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THE IMPACTS OF CHILD CARE ON SOCIAL AND EMOTIONAL DEVELOPMENT OF CHILDREN: INSTITUTIONAL AND HOME BASED CARE IN ADAMA TOWN IN FOCUS

A research paper presented by

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in partial fulfillment of the requirements for obtaining the degree of
MASTERS OF ARTS IN SOCIAL PSYCHOLOGY

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TABLE OF CONTENTS

Page

APPROVAL OF BOARD OF EXAMINERS

As members of the Thesis Board of Examiners, we certify that we have read the Thesis prepared by Tadu Alemu that is entitled: **The Impacts of Child Care on Social and Emotional development of Children: Institutional and home based care in Adama City in Focus** is recommended that it should be accepted as fulfilling thesis requirements for the degree of Masters of Arts.

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Lists of Tables

ABBREVATION

AIDS: Acquired Immune Deficiency Syndrome
ASTU- Adama Science and Technology University
FDRE-Federal democratic republic of Ethiopia
HIV- Human Immune Virus
MOLSA-: Ministry of Labor and Social Affairs
MOWA- Ministry of women affairs
NPA: - National Plan of Action
OVC- Orphan and vulnerable children
SED- Social and Emotional Development
UNCRC-: United Nations Convention on the Rights of the Child
UNICEF-: United Nations Children's Educational Fund.
WHO-: World Health Organization

Abstract

This study is concerned with the impacts of child care on social and emotional development aspects of children in the institutional care facilities and home based setting in Adama town, Oromia regional state. Its aims were to investigate how upbringing children in institutional and family setting has impacts the social relations and emotional stability of children. The theoretical framework of the study is based on the psychodynamic theory, attachment theory, behaveralist approaches. The study was carried out in Adama town, in institutional child care and schools as the main inquiry site. All institutional child care centers are private owned organizations and are mostly supported by foreign donors. Besides, the schools are supervised and owned by government and private legal entity. Methodologically, this study applies mixed method approaches and includes the triangulation of a variety of quantitative and qualitative instruments of data collection. The data has been collected from institutional child care facilities which consist of eighty participants and with equal eighty participants from home based which accounts for 160 children from the ages ranges of 10-19. Furthermore, interview was conducted with children from the ages of thirteen. The thesis concludes that the social structures and care for children available at the institutional care and home based care have strong impacts on the children's lives and aspects of social and emotional development of life. The
Institutional care facilities represents sets of structures that both enable and restrict the children to act as competent social actors. Even though the material and social structures and supplies at the homes determine much of the children's lives, the children have some degree of freedom to act within these structures and are able to influence their own lives. Therefore, this study reveals that there are significant differences in terms of social and emotional development for institutional and home based care approaches. And, the qualitative finding also discloses that the home based care has positive impacts for children's social and emotional development.

CHAPTER ONE
1. INTRODUCTION

1.1 Background to the Study

Universally, families care for children. Despite cultural differences, religious beliefs, traditions, or customs, we expect to find parents working to ensure a safe and caring home for their offspring. Abundance of research findings and expert opinion back that, the family best provides for children's needs, and that the prevention of family breakdown will best assist children (with the exception of an abusive family) throughout childhood period. Throughout the developing world, the vast majority of children unable to live with their own families are cared for within extended family or community networks. But, most of the agencies, which provide care for separated children, concentrate their energies and resources on developing institutional forms of care which in most cases fails to provide children with the environment they need to grow up into healthy and well-adjusted adults, Tolfree, David. 1995.

Home and home-based care are imperfect, but on the whole they are better than the alternatives. Any type of care, home-based or residential, can be implemented badly and damage children. It is clear, though, that the available literature on child development indicates that families have better potential to enable children to establish the attachments and other opportunities for individual development and social connectedness than does any form of group residential care. Well-implemented home-based care is preferable to well-implemented residential care.

Institutionally reared children have captured attention for decades. Early research on these children emphasized the deprivation of maternal care, although as Rutter (1981) rightly noted, not only maternal stimulation, but also many other types of stimulation needed for normal

development is deficient in institutional environments. Institutional care dramatically increases the risk for social behavioral difficulties, including social attachment and relationship disturbances, disruptive behavior problems, sensitivity to social boundaries, establishment and maintenance of intimacy, and emotional regulation (Ames, 1997;Groze & Ileana, 1996;O'Connor, Bredenkamp, Rutter, & ERA Study Team, 1999;Rutter et al., 1999;Zeanah, 2000). Yet, little is known about the processes through which early experiences of neglect lead to these developmental problems.

Many institutions still focus on meeting children's physical needs while ignoring more important psychological and social needs. The study revealed that many institutional caregivers contributed to the psychological stress of children and youths because they failed to appreciate they were dealing with a traumatized and vulnerable group who required special support and encouragement.

Likewise, meeting psychosocial and developmental needs of children is based on a healthy bond between parent and child, the quality of the attachment, and the interaction between a growing child and the adults that shape a child's future. If we can safeguard a healthy attachment or bond between children and the adults caring for them, their chances of survival and a better quality of life are significantly improved.

Although institutions may allow children to remain within their home country, speak the same language as before, and maintain dietary or cultural beliefs, they cannot replace the day-to-day exposure to cultural customs and practices, from which children learn the roles and expectations of the community in which they belong. In families, daughters work side-by-side with mothers, aunts, and sisters. Sons learn from fathers, uncles, and brothers. Through these

bonds, children gain the confidence and knowledge to take their place in the adult world and feel a sense of belonging, all of which provide them with an identity.

It is not the intention of this paper to discourage institutional care. They can be well managed and run with only the best intentions for children. There are many groups and individuals around the world who support, manage, work or volunteer in orphanages. Some of this work is rooted in good practice - integrated with the surrounding community, staffed by qualified staff caring for no more than 8-10 children, active in family tracing and reunification, and linked with broader systems (formal state structures and informal community mechanisms) to ensure every child's case is regularly reviewed with the aim of placing that child back into family care.

Neither does this paper seek to idealize home based care. As the United Nations Study on Violence against Children has revealed, neglect and abuse occur in families at an alarming rate. If supportive interventions cannot improve a family situation where there is serious neglect or abuse, the child should be placed with a family that will provide a nurturing environment.

The concept of a "good enough" family has been put forward as a way of recognizing the inherent imperfection in families while also placing a premium on love, care, continuity, commitment and facilitation of development—all of which are better fulfilled in a family setting. Although applied in the context of child and family welfare in the developed world, in many ways the concept is relevant to the arguments presented in this paper. A "good enough" family may not be the ideal family, but it is often far better than the alternative in terms of what the evidence shows is in the best interests of the child.

In November 2009, the United Nations welcomed the "Guidelines for the Alternative Care of Children." At the heart of the document is a call for governments to prevent unnecessary

separation of children from their families by strengthening social services and social protection mechanisms in their countries. The Guidelines acknowledge that some residential care will be needed for some children. However, the emphasis and priority is on developing and supporting family-based care alternatives.

Children need more than good physical care. They also need the love, attention and an attachment figure from which they develop a secure base on which all other relationships are built. Research in the early 1900s and work on the effects of institutional care and attachment theory beginning in the 1940s, especially that of John Bowlby, established a foundation for the current scientific understanding of children's developmental requirements that led to policy change in post-war Europe and the United States. Based on their research during the Second World War, Anna Freud and Dorothy Burlingham described the importance of family care in stark terms:

The war acquires comparatively little significance for children so long as it only threatens their lives, disturbs their material comfort or cuts their food rations. It becomes enormously significant the moment it breaks up family life and uproots the first emotional attachments of the child within the family group, Powell, G. M., S. Morreira, C. Rudd and P.P. Ngonyama, 1994.

