

**Kinship Care for Orphans and Vulnerable Children in Ethiopia:**

**A Mixed Methods Study of Caregiver Coping**

BY

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DISSERTATION

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## **LIST OF ABBREVIATIONS**

AAHAPCO	Addis Ababa HIV/AIDS Prevention and Control Office
AIDS	Acquired Immune Deficiency Syndrome
CBOs	Community Based Organizations
CIA	Central Intelligence Agency
CWLA	Child Welfare League of America
ESTC	Ethiopian Science and Technology Commission
FBO	Faith Based Organizations
FDRE	Federal Democratic Republic of Ethiopia
FHAPCO	Federal HIV/AIDS Prevention and Control Office
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IDA	Italian Development Cooperation
MoFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
MoWA	Ministry of Women Affairs
NGOs	Non-Governmental organizations
OVC	Orphan and Vulnerable Children
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PEPFAR	President's Emergency Plan for AIDS Relief
PSI-SF	Parenting Stress Index Short Form
SPSS	Statistical Package for the Social Sciences

SS-B	Social Support Behavior Scale
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCRC	United Nation Child Rights Convention
UNDP	United Nations Development Fund
UNDP	United Nations Development Programs
WCQ	Ways of Coping Questionnaire
WHO	World Health Organization

## SUMMARY

Despite the valuable contribution of kin caregivers for orphans and vulnerable children in Ethiopia, little is known about their strategies for coping with the stressors that arise in the caregiving process. The purpose of this study was to examine and explore the stressors experienced by kin caregivers in Ethiopia and the available social support that helps them sustain their caregiving role and their coping processes. The study was guided by the stress coping conceptual framework and included social support as a buffering hypothesis. By using a concurrent, quantitative and qualitative mixed methods crosssectional design, the study explored and examined Ethiopian kin caregivers' experiences of coping. Further, the study explored kin caregivers' own experiences and understanding of the pathways and motivations that led them to assume caregiving responsibility for related children.

In the quantitative component, four questions and related hypotheses were addressed. The first question predicted that kin caregivers' scores on coping will vary based on whether they have a blood or non-blood relationship with the child. The second question examined whether kin caregivers' coping varies by their age, income, and ethnic background as well as whether there is an association between stress, social support and coping. The third question posited that stress and social support predict coping. Finally, the fourth question hypothesized that social support moderates the relationship between stress and coping.

Findings suggest that the first question and its related hypothesis were not supported. Results from a t-test show that kin caregiver scores on coping were not different based on their blood or non-blood relationship with the children in their care. Results from testing the second hypotheses related to the second question reveal that significant differences in coping were found by age group and a significant positive association was found between kin caregivers' social

## SUMMARY (continued)

support and coping. The hypothesis related to the third question was partially supported. While stress did not predict coping, social support did. The hypothesis related to the fourth question was not supported at all. Social support did not moderate the relationship between stress and coping.

Qualitative findings reveal that various issues such as living arrangement patterns, parents' inability to care for their own children because of HIV/AIDS, family expectations, and prior relationships with deceased neighbors were identified as major pathways that led kin caregivers to assume the caregiving role. In addition, lack of choice either to accept or decline the caregiving responsibility, and the opportunity to rear children were identified as major motivation factors that prompted kin caregivers to begin their caregiving role. In the quantitative analysis kin caregivers' scores on the Social Support Behavior Scale indicated a low level of social support. Qualitative findings supported this finding in that kin caregivers currently receiving support from formal sources indicated that the support was inadequate, irregular and lacked consistency. Although the majority of kin caregivers reported that they received support for one child, their overall perception was that they do not have support. Furthermore, kin caregivers identified their inability to provide food for the children and their lack of resources to provide close and habitable housing were experienced as major stressors. Caregivers of HIV positive children reported that the child's health as well as their inability to disclose the child's HIV status were sources of stress. Disclosure of orphan status as well as children's loss and grief were stressors for kin caregivers. Although kin caregivers reported that they use a combination of various coping strategies, praying was described as the most vital of the coping strategies.



## SUMMARY (continued)

In addition, the majority of kin caregivers used positive attitude and appraisal processes in response to the various stressors associated with their kin caregiving role. These findings provide insight into the caregiving process for kin caregivers in Ethiopia and have profound implications for future research, theory development, social work practice, social policy advocacy, and social work education in the country and beyond.

## **I. INTRODUCTION**

### **A. Background and Description of the Study**

In Ethiopia, enhancing the wellbeing of families and children is a growing issue of concern as the country remains one of the poorest nations in the world. The majority of the population is experiencing multiple risks and vulnerabilities as a result of pervasive poverty (Oxfam International, 2010). In 2009, Ethiopia's estimated annual per capita income was \$900 compared to \$1077 for all of sub Saharan Africa (Central Intelligence Agency [CIA], 2009; World Bank, 2010). The same report indicates that 37.8 % of the population lives on less than \$2 a day. Similarly, the United Nations Development Program's [UNDP] Human Development Report shows that Ethiopia scores low on human development, and ranks the country 171st out of 177 countries in all measures on the Human Development Index (HDI). The HDI measures the average achievements of countries in three basic dimensions of human development: constituting a long and healthy life; access to knowledge; and a decent standard of living (UNDP, 2009).

Amidst this pervasively difficult socio-economic context, HIV has continued to be one of the major socio-economic development challenges adding a significant burden to the Ethiopian society (Ministry of Finance and Economic Development [MoFED], 2006). Since 1986 when the first HIV cases were reported, the epidemic has shown a widespread impact, negatively affecting a large proportion of individuals and families in terms of their social, psychological, and economic wellbeing irrespective of differences in age, gender, ethnic, religious, and socio-economic background. After more than two decades of dealing with HIV/AIDS, Ethiopia has yet to capably address the complex and multifaceted effects of HIV/AIDS (Ministry of Health [MOH], 2006). According to Haldik, et al., (2006), AIDS is still among the leading causes of

death of Ethiopian youth and adults. Recent reports by the Federal HIV/AIDS Prevention and Control Office ([FHAPCO], (2009) show that the HIV/AIDS prevalence rate in the country is estimated to be 2.4 % constituting 7.7 % of the urban and 0.9% of the rural populations. In the year 2010, it was estimated that 1.2 million people in Ethiopia were living with HIV/AIDS of which 717, 669 were women and 72, 945 were children. After the advent of the HIV/AIDS epidemic, the number of orphaned children in the country escalated. The same report indicates that Ethiopia had an estimated 804, 184 AIDS related orphans ages 0-17 who have lost at least one parents due to AIDS.

The term orphan has several meanings based on the socio-cultural and economic reality of a given context. According to Back, Michaels, and Levine (1996) the term orphan originated from Greek and Latin and was used to mean “a child bereaved by the death of one or both parents” (p. 275). Williams and Wilkins (2000) indicate the existence of diverse understandings of orphan in the Sub-Saharan Africa context. The diverse use of the term orphan is also evident in Ethiopia. Drawing from a qualitative analysis of the lives of orphans and working children in Addis Ababa (urban community) and Gedeo (rural community), Abebe (2008) illustrates how the socio-cultural and economic context of Ethiopian communities determines the notion of orphanhood. This author argues that many children in a well functioning extended family network system did not consider themselves as orphans even when both of their parents have died. Abebe further argues that “...their identity as orphans is driven primarily by attempts to obtain the badly needed economic support that Non-Governmental Organizations might offer them” (p. 6). Abebe’s findings suggest that parental death does not suffice to define whether a child is an orphan or not in the Ethiopian context.

In addition, due to the fact that the majority of the population is experiencing difficult economic situations children who have lost one parent are exposed to similar levels of risk and vulnerability to that experienced by children who have lost both parents (Ministry of Women Affairs [MoWA], 2009). As a result, there is a general recognition among researchers, policy makers, and practitioners in Ethiopia that orphans and vulnerable children comprise an important sub-group of Ethiopian children who live under difficult circumstances and are in need of comprehensive psychosocial and economic support. Therefore, in the current study, the use of the term Orphan and Vulnerable Children (OVC) is crucial since it includes vulnerable children encompassing paternal orphans (children who lost their fathers); maternal orphans (children who lost their mothers); and double orphans (children who lost both parents), children whose biological parents are unable to provide appropriate care and support due HIV/AIDS and are currently under the care of their extended family members.

The situation of OVC in the context of the HIV/AIDS epidemic is alarming as the country lacks formal child welfare systems that provide appropriate psychosocial and economic services (MoWA, 2009; Radeny & Bunkers, 2009). Abebe and Aase (2007) indicate that lack of resources apparently limits the capability of the country to institute state administered comprehensive welfare programs for vulnerable and orphan children. In contexts where formal support is meager or doesn't exist, as is true in many poor developing countries, most vulnerable people rely heavily upon community and family relationships for care and support of individuals and families under difficult circumstances (Wood & Gough, 2006). By the same token, Ethiopia predominantly depends on the informal kin system for various forms of support (Bevan, 2006). Consequently, kin caregiving for needy family members including orphans and vulnerable children is the most available child care alternative in the country.

Kin caregiving for orphan and vulnerable children is a universally existing phenomenon exhibiting unique socio-cultural meanings in diverse settings. Kin caregiving has long been practiced without the involvement of formal authorities. However, it is only very recently, in fact mainly after the crisis of HIV/AIDS, that kin caregiving has gained significant attention among researchers in developing countries including sub-Saharan Africa (D'Cruz, 2002; Szapocznik & Miami, 2000; World Health Organization [WHO], 2002).

With regard to what constitutes kin caregiving, an anthropological account provides a definition for kinship as overarching networks of families, households, and social groups manifesting the principle of reciprocity beyond a single family relationship based on blood (Bowdon, 2004). Bowdon's conceptualization of kinship appears relevant as it helps to understand the extended family network as a system in which individuals are either related by blood, marriage or as a cultural network structure defined by the community as a fundamental social unit responsible for the wellbeing of its members beyond blood relationship.

In this study, however, kinship care is defined as "the full time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child" (Child Welfare League of America [CWLA], 2000). The kinship bond refers to family members who are related to orphan children by blood, by marriage, and by any other social tie. This definition is appropriate in this study as it provides an inclusive understanding of the living arrangements of children within the socio-cultural context of Ethiopian society.

Literature on kin caregiving for orphan children in Ethiopia is extremely sparse. However, a qualitative study that looked at the politics of orphan care through revisiting the extended family network system in the context of HIV/AIDS revealed that Ethiopian communities show

strong extended family network systems and have a history of sustained self-help support and coping mechanisms during various forms of social and economic crises, including HIV/AIDS (Abebe & Aase, 2007). This reveals that kin caregiving for orphans and vulnerable children is embedded within the existing culture of family care.

However, much remains unknown about the situation of Ethiopian kin caregivers who are providing care and support for orphans and vulnerable children. Specifically, the effect of caregiving on the kin caregivers themselves, available social support systems that help kin caregivers sustain their caregiving responsibilities as well as kin caregivers' coping processes have not been examined in Ethiopian context. Thus, the current study attempted to explore and analyze the pathways that led kin caregivers to assume their caregiving responsibilities, the effect of caregiving on the caregivers, available social supports, and their coping processes.

## **B. Statement of the Problem**

In Ethiopia, the past two decades have shown an increased awareness of the nature and effects of HIV/AIDS on the overall socio-economic development of the country, the family system, as well as individuals and children (MOH, 2007). The increased recognition of the devastating effects of the HIV/AIDS epidemic has been reflected in the country's key policy documents. The 1998 policy on HIV and the 2006 Federal Democratic Republic of Ethiopia Plan for Accelerated and Sustained Development to End Poverty (PASDEP) clearly show the country's commitment to undertake comprehensive intervention plans for HIV/AIDS prevention, treatment, and control (MoFED, 2006). In addition, the Ethiopian Alternative Childcare Guidelines indicate the commitment to deal with the ever growing number of orphan and vulnerable children affected by HIV and AIDS (Ministry of Labor and Social Affairs [MOLSA] & Italian Development Cooperation [IDA], 2001).

However, the country is not able to meet the needs of people living with HIV and affected family members, such as orphans and their caregivers, to a satisfactory level. Abebe and Aase (2007) argue, "...the role of the State in the care of orphans and other children in need in Ethiopia is minimal" (p. 2059). Another qualitative study by Gebre (2007), which explored the availability of services for people living with HIV and affected families, concludes that the capacity and efficiency of formal institutions are inadequate to fulfill the growing demand of people infected by the virus and their significant family members.

A recent report of progress toward implementation of the UN Declaration of Commitment on HIV/AIDS reveals the number of children who received support through various formal welfare service providers. According to this document, only 273,300 out of 898,350 HIV and AIDS affected orphans and vulnerable children were able to receive formal care and support, accounting for only 30.4% of needy orphans (FHAPCO, 2008). This is an indication that the majority of orphans and vulnerable children in Ethiopia are out of reach of the formal support system. These facts suggest meaningful questions, such as: Who is taking care of orphaned children who have no access to the formal care system? How did they (the families) end up with the caregiving responsibility? What are major stressors associated with the caregiving processes? What personal and social factors facilitate or hinder kin caregivers' ability to cope with their caregiving responsibilities? How well do kin caregivers cope with the responsibility of raising additional children?

In Ethiopia the amount of explicit and reliable research conducted to answer or explore the above questions has been minimal. Although a few qualitative studies reveal that relatives are the most available support system for most orphans and vulnerable children due to HIV/AIDS, they provide little information about the children's caregivers. The majority of the research

conducted so far considers children as the main unit of analysis (see, for example, Abebe & Aase, 2007; Gebre, 2007; Philipos, 2005). In other words, although these studies provided descriptive information on the caregivers' socio-economic and psychological condition, none of these studies looked in depth at the issue from the kin caregivers' perspective.

Specifically, none of the existing literature offers information about the effect of kin caregiving on the caregivers' general wellbeing and coping processes. No research has specifically explored the pathways that led Ethiopian kin caregivers to assume the caregiving role. No research study has attempted to examine the degree and direction of relationship between kin caregivers' age, gender, income level, marital status, ethnic background, relationship with the child, kin caregivers' stress, social support and the caregivers' coping levels. In addition, the type and amount of support that kin caregivers receive from either informal or formal sources is unknown and nothing is known regarding whether the perceived or actually received support moderates the relationships between stress and caregivers' coping when demographic variables are controlled. Thus, examining the effects of personal and social factors on kin caregivers' coping levels is vital in order to understand factors that affect how well kin caregivers are coping with their caregiving responsibility.

Understanding kinship care in the Ethiopian context requires a critical look, from the perspective of the caregiver, at the culture of caregiving practices that appear to force most relatives to assume caregiving responsibility as they are embedded within the prevailing socio-cultural and economic contexts of the country. Further, research that attempts to understand the Ethiopian kinship care system for children affected by HIV/AIDS requires both quantitative and qualitative exploration of the family system to develop empirical data.



### **C. Purpose of the Study**

The goal of the current study was to explore and examine the effects of kin caregivers' demographic and socio-economic factors such as age, gender, income level, ethnic background, and relationship to the child and social support on kin caregivers' coping. Moreover, the study explored kin caregivers' experiences that led them to engage in caregiving responsibilities and the extent of stress caused by the caregiving process. In general the study aims to generate a relevant and empirically supported analysis of the subject that could be helpful in improving policy provisions and practice interventions related to kin caregivers' well-being in Ethiopia. Specifically, the current study aimed to:

- a) Describe the socio-demographic and economic characteristics of kin caregivers;
- b) Explore the processes and pathways that led kin caregivers to assume the caregiving role for their related children affected by HIV/AIDS;
- c) Measure the degree of coping that exists among kin caregivers of children affected by HIV/AIDS in Ethiopia;
- d) Examine the relationships between caregiver income level, age, gender, ethnic background, relationship status, stress, social support and kin caregivers' coping;
- e) Examine relationship between kin caregiver gender, income, ethnic background, relationship to the child and caregiver's report of coping level;
- f) Explore the influence of social support on kin caregivers' stress level and coping.

### **D. Significance of the Study**

Taking into account the scarcity of kinship care related research in Ethiopia, this study attempted to explore and determine the main and moderating effects of social support on the relationship between kin caregivers' stress and kin caregivers' coping by controlling caregivers'

socio-economic and demographic characteristics. In addition, the current study explored the processes and pathways that led kin caregivers to assume the caregiving role for their related children affected by HIV/AIDS as well as their experience of stress and coping qualitatively.

As the first research study of its kind in Ethiopia, this study provides groundbreaking work to understand the experiences of kin caregivers to OVC affected by HIV and AIDS and factors that contribute to caregiver coping. This study has been designed within the guidelines of the social work profession in Ethiopia, and fits within the general codes and ethics of the social work profession.

Studies within the social work profession should aim to attain the prime goal of the profession, which is to enhance the psychosocial and economic wellbeing of all people by responding to the needs of vulnerable members of a society and people living in abject poverty (Fortune & Reid, 1999; Rubin & Babbie, 2008). According to Jenson (2006), studies serve the public good if they are geared towards advancing knowledge on particular social phenomena, inform practitioners toward effective practice interventions and service delivery, and help to foster change in social policy.

Guided by the general principles of the social work profession, this research has both scientific and social significance in five ways. First, the research expands the utility of the stress coping model as well as the buffering hypothesis of social support in the Ethiopian context. It is my belief that the process of testing the instruments and exploring the applicability of these conceptual frameworks will help produce empirically supported evidence that may be useful in making statistical inference as well as an interpretative analysis about kinship care for children affected by HIV/AIDS in Ethiopia.

Second, the research begins the development of a knowledge base about family care and the kinship system as an option for orphans and vulnerable children by attending to the lived experience of Ethiopian kin caregivers within the HIV/AIDS context, which will have great utility in social work education in the country.

Third, the research provides insight to inform the ongoing service delivery efforts by uncovering the predictive values of selected variables on kin caregivers' coping. This will help practitioners to develop intervention models to address specific stressors in the caregiving processes.

Fourth, the current study produces valuable information for policy advocates and policy makers to use in developing appropriate policy provisions at the local and national levels.

Fifth, the research suggests future research questions that could be used to examine the determinant factors associated with caregiving processes in a wider context.

## **II. LITERATURE REVIEW**

This section provides an analysis of relevant literature that deals with kinship care for orphans and vulnerable children in the context of the HIV/AIDS epidemic. The body of literature includes studies of kin caregivers/extended family care/relative care, orphans and vulnerable children's care, the HIV/AIDS epidemic and related crises, and orphans and vulnerable children in the context of HIV/AIDS. A broad and inclusive review of the literature was conducted using electronic database searches on the Project Muse and Psycho Info databases, JSTOR, Science Direct, EBSCOhost, multilateral aid donor agencies' archives such as UNAIDS, UNICEF, UNDP, and World Bank; reports and policy documents of the government of the Federal Democratic Republic of Ethiopia, and International Non-Governmental Organizations (INGOs).

This section presents what studies tell us about kinship care for orphans and vulnerable children in Ethiopia. However, studies from other countries are also considered. In addition, due to the scarcity of data to help us understand kin caregivers' motivation and pathways that lead them into caregiving responsibility and the effect of the caregiving process on caregivers' coping, studies outside of Ethiopia were reviewed. The section also discusses kin caregivers' stress, social support, and caregivers coping within the context of the caring for HIV/AIDS affected orphans and vulnerable children.

### **A. Kinship Care for Orphan and Vulnerable Children in Ethiopia**

#### **1. What do studies in Ethiopia tell us?**

Caring for orphan and vulnerable children has been the subject of discussion for several decades in Ethiopia. For example, in a book that examined the context of social welfare in Africa, in late 1980s, Quentin and Schenk (1987) based on their extensive review on Ethiopian

social welfare approach argue that Ethiopia is unable to ensure enhancing the quality of life for its citizens. This is mainly related to Ethiopia's inability to alleviate poverty and recurrent famine as well as being unable to institute an overall welfare system that ultimately enhances the well being of individuals, families, and communities. According to Quentin and Schenk, human problems outstrip the available resources. Since the country lacks resources and is highly dependent on foreign support, Ethiopia is not in a position to appropriate funds and institute formal welfare provisions to meet the ever-growing demands of the needy people. In their analysis, the authors pointed out that the severity of the problem for orphan children who have lost either one or both parents. Quentin and Schenk further assert "...although Ethiopia has a young age structure, and a growing population under age 15, the range of welfare services available to this group is extremely limited" (p. 15). Even two decades after Quentin and Schenk made such a conclusion, much remains the same in terms of meeting the needs of orphans and vulnerable children through the formal welfare system.

Seeling and Tesfaye (1994) in their critical analysis of Ethiopia's child welfare provisions, report that the most available care and support for vulnerable children is from the informal support systems. The informal support system represents Ethiopian communities' attempt to care for abandoned, displaced, and orphaned children without the involvement of legal authorities. According to Seeling and Tesfaye, relatives take the primary responsibility of caring for vulnerable children whether they are displaced or orphaned. When the extended family system fails to provide appropriate psychosocial services for vulnerable children, the children often begin to live on the street.

In addition to informal kinship care, Seeling and Tesfaye (1994) discuss reunifying displaced and street children with their extended families as a major set of strategies established

to help orphans and vulnerable children. According to Seeling and Tesfaye, although foster care and adoption have been tried in the country, both care options are the least-favored practices among Ethiopian communities due to two major reasons. First, the principle of blood in which families prefer to raise children related to them by blood and are unwilling to take somebody else's child. Second, many Ethiopians tend to avoid the additional responsibility of taking care of unrelated children because they live on a subsistence level economy. Seeling and Tesfayes' analysis suggests that the formal child welfare system is too unresponsive and underdeveloped to address needs and problems of vulnerable children whereas kinship care serves as a major child care approach.

Quentin and Schenk's (1987) as well as Seeling and Tesfaye's (1994) work is based on secondary data sources lacking empirical evidence to support their claims. However, looking at Quentin and Schenk (1987) as well as Seeling and Tesfaye's (1994) work, reveals the need to inquire about how the country is dealing with the enormous number of orphans and vulnerable children amidst the HIV and AIDS epidemic.

Scientifically rigorous and empirically supported data that provides a comprehensive understanding of the situation of alternative care for orphans and vulnerable children in contemporary Ethiopia are extremely scarce. However, a few, mostly qualitative studies illustrate that Ethiopian communities are utilizing their traditions of age-old values of supporting vulnerable members of the family including orphans and vulnerable children through the kinship system (Abebe, 2008; Abebe & Aase, 2007; Gebre, 2007; Philipos, 2005). Extended family/kinship care is the obvious social safety net available for orphan and vulnerable children. The kinship bond includes family members related with the orphan children either by blood, marriage, friendship, and or other deliberately created social ties.

A qualitative study that examined the care of orphans through revisiting the extended family system in Ethiopia with particular references to Addis Ababa (urban community) and Gedeo area (rural community), identified two sets of extended family network structures (Abebe & Aase, 2007). The first family network includes kinship ties based on blood encompassing “front-line” family members and relatives such as uncles, aunts, grandparents, and cousins. This kinship pattern also includes distant relatives related to a given family based on marriage. Another kinship structure apparent among Ethiopian communities is a deliberately created social tie with no blood relationship with each other. Families deliberately create social ties that would help them support each other in times of happiness and sorrow.

Speaking about the kinship structure in Ethiopia, one should bear in mind that the country is a multiethnic and multicultural society exhibiting distinctive social structures. Although published literature is unavailable on the kinship structure of various ethnic groups, the work of Levine (1972, 2000) on Ethiopia illustrates how the Amhara and Oromo family systems use the kinship structure to support family members in times of crisis. As Levine aptly describes, the kinship system among the Amhara offers a sense of reciprocal obligations among relatives who are in good terms through helping one another in times of family crisis including caring for orphan children. Whereas, the kinship structure among the Oromo ethnic group operates differently in a way that the entire clan looks after for the wellbeing of members as corporate a body. Understanding kinship care for orphans and vulnerable children in Ethiopia requires a broader understanding of the community-based response to the orphan crisis due to the HIV and AIDS epidemic. Abebe and Aase (2007) highlight the contextual reality of the caregiving and care-receiving processes through an in-depth exploration of the socio-economic context of the Ethiopian extended family system currently caring for orphan and vulnerable children. Abebe

and Aase categorize caregivers as rupturing, transient, adapting, and capable family. According to the authors, the rupturing families represent most families who already affected by chronic poverty; whereas the transient families are in relative poverty characterized by female headed and grandmother headed families. Adaptive families are well off in terms of their economic capacities compared to the previous categories. Finally, capable families are not in need of any kind of external support in caring for the orphan children. These categories of Ethiopian families shed light on the understanding of the socio-economic variations on the capabilities and challenges evident among kin caregivers in the process of providing care for orphan children. In addition the categorization helps to understand the overall effectiveness and functioning of kinship care in the context of the HIV/AIDS. Another qualitative study by Philipos's (2005) also indicates that the majorities of orphans and vulnerable children are being cared for by the extended family system/kinship care.

With the prime objective of understanding the notion of caregiving within the cultural context of Ethiopian family system, Aga, Kylma, and Nikonnen (2008) conducted an ethnographic study involving an in-depth-interview of twelve caregivers. Grounded in the lived experience of family caregivers for people living with HIV and AIDS, the authors highlighted how caregivers within the extended family system provide care and support that apparently rivets their role for the wellbeing of the family system in general and the person in need in particular. As a culturally and morally appropriate responsibility, study participants in the Aga et al. study conceptualize caregiving as nourishing the care receivers, maintaining cleanliness and hygiene of the person; comforting the care receivers, and sacrificing self to sustain the person.

Although the Aga et al. (2008) unit of analysis is the relative caregiver for persons living with HIV and AIDS, their findings would definitely transcend to the life trajectory of the wider



defined group of kin caregivers for children affected by HIV/AIDS. Ethiopian caregivers' perspective of care evident in the Aga, et al. study highlights how caregivers provide more value for meeting the basic survival needs of care receivers as well as focusing on hygiene and sanitation. These major themes emanate out of love and affection that obviously exists within a familial relationship. Further, the notion of scarifying oneself for the wellbeing of the care receiver indicates kin caregivers' commitment while struggling with poverty.

## **2. Is Kinship Care for Orphans and Vulnerable Children Viable in Ethiopia?**

While inquiring about the knowledge base of kinship care for orphans and vulnerable children in Ethiopia, opposing views on the viability of kin caregiving as an alternative child care approach were noticed.

On the one hand, Abebe and Aase's (2007) empirical finding on the politics of orphan care clearly demonstrate the resilience of the Ethiopian extended family system in caring for orphan children within the context of HIV/AIDS. Abebe and Aase illustrate kin caregiving in Addis Ababa and Gedeo is not a linear process where the extended family members provide care and support; whereas the orphan and vulnerable children receive care. According to the authors, the kin caregiving process involves a dynamic relationship between relatives as "caregivers" and orphan children as "contributors" to the household labor. This dynamic relationship as caregiver and household labor contributors probably creates opportunity to trade-off and balancing the burden that could be associated with the caregiving responsibility. The dynamics of the caregiving/care receiving process between kin caregivers and orphans and vulnerable children may be apparent for older children who can contribute their labor to the household economy. Furthermore, Abebe and Aase assert that the extended family system can and is providing psychosocial and economic care for orphans and vulnerable children in the era of HIV/AIDS.

Abebe and Aase's (2007) investigation is not without limitations. Their entire analysis is based on qualitative data obtained through an open ended questions, observation, and focus group discussions. A total of 42 orphans, 12 social workers, and 18 heads of households were involved in the open ended questions. Although the study provides an insight regarding the dynamics of the orphan care situation within extended family structures, the study is not sufficient to make any generalized statement about Ethiopian kin caregivers.

In another account, based on an extensive review of available literature on the overall Ethiopian community response for orphans and vulnerable children due to HIV/AIDS, Varnis (2001) asserts that the extended family care/kinship care system in Ethiopia is incapable of fulfilling the needs and problems of orphans and vulnerable children. Varnis describes the kin caregiving system for HIV and AIDS affected orphans in Ethiopia, as an old and traditional approach. The author argues that the family based care arrangement for orphans and vulnerable children is both inadequate and lacks a proper understanding of children's needs. For Varnis (2001) the Ethiopian response to the orphan crisis due to AIDS through a family based approach has two major limitations. Varnis states:

First, it often is based on an outdated understanding and assessment of the capabilities of traditional institutions to care for children. Second, it provides inadequate protection and condones a variety of arrangements that are inconsistent with the needs and interests of orphan children (p. 143).

Varnis's (2001) proposal to establish a caregiving arrangement that would ensure the best interests of the child through meeting their physical, psychological, emotional, and economic needs would be ideal. However, the author's claim that Ethiopian society's reliance on the extended family based interventions to care for orphan children are an outdated approach is naive

and subjective. This is because Varnis's assertion suffers from lack of empirical evidence. Methodologically it appears the author made a conclusion without trying to understand kin caregivers' and orphan children's' perspectives on the caregiving process empirically. It further connotes a value bias that disregards the social support mechanisms of the Ethiopian family system that has sustained kinship care for a very long period for orphan children due to a variety of reasons. The Ethiopian kin caregiving system is embedded within the socio-cultural and economic contexts and requires a comprehensive and scientific understanding to judge both its merits and its limitations.

Therefore, supporting or rejecting these opposing views of kinship care as viable or incapable for orphan and vulnerable children in Ethiopia without adequate information and more representative sample of the Ethiopian kinship caregivers would be unrealistic. In order to support or reject, it is important to critically examine the caregiving responsibilities within the totality of the social and cultural values.

Without any doubt, the economic incapability of the majority of caregivers extremely limits their ability to provide adequately for the physical, emotional, and psychological needs of orphan children. However, the poverty situation of kin caregivers should not bias our understanding of the Ethiopian culture of kin caregiving. Kinship care in the Ethiopian context is embedded within the socio-cultural and economic context of the Ethiopian family system forcing relatives to assume greater responsibility for the provision of psychosocial and economic care of children affected by HIV/AIDS. Thus, kinship care is not a matter of choice. In addition, any analysis regarding the viability of kin caregiving as alternative child care option takes the unavailability and inadequacy of the formal social welfare services in to consideration. Therefore,

kin caregiving for orphan and vulnerable children is inevitable in the effort to address the needs of orphans and vulnerable children in Ethiopia.

### **3. What do we know about Alternative Care Strategies for Orphan and Vulnerable Children in Ethiopia?**

The kinship care practice that naturally occurs within the extended family system networks and mostly without the involvement of formal authorities. Knowing that Ethiopia is a non-welfare state and observing the increasing number of orphans and vulnerable children in the country, it is crucial to ask what other forms of care system are available for orphans and vulnerable children in Ethiopia apart from the kinship system.

With regard to the formal structural response for orphans and vulnerable children care in the country, practitioners and policy makers have been advocating for the establishment of legal and policy provisions that helps address the growing needs of orphan and vulnerable children. Accordingly, the country issued the 1995 Developmental Social Welfare Policy (MoLSA, 1995) that clearly made orphans and vulnerable children of the top on the government agenda. One of the major provisions of the policy was the recognition of orphan children as the most vulnerable segment of the Ethiopian population whose social welfare is the priority concern of the government. The establishment of the Federal Democratic Republic of Ethiopia [FDRE] constitution issued in 1995 was also a great achievement demonstrating the political will of the country that intends to promote children's socio-cultural and politico-economic wellbeing comply with the United Nation Child Rights Convention (FDRE, 1995).

Right after the global community set out new millennium development goals in the year 2000, Ethiopia developed the first Sustainable Development and Poverty Reduction Program and

the second phase in the year 2002 and the second phase on 2006 respectively making child welfare the central agenda of its poverty reduction effort (MoFED, 2002, 2006).

Furthermore, the 2009 Alternative Childcare Guidelines (ACG) identify community based child care, reintegration and reunification, foster care, and adoption and institutional care services as alternative care options for orphan and vulnerable children. Institutional care has been indicated as the last resort (MoWA, 2009). The ACG sets a standardized child care approach for practitioners and caregivers within the rights based perspective that enables orphans and other vulnerable children seek the fulfillment of their own rights as stipulated in the supreme law of the country that incorporate the United Nation Convention on the Rights of Children (UNCRC). The new ACG provisions are deliberately developed to reflect the basic principles of UNCRC i.e. “the best interest of the child, non discrimination, survival and development of the child, and child participation” (p.7).

Despite the country’s commitment reflected in the aforementioned legal and policy documents, data suggest that formal and appropriate welfare services are extremely scarce to address the social, psychological, and economic needs of vulnerable children in general and children affected by HIV/AIDS in particular. Abebe and Aase (2007) illustrate that government administrated support systems for the care of orphans and other vulnerable children in the country are minimal. The authors indicate that lack of resources apparently limits the capability of the country to institute a state administered comprehensive welfare programs for orphans and vulnerable children.

However, the involvement of charity organizations such as Non Governmental Organizations (NGOs), traditional Community Based Organizations (CBOs), and Faith Based Organizations in the provision of welfare services for vulnerable members of the Ethiopian

society including orphans and vulnerable children is worth mentioning (Abebe, 2007; Gebre, 2007; Gebre, 2007; Philipos, 2005). In addition, the introduction of the President's Emergency Plan for AIDS Relief fund (PEPFAR) facilitated the country to progress in availing appropriate formal support system for orphans and vulnerable children affected by HIV and AIDS (FHAPCO, 2008).

