsorship program maintain on time child-sponsor correspondence communication and letter delivery;
- Develop the capacity of 17 social workers and partners skill in Zeway Child Development Program (CDP) areas;
- Conducted monthly community dialogues and OVC family Home visit in different Zeway CDP project sites; and
- Developed a tool used by social workers for tracking psycho-social support and holistic message delivery

Teaching and Training Coordinator (2005-2006)

Key accomplishments

- Developed Four (4) Child Behavioral and Ethical Development Training Booklets for Grades 1 to 5, and Teachers' Manual;
- Lecture on "The Fundamentals of Christian Education, Hermeneutics, and Homiletics"

Golden Oil Leadership Institute Manager (2004-2005)

Key accomplishments:

- Recorded and analyzed the leadership research data;

- Developed Leadership Course Curriculum; and
- Produced Two (2) Diploma Level Correspondence Courses books: Doctrine of Church and Eschatology, and Doctrine of God and the Bible.

Training And Certifications

- Orphan and Vulnerable Care and Support Intervention Program in Addis Ababa (March,24-31,2008) ;
- Value Chain Analysis, Marketing and Tradeeshow,Addis Ababa (December 16-18, 2008) ;
- Conflict Mitigation and Reconciliation,USAID, and FHI (October 21-23, 2012) ;
- FHI, Africa Academic Interative /GO-ED Confrance-, Kapala,Uganda (2008);
- Community Trasformation Strategic forum, at Nairobi (September, 2008);
- Certificate in FH's Vision, Mission and Value, Training Facilitation, Rwanda (April, 2009);
- Disaster Response Management and Emergency First Responder:NCM, Manila, Philippines (May 23-27, 2011);
- Project Cicle Management, in Mozambique (14-24, June 2015); and
- Theory of Change and Barrier Ananlyses in Ethiopia (10-21 August, 2015)

Language Proficincies:

- Amharic, English, Oromefa