There is now an abundance of global evidence demonstrating serious developmental problems associated with placement in residential care, Ainsworth, M., et al., and 1999. For the last half century, child development specialists have recognized that residential institutions consistently fail to meet children's developmental needs for attachment, acculturation and social integration, Williamson, Jan, 2009.

A particular shortcoming of institutional care is that young children typically do not experience the continuity of care that they need to form a lasting attachment with an adult

caregiver. Ongoing and meaningful contact between a child and an individual care provider is almost always impossible to maintain in a residential institution because of the high ratio of children to staff, the high frequency of staff turnover and the nature of shift work. Institutions have their own "culture," which is often rigid and lacking in basic community and family socialization. These children have difficulty forming and maintaining relationships throughout their childhood, adolescence and adult lives. Indeed, those who have visited an orphanage are likely to have been approached by young children wanting to touch them or hold their hand. Although such behavior may initially seem to be an expression of spontaneous affection, it is actually a symptom of a significant attachment problem, Bower, B., 1998. A young child with a secure sense of attachment is more likely to be cautious, even fearful, of strangers, rather than seeking to touch them.

Countries with a history of institutional care have seen developmental problems emerge as these children grow into young adults and experience difficulty reintegrating into society. Research in Russia has shown that one in three children who leaves residential care becomes homeless, one in five ends up with a criminal record and up to one in 10 commits suicide, Tobis, David, 2007. A meta-analysis of 75 studies (more than 3,800 children in 19 countries) found that children reared in orphanages had, on average, an IQ 20 points lower than their peers in foster care, van Ijzendoom, H. Marinus, Maartje Luijk and Femmie Juffer, 2008.

Traditionally child care in Ethiopia was the preserve of the nuclear family, extended family and communities. The social set-up has since changed and an increasing number of children are unable to grow up in the above mentioned institutions, thus necessitating 'out-of-home' care in the form of children's homes,(Ministry of women and children affairs). The

number of orphans and vulnerable children in institutions is continuously increasing. Information from Save the Children indicates that eight million children live in institutions worldwide, (Mulugeta, 2003). The same author notes that in Liberia for instance, the number of orphanages grew from four in 1989 to one hundred and seventeen by 2001. According to International Services and UNICEF (2004) children in institutional care increased by 66% between 1998 and 2001, worldwide. Institutionalizing children has got some negative consequences for both individual children and for the society. Sachiti(2011) cites a research conducted by a United States based organization which shows that institutional care negatively affects child development and adult productivity.

The same study shows that children in orphanages are uniquely vulnerable to the medical and psycho-social hazards of institutional care. Short term effects of institutionalization are that children risk contracting serious illnesses and developing language impairments while long term effects include children developing psychological problems like personality disorders.

Sachiti (2011), further quotes Ford and Kroll (1995) who argue that examination of institutionalization reveals that even good institutions harm children, leaving teens ill-prepared for the outside world. Furthermore, a research by Save The Children established that institutional care often causes serious and negative impacts on the development and rights of children, (Mulugeta, 2003). The second international conference on children and residential care held in Stockholm in May 2003 came up with a declaration (The Stockholm Declaration) indicating that the negative impact of institutional care should be prevented through diminishing the use of institutions and strengthening of community based approaches such as re-integration.

By 2003 an estimated 8 million children worldwide were living in residential child care facilities (International Save the Children Alliance, 2003). Countries heavily affected by

HIV/AIDS have often responded by development of residential child care facilities as a solution to the growing number of orphans and vulnerable children. The arguments for doing this are based on the lack of alternatives as the extended family system and the communities are claimed to be overburdened and that foster care or adoption are non-traditional forms of child care and may expose the children to abuse and exploitation.

Institutional child care facilities seem to have a high level of "donor-appeal", as donors tend to favor residential child care as it provides a visible and tangible manifestation of their donations. They also have a high level of appeal to media as they are seen as easy to monitor, as opposed to a family based setting. They can also be preferred by social service professionals as they are organizationally convenient (Forster, 2005; Tolfree, 1995). There is a growing understanding that residential child care facilities are not an appropriate solution to the increasing numbers of orphans and vulnerable children. Research literature has shown that residential child care facilities can have serious damaging effects on children's development and on children's rights and there is little or no empirical evidence to contradict these findings. In the worst cases children's rights are being violated by systematic sexual abuse, exploitation, lack of proper nutrition and health-care that severely damages the children's health, educational deprivation and strict, regimented discipline. Even where the physical conditions are good there will most certainly exist problems associated with any form of residential care. Damaging effects residential child care can have on children include segregation, discrimination and isolation, risk of institutional abuse, lack of personal care, stimulation and attention to specific psychological needs and lack of opportunities to learn about adult roles. In addition, admission is often not based on the child's best interest, but on the needs of the parents or extended family. Children

living in residential child care facilities often have trouble adjusting to adult life when they move out (Foster, 2005; Tolfree, 1995 and 2003).

In recent years there has been a move towards community-based approaches as a means to prevent unnecessary family-separation and to ensure that children who loose their parents, in one way or the other, can live in a family based setting within their local community. The cost of caring for a child in residential child care facilities is five to ten times higher than foster care. It produces poor results for a small number of children at a high cost. They also produce a "magnet effect", as they draw in children that are not orphans and do have parents or other family members who can act as caregivers. This undermines the traditional family and community responsibility for orphans and vulnerable children (Tolfree, 1995; Foster, 2003). Therefore, institutional care and family based care are both considered throughout this study and one of the main intention of the research has been looking at whether either one of these options produces better outcomes for the child

1.2 Statement of the problem

Throughout the developing world, the vast majority of children unable to live with their own families are absorbed - often unquestioningly - within their extended families, or within wider community networks. But, the majority of agencies (governments and NGOs) are providing care for separated children have concentrated their energies and resources on developing institutional (or residential) forms of care.

According to the Alternative Care Guidelines on Community-Based Childcare, Reunification and Reintegration Program, Foster Care, Adoption, and Institutional Care Service issued by MOWA in June 2009, "childcare within an institutional setting should be used as a short-term alternative care strategy and only as a last resort when all other types of childcare

options have been exhausted" (MOWA 2009:47). The excessive cost of institutional care is commonly criticized, suggesting the viability of more economically sustainable interventions such as childcare grants or community-based care. The outcomes of institutionalized children have been proven to be worse than those placed in foster care, both through longitudinal studies such as the Bucharest Early Intervention Program and through the words of the children themselves.

Even though, Social and Emotional Development (SED) aspects are the two building blocks of children future success in life, fortunately or unfortunately, successful social and emotional development of children in institutional setting and home environment is affected by different factors as, poverty, lack of warmth and affection, abuse, poor secure relationship with significant others, poor health and etc. Children are frequently placed in institutional care throughout the world despite wide recognition that institutional care is associated with negative consequences for children's development (Carter, 2005; Johnson, Browne and Hamilton-Giachritsis, 2006). For example children in institutional care are more likely to suffer from poor health, physical underdevelopment and deterioration in brain growth, developmental delay and emotional attachment disorders. Consequently, these children have reduced intellectual, social and behavioral abilities compared with those growing up in a family home.