However, these organizations are not in a position of providing comprehensive supports for the needy children and their caregivers. Abebe and Aase (2007) argue that even those available non-governmental organizations lack coordinated and coherent principles and are operating with limited outreach and are unable to address the needs of the most affected children especially rural children.

Although the existing data shows that the situation of the formal social support mechanisms in Ethiopia is inadequate to enhance the wellbeing of orphans and vulnerable children, none of the aforementioned studies, however, rigorously examined the role of non-governmental organizations on the child welfare issues using representative sample.

**B. What do Studies outside of Ethiopia tells us about kinship care for orphans and vulnerable children?**

Despite the greater contribution of kin caregiving for orphan and vulnerable children in the context of limited formal social support in Ethiopia, the lack of sufficient and rigorously conducted studies limit our understanding about the pathways that led kin caregivers in assuming the caregiving responsibilities as well as the effect of caregiving on kin caregivers. Thus, I reviewed studies with methodological significance and that pertain to kinship care for orphans and vulnerable children conducted outside Ethiopia mainly from Sub Saharan Africa, North America, and other developing nations.

# **1. Kinship Care for Orphans and Vulnerable Children in Sub Saharan Africa**

Sub-Saharan Africa is the region most affected by various problems such as poverty, famine, war, and HIV/AIDS (Liard, 2006). The 2007 World Human Development Report states that sub-Saharan Africa is far behind other regions in the world on key development measures such as income/poverty, child mortality, and health care indicators (UNDP, 2007). The same report shows that more than 100 million people in sub-Saharan Africa live on less than \$2 per day.

HIV/AIDS remains one of the major challenges that sub-Saharan African countries face. According to the 2007 global AIDS epidemic report, sub-Saharan Africa alone constitutes 67% of the 33 million people living with HIV globally (UNAIDS, 2008). HIV/AIDS is one of the leading causes of death in the region. Accordingly, in 2007 alone of the 2 million people who died of AIDS, 75% were in sub-Saharan Africa. Moreover, this region accounts for 90% of the 2 million children who live with HIV globally. Sub-Saharan Africa also recorded 1.7 million new infections of HIV in 2007. With regards to the prevalence of orphan children who lost either one or both parents due to AIDS, out of 15 million worldwide, 11.4 million children are in sub-Saharan Africa (UNAIDS/WHO, 2007).

Social welfare systems are not well developed in sub-Saharan African countries. As a result the family system is the most available safety net and provides the primary caregivers for sick individuals and orphan children due to HIV/AIDS (Mutangadura, Mukurazita & Jackson, 1999). Several other reviews that focused on the survival strategies of the region with specific emphasis on the HIV/AIDS epidemic confirm that household and the family system function as the primary social and economic supports for family members including orphan and vulnerable

children (see for example Atwine, Cantor-Graae & Bajunirwe, 2005; Liard, 2006; Lombe & Ochumbo, 2008; UNICEF, 2006; Velkoff & Kowal, 2006; Zimmer & Dayton, 2003).

Many of the studies do not provide explicit empirical data that could help to explain the prevalence and magnitude of caregivers providing care for vulnerable and orphan children. However, at least two studies estimated that 90% of orphans and vulnerable children are being cared for by the extended family network system (Monasch & Boerma, 2004; UNICEF, 2006).

## **2. Kinship Care in sub Saharan Africa for Orphans and Vulnerable children: Viable vs. Incapable?**

Considering the pervasive poverty of most sub-Saharan African countries and the poor economic status of most kin caregivers as a reference, several authors question the caring capability of the sub-Saharan Africa kinship system to meet the needs of the growing number of vulnerable children. In addition, several authors claim that the sub-Saharan African extended family system is over strained due to the HIV/AIDS epidemic, which produced a huge number of adults and orphan children needing care in the past two decades (Gilborn, 2002; Liard, 2006; Monasch & Boerma, 2004). For these writers, informal kin caregiving is becoming less viable as a child welfare approach is needed to provide appropriate economic and psychosocial care for the increasingly growing large number of orphan children.

A study among caregivers and orphan children in western Kenya shows that significant numbers of caregivers, mostly grandparents, are incapable of providing appropriate care for themselves and the orphan children living under their care (Nyambedha, Wandibba, & Agaard-Hansen, 2001). This study found that the orphans being cared for by their relatives faced problems related to food, clothing, schooling, and health care. Monasch and Boerma's (2004) study made similar observations. Their analysis focused on data collected in 37 countries during



1999–2002, including 23 Multiple Indicator Cluster Surveys 14 Demographic Health Survey of orphanhood and childcare patterns in 40 sub-Saharan African countries. The findings illustrate that almost half of the caregivers who participated in the survey report they are challenged in meeting the overall needs of the orphan children under their care.

Liard (2006), in a critical analysis that looks at the traditional family system as social welfare approach, expressed concerns about the viability of the extended family system in the context of HIV/AIDS that disproportionately affecting sub-Saharan Africa. For Liard, until recently when the region experienced severe HIV/AIDS crises, previous experiences demonstrate the capabilities of the sub-Saharan Africa family system as a viable welfare system in responding to various socio-economic crises. However, the additional burden of the HIV/AIDS epidemic is increasingly limiting the likelihood of the extended family system to serve as a welfare mechanism.

Authors who promote the incapability notion about the sub-Saharan Africa kinship systems for orphans and vulnerable children claim that the family system as a social and economic safety net has been weakening due to the prevailing poor economic context of the region. Proponents of the incapability argument often cite the growing number of children who are unattended by the family system and living on the street as well as the emerging new phenomenon of “child headed households” as evidence (Foster & Williamson, 2000; Gilborn, 2002; Mutangadura, 2001). Since the advent of the HIV/AIDS epidemic, the number of street children and child headed households has grown at an alarming rate, increasingly straining the capability of the extended family system amidst the pervasive poverty.

On the other hand, several groups of writers assert that despite the challenges, the extended family system still can and is actually in the forefront and providing economic and

psychosocial support for orphans and vulnerable children in the era of HIV/AIDS. For these scholars looking at the strength of the extended family system is the central theme (Chirwa, 2002; Mdhayan, 2004). Supporters further cite a discussion point on how to enhance and extend the continuity of the extended family system through creating culturally relevant and innovative ways to deal with the prevailing challenges.

For example, Chirwa (2002) and Mdhayan (2004) amplify the strength of the sub-Saharan Africa family system that sustains the legacy of caring for the family members including children among the sub-Saharan African societies. For these authors, the sub-Saharan African society sustained the culture of caring for vulnerable children amidst various socio-economic and political crises, including the HIV/AIDS epidemic. For Chirwa (2002) sub-Saharan African societies often show innovative and adaptive capability corresponding to emerging challenges including AIDS induced orphanhood. The sub-Saharan Africa family system is not totally broken; rather it is creating a new process of adaptive mechanisms. Despite the challenges in fulfilling the needs and problems of orphan and vulnerable children through traditional family based care, it appears that embracing the value of the kinship care system in sub-Saharan Africa is preferable to abandoning it.

Concisely, both arguments hold true. The prevailing socio-economic status of most sub-Saharan African countries that are repeatedly affected by recurrent draught/famine and civil war coupled with the overwhelming negative impacts of the HIV/AIDS epidemic notably affects the caring capability of the family system for orphans and vulnerable children. At the same time, sub-Saharan African countries demonstrate a strong social and cultural heritage of the family system sustaining care for vulnerable children even amid the existing difficulties. Magnifying the

strength of the extended family by recognizing the family system as an important resource would help to reconfigure and build kin caregiving as a viable strategy.

**C. Pathways and Motivations for Caregivers to Assume the Caregiving Role**

Despite the challenges associated with caring for orphans and vulnerable children, members of the extended family network system generally step in assuming needed caregiving responsibilities. Thus, it is important to inquire why kin members take on the caregiving responsibility while struggling to attain basic services for their own survival. The literature refers to motivation and reasons for providing care; the term “pathway” is used to describe the circumstances that lead the caregiver to take on the caregiving responsibility.

In most societies, kinship care is part and parcel of the larger socio-cultural system that continuously promotes the extended family system involvement in caring for people unable to care for themselves including people both infected and affected by HIV/AIDS. Reasons for pathways that led relatives to take on the caregiving responsibility vary. Globally, studies reveal several motivation factors that lead kin caregivers to engage in the caregiving responsibility such as keeping the family ties, bonds, family identity, and children’s sense of belongingness, need for extra household labor, and spiritual influence (Backhouse, 2006; Gleeson, et al., 2008; Goodman & Silverstein, 2002; Musil & Ahmad, 2002; Spence, 2004).

Reasons associated with keeping children safe, ensuring their well-being, providing a sense of belongingness, and sense of obligation or family legacy are universally recognized motivational factors.

**1. Keeping Family Ties, Bonds, and Children’s Sense of Belongingness**

Globally, the family system as a fundamental social institution has a greater commitment in maintaining the continuity of intergenerational relationships through extending

support for orphaned and abandoned children. Studies in the Middle East (Al-Adili, Shaheen, Bergstrom, & Johansson, 2008) in India (D'Cruz, 2004), in Australia (Backhouse, 2006; Spence, 2004) among the African American community in the US (Gibson, 2005) confirm kin caregivers commitment to keep the family tie, legacy, and identity of children. Based on an assessment of 73 programs engaged in caring for over 100,000 vulnerable and orphaned children in Malawi, Beard (2005) concludes that the model of care that the Malawi community prefers is a community based orphan care because it allows children to stay in a family environment in their own village and tribe.

Similarly, within the framework of maintaining the family ties and relatedness, Varnis (2001) observes the existence of a strong collective responsibility that obliges members of the Ethiopian extended families within the kinship system to make the necessary arrangements for children who have lost either one or both parents. For Varnis, the belief and practice of kinship care for orphan children, as a morally correct and necessary means of maintenance of intergenerational relationships, is a principal motivating factor that relatives use to assume the caregiving role for orphan children. Varnis's observation about intent of preserving the family bonds and reinforcement of a child's sense of identity is also consistent with other studies on caregiving for person living with HIV/AIDS and orphan children (Abebe & Aase, 2007; Philipos, 2005).

## **2. To add an extra household labor**

Children's contribution of labor in productive activities and household chores is another motivating factor for members of the extended family system to take the responsibility of orphan care in most sub-Saharan Africa including Ethiopia. Available literature on orphan children and the extended family systems in sub-Saharan Africa, where the majority of

households live on subsistence farming and other non-agricultural means of livelihood confirm that children's labor is an important asset throughout the region (Abebe, 2005; Juma, Okeyo, & Kidenda, 2004); Lombe & Ochumbo, 2008; Miller, et al., 2006; Varnis, 2001). Based on a qualitative study in Ethiopia, in Gedeo district, Abebe and Aase (2007) assert:

Most children including orphans in Gedeo work in backyard gardens and on the coffee farms of their own households as well as undertaking work for cash for other families who lack labor. Children's labor in coffee production is particularly welcomed because picking coffee beans is a tedious, labor-intensive job at which children are considered more adept than adults. ...children are also engaged in diverse household reproduction activities including childcare, care for ailing relatives, cooking, fetching water, cleaning, etc. as part of the social responsibility, which is structured on the basis of age and gender (p. 2066).

Orphans and vulnerable children's contribution for caregivers household survival strategy introduces reciprocity that captures the relationship between caregivers and orphan children in Ethiopia, i.e. caregivers provide basic services in return, children will contribute their labor. Abebe and Aase's (2007) work on the extended family explicitly discusses that the fundamental relatives' caregiving role for vulnerable children within the framework reciprocity involving a two way "care-giving" and "care-receiving" processes between kin caregivers and orphan and vulnerable children. Although the existence of mutual support within the extended family network systems provides insight for further conceptualization of kinship care process, Abebe and Aase's study that predominantly employed a qualitative research design, doesn't allow us generalizing towards the larger population of Ethiopian caregivers. Although the review of literature permits us to understand the nature of the caregiving process embedded within the culture of reciprocity, it further poses an important question that needs empirical investigation using representative sample.

#### **D. Caregiver Stress, Social Support, and Coping Mechanisms**

Globally, studies indicate a growing concern about the wellbeing of kin caregivers who are providing care for orphans and vulnerable children (Foster & Williamson, 2000; Shetty & Powel, 2003). Empirical evidence suggests that kinship caregivers who are providing care for their relative orphans and vulnerable children are at high risk of experiencing emotional, physical, and economical distress.

Although studies in Ethiopia do not provide explicit understanding on the situation of caregivers for orphans and vulnerable children, exploring stress emerging due to the caregiving process and caregivers coping mechanism will be instrumental to better understand kinship care in the country. As a result, the following section provides a review of studies that focus on caregivers stress, social support, and coping globally.

##### **1. Caregiver stress**

A variety of factors contribute to caregiver stress. In a qualitative study of seventeen caregivers affected by HIV/AIDS and eleven non HIV/AIDS affected caregivers, Linsk and Mason (2004), discovered a combination of emotional and behavior issues as major stressors. Specifically, Linsk and Mason identified child behavioral problems, concern for their own health and multiple roles, HIV related concerns, emotional difficulties, and abuse as caregivers' stressors. Kelley, Whity, and Sip (2000) investigated predictors of psychological distress among 102 African American grandmother kinship care providers. They found that caregivers with fewer resources, less social support, and poorer physical health tend to experience higher levels of psychological distress. Lack of adequate social services is another factor associated with caregivers' depression (Poindexter & Linsk, 1999).

Caregiving for vulnerable children by itself is a very complex phenomenon that involves multiple responsibilities. Fulfilling multiple responsibilities increases caregivers' burden. Available literature suggests that caregivers' burden is significantly associated with caregivers' depression (Cimmarusti, 1999; Hong, 1995; Minkler et al., 2000).

According to Berrick (1997) children in kinship care exhibit greater behavioral problems than children in the general population. As a result, caregivers often deal with emotional fluctuations resulting from behavioral difficulties of their relatives' children. Similarly, Petras (1999) in her article based on a study of 80 kinship caregivers indicates child behavior problems is a significant predictor of caregivers' depression. In addition, kinship caregivers are characterized as the most vulnerable population who are living in poverty (Cuddeback, 2004).

Ehrle and Geen (2002) in their study also note that most kinship caregivers experience high levels of financial and housing difficulties further affecting their health status. Financial hardship limits kin caregivers' ability to meet the needs of children in their care. Financial difficulties coupled with children's behavioral problems increase caregivers' depression (Shore, Austin, Huster, & Dunn, 2002). One study that examined the depression level between rural Native American and European American grandparents caring for their grandchildren, revealed that total time providing primary care to grandchildren, household income, and race were the most significant predictors of caregiver depression (Letiecq, Bailey, & Curtz, 2008).

Although empirical evidence derived from the examination of stressors using a standardized measure are nonexistent, studies in sub-Saharan African countries including Ethiopia identify poverty as a major source of stress profoundly affecting the general wellbeing of kin caregivers (Abebe & Aase, 2007; Cluver & Gardner, 2007; Miller, Gmskin, Subramanian, Rajaraman, & Heymann, 2006; Philipos, 2005). Further, the caregiving responsibility itself

coupled with their poor financial situations appear to elevate caregivers' frustration (Oburu, 2005; Morre & Henry, 2005).

Kuo and Operario (2010), in their recent qualitative exploratory study of challenges faced by caregivers conducted in KwaZulu-Natal, South Africa, interviewed carers in non-governmental organizations and community based organizations that provide services to carers. They also conducted a focus group of adult carers of children who were orphaned due to AIDS. The authors found that the caregivers encountered economic challenges, challenges related to children's needs, and physical and mental health challenges. The economic challenges include poverty, lack of food, shelter, clothing, shelter, unemployment, transport, as well as school fees and uniforms. Challenges associated with children's needs include sexual abuse of children, disciplining of children, and children's physical needs. Challenges associated with physical and mental health include carer bereavement, fatigue and stress due to caring for children, stigma, and carers' physical health problems.

Lack of adequate formal welfare services for families and children, heavier workloads, multiple losses of family members, physical and mental health of older caregivers are also identified as major stressors (Gebre, 2007; Juma, Okeyo, & Kidenda, 2004; Philipos, 2005; Ssengonzi, 2007). Miller et al. (2006) conducted a secondary data analysis among 1033 working adults, who were caring for orphan children in the context of HIV/AIDS in Botswana. Results show major negative outcomes for kin caregivers such as financial difficulties, caring for multiple orphans, caring for sick adults and orphans simultaneously, receiving no assistance, and low income. In addition, lack of decent housing and inability to meet basic needs such as food, clothing, health care services and education increases the stress of kin caregivers in Kenya (Juma, Okeyo, & Kidenda, 2004).



The burden of a heavier workload because of caring for orphans is another challenge for kin caregivers. Ssengonzi (2007) conducted a qualitative analysis based on a focus group and open ended questions of elderly caregivers for people infected with HIV and affected children in 10 rural and urban communities within two Ugandan districts. The findings suggest that the responsibility of care for children begins while their parents are alive but are continuously sick and unable to take the primary responsibility of caring for their own children. This double responsibility of caring for the sick adult as well as caring for their grandchildren negatively affects older adult caregivers economically, emotionally, physically, and nutritionally, adversely affecting the caregivers' physical and psychological wellbeing.

The first systematic review of research literature on those who care for children orphaned due to AIDS in developing countries, including Ethiopia, was conducted by Kuo and Operario (2009). Their study shows that caring for orphaned children has serious impacts such as higher dependency burden, relocation of family members to a household, financial difficulties due to provision of care, and chronic health conditions. In addition, the authors conclude that due to the pre-existing levels of economic hurdles, additional caregiving duties become a burden, increasing caregivers' economic and psychological level of stress.

Multiple losses of members within the extended family system, profoundly limit the emotional capability of kin caregivers, which negatively affects their ability to maintain a healthy relationship with children under their care (Chirwa, 2005). Studies from Cape Town, South Africa and Togo show caregivers experience increasing physical and mental health problems due to stress emanating from the caregiving process (Cluver & Gardner, 2007; Hosegood & Timaeus, 2006).

Lombe and Ochumbo's (2008) critical analysis on the challenges and opportunities of the sub-Saharan Africa orphan crisis, indicate prevailing challenges of kin caregivers in caring for orphan children should be conceptualized within the broader context and magnitude of the socio-economic problems of the region. The authors say:

The major challenge presented by sub-Saharan Africa's orphan crisis is best conceptualized in terms of problem magnitude vis-à-vis the lack of capacity of both government and familial systems of care. Many governments in affected countries simply do not have the capacity to deal with the large number of orphans (p. 688).

Lombe and Ochumbo's (2008) findings regarding the inevitability of kin caregivers' challenges embedded within the broader socio-economic context helps to clarify the severity of the problem. The limitation of governmental capability to assure the welfare of children often places pressure on the private family system in meeting the basic needs and psychosocial needs of orphan children adversely affecting the physical and psychological wellbeing of caregivers.

In summary, the published literature on kinship caregivers of children affected by HIV/AIDS consistently finds that caregiving with these children is stressful, especially for older adults. Major sources of stress for these caregivers include poverty and the resultant inability to meet the basic needs of both caregiver and child, physical and mental health limitations, loss and grieving, as well as behavior problems of the children in care. One of the most often cited symptoms of stress among kinship caregivers is caregiver depression.

## **2. Social support**

Studies have highlighted the buffering role of social support for a person encountering negative outcomes of difficult life circumstances over the last quarter century (Cohen & Wills, 1985; Hobfoll & Vaux, 1993; Lazarus & Folkman, 1984). Various authors conceptualize social support differently. Hupcey's (1998) analysis on the various conceptualizations of the notion of social support reveals the existence of five major categories:

1) types of social support provided, 2) recipients' perception of social support, 3) intentions or the behavior of the provider, 4) reciprocal support, and 5) social networks. Conceptualizing social support either as perceived, actually received, intention of the provider, or network systems will definitely lead the research in different paths. Hupcey also notes the danger of viewing social support as a one-way linear process. For Hupcey, social support encompasses the notions of relatedness and reciprocity from the provider as well as the receiver. Similarly, Cohen and Wills (1985) assert that the way we conceptualize and measure the construct of social support affects the results.

Vaux (1988) discusses social support as three sub-constructs constituting social support network resources; supportive behaviors; and subjective appraisal of support (Vaux, 1988). Support network resources represent the availability of social relationships that are ready to offer support for members of the social network in times of need in a stable manner. In addition to the availability of support and social relationships, perception of social support is important in the support network resources. Supportive behaviors on the other hand entail the understanding of exchanging resources by the provider with the intention of maintaining the wellbeing of the recipient. According to Vaux, the construct of subjective appraisals of support recognizes the importance of the individuals' evaluation or judgment of the supportive relationship as well as supportive behavior within their environment. These three interrelated constructs of social support show the multidimensional nature of the concept itself highlighting the necessity of further inquiry about whether individuals in difficult life situations perceive, request, access, and accept available social support as a social transaction in a given socio-cultural environment.

Thus, whether it is perceived or received, social support would produce significant adaptation outcomes on people's life through expanding people's capability to cope with various

difficult life events (Cohen & Wills, 1985; Sarason, Pierce, & Sarason, 1990; Hobfoll & Vaux, 1993; Huepky, 1998;). Furthermore, Pierce, and Sarason (1990) suggest the motivations and expectations of both support providers and recipients, the nature of the relationship in which supportive behavior occurs, and the problematic situations to which the supportive efforts are directed affect the outcome of social support.

Social support can be obtained from informal and formal sources (Zarit, Pearlin & Schaie, 1993). The informal mode of social support constitutes a variety of social network/association including immediate family members, extended family system/kin, and or neighbors. Whereas, the formal sources entail supports provided through the formal organizations including non-governmental and governmental service providers. Whether provided either by informal or formal sources, social support has several functions. As available literature suggests, four categories are most consistently emphasized. These are 1) esteem, 2) informational, 3) social companionship, and 4) instrumental supports (Cobb, 1976; Cohen & Wills, 1985; Lazarus & Folkman, 1984). Esteem support, which has also been referred to as emotional or expressive support, serves to elevate a person's sense of worth. It communicates a message that the person is valued and accepted despite their difficulties within the support network system. Informational support has been interchangeably used as advice, appraisal and cognitive support. Social companionship support constitutes spending time with others in leisure and recreational activities. According to Cohen and Wills (1985), social companionship support may minimize stress by offering being together which would further alter the person's continuous worry about the problems. Companionship support also enhances positive affective moods. The fourth support function is instrumental support. Instrumental support refers to the provision of tangible support constituting financial aid, material resources, and needed services. The instrumental

support functions in a way of addressing the material needs of a person. Understanding the various functions of social support has great utility. As leaders in social support research acknowledge, for social support to buffer a negative consequences of stressful life event there should be a match between the needed resources and support systems with the sources of stressors (Cohen & Wills, 1985; Folkman & Lazarus, 1984).

Empirically, the social support as a buffer hypothesis has demonstrated wider utility in various stress related studies evidencing significant association between social support and caregivers' wellbeing. For example, Kelley, Whitley, Sipe, and Yorker (2000) examined the predictors of psychological distress in grandmother kinship care providers and reported that caregivers with less social support exhibit higher level of psychological distress. In a cross sectional study of 129 grandparent kinship care providers Sands and Goldsberg-Glen (2000) examined the relationship between social support and grandparents' stress. Their study results show that lack of supports accounted for 35% of the variance on caregivers' stress.

Goodman, Poots, and Pasztor (2007) conducted a comparative study that examined the needs, formal service utilization, informal support, and caregiver burden among grandmothers parenting grandchildren among 73 public caregivers with child welfare system involvement and 108 private caregivers without the involvement of the child welfare system. The study found out that for the total sample and for private caregivers, lower levels of informal social support were significantly associated with higher levels of caregiver burden. The finding suggests that availability of higher level of social support buffers the negative outcome of the caregiving responsibility.

In another study, Landry-Meyer, Gerard, and Guzella (2005) assessed the associations among caregiver stress, social support, and stress outcomes measured by life satisfaction and

generativity among a non-probable sample size of 33 grandparents raising grandchildren.

Findings suggest that both informal and formal social support was found to have an effect on stress outcomes despite the level of stress that kin caregivers experience. However, social support did not buffer the association between caregiver stress and life satisfaction. It also did not buffer the association between caregiver stress and generativity.

Although stable results have yet to be established, social support continuously has been associated with increases in well-being. However, much remains unknown about the effect of social support including esteem, social companionship, informational, and material support on caregivers' coping ability in the developing countries. Moreover, none of the existing studies has tested the buffering effect of social support in sub-Saharan African countries including Ethiopia. Grounded in the findings of the first systematic review on caregivers for orphan children, Kuo and Operario (2009) indicate how available studies on orphans and vulnerable children care or kinship care literature in developing countries neglect the effect of support provisions on caregivers' wellbeing.

In Ethiopia, secondary data sources reveal the existence of the several informal associations and support network systems that are deliberately established as support resources. Supporting each other, claiming support, and accepting support from the family system, friends, neighbors, and the larger community is profoundly embedded within the socio-cultural settings of most Ethiopian communities (Bevan, 2006; Newton, 2007). In Ethiopia, at least two informal social support systems should be considered as a support mechanism in the HIV and AIDS context. These are *Mahiber and Iddir* (Bevan, 2006; Newton, 2007; Pankhrust & Mariam, 2002)

*Mahiber* refers to religious associations devoted to honoring a saint for whom the group is named (Mequanint, 1998). Their functions include promoting mutual support, as well as social

and spiritual life, and resolving small-scale conflicts. Whereas, *Iddir* refers to an indigenous voluntary association established primarily to provide mutual aid in burial matters but also to address other community concerns such as HIV/AIDS issues including orphans and vulnerable children (Pankhurst & Mariam, 2000). *Iddirs* may serve as a key support mechanism at times of stressful life events through the provision food, as well as allowing sick members to use their post death payouts for health related services (Bevan, 2006; Newton, 2007). These informal social networks and associations are greater sources of social support that most Ethiopian use in times of social and economic difficulties including the HIV/AIDS epidemic (Pankhurst & Mariam, 2002).

Within the informal social support systems, however, Bevan (2006) found that individuals prioritize close family and household members as key primary support network systems rather than other forms of associations/networks. Individuals often perceive, can access, request, and accept resources to manage any stressful events first from their close family system and later from the community. These support associations or networks are involved in providing complex and reciprocal support. Here, interdependency among members of any of the support association or network system is fundamental.

Despite the existence of various networks where kin caregivers could access or receive various types of supports, none of the existing studies on orphan care in Ethiopian settings has looked at the effect of social supports on kin caregivers coping. Hence, examining social support is believed to enhance our understanding of kin caregivers' capacity to cope with the caregiving responsibility and whether or not social support buffers caregivers from the negative outcome of the caregiving processes.

### 3. **Coping**

Coping strategies in relation to orphans and vulnerable children care vary depending on the socio-cultural and economic social setting (Foster & Williamson, 2000; Hobfoll & Vaux, 1993; Lazarus & Folkman, 1984). According to Lazarus and Folkman, coping represents the cognitive and behavioral efforts to deal with issues recognized as something beyond the person's resources and constitutes three fundamental features. First, coping involves a process referring to the way the person actually thinks and acts to alter a specific stressful life event.

Second, coping operates in a context, involving peoples' way of judging stressful life event and the amount of resource needed to deal with the event. Viewing coping in context helps to understand how the intersection of both personal and environmental resources expands individual's coping efforts.

Third, conceptualizing coping as individual's effort to manage a challenging life event, occurs without judging the effort as good or bad. Lazarus and Folkman's conceptualization of coping as a process, contextuality, and viewing individual's effort to manage a stressful life situation without appraising it as good or bad sheds light on how individuals' and communities think about their situation and act through tapping relevant resources available at their disposal to effectively manage stressful situations.

Most sub-Saharan African communities employ several coping strategies in order to survive stressful life events. Liard (2006) based an extensive review of literature on the survival strategies of most sub-Saharan African countries affirms that traditional coping strategies are the most commonly used. The most frequent traditional coping mechanisms is dispersing the children among various family members so they will raise them on their own. According to Liard,



most sub-Saharan African countries' reliance on the traditional coping strategies is due to the both the absence or inadequate development of welfare structures and the deeply rooted absolute poverty that draws most households to experience scarcity of basic needs.

In the context of HIV/AIDS, caregivers employ several strategies to manage the burden of caregiving responsibility amidst their poor economic and financial situation. In their qualitative study about orphan children's and caregivers perspectives on the risks and protective factors for the psychological well-being of children orphaned by AIDS in Cape Town, South Africa, Culver and Gardner (2007) found caregivers' resiliency as a major ways of coping with their challenges. In addition to their strength, various protective factors help caregivers cope with their day-to-day stressful encounters such as receiving various forms of supports from other members of the extended family system and neighbors (Heyman, Earle, Rajaraman, Miller, & Bogen, 2007).

Another study that explored the challenges of caregivers for orphan children in rural Kenya posits caregivers employ several coping mechanisms (Juma, Okeyo, & Kidenda, 2004). Specifically, to address the economic challenges, caregivers undertake small-scale farming and businesses; engage in manual labor; sell household property or lease land; engage in begging; utilize retirement benefits; and rely upon the estates or property of their deceased children. All of these may support to sustain the caregiving role. Although not comprehensive, the review of literature shows that family caregivers use various adaptations as mechanisms to cope with their caregiving responsibility.

In Ethiopia, very few studies mention caregiver coping mechanisms to sustain their caregiving role. For example, Philipos (2005) in his qualitative study on the impact of HIV/AIDS on orphans indicates that caregivers with lower economic capabilities use selling household

assets, sending orphan children to better-off family members, and sending children to rural areas to other members of the extended family system as a mechanism to cope with the challenge of sustaining their caregiving role. Abebe and Aase (2007) made a similar observation that kin caregivers often sell their household assets to cope with their caregiving challenges.

The coping strategies currently in use by the Ethiopian kin caregivers are similar to Chambers and Conway's (1992) typologies of survival strategies in African countries, i.e. relying on relatives, community members, governments and non-governmental organizations, and dispersing family members to other members of the extended family network system.

Where prior studies neglect the issue of caregivers coping strategies in the process of raising children affected by HIV/AIDS, undertaking an empirical examination on how caregivers define their caregiving role and the resources they use to provide care would make a contribution to the existing family care literature. Especially in the context of HIV/AIDS it would inform policy makers and practitioners.

## **E. SUMMARY**

Kinship care is one of the universally existing alternative child care approaches. Available literature shows that various reasons including HIV/AIDS leads relatives within the extended family system to step into the caregiving role for orphans and vulnerable children globally. The fact that caregivers are part of the extended family system means they are expected to step in raising orphans and vulnerable children with or without formal social supports.

In sub-Saharan Africa, where the negative consequences of the HIV/AIDS epidemic disproportionately affects millions of children, the role of kin caregivers is prominent in the provision of social, psychological, emotional, and economic care and support in the absence of adequate formal support. The preexisting poverty context of kin caregivers limits caregivers'

ability to provide basic needs for children under their care and identified as one of the major stressors that lower caregivers coping ability with the new caregiving responsibility for orphans and vulnerable children. Further factors such as caregivers' mental and physical health status, lack of decent housing, heavier work load, multiple losses of family members, and unavailability, appropriate and accessible formal support, and child behavior problems are continuously cited as factors increasing caregivers' stress.

In the Ethiopian context, limited available studies have demonstrated how kin caregivers provide care for the majority of orphan children and their own difficult socio-economic circumstances. As a component of a familial adaptation mechanism, kinship care within the Ethiopian extended family system has been sustained for long period of time and has been serving as an alternative safety net for the sick, elderly, and children. However, it has gained significant attention after the HIV/AIDS epidemic.

Despite the role that kin caregivers play in caring for HIV/AIDS affected orphans and vulnerable children, none of the existing studies have explored kin caregivers' situation from their own perspective. Although a few studies provide insight about kin caregivers, most of these are qualitative and are limited in their scope and generalizability and representativeness of their sample population as well as being uneven on methodological rigor. In addition, there is a huge knowledge gap in understanding the nature and extent of kin caregivers' stress. Although available studies report challenges and problems of kin caregivers' ability in sustaining their caregiving responsibility, none of the research studies employed a standardized instrument to understand the level of stress the caregiving process produces as well as the relationship of other personal factors in affecting their coping. Furthermore, the role of existing social support

network systems in moderating the relationship between caregivers stress and coping needed more evidence.

Thus, the proposed study explores and explains factors affecting kin caregivers' stress and coping, as well as tests the moderating effect of social support on the relationship between kin caregivers stress and ways of coping after controlling for caregivers demographic variables. Simultaneously, the study will include qualitative explorations of the experience of kin caregivers in undertaking the caregiving role amid their own socio-economic difficulties as well as the pathways that led them to their caregiving responsibilities and identify what helped them sustain their caregiving.