According to the report of Swedish development cooperation, growing up in an institution is not good for children. Its justification was both from experience and well-documented research findings. Being separated from one's parents in childhood leaves scars. Other unfavorable factors are the isolation of institutions from the rest of the community, the under stimulation and the lack of contact with adults, which mean that children's basic needs are

not met. Many people who have grown up in isolated institutions have difficulty, as adults, in being integrated into society–and this may result in their continued institutional life in adulthood. Any abuse and neglect prior to being taken into care will have had a part to play in their emotional and social stability, however It was found that living in residential care can further damage their emotional well- being and this seems to be dependent on their age at the time of entering care as well as their personal resilience. There is consistent evidence that the occurrence of emotional, social and behavioral problems found in children and adolescents in out-of-home placements or state.

The evidence has shown that living in institutional care has many social and emotional effects on a child and equally once they have left the care system. The age of the child and their previous attachment to family members has a huge impact on their behavior and mental health once living within care and often this will follow them into their adulthood. As a consequence of this, it was found that children living in residential care are some of the most vulnerable within our society.

There has long been scientific evidence that children are harmed by institutional life. Although this is a known fact, there are between eight and ten million children in the world today living in various types of institutions. The evidence strongly suggests that the experience of institutional care is most damaging for children under the age of five, Tolfree, (2003) and especially so for children under the age of three, since it is during these critical years that children need to develop the physical, cognitive, psychological, and social foundation for the rest of their lives.

Extensive research in child development has shown that living in an institution from an early age can result in severe developmental delays, disability physical stunting, and potentially

irreversible intellectual and psychological damage. The negative effects are more severe the longer a child remains in an institution, and are the most severe in younger children. One study on institutions in Europe, for example, found that young children (0-3 years) placed in orphanages were at risk of harm in terms of attachment disorder, developmental delay (i.e., reaching developmental milestones and gross and fine motor skills), and neural atrophy in the developing brain, WHO, (2004).

The ratio of children to staff in an institution is nearly always higher than to adult carers in a home setting and the continuity and dependability of relationships is lacking. These deficits deprive a child from the continuous, attuned relationships with caregivers that are necessary to developing attachments, a fundamental human requirement. In contrast, families, even those that are poor, provide these essential developmental connections. Nothing can make up for the personal attention and love of a parent, aunt, or grandmother. Furthermore, children living in institutions are more likely to have health problems and are at increased risk of infectious diseases, Johnson, D. E., et al., (1992). Children raised in orphanages often suffer from severe behavior and emotional problems, such as aggressive behavior, antisocial development, have less knowledge and understanding of the world, and become adults with psychiatric impairments, Wolkind, S. N. (1974).

According to UN Secretary General's Report on Violence against Children, popular perception is that institutions protect children from abuse and neglect. However, research has shown that children in orphanages can face a higher risk for violence and abuse than in family settings, especially if they are disabled. These risks stem from a variety of sources, including staff and other children. Reports have documented instances of children subjected to beatings with hands, sticks, and hoses, and having their heads hit against a wall, while in orphanages for

children with disabilities children may be subjected to violence as part of their purported "treatment."

In Ethiopia, as in most traditional societies, a strong culture of caring for children, the sick, the disabled, and other needy members of the community by nuclear and extended family members, communities, churches, and mosques has existed for centuries. Based on cultural and religious beliefs, provision of care to orphaned, abandoned, and vulnerable children has been seen as the duty of the extended family system among most of the ethnic groups in the country. Thus, child welfare services in Ethiopia emerged as a result of traditional practices among the various ethnic groups.

Ethiopia is home to one of the largest populations of orphans and vulnerable children (OVC) in Africa. There are more than five million one- and two-parent orphans, who represent more than six percent of the entire population of Ethiopia (82,800,000) and number more than the total population of the neighboring country of Eritrea (Population Institute 2009:1). The high number of orphans is attributed to the loss of one or both parents to HIV/AIDS, other diseases such as tuberculosis and malaria, high maternal mortality rate, extreme poverty, famine, armed conflict, child labor practices, and migration (FHI 2010:10; MOWA 2010:1). Almost sixteen percent of the orphan population of 5,423,459 is orphaned by HIV/AIDS (MOH 2007:8) and 537,501 of those orphans under age 18 have lost both parents (Population Census Commission of Ethiopia 2007:239). Approximately 18% of Ethiopian households are caring for an orphan (Save the Children 2009:1).

The Ethiopian child protection system is managed by the Ministry of Justice, the Ministry of Labour and Social Affairs, the Ministry of Women's Affairs, and the Federal HIV/AIDS Prevention and Control Office, but "the protection and care of orphan children [has] fallen

largely upon private organizations" (Varnis 2001:146) and is characterized by a "lack of standards and uniformity in the services" (MOWA 2010:1). The GOE has a favorable view of institutional care as a viable option for orphan children as evidenced in recent adoption policy and the exponential increase in adoptions from Ethiopia; many speculate this is a result of the underfunding of the ministries in charge (Ibid., Howell 2006). While social protection represents an effective strategy to reduce poverty, particularly in situations of social vulnerability where the impact of HIV/AIDS and social change are primary contributors to an increase in poverty (Devereux 2006:9), it is painstakingly clear that access to social protection programs is limited; the most marginalized children and families too often face barriers that lead to their exclusion from government programming

The population in Ethiopia is generally characterized by a very young structure, with children below age 18 years accounting to 52% of the national population. Children below age 15 represent 44% of the national population. The number of children living in difficult circumstances is noted to be significant due to social, economic, political as well as cultural factors (MOLSA, 2005). It is currently estimated that there are about 4.6 million orphans, out of which 1 million have lost their parents due to AIDS (UNICEF, 2004). Many studies indicated that there are at least 100,000 street children in Ethiopia (about 25% are girls). UNICEF's projected estimate puts the figure to 185,000 in 2003 (UNICEF, 2001). Children with disabilities account for 51%, out of the estimated 4.9 million persons with some impairment in the country (NPA, 2004). It is to be noted that there is also a large number of Ethiopian children who are in conflict with the law, children working in hazardous conditions, displaced and refugee children. Ethiopia has ratified the United Nations Convention on the Rights of the Child (UNCRC) and designed favorable policies and national plans to address the plights of children. However, the

emphasis directed to mitigate the problems of children living under difficult circumstances still requires much more effort from all concerned actors. In this regard, various governmental and non-governmental organizations are making efforts to support children in general and children under difficult circumstances in particular through different modes of care and services. Despite the fact that the practice of rendering childcare services for unaccompanied children has a long history in the country, it was not until 2001 that standardized regulatory mechanisms (Alternative Childcare Guidelines) were developed. This was made possible by a joint undertaking of the Ministry of Labor and Social Affairs (MoLSA) and the Italian Development Cooperation (IDC), as part of the interventions to alleviate the problems of children under difficult circumstances in the country. Accordingly, the national Guidelines consisting of services on institutional care, community-based child support programs, and adoption, foster-care and child-family reunification were developed in 2001.

Despite policy formulation and implementation of alternative child care program, in Ethiopia attention has not given to residential care. Private or non governmental organizations continued to provide institutional based form of care program whether it is quality oriented or not, produce negative or positive impacts on children's psychosocial development. The same problems is found in Adama town, at which many children are sent to institutional care facilities which may have positive or negative social and emotional impacts on children's development. Sending children to child care center has many factors but, poverty and HIV/AIDS is the core contributing reasons. As to the researcher's best knowledge, there is no locally conducted research on this issue. In this regard, in order to ensure institutional care and home based care has positive or negative impacts on children's social and emotional development, it should be researched.

1.3 Relevance and Justification

Having spent 5 years as senior social worker and child welfare officer in Labor and Social Affairs office of Adama, I have had personal and professional contacts with children in institutional care centers and out of institutions in Adama city. During those times, I meet children in different children in need of psychological support from me and my office. Since those days, their social relations and emotional stability was my concern. My frequent encounter with them enabled me to understand the psychological susceptibility of children being in institutional care to poor social relationships and emotional instability.

However, in literature, I have found out that there are overall adverse impacts of institutional care on children's health and identity. But, it should be noted that the social and emotional development aspects are the building blocks for other aspects of development. Children placed in an institution are separated from their parents, and also often from their siblings and friends. This separation leaves a deep mark on their development and may affect them up to adulthood.

Individual children manifest in different ways the risks of the adverse development conditions that institutional life involves. They may, for example, exhibit mental disturbances and an inability to feel empathy for others. They are commonly unable to develop trusting relationships with others. Many children who have grown up in isolated institutions have difficulty in becoming integrated members of society in adulthood, and this may result in their continuing to live in institutions as adults. Many of those who, for example, go to prison prove to be former institutional inmates. Many of those found in institutions for the physically disabled and mentally handicapped also prove to have been inmates of institutions in their childhood as well. And many of the parents who leave their children to grow up in institutions were once themselves children in institutional care.

Although institutionally cared children have experienced a variety of extreme early adversities including poor nutrition and poor prenatal care, there is good reason to consider the role of emotional neglect in the ontogenesis of the social difficulties apparent in these children. A prominent lack of emotional and physical contact from caregivers is consistently found throughout institutional settings in Eastern Europe (Human Rights Watch, 1998); although any individual child's experience may be different, the probability of a child receiving warm, consistent care giving in these setting is quite low. Although there are variations in the degree of

neglectfulness both across and within orphanages, these settings have been characterized as ranging from poor to appalling (Human Rights Watch, 1998).

Although some orphanages may provide very basic stimulation to meet children's cognitive, motor, and linguistic needs, none of the orphanages previously studied have adequately met the relationship needs of infants such as providing stable, consistent relationships that foster emotional learning and social bonds (Gunnar, 2001). This is because in orphanage settings children receive minimal communication or attention from caregivers, and experience little responsiveness to their individual needs (Johnson, 2000b; Rutter et al., 1998).

Thus, the relevance of this study is that it contributes to our understanding of the institutional care impacts has on children's social and emotional aspects of development. Yet, extant research has employed relatively gross measures of functioning, such as parent reports, interviews, or global IQ tests (Gunnar, 2001). These macro-level observations provide rich descriptive data about areas in which institutional children experience difficulties. However, while such global measures provide some suggestion about processes that may be affected by early experience, they cannot test hypotheses about the development of specific processes that underlie children's social behavior. An attempt to further assess the bases of institutional and home based rearing impacts of children's socio and emotional development motivates the present study.

1.4 Research questions

This study aimed to answer the following main, and sub research questions:

Main research question

1. What are the impacts of child care on social and emotional development of children?

Sub-research Questions

4. What is the impact of child care on the social relations of children?
5. How do child care impacts the emotional development of children?
9. Is their significant difference between institutional and home based care in terms of social and emotional development variables?
10. What are the program and policy responses to promote optimal childcare practices in Adama?

1.5 Objectives of the study

The purposes of this study are the following.

3. To understand the impacts of child care on children's social development.
4. To recognize the impacts of institutional care on children's emotional development.
5. Whether institutional care is a positive experience for children or whether living with a family has more advantages for the children.
6. Whether there are any adverse impacts, socially or emotionally on the children who have experienced living in an institutional and home based care and whether this influences their future likelihood.
7. How current legislations and policy frameworks protects and assists child care arrangements and to identify if these children are equally equipped to achieve and succeed positive and healthy social relationship and emotional stability.

1.6 Significance of the Study

The significance of the study is illustrated by the constantly growing number of orphans and vulnerable children, especially in Adama mainly due to the HIV/AIDS-epidemic. The

numbers of children that are left alone without parental care are staggering and the extended family system are crumbling under the weight of the number of children that are in need of care. Many of the children that falls outside the extended family system ends up as street children having to fend for themselves in an adult world where the dangers and risks are many. Adama has responded to this growing problem with a sudden mushrooming of Institutional care. This thesis is essential because it contributes to the knowledge of how child care approaches impacts aspects of children's social and emotional development in a very profound way. It also help the concerned body of child care centers and extended families to understand the impacts of institutional care center on child's social and emotional development. The finding of this study enables institutional child care centers to compare other alternative child care approaches. Furthermore it encourage institutional child care centers, families, communities and concerned government bodies to understand healthy and positive upbringing of children's social and emotional development and finally give readers and other researchers insights into other research topics in the area.

1.7 Delimitation of the Study

There are considerable areas of development that can impact the positive upbringing of children both at institutional setting and home based care arrangements. For instance, there are aspects of physical, cognitive, personal, and moral development and etc. But, the scope of this study is limited to child care impacts only on the aspects of social and emotional development because, social and emotional development of children's are the building blocks even for others aspects of child development. This study focuses mainly on non-material resources facilities

typically psychological handling as social and emotional development which was not highly considered by institutional care facilities and seen by researcher as a considerable problems exists in the area of the study. Even though, there are others alternatives types of child care such as inter- country adoption, local adoption, foster care, kinship care, family based care, community care, and so on, and this study is delimited to institutional care and home based care because institutional care is listed as the last resort alternative child care approach by UN guideline for alternative child care and home based care contrarily sited by different researchers as good for children's upbringings. Moreover, the study is limited to institutional and home based care in Adama town. Adama town is selected as the enquiry of this study since, Adama town is at the zenith of orphan and vulnerable children, institutional child care facilities (Adama town women and child affairs office).

1.8 Limitation of the Study

Despite all the efforts to make this study both valid and reliable, there were still some limitations the researchers was aware of, but could not totally eliminate. The location and number of children's homes were chosen purposefully depending on what children's homes my contacts were able to locate. Limitations also occurred because some children were selected by the managers. However, it was not possible to re-examine or over-rule this decision. This can cause a bias in that the managers might have chosen children that where likely to portray a very single-minded, positive and non-nuanced image of the children's home, as the managers might have chosen their 'favorite' children. The children chosen may also have been the ones that were

fairly well adjusted, positive and extrovert, as opposed to children that where more introvert, negative and aggressive.

1.9 Operational definitions of terms

Child: Any person under the age of eighteen.

Institutional/residential care: Care provided in any non-family-based group setting. This includes orphanages, small group homes, transit/interim care centers, children's homes, children's villages/cottage complexes, and boarding schools used primarily for care purposes and as an alternative to a children's home[1]

Home-based care: A form of alternative care that involves a child living with a family other than his/her birth parents. These includes kinship care, foster care, adoption, kafala (an Islamic form of adoption), and supported child-headed households

Emotional Development: how children come to understand their own and others' feelings and develop their ability to 'stand in someone else's shoes' and see things from their point of view, referred to as empathy.