### **III. CONCEPTUAL FRAMEWORK AND RESEARCH QUESTIONS**

#### **A. Conceptual Framework**

The proposed study draws a conceptual model building on Lazarus and Folkman's (1984) theory of stress and coping and Cohen and Wills's (1985) concept of social support as buffer.

##### **1. The stress coping model**

The stress coping model presented by Lazarus and Folkman (1984) illustrates how people see an event, evaluate the event as either affecting their wellbeing or not, and their ability to develop a strategy to effectively handle the situation. The model further suggests stress and coping are transactional and arise during the person's interaction with his/her social environment. In this model, Lazarus and Folkman conceptualize stress as inevitable to human life and define stress as "a relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his or her wellbeing" (p. 21). Individuals, after facing any stressful event engage in evaluation of the event. The evaluation process of a situation refers to cognitive appraisal.

According to Lazarus and Folkman (1984), cognitive appraisal involves several levels such as primary, secondary, and/or reappraisal. Primary appraisal ranges from evaluating a life event as irrelevant to stressful, harmful/loss, and or evaluating an event as a challenge. This primary appraisal of the situation often leads a person to further evaluate and attempt to hold the possibility for mastery or gain. At the secondary appraisal level, a person usually evaluates coping options and assesses what could be done to alter a stressful event. In addition, a person might engage in assessing the effectiveness of the coping strategy or strategies to see whether a given coping option is successful or effective or not in the context of internal and external constraints.

The third level of appraisal is reappraisal. Lazarus and Folkman (1984) argue that a person, when introduced to additional or new information on a situation, may change his/her prior appraisal, which the authors refer to as defensive appraisal. This is actually a result of the cognitive coping efforts of an individual and occurs after the first appraisal. The appraisal processes have a fundamental impact on the immediate and long-term outcome of the stressful encounters on the person. In addition, the perceived outcome of the appraisal process of a situation may be beyond the individual's resources and capability, thus adversely affecting the person's physical and psychological wellbeing. In this process of appraisal, especially when there is scarcity of resources, people with stressful events often experience vulnerability.

In the stress coping model, understanding both personal and situational factors becomes vital as the two conditions strongly influence the stress appraisal and coping processes. According to Lazarus and Folkman (1984), personal factors such as commitments that underpin motivations of a person in the process of making choices, a belief system that includes existential beliefs in which people try to make meaning out of a given situation, and control factors that facilitate people maintaining their aspirations. On the other hand, situational factors such as the newness of an event, the nature of predictability, and event uncertainty in terms of proximity, duration, temporal uncertainty, ambiguity, and timing will either facilitate or restrain people's appraisal and coping ability.

In the stress coping model, Lazarus and Folkman (1985) define coping as "constantly changing cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of a person" (p.141). This conceptualization helps us to understand coping as process. The authors point out that coping is only concerned about a person's effort to think or do something. This conceptualization helps to

understand whether or not a person makes a constant effort to manage his/her stressful situation emanating from either personal or situational factors. Managing a stressful encounter encompasses minimizing, avoiding, tolerating, and/or accepting the stressful situation as well as mastering the environment.

Lazarus and Folkman (1984) further argue that coping has two major functions. The first function involves altering the problem causing psychological distress through a strategy of “defining a problem, generating alternative solutions, weighing the alternative solutions in terms of costs and benefits, choosing among them, and acting” (p. 152). This type of coping is referred to as a problem-focused form of coping. The second function of coping is emotion-focused. Emotion focused coping encompasses various strategies such as redefining the situation without changing it objectively or regulating emotion. An individual’s appraisal of the severity of a stressful event also determines their success in coping with the situation.

In this research, the stress coping model will be the vehicle to explore and understand how kin caregivers raising children affected by HIV/AIDS experience stress and effectively managing the stress outcome emanating from the caregiving processes. Although explicit research on the effect of stressors on Ethiopian kin caregivers is unavailable, Philipos’s (2005) study shows how poverty produces stress on caregivers. Caregivers often provide care without formal support. Their preexisting poor economic situation limits kinship care providers from providing basic survival necessities for their relative children under their care.

Causes of kin caregivers’ stress and specific coping options available for kin caregivers varies based on the social, cultural, and economic context in which the person lives. Lazarus and Folkman (1984) suggest considering different socio-cultural environments that may provide different challenges and various resources to deal with difficult life circumstances. In the

context of kinship care for children affected by HIV/AIDS, it is imperative to elucidate the role that culture plays in explaining caregivers stress and coping.

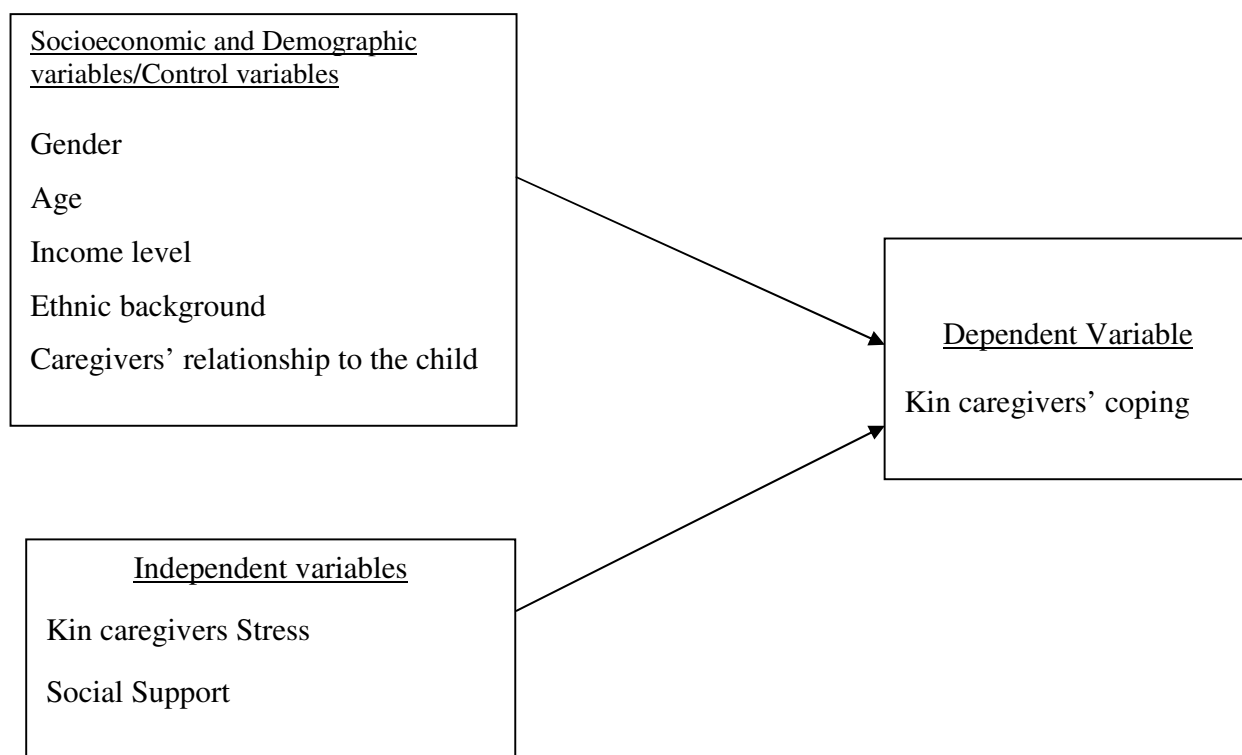
## **2. Social support: The buffering hypothesis**

In stress and coping processes, social support has been gaining greater acknowledgment in facilitating positive coping outcomes when individuals face difficult life events (Folkman & Lazarus, 1985). The buffering hypothesis on social support posits that having a particular resource, either personal or social, helps protect individuals against the adverse impact of stressful life encounters. A high level of social support predicts a high level of the individuals' capability to better handle or cope with negative consequences of stressors (Cohen & Wills, 1985). Furthermore, Cohen and Syme (1985) note that for social support to buffer a stressful life event, it should meet three conditions. First, the type of support should match the needed coping requirements of a person's specific difficult life situation. Second, the timing of support should occur when support is needed. Third, the appropriateness of the duration of support has to fit with the needed social support.

In this study, the buffering hypothesis of social support is used to examine the moderating role of social support in facilitating better coping amongst caregivers in the process of caring for HIV affected children in Ethiopia. Although in Ethiopian extended family systems family members assume the caregiving role amid their own socio-economic difficulties, examining the buffering effect of social support will help to determine the factors helping Ethiopian kin caregivers sustain their role as caregivers. Further, the study examines applicability of the buffering hypothesis in the diverse socio-cultural context of Ethiopian family caregivers who have greater diversity in religion, ethnicity, and socio-economic background compared to the socio-cultural and economic setting through which the construct of social support first



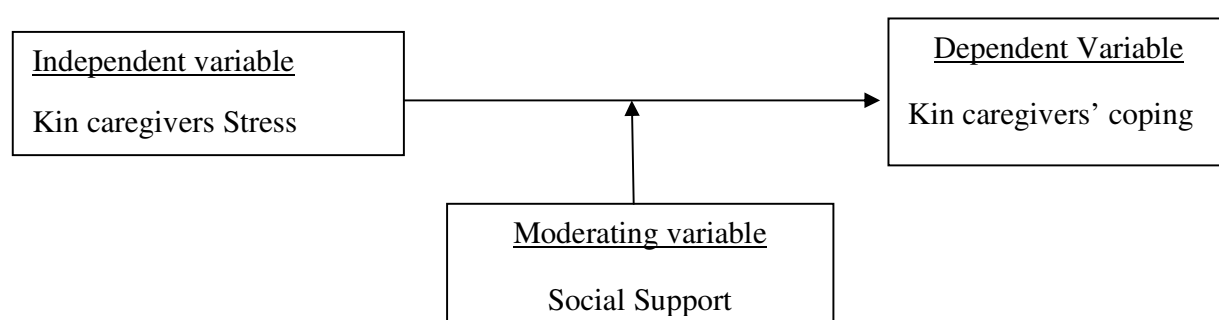
developed. Based on the theoretical framework as well as empirical evidence regarding the stressful nature of caregiving for orphans and vulnerable children, the following conceptual model is developed. Figure 1 and 2 will present the conceptual framework of this proposed study.



**Figure 1. Prediction model**

Figure (1) depicts a prediction model where socio-economic demographic variables (kin caregiver age, gender, income level, ethnic background, and kin caregiver relation to the child) and independent variables (caregivers stress and social support) are expected to have a relationship with kin caregiver coping.

Kin caregiver stress is, in particular, assumed to have a negative relation with kin caregivers coping. On the other hand, social support is expected to have a positive relationship between caregivers' coping level. In addition, this proposed study predicts moderating role of social support in the relationship between caregiver stress and caregiver coping. Figure 2 shows the moderation model.



**Figure 2. Moderation model**

Figure (2) illustrates the proposed moderating effect of social support in the relationship between kin caregivers stress and coping.

## **B. Conceptual Definition of Variables In the Study**

### **1. Dependent variable**

The dependent variable in this study is coping. Coping is defined as “constantly changing cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of a person” (Lazarus & Folkman, 1984, p.141). It is conceptualized as a protective mechanism involving problem-focused coping, emotionally-focused coping, and denial, producing both positive and negative influences on the individual.

## **2. Independent Variable**

In this proposed study the first independent variable is stress, and is defined as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his/her resources and endangering his or her wellbeing” (Lazarus & Folkman, 1984, p. 21). Stress is conceptualized as a life event that arises when an individual interacts with his/her environment and appraises a situation as needing an appropriate response. However, the situation exceeds an individual’s capability to deal with the issue and threatens that person’s wellbeing.

## **3. Moderating variable**

Social support is included as a moderating variable as it represents an integral part of the stress coping model. In this study, social support is defined as a meta-construct encompassing support network resources, supportive behavior, and subjective appraisal of support. Viewing social support as a combination of functions as well as modes of providing support helps to examine whether or not the relationship of caregivers’ stress and kin caregivers’ coping varies depending on the level of support perceived, appraised, or actually received (Hobfoll & Vaux, 1993).

## **4. Demographic/control variables**

In addition to the independent and moderating variable, socio-economic and demographic variables are included in order to account for their influence in the overall statistical analysis. Demographic variables include the characteristics of kin caregivers including age, gender, ethnic background, religious background, income level, marital status, and kin caregivers’ relationship with the child.

### C. **Research Questions and Hypothesis**

This study assessed four quantitative and four qualitative research questions. In the quantitative components, the research questions are designed to examine the relationship between kin caregivers' demographic variables (kin caregivers' age, income level, kin caregivers' ethnic background, and kin caregivers' relationship to the child) and the dependent variables (stress and social support) upon kin caregivers' coping. Further, the research questions attempt to see the effect of the demographic, predictor variables and moderating variable on caregivers' coping. These research questions, each with its respective hypotheses, have been developed from the stress and coping model and the buffering hypothesis.

As indicated earlier, in Ethiopia past empirical research studies on the HIV/AIDS epidemic and the situation of orphans and vulnerable children has neglected the perspective of kin caregivers. Thus, the qualitative component of the research question sought to obtain a rich description about the caregivers, obtain information on how they became engaged in the caregiving responsibilities, why they provide care, explore how this leads to stress and how they cope with their caregiving roles. Qualitative questions are vital to gain empirical evidence about whether, and if so how and why, the stress and social support are related to kin caregivers' coping processes.

#### 1. **Quantitative research questions and hypotheses**

- a. Are there significant differences in coping by caregiver's relationship with the child?

**Hypothesis 1:** Caregiver coping will vary by the nature of their relationship with the child.

- b. Are there significant associations between caregiver coping and factors such as age, ethnic background, kin relationship to the child, caregiver stress, and social support?

**Hypothesis 2a:** Caregiver coping varies by income level.

**Hypothesis 2b:** Caregiver coping varies by ethnic group.

**Hypothesis 2c:** Caregiver coping varies by caregiver age group.

**Hypothesis 2d:** A significant relationship will be found between caregiver coping and caregiver stress.

**Hypothesis 2e:** A significant relationship will be found between caregiver coping and social support.

- c. Do kin caregiver stress and social support predict caregiver coping?

**Hypothesis 3a:** Kin caregiver stress is negatively associated with kin caregiver coping.

**Hypothesis 3b:** Kin caregiver social support is positively associated with caregiver coping.

- d. Does social support moderate the relationship between kin caregiver stress and caregiver coping?

**Hypothesis 4:** Controlling for demographic variables, social support significantly moderates the relationship between kin caregiver stress and caregiver coping.

Hypotheses 3a and 3b predict the direction of the hypothesized significant relationships because this is consistent with findings of published studies as illustrated in the conceptual framework of this study. Other hypotheses are non-directional.

**2. Qualitative research questions**

- a. What are the motivations that led kin caregivers to assume the caregiving role for their relative children affected by HIV/AIDS?
- b. What do kinship caregivers perceive to be the major stressors in the kinship caregiving processes?
- c. What type of supports do kin caregivers receive?
- d. How do kin caregivers cope with stressors?

## **IV. METHODOLOGY**

This chapter presents the methodology that guided and transformed the overall research questions to generate empirical data. In this section, I discuss the research design, the sample selection plan and procedures, including the selection criteria, the study setting, and instrumentation for this study. In addition, this chapter presents the data analysis plan for both quantitative and qualitative data. Reliability and validity tests for quantitative data as well as the trustworthiness of the qualitative data are discussed. Lastly, the chapter presents the procedures used to protect human subjects.

### **A. Research design**

In this study a concurrent, mixed methods, cross-sectional research design was used. Mixed methods research design acknowledges the complementary strengths of the qualitative method in generating a breadth of data and of quantitative data in producing independent numerical evidence that allows statistical understanding of social phenomena (Johnson & Onwuegbuzie, 2007).

In the current study the relationships between the kin caregivers' relationship to the child, caregivers' age, caregivers' ethnic background, income level, stress, social support, and kin caregivers' coping were explored. The study sought to understand each variable from the perspective of kin caregivers. Thus, the quantitative research questions and testing of related hypotheses provided statistical data regarding whether the variables are significantly related or not. In addition, the use of qualitative data answered questions regarding kin caregivers' perception and appraisal of social support, stress, and coping.

The conceptual frameworks that guided this research as well as the instruments chosen to test the proposed hypotheses were developed in the USA and have never been used within the

Ethiopian social, cultural, and economic context. Thus, the use of a mixed methods research design was instrumental in assessing the applicability of the conceptual framework to explain the situation of Ethiopian kin caregivers for orphans and vulnerable children. Furthermore, this mixed methods research design helped to probe, illuminate and triangulate inconsistencies that were evident in the analysis and interpretation phases of the quantitative data.

## **B. Study setting**

The study was conducted in three Sub-Cities of Addis Ababa Administration, the capital city of Ethiopia, namely Arada, Cherkos, and Addis Ketema. These Sub-Cities were identified as vulnerable settings with higher rates of HIV/AIDS prevalence as well as large numbers of orphaned children as a result of the HIV/AIDS epidemic (in formal conversation with the head of the Psychosocial Care Department at Addis Ababa HIV/AIDS Prevention and Control Office in February, 2009). Studying the kin caregivers' situation in three Sub-Cities of Addis Ababa helped to generate needed empirical data about the kinship care system and the caregiving process for children affected by HIV/AIDS within the extended family network system.

## **C. Sampling plan, Procedure, and Selection Criteria**

### **1. Sampling plan**

In this study, obtaining or developing a sampling frame including a list of possible subjects was not feasible as many of the kin caregivers assumed the caregiving role for orphaned children informally without the involvement of formal authorities. A purposive/convenience sampling technique was used to guide the quantitative data collection process.

Although I used a convenience sampling technique, I followed Green's (1991) formula to obtain the minimum number of study subjects to undertake the statistical analysis with a maximum statistical power. Green's sample calculation (i.e.  $N \geq 50 + 8m$ ; where  $m$  = number of



predictors) was used with seven demographic variables (kin caregivers' age, gender, income level, marital status, kin caregivers ethnic background, kin caregivers' relationship to the child), the independent variable (caregivers stress), and one moderating variable (social support). This calculation revealed that a total sample size of 122 kin caregivers was sufficient to conduct the statistical analyses. However, I interviewed a total of 130 kin caregivers from the three Sub Cities. Informed consent to participate in the research was obtained from 130 participants who were asked to respond to the structured as well as the open ended questions that were nested under the dependent, independent, moderating, and dependent variables of this study.

Participants for the qualitative portion of the study were selected from the 130 participant in the quantitative portion of the study. I randomly picked every seventh study participant for open ended questions. The expected total number of participants for the in-depth analysis was 18. However, at the 12<sup>th</sup> respondent, data were saturated. According to Corbin and Strauss (2008), saturation of data in a qualitative study refers to the point where no new categories in terms of their properties, dimensions, and variations are emerging.

## **2. Recruiting study participants**

Prior to beginning data collection, I completed and obtain Institutional Review Board clearance from Jane Addams College of Social Work, University of Illinois at Chicago as well as from the appropriate Ethiopian institution, Addis Ababa University. In addition, I established contact with Addis Ababa HIV/AIDS Prevention and Control Office [AAHAPCO] and Sub City level HAPCO offices. HAPCO is a governmental institution responsible for the coordination of psychosocial, economic, and treatment services for people infected and affected by HIV/AIDS.

I informed service staff about the research and presented the copy of the IRB approval to agencies in three Sub-Cities in Addis Ababa. (Sub Cities are municipal administrative units within the city of Addis Ababa City Administration. The city of Addis Ababa has ten Sub Cities.) In the process of contacting and identifying agencies and staff members, I showed them support letters from the School of Social Work, Addis Ababa University (*see Appendix F*). In addition, I provided flyers (*see appendix D*) that described the study as well as the inclusion and exclusion criteria of study participants so that they could provide this information to caregivers who are caring for children who are affected by the HIV/AIDS epidemic for whom they provide service. Although the agencies I contacted provide services to both HIV/AIDS affected children and families as well as those who are not affected by HIV/AIDS, I specifically requested that they refer only caregivers who were caring for children affected by HIV/AIDS to the study. This was the only screen to assure caregivers met the HIV/AIDS criterion. The flyer asked potential participants to meet me at the agencies on specific days for an information session and recruitment into the study. An information sheet (*see Appendix E*) was used to provide more information to potential participants, and assess them for eligibility for the study. Eligible participants who were willing to take part in the study were asked to give their contact information for a meeting with me to conduct the interview.

Before asking kin caregivers to participate in the research, I obtained written informed consent by reading and explaining the purpose of the proposed study, the inclusion criteria, the voluntary nature of participation, and benefits and risks of participating in the research for all study participants. The participants were told that they will not receive any direct benefits for participating in this study. However, they were informed that their participation in this study provides an in-depth understanding of kin caregivers' situations, which may help service

providers and policy makers to design an appropriate policy and formal services to better help kin caregivers. Kin caregivers who fulfilled the sample selection criteria and who provided their informed consent to participate in the study were included in the interviewing process (*see Appendix C*). The majority of kin caregivers whom I met and were caring for their relative children at the time of data collection showed great interest and willingness to participate in the study.

### **3. Sample inclusion and exclusion criteria**

Kin caregivers who met the following criteria were included in the study:

- The caregiver must be above the age of 18 years;
- The caregiver must be providing care to at least one related child between the ages 4 – 12 years;
- Kin caregiver must have been providing care for at least six months. This excludes kin caregivers who had provided care less than six months;
- The related children must have been residing in the caregiver's home. This excludes those caregivers who are providing out of home care;
- Caregiver must be caring for a child who is affected by HIV/AIDS. This excludes caregivers who are caring for non-HIV/AIDS affected orphans and vulnerable children;
- The caregiver must be able to communicate clearly in Amharic and be willing to speak freely and voluntarily about their experiences in providing care for orphan and vulnerable children due to HIV/AIDS.

## **D. Instrumentation**

In this mixed methods research design, the quantitative and qualitative data were generated using a semi-structured questionnaire with open ended questions nested under the dependent, independent, and moderating variables.

### **1. Quantitative data**

In this study, the dependent variable was coping and Lazarus and Folkman's (1985) Ways of Coping Questionnaire was used to examine caregiver coping. The independent variable was caregiver stress. Abidin's (1990) Parenting Stress Index Short Form (PSI-SF) was used to measure caregivers' stress. The moderating variable was social support. Social support was measured by the Social Support Behavior Scale (SS-B) developed by Vaux, Riedel, and Stewart (1987).

The instruments included in this study have been found to be reliable in previous research in the US context. For example, factor analysis for WCQ, was reported for a variety of samples including middle aged married couples with a good internal consistency alpha ( $\alpha$ ) .80 (Folkman & Lazarus, 1980). Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) used WCQ among college students and reported internal consistency coefficients ranging from  $\alpha$  =.61 to .79. However, variability in sample characteristics and repeated administration of an instrument in various settings may affect the reliability of an instrument (Rexrode, Peterson & O'Toole, 2008). Thus I checked for the internal consistency through testing the repeatability of the items in the same construct of the dependent, independent, and moderating variables using Cronbach's alpha ( $\alpha$ ). Cronbach's alpha ( $\alpha$ ) helps to assess the possible average split half estimate of correlations of items used to measure a given construct (Fortune and Reid, 1999; Heppner & Heppner, 2004).

In addition, demographic data were collected regarding kin caregivers' age, gender, income level, ethnic background, marital status, and kin caregiver's relationship with the child. These demographic variables were used to describe the study population and as control variables to test the unique contribution of the main and moderating variables to the variance of the outcome variable.

**a. Coping**

The dependent variable, coping, was measured by the Ways of Coping Questionnaire (WCQ) consisting of a 66 item scale that is scored using a 4-point Likert-type scale (0 = not used; 1 = used some-what; 2 = used quite a bit; 3 = used a great deal). It is intended to measure coping processes through assessing individuals' thoughts and actions in dealing with stressful encounters of everyday living. The WCQ is made up of eight subscales intended to measure: 1) confronting coping, aggressive efforts to deal with the stressful situation and suggests some degree of hostility and risk-taking; 2) distancing, cognitive efforts to detach oneself and to minimize the significance of the situation; 3) self controlling, efforts to regulate one's feelings and actions; 4) seeking social support, efforts to seek informational support, tangible support, and emotional support; 5) accepting responsibility, acknowledges one's own role in the problem with a concomitant theme of trying to put things right; 6) escape avoidance, describes wishful thinking and behavioral efforts to escape or avoid the problem; 7) planful problem solving, deliberate problem-focused efforts to alter the situation; and 8) positive reappraisal or efforts to create positive meaning by focusing on personal growth or spiritual growth.

I computed the internal consistency of each subscale using Cronbach's alpha. With the exception of the Seeking Social Support subscale, the Cronbach's alpha indicated that the

subscales of the Ways of Coping Questionnaire have low reliability, i.e. Social support  $\alpha = .85$ ; Accepting Responsibility  $\alpha = .3$ ; Escape Avoidance  $\alpha = <.2$ ; Planful Problem Solving  $\alpha = .60$ ; Positive Reappraisal  $\alpha = .50$ ; Confronting  $\alpha = .54$ ; Distancing  $\alpha = .40$ ; and Self Controlling  $\alpha = .27$ .

The reliability scores of most of the subscales were too low to be included in the analysis. Further, the original plan to use the total score was not feasible for two reasons. First, it does not measure every type of coping people might engage in and second, one of the sub scales, seeking social support, is similar to the independent variable, social support. To address this problem, a shortened version of the coping scale consisting of 13 items was created by combining the Planful Problem Solving and Positive Reappraisal sub scales. These sub scales were selected because they are conceptually consistent in that they both measure positive coping strategies. The new Coping Scale was found to have a reliability score of  $\alpha = .72$ . I used the new Coping Scale in the analysis. A higher score on the Coping Scale indicates more frequent use of a given coping strategy with a possible range of 0-39. The mean of the new coping scale is  $M=20$ , with a standard deviation  $SD=5.4$

Regarding the validity of WCQ, I used content validity/face validity. Content validity was established using two expert consultants who are familiar with Ethiopian culture, fluent in the local language, and have expertise in social work and research methods. The expert consultants were PhD candidates at the School of Social Work, Addis Ababa University. After analyzing the content of the WCQ, the experts confirmed that the WCQ is appropriate for use in the Ethiopian context without modifications.

**b. Parenting Stress Index Short Form (PSI-SF)**

Abidin's (1990) 36-item Parenting Stress Index Short Form (PSI-SF) was used to measure kin caregiver stress. PSI-SF is a five point Likert-type scale (1= strongly agree, 2 = Agree, 3 = not sure, 4 = disagree, and 5 = strongly disagree). This instrument has three sub-scales: 1) parental distress; 2) parent-child dysfunctional interaction; and 3) difficult child. The parental distress subscale assesses stress resulting from kin caregivers' perceptions of their own incompetence, role restrictions, social isolation, depression, and relationship problems. The parent-child dysfunctional interaction subscale examines stress resulting from kin caregivers' perceptions of the emotional quality of current relationships with the children; while the child difficulty subscale focuses on the children's behavioral manageability. Drawing from Abidin's recommendation, results from this instrument was computed using the total score.

PSI-SF has been used widely to determine the level of stress among African American grandparents who are raising their grandchildren. The PSI-SF has a reported Cronbach's alpha of  $\alpha = .95$  for the total score (Trail Ross, & Aday, 2006). PSI-SF has been used among Kenyan caregiving grandparents and the test re-test reliability was  $\alpha = .68$  (Oburu & Palmérus, 2003).

In this study, however, the reliability test showed a Cronbach's alpha of  $\alpha = .90$ .

**c. Social support**

Social support was measured using the Social Support Behavior Scale (SS-B) developed by Vaux, Riedel, and Stewart (1987). SS-B is a 45 item, five point Likert type scale designed to measure five modes of social support including : 1) emotional support ; 2) socializing ; 3) practical assistance ; 4) financial assistance ; and 5) advise/guidance. The five sub-scales were confirmed through factor analysis and the scale has acceptable internal consistency with Cronbach's alpha  $\alpha = .85$ . Based on Vaux, Reidel, and Stewart's

recommendation, the overall social support score was computed using the total score. In this study, the internal consistency was Cronbach's alpha  $\alpha = .98$ .

**d. Demographic variables**

Kin caregivers' demographic information including kin caregivers' age, sex, income level, relationship to the child, ethnic background, and marital status were measured by self report.

- Age: Age was measured as an ordinal variable and coded as 0= 18-35, 1= 36-50, 2 =51 and older.
- Gender: Was measured nominally and coded as a dichotomous variable 1= Male and 0=Female.
- Caregivers income level was treated as ordinal categories and coded as 0 = <Et Birr 8999.99 and 1 = >Et Birr 9000.00.
- Ethnic background: Ethnic groups were measured categorically and coded as 1=Oromo, 2=Amhara, 3=Tigre, 4=Gurage
- Kin caregivers relation to the child: Kin caregivers relationship to the child was measured categorically and was coded as 1= grandparent, 2= aunt/uncle, 3= sibling, 4= neighbors, 5= parents' friends , 6= others
- Marital Status: marital status was measured categorically and coded as 1= never married, 2= married, 3= divorced, and 4= widowed
- Partner situation: Partner situation was measured as dichotomous variable and coded as 0= not living with partner, 1 = living with partner



## 2. **Qualitative data**

Open-ended questions were nested under the Likert type scales that were included to measure the kin caregivers coping, kin caregivers stress and social support. Additional open ended questions were included to explore and obtain a deeper understanding of the pathways and motivation that led kin caregivers to step into the caregiving role (*See Appendix A*). Sample questions included:

- Would you please share with me the story of how you started providing care for your relative children?
- What mechanisms/supports are available for you to sustain your caregiving role?
  - Whom do you ask when you need support?
- Would you please share with me the most stressful events that you have faced in the caregiving role?
- What do you do to deal with the stressful events?

## E. **Data collection procedure**

Both quantitative and qualitative data were collected concurrently using a face to face interview. I conducted the interview using the semi-structured questionnaire that was developed to measure the dependent, moderating, and independent variables as well as to gain an in-depth understanding of each variable by exploring the lived experience of kin caregivers. During the quantitative portion of the interview in which questions were based on standardized scales with interval level responses, I provided five different color cards to the participant with options for answers to facilitate appropriate answers.

The research participants were non-English speakers. Thus, I conducted the interviews in Amharic, the official and local language of Addis Ababa City Administration, Ethiopia.

Permission to translate and use the PSI-SF was secured from the publisher of PSI-SF. I also contacted the authors of Ways of Coping and Social Support Behavior. Both Ways of Coping and Social Support Behavior instruments were available for public use. Thus, I translated the instruments into Amharic. In order to check the wording and arrangement of the translated versions and whether the translated versions adequately convey the item contents of the original language, I used the back translation method (Harkness & Schoua-Gluberg, 1998). Back translation was conducted by two of my colleagues who are faculty members of School of Social Work, Addis Ababa University. The back translators found all but one item to be culturally congruent. The item found to be culturally incongruent was changed to fit within the cultural context as follows: On the Social Support Behavior Scale, Item #21 originally read “Would buy me a drink if I was short of money.” This statement was changed to read, “Would buy me coffee if I was short of money.”

Before the actual data collection, I pre-tested the translated questionnaire with five kin caregivers to explore the language clarity, study participants’ understanding of the questions, the similarity and variation of questions in the different scales, and study participants’ interest and attention in answering the questions. After participants in the pre-test completed the questionnaire, I used cognitive interviewing to ask them to state the meaning of items in the questionnaire and their understanding of the language in the questionnaire. During this think-aloud practice, I learned that stress has no direct meaning in Amharic. Thus, based on the participants’ suggestion, the word challenge was found to have an equivalent Amharic meaning as stress in English and was used during the interview process. After the questionnaire was pre-tested the instruments were used without further changes.

Most of the interviews were conducted in the study participants' residences. However, whenever study participants' preferred to have the interview outside of their house because of their living arrangements (i.e. some kin caregivers' share a house with other household members), Iddir offices (Iddirs are a traditional community society originally developed as mutual support groups for burial purposes, but now provide additional social services to the sick and needy) as well as social service agency offices were used. Furthermore, whenever a third person entered the room while the interview was being conducted, the interview was momentarily discontinued. This occurred in seven interviews.

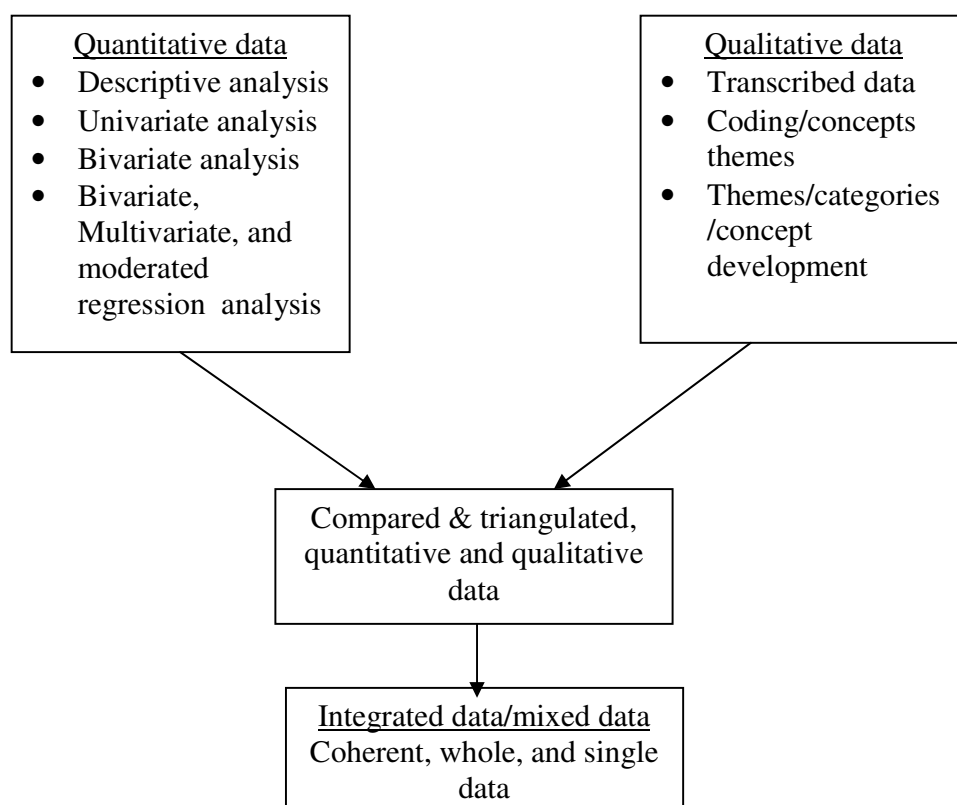
Conducting the data collection in the local language was helpful in that it enabled kin caregivers to answer clearly as well as to reflect upon the interview questions without any difficulties. When kin caregivers who participated in the open ended questions were told about their rights and the study procedures, most refused to be audio recorded. Thus, the initial plan to audio record the open ended questions process was not possible. Hence, the qualitative data is based on notes taken during the interviews of kin caregivers' statements and the interviewer's reactions during the interviews. I was diligent in documenting the kin caregiver's statements word for word. To make the notes more reliable, I often times repeated what kin caregivers said in their answers to the open-ended questions. In some cases, paraphrasing was used to make sure the note taking was congruent with their descriptions. Hence, minor changes were made based on the kin caregiver's feedback.

#### **F. Data analysis**

In this study, I used a mixed methods confirmatory data analysis approach that involved testing hypotheses through performing univariate, bivariate, and multivariate analyses of the quantitative data as well as exploring and undertaking an in-depth qualitative explanation of

ways these variables are related or unrelated (Onwuegbuize & Teddlie, 2003). Although the data sources for this study were both quantitative and qualitative, I used a coherent, integrated, and single data set in which both quantitative and qualitative data are rigorously interpreted, triangulated, and presented.

In the process of performing a mixed methods research analysis procedure, I followed three interrelated processes to ensure interpretive consistency as well as to result in well integrated data set. First, I analyzed the quantitative and qualitative data separately using several analysis approaches specifically appropriate to address the proposed research questions. Second, I made comparisons and performed triangulation to ensure interpretive rigor and ensure credible and valid data. Finally, I integrated the data on the basis of reduced and transformed data and compared data obtained from the quantitative and qualitative sources. I presented the transformed data in the form of single, coherent, and integrated data. Figure C shows how the two separate data analysis processes lead to the integration process.



**Figure 3. Overall data integration plan from quantitative and qualitative sources**

### **1. Quantitative data analysis**

Statistical software known as the Statistical Package for the Social Sciences [SPSS] (version 16), was used to perform descriptive statistics, as well as statistical analyses.

Data were analyzed at the univariate, bivariate, and multivariate levels. Prior to performing several statistical procedures at univariate, bivariate, and multivariate levels to make decisions about the stated hypotheses, data screening that involves diagnosing, and editing incorrect values/scores was performed. Regression diagnostics were also conducted to explore whether or not assumptions of regression analyses were met (Van den, Argeseanu, Eeckels, & Herbst, 2005). Additional tests for reliability and validity of data was performed (see below).

**a. Data Screening/diagnosis**

In this step, first the raw data were coded and entered manually into SPSS. Then, I checked for the data ranges and distributions to ensure the data were appropriately and accurately entered. Inaccurately entered values were found and corrected by checking the original data collection tool. In addition, the “Missing Values Analysis Procedure in SPSS” was employed to check for missing values. The volume of missing data was quite small and I used mean substitution to manage missing data as this is a conservative approach (Tabachnick & Fidell, 2001).

Cook’s D statistical test was performed to detect univariate outliers. The Cook’s D test was  $< 1$ , indicating the lack of influential cases. In addition Mahalanobis distance was performed to detect multivariate outliers. The Mahalanobis distance test revealed one influential case. To rule out whether the outlier was due to data entry error, I reviewed the original data collection tool. Since the outlier was not due to data entry error, I excluded that case and used 126 cases for testing and analyzing hypotheses #3 and #4.

Prior to performing data analysis using regression models, a test was conducted to determine if assumptions of linear regression (linearity, homoscedasticity, independence, normality, and multicollinearity) were met. Residual plots were examined to determine linearity. The data showed a linear relationship between the independent and dependent variables. To check whether the assumption of normality was met plots for residual versus predicted values, histograms and normal probability plots of the regression standardized residuals for each independent variable with the predicted values were examined. The assumption of normality was violated in one of the independent variables, social support. This variable was transformed using the log transformation technique. However, the transformation did not change the distribution of

the variable. Since multiple regressions are robust for the violation of normality, I used the original variable in the analysis (Osborne & Waters, 2002). Multicollinearity between predictor variables was checked by testing the variance tolerance statistics for each regression coefficient. The tolerance test was not  $< 0.1$ .

#### **b. Univariate Analysis**

At the univariate level, descriptive statistical analysis was conducted to obtain demographic profile of the study participants. Descriptive frequency tables were used to observe the patterns of study participants' response to each of the study variables. Descriptive statistics will help to understand the frequency, nature of the distribution of the data, and how widely the responses are dispersed around the central value (Fortune & Reid, 1999; Huck, 2008).

To further understand patterns and prepare for inferential analysis, measures of central tendency were computed. Since kin caregivers coping, stress, and social support were measured on an interval scale, the mean score was used to determine the central tendency of each of the variable. In order to assess how widely the scores are dispersed around the central value, standard deviation was used as a measure of variability (Fortune & Reid, 1999; Huck, 2008).

#### **c. Bivariate analysis**

At a bivariate level of analysis, Pearson's coefficient of correlation-tests, and One Way Analysis of Variance (One-way ANOVA) were used. T-test and one-way ANOVA were used to examine the mean differences of categorical variables: ethnic background of caregivers, kin relationship to the child, age, and income. Pearson's correlation coefficient was computed to assess the degree and direction of linear relationship between independent, moderating, and dependent variables as they are measured on interval scales. In addition, a

bivariate regression was used to test whether the scores on caregivers coping would be predicted from the score of each independent variable independently.

A t-test was performed to test hypothesis #1 and 2a. A one-way ANOVA was used to determine question # 2 and related hypotheses # 2b and 2c. A Pearson Correlation Coefficient was used to determine research question #2 and its related hypotheses 2d and 2e.

Data were presented using Pearson's  $r$  correlation matrix, a t-test, and one-way ANOVA tables (Huck, 2008; Tabachnick & Fidell, 2001).

#### **d. Multivariate analysis**

At the multivariate level, a series of hierarchical multiple regression analyses were conducted. Thus, kin caregivers' coping scores were regressed on kin caregivers' stress and social support. In addition, a moderated hierarchical regression analysis was used to test for the moderating effect of social support on the association between kin caregiver stress and coping level controlling for kin caregiver demographic variables that were found to be significantly correlated with the dependent variable in the bivariate analysis.

Prior to conducting the moderated regression, two multiplicative interaction variables between kin caregivers stress and social support was created by centering their mean. After the interaction variables were created, a hierarchical multiple regression analysis was performed. In each hierarchical regression analysis, the control variables (demographic variables) were entered first, followed by kin caregivers' stress and the interaction variables were entered at last. The main effect of caregivers' stress and of social support (moderating variable) on kin caregivers' coping was assessed.



## **2. Qualitative data analysis**

The qualitative data were analyzed using a narrative analytical approach.

Narratives are stories in which study participants present their lived experiences (Ollerenshaw & Creswell, 2002, see also Padgett, 2008). Caregiver's responses regarding the pathways and motivations that led them to assume caregiving responsibility for their relative children, the stress related to the caregiving responsibility, available social support, and their ways of coping were gathered through open-ended questions.

The findings of the qualitative data are based on the stories of 12 kin caregivers, consisting of five aunts, six grandmothers, and one neighbor who were involved in raising orphaned child/children.

### **a. Steps to analyze the qualitative data**

To better facilitate and manage the data, I have used the qualitative data analysis software program, Atlas.ti5. I used the interrelated analysis step to produce compared and coherent qualitative data. The steps include: preparing and transcribing the raw data for the purpose of making it ready for coding; coding; memoing; creating themes/categories/concepts; and interpretation (Padgett, 2008).

In the first step, since the open ended questions were asked in Amharic, the raw data were translated into English, prepared in the form of transcription, and then imported into an Atlas ti5 hermeneutic unit. Translating the Amharic raw data into English was not an easy process. In addition to my own limitations as a translator, I realized that some important Amharic words do not translate directly into English. In fact, any word, phrase, and sentence in a given language carry with them a set of cultural values and assumptions, as well as emotions, which cannot be fully captured in another language (Temple & Young, 2004). In the translation

process, whenever I encountered kin caregiver's words or phrases that do not translate directly into English, I tried to express the conceptual equivalence.

In the second step of analysis, I performed coding based on the identified variables and emerging themes from the raw data. In the first level of identifying concepts/themes in the data, 246 codes were produced. Using a constant comparison method and clustering related codes together, I performed the second level of coding by going forward and backward to the data and the already identified codes. The second level codes linked the first level codes to each other. The second level coding yielded 53 super themes and 49 sub themes for all the variables in this study. At this level of coding, relationships of major themes explaining conditions related to the study's major variables such as pathways to assume the caregiving responsibility, motivations of kinship caregivers, available social support, kin caregiver's major stressors/challenges and kin caregiver's coping mechanisms to sustain the caregiving role were identified.

Looking at the memoing sheet used during the interview, I reflected upon the data by elaborating views and relationships between identified themes and categories which enabled me to develop a story line. Based on the coded sub-themes I developed core themes that concretely showed relatedness. I have used tables to display the major themes. Furthermore, I interpreted the themes identified in prior steps by examining the data. In this step of analysis, meaningful and higher-level summarizations of major themes/categories emerged. In presenting the themes, I used numbers referring to the frequencies of responses.

**b. Trustworthiness of qualitative data**

Ensuring the trust worthiness of qualitative data refers to the assurance of scientific rigor within the qualitative research paradigm. It mostly refers to ensuring: credibility and transferability, representing the internal and external validity of data; dependability, referring

to reliability; and confirmability which is largely related to the issue of presentation (Lincoln & Guba, 1985).

Padgett (2008) in her book identified three major threats to the trustworthiness of qualitative data: 1) respondent bias; 2) researcher bias; and 3) reactivity. Respondent bias occurs when study participants provide untruthful information or when they tell what the researcher would like to hear. The researcher's prior theoretical orientation, perception, and attitude about the study subjects and study phenomena may distort the data collection and interpretation process. Moreover, the researcher's presence could affect the naturalism of the setting and the phenomenon under investigation. Bearing these three threats to the trustworthiness of qualitative data in mind, I established good rapport to create a trusting relationship with study participants to reduce reactivity as well as to enhance study participants' commitment to provide genuine information (Padgett, 2008).

I employed several strategies to verify the trustworthiness/genuineness, credibility and transferability of the qualitative data including 1) triangulation; 2) negative case analysis, and 3) audit trail. In addition, I used a second coder to ensure the conformability of the data, which indicates that the findings emerged from this particular inquiry rather than from the researcher's bias.

#### **i. Inter coder agreement**

To ensure coding dependability, I asked an experienced qualitative researcher who is currently working at the Midwest AIDS Training and Education Center, University of Illinois at Chicago to assist in establishing inter-coder agreement. Coding dependability was established by having half of the transcripts coded by this second coder independently. The second coder read and coded the narratives of six cases. Every other case,

those odd case numbers, were selected for coding. After the coding was completed, a consensus discussion was convened between myself and the second coder to check the agreement level on the coding of narratives regarding pathways and motivation, social support, stress and coping.

During the consensus discussion, the primary document for each case from the Atlas.ti 5 hermeneutic unit was opened and the second coder and I checked whether we coded the narratives of kin caregivers similarly. We found that in pathways and motivation related coding, the second coder missed the following three codes: relative's (Son/daughter/sister) HIV status, relative/my daughter moved in to my place as a pathway, and relative/children used to live with me as a pathway. Also, we observed that the researcher missed two codes: relative's lack of adequate income, and not lucky fate. Furthermore, the researcher coded as "protecting children" for the same responses the second coder coded as "not wanting to send the children to rural area". All in all, the agreement level for codes related to pathways and motivation was high, estimated at about 80%.

In relation to social support related codes, there was a high level of agreement between the researcher and the second coder, estimated at about 90%. However, the researcher missed "support from older children" as one form of support that the second coder coded. The two coders also had quite a high level of agreement with stress-related codes. Nevertheless, the researcher missed three codes that the second coder found in three narratives. These were "sad boy", "lost job" "housing". However, when the researcher crosschecked the list of codes, the frequency used for housing and sad boy was correct. One of the codes "lost job/income related" stress was missed by the researcher.

With respect to coping related codes, except for three codes that the second coder missed, which were “believe in miracle”, “working very hard” and “my life cannot be changed” as coping strategies, there was a high level of agreement.

The differences in coding helped the researcher to enhance the coding process as well as filter what was coded and check the dependability of themes that emerged from the data. Revisions of the primary codes were made on codes that describe stress and social support found by the second coder. In addition, the second coder agreed to leave what the researcher coded as primary codes in pathways and coping processes.

## **ii. Triangulation**

Triangulation was used to ensure the dependability of the qualitative data. Triangulation is an important means to enhance the rigor of qualitative data and obtain a comprehensive picture of the phenomenon under inquiry (Padgett, 1998). Furthermore, it is very helpful to enhance the quality of interpretation. Several types of triangulation exist such as triangulation by theories, by method, by observation, by data source, and by interdisciplinary triangulation. This study used triangulation by method and data source. According to Padgett (1998), triangulation by data source refers to the use of multiple sources of data. In this study, I used data from field notes, observation, open ended questions, and the data generated from the quantitative analysis method.

## **iii. Negative case analysis**

Negative case analysis involves searching for evidence that contradicts the dominant explanation. This process is vital to increase the credibility of data. Thus, I used negative case analysis through presenting the narratives of cases that provide an

alternative explanation that are divergent experiences and do not fit with the majority responses and interpretations.

#### **iv. Audit trail**

Recognizing the potential biases as an insider researcher, I prepared detailed descriptions of the overall processes of data collection, interpretation, and analysis including the emerging themes and patterns of the analysis. This helps any interested researchers to reproduce the study in another context (Padgett, 1999). Furthermore, I made available the transcribed data and summary of each interview for further review.

#### **G. Human subjects protections**

Ethical considerations in a research study are a major component of the social work research process. Consistent with the requirement of Social Work professional ethics and principles, this study made an effort to adhere to protection of human subjects guidelines. Hence, the study was conducted after obtaining relevant approval from the Jane Addams College of Social Work Protection of Human Subjects Committee, University of Illinois at Chicago Office of Protection of Research Subjects, Institutional Review Board (IRB) (*See Appendix Fa: IRB approval document from UIC*) as well as from the relevant Ethiopian Institutional Review Board (*See Appendix Fb: IRB Committee Review Result from School of Social Work, Addis Ababa University*). Hence, relevant protection of human subject procedures were carried out both in the USA and in Ethiopia at the School of Social Work, Addis Ababa University, a responsible government institution to ensure human subject protection.

Protection of study subjects in this research encompassed ensuring equitable selection, informed and voluntary participation in the research process, confidentiality and anonymity of

study participants. Protections were in place to minimize risks of harm to participants as well as obtaining informed consent (Fortune & Reid, 1999; Rubin & Babbie, 2008).

### **1. Voluntary participation and informed consent**

Kin caregivers participated in this research process without coercion. Study participants were told about their right to obtain clear and complete information about the purpose and characteristics of the research. I clearly notified study participants of their right to withdraw or decline participating in the research even after signing the informed consent (*see Appendix C*). Moreover, I ensured equal opportunity for participation of kin caregivers in the research process. To this effect, kinship caregivers were not excluded from the research because of their sex, ethnic background, socio-economic status, and or religious background. After fully informing potential participants about the study as described above, written informed consent was obtained.

With regard to procedures for ensuring informed consent, I provided information about the study to available kin caregivers in order to obtain better reception of the research in the area and to reduce barriers. I prepared a written summary of the proposed research project in Amharic to create a common understanding about this study and avoid any confusion (*See Appendix D: Information Sheet*). I have established suitable communication strategies and secured support letters from School of Social Work, Addis Ababa University and Pro Pride Ethiopia to recruit study participants. I obtained the agreement of human service agencies in the respective sub-Cities of the Addis Ababa City Administration to contact kin caregivers and initiated contact with those kinship caregivers who were willing to participate in the study.

## **2. Confidentiality**

Ethically, researchers are obliged to protect the identity of participants (Ryen, 2004). Therefore, maximum care to safeguard the confidentiality of the kin caregivers' personal information was guaranteed. Accordingly, I prepared a case number without putting any identifiable information about the study participants on the semi-structured questionnaire. In addition, I separated any identifiable information of the interviewees from the transcribed data after the verbatim transcript of the interview was prepared. Any related hard data such as verbatim transcripts, observation sheets, and consent forms were stored in a locked file cabinet. In presenting the analysis of study findings and whenever I needed to present their narratives or quotations from the data, I used the age and relation type of kin caregivers to the child and did not include any identifying information.

## **3. Protecting study subject from unnecessary harm**

Protecting study subjects from unnecessary harm is another ethical consideration in any research processes. In this research, some study participants experienced emotional upset because of the nature of the study questions that ask them to share their lived experience in the process of caring for HIV/AIDS affected children. Specifically, the interview questions that explored the pathways that led kin caregivers to step into the caregiving role and their challenges led some study participants to experience emotional distress. I addressed the emotional distress using empathic responses and active listening to help ease their emotional distress. Furthermore, I often notified study participants that we could stop the interview process any time.

Although participation in this research led some study participants becoming somewhat emotionally upset, the findings of the present study are believed to bring important indirect benefits for kinship caregivers in the future in two ways. First, the research findings provided



insight to inform the ongoing service delivery efforts by identifying factors that either facilitate or hinder kin caregivers' coping processes. The qualitative data uncovered the contextual realities of caregivers in the caregiving process. Furthermore, the findings may be used to mobilize service providers such as government, non-governmental, and voluntary community based associations to design appropriate interventions that address identified needs of Ethiopian kin caregivers. Second, the research findings provided valuable information for policy advocates, policy makers and social service providers in developing alternative policy provisions.

## **V. FINDINGS**

Through the use of mixed methods cross-sectional research design, this study explored and examined the effect of social support and parenting stress on kin caregiver's coping as well as the moderating effect of social support in the relationship between stress and coping quantitatively. In addition, this study explored the pathways and motivations that led kin caregivers to assume caregiving responsibilities, available social support, stress related to the caregiving responsibility as well as kin caregivers' coping strategies that enable them to sustain the caregiving responsibility qualitatively. Thus, this chapter presents the findings obtained through a quantitative and qualitative analysis.

### **A. Quantitative data findings**

The overall goal of the quantitative component of this study was to explore and examine the effects of kin caregivers' stress and social support on caregiver coping. In addition, the study sought to determine the moderating effect of social support on the relationship between caregiver's stress and coping after controlling for caregiver's demographic characteristics such as age, gender, income level, and relationship to the child. This section of the chapter starts with a description of the participants in the study and of the dependent and independent variables. The results of hypothesis testing are presented.

#### **1. Characteristics of kin caregivers**

Almost all of the kin caregivers who participated in this study were female [121 or 95%]. The participants' mean age was 48 (SD=13.5 years) with a median age of 49. Only a fourth of the study samples were living with their marital partner at the time of interview. The overwhelming majority of kin caregivers (94%) self reported annual incomes below Et Birr 900.00 per annum (\$1=16.80 Et Birr).

TABLE I

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF KIN CAREGIVERS  
N (127)

Characteristics	Responses	Frequency	Percent
Income	<899.99 Et Birr	119	93.7
	> 9, 000.00 Et Birr	8	6.3
Marital Status	Widowed	64	50.4
	Married	36	28.3
	Divorced	19	15
	Never Married	8	6.3
Partner situation	Not living with partner	95	25.2
	Living with partner	32	74.8
Ethnic Background	Amhara	67	52.8
	Oromo	36	28.3
	Gurage	14	11
	Others	10	7.9
Relationship to the child	Grandmothers/fathers	59	46.5
	Aunt	42	33
	Siblings	9	7.1
	Uncle	6	4.7
	Neighbors	7	5.5
	Other	4	3.1
Orphan status	Single	50	39.4
	Double	77	60.6
Number of Children under care	One	64	50.8
	Two	40	31.7
	Three	15	11.9
	Four	3	2.4
	Five	3	2.4
	Six	1	.8

Self-reported ethnic background of kin caregivers indicates that a majority were from the Amhara group, a quarter was from the Oromo group, and the rest were from the Gurage, Tigre and Gamu ethnic groups. Most of caregivers were grandmothers or aunts. The number of children living with kin caregivers ranged from one to six, but half cared for 1 child. Most of the children were double orphaned. (See Table I.)

## **2. Dependent and independent variables**

### **a. Dependent variable**

The dependent variable, coping, was measured using the Ways of Coping scale. However, a shortened version of coping consisting of 13 items was created by combining the planful problem solving and positive reappraisal subscales of the Ways of Coping Questionnaire. A higher score on the coping scale indicates more frequent use of a positive coping strategy with a possible range of 0-39. Accordingly, the mean of the new coping scale is  $M=20$ , and a standard deviation of 5.4. The variable was normally distributed. (See table II.)

TABLE II

#### **DISTRIBUTION OF THE DEPENDENT VARIABLE (N=127)**

Sub-Scales	Responses		
	Minimum	Maximum	Mean (SD)
Positive coping (Combined Planful and Positive Appraisal subscales)	9.00	36.00	20.85 (5.41)

**b. Independent variables**

**i. Stress**

The independent variables in this study were stress and social support. To measure stress, the Parental Stress Index Short Form (PSI/SF) consisting of 36 items was used. The score for Total Stress was calculated by adding the raw scores for all items. According to Abidin (1995) a at or above the 90th percentile indicates that the caregiver is experiencing clinically significant levels of stress (p.55). In this study, kin caregivers' self reported score on total stress ranged from 61 to 166 with a mean of 117.8 (SD = 20.42). This indicates that 15 (11.8 %) of the study sample scored in the clinical range (*See Table III*).

**ii. Social support**

The second independent variable, social support was also used as a moderator variable and was measured by the Social Support Behavior (SSB) scale consisting 45 items. On the social support scale, higher scores indicate higher levels of social support. In this study caregivers' scores on social support ranged from 45 – 218 with a mean of 74.02 (SD= 47.88) (*See Table 3*). This mean indicates that caregivers in this study reported levels of support at the lower end of the scale. (See table III.)

TABLE III

**DITRIBUTIONS of THE INDEPENDENT VARIABLES**

Variables	Minimum	Maximum	Mean (SD)
Stress	61.00	166.00	117.8 (20.42)
Social Support	45.00	218.00	74.02 (47.88)
Valid N (listwise)	127		

### **3. Bivariate and multivariate analyses**

#### **a. Research question # 1**

The first research question examined whether caregiver scores on coping vary based on the caregiver's relationship with the child. I hypothesized that caregivers' scores on coping would vary by whether they have a kin relationship with the child. In testing the hypothesis, I recoded kin caregiver's relationship to the child based on blood relationship (grandparents, aunts/uncles, and siblings as related to the child by blood = 0; and recoded neighbors, landlady, and Godmothers not related to the child by blood =1). T-test for independent samples was performed to determine whether caregivers' scores on coping vary by blood relationship to the child under care. Results (Table IV) suggests that there is no difference on kin caregivers' score on coping by relationship type. Therefore, hypothesis # 1 is not supported.

TABLE IV

## INDEPENDENT T-TEST OF COPING AND KIN CAREGIVER'S RELATIONSHIP TO THE CHILD

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>t</i>	<i>p</i>
Caregiver's relationship							
Related by blood	115	20.49	5.21	(124)	.02	-1.68	.09
Not related by blood	11	23.27	5.33				

**b.     Research question # 2**

The second research question examined whether or not there are associations between caregiver coping and caregiver age, caregiver income, and kin relationship to the child, as well as by caregiver stress, and social support. For this research question, I tested five hypotheses.

**Hypothesis 2a:** Caregiver coping will vary by income level.

**Hypothesis 2b:** Caregiver coping will vary by ethnic group.

**Hypothesis 2c:** Caregiver coping will vary by caregiver age group.

**Hypothesis 2d:** A significant relationship will be found between caregiver coping and caregiver stress

**Hypothesis 2e:** A significant relationship will be found between caregiver coping and social support.

### Hypotheses 2a

A t-test was conducted to compare kin caregivers coping by kin caregiver income level. The independent variable, kin caregivers' income level included two categories: income level < Et Birr 899.99 per annum; (group 1,  $n = 119$ ) and Income level > Et Birr 900.00 per annum (group 2,  $n = 8$ ). The dependent variable was kin caregivers coping strategy. Result (Table V) suggests that there is no difference on kin caregiver's score on coping by caregiver's income level. Therefore, hypothesis # 2a is not supported.

TABLE V

INDEPENDENT t-test OF COPING BY KIN CAREGIVER'S INCOME LEVEL  
(HYPOTHESIS 2a)

	<i>N</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>t</i>	<i>p</i>
Income Level							
< 899.99	118	20.58	5.22	(124)	.08	1.26	..21
>900.00	8	23.00	5.63				

### Hypothesis 2b

A one-way ANOVA was conducted to compare the mean of kin caregiver coping by kin caregiver ethnic background. The dependent variable was kin caregivers coping strategy. Results indicate that coping differences by ethnicity was not significant,  $F(3,122) = 1.914$ ,  $p = .13$  *n.s.* (See Table VI). Therefore, hypothesis # 2b is not supported.



TABLE VI

ONE-WAY ANOVA FOR KIN CAREGIVER COPING BY ETHNICITY (HYPOTHESIS 2b)						
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>p</i>
Ethnicity						
Oromo	36	22.34	5.6	(122)	1.91	.131
Amhara	66	19.79	5.1			
Gurage	14	21.21	4.6			
Others	10	20.50	5.2			

### Hypothesis 2c

The mean coping difference by the three kin caregiver age groups that includes three categories was conducted using one-way ANOVA. Result indicated that kin caregivers coping strategy differed significantly across the three age groups,  $F(2, 123) = 6.59, p = .001$ . (See Table VII ). Therefore, hypothesis # 2c is supported.

TABLE VII

ONE-WAY ANOVA FOR KIN CAREGIVER'S COPING BY AGE (HYPOTHESIS 2c)							
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	<i>t</i>	<i>p</i>
Age							
18 to 35 yrs old	29	20.96	4.98	(123)	6.96		.001**
36 – 50 yrs old	48	22.58	4.76				
> 51	49	18.78	4.21				

A post-hoc comparison of the three age categories were conducted using Tukey post hoc analysis. The post hoc test showed that the second kin caregiver age group, i.e. 36 – 50

( $M=18.78$ , 95% CI [17.57, 19.99]), reported a significant higher coping scores than the age group labeled “greater than 51” ( $M = 22.58$ , 95% CI [20.91, 24.25]),  $p = .001$ ). (See Table VIII).

TABLE VIII

## POST HOC ANALYSIS OF KIN CAREGIVER COPING BY AGE GROUP

(I) Age of Kin Caregiver	(J) Age of Kin Caregiver	Mean Difference (I-J)	Std. Error	Sig.
18 -35	36 - 50	-1.61	1.18	.36
	> 51	2.17	1.17	.16
36 – 50	18 -35	1.62	1.18	.36
	> 51	3.79*	1.02	.00
> 51	18 -35	-2.17	1.17	.16
	36 - 50	-3.79*	1.02	.00

\*. The mean difference is significant at the 0.05 level.

**Hypothesis #2d & 2e**

Pearson’s correlation was used to determine hypothesis # 2d and # 2e that sought to examine the correlations between caregivers’ stress and coping as well as social support and coping. Contrary to the hypothesis, results from the Pearson’s correlation showed a positive correlation between caregivers’ stress and coping ( $r=.27$ ,  $p < .01$ ) accounted for 7.2 percent of the variance in caregiver coping. In addition, a modest positive correlation was found between social support and coping ( $r=.48$ ,  $p < .05$ ). The results indicate that higher social support is associated with increased use of a given use of coping strategies. Although this result was

unexpected and unsupported by prior studies, the results might suggest that social support accounts for 23% of the variance in coping.

Furthermore, the Pearson's correlation result revealed a positive correlation between stress and social support ( $r=.33$ ,  $p < .05$ ). This suggests that kin caregivers with stress might seek more social support. In summary, the examination of research question #2 revealed mixed findings. Results indicate that the stated hypotheses are supported for age and social support but hypotheses regarding income, ethnic background, and stress are not supported.

TABLE IX

CORRELATIONS OF CAREGIVER'S PERCEIVED SOCIAL SUPPORT, STRESS, AND COPING (HYPOTHESES 2d AND 2e).

	M	SD	Stress	Social Support	Coping
Stress	117.8	20.42	1		
Social Support	74.02	47.88	.33**		
Coping	20.85	5.41	.27**	.48**	1

*Note.*  $N = 127$ . Social Support Behavior was coded as 1 (no one would do this), 2 (Someone might do this), 3 (Some family member/friend would probably do this), 4 (Some family member/friend would certainly do this), 5 (Most family members/ friends would do this). Stress was coded as 1 (Strongly agree), 2 (Agree), 3 (Not sure), 4 (Disagree), 5 (Strongly disagree). Ways of Coping was coded as 0 (Not used), 1 (Used somewhat), 2 (Used quite a bit), 3 (used a great deal).

\* $p < .05$  (two-tailed); \*\*  $p < 0.01$  (two-tailed).

**c. Research question # 3:**

The third research question examined whether caregiver's stress and social support predict caregivers' coping. To this end, I hypothesized that caregivers' stress does not predict caregivers' coping and social support predicts coping.

Prior to testing the hypothesis using a standard regression with coping as the dependent variable and stress and social support as independent variables, evaluation of the assumptions of

linear regression was performed. Evaluation of the assumptions of normality using histograms and a normal probability plot shows that the dependent variable satisfies the criteria for normal distribution. The skewness (0.711) and kurtosis (0.501) are within the acceptable ranges i.e. -1 and +1. The independent variable, stress, also satisfies the assumptions of normality i.e. skewness (.029) and kurtosis (-.402). However, social support violates the assumptions of normality. Skewness (1.431) was outside the acceptable range but, kurtosis (.215) falls within the acceptable range (*See Table 7*). The violation of normality led to transformation of the variable, Social Support to reduce its skewness and improve normality. Natural logarithmic transformation was used. The transformation of the independent variable social support did not improve the overall distribution. Since, multiple regression is robust for the violation of normality. I used the original variable in the analysis.

To determine the assumptions of linearity, I examined the residual plots. Results show that the relationship between stress and social support satisfies the assumption of linearity. The Durbin-Watson statistic for the regression analysis was calculated. Results show that the analysis satisfies the independence of residuals assumption because the statistic is within the acceptable range of 1.50 to 2.50.

A standard multiple regression analysis was performed to test whether kin caregivers' stress and social support (independent variables) predict caregivers' coping strategies. In a standard regression analysis all independent variables are entered at once in the regression equation and each independent variable is examined in terms of what it adds to the prediction of the dependent variable that is different from the predictability afforded by all the other independent variables. Results suggest that social support but not stress predict coping (*See table X*).

TABLE X

## REGRESSING COPING ON STRESS AND SOCIAL SUPPORT

Model		Unstandardized Coefficients		Standardized Coefficients
		B	SE	Beta
1	(Constant)	13.396	2.441	
	Social support	.050	.009	.441*
	Stress	.031	.022	.121

a. Dependent Variable: Coping

- $p < .001$

**d. Research question #4:**

The fourth research question sought to determine whether social support moderates the relationship between kin caregiver stress and caregiver coping. To test whether social support moderates the relationship between kin caregiver stress and coping, it was hypothesized after controlling for caregiver's age, income level, and presence of kin relationship with the child, the relationship between kin caregiver's stress and coping would be lower for those who had higher social support as compared to those who had lower levels of social support.