Social Development: Social development (Being social) – how children come to understand themselves in relation to others, how they make friends, understand the rules of society and behave towards others.

Impacts: The consequence of something on others, negatively or positively.

Institutional care center: Legally authorized institutions or nongovernmental organizations that provide and support children.

Development: Is the pattern of change that begins at conception and continues through the lifespan.

1

1.10 Background to the study area

This section gives a brief introduction to the socio-economic situation in Adama, with special emphasis on poverty and HIV/AIDS which affects children's livelihoods in turn provoke children's to institutional care facilities. It also gives an overview of the situation of orphans and vulnerable children in Adama, the official political aims and regulations for child care facilities and the official political position and mandate on caring for OVC's. Then follows an introduction to the specific sub cities where the study was conducted and justification for selection of Adama as the main focus of this research.

Location

Adama city is located between $8^0$33'to $8^0$36'north latitude and $39^0$11'57''to $39^0$21'15'' east longitude. Geographically Adama is located in the rift valley at a distance of 100 km south east of Addis Ababa / Finfinne (the capital city of the country and the Oromia regional state). The city is also located on the rail way to Addis Ababa- Djibouti and the High-way to Harar and Assela.

Population

According to Adama project informal socio economic study team evidenced by quoting CSA survey that in 1964 Adama had a population of 27,812 and after 30 years in 1994 it had grown to 127,842 population size. Just after 13 years, the population census of CSA in 2007 had revealed us the population of the city was 222, 035. Out of this 109,659 are males, whereas 112,376 are females. It has been also projected by the city finance and economic development office that the population of the city in year 2012 would be 270,871. From these results any one can understand that the population of the city is growing fast which place tremendous pressure

on the city in terms of shelter, health care, water supply and other economic and social services for its dwellers.

Information from Adama city women and children affairs office shows that the population of children below 18 years is 36, 468, of which 18, 457 are females and 18, 011 are males.

Present Political Mandate of child welfare

The Oromia National Regional State Government has initiated urban governance and management restructuring plan in year 2003/4 by announcing proclamation No.65/2003/04 to strengthen towns and cities to be able to provide full socio economic services to their inhabitants. As specified in art 8 and 9 of this proclamation, the city government is provided with autonomous power over local issues like: In this regard, Adama city women and children affairs office have the full mandate over the all issues concerned with children welfare and assurance of proper care. This Office has a mandate of monitoring, guiding and implementing child focused issues and coordinate and facilitate the proper implementation of activities of the intervention by other actors on issues related to child protection.

Specifically, this Office has the following responsibilities in the city level on child protection and care. It shall:

- With the support of the key actors on child welfare, organize awareness raising forums on child rights and alternative child care guideline in all communities at all level in the City.
- Advocate for and raise awareness on the basic rights of children
- Shall have commitment in any other regards for the successful implementation of child welfare program

- Shall offer protection to vulnerable groups particularly children, which the service ranges from supervision while they remain in the custody of their parents, through foster placement, adoption to placement in institutions.
- Shall have commitment in any other regards for the successful implementation of the institutional child care program.

Child care facilities in Adama

The institutional homes are not "total institutions", such as prisons or mental institutions, where people's lives are subject to "total control" (Aubert, 1964). Nonetheless, they represent sets of a structure that both constrains and enables the children's actions. The children are in many circumstances treated as a group, rather than individuals, and in most circumstances they have access to the same material and non-material resources, such as the same food, clothing, shelter, and psychosocial services. These resources are all part of a total package as provided by the care center and are available to all the children. Hence, most resources they have access to are considered collective resources.

Information from Adama town women and children affairs office discloses that, totally, there are 10 institutional child care facilities in Adama town, which form the focus of this study. These institutions are operated as charitable associations or organizations, and they are registered as Ethiopian resident charity associations by FDRE charities and societies agency. Most of these residential care facilities are supported by foreign donors and faith based organizations. Adama city is selected as the study area because of the grown number of orphan and vulnerable children and the existence high number institutional care facilities.

1.11 Organization of the Thesis

This thesis is divided into 5 chapters. The first chapter introduces the general background of the study. Background to the study problem starts with a general background which is followed by statement of the problem, research questions, relevance and justification, objectives of the study, significance of the study, delimitation of the study, limitation of the study and operational definition of terms. The second chapter which is review of related literature starts with clarification of some important concepts and then moves on to the theoretical framework this thesis is built upon. The third chapter, which is research methodology and research process, deals with the choice of using mixed methodology and the research process. Research design, target population, sampling method and procedures, instruments used, methods of data collection, method of data analysis were incorporated under this chapter. It also discusses ethical issues when working with children, the reliability and validity as well. The forth chapter deals with analysis, interpretation and findings part which aims to answer the main objective and the specific objectives. Discussion, Conclusions and recommendations make concluding remarks about the study, and put implications and suggestions for the findings and further study.

CHAPTER TWO
2. REVIEW OF RELATED LITERATURE

2.1 Conceptual framework

2.1.1 Children and childhood

At its initial glance what it means to be a child look straightforward enough to explain. In western societies childhood is seen as a long protracted and protected period of dependence, in which going to school is a dominant feature. This concept of childhood begins to dissolve when one's view is shifted to other parts of the world (Geddes, 1997:1).

In the centuries old Ethiopian legal code, the Fetha Nagast, however it was indicated that: "majority (adulthood), of the man is reached with the completion of the twentieth or twenty fifth years of age and for the women, with the twelfth or fifteenth years of age". The age of twenty years was for the sons of wealthy families who are supposed to have learned enough at that age. The age of twenty five years was for the poor and unlearned young men. The same reasoning applies to the ages given for women (Radda Barnen, 1997:6).

The modern law of the country, the Ethiopian civil code of 1960, defines a child as every individual of either sex who has not attained the full age of 18, in accordance with article 1 of the Convention on the Rights of the Child. Nevertheless, articles 329 and 330 of the Civil Code state that for specific purposes a child may be emancipated at an earlier age. Such specific emancipation could take place either by marriage or upon authorization of the family council (OMCT, 2001:14).

Meaning much more than just the space between birth and the attainment of adulthood, childhood refers to the state and condition of a child's life: to the quality of those years. A child who has been kidnapped by a paramilitary group and compelled to bear arms or forced into

sexual slavery can not have a childhood, neither can a child put to hard labor in workshops in cities far from family and home village. Children living in abject poverty without adequate food, access to education, safe water, sanitation facilities and shelter are also denied their childhood (UNICEF, 2005:3).

The concept of childhood as a period of protracted protection was developed in Europe in the 17thc. Today, most of the world's children live in the earth's poorest parts or in the slum and impoverished rural sections of the so-called developed countries. For children from poor families in these areas childhood is much shorter than it is for children from well-to-do families. This is because poor children usually have to go to work from a very early age to support their families. For that reason the majorities of children in poor countries either never go to school or, if they do, never have a chance to go beyond elementary school (Geddes, 1997:2).

The experiences of these children contrast with the ideal of childhood as a time when children are allowed to grow and develop to their full potential (UNICEF, 2005: 1).

From the above premises: if childhood is defined in a western sense, for many children in the world this is a broken promise, as they will never experience such a long period of care and protection. The gap between the reality in many parts of the world and the ideal childhood is clearly visible.