Before examining the moderating effect of social support in the regression equations the predictor (stress) was centered by subtracting the mean score from each data-point. The same procedure was conducted for the moderator (social support). After centering both stress and social support, I created the interaction term by multiplying the two new centered variables. Furthermore, caregiver's age was dummy coded using the study participants' mean age as 0 = age < 48 and 1 = age 49 + because the majority of study participants have a median age of 48.

To test the hypothesis, I conducted a moderated regression using hierarchical regression. Caregiver's age, income level, and caregiver's relationship with the child were control variables and entered on Step 1. On Step 2, centered scores for stress and social support as well as the interaction between these two variables were entered to predict caregiver's coping.

Results (Table XI) indicated that caregiver's age, income level and presence of kin relationship to the child did not have significant effect on kin caregiver's coping. After controlling for caregiver's age, income level, and presence of kin relationship to the child, it was found that caregiver stress did not show a significant main effects on kin caregiver's coping. However, social support had a significant main effect on caregiver coping  $B = 2.3$ ,  $t(125) = -5.09$ ,  $p < .05$ .

The interaction effect between stress and social support did not significantly effect caregiver coping. The results of the analysis indicated that the interaction of stress and social support did not account for a significant proportion of coping variance after controlling for social and demographic characteristics. The results did not support the hypothesis that the relationship between caregiver stress and caregiver coping would be moderated by social support.

TABLE XI

## MAIN AND INTERACTION EFFECT OF STRESS AND SOCIAL SUPPORT ON COPING

Model	Unstandardized Coefficients		Standardized Coefficients
	B	Std. Error	Beta
1 (Constant)	20.40	.69	
Age of Kin Caregiver	-.02	.94	-.002
Income	1.97	1.94	.092
Kin relationship to the child	2.52	1.67	.136
2 (Constant)	187.68	32.88	
Age of Kin Caregiver	.19	.83	.02
Income	2.38	1.75	.11
Relationship to the child	1.85	1.53	.10
Stress_centered	-.16	1.28	-.63
Support_centered	2.31	.45	.44*
Stress_CXSupport_C	-.00	.02	-.73

a. Dependent Variable: Coping \*  $p < .001$

## **B. Qualitative findings**

### **1. Introduction**

The qualitative data in this study were gathered through open-ended questions that were intended to understand the pathways and motivations that led kin caregivers to assume the caregiving responsibility, informal and formal support systems, and stressors related to the caregiving process, as well as coping strategies to sustain their caregiving role.

### **2. Pathways and motivations to kinship care**

Caregivers' motivation: refers to the caregivers' interest and decision to assume the caregiving responsibility. Pathways: refers to the route that the caregivers took to assume the caregiving responsibility.

#### **a. Pathways**

In order to gain an in-depth understanding of kin caregivers' views about the pathways and motivations that led them to assume the caregiving responsibility for their relative's child/ren, I asked the following question "Would you please share with me the story of how you started providing care for your relative children?" During the interview, most kin caregivers showed emotionality while responding to the question. Specifically, three grandmothers were crying because they had lost their daughters who used to support them emotionally as well as financially. I did my best to comfort kin caregivers who burst into tears by empathizing with them and telling them that we could stop the interview, but all of them agreed to proceed to share their stories with me.

Using the two levels of coding to obtain themes/categories/concepts that are meaningful and related with the pathways, five core themes emerged. Accordingly, living arrangement, family expectations, relative's inability to care because of HIV/AIDS, and prior relationship



were identified as super themes for pathways that had led kin caregivers to assume the caregiving responsibility. The following table presents the core themes and sub-themes that explain how kin caregivers became involved in raising a relative's child/ren. (See table XII.)

TABLE XII

## THEMES ON PATHWAYS TO KINSHIP CARE

Sub-themes	Super-themes	Description
Relative and child/ren moved into my place Relative and child/children used to live with me	Living arrangement (10)	Grandparents or aunts would assume the caregiving role for their related children before the death of the children's parent/s due to the living arrangement patterns.
My blood To maintain blood relationship To protect children	Family expectation (4)	Kin caregiver's perception that it is their responsibility to look after a relative's child/ren because of the blood tie and protect children from harm
Relative died of AIDS Daughter/son was HIV positive Sister is HIV positive	Relative's inability to care because of HIV/AIDS (7)	Relative's HIV status and their illness forces kin members to step in and care for ill relative as well as for relative's child/ren.
Addis Ababa has better education service The boy can get better treatment	Not wanting to send the children to rural area (2)	Preference to provide relative's children better education in the capital city rather than sending them to other kin members in rural areas
Good neighbor	Prior relationship (1)	A caregiver caring for her deceased neighbor's child

i. **Living arrangement**

According to the narratives of kin caregivers in describing how they began caring for their relative's child/ren, the living arrangement pattern emerged as a major theme for ten kin caregivers. Two major living patterns were identified as pathways for kin caregivers to assume the caregiving responsibility for orphaned children. The first living arrangement pattern is that kin caregivers lived in the same household as the ill parent/s of the children and the child/ren who needed their care prior to the death of the parent/s. This living arrangement was observed in the case of two kin caregivers. The second living pattern is that ill relatives had moved into the current kinship caregiver's home with their children. This type of living pattern was observed among eight kin caregivers. According to these kin caregivers, their relatives often move into their place when they developed difficulties living independently. The difficulties identified in the data are marital conflict or the death of one marital partner, chronic illness (in all cases AIDS), and the poverty situations. In both of the living arrangements, kin caregivers and their relative children live in one or two room houses.

A grandmother who is caring for her two grandchildren illustrates these two living arrangement patterns.

I am raising my grandchildren from two daughters. One of my daughters, the mother of my grandson, used to live in Dire Dawa with her husband. When she had conflict with him, she left him and moved into my place, and started living with me. After a while, she got sick. She was seriously sick. I tried all my best to help her. However, she died after suffering for a long period. No one could help her and finally, I discovered that she had died of AIDS...The other daughter (the mother of my granddaughter) had married and she and her husband were living with me. After they gave birth to their first child, my daughter got sick. After a while, her husband also got sick. After one year, my daughter died. The doctor told me that she died of TB. After forty days, her husband died with similar illness. They left their daughter in my hands. Both my daughters left their children for me.

A 60-year-old grandmother, raising two grandchildren noted:

My daughter used to live with her husband and their children. She had her own job and her husband had a nice income. She had a good life, and she used to help me a lot. After her husband died, her health deteriorated and she had to move into my place with her children.

A 49-year-old grandmother who is raising three grandchildren shares a similar story. She said:

I started caring for my grandchildren who are nine, seven, and two years old since my daughter became bedridden... I have been caring for her and her three children for the last two years... When her husband died; she had to abandon their rented house because she had no money to pay the rent. In fact, I told her to move into my place.

These two patterns of living arrangements were observed among ten kin caregivers suggesting grandparents or aunts start the caregiving role for their related children before the death of the children's parent/s as a continuation of caring for their ill relative.

## ii. **Family Expectations**

The fact that kin caregivers often had assumed caregiving responsibility for vulnerable children before the parent became ill or died, including having the entire family move into the caregivers household, created huge family expectations that the current kin caregiver would continue in the caregiving role. The family expectation is highly associated with the blood relationship that kin caregivers have with the children. Accordingly, three kin caregivers reported that they were caring for children because the children are their blood. This indicates they wished to maintain their blood tie and fulfill family expectations.

A 45-year-old woman raising her nephew said "there was no one who could take the boy to raise him. He is my blood. I am the one who should be available to help nurture the kid. Who would not take responsibility of his/her nephew?"

A 35-year-old woman, caring for three double-orphaned children also emphasized the family expectation as related to the blood relationship as follows:

Although I did not have much money, I tried to care for the kids by showing them love. I also give them advice to be strong in their education. One of them might be successful. I cannot shun away from them. They are my blood. Who else should care for them? In my culture, your sister's children are yours. I am expected by my family members to raise these kids as my own.

The investigator observed that caregivers and other family members seldom considered the caregivers' capability to provide good care prior to making the decision that they would assume responsibility for their relative's children. Furthermore, the culture emphasizes the importance of blood relationships and maintains high expectations that family members be available for needy children.

**iii. Relative's inability because of HIV/AIDS**

A relative's incapability to care for the child due to their HIV/AIDS status was reported as a pathway for the involvement of kin caregivers in caring for their relative's children. HIV/AIDS was not included in the research questions and caregivers were informed that they would not be asked about their own HIV status or that of the children or their parents as part of the Informed Consent process. However, when they were describing answering the question regarding the pathways that led them to assume caregiving responsibility, seven of the kin caregivers talked about the HIV/AIDS status of the children and their parents.

A story from a 39-year-old woman, caring for her 4-year-old niece describes how her niece's parents were unable to care for their daughter because of HIV/AIDS. She said:

...My sister and her husband were HIV positive. After my sister gave birth of her first daughter, and when the girl turned 9<sup>th</sup> months old, her husband had passed away. My sister was furious and developed hopelessness. Right before my sister's death, she asked me if I could be willing to raise her daughter together with my three children. I assured her that I would take care of her daughter. She had died of AIDS shortly.

A 50-year-old woman raising two children also reported that she was caring for her brother's children who had lost his wife because of AIDS. She said, "My brother had lost his wife for the disease, AIDS and he had no means to raise his daughter. He is alive but never supported his daughter. Sometimes, he visits her."

Similarly, a narrative from a 60-year-old grandmother raising two grandchildren explains parental inability to care for their own children because of HIV/AIDS. She noted:

...Five year ago, she (my daughter) had died of AIDS. I was taking care of her while she was suffering from a chronic illness and her children. I did not know that she had HIV/AIDS. I knew her HIV status five days before her death.

Another kin caregiver, on the other hand, reported that her sister who found out her HIV/AIDS status had left her son in her sister's place and ran away. As a result, the current kinship care provider had become the de-facto caregiver. She said:

My sister used to live with her husband. She had problems in her marriage and once wanted to migrate to an Arab country and work there. By the employment agency, I think, she was asked to present a blood test to know her HIV status. She went to do the blood test in a nearby clinic and later she had found out that she has the virus in her blood. After she knew her HIV status, she abandoned her son at my place and disappeared.

Thus, kin caregivers who began caring for relatives who were suffering from AIDS continue caring for their relative's children after the death of the children's parent/s.

#### **iv. Not wanting to send children to rural areas**

Two caregivers reported not wanting to send the children to a rural area as a pathway to become involved in kinship care.

For example a 57 old woman, raising two children reported:

...My brother died of AIDS. At that moment, other relatives decided to send his children to a rural place in Tigray region where their grandparents live. The children's aunt from their mother's side and I said, the kids should not go to the rural place because they cannot get good education there. Besides, the kids had no idea about rural life. They

never were in rural areas. They were born and grown in Addis Ababa city. For a couple of months, their mother's sister took the responsibility of raising them. After a few months, when she was preparing to send the children to the rural area, I and other relatives from the kids' father's side intervened. I said, although I do not have any thing, I will raise them.

Another caregiver raising her nephew and her own two children said:

...If I did not take him, other relatives in rural area would have taken the boy. However, I decided to raise him because Addis Ababa would be the best place for the boy. He can go to school and get better education. He also can get better treatment as he is an HIV positive boy.

As in the last example the narratives of the caregivers on not wanting to send their relatives' children to a rural area are explained by the caregiver's preference to provide better education services. For them, the quality of education service in the capital city is better than the rural area. Furthermore, in the case of one of the caregivers raising an HIV positive boy and she thought that the boy could get better health services in the capital city.

#### **v. Prior relationship**

In addition to kin caregivers who have blood relationships with the child/ren, the study found that neighbors, friends, and landladies were involved in caring for orphaned children. A neighbor who had participated in the open ended questions reported that her prior relationship/friendship with the deceased neighbor was a pathway to take the caregiving responsibility for one neighbor's daughter. During the interview, I learned that the neighbor began caring for the child because blood relatives of the orphaned child did not show up during or after the funeral of the deceased neighbor to claim the child. A neighbor raising a neighbor's daughter noted:

Four year ago, my neighbor died after suffering from a chronic disease. I am sure it was AIDS. My neighbor really had suffered a lot because of the illness. My neighbor and I had a good relationship. We used to share many things together. My neighbor was living with her daughter. The daughter's relatives neither from her mother nor from her father's

side had shown during or after the funeral... When no one was willing to take care of the orphan child, I talked to my husband and we started taking care of her.

**b. Motivations**

In addition to the pathways to caregiving that emerging from the data obtained from the open ended questions, kinship care providers described their motivations for assuming the caregiving role for their relative's children. Accordingly, nine kin caregivers reported that they did not have a choice but to continue their care for the orphaned children; one kin caregiver said that she was motivated to care because it gave her a chance to rear children, and another kin caregiver had begun caring for an orphan child due to spiritual reasons. Table XIII shows the emerging themes for motivations for providing care.

TABLE VIII

THEMES ON KIN CAREGIVER'S MOTIVATION TO CARE FOR RELATIVE'S CHILDREN

Sub-themes	Super-themes	Descriptions
No one had shown up to care Children have no other place to go Did not want to turn my face away from children Do not have own children Never enjoyed life	Did not have choice (9)  Chance to rear children (1)	Kin caregivers continue caring for orphaned children without their perceiving another option and because the children have no other place to live.  Kin caregiver who never had her own children wanted to care for her ill sister's children as a chance to rear children.
To inherit the kingdom of God	Spiritual reason (1)	Kin caregiver decided to care with a belief that they will be reward spiritually after their death.

**i. Did not have choice**

In explaining the motivations to continue caring for orphan child/children, nine kin caregivers reported that they did not have the choice either to assume or refuse the caregiving responsibility given their living situation. This suggests that they took on the caregiving role because their situations obligated them to do so. The fact that the majority of kin caregivers used to live with their relatives and the relative's children because of the living arrangement pattern that was discussed above, kin caregivers often continued caring for orphaned children because no one else would assume the caregiving role. Furthermore, the current kin caregivers were not willing to turn away children who had no other place to go. They saw the child's future was dependent on the kin caregiver's willingness to keep the children with them.

For example a 65-year-old grandmother caring for two grandchildren reported:

The major reason that I stepped in the caregiving process for my grandchildren is that they have no place to go and I did not have a bad heart to give them away to orphanages. I did not have much choice to decide about them. Their mothers had died in my place and there were no other options for the kids.

A 57-year-old woman who is caring for two of her nephews shared her story as follows:

...The kids were very humble and I did not have the heart to turn my face away from them. I clearly told them that I could not offer them what their parents used to provide but I will strive to get their basic needs met. I offered my support because no relatives were willing to take them. (She was emotional and crying while sharing this story). I am raising them as a mother, not even as an aunt.

A 50-year old woman who is raising two of her sister's children shares a similar story.

She said, "I am raising these children as my own because there is no one who could raise them. There are no other people who could shelter them, feed them, and provide the necessary support to educate them."



A 39-year-old woman raising her niece also explained:

There was no one who could take the boy to raise him. He is my blood. I am the one who should be available to help nurture the kid. Who would not take responsibility of his/her nephew? I had taken up the responsibility because I did not have a choice. In my culture (Gammo community) we are supposed to take care of our immediate family members whether orphaned children, chronically sick person, or the elderly.

During the open ended questioning process, it was clear that these kin caregivers were struggling to fulfill their own needs as well as those of their relative's children. They are generating a meager income through involvement in the informal economy, i.e. selling food items by the street in their neighborhood. Additionally, they did not feel they had a choice to accept or refuse the caregiving role as one or both parents of the children had died already. The living parents in the case of single orphans were no longer able to provide care for their own children as they were chronically ill or in absolute poverty. In the case of one kin caregiver, the living parent had abandoned her son and disappeared after she discovered her own HIV status. Thus, these seven kin caregivers were left with no choice to accept or refuse the caregiving role.

## **ii. Chance to rear children**

Unlike the majority of kin caregivers who had reported that they did not have a choice to assume the caregiving responsibility, one caregiver indicated that her motivation to care for her nephew and nieces was mainly to fulfill her purpose in life. It was a chance to nurture children because she did not have her own child. She explained:

...I never had enjoyed my life because I did not have my own kids. When I heard about my sister's condition that she is suffering from poverty because she had lost her husband, I decided to bring her with her kids. Since my husband had died a few months ago, I talked to myself and said this might be the purpose of my life. When I heard that she has two children, I thought that might be the chance to nurture children.

Unlike others, this caregiver reported that she was an employee and had a regular income that was sufficient to raise her sister's and brother's children. At the time she decided to bring

her nephew and nieces into her place, she had sufficient income to raise three of her sister's children (in fact, her house was well furnished, and well kept unlike the majority of kin caregivers). However, when interviewed, she said that she had lost her job and her current situation did not allow her to raise five children. In her own words:

Unfortunately, I lost my job and could not get another job. I started stressing myself as I was struggling to provide their daily meal...Currently, I feel like I am walking in fire as I am struggling to raise five relative children who lost both of their parents. I do not have anything to cover their school expenses. However, I am trying all my best.

### iii. **Spiritual reason**

One kinship caregiver described a spiritual reason as her motivation to care for her relative's child. During the open ended questions, she explained her motivation to care for a 4-year-old niece who is also HIV positive as follows:

...In addition, no one would be interested to take an ill child. Since she is my blood, I just assumed the caregiving responsibility. Although taking care of a child without sufficient income is tough, I do care for her because I will get a heavenly reward from God in my later life, i.e. life after death.

## 3. **Social support**

In order to understand the mechanisms that helped kinship care providers to sustain the caregiving responsibility, I explored caregivers' perceptions about social support, asking for support, as well as receiving support, during the open ended questions. In this study, the construct of social support is conceptualized as constituting material, financial, emotional, and informational support as well as advice/guidance. When I asked open ended questions participants to describe the mechanisms/supports that are available for them and help them to sustain the caregiving role, kin caregivers' explained their views on material or financial forms of support. None of the open ended questions participants mentioned emotional, informational or advice/guidance aspects of support as support they were receiving from informal or formal

sources. Thus, if caregivers are not receiving any support in the form of financial or material assistance, the likelihood of reporting other forms of support apparently was almost nil.

I organized the findings on social support according to the subthemes and super themes that emerged from kin caregivers' views of social support. Kin caregivers' accounts of social support are summarized in table XIV.

TABLE VIV

## SOCIAL SUPPORT RELATED THEMES

Sub-theme	Super-theme	Description
Free medical service for caregivers and orphaned children, Clothes and shoes including school uniforms for orphaned children, school materials (exercise books, pen, and pencil) Day care for working caregivers Startup capital, business management training, and equipment to begin micro business (3) Food items: 15 kg wheat, 1 liter oil	Formal Support (12)	Support type provided through the Kebele administration HIV/AIDS desk or from non-governmental agencies. School materials including uniforms are provided once a year
Insufficient support Irregular support	Insufficient and irregular support (8)	Kin caregivers receiving formal support from various agencies but feel that the support they are getting is not enough to raise one child. Moreover, the supports are not on a regular basis and caregivers are not certain of the timing of support
Neighbors look after my child (2) Brother visits Sister support	Informal support (5)	Kin caregivers receiving support from family members (brothers) and neighbors
No one would help me No one would support me	Do not have support (8)	Kin caregiver's understanding of support is that it should be adequate and consistent from informal or formal sources and enable them care for their relative children without a challenge
All are suffering from poverty No one was interested to support	Did not seek support (7)	Kin caregivers who perceive that there is no one who could help them because of the poverty situation as well as the increasing living cost that the city is experiencing currently
God cares for me My God knows My God provides	God is my support (3)	Kin caregivers' perceptions about support. Although they are currently receiving forms of support either from informal or formal sources, kin caregivers attribute it to their God
Generate income Household chores Looking after younger children	Children support (3)	Children receiving care also support kin caregivers in household chores (cleaning the house, going to local small market to purchase items), looking after younger children, and selling small items on the street and bringing the income for household consumption
My sons support me	Financial support from own children	When a caregiver has her own children who are currently employed and provide financial support for the family

**i. Formal support**

When asked about the available support system, eleven open ended questions participants reported that they have been receiving support from available non-governmental agencies or from government administered social support services. Although kin caregivers were happy to obtain whatever amount of support, they emphasized that they had started caring for their relative's children without knowing the availability of support in their locality. However, most kin caregivers explained that they were getting support only for one child irrespective of the number of orphaned children they were rearing.

A story from a 73 year-old grandmother who was caring for two granddaughters indicates how organizations administer formal support. She said:

...I have been receiving support for one of my granddaughters from an organization called ISAPSO for about five years. They have been supporting her since her seventh birthday. They have been providing food items (wheat flour, oil, sugar, milk); clothes and shoes and school materials including school uniforms. In fact, the support type varies from time to time. They provide us whatever is available in the organization. They also reimburse medical expenses if the child is ill... However, the organization told us that they support many children and cannot take more than one child from one household. I would be happy if they could have supported both of my grandchildren but I can understand why they are not.

Another caregiver reported that she had started caring for her niece and nephew without the expectation that she might have receive support. She said,

I did not start caring for my nieces and nephews thinking I might get formal support from an agency. I cared for my nieces and nephew for more than two year before knowing about the availability of the services.

Although kin caregivers had not begun caring for their relative's children with an expectation that they would receive support, those who participated in the open ended questions were receiving support from formal sources. The type of support that kin caregivers were

receiving varied from organization to organization. For example, an agency called Brothers of Good Works within the Ethiopian Catholic Church provides cash money depending on the number of orphan children under a kin caregiver's care. Most organizations, both government administered or non-governmental organizations, provide services such as food items that include 15 Kg wheat and 1-liter oil per month if it is available and school uniforms and school materials once a year. Kin caregivers caring for younger children and HIV positive children receive additional nutritious food items like milk. However, kin caregivers repeatedly mentioned that that they do not get the additional nutritious food items on a regular basis.

Furthermore, an agency called Pro Pride follows a different strategy of supporting kin caregivers. Their aim is to economically empower kin caregivers through an income-generating scheme. Three study subjects currently living in Addis Ketema Sub-City said that the organization has been helping them to start up micro businesses based on their prior experience so that they can generate income that would support raising their relative's children.

The narratives suggest that the organization provided kin caregivers with startup capital, relevant equipment that could be important to begin their business, and raw materials to start the business. In addition to the start up cash and equipment that is important to start a business, the organization provided training on micro-business management and saving. Before the organization provided the support, kin caregivers were expected to identify their business interest.

A 50-year-old woman raising a niece and a nephew told her story in relation to the income-generating scheme that helped her to support the children under her care as follows:

Pro Pride had given me startup capital to expand my business, after I told them [the organization] that I am a street vender. They [the organization] gave me various items worth of 1500.00 Et Birr. That is how the kids and I have been surviving. I have used the startup capital to increase the varieties that I sell on the side of the street. Thanks to Allah, I was able to save some money. In addition to the startup capital, Pro Pride offered training on business skills for me and other women who are doing small businesses in our

neighborhood. They taught us how to save and how to identify my profit from the main investment. Previously, I had no idea and did not calculate how I had done in my business. Now, I am doing good business and I am very happy.

A similar story was heard from a 57 year- old woman who was caring for two of her sister's children and engaged in a handicraft business. She noted:

I am raising two children by selling some consumption food items on the street. Finally, I sought public support and, thanks to the Kebele people, they connected me with Pro Pride who helps orphaned children. The organization supported me in various ways. The organization gave me startup capital worth 2000.00 birr to produce a handcraft that helps to decorate households and all of us were producing and selling the product with good profit up until recently.

Another grandmother caring for two grandchildren described how she was supported to start an enjera [Enjera is a local bread made of a teff seed and widely used in the country] business. She said:

I had received a local stove that could be used to bake. They [the organization] had bought me all the accessories, equipments, and ingredients to start an enjera business. Let God give them long life. They also opened me a bank account and told me to save some money on weekly basis from the income I am getting from selling enjera. Although I consumed some of my savings, I was successful to make some profits and had saved. However, I had to quit the enjera business this year because of my health.

The income generating scheme that Pro Pride used to support kinship care providers for orphans and vulnerable children appeared to be the most valuable support. The stories from three kin caregivers revealed that engaging in a micro business greatly helped them by giving them the means to generate income for their own and their children's use rather than waiting for a handout. However, kin caregivers reported that they were encountering challenges to running their businesses as usual due to various reasons. Older caregivers indicated that their health situations have become a major challenge to running their businesses.

For example, a 65-year old grandmother who had been running an enjera business reported that she had stopped her business at the time of the open ended questions says:

I was successful to make some profits and had saved some money. However, I had to quit the enjera business this year because of my health. My health is deteriorating and I could not bake more enjera for sell as I used to. Even now, my health is in trouble. I have problem in my eyes... I have a knee pain.

Others complain about the increasing living cost that made their business fail as their customers lack the ability to purchase their items. A story from a 50-year-old caregiver shows the difficulties of making a profit because of the increasing living cost. She says "... these days, the living cost is getting increasingly higher. As a result, I could not make much profit."

Although income generating schemes need further development in terms of maintaining reliable support systems for caregivers, it provided kin caregivers the opportunity to feel capable of generating an income that helps to support themselves as well as to raise children under their care.

Another type of support available to kin caregivers from formal support systems is medical support for caregivers and the children under their care. Specifically, caregivers obtaining support from non-governmental organizations indicated that they receive reimbursement for any medical related fees for the child/children in their care. Kin caregivers receiving support from government-administrated support systems also receive free medical treatment by presenting a Kebele support letter that describes the caregiver's living situation and socio-economic status. However, caregivers who are receiving health support from government-funded hospitals reported that the support is incomplete. This is mainly due to the unavailability of some diagnostic services as well as most prescribed medicines in the hospitals. While kin



caregivers are supposed to purchase prescribed medicine on their own they indicate that the prescribed medicines are unaffordable.

**ii. Inadequacy and irregularity of support**

Although kin caregivers who participated in this study seemed grateful for the support they were receiving from formal social service agencies, they also revealed their dissatisfaction with the amount and type of support, because of the inadequacy and inconsistency of available formal support to meet the needs of the child/children under their care. Kin caregivers currently caring for more than two orphaned children showed greater concern about the system of support. Although kin caregivers are aware of the mismatch between the existing high demand for support from the community and the lack of resources to meet community's need, receiving support for one child only while caring for two or three children appeared unacceptable to them. However, they indicated that they could go along with the existing support system because no one would give them more support.

A caregiver who mentioned the inadequacy of the existing resources repeatedly during the interview explained as follows. "...the Kebele people had helped me to get 15 kilos of wheat and 1 liter of oil every month for the younger child under my care. I have received this two times this year. Although it is not sufficient, it is okay..."

Another caregiver expressed her concern about the inadequacy and inconsistency of the existing support system. She reported, "Although the amount of support is not sufficient and sometimes irregular, who would have given me these items had it not been for the organization?"

**iii. Informal support**

The category of family/informal support system that emerged from the open ended questions data indicated that kin caregivers receive support from their neighbors.

During the open ended questions, it was observed that kin caregivers caring for children under the age of eight years often expressed huge respect for their neighbors. According to kin caregivers, neighbors are more available as a major support system than immediate blood related family members who live in far places. In most cases, support from neighbors included looking after younger children when caregivers need to go out from home.

A narrative from a 35 old woman who is raising her own and her sister's children said, "...my neighbors are also good support. They support me by looking after my younger kids."

A 35-year-old woman raising her 4-year-old niece also shared a similar story. She said, "Sometimes when I need to go outside for social events or business, I will ask my neighbors to look after the girl for a while. Otherwise, no one would provide my children and me what we need".

Another kin caregiver who used to receive informal support from her neighbors in looking after for her grandchildren and bringing food for her ill daughter said:

... The children were too young and my neighbors used to look after them if I needed to go outside to do something. My neighbors also used to bring food for my ill daughter and they were emotionally supportive for all of us. After my daughter died and we started living a normal life after her funeral, all my neighbors abandoned me.

From this story, it is clear that neighbors stopped supporting the caregiver after the major crisis had passed.

#### **iv. Do not have support**

"I do not have support" was another theme that emerged when kin caregivers were asked about availability of social support and whom they would ask for support. Accordingly, eight kin caregivers said quite a number of times, "I do not have support", even though they were receiving support from various governmental and non-governmental

organizations. Initially, it was quite a puzzle for me to understand why kin caregivers repeatedly said “I do not have support” while they were receiving social support from formal sources. However, after conducting three open ended questions, it became clear to me that kin caregivers’ perceptions about the existence of social support revolved around the adequacy, relevance, and timeliness of support.

A story from one kin caregiver illustrates how she perceives that she has no support although she is getting support from an organization.

I do not have any supporter. No one cares about where I live and how I live except my God. Although I get support from CHADET, it is only for one child. I am raising three children, but the support I am getting is not enough even for that one child.

Another caregiver caring for five children and receiving formal support for one child reported:

I do not have support from organizations. When they look at my age and my household furniture that I bought when I was working for a company, they think I am a well to do woman and do not need any support.

Another caregiver indicated, “In terms of meaningful support there is no one around to give me support...”

#### **v. Do not seek support**

In describing the perception of availability of support from their relatives and neighbors, kin caregivers described how the current economic context of the city makes it difficult to maintain the informal support system. Kin caregivers perceived that many of their relatives and neighbors were equally struggling to lead their day to day lives and the increase in living cost had seriously affected the ability to support each other in times of

challenges as they used to do. As a result, most kin caregivers indicated that no one would be willing or able to provide practical or financial support.

A narrative from an aunt caring for a niece and nephew shows how the existing high living cost affected the availability of support from informal sources, i.e. family members and friends. She said:

I did not receive any forms of support from family members. My provider is my God. I also do not have friends who could offer me help. You know how the current living situation is [...]. It is very difficult. Everybody is struggling with their own life. No one is interested to support the kids.

Another grandmother caring for two grandchildren shared a similar understanding about seeking support from family members. She noted:

Speaking of support from other family members, no one is available to provide support for the children or for me. You know these days; many people are struggling to win their own life. No one has extra resource to support ... Many of my relatives know that I am raising these children alone. For this reason, I do not opt to ask support from anybody.

To describe the difficulties in their current living situations, significant numbers of kinship care providers used the following Amharic expression: “Bager Yemeta new” meaning “the problem is a national problem”. It also means, “Ethiopians are currently suffering from poverty and I am not an exception”.

#### **vi. Child/ren support**

Three kin caregivers reported that older children under their care also supported them by doing household chores like cleaning, cooking, and looking after younger children. In the case of street vendors and caregivers operating other types of micro business, older children were supposed to help through bringing items important to the

caregiver's business from the market place or take the items for sale to the place where kin caregivers operated her business.

A caregiver who is raising her own and her deceased sister's children reported how the older female child supports her in household chores as follows: "the older children help me in household chores. The female child helps me in cooking and cleaning the house. The boys also look after my children. They play together...We are supporting each other".

Another caregiver who used to do business with the support she received from an agency described how her granddaughter helped her by taking the enjera to the local market place. She said, "The girl is now growing and helps me in the house. She does all the household chores. When I used to sell enjera, she used to help me by taking it to the market."

Similarly, an aunt caring for her 13 years old nephew and 8 years-old niece explained how the children understand and provide support. She noted:

... the boy is in 7<sup>th</sup> grade and he is very clever. I also tell him to be good in his school. The girl is in grade 2. Both are good children. They do not bother me much to get them what I cannot afford. None of them request things beyond my capacity. They know what I am going through and they help me in getting these items from Merkato [Merkato is the largest open market in Africa]. Both kids understand my situation.

Children's support for caregivers in and outside of the house is observable because of the nature of kin caregivers living situations. Kin caregivers who are physically weak may not be able to carryout daily routine household chores. Furthermore, if a caregiver is raising younger children, older children living in the same house are expected to look after the younger ones so that the caregiver can engage in other activities. Furthermore, going to the market place and taking items to the market is the responsibility of older children since the task requires physical fitness, which, in the opinion of many caregivers automatically makes children eligible for the task. Furthermore, female children support kin caregivers by taking care of the household chores

as the culturally accepted gender based role socialization process requires them to be equipped with the necessary skills from early ages.

**vii. God is my support**

Three kin caregivers who were caring for their relatives' children indicated that their God had been supporting them to maintain their caregiving role. These kin caregivers attributed the support they were getting from agencies to provisions from God.

A caregiver who indicated that she had no one whom she could ask for support said, "I do not have anyone whom I ask for support except my God. God is helping me to survive in his miracle."

Another kin caregiver reported that her family members do not provide support while she is caring for orphaned children. In her narrative, it was clear that the fact that she was receiving support from a formal organization is because of God's provision. She noted, "I do not receive any forms of support from family members. My provider is my God."

A 49 year-old grandmother who was caring for three grandchildren and living in a very difficult situation reported that except her God, no one cares about her and the grandchildren. She said, "I do not have any supporter. No one cares about where I live and how I live except my God".

**viii. Financial support from own children**

One caregiver who has sons who are grown up and currently employed reported that "Thanks to God, I have two sons and they are now working. This year, they have started supporting me." For this caregiver financial support from her sons is vital since their contribution is regular and on a monthly basis.

In summary, adequate material or financial support is unavailable for the majority of kin caregivers who participated in the open ended questions. Although formal support in terms of food items, school materials and uniforms, and medical support are available for kin caregivers, the support is inadequate and irregular. In most cases, irrespective of the number of children kin caregivers are raising formal institutions provide support only for one child. Furthermore, kin caregivers did not mention other forms of support such as emotional, informational, or guidance. The kin caregivers' views about support mainly revolve around material and/or financial support.

#### **4. Caregiver's stress**

This section of the chapter presents kin caregivers' qualitative appraisal of stressors associated with their roles as caregivers for their relative's children. During the open ended questions, it was observed that kin caregivers embrace the socio-cultural context that places an expectation on blood relatives to care for orphaned and vulnerable children, irrespective of the individual's capability. During the interview I observed that caregivers' acceptance of the socio-cultural context appeared to buffer kin caregivers from being highly stressed. The conceptual framework that is guiding this study views stress related to children's needs, the caregiver's own situation as well as the interaction between the caregiver and the child/children under their care. With the exception of two caregivers who mentioned stressors in relation to the children's behavior, most kin caregivers attributed the source of their stress to the lack of income to provide what the family needs in terms of food, clothing, housing, school materials including uniforms and medical treatment. The older children's health status as well as grandchildren or niece's health issues were also described as stressors. Disclosure of HIV status for children under care, disclosure of orphan status, and grandchildren's grief were also

identified as stressors in relation to caring for relatives' children. Table XV summarizes themes that emerged from data in relation to stressors associated with caregiving for relative's children.

TABLE XV.

## STRESS RELATED THEMES

Sub Themes	Super Themes	Description
Cannot provide food Food is very expensive (1) Cannot afford to buy food (1) Living cost is high (4) Cannot purchase enough food	Food insecurity (9)	Food prices have been increasing in recent years and, at the time of interview, it has become almost unaffordable for the lower income group
Missing parents Watching ill mother	Children's grief (3)	Looking at an ill mother suffering from AIDS and as well as witnessing the death of parents.
Moody child  Fights Depressed and sad boy	Child's behavior (2)	One fights with other children in the neighborhood. One is mostly depressed (sad)
Unable to buy clothes and shoes	Clothing (2)	When caregivers fail to provide clothes and shoes to children under care
Lack sufficient rooms Clean HIV positive older child HIV positive grandchild Why medicine every day? Grandchild illness Older child health situation	Housing (2)  Older child and grandchildren or niece illness and disclosure of the child's HIV status (2)	More than five family members living in a one or two room house Caregiver's difficulty telling why the child under their care is taking ART medicine regularly.
	Disclosure of child's orphan status (1)	When caregivers raise very young orphaned children they have difficulty telling them who the biological parents are.
Aging Knee problem Eye problem	Caregiver's own health (2)	Caregiver who is sick at the time of the interview indicates that her own health concern is a major stressor
Children might be abused What will happen to them	Caregiver's fear about the future of the children (2)	Older caregivers worry a lot about what will happen to the children in their care when they die.



i. **Food insecurity, housing, and clothing**

The rising food prices were found to be a major stressor that revealed the problem of food insecurity for nine kin caregivers. These kin caregivers do not have the capacity to feed regularly the children in their care. Securing meals for the family is a daily challenge for them. As a result, most caregivers indicate that they purchase meals whenever they get money. Two kin caregivers reported that sometimes all family members go to bed without dinner.

A story from a 45-year-old aunt caring for five children shows how she is struggling to feed the children in her care. She said, "...the living cost these days is getting higher and higher. I cannot afford to buy food for all of us. I always feel worried thinking what I could do for tomorrow".

A similar story from another caregiver reads as follows:

Another stressing factor for me is the living cost. As you know, the living cost rises every day. It is unbelievable to buy 1 liter of oil for 40 birr. In addition, bread is now sold for one birr, which used to be .025 cents. It is very expensive. I cannot provide the kids a balanced food.

A 60-year-old grandmother caring for two grandchildren also noted:

I am raising the two grandchildren without regular income. It is very difficult and stressing to raise children without fulfilling their needs. Children need many things. They want me to get them several things that I cannot afford to pay. I cannot even provide them food regularly.

The inability to afford food prices has been found very troubling for caregivers who are caring for HIV positive children.

A 39 old woman caring for a 4-year-old niece who had lost both of her parents reported, “...I cannot prepare her quality food. She has poor appetite. She does not eat what I give her. As a result, she is weak. That is very stressing. Sometimes I feel terrible that I cannot give her more.”

Another caregiver reported that whenever she feels distress because of lack of food in the house, the children under her care cry with her. She says, “Sometimes, when I do not have money to purchase enough food and when I feel sad, they shed tears with me.”

A 73-year-old grandmother caring for two grandchildren indicated that food insecurity is most stressing not only for her but also for the children in her care. She explained:

Life is too challenging. Our living situation is too difficult. I do not have regular income or sufficient support to provide what we all need. I cannot assure the kids that they can get food all the time when they return from school.

Most kin caregivers reported that if they were capable of feeding the children, they would not mind about the rest of challenges. Most kin caregivers used a phrase “if your stomach is empty, it does not give a day” to describe how food insecurity is a major stressor. If a caregiver does not get some money to purchase food for the day, it will be a very stressful day.

Two caregivers also identified their inability to purchase clothes and shoes as another stressor they experienced while they were caring for their relative’s children, especially on holidays. In the Ethiopian tradition buying new clothes as a way of celebrating holidays is the most common practice. Children love to get new clothes especially on holidays.

Two caregivers reported sharing a poorly built, furnished, and congested housing facility with younger children as a stressor. The housing problem was evident, as I observed their place of living. Although most kin caregivers share a one room house for an average of five individuals, the situation of these two caregivers is worse. These two caregivers were living in a

one-room house sharing with their relative's children and other adult relatives. The houses are made of corrugated iron sheeting and are in poor condition. For these kin caregivers the house is not a safe place to raise children. However, the caregivers have no means of getting adequate housing.

A 60-year-old grandmother said:

I cannot keep them in clean place. I have only a one room house and all of us sleep in one bed. I have two young sons who are sleeping inside the roof (inside a ceiling). It is very challenging for me to deal with kids at this age.

**ii. Child illness and disclosure of the child's HIV status**

Although caregivers were aware that they had the right to not disclose their own HIV/AIDS status, the HIV status of children in their care or the HIV status of the children's parents prior to the interview, caregivers openly described HIV/AIDS as one of the stressors associated with their role as kinship care providers for their relatives' children. Three kin caregivers reported the challenges they were facing because they were caring for an HIV positive older child and grandchild or nieces. These three kin caregivers were economically poor. Thus, they had difficulty providing food that would be appropriate for an ill person. While exploring available social support, kin caregivers reported that they receive nutritious food items from formal social service providers if they are caring for an HIV positive child. However, three kin caregivers said that the nutritious food items are small in quantity and the organizations do not provide the food items on a regular basis.

A caregiver of an HIV positive niece said, "...She is an ill child. I always worry when she gets sick. When she is ill, she usually gets easily upset and she becomes moody."

Similarly, a grandmother shared her story of how stressful it is to care for an HIV positive child as follows:

I have been facing stress mostly because of my grandchild's health situation. Before she started her HIV treatment, she used to get sick often and suffer a lot. It was very stressing to see her that way. I still feel stressed thinking about her. I usually worry thinking what would happen to her at any time. As I learned from the doctor, the disease has no cure. This medicine only helps her extend her life. It is sad that she has to live with the virus without her own mistake. She does not deserve the disease... In addition, I feel distress when she asks why she is taking the medicine every day.

Another aunt raising three nieces and two nephews reported how watching her younger niece who is HIV positive is very stressful. According to the caregiver, her sister moved into the caregiver's house with her three children after she lost her husband. After living for a few years together, the mother died of AIDS. The younger niece is HIV positive. The caregiver described the situation as follows: "My younger sister also got sick and died of AIDS one year ago. Since then, the younger niece became very challenging to rear..."

### **iii. Children's loss and grief**

Three kin caregivers reported that observing a grandchild's sadness and grief because of their parent's illness and or death was a stressor. A grandmother reported how her grandchildren were grieving by observing their mother's illness due to AIDS. She said, "It is very stressful watching my daughter's misery from her sickness. My grandchildren also weep whenever their mother gets seriously ill. Their sadness is enormous."

Another grandmother raising three grandchildren indicated how seeing her grandchildren grief and mourn is the most stressful event. She noted:

The most stressful situation in the caregiving process is watching my grandkids grieving. They miss their parents. I know they are deeply sad and grieving a lot. They did not enjoy their parent's love. Although they did not express it verbally, I can imagine how they are mourning. That makes me feel more stressed.

A grandmother also reported how her grandson misses his deceased mother and feels sad and depressed most of the time. She said:

I can tell you that my grandson is a sad boy. I know why he is sad all the time. He missed his mother a lot. Sometimes, he used to tell me what she used to do with him and for him. He remembers most of the things they used to do together.

**iv. Child's behavior problem**

Two kin caregivers reported a child's behavior problem as a stressor. A 27 year-old caregiver had been caring for an 11 year-old girl who is unrelated by blood. The child's mother was the caregiver's neighbor and had died of AIDS. While the girl's mother was seriously ill, the girl begged on the street to bring some money to feed herself as well as her ill mother. According to the current caregiver, neighbors provided some sort of care for the ill mother too. After the mother's death, no blood relative comes forward to take the responsibility of raising the orphaned girl. Then, the current caregiver assumed the responsibility of caring for the orphaned girl after consulting with her husband. The caregiver said "the fact that the girl had the experience of begging on the street, she wanted to continue begging after I started caring for her." In addition, the girl always fights with other children in the neighborhood. The current caregiver was unhappy with the child's interest to continue begging as well as with her violent behavior. She explained:

The child used to beg and had the experience of living on the street. She still enjoys being out there. I always tell her to stay home but she is a stubborn girl...Sometimes, I feel like I put myself in bad situation. The other stressor is the child's mood. Sometimes, she just seems depressed. She gets annoyed easily. She also fights with children in the neighborhood.

v. **Fear about the future of children**

Older kin caregivers also reported that they are highly worried thinking what would happen to the children under their care in the future. While describing their major stressors, two kin caregivers, an aunt and grandmother demonstrated considerable concern about their own health. In fact, these two kin caregivers were suffering from various diseases such as high blood pressure, eye related problems, and knee problems. The situation is becoming worse as they are unable to get quality medical care and treatment because of their poor economic status.

A 45-year-old aunt said, “I also fear and feel distressed when I think that what will happen to them if I die. I am growing old and that makes me feel worried about their future wellbeing”.

Similarly, a 65-year-old grandmother reported:

I am worried that I might be deceased soon. That makes me more stressed. Unfortunately, all my children had died and there is no one who could look after my grandchildren. If something bad would happen to me, what will be the fate of my grandchildren? That worries me a lot. Since I do not know about their future, I am in great stress.

vi. **Disclosure of children’s orphan status**

A caregiver caring for her double-orphaned niece right after her birth described her inability to disclose the child’s orphan status. Although she had been telling the child under her care that she is her biological mother, she reported that she become stressed since the child has begun interacting with other children in the neighborhood. Thus, the caregiver has started worrying about disclosing the niece’s orphan status. The caregiver had not told the niece about her biological parents. However, the caregiver reported that the children in the neighborhood might tell the niece and she might find out who her biological mother is. She

noted "...the girl has begin inquiring about her parents. I think kids from the neighborhood had told her about her father and mother. Recently, she has started questioning about who her real parents are. That also makes me more stressed."

**vii. Job loss/income related stress**

A caregiver who used to work for a company with better monthly salary lost her job after she became involved in kinship care for her three relatives' children. For her, losing her job brought her extreme stress. She said "After I brought those three children in my place, my living situation became challenging. Unfortunately, I lost my job and could not get another job. I started stressing myself as I was struggling to provide their daily meal."

**viii. I do not have stress**

Unlike the accounts of eleven kin caregivers who had mentioned several factors as their major stressors while caring for their relative's children, one kin caregiver expressed a different stance in appraising her caregiving responsibility. She reported that she accepts her situation as it is and she is happy with what life had to offer. She believes that many people in her neighborhood live in a similar living standard. Thus, she does not see the importance of worrying or stressing too much as stress would bring nothing. She described her situation as follows:

I accept what life had to offer and I move on. I do not want to get depressed. Hence, I focus on what I have to do to generate income. I am not alone. Many people are poor. Why would I get stressed?" ... I provide what I could for all children and we are happy. Sometimes, when I do not have much, the older children (my nephews) encourage me not to worry too much. They also say you will be better when we grow.

Here, it should be noted that this caregiver lives in similar living conditions like the other kin caregivers who have participated in the open ended questions. The difference, however, is that she had reported that her husband supports the family. Although the income is meager, the

caregiver works as a daily laborer. Furthermore, her niece helps in household chores and her nephew looks after her two children.

In conclusion, kin caregivers' qualitative description of the challenges they are experiencing on a day-to-day basis indicate the stressful encounters kin caregivers are facing while caring for orphaned and vulnerable children. Despite the challenges however, kin caregivers do not consider taking the caregiving responsibility for their relative's child/ren as a burden. According to kin caregivers who participated in the open ended questions, although they are unable to provide quality of care in terms of providing sufficient food, clean and spacious housing, or sending relative's children in better education facilities and fulfilling education materials, kin caregivers appear happy because they are at least available for their relative's child/children. For most kin caregivers, the fate of the children would have been living on the street had it not been for their availability and willingness to take the caregiving responsibility.

Kin caregivers also reported that they usually talk about their living situation and make their relative's children aware of everything. Thus, children, although they might demand certain things they do not press kin caregivers to fulfill what they need. According to kin caregivers, the children are aware the day to day battle to obtain some income and put food on the table. Hence, care providers and their relative's children support each other in creating common understanding about their challenges.

## **5. Ways of coping**

In addition to understanding the pathways to caregiving, kin caregivers' motivations to take the caregiving responsibility, available social support, and the challenges kin caregivers were facing while caring for their relative's children, their strategies to deal with challenges were also the focus of this dissertation study. Although Lazarus and Folkman's (1984)



definition of coping was used to guide this study, the qualitative component sought to gain an understanding of their perceptive and intentional responses to the perceived and actual stressors that were identified as exceeding their resources in the caregiving process.

In view of that, kin caregivers explained how they deal with stressful events. According to data that emerged from the open ended questions transcripts, most caregivers share a common understanding that their living situation is unchangeable and it is beyond their control. The main coping mechanisms kin caregivers reported were praying, believing in miracles, accepting life, believing that they cannot change their life, working very hard, establishing good relationships with grandchildren, receiving support from an agency, blaming self, and by trying to forget the stressful situation. (See table XVI.)

Table XVI.

Themes on Coping Strategies		
Sub-themes	Super-themes	Descriptions
Pray for sick children Praying for daily meal Praying for problems Praying for own health Expecting miracle	Pray/ Crying out to God/ Ask my God (11)	Crying out to get God's help, talking to God about difficult situations including inability to secure food for the family, children and caregiver's own health, and for the future of the children under their care
Accepted life Life cannot be changed Why would I get depressed? Advising children It is my fate	Accepting life (7)	An attitude that a caregiver has regarding their life as unchangeable and believing that they are destined to their current living situation and accepting it as their fate
Improving my business Doing something to generate income	Keep Working very hard (2)	
Good relationship with children	Good relationship with grandchildren (1)	Telling grandchildren about the reality of life so that grandchildren will understand the difficulties that a caregiver is facing
Support from an agency	Receiving support from an agency (1) Draws on past experience (1)	A caregiver who is grateful for a formal support to sustain her caregiving role

In analyzing data that emerged from the open ended questions, I observed individual differences coping strategies. However, kin caregivers did use some similar coping strategies in dealing with stressors that arose during their caregiving responsibility. Furthermore, a caregiver might use two or three coping strategies to deal with one stressor. The most commonly used combination of coping strategies were praying, accepting life, believing that they cannot change their life, and expecting miracles to happen.

**i. Praying/crying out to God/telling God**

Most kin caregivers often used praying i.e. telling God what they and the children under their care need, as the most viable coping strategy. The idea of praying as a coping strategy was prominent for eleven kin caregivers who participated in the open ended questions. This might be associated with the existence of three Ethiopian Orthodox Churches named Emmanuel, Cherkos, and St. Mariam in close proximity where kin caregivers' dwell in the three study areas. Accordingly, caregivers often walk to the church compound twice a day to pray or cry out as they describe it "talking to my God". Kin caregivers who reported praying as their major coping mechanism also reported that their praying topics were multiple. For example, kin caregivers prayed whenever they feel distressed because of their inability to secure food in the house, for their own health, for the health of a sick child as well as the children's future fate. In addition, they use praying as a coping strategy for any other problems they might encounter day by day. Furthermore, few kin caregivers expected a miracle to happen and transform their living situation.

A 73-year-old grandmother who is caring for two grandchildren narrates her coping strategy as follows:

When I feel stressed, I go to church and pray. I shed my tears in prayer and ask my God to give me more year so that I can see my grandchildren taking care of themselves. I wanted to see them grown before my death.

Another grandmother who is caring for three single orphaned children shares her story on how she copes whenever she feels stressed because of the caregiving responsibility as well as her fear about the future fate of the children. She says:

Whenever I feel distressed, I often go to church and pray. I ask my God to insure my grandchildren. I want them to grow without any more troubles. I also pray for God to give me more years so that I can be available for the children. They need someone to care for them. If something happens to me, what will happen to them? Thus, I pray to stay healthy until my grandchildren are able to take care of themselves.

A 57-year-old aunt caring for her niece and nephew believes that God will provide her family the daily needed meals. Hence, she prays and asks her God to fulfill the family needs. She reports, "I go to church and pray. I know my God will provide us our daily bread."

A kin caregiver currently caring for five children reported that she prays for the family wellbeing and especially for the younger and sick child so that God can heal her. She said:

Whenever I have such distressing thoughts, I cry out for God's help. I always go to Church and pray for my health and kids wellbeing. I often pray especially for the younger and sick one. I put request to my God. I say, give me more years until these kids are able to take care of themselves.

## **ii. Accepting life**

In addition to praying, six kin caregivers also reported that they cope with the life difficulties in general and the challenges related to the caregiving responsibility in particular by accepting their life as it is and believing that they cannot change their life. In describing how they cope with stressors related to their caregiving responsibility, kin

caregivers also repeatedly mentioned believing the existing living situation is their predestined fate and advising and telling children under their care about their life circumstances.

A 39-year-old aunt caring for her 4-year-old niece noted:

I accepted my life since it is my fate. There is nothing I could change about it. I always accept what is happening and move on. I do not feel anxious about life. I do not worry to build a house or to purchase a car. I am poor. I know that I am extremely poor. You know poor people take risk without worrying about the consequences.

Accepting and believing in life as a fate appears relate with kin caregivers' belief that they cannot change their situation. There is a strong attitude among seven kin caregivers that they cannot change their life and it has never been easy for them to alter their living situation.

For example, a 45-year-old aunt raising her own three children and a four and half-year-old nephew explained how difficult to change her own living situation as follows:

I have been living this life for many year and had never seen significant changes neither in mine nor in my friends living situation. Life had never been easy and unless a miracle happens, it will not change the pattern. It is rather getting worst.

Similarly, a 49-year-old grandmother caring for three grandchildren described how she came to believe that her life would not change as follows:

I always wish something good to happen in my grandchildren's life. Unless God will have compassion and mercy on me, I cannot change a thing. What can I do other than praying and wishing good things to happen in our life? I know I never been able to change my situation. I have been like this before. I am living in the same way I used to. Nothing has changed. Thus, I pray not to experience the worst things in addition to the burden I have.

A 27 year-old caregiver currently raising her only son and caring for a deceased neighbor's daughter said, "I do not think I can change most of the things that bothers me."

### **iii. Keep working**

Turning their attention to work in order to make oneself busy was reported as coping strategy by five kin caregivers. For some kin caregivers, working served as a

copied strategy when they engaged in an income generating activities so that they could fulfill their own as well as the children's need. For example, one caregiver said, "I had taken a loan from Kebele to expand my business. I am trying to cope with my challenge by working very hard to improve my business". For this caregiver, trying all her best to improve her business is vital to support herself and the children under her care.

Similarly, a 60-year-old grandmother who is caring for two grandchildren also indicated that she had to work to feed her grandchildren. She described that working is her best coping strategy. She noted:

I do not like sitting and yearning. I always try to think what I could do to change my problems. The only way I cope with my life is by doing something... I have to work to feed my grandchildren and myself.

A 39-year-old aunt caring for one child indicates that she prefers to concentrate on what she has to do rather than spending more time on thinking about stressors and other challenging life encounters. She said:

I also concentrate on what I have to do next rather than dwelling on issues that bother me. In addition, I prefer to work. I do not like sitting and feeling depressed. I go out and look for what I could do. Sometimes, I clean the house twice if I do not have anything to do.

A seventy-three-year-old woman also reported that she sometimes make herself busy with activities in addition to praying and talking to grandchildren as her coping strategy. She says, "...Sometimes however, if there are stressing situations, I will engage myself with stuff to make myself busy".

iv. **Good relationship with children and receiving support from an agency**

A 74-year-old grandmother caring for three grandchildren whose age are 18, 16, and 10 reported that maintaining good relationships with her grandchildren and receiving support from an agency helped her to cope best with her stressors. She said:

I am coping well with the situation because I have a good relationship with my grandchildren. They are humble and listen what I have to say in any matters. In addition, I receive support from the Keble. The support I am getting helps me to ease my stress.

For this caregiver, her good relationship with her grandchildren helped her to gain better communication where the grandchildren would listen and obey her without a problem since she had begun caring for them. In fact, the relationship was vital, as the two granddaughters are now 18 and 16-year-old girls. The granddaughters also supported their grandmother through taking care of household chores. Furthermore, the caregiver appreciated the agency support that helped her to stop worrying about fulfilling his needs related to education.

v. **Drawing on past experience**

A kin caregiver reported that she draws from her past experiences on how she had dealt with difficult situations. For this caregiver, the stress that arose because of her caregiving responsibility could be dealt with using insights and skills she had gained passing through various life encounters. This caregiver is raising her own daughter and her sister's son. She noted:

I also cope with stressful situation by telling myself about what I had been through and assuming that this also passes away. I believe all things pass away. Who knows? My God might turn my life in a better condition.

For this kin caregiver, the stress arose because of her caregiving responsibility would also be dealt with the insights and skills she had gained passing through various life encounters.

### **C. Summary of findings**

In general, the current study found that a significant majority of kin caregivers are female and live on less than \$2 per day. The majority of kin caregivers were caring for two children most of whom are double-orphaned children. Study participants identified various pathways and motivations that led them to assume the caregiving responsibility for their relative's children. Living arrangement patterns, parents' inability to care for their own children because of HIV/AIDS, family expectations, prior relationships with deceased neighbors, and not wanting to send children to rural area were identified as major pathways that led kin caregivers to assume the caregiving role. Lack of choices either to accept or decline the caregiving responsibility, and the chance to rear children were identified as major motivation factors for kin caregivers to begin caring for their relative's child/ren. Kin caregivers' scores indicated a low level of social support. Kin caregivers currently receiving support from formal sources indicated that the support was inadequate and irregular and lacks consistency. Although the majority of kin caregivers received support for one child, their overall perception was that they do not have support. The high cost of living influenced their views about the availability of support from informal networks i.e. family members and neighbors.

Quantitative data show that 15% of kin caregivers who participated in this study had a stress score that was clinically significant. Kin caregivers indicated that their inability to provide daily meals for the children in their care and lack of resources to provide close and habitable housing were major stressors. Caregivers of HIV positive children reported that the child's health as well as their inability to disclose the child's HIV status was sources of stress. Although kin caregivers reported that they use a combination of coping strategies, this study revealed that praying was the most vital coping strategy. Furthermore, kin caregivers tended to use a positive

attitude and appraisal processes in response to the various stressors associated with their kin caregiving role.

This study explored four research hypotheses regarding kin caregivers' coping. The first hypothesis sought to determine whether kin caregivers' scores on coping vary based on relationship type. In the second hypothesis, this study examined whether kin caregivers' coping varies by their age, income or ethnic background. The second research question explored whether there is an association between stress, social support and coping. The third hypothesis examined whether stress and social support predict coping. Finally, the fourth hypothesis sought to test whether social support moderates the relationship between stress and coping.

The first hypothesis was not supported. Results from the t-test show that kin caregiver scores on coping did not vary based on their blood or non-blood relationships with the children in their care. In testing the hypotheses related to the second research question, a significant difference in coping were found by age group and a significant positive association were found between kin caregiver's social support and coping. The third hypothesis was partially supported. While stress did not predict coping, social support did. The fourth hypothesis was not supported. Social support did not moderate the relationship between stress and coping in this sample.



## **VI. DISCUSSION, LIMITATIONS, AND IMPLICATIONS OF THE STUDY**

This study sought to understand available social support and the stress and coping process of kinship care providers for orphans and vulnerable children in the context of HIV in Addis Ababa, Ethiopia. Using a mixed methods research design, this study contributes knowledge about the care of orphan children by kin caregivers in Arada, Addis Ketema, and Kirkos Sub Cities of Addis Ababa City Administration. Data were collected through a structured in-person interview and included information regarding socio-economic and demographic characteristics of kin caregivers and social support, stress, and kin caregiver's coping strategies. Data collected during the 127 interviews were used to perform the quantitative analysis. With the objective of gaining an in-depth understanding of pathways and motivations that led kin caregivers to assume the caregiving responsibility, available social support and kin caregivers' stress and coping strategies, kin caregivers were randomly selected from the total sample for in depth interviews.

Data collected through the qualitative open ended questions made the analysis of the findings more interesting. The process of data integration involved examination of similarities and differences of major findings obtained from the qualitative and quantitative analyses, as well as data from recent literature. It was possible to look for unique information and cases in presenting the discussion section of this study.

Thus, this chapter will have three sections. The first section presents the discussion of findings from qualitative and quantitative analyses through by comparing the current results with results found in prior related studies of orphan care in Ethiopia, Sub-Saharan Africa, and in the USA. The second section discusses the limitations of the study and the final section presents the implications of the findings for social work education, practice, policy, and future research.

## **A. Discussion of the Findings**

### **1. Pathways and Motivations to Kinship Care**

In order to gain a comprehensive understanding about the pathways for kin caregivers to assume the caregiving responsibility, kin caregivers who participated in the open ended questions were asked to share the stories of how they started providing care for their relative's children. The narratives from 12 kin caregivers identified living arrangement, family expectations, the parent's inability to care because of HIV/AIDS, and prior relationship as super themes for pathways that led kin caregivers to assume the caregiving responsibility.

In describing the living arrangement patterns, kin caregivers indicated that either the children's parents lived with them together with their children or the children moved into the caregiver's place when their parents encountered difficult circumstances. These living arrangement patterns indicate that kin caregivers had begun caring for their relative's children prior to the death or chronic illness that rendered the parents incapable of caring for their own children. In the case of chronically ill relatives, kin caregivers were performing doubly by caring for ill relatives as well as orphaned and vulnerable children, suggesting a continuum of care. This finding is in line with Ssengonzi's (2007) results from a qualitative study of elderly caregivers for people infected with HIV and affected children in two Ugandan rural and urban communities. Ssengonzi's qualitative analysis revealed that kin caregivers demonstrate double responsibility by caring for ill relatives as well as caring for grandchildren whose parents are alive but are continuously sick and unable to take the primary responsibility of caring for their own children.

The accounts of four kin caregivers in relation to the question about pathways to assuming caregiving responsibility suggested that they are caring for their relative's children to fulfill their family's expectations. Ethiopia does not have an economic safety net for its citizens

and has no capacity to ensure the wellbeing of its orphans and vulnerable children through government financed programs. Thus, the extended family system is the most available option to assure the welfare of orphans (See Abebe & Aase, 2007; Bevan, 2006; Gebre, 2007). Kin caregivers assume the caregiving responsibility to maintain the family relationship because the children are part of their blood. Irrespective of their capability to provide quality care and fulfill the children's basic needs, kin caregivers assume the caregiving responsibility. Family expectations were cited as a major pathway to assuming the caregiver role for kin caregivers who are blood relatives.

In addition to kin caregivers related by blood, this study found that neighbors, unrelated to the orphaned child by blood also assume the caregiving responsibility. In these cases prior relationship with the deceased neighbor was the major pathway for the caregiver to step in and care for her neighbor's daughter.

Children's parents' HIV/AIDS status was found to be one of the major reasons for parents' inability to care for their own children that served as a pathway for seven kin caregivers to assume the caregiving responsibility. As discussed earlier, one of the reasons for the change in living arrangement pattern for orphans and their parents were the parents' AIDS status. Among eight relatives who moved into the kin caregiver's place after they encountered difficult circumstances and were unable to lead their own life independently, six were AIDS patients. One grandmother reported that her daughter left her son and disappeared when she found out that she was HIV positive. Hence, the grandmother started caring for her grandson after her daughter abandoned her son.

In addition to the pathways to kinship care, kin caregivers who participated in the open ended questions described their motivations to assume the caregiving responsibility. In describing their motivations, nine kin caregivers reported that they did not have a choice either to accept or to refuse the caregiving responsibility. The majority of the children lived with the current caregivers prior to the death of one or both parents. After the death of the parent kin caregivers remained the de facto caregiver without seeking other options. Caregivers perceived that they had no option except taking the responsibility of caring for the orphaned child/ren. Furthermore, kin caregivers indicated that the children had nowhere to go and no one from the extended family offered to provide care. As a result, the current caregivers asserted that they did not have the heart to turn the children away knowing that the children's fate would be living on the street.

For one kin caregiver, however, the motivation to care for her nieces and nephews was to have the opportunity to rear children since she never had her own children. Another caregiver, a neighbor who was caring for her deceased neighbor's daughter, reported that her motivations were spiritual.

The findings regarding motivation to take on the role of a kin caregiver related to spiritual reasons and the sense of obligation to maintain familial relationships are similar to research findings in the United States (See Linsk & Mason, 2004; Gleeson et al., 2009). No externally induced incentives were identified during the open ended questions as motivations to assume the caregiving responsibilities. The provision of support by governmental and non-governmental organizations is a very recent phenomenon. Most kin caregivers explained that they had been caring for their relative's children long before learning about the availability of formal support.

## **2. Social support**

In this study, social support is conceptualized as a construct encompassing emotional support, socializing, practical assistance, financial assistance, and advice/guidance. The study hypothesis intended to test whether social support buffers kin caregivers from stressors that arise during the caregiving process. Findings from the quantitative component of this study revealed that caregivers reported levels of support at the lower end of the scale. As hypothesized, social support was positively associated with coping, suggesting more social support enhances coping. This further highlights the importance of mobilizing available social support to assist kin caregivers to achieve improved caregiving outcomes. The hypothesis that social support moderates the relationship between stress and coping was not supported by data in this study. However, this finding needs to be taken with caution because of the limitation of the sample size and the sampling procedures used in this study.

Themes that emerged from the qualitative open ended questions support the quantitative results. Kin caregivers reported that they did not have adequate social support to meet the needs of children in their care. Although kin caregivers reported they were receiving formal support, the majority also reported that they did not have support. Vaux (1988) identified the importance of support network resources referring to the availability of social relationships that are ready to offer support for members of the social network. In addition, Vaux highlights that social supports have a greater impact when an individual in any difficult situation perceives, requests, accesses, and accepts available social support within a given socio-cultural environment. In light of this, the study findings indicate that kin caregivers' subjective appraisal of the availability of network resources that could provide support is virtually none. This is associated with kin caregivers' perceptions that their families and or neighbors are in similar living conditions and experience

similar levels of need. This leads them to conclude that no one could offer help/support because everybody in their network system is struggling to survive given the poverty situation. This is mainly explained by the fact that kin caregivers associate and interact with people within the same economic status and primarily within the same neighborhood. Hence, kin caregivers' perceptions of the availability of support from the informal network resources such as from neighbors, friends, and or other members of the extended family system are that support is almost nonexistent for nine out of twelve kin caregivers who have completed the qualitative interviews .

Some kin caregivers have the dominant perception that no one could offer support. In line with this, seven kin caregivers said that they did not seek support knowing the socio-economic status of individuals around them. This suggests that kin caregivers' subjective appraisal about the availability of social support influences their willingness and/or ability to seek support to cope with stressors associated with the caregiving process.

Cohen and Syme (1985) argue that social support has a significant buffering function in stressful life events when: 1) the type of support provided matches the needed type of support for a person's specific difficult life situation; 2) support occurs when it is needed; and 3) the amount and duration of support fits with the needed amount of support. Empirically, Ethiopian kin caregivers who participated in this study revealed that the type and amount of support that they were receiving from governmental or non-governmental organizations did not match with their need. Furthermore, the supports were not provided during the time of their need. As a result, kin caregivers said, "I do not have support" because of their dissatisfaction with the available support systems due to its inadequacy and inconsistency. In addition, because the sources of support are irregular and unreliable, kin caregivers do not believe they can depend on them.

Instead they say, “God is my support”. Studies of kin caregivers in the USA (Petras, 1999; Anderson, 2006) have found that even in their relatively more affluent circumstances kin caregivers reported a strong reliance on religious faith as a major source of support.