The new sociology of childhood claims that the concept of childhood is a social construction which varies across cultures and societies. Hence, its meaning and contents varies across time and space (James and Prout, 1997). In the Western societies childhood has become more or less synonymous with the first eighteen years of human life. This age-set criterion and the contents of childhood vary with what expectations and responsibilities a specific culture or society puts on a child. Childhood is not just a word to describe certain years of the human life. UNICEF (2005)

claims that the concept of childhood also "*refers to the state and condition of a child's life: to the quality of those years"*, (UNICEF).

The most obvious way to define a child would seem to be in terms of age. The United Nations Convention on the Rights of the Child, adopted by the UN in 1989, defines a child as "every human being below the age of 18 unless, under the law of his/her state he/she has reached his/her age of majority earlier" (Eade et al, 2000:270).

The Convention on the Rights of the Child (CRC) defines a child as *"every human being under the age of eighteen years, unless under the law applicable to the child, majority is attained earlier"* (The Convention on the Rights of the Child, Art.1, 1989). The CRC was presented by the UN in 1989 and even though a Human Rights Convention already existed there was a growing understanding that children as a group are in need of special attention and protection. The Convention on the Rights of the Child (CRC) recognizes that children have the best chance of developing their full potential in a family environment. The primary responsibility for their care rests upon their parents and legal guardians, who are entitled to support from the government in raising their children. When parents are not able or willing to fulfill this responsibility, kinship and community resources may be relied upon to provide care for the children. However, the ultimate responsibility falls on the government to ensure that children are placed in appropriate alternative care. Of the major forms of alternative care are institutional cares, adoption, foster care, community care and etc.

2.1.2 Orphans and Vulnerable Children (OVC)

Orphans

There exists a large number of ways to define orphans depending on the usage of the definition; epidemiologically, legal or as a social and cultural definition. The latter will vary between people and societies. People did not refer to children that had lost their parents as orphans, because (at least in theory) these children still had caretakers and thus where not orphans by their definition. In addition to the usage of various age-groups when defining orphans, there is also the pattern of parental death; maternal, paternal or double orphans. All these different ways of defining orphans have program and policy implications and need to be thoroughly considered and fully understood before set into practice.

Vulnerable children

Vulnerable children are those "*whose safety, well-being, and development are, for various reasons, threatened"* (Subbarao et al, 2004:1). Lack of care and affection, adequate shelter, nutrition, education and psychological support are some of the most important factors that accentuate the vulnerability of children. The types of vulnerability children are exposed to, are highly contextual and will vary between different settings (ibid).

The definition above is a very broad one and includes a huge number of children for various reasons. It is therefore a difficult definition to use in the field. In this study vulnerable children are those that for one reason or another cannot or do not want to live with their parents or extended family. Like orphans they have in a way "lost" their primary caretakers. Often these children are neglected, abandoned, abused or their parents may simply lack the resources to take proper care of them. Children that have lost their primary caretakers are more vulnerable to health risks, violence, exploitation and discrimination (UNICEF, 2004).

In this study the term orphans and vulnerable children used as one single category. It proved very difficult to separate between the children that were actual orphans and the ones that were not. This was due to the fact that in some cases the institutional care centers did not have any information about the children's families, either because the children did not want to reveal anything about their families for fear of being sent back or because the children's homes were unable to locate any family.

2.1.3 Child Care approaches

The 419 delegates who attended the First International Conference in Africa on Family Based Care for Children in 2009 noted that there were "overlaps and contradictions in the use of alternative care concepts and terminologies, such as, a child, family, orphan, foster care, biological family, kinship, guardianship, formal and informal care, institutional and residential care, cluster and village care, adoption, permanent and temporary care, child headed household and a social worker." Terminology and definitions continue to be a problem. Simply put, it is impossible to put in place laws and systems that support family-based care for children if you do not even have a clear and universally agreed upon definition of what family-based care is. To be more concise, despite the existence of the United Nation's Guidelines for the Alternative Care of Children, many countries are moving forward policies without clear definitions of critically important terms such as "family care," "alternative care," "institution" and "child outside of family care."

Institutional or residential care: The term *institutional care* has more interchangeably used with the term *residential care* which is referring to child group-care settings. *It* ***is*** "a group living arrangement for children in which care is provided by remunerated adults for service provision" Tolfree, D. (1995) e.g. orphanages, recovery centers, child protection centers.

Children in such settings receive full-time care for appropriate length of time. These residential care-settings do not only house children that have lost their parent(s), but also vulnerable children that for one reason or another cannot or do not want to live with their families. In practice, institutional care is established and operated by the State or by non-governmental organizations. Institutions generally address a genuine need by providing both short-term and long-term care to children. Nevertheless, several studies have shown that the placement of children in long term institutional care can have a negative impact in terms of development and expose them to discrimination, exploitation etc, thus highlighting the need to promote non-residential care. An institutional care arrangement is the focus of this study.

Non-institutional or non-residential care relates to family-/community-based cares. Generally, there are many forms of this type of care such as adoption, fostering, kinship care and family based care. Another form of alternative care which has recently emerged in the wake of the HIV/AIDS epidemic is the child headed household care. Non-residential care can also refer to part-time care provided by unrelated adults e.g. drop-in centers, day care centers, outreach activities. Home based care is also considered under this study

2.1.4 Institutional Care Vs Homes based care

This section is look for differences between the two types of care considered under this study and which has better outcomes for children. There are almost no studies that rigorously compare outcomes for residential care and home based care among children (Chamberlain, 1998). Current practice decrees that children and young people are much better off being cared for in families and home units rather than the traditional residential home where they are only one of a large number of children being cared for. It is currently thought that having more individual

attention is in the best interests of the child and this is more likely to be the case within a family unit. Interestingly, a study carried out by Save the Children in Scotland among 34 young people, aged between 15 and 25 and who had been in care on average for seven-and-a-half years, has revealed a strong preference for residential homes and schools rather than homes based care. The children and young people who were studied said they preferred residential care because it was more stable. Constant moving between placements and schools was affecting the trust and affected their ability to maintain long term relationships. The continuity of their care and education was more important to them than the environment in which they were placed. Furthermore, some of the young people felt more threatened with abuse and neglect as it was a closed environment whereas a residential home had a large number of staff which could be a positive element in the abuse of a child. However, the downsides to Residential Care were also discussed and the findings were the difficulty of having time alone, often a lack of discipline and sometimes the volatile atmosphere that was created by the vulnerable young people all living under one roof together. Save the Children stressed that the research was carried out with a relatively small sample of children and young people, but it does believe the findings merit further investigation.

On the other hand, another study (Festinger, 1983) concluded that children who were in home based care functioned better than children in residential care in the following areas: they attained higher levels of education, had a lesser likelihood of arrest or conviction, had less dissatisfaction with the amount of contact they had with their biological siblings, they were less likely to move or to be living alone and more likely to be a parent. In addition fewer reported substance use problems (Jones & Moses, 1984).

2.2 Theoretical Framework

Theory relating to child care and looked after children is predominantly based on Sigmund Freud's Psychodynamic theory (1927). This Psychodynamic theory explains how the sense of one's self derives from relationships with others. Following on from Freud's work, Bowlby (1969) produced the attachment theory which was derived from the Psychodynamic approach and stresses the importance of the fundamental need of emotional care between the child and the care giver. In 1951, John Bowlby's findings on the long-term negative impacts of institutional care on children were presented in Maternal Care and Mental Health, published by the World Health Organization. These and other studies on attachment helped move child welfare practice away from institutional care for separated and orphaned children and toward home based care. The work of Skinner (1938) developed another theory based on behavior and personality and this became known as the behaviorists approach. This approach was based on the belief behavior was learned and could be unlearned. This could be achieved by operant conditioning, which controls behavior by reward and punishment. In comparison the developmental model (Forrest, 1976) was introduced in the 1970's. This approach has similarities to the Psychodynamic theory, which proposes that children have a range of needs from birth. However, the main difference between Freud's theory and the Developmental model is the introduction of social needs being important in the child's development.

There does not seem to be one theory that has proved to have had better outcomes for children in care. Visser (2002) and Clough (2006) indicated that residential staffs who work to one particular model achieve better outcomes and are more focused and effective in their work. For that reason, the theory of choice for residential care home managers seems to be less important than the need to have a particular theory in place..

2.3 General condition of Ethiopian children

In Ethiopia nearly half of the populations (48.6%) are children under the age of 15 years, of which nearly 18% are under the age of 5 years. The country is characterized by a high fertility rate and a rapid population growth. The fertility rate rose from 2.6% during 1970-1990 to 2.7% during 1990-1998. The rapid population growth and other related factors pose a major challenge to the realization of children's rights. Of the total child population, 85% live in the rural areas and the remaining 15% live in the urban areas. Ethiopia has experienced enormous problems of severe and widespread poverty despite its vast natural resources and has been unable to meet the basic needs of its population in general and children in particular.

2.4 Institutional child care and the Ethiopian experience

According to country report of save the children, the problems are mainly caused by poverty, HIV/AIDS, death of parents, drought and famine and family breakdown in situations where children have been forcibly displaced from their natural family and community environments and are therefore in need of alternative care service.

The situation has led to a range of serious problems, including family destabilization, displacement and related forms of social and psychological breakdown. As one of the main consequence, thousands and thousands of children have been exposed to malnutrition and various forms of abuse. Among these are those children termed as children in especially difficult circumstances, which include street children, orphans, children with disabilities, abandoned and unaccompanied children, abused children and children in conflict with the law. The need for residential care has become a necessity in order to address the needs of these children who have been denied the care and protection of the family.

The need for institutional care came into being in Ethiopia in the 1950s for the main purpose of providing institutional support for abandoned and unaccompanied children and children from poor families. The services mainly included meals, clothing, and educational support. Many government organizations and NGOs have been provided residential care for children, especially after the drought and famine in the 1980s that resulted in severe socio-economic problems. However, it was found that institutionalization has its own negative physical, social and psychological effects on the lives of children.

In Ethiopia, thousands of children are living in especially difficult circumstances, including the many children who have been orphaned. A number of residential care centers have since been established by different child-oriented organizations in different parts of the country. The existing data show that there are over 100 institutions that provide institutional care services to unaccompanied children.

However, in line with the change in the global trend from institutionalization to community-based care alternatives and based on the existing reality of children, the government has shifted its focus to the community-based approach of rehabilitating deinstitutionalized children. Consequently, the scope of residential care (institutional service) has decreased progressively. Thus, there is a need to devise alternative strategies aimed at providing better care services that would enable children to integrate with the community and establish meaningful and productive lives. Based on this initiative, efforts are being made to deinstitutionalize the children and reintegrate them with the community.

2.5 Universal Standards of Care

Whether children are in family based or institutional care, a universal standard of care guidelines does not exist to protect them from neglect, mistreatment, or abuse. With few

exceptions, governmental guidelines either rely on institutions as a form of care or they do not specify the methods of care that prevent the negative effects of institutionalization. Within some governments that have recognized the drawbacks of institutionalization, the responsible departments have neither the staff nor the resources to make the transfer of children into family care a priority. In some countries, institutions are maintained to keep the staff employed, and children continue to replace those who leave, keeping the numbers steady.

Care guidelines are similar to basic child welfare guidelines, which protect children from abuse, neglect, deprivation of basic needs, and lack of education, and allow access to family and relatives. Although the Convention on the Rights of the Child provides a universal framework for defining children's rights, in many countries it has not been made operational in specific standards of care.

An important care issue that needs to be addressed through a standard of cares—those methods that best support the developmental and psychosocial needs of children—is also one of the strongest arguments for alternative care for children. The developmental needs of children are best met in a stable, consistent, protective environment in close contact with the same caregivers throughout childhood. Children require a sense of stability and safety to be able to attend to the task of childhood, which is the integration of intellectual, emotional, physical, and social growth. Universal standards of care would be applicable for:

- Extended family and foster family
- Those providing community or institutional (residential) care
- Child-headed households
- NGOs and religious organizations responsible for day-to-day care of children
- Private and individual donors funding programs that provide care for children

• Regional, national, and international bodies that provide funds, direct services, or contract with others to provide care for children

2.6 Global trends of Institutionalized Children

Few countries in the developing world have a long history of institutional care for children:

The concept of the institution was commonly introduced by missionaries or by government departments which modelled themselves on their counterparts in the colonial power, often emulating the pattern of residential care which was widespread in Western Europe in the earlier decades of the present century. Despite strong traditional pattern of extended family obligations towards parentless children which exist in virtually all non-Western societies, large-scale institutional care has continued to be the norm for organisations providing care facilities in most parts of the developing world, with programmes of substitute family care often remaining at a relatively embryonic stage of development.

There are no reliable global figures regarding the numbers of children presently living in institutional care. Estimates suggest that as many as 8 million children are in this situation, but there could be many more, David Tolfree, (1995).

Governments may not be fully aware of how many homes have been established within their borders, how many children are in them or why they are there. The available information shows that there are large variations in the proportion of children in institutions in different countries, their length of stay, and the personal circumstances that led to admission.

According to save the children's alliance's statistics, it appears that in many countries placement in residential homes is still the main strategy for the care of children separated from their parents. This is particularly the case in Central and Eastern Europe and former Soviet countries where

transition to market economies has increased the numbers of children entering residential care for poverty-related reasons.

According to UNICEF, in Bulgaria and Romania, which have the highest levels of public care, the numbers of children in public and residential care increased by 39 and 26 per cent respectively from 1990 to 1995. Currently there are about 1 million children in public care across the 18 countries monitored by UNICEF, an increase of about 50,000 since 1989. In Russia, 1 per cent of children are in residential care. These children are mostly living in large-scale institutions: infant homes, orphanages, homes for disabled people and/or children, and hospitals. In eight of the 18 countries – Slovakia, Bulgaria, Romania, Estonia, Latvia, Belarus, Russia and Ukraine – the number of children aged under three placed in infant homes has risen by over 20 per cent since 1989. In some cases the increases are very large – between 35 and 45 per cent in Romania, Russia and Latvia, and as much as 75 per cent in Estonia.

China, on the other hand, has a smaller number of children in residential care than its size would suggest, Save the Children (1996). In 1993, figures indicated that China only had 63 registered orphanages. But less than half of China's children in institutions are in specialised units for children, and it is still possible to find children placed in institutions with disabled adults, people with mental illnesses and elderly people.

In Africa, armed conflict and the HIV/AIDS pandemic have led to a rise in the number of children in orphanages, and a perceived need for residential care for the growing number of children outside of family care. Latest estimates put the number of orphans aged under 15 in sub-Saharan Africa at around 34 million, which is equal to about 12 per cent of the child population.

In the most heavily affected countries in southern Africa, up to one-quarter of children will be orphans by the year 2010, UNAIDS/USAID (2002). Research has shown, however, that many of the children in existing institutions are not actually orphans.