The findings of this study regarding the inadequacy and irregularity of support are similar to the findings of Abebe and Aase’s (2007) study. In their in-depth qualitative exploration of the Ethiopian extended family system caring for orphans and vulnerable children, Abebe and Aase reveal that formal organizations are unable to address the needs of the neediest children. The mismatch between kin caregivers’ need for support and available formal support as well as the lack of consistency in the availability of support was a determinant factor in caregivers’ appraisal of the available formal support from agencies as insufficient support. As a result, the subjective appraisal of support among kin caregivers participated in the open ended questions is imprecise.

The fact that some kin caregivers report that children provide support by contributing their labor in household chores is in line with Gebru’s (2009) findings. Gebru conducted a dissertation study on poor children’s perspectives and experiences of risk, coping, and resilience in Addis Ababa using a phenomenological approach. In her study, Gebru found out that, female children, whether they are living with their parents’ (double family), single family or under kinship care, contribute by performing household chores including cleaning the house, washing dishes, preparing food and taking care of younger siblings. Furthermore, Abebe and Aase (2007) also observed similar child labor contributions for household economy in both urban and rural parts of Ethiopia.

In this dissertation study, three kin caregivers described child labor contributions as support, suggesting that orphaned and vulnerable children are not mere passive recipients of care from their extended family members. They also reciprocate their labor for the care and support they are receiving from their extended family members.

Although no prior published studies on orphan care in Ethiopian settings has looked at the effect of social supports on kin caregivers coping process, Bevan's (2006) unpublished work revealed that close family and household members are key primary support network systems rather than other forms of support networks in coping with difficulties in their life. The findings from this dissertation study, however, do not fully support Bevan's assertion. For the majority of kin caregivers who participated in the open ended questions, the informal family support is very rare because of the poverty situation. Only a few kin caregivers indicated that they were receiving some forms of support from other family members and neighbors such as looking after younger children when caregivers need to go out from home.

In general, although the findings from this study enriched the understanding that kin caregivers' were receiving insufficient and inconsistent support from formal sources. The existing pervasive poverty in the study setting that led them to associate with similar socio-economic group of people, however, hindered kin caregivers from perceiving and requesting social support from their relatives and neighbors. Kin caregivers tend to deal with their caregiving responsibility on their own and from the limited support they are receiving from formal sources. As a result, the available social support resources do not seem to totally buffer caregivers from the negative outcomes of the caregiving processes.



### 3. Stress

Findings from both quantitative and qualitative data suggest that Ethiopian kin caregivers who participated in this study are in great distress. Data that emerged from the open ended questions reveal that household food insecurity, inability to provide clothing, and lack of decent housing are frequent stressors. In addition, lack of disclosure of orphan and HIV/AIDS statuses were reported as stressors. Kin caregivers' concerns about their own health, the futures of children in their care, child behavior problems, and children's grieving also contribute to kin caregivers' stress.

According to the quantitative analysis kin caregivers' self-reported scores on total stress suggest 15% of study participants are experiencing clinically significant stress level. Further quantitative data analysis showed that stress did not predict coping. These results need to be considered with the caution that limitations of sample size and sampling procedure may have influenced the limited variability on the scores for these variables. The cultural and language differences in which the stress and coping measures were used in this study may have contributed to the unexpected results.

During the open ended questions, kin caregivers' subjective appraisal reflected that the caregiving responsibility was taxing their resources. Kin caregivers' inability to provide adequate and relevant care seemed to be related to their poor economic status that predated their caregiving role. The major stressor identified by the kin caregivers was household food insecurity. For most kin caregivers who participated in the open ended questions, their inability to provide daily meals for the children in their care produced most stress. Their situations were further exacerbated by the increasing living cost that the country has experienced in recent years. As a result, kin caregivers reported that they were unable to afford to purchase some of the food

items that they formerly purchased for the family two years earlier. Kin caregivers also reported that they had difficulties providing clothing and shoes for children in their care. This also creates a stressful situation. The situation is worse for kin caregivers caring for more than one child and during holiday seasons. This finding is in line with the findings of Philipos's (2005) qualitative study. Philipos who explored the impacts of HIV/AIDS on orphans in Addis Ababa reported that kin caregivers often face difficulties providing basic needs including food, clothing, and decent housing for their relative's children.

In Ethiopian tradition, children expect new clothes and shoes especially at the New Year, Christmas, and or Easter for Christians and Ramadan for Muslims. Children in kinship care expect new clothes at these times because they observe other children in the neighborhood getting new clothes. According to Gebru (2009) , who made a similar finding, buying new clothing for children is part of celebrating the holidays, which creates expectations among children and leads to their comparing their situations with those of their peers.

Kin caregivers' inability to meet the basic needs of their relative's children should be examined within the context of the preexisting difficult socio-economic situation resulting from pervasive poverty. Lombe and Ochumbo (2008), in their critical analysis of the challenges and opportunities of orphan care in sub-Saharan Africa, argued that the broader magnitude of the socio-economic problems of the region should be taken into consideration. During the data gathering process, I observed that kin caregivers were living in difficult socio-economic situations. The neighborhoods where most kin caregivers live within, the houses in which kin caregivers and their relative's children dwell, the quality of furniture inside the house, as well as their housekeeping style reveals that the majority of kin caregivers are among the most disadvantaged segment of the Ethiopian population. Kin caregivers' self-reported income level

also suggests that the majority of them are living on less than \$2 per day. This suggests that kin caregivers were struggling to survive their own poverty prior to assuming the caregiving role. Thus, it is possible to argue that caring for their relative's children increases their stress as they are often unable to fulfill the orphan children's needs.

Grandmothers who participated in the interview identified watching their grandchildren grieving because of their parents' illness or death as a cause of stress. This is similar to Philipos (2005) finding that kin caregivers and children begin mourning as they observe the suffering of the children's parent due to AIDS. This suggests the need to develop interventions for children's and caregivers' grief and loss.

Kin caregivers reported children's behavior as stressors. One grandmother reported that her grandson was extremely sad and mostly depressed because of the death of his parents. A caregiver of a neighbor's daughter reported that the girl often fights with other children in the neighborhood. These two cases exemplify both internalizing and externalizing behavior problems where one child is extremely sad and depressed and the other engages in fighting with other children. Child behavior problems have been consistently associated with kin caregiver's stress in kinship care studies in the United States (see Berrick, 1997; Linsk & Mason, 2004; Petras, 1999). This suggests that caregivers need to be aware of child behavior issues to better manage children's behavior and help them integrate into the family system without harming themselves or disrupting the family.

The inability to disclose the child's HIV status or the child's orphan status contributes to kin caregivers' stress. Kin caregivers who raised their relative's child from an early age reported that telling the child about his or her biological parents death is very difficult. As a result, disclosing the orphan status creates stress when the child begins inquiring about the biological

parents. In addition, disclosing HIV status is a stressor for kin caring for HIV positive children. This was reported as a serious problem by two kin caregivers because their HIV positive children have to take the ART treatment on a daily basis. Children who are taking the ART medicine often ask why they have to take the medicine. Kin caregivers reported that they did not know how to tell children about the child's HIV status. This finding indicates the need for specific support to caregivers regarding HIV/AIDS, ART for children and disclosure of HIV status.

Kin caregiver concerns about their own health and age and their fear for the future of the children in their care were reported as stressors. Kin caregiver's concerns for their own health is similar to the finding of Linsk and Mason (2004) in their study on stresses of grandparents and other relatives caring for children affected by HIV/AIDS in the US. Linsk and Mason found that kin caregivers' physical health and mental health are associated with stress. Kin caregivers' fears about the future of the children under their care are related to their aging process and health situation. Kin caregivers indicated that no one would be available to continue the care should they become disabled or die. This contributes to the vulnerability of the children in their care.

In conclusion, Ethiopian kin caregivers who participated in this research are encountering various stressors associated with the caregiving process. The findings regarding stress suggest kin caregivers are in need of interventions that equip kin caregivers with the necessary knowledge and skills to cope with non-material stressors. The stressors associated with basic needs such as food and housing suggest that strategic policy and practice changes are needed in order to address the caregiver's own poverty situation and meet the children's needs.

#### 4. Coping

One of the objectives of this research was to examine how Ethiopian kin caregivers respond to stressors arising from their caregiving responsibility. Kin caregivers' coping efforts were measured quantitatively. In order to gain a comprehensive understanding of kin caregivers' perspectives on how they are coping open-ended questions were used. Data that emerged from the open ended questions interview indicate that praying, accepting life, working very hard, receiving formal support, good relationships with grandchildren, and drawing upon past experiences were the major coping strategies that kin caregivers were using to deal with stressors that emerged in the caregiving process.

The quantitative analysis revealed that kin caregivers tend to use a positive attitude to deal with their stressful situations. In measuring coping, a higher score on the Ways of Coping scale refers to a more frequent use of a given way of coping. Positive appraisal refers to efforts to create positive meaning by focusing on personal growth including spiritual and personal dimensions whereas the self-controlling way of coping describes a strategy to regulate one's feelings and actions when encountering stressful situations. Caregivers' scores on coping strategy suggest that kin caregivers tended to use both positive appraisal and self-controlling as ways of coping.

Kin caregivers' qualitative appraisal of major coping strategies is consistent with the quantitative data. Accordingly, all but one of the kinship caregivers who participated in the open ended questions reported that they pray when they encounter stressful situations in the caregiving process. Kin caregivers often pray to deal with stresses related to lack of daily meals, sick child/ren, their own health, and other interrelated problems that they might encounter on a day-to-day basis. Hence, kin caregivers believe in and expect a miracle to happen. This suggests that

kin caregivers both use positive attitudes as well as avoidance as major ways of coping. Kin caregivers' low scores on seeking social support as a way of coping is consistent with their qualitative appraisal regarding availability of social support. According to open ended questions data, more than half of kin caregivers reported that they do not seek support because they perceive that no one in their network is capable of providing support.

Three more research hypotheses were tested using quantitative data. In the first, I hypothesized that caregivers' scores on coping would differ based on the type of their relationship with the child. Contrary to the hypothesis, no statistically significant difference was found on coping scores between blood related kin caregivers (aunts, grandmothers, and siblings) and caregivers unrelated to the child by blood (neighbors, God mothers, and landlady). Accordingly, data did not support the assumption that blood related kin caregivers would have a different coping score than kin caregivers who are not related to the child by blood.

For the second hypothesis, I tested whether the mean of the kin caregivers' coping scores would vary by their income level, ethnic background, and age. Results show that, except for age, there were no statistically significant differences between kin caregivers' coping and income level or ethnic background. Caregivers older than 51 years reported higher levels of coping than younger caregivers. Greater life experience and life style differences between the age groups may explain the differences between the age groups.

I explored whether there would be a significant relationship between kin caregivers' stress and social support and coping. Social support demonstrated a statistically significant association with coping. The significant positive relationship found between caregivers' support and coping suggests higher levels of social support increases use of positive coping strategies.

Standard regression analysis was performed to test whether social support and stress would predict coping. The results show that social support predicts coping but stress did not predict coping. This statistical result shows that the relationship between stress and coping was more complicated than tested in this study. When comparing the quantitative results regarding the effects of stress and social support on coping with kin caregivers' qualitative evaluation of the coping strategies, it is possible to draw some conclusions. According to data that emerged from the qualitative analysis, the majority of kin caregivers experience stress but, are dealing with multiple stressors by appraising their situations. Kin caregivers' beliefs about prayer as a major coping strategy coupled with their perception that their lives cannot change until a miracle happens appears to shield them from the negative impact of stressors.

This study tested the buffering role of social support in the relationship between stress and coping. After controlling for caregiver's age, income level, and relationship with the child, it was found that stress did not have a significant main effect on kin caregivers' coping. Social support does have a significant main effect on caregivers' coping. However, the interaction between stress and social support was not significant. Therefore, the hypothesized buffering effect was not supported. Kin caregivers indicated that although it is very small, the support they are receiving is helping them to ease problems associated with their caregiving role. In fact, one kin caregiver stated that support from an agency helps her to cope better with stressors associated with her caregiving responsibility. As discussed earlier, caution is necessary when interpreting the quantitative data, because of the limitation of sample size and sampling procedures as well as the limitation of using the stress coping theory developed in the west that has significant cultural, social, and economic differences from the Ethiopian context.

Finally, data that emerged from the qualitative open ended questions indicates that keep working, maintaining good relationships with grandchildren, and trying to forget stressful situations have helped some kin caregivers cope with the stressors arising during the caregiving process.

In summary, Ethiopian kin caregivers who participated in this study have shown resilience in raising their relative's child/ren amid their own difficult living conditions. Despite their poverty situations, their commitment to maintain their caregiving role without sufficient social support from the government and other members of society is impressive. Kin caregivers have shown great courage in supporting the hope of orphaned and vulnerable children. Kin caregivers' spirituality has been shown to have great significance in helping them deal positively with the multiple stressors emerging from their caregiving responsibilities.

## **B. Limitations of the Study**

The current study findings highlight the importance of kinship care for orphans and vulnerable children in Ethiopia. However, the findings need to be interpreted in light of the conceptual and methodological limitations.

### **1. Conceptual limitations**

Conceptually, I found it very difficult to come up with a simple word or phrase for the concept of "kinship care" in the Amharic language. In the study setting, I learned that kin caregivers often assume parental roles with their relatives' children. In the conversation, most kin caregivers reflected on their relationship with relative's children as mother and father in the case of female and male caregivers respectively. Hence, children use the Amharic word "emaye" for female kin caregivers, which mean 'mom' and "abaye" for male caregivers, which means 'dad'. Hence, the way this research conceptualized kinship care as caring for relative's children



should be understood from the cultural meaning and understanding of the Ethiopian kin caregivers view that “my relative’s children are my own,” suggesting the use of the term family care rather than kinship care. The use of terminology that does not reflect the contextual reality may impose external perspectives and limit the validity of the responses.

Furthermore, the use of the stress coping theory in this dissertation has shown some limitations in the fundamental understanding of Ethiopian kinship care practice. As noted earlier none of the existing literature on orphans and vulnerable children in the country had explored the perspective of kin caregivers about their experience. During the introduction of the interview, I observed an elevated expectation from study participants when I told kin caregivers that I would ask them questions related to challenges/stressors related to their caregiving role. Specifically, when I was recruiting study participants in Kirkos Sub City, I had to turn away many parents who were caring for their own children and some kin caregivers who did not fulfill study participants selection criteria. Those parents who did not qualify to be in the study were begging to be part of the study. At the moment, they had greater expectation that the researcher might connect them with agencies. The expectation was triggered because of the specific research question that intended to explore and measure stress and coping in addition to social support.

## **2. Methodological limitations**

The methodological limitations of this study are related to the design, sample size, and measurement.

### **a. Design**

The methodological limitation of this research is associated first with the design itself. According to Johnson and Onwuegbuzie (2004), undertaking both quantitative and qualitative methods concurrently has limitations in the process of managing the two research

methods and integrating the data generated through the two methods. After conducting this study, I share Johnson and Onwuegbuizie's view that integrating the data from the two sources is not easy. Specifically, interpreting the quantitative data and integrating the meanings that the interpreted data conveys from quantitative and qualitative data at times was challenging. Furthermore, the stress coping model and the buffering hypothesis that guided this research and my own prior theoretical biases may have influenced the coding and interpretation process of the qualitative component of the data. However, I tried to control my biases through constantly going back and forth between the coded and transcribed data to compare study participants' responses and ascertain meaningful themes that best capture what the caregivers had to say.

**b. Sample size**

The data for this study were obtained from a self-selected convenience sample of 130 kin caregivers residing in Addis Ketema, Arada, and Kirkos Sub Cities and are thus inherently biased (Rubin & Babbie, 2008). It would have been good if study participants had been a randomly selected group of kin caregivers of their relative children affected by HIV/AIDS. However, it was not possible to obtain or develop a sampling frame for kin caregivers for two reasons.

First, many of the Ethiopian kin caregivers assume the caregiving role for orphans and vulnerable children informally without the involvement of formal authorities. Second, lack of research funds to finance this study limited the feasibility of developing a sampling frame from the population. As a result, the findings of this study only reflect the perspectives and experiences of a convenience sample of kin caregivers in Addis Ketema, Arada, and Kirkos Sub Cities. This limits the external validity as well as generalizability of the data to the population of kin caregivers raising their relative's children affected by the HIV/AIDS epidemic. However,

this does not mean the data from these three Sub Cities have no role in understanding kin caregivers' situation in Addis Ababa. The data is illustrative of the situation of many kin caregivers in Addis Ababa as well as in other urban areas.

**c. Instrumentation**

The use of the Ways of Coping (WOC) instrument to measure the dependent variable contributed hugely to the challenges in the current study. During the analysis phase, I discovered that the total score of the WOC is not interpretable as a measure of total coping effort during the time of data analysis. In addition, the WOC does not measure every type of coping people might engage in as a response to various stressors and WOC is a contextual measure of coping. As a result, the idea of using the total score was dropped since it was found to be meaningless. An acceptable alternative for analyzing the study data was found by creating a shortened version of PWOC consisting of 13 items as described in the data analysis section of this report. However, it would have been better to had an alternative coping measurement instrument been available that could measure a broad array of coping strategies and whose total score could be used in the statistical analyses.

The study was conducted in Addis Ababa, Ethiopia which required the use of the Amharic language in the data collection process. This made translation from English to Amharic necessary in the case of the instruments and translation of the collected data from Amharic to English. Obviously, conveying the meaning of words/phrases/statements in two different languages is very challenging. I diligently worked to assure the fidelity of the translation by using back translation to ensure the translated version adequately conveyed the same meaning for each items in the three instruments. However, translation involves not only the linguistic aspect. It also requires the competence to understand the context or culture within which the

language is used. Thus, some of the words/phrases used in the English version of the three instruments did not directly translate into Amharic and vice versa. This could have been avoided had standardized and reliable instruments that were developed in Ethiopia been available in Amharic.

### **C. Implications of the study**

No previous studies related to orphans and vulnerable children or the impacts of HIV/AIDS in Ethiopia have explored the kin caregivers' perspectives regarding their caregiving role. This study begins to fill this gap in the knowledge base by addressing the caregiving experience from the caregivers' perspective. However, this study is exploratory and further investigation is needed to confirm the findings with a large representative sample that will enable generalizable findings regarding the experiences of Ethiopian kin caregivers. The present study provides an important contribution to the knowledge base and has implications for social work theory, social work practice, social work education, policy and future research.

#### **1. Implications for future research**

The findings of this study have significant implications for future research. Kin caregivers' perspectives on the pathways and motivations in assuming the caregiving responsibility for their relative's children illuminates the importance of familial relationships as a key factor in continuing the caregiving role for orphans and vulnerable children in Ethiopia. Furthermore, kin caregivers' decisions to assume the caregiving responsibility are a continuum of their care to the parents of orphans and vulnerable children primarily because of the AIDS related studies. The findings of this study added the voice of kin caregivers of the orphans and vulnerable children in Ethiopia in related literature.

The overwhelming majority of kin caregivers who participated in this study are female and their self-reported income level shows that the majority are living in abject poverty. Furthermore, female children in kinship care provide significant support to their caregivers by performing various household chores. This suggests the importance of conducting future research that explores the dynamics of gender issues and kinship care for orphans and vulnerable children in Ethiopia.

This study was conducted in three Sub Cities in Addis Ababa City Administration, the capital city of Ethiopia. Although the findings regarding the availability of social support, stressors, and kin caregivers' coping strategies provide valuable information regarding the circumstances under which relatives are providing care to orphaned and vulnerable children in Ethiopia, it is not possible to make a generalized statement about Ethiopian kin caregivers. Furthermore, the study setting represents urban Ethiopia. Since Ethiopia is a rural country with more than 85% of its population living in rural places, additional research is needed to confirm and enhance the findings gained from this study and to provide a broader knowledge base regarding kinship care providers in the country. This can be done by including caregivers residing in other regional states and, most importantly, in rural areas.

This study investigated only the perspectives of the kin caregivers who are caring for orphans and vulnerable children. Future research is needed that includes the perspectives and experiences of orphans and vulnerable children themselves in order to compare their views with the perspectives of kin caregivers. This would help to understand the extent to which kinship care is a viable option for orphans and vulnerable children in the country.

The current study explored kin caregivers' perspectives on the availability and use of social support in the caregiving process. Future studies could examine how government and non-

governmental agencies determine the inclusion criteria for kin caregivers in formal social support provisions as well as their criteria for determining the amount of support to provide. This is especially needed for kin caregivers who are providing care for more than one child.

## **2. Implications for theory**

The findings from this study suggest the importance of social support in coping processes. Further research could help to determine what type of support best predicts coping processes in the Ethiopian context. Findings were insignificant regarding the buffering role of social support in the relationship between stress and coping. This can be attributed to the fact the measurement instruments that were used in this study which were developed and have been widely used in western industrialized nations. As a result, some of the concepts did not translate exactly into the Amharic language which created some difficulty during data collection process. Future research is vital to explore whether social support buffers the relationship between stress and coping with a larger sample size.

The findings from this study highlight the importance of the appraisal of stressors by kin caregivers. Consistent with Lazarus and Folkman's (1985) conceptualization of appraisal levels in evaluating stressors and coping options, Ethiopian kin caregivers demonstrated that they often deal with stressors using various coping strategies. This study did not attempt to evaluate whether a given coping option is successful or effective, however, kin caregivers indicated that their preexisting poverty situation was a major constraint to better coping with the caregiving process.

### 3. **Implications for social work practice**

According to the Social Work Manifesto on HIV/AIDS, social work professionals around the world are expected to advocate for services to address the needs of people affected and infected by HIV/AIDS to secure proper psychosocial and economic support and the ability to exercise their rights without barriers (International Federation of Social Work, 2001). Furthermore, social work research often provides new evidence for effectiveness of practice (Rubin & Babbie, 2008).

Thus, the findings of this research are vital in that they provide empirical data regarding kin caregivers' socio-economic and demographic characteristics, and the categories of kin caregivers providing care for orphans and vulnerable children in the context of HIV/AIDS. The fact that the majority of kin caregivers participating in this study are women and most of them live on less than \$2 per day reflects the existing gendered role of Ethiopian women and their double burden because of the feminized nature of persistent poverty in the country. Hence, the findings suggest the importance of understanding the gender dynamics of the society as well as designing a gender sensitive and empowering approach to promote kin caregivers' psychosocial and economic wellbeing.

The findings of this study provide practitioners with empirical knowledge that could help them reflect upon their practices and service delivery processes and make available support systems more responsive in redressing the needs and problems of orphans and vulnerable children in kinship care. For example, the quantitative results from this study show that social support predicts kin caregivers' coping strategies, suggesting the importance of social support in helping kin caregivers better cope with their caregiving responsibilities. However, the qualitative data indicate that kin caregivers are not consistently receiving adequate support from formal

agencies. Hence, these findings inform service providers of the importance of revisiting their service provision standards or guidelines. These findings will help social workers assist kin caregivers by linking them with various support providers and advocates on behalf of kin caregivers. Such networking can help them obtain support that is appropriate and responsive to the needs of the orphans and vulnerable children in their care.

The findings from the quantitative univariate analysis show the existence of high levels of stress among kin caregivers that requires practitioners' careful intervention. Although the quantitative data shows no relationship between stress and coping, the qualitative data revealed valuable information on stress. Specifically, caring for HIV positive children requires a comprehensive intervention for both the child and caregivers. Except for the ART treatment that the caregivers mentioned during the open ended questions, none of them indicated that they received psychosocial care that would help them disclose the HIV status of the child. A few kin caregivers indicated they had difficulties in disclosing the orphan status of the child in their care as well as dealing with some of the child's behavior. This finding suggests that practitioners and service providers should revisit their support systems and include services related to children's behavior problems, disclosure of the child's orphan status, as well as disclosure of the child's HIV status.

#### **4. Implications for social work education**

In Ethiopia, Social Work education is in its infancy. As a result, the profession has yet to help generate a local knowledge base regarding various social phenomena with which to educate Bachelors of Social Work, Master of Social Work, and PhD students. Furthermore, Social Work education has not yet developed sufficiently to influence social work related services, practices and policy-making processes through the use of empirical data related to the



various social problems that exist in the country. According to Tasse (2006), Ethiopia is making a tremendous effort to establish the Social Work profession after the opening of the first Master of Social Work program in 2004. Since then, the country has re-opened a Bachelor of Social Work program established the first PhD program in Social Work and Social Development and has made progress at six other schools. This study was conducted within the ethical principles of the social work profession while recognizing the status of social work education in the country. As a result, this study will have a vital role in addressing the existing knowledge gap regarding kinship care for orphans and vulnerable children in the Ethiopian context.

The findings of this dissertation have several additional implications for Social Work education. First, the findings will be useful in the Child and Family Concentration of the Master of Social Work Program at the School of Social Work, Addis Ababa University. The country is home to more than 5.5 million orphans and vulnerable children. Although data is sparse, kin caregivers are the de facto caregivers for the majority of these children. Hence, the findings from this study can be used in discussing the issue of orphan care in general and to understand the situation of kinship care providers in particular. Secondly, this study will be useful in teaching social work research methods. This study used mixed methods research design. Hence, it might provide insights for social work students on how to design and conduct mixed methods research. Lastly, the findings of this study can be used in teaching advocacy related topics, specifically promoting the psychosocial and economic wellbeing of kin caregivers who are at the forefront taking the responsibility of caring for orphans and vulnerable children.

## 5. **Implications for policy**

Research should inform policy advocacy. Specifically, in the Social Work profession, research is believed to enhance our understanding of social phenomenon that requires policy change (Rubin & Babbie, 2008). Ethiopia has long acknowledged the problem of orphans and vulnerable children as its key priority in its policy and strategic planning documents. These policy and strategic documents were developed utilizing the framework of sustainable socio-economic development with a priority given to poverty reduction (See MOFED, 2002; 2006; 2010).

However, the available policy options do not provide specific and comprehensive policy responses for the overwhelming number of orphans and vulnerable children in the country. In addition, none of the current policies explicitly acknowledges the significant role of kinship care as a primary welfare option for orphans and vulnerable children. This has been exacerbated by the absence of a well-developed discipline of social policy in the country. Policy discussion helps to highlight the limitations of existing policy options and suggests policy alternatives to address issues pertinent to the most marginalized and underserved segment of the Ethiopian society. Thus, the findings of this study on kinship care could be used to initiate a policy debate among key stakeholders currently working on the issue of orphans and vulnerable children. In addition, the findings from this study can inform policy makers of the importance of kinship care for orphans and vulnerable children in policy formulation as well as developing a strategic plan in the country.

Furthermore, within the developmental social welfare approach, the findings from this study help policy makers to incorporate kin caregivers' views in addressing the issue of orphans and vulnerable children. Although the country has a limited social welfare structure policy

provisions that specifically benefit orphans and vulnerable children, there are social services designed to help orphan children that are provided through the collaborative efforts of the government of Ethiopia, International Organizations, National Non-Governmental Organizations, and Community Based Organizations. However, it is vital to develop a specific policy that has clear forms of benefits or services to be delivered, entitlement (eligibility) rules, administrative or organizational structure for service delivery, and financing methods.

## APPENDICES

## **Appendix A**

### **Kinship Care for Orphans and Vulnerable Children in Ethiopia: A Mixed Methods Study of Caregiver Coping Questionnaire**

Time Began \_\_\_\_\_

Case Number \_\_\_\_\_

The major purpose of this study is to explore Kinship Care for Orphan and Vulnerable Children in Ethiopia, particularly exploring the processes and pathways that led kin caregivers to assume the caregiving role for their related children affected by HIV/AIDS. This study also seeks to assess kin caregivers stress, social support, and coping. It is believed that the information will help us understand the kinship care processes and kin caregivers' perspectives on stress related to the caregiving processes and how they are coping.

You are invited to participate in this research because you are providing care and support for your relative child/children. Although I kindly request you to participate in this study, please be reminded of the following. 1) Participation in this research is voluntary and your decision whether to be in the research or not will not affect your current and future relationship with Addis Ababa University or any other service agency that you are currently associated with. You are also free to withdraw from the research process any time without any consequences; 2) you will not be asked to provide any identifiable information about yourself or the child/children for whom you are caring. All your questionnaire responses and the audio record remain confidential and anonymous; 3) you can ask any questions about the study any time.

## Appendix A (continued)

### i. Socioeconomic and Demographic Variables

a. Age

0=18-35

1=36 – 50

2=>51

b. Gender

0=Female

1= Male and

c. Income level

1= (less than 8999.99 ET birr),

2 = (9,000.00 -9,499.99 ET birr),

3= (9, 500.00- \$9,999.99 ET birr),

4 = (10,000.00 or above ET birr).

d. Ethnic background

1=Oromo,

2=Amhara,

3=Tigre,

4=Gurage,

5= others

e. Marital Status

1= never married,

2= married,

3= divorced,

4= widowed

f. Are you living with a partner at the present time?

1= Yes

2= No

g. Relationship to the child under care

1= grandparent

2= aunt/uncle

3= sibling

4= neighbors

5= parents' friend

6= other

## Appendix A (continued)

### ii. Pathways and Motivations

**Would you please share with me the story of how you started providing care for your relative children?**

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### iii. Social support

**a. What mechanisms/supports are available for you to sustain your caregiving role?**

**o Whom do you ask when you need support?**

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### b. Social Support Behaviors (SS-B) Scale

People help each other out in a lot of different ways. Suppose you had some kind of problem (were upset about something, needed help with a practical problem, were broke, or needed some advice or guidance), how likely would (a) members of your family, and (b) your friends be to help you out in each of the specific ways listed below. We realize you may rarely need this kind of help, but, if you did would family and friends help in the ways indicated. Try to base your answers on your past experience with these people. Use the scale below, and circle one number under family, and one under friends, in each row.

- 1 no one would do this**
- 2 Someone might do this**
- 3 Some family member/friend would probably do this**
- 4 Some family member/friend would certainly do this**
- 5 Most family members/ friends would do this**



## Appendix A (continued)

No	Items	Family					Friends				
		1	2	3	4	5	1	2	3	4	5
1	Would suggest doing something, just to take my mind off my problems	1	2	3	4	5	1	2	3	4	5
2	Would visit with me, or invite me over	1	2	3	4	5	1	2	3	4	5
3	Would comfort me if I was upset	1	2	3	4	5	1	2	3	4	5
4	Would give me a ride if I needed one	1	2	3	4	5	1	2	3	4	5
5	Would have lunch or dinner with me	1	2	3	4	5	1	2	3	4	5
6	Would look after my belongings (House, pets, e.t.c.) for a while	1	2	3	4	5	1	2	3	4	5
7	Would loan me a car if I needed one		2	3	4	5	1	2	3	4	5
8	Would joke around or suggest doing something to cheer me up	1	2	3	4	5	1	2	3	4	5
9	Would go to a movie or concert with me	1	2	3	4	5	1	2	3	4	5
10	Would suggest how I could find out about a situation	1	2	3	4	5	1	2	3	4	5
11	Would help me out with a move or other big chore	1	2	3	4	5	1	2	3	4	5
12	Would listen if I needed to talk about my feelings	1	2	3	4	5	1	2	3	4	5
13	Would have a good time with me	1	2	3	4	5	1	2	3	4	5
14	Would pay for my lunch	1	2	3	4	5	1	2	3	4	5
15	Would suggest a way I might do some thing	1	2	3	4	5	1	2	3	4	5
16	Would give me encouragement to do something difficult	1	2	3	4	5	1	2	3	4	5
17	Would give me advice about what to do	1	2	3	4	5	1	2	3	4	5
18	Would chat with me	1	2	3	4	5	1	2	3	4	5
19	Would help me figure out what I wanted to do	1	2	3	4	5	1	2	3	4	5
20	Would show me that they understood how I was feeling	1	2	3	4	5	1	2	3	4	5
21	Would buy me a drink if I was short of money	1	2	3	4	5	1	2	3	4	5
22	Would help me decide what to do	1	2	3	4	5	1	2	3	4	5
23	Would give me a hug, or otherwise show me I was cared about	1	2	3	4	5	1	2	3	4	5
24	Would call me just to see how it was going on	1	2	3	4	5	1	2	3	4	5
25	Would help me figure out what was going on	1	2	3	4	5	1	2	3	4	5
26	Would help me out with some necessary purchase	1	2	3	4	5	1	2	3	4	5
27	Would not pas judgment on me	1	2	3	4	5	1	2	3	4	5
28	Would tell me who talk to for help	1	2	3	4	5	1	2	3	4	5
29	Would loan me money for an indefinite period	1	2	3	4	5	1	2	3	4	5
30	Would be sympathetic if I was upset	1	2	3	4	5	1	2	3	4	5
31	Would stick by me in a crunch	1	2	3	4	5	1	2	3	4	5
32	Would buy me clothes if I was short of money	1	2	3	4	5	1	2	3	4	5
33	Would tell me about the available choices and options	1	2	3	4	5	1	2	3	4	5



34	Would loan me tools, equipment, or appliances if I needed them	1	2	3	4	5	1	2	3	4	5
35	Would give me reasons why I should or shouldn't do some thing	1	2	3	4	5	1	2	3	4	5
36	Would show affection for me	1	2	3	4	5	1	2	3	4	5
37	Would show me how to do something I didn't know how to do	1	2	3	4	5	1	2	3	4	5
38	Would bring me little presents of things I needed	1	2	3	4	5	1	2	3	4	5
39	Would tell me the best way to get something done	1	2	3	4	5	1	2	3	4	5
40	Would talk to other people to arrange something for me	1	2	3	4	5	1	2	3	4	5
41	Would loan me money and want to "forget about it"	1	2	3	4	5	1	2	3	4	5
42	Would tell me what to do	1	2	3	4	5	1	2	3	4	5
43	Would offer me a place to stay for a while	1	2	3	4	5	1	2	3	4	5
44	Would help me think about a problem	1	2	3	4	5	1	2	3	4	5
45	Would loan me a fairly large sum of money (say equivalent of a month's rent or mortgage)	1	2	3	4	5	1	2	3	4	

#### IV. Stress

- a. Would you please share with me the most stressful events that you have faced in the caregiving role?

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#### b. Parenting Stress Index Short Form (PSI-SF)

In answering the following questions, please think about the child you are most concerned about.

The questions on the following pages ask you to mark an answer which best describes your feelings. While you may not find an answer which exactly states your feelings, please mark the answer which comes closest to describing how you feel.

Your First Reaction to each question should be your answer.

Please mark the degree to which you agree or disagree with the following statements by circling the number which best matches how you feel. If you are not sure, please circle #3.

## Appendix A (continued)

1                      2                      3                      4                      5  
 Strongly agree                      Agree                      Not sure                      Disagree                      Strongly disagree

No.	Items	1	2	3	4	5
1	I often have the feeling that I cannot handle things very well.	1	2	3	4	5
2	I find myself giving up more of my life to meet my children's needs than I ever expected.	1	2	3	4	5
3	I feel trapped by my responsibilities as a parent.	1	2	3	4	5
4	Since having this child, I have been un able to do new and different things.		2	3	4	5
5	Since having a child, I feel that I am almost never able to do things that I like to do.	1	2	3	4	5
6	I am unhappy with the last purchase of clothing I made for myself.	1	2	3	4	5
7	There are quite a few things that bother me about my life.	1	2	3	4	5
8	Having a child has caused more problems than I expected in my relationship with my spouse male/female friend.	1	2	3	4	5
9	I feel alone and without friends	1	2	3	4	5
10	When I go to a party I usually expect not usually expect not to enjoy myself.	1	2	3	4	5
11	I am not as interested in people as I used to be.	1	2	3	4	5
12	I do not enjoy things as I used to.	1	2	3	4	5
13	My child rarely does thing things for me that make me feel good.	1	2	3	4	5
14	Sometimes I feel my child does things for me that make me feel good.					
15	My child smiles at me much less than I expected.	1	2	3	4	5
16	When I do things for my child I get the feelings that my efforts are not appreciated very much.	1	2	3	4	5
17	When playing, my child doesn't often giggle or laugh.	1	2	3	4	5
18	My child doesn't seem to learn as quickly as most children.	1	2	3	4	5
19	My child doesn't seem to smile as much as most children.	1	2	3	4	5
20	My child is not able to do as much as I expected.	1	2	3	4	5
21	It takes long time and it is very hard for my child to get used to new things.	1	2	3	4	5
22	I feel that I am a. Not a very good at being a parent b. A person who has some trouble being a parent c. An average parent d. A better than average parent e. A very good parent	1	2	3	4	5
23	I expected to have closer and warmer feelings for my child than I do and this bothers me.	1	2	3	4	5
24	Sometimes my child does things that bother me just to be mean.	1	2	3	4	5
25	My child seems to cry for fuss more often than most children.	1	2	3	4	5
26	My child generally wakes up in bad mood.	1	2	3	4	5



## Appendix A (continued)

No.	Items	1	2	3	4	5
27	I feel that my child is very moody and easily upset.	1	2	3	4	5
28	My child does a few things which bother me a great deal.	1	2	3	4	5
29	My child reacts very strongly when something happens that my child doesn't like	1	2	3	4	5
30	My child gets upset easily over the smallest thing.	1	2	3	4	5
31	My child sleeping or eating schedule was much harder to establish than I expected.					
31	For the next statement choose your response from the choices "1" to "5" below I have found that getting my child to do something or stop doing something is: 1. Much harder than I expected 2. Somewhat harder than I expected 3. About as hard as I expected 4. Somehow easier than I expected 5. Much easier than I expected	1	2	3	4	5
33	For the next statement choose your response from the choices from "10+" to "1-3" Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc 1. 10+ 2. 8-9 3. 6-7 4. 4-5 5. 1-3	1	2	3	4	5
34	There are some things my child does that really bother me a lot.	1	2	3	4	5
35	My child turned out to be more of a problem than I had expected.	1	2	3	4	5
36	My child makes more demands on me than most children	1	2	3	4	5

## I. Coping

## a. What do you do to deal with the stressful events?

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## Appendix A (continued)

### b. Ways of Coping Questionnaire

Please read each item below and indicate, by using the following rating scale, to what extent you used it in the situation [to be determined by researchers, for example, “the most stressful situation this past week,” “the most stressful situation related to your illness this past week,” “the laboratory task we have asked you to perform”]

No.	Items	Not used	Used some what	Used quite a bit	Used a great deal
		0	1	2	3
1	Just concentrated on what I had to do next – the next step	0	1	2	3
2	I tried to analyze the problem in order to understand it better.	0	1	2	3
3	Turned to work or substitute activity to take my mind off things.	0	1	2	3
4	I felt that time would make a difference – the only thing to do was to wait.	0	1	2	3
5	Bargained or compromised to get something positive from the situation	0	1	2	3
6	I did something which I didn't think would work, but at least I was doing something.	0	1	2	3
7	Tried to get the person responsible to change his or her mind.	0	1		3
8	Talked to someone to find out more about the situation.	0	1	2	3
9	Criticized or lectured myself.	0	1	2	3
10	Tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11	Hoped a miracle would happen.	0	1	2	3
12	Went along with fate; sometimes I just have bad luck.	0	1	2	3
13	Went on as if nothing had happened.	0	1	2	3
14	I tried to keep my feelings to myself	0	1	2	3
15	Looked for the silver lining, so to speak; tried to look on the bright side of things.	0	1	2	3
16	Slept more than usual	0	1	2	3
17	I expressed anger to the person (s) who caused the problem	0	1	2	3
18	Accepted sympathy and understanding from some one	0	1	2	3
19	I told myself things that helped me to feel better	0	1	2	3
20	I was inspired to do something creative	0	1	2	3
21	Tried to forget the whole thing	0	1	2	3
22	I got professional help	0	1	2	3
23	Changed or grew as a person in a good way	0	1	2	3
24	I waited to see what would happen before doing any thing	0	1	2	3
25	I apologized or did something to make up	0	1	2	3



## Appendix A (continued)

No.	Items	Not used	Used some what	Used quite a bit	Used a great deal
26	I made a plan of action and followed it	0	1	2	3
27	I accepted the next best thing to what I wanted	0	1	2	3
28	I let my feelings out somehow	0	1	2	3
29	Realized I brought the problem on myself	0	1	2	3
30	I came out of the experience better than when I went in	0	1	2	3
31	Talked to someone who could do something concrete about the problem	0	1	2	3
32	Got away from it for a while; tried to rest or take a vacation	0	1	2	3
33	Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, e.t.c	0	1	2	3
34	Took a big chance or did something very risky	0	1	2	3
35	I tried not to act too hastily or follow my first hunch	0	1	2	3
36	Found new faith	0	1	2	3
37	Maintained my pride and kept a stiff upper lip	0	1	2	3
38	Rediscovered what is important in life	0	1	2	3
39	Changed something so things would turn out all right	0	1	2	3
40	Avoided being with people in general	0	1	2	3
41	Didn't let it get to me; refused to think too much	0	1	2	3
42	I asked a relative or a friend I respected for advice	0	1	2	3
43	Kept others from knowing how bad things were	0	1	2	3
44	Made light of situation; refused to get too serious about it	0	1	2	3
45	Talked to some one about how I was feeling	0	1	2	3
46	Stood my ground and fought for what I wanted	0	1	2	3
47	Took it out on other people	0	1	2	3
48	Drew on my past experiences; I was in a similar situation before.	0	1	2	3
49	I knew what had to be done, so I doubled my efforts to make things work	0	1	2	3
50	Refused to believe that it had happened	0	1	2	3
51	I made a promise to myself that things would be different next time	0	1	2	3
52	Came up with a couple of different solutions to the problem.	0	1	2	3
53	Accepted it, since nothing could be done	0	1	2	3
54	I tried to keep my feeling from interfering with other things too much	0	1	2	3
55	Wished that I could change what had happened or how I felt	0	1	2	3
56	I changed something about myself	0	1	2	3
57	I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3

## Appendix A (continued)

No.	Items	Not used	Used some what	Used quite a bit	Used a great deal
58	Wished that the situation would go away or somehow be over with	0	1	2	3
59	Had fantasies or wishes about how things might turn out.	0	1	2	3
60	I prayed.	0	1	2	3
61	I prepared myself for the worst.	0	1	2	3
62	I went over in my mind what I would say or do.	0	1	2	3
63	I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64	I tried to see things from the other person's point of view.	0	1	2	3
65	I reminded myself how much worse things could be.	0	1	2	3
66	I jogged or exercised.	0	1	2	3

Thank You!

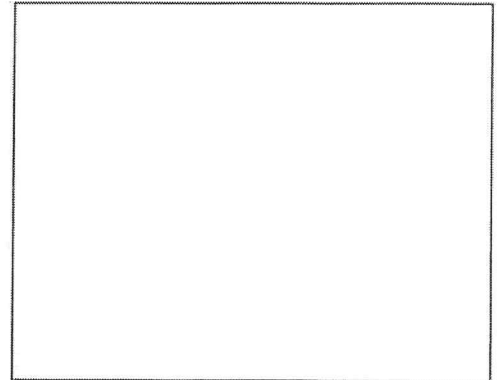
Time Ended \_\_\_\_\_

**Appendix B**  
**Memoing Sheet**

Researcher feeling/reaction/ insights	Further questions

## **Appendix C**

### **Informed Consent**



University of Illinois at Chicago  
Consent Information Sheet

#### **“Kinship Care for Orphans and Vulnerable Children in Ethiopia: A Mixed Methods Study of Caregiver Coping”**

##### **Why am I am being asked?**

You are invited to participate in this research that explores Kinship Care for orphans and vulnerable children in Ethiopia. This study is being conducted by Meseret Kassahun Desta, a doctoral student at Jane Addams College of Social Work, University Of Illinois at Chicago. This is a PhD dissertation research study. You are being asked to participate in this research because you are providing care and support for your relative child/children. Before making your decision to participate in this dissertation research study, I will read and explain the purpose of this study. You can ask any question before deciding to be in the research.

Participation in this research is voluntary and your decision whether to be in the research or not will not affect your current and future relationship with Addis Ababa University or any other service agency that you are currently associated with. You are also free to withdraw from the research process any time.

##### **Why this research is being conducted?**

This study focuses on Kinship Care for Orphan and Vulnerable Children in Ethiopia, particularly exploring the processes and pathways that led kin caregivers to assume the caregiving role for their related children affected by HIV/AIDS. This study also seeks to assess kin caregivers stress, social support, and coping. It is believed that the information will help us understand the kinship care processes and kin caregivers’ perspectives on stress related to the caregiving processes and how they are coping. We hope this information will help service providers and policy makers to design a mechanism to better support Ethiopian kin caregivers in the context of HIV/AIDS.



### **What procedures are involved?**

If you agree to participate in this research, you will be asked to answer closed and open ended questions on pathways that led kin caregivers to care for their relative children, the stress associated in the caregiving processes, the social support kin caregivers are obtaining from formal and informal sources, and how you are coping with the caregiving responsibilities. The interview process will take 60 - 90 minutes of your time. In addition, you will be asked for audio recording when you answer the open-ended questions. Participants will have the options of refusing the audio recording entirely or specific sections of the interview. If a further interview session is needed to complete the open-ended interview questions, you will be asked to volunteer for the second interview session at your convenience.

A total of 130 kin caregivers will be participating in this study.

### **What about privacy and confidentiality?**

In this research study, you will not be asked to provide any identifiable information about your self or the child/children for whom you are caring. All your questionnaire responses and the audio record remain confidential. All the information will be entered in a data statistical analysis packages and the soft copy will be stored in a secure password-protected computer at Addis Ababa University and transported to Jane Addams College of Social Work, University of Illinois at Chicago in an electronic format via a secure password protected personal lap top and flash disk. At UIC, the data will be kept under lock and key and on password protected computers. The audio-recorded data will be destroyed after transcribing the information. All the questionnaire response will be destroyed one year after the project has been completed. Access to the electronic data files will only be accessible to the researcher. In reporting the result after analysis, I will use pseudonym.

### **Are there any benefits to taking part in the research?**

There are no direct benefits for participating in this research study. However, your participation in this study provides an in-depth understanding of kin caregivers' situations, which may help service providers and policy makers to design an appropriate policy and formal services to better help kin caregivers. The findings of this research will be shared with you and other participants as well as policy makers, service providers, and the general public.

### **What are the potential risks and discomforts?**

In this research, the potential risk and discomfort to you is that you may experience a short term emotional upset while sharing your stories of pathways that let you to engage in the caregiving role and explaining the challenges that you are facing. This kind of emotional reaction is expected to be reversible. However, if your situation requires further professional assistance, upon receiving your consent, I will direct you to service providers who may help you to deal with your emotional disturbances.

### **Can I withdraw from the research?**

Participatory in this research is completely voluntary. You can withdraw any time from the research process without consequences of any kind.

Most of the questions in this research study are not sensitive questions. Although you are caring for children whose parent are unable to provide care due to their parent's HIV status, you will not be asked questions related to HIV/AIDS about yourself, the children under your care or the children's parents. However, sometimes you may find it upsetting when you are explaining the pathways that led them to care for the child/children. If this happens to you, you can take a break or decide not to answer the questions. If you would like, the researcher will refer you to the nearest counseling service providers with your consent.

### **Whom should I contact if I have questions?**

The researcher conducting this study is Meseret Kassahun Desta. I am available to answer any question related to this study any time. You can ask any question during the interview as well as after the interview. You can call me via my mobile phone: 251-911-649670.

### **What are my rights as a research participant?**

You can ask any question regarding this research at the School of Social Work, Addis Ababa University at +251 114-349392.

You can also contact the faculty sponsor (my research supervisor) Dr. Nathan Linsk via his office phone number 011-312-996-142 or by email at [nlinsk@uic.edu](mailto:nlinsk@uic.edu). If you have further questions, you can contact the Office for the Protection of Research Subject /Institutional Review Board via the OPRS phone number (001-312-996-1711).

You will be given the copy of this form as soon as you agree to answer the open ended and closed questions.

### **Remember**

Participation in this research study is voluntary.

Do you understand the information I have shared with you about the study?

Do you have any questions about the study or your participation in it?  
(I will answer any questions raised by the prospective participant.)

Signing your name at the bottom means that you agree to be in this study. You will be given a copy of this form after you have signed it.

Study participants

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Principal Investigator

Meseret Kassahun Desta

Signature \_\_\_\_\_

Date \_\_\_\_\_

Do you agree to be audio taped?

- ☐ Yes, I agree.
- ☐ No, I do not agree.

## **Appendix D**

### **Flyer**

Are you a relative caregiver for orphan and vulnerable child whose parents are not available to provide care due to HIV/AIDS? If yes, please join my dissertation project, which will study the pathways that led relatives to assume the caregiving responsibility, available types of support, major stressors, and coping strategies.

In order to participate in this dissertation study, you should fulfill the following inclusion criteria.

- You are providing care to at least one related child ages 4 - 12;
- You have provided care for at least six months;
- Your relative children must have been residing with you;
- You should be caring for a child whose parents are not available due to HIV/AIDS;
- You can communicate clearly in Amharic and are willing to speak freely and voluntarily about their experiences in providing care for orphan children.

Would you like to share your experiences?

Participatory in this research is completely voluntary. You can withdraw any time from the research process without consequences of any kind. All the interviews will be private (in your home or other convenient location) and confidential. The interview will last approximately from 1 hour to 1 and half hours. The interview is part of my PhD dissertation at the University of Illinois at Chicago.

If you would be interested in participating in this dissertation study, please come to Kebele/service agency \_\_\_\_ Sub City, \_\_\_\_ Kebele \_\_\_\_\_ on \_\_\_\_\_, 2010 at \_\_\_\_\_ to meet with me. I will provide you information about the research in detail and will ask you to sign a consent form.



## **Appendix E**

### **Information Sheet**

In Ethiopia, where formal welfare services are extremely minimal, people affected or impacted by HIV/AIDS including orphans and vulnerable children rely up on the extended family system for social, emotional, and economical support. Despite the tremendous role of kin caregivers in caring for orphans and vulnerable children much remains unknown about the caregiving process whether or not affecting their psychosocial and economic wellbeing. Although this research does not intend to provide direct benefits for kin caregivers, it will shed light on understanding kinship care, the pathways and motivations that led kin caregiver to assume the caregiving responsibility as well as examining the effect of demographic and socio-economic factors in affecting caregivers coping process. The empirical evidence that this research would seek will be used to improve the practice setting and policy provisions to effectively support kin caregivers.

Participatory in this research is completely voluntary. You can withdraw any time from the research process without consequences of any kind. All the interviews will be private (in your home or other convenient location) and confidential. The interview will last approximately from 1 hour to 1 and half hours. The interview is part of my PhD dissertation at the University of Illinois at Chicago.

If you would be interested in participating in this dissertation study, you can tell your contact information for Kebele HIV/AIDS desk officers or community workers. I will contact you and will ask you to sign a consent form.

# Appendix F,

## UNIVERSITY OF ILLINOIS AT CHICAGO

Office for the Protection of Research Subjects (OPRS)  
Office of the Vice Chancellor for Research (MC 672)  
203 Administrative Office Building  
1737 West Polk Street  
Chicago, Illinois 60612-7227

### Approval Notice Initial Review (Response To Modifications)

August 20, 2010

Meseret Desta, MSW  
Jane Addams School of Social Work  
1640 W Roosevelt Rd, Rm #511  
M/C 779  
Chicago, IL 60607  
Phone: (312) 996-9810 / Fax: (312) 413-4184

**RE: Protocol # 2010-0533**  
**"Kinship Care for Orphans and Vulnerable Children in Ethiopia: A Mixed Methods Study of Caregiver Coping"**

Dear Meseret Desta:

Your Initial Review (Response To Modifications) was reviewed and approved by the Expedited review process on August 15, 2010. You may now begin your research

Please note the following information about your approved research protocol:

- Protocol Approval Period:** August 15, 2010 - August 14, 2011  
**Approved Subject Enrollment #:** 130  
**Additional Determinations for Research Involving Minors:** These determinations have not been made for this study since it has not been approved for enrollment of minors.  
**Performance Sites:** UIC, Addis Ababa University  
**Sponsor:** None  
**PAF#:** Not Applicable  
**Research Protocol(s):**  
a) Kinship Care for Orphans and Vulnerable Children in Ethiopia: A Mixed Methods Study of Caregiver Coping  
**Recruitment Material(s):**  
a) Flyer (Amharic); Version 1; 07/20/2010  
b) Information Sheet (Amharic); Version 1; 07/20/2010  
c) Kinship Care - Flyer (English); Version 1  
d) Kinship Care - Information Sheet (English); Version 1  
**Informed Consent(s):**  
a) Kinship Care for Orphans and Vulnerable Children in Ethiopia - Informed Consent

(English); Version 3; 08/04/2010

b) Informed Consent (Amharic); Version 2; 08/04/2010

c) Waiver of Signed Consent Document granted under 45 CFR 46.117 for recruitment purposes

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

**Please note the Review History of this submission:**

Receipt Date	Submission Type	Review Process	Review Date	Review Action
06/14/2010	Initial Review	Expedited	06/17/2010	Modifications Required
07/23/2010	Response To Modifications	Expedited	07/29/2010	Modifications Required
08/06/2010	Response To Modifications	Expedited	08/15/2010	Approved

Please remember to:

→ Use your **research protocol number** (2010-0533) on any documents or correspondence with the IRB concerning your research protocol.


→ Review and comply with all requirements on the enclosure,  
"UIC Investigator Responsibilities, Protection of Human Research Subjects"

**Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.**

**Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.**

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 996-9299. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,



Marissa Benni-Weis, M.S.

IRB Coordinator, IRB # 2

Office for the Protection of Research Subjects



Enclosure(s):

1. **UIC Investigator Responsibilities, Protection of Human Research Subjects**
2. **Informed Consent Document(s):**
  - a) Kinship Care for Orphans and Vulnerable Children in Ethiopia - Informed Consent (English); Version 3; 08/04/2010
  - b) Informed Consent (Amharic); Version 2; 08/04/2010
3. **Recruiting Material(s):**
  - a) Flyer (Amharic); Version 1; 07/20/2010
  - b) Information Sheet (Amharic); Version 1; 07/20/2010
  - c) Kinship Care - Flyer (English); Version 1
  - d) Kinship Care - Information Sheet (English); Version 1

cc: Creasie Finney Hairston, Jane Addams School of Social Work, M/C 309  
Nathan Linsk, Jane Addams School of Social Work, M/C 779



# Appendix F1

## አዲስ አበባ ዩኒቨርሲቲ ADDIS ABABA UNIVERSITY

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SCHOOL OF SOCIAL WORK

Date: August 26, 2010  
Ref. SSW/704/02/10

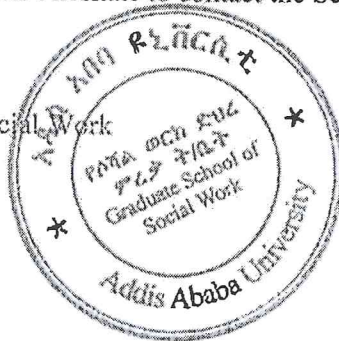
To: Meseret K. Desta

The School of Social Work at Addis Ababa University assigned the Ethical Review Committee of the School to evaluate your dissertation proposal, which is entitled "Kinship Care for Orphans and Vulnerable Children in Ethiopia: A Mixed Methods Study of Caregivers Coping" based on your request written on August 24, 2010. Hence, the committee reviewed your proposal based on the School's ethical review guideline. Here with this letter the decision of the committee is attached. If you have any question, please don't hesitate to contact the School.

With Best Regards

Ashenafi Hagos

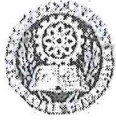
Associate Dean of School of Social Work



☎ 011-4349392

FAX 0114 34 94 22

✉ 68



ADDIS ABABA UNIVERSITY  
Graduate School of  
Social Work  
Ethical Review Committees

SOP# 002  
Version 1.0  
Effective date:

Title:

### 1.1 Evaluation Protocol

Annex: 2

#### Ethical Review Committee Decision

Meeting No. 002/10  
Document no. 002

Date (D/M/Y) 02/26/2010  
Assigned no. 002/02/10

Document Title: <u>Kinship care for orphans and vulnerable children in Ethiopia: A mixed methods study of caregiver coping.</u>				
Principal Investigator: <u>Emebet Mulusale</u>				
Institute: <u>University of Illinois at Chicago</u>				
Elements Reviewed (01-008)			<input checked="" type="checkbox"/> Attached <input type="checkbox"/> Not attached	
Review of Revised Application <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Previous review:	
DECISION:		<input checked="" type="checkbox"/> Approved s <input type="checkbox"/> Approved with recommendation <input type="checkbox"/> Resubmission <input type="checkbox"/> Disapproved		
No.	Voting ERC Members			Date: <u>02/26/2010</u>
				AP AR RES DA
1.	<u>Ashenafi Hagos</u>	<u>Ashenafi</u>	<u>✓</u>	
2.	<u>Emebet Mulusale</u>	<u>Emebet</u>	<u>✓</u>	
3.	<u>Abraham Mule</u>	<u>Abraham</u>	<u>✓</u>	

Signature:

Emebet Mulusale

Chairperson

Date: 02/26/2010



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## VITA

### NAME

Meseret Kassahun Desta

### EDUCATION

Ph.D., Social Work, University Of Illinois at Chicago, 2011.

M.S.W., (Master of Social Work), Graduate School of social Work, Addis Ababa University, August, 2006

B.A., in Sociology & Social Administration, College of Social Science, Addis Ababa University, July, 2004.

### PUBLICATION (Book)

Desta, Meseret. (2010). *Dallocha Women Water Development Association: Is it Empowering?* LAP Lambert Academic Publication: Germany

### CONSULTING

The Women's Movement in Ethiopia: Opportunities, Challenges, and Ways Forward. The Network of Ethiopian Women Association, Addis Ababa, March, 2011.

Gender Mainstreaming Training for Actionaid Ethiopia senior and middle level managers. Addis Ababa, December 2010.

Good Donorship for Ethiopian Civil Societies. (June 4 – August 15). Tocaire/CAFOD, Ethiopia, Addis Ababa

Evaluation research on Zega Leidget's urban project on Good governance (from May – July 2007). Ethiopia, Addis Ababa.

Training Manual on Gender Mainstreaming (November 2005 – January 2006). Adult and Non-formal Education Association.

Training on Gender Analysis, Gender mainstreaming, Gender and Development, Empowerment approach. ISSAPSO, Love for Children, MCDP, Addis Ababa Youth association and World Vision-Ethiopia

Training on teaching methodologies and learning aid preparation. Pro Pride, Progynist, Forum for Street Children, Focus on Street Children, Adult and Non Formal Education Association Ethiopia.

## **PRESENTATIONS**

Desta, Meseret Kassahun. (2011). The Ethiopian Women's Movement. The Network of Ethiopian Women Association, Gion Hotel, March 9, 2011: Addis Ababa,

Desta, Meseret Kassahun. (2010). Kinship Care for Orphans and Vulnerable Children in Ethiopia: What Do We Know and Why It Is Important. 1<sup>st</sup> OVC in Africa Conference, Johannesburg (Sandton City), South Africa from October 31<sup>st</sup> - November 1, 2010.

Desta, Meseret Kassahun. (2010). Kinship Care for Orphans and Vulnerable Children the Context of HIV/AIDS. On *The first best practices symposium on Psychosocial Care for People infected and affected by HIV/AIDS*. Addis Ababa University, Ethiopia on March 6, 2010.

Desta, Meseret Kassahun. (2009, August). *Seminar on Social Work ethics and values, Social Work Practice theories, Policy Analysis, and Research*, Addis Ababa University, Ethiopia

Desta, Meseret Kassahun. (2006, March). *Gender mainstreaming in non-formal education programs*. Nazreth, Ethiopia.

Desta, Meseret Kassahun. (2006, July). *Dallocha Women Water Development Association in Managing Community Water Project: Is it Empowering?*, Master's Thesis, 2006. Dallocha, Ethiopia.

Desta, Meseret Kassahun. (2006, April). *Gender concepts and problems of female university students*. Gender Club, Addis Ababa University. Addis Ababa, Ethiopia.

## **TECHNICAL REPORTS, TRAINING MANUAL AND PROJECT PROPOSALS**

Desta, Meseret Kassahun. (2011). The Ethiopian Women's Movement. The Network of Ethiopian Women Association, Gion Hotel, March 9, 2011: Addis Ababa

Desta, Meseret Kassahun. (2007). Enhancing Good Donorship for Ethiopian Civil Society Organizations. Trocair/CAFOD. Ethiopia, Addis Ababa

Desta, Meseret Kassahun. (2007). Evaluation of Zega Leidget's Good governance project. Ethiopia, Addis Ababa;

Desta, Meseret Kassahun. (2005). *Gender mainstreaming in non-formal education*. A training manual. Adult and Non Formal Education Association Ethiopia. Addis Ababa, Ethiopia;

Desta, Meseret Kassahun. (2005). *Situation analysis report of Kirkos Sub city, Kebele 13/14*. Zega Leidget. Addis Ababa, Ethiopia;

Desta, Meseret Kassahun. (2005). *Project Proposal Document for Commercial Sex Workers and persons Living with HIV and AIDS, Kebele 13/14. Zega Leidget*. Addis Ababa, Ethiopia;

Desta, Meseret Kassahun. (2004). *Entoto program seven years organizational report*. Pro Pride. Addis Ababa, Ethiopia;

Desta, Meseret Kassahun. (2002). *Entoto Education Sector Phase Out Plan*. ProPride. Addis Ababa;

Desta, Meseret Kassahun. (2003). *Gender Audit Report*. Pro Pride Addis Ababa, Ethiopia.

### **PROFESSIONAL EXPERIENCE**

**Graduate Research Assistant and Triangle Partnership Project Coordinator:** Jane Addams College of social Work/ Midwest Aids Training Education Center, University of Illinois at Chicago, from July, 2008 to May, 2011.

**Graduate Research Assistant.** Jane Addams College of Social Work, University of Illinois at Chicago, from August 2006 to July 15, 2008;

**Program Coordinator Citizen for Progress (Zega LeIdget)**, from July 11 to October 11, 2005

Coordinated financial and human resources of the organization

Conducted a preliminary situation analysis of the project area i.e. Kebele 13/14 of Kirkos sub city

Designed a project proposal for commercial sex workers and persons living with HIV/AIDS

**Program Manager.** Pro Pride Entoto program from November 2003 to September 2004.

Coordinated Preparation of annual plan and budget in collaboration with sector coordinators;

Managed human resources in a team spirit to achieve the objectives of the organization;

Managed the organization's material and financial resources to be utilized for the objectives of the organization efficiently and effectively;

Coordinated Participatory Review and Reflection session quarterly and annually with major stakeholders of the program;

Represented the program office in all external relations with the community, local and regional government offices and in various networks;

Coordinated the institutionalization process of the phase out period which involved the community and staff to ensure the sustainability of the projects

**Gender Focal Person.** Pro Pride Entoto Program from September 2002 to September 2004

Coordinated the gender analysis process of the program area

Conducted gender audit as team leader and facilitator

Conducted gender awareness and mainstreaming trainings for staff of Pro Pride (Entoto, Merkato and Mesalemiya programs)

Conducted gender awareness and mainstreaming trainings for Entoto Subcity teachers

**Education Sector Coordinator.** Pro Pride Entoto Program from Nov.1999 to November 2003

Prepared annual plan and budget of the sector for six years and coordinated the performance of the sector;

Recruited and trained education facilitators on Education concepts and principles, methodologies of teaching Language, Mathematics and Environmental education, Teaching aid preparation and Lesson plan preparation;

Prepared three years phase out plan for the sector;

Adopted the Minimum Learning Continuum of ACCESS program of Actionaid in Pro Pride program context in collaboration with Pro Pride education sector staffs;

Coordinated the advocacy work of education sector with relevant NGOs and regional education bureau to make known the ACCESS program and bring the support of government officials to legalize the education initiative as alternative for out of school children;

Established strong local education board capacitated to hand over the project after phase-out;

**Education Office.** Pro Pride Entoto Programme from March 1997 to November 1999

Plan and manage the sector;

Coordinate and follow up the sector;



Liaise with concerned agencies;

Communicate and Reporting;

Design project proposal;

Coordinate gender related activities in the development area.

**Education Assistant** ACTIONAID- Ethiopia Dalocha Integrated Rural Development Programme, from March 1994 to March 1997.

Participate in plan and Budget of the Education sector;

Train the Non Formal Education Facilitators in Participatory method;

Reporting the Education sector activities carried out in one zone of the Development area;

Creating awareness and mobilize the community for participation in Education;

Preparing Teaching and Learning Materials in Pedagogical center.

### **TEACHING POSITIONS**

Part time lecturer. Addis Ababa University. Sociology and Social Anthropology Department. Fall 2005.

### **TRAINING AND WORKSHOPS**

Peace building and conflict transformation. World Learning African Peace Development Initiative, Kenya January 2004

Gender and organizational change. Christian Relief and Development Association, 2003

Gender mentoring training of trainers. PACT-Ethiopia, September, 2002

Gender training of trainers (TOT). ActionAid-Ethiopia, December, 2001

Team building and communication. Christian Relief and Development Association. August, 2001

Gender mainstreaming. ActionAid-Ethiopia. February, 2001

Training's of trainer workshop on participatory methods. Save The Children. Nazareth, 1998



Syllabus preparation for non-formal education system adopted for Appropriate Cost Effective Centers for Education within the School System in Ethiopia. Actionaid-Ethiopia. Nazreth, 1996

### **SERVICE TO THE COMMUNITY**

Counseling service and Mentoring youth, Bole Kalehiwot Church. Addis Ababa from 2004 –to date.

Board Chair Person. Yakin Ministry (local Non Governmental Organization). Addis Ababa from 2002 – 2006.

Mentor. High school female students. Pro Pride, 2006.

### **PROFESSIONAL MEMBERSHIPS**

Ethiopian Sociologist, Social Anthropologist and Social Workers Association  
Sorooptimist International Ethiopian chapter

### **AWARDS**

MA thesis research grant (Graduate scholarship Award €2000.00). DAAD (German Academic Exchange Service). Addis Ababa University, 2006