In Uganda, the most comprehensive information on children's institutions was obtained through research conducted by the then Ministry of Labour and Social Affairs and Save the Children in 1997. The significant finding, contrary to the popular belief that the children in institutions were orphans, was that 85 per cent of the children had identifiable and traceable relatives.

According to save the children alliance, in Liberia, after seven years of civil war, up to 2,500 children separated from their families had been placed in 'orphanages'. In 1989, there were just four orphanages in Liberia and an SOS of Village. Even so, there was concern about the need for so many. By late 1995, there were 24 accredited orphanages in Monrovia alone and, by 2001 Liberia had a total of 117 orphanages accommodating 8,168 children. Many of these orphanages are run by faith-based groups.

Information from a study in the Middle East also indicates widespread use of residential care. In Lebanon, the figure is surprisingly high: there are 25,170 children in residential care (1999–2000) excluding the 5,708 children served in day and overnight institutions for special needs. The total number of children in residential institutions in Lebanon is 43,096, including reformatories and vocational training centers. In Morocco, according to religious leaders, there were 31,600 people in residential institutions in the year 2000–2001. For 1999–2000, the number of children in residential care was estimated to be 25,317.

Some organizations, like SOS Children's Villages, specialize in residential provision. SOS, is active in 131 countries and territories as of March 2001. Around 49,000 children and

youngsters are growing up in 423 SOS Children's Villages and 312 SOS Youth Facilities worldwide. The number of children they look after in residential care is five times the number of children looked after in residential care by the local authorities in England. Recent moves by SOS to explore community-based support options are encouraging, as are emerging good practices in de institutionalization of children from orphanages, such as those in Ethiopia, Gebru. M., Atnafou, R. (n.d.).

2.7 International legal frameworks related to child care

The CRC provides a comprehensive framework to ensure protection of children from many violations of their rights, as well as underlining the premises for healthy child development. Children have the right to protection from abuse and neglect (Article 19). It is the state's obligation to protect children from all forms of maltreatment perpetrated by parents or others responsible for their care, and to undertake preventive and treatment programs. In this regard, many children living in institutions do not enjoy this right. There are, particularly in the West, increasing reports and allegations of abuse of children by staff or older children. The very people given the responsibility of protecting vulnerable children may be the ones perpetrating abuse. In recent years, public inquiries and convictions against staff have received widespread media attention. In many countries, there are no well-functioning child protection services, and the closed nature of institutions makes reporting of abuses by children or holding inquiries very difficult. Even when abuses are documented by organizations like Human Rights Watch, very little action is taken to prevent further abuse or provide justice.

The CRC and other human rights instruments also emphasize the role of the parents. Parents or, when applicable, the extended family or legal guardians have the primary responsibility to take care of, support and guide the child in a way that is in the child's best

interest. The state shall render appropriate assistance to parents and legal guardians (Articles 18, 5, 3 and 27). If the child is deprived of his or her family environment, the state shall provide special protection and assistance (Article 20), but it is the right of children placed by the state for reasons of care, protection or treatment to have all aspects of that placement evaluated regularly (Article 25). When the child's placement is not periodically reviewed in accordance with the CRC it means that there is no regular assessment of the child's situation in terms of their best interests or that of the family, and the question of alternative solutions is not considered. This paves the way for long-term institutionalization.

2.8 The view of institutions enshrined in the Convention on the Rights of the Child

A child is entitled to grow up in a family. In the preamble to the Convention on the Rights of the Child, the family is emphasized as the natural setting for a child's development and wellbeing: 'the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding'. That children need and have a right to their parents is a theme of the entire Convention. Parents 'have the primary responsibility for the upbringing and development of the child' (Article 18:1), and the state 'shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family' (Article 5). When it comes to solitary refugee children, the child's rights to its parents is expressed in terms of the obligation of the host country to trace the child's parents or other family members, for the purpose of reuniting the family (Article 22:2). The Convention on the Rights of the Child thus confirms the knowledge and research finding concerning children and child development that emerged in the 20th century: that children's relationship with their parents is their most fundamental need

Throughout their upbringing, children depend on their parents and on interaction with them. This interaction and parent-child bonding form the basis of the child's entire development. It is thus in close contact with parents that are capable of providing the security and care the child needs that the rights of the child assume a genuine meaning.

A parallel line throughout the Convention is the state's obligation to assist and facilitate parents' exercise of responsibility for the child's upbringing. To this end, the state must 'take all appropriate legislative and administrative measures' (Article 3:2). These measures are described in several of the subject articles of the Convention, such as those concerning social security (Article 26), healthcare (Article 24) and the right to a reasonable standard of living (Article 27). In the event of children not being permitted to remain in the family for their own good, or being temporarily or permanently deprived of their family environment for other reasons, the state has an obligation to intervene. In such cases, the child is entitled to special protection and assistance. Such care may, for example, include foster placement, adoption or, if necessary, placement in a special institution for the care of children (Article 20).

The UN Committee on the Rights of the Child, which is the authoritative interpreter of the Convention, interprets Article 20 as stipulating that institutional placement of children should be seen as *the very last resort*, when no other options are available. The Convention proposes the following alternative solutions for children who, for one reason or another, cannot be cared for by their parents. First, a solution in the child's extended family environment should be sought; that is, the child should be looked after by relatives or others who are close to the child. Secondly, an alternative family environment–i.e. placement in a foster home or adoption–should be sought. Finally, as a last resort, placement in an institution should be opted for.2

With the UN Convention on the Rights of the Child as a starting point, the objectives for measures aimed at children who live in, or risk being sent to, institutions are that:

2. No child should need to grow up in an institution.
3. Measures for children should be provided mainly within the family framework.
4. Children living in institutions should be guaranteed the rights due to them under the Convention.

2.9 National policies and legal instruments related to child care

The issues of child care arrangements are contained in various policy documents of the Federal Democratic Republic of Ethiopia.

The Constitution of the Federal Democratic Republic of Ethiopia stipulates in Article 36 the rights of the child, which is an indication of the government's firm commitment to ensure the rights of Ethiopian children.

The UN Convention on the Rights of the Child: Ethiopia signed and ratified the UN CRC in 1992 and incorporated the provisions of the convention into the constitution of the country. To translate the CRC into tangible realities, different child-focused program have been designed and are currently being implemented in various parts of the country. Based on this, a guideline on alternative childcare program was prepared by the government.

The Developmental Social Welfare Policy: This is a policy document that focuses on promoting social development whereby a environment is created that will enable all citizens to live in peace and fulfill their basic needs. Child welfare is one of the policy's major areas of focus.

National Program of Action for Children and Women: (1996-2000): The National Program of Action was developed within the broad perspective of the World Summit for Children of 1990

in which all nations of the world were called upon to chart national program of action for the survival, protection and development of children within the framework of each country's overall socioeconomic development strategies. The Program of Action was prepared on the basis of the socio-economic realities of the country and is aimed at ensuring the wellbeing and development of Ethiopian children.

2.10 Feature of Children's social and emotional development

Social and emotional development includes the child's experience, expression, and management of emotions and the ability to establish positive and rewarding relationships with others (Cohen and others 2005). It encompasses both intra- and interpersonal processes.

The core features of emotional development include the ability to identify and understand one's own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one's own behavior, to develop empathy for others, and to establish and maintain relationships. (National Scientific Council on the Developing Child, 2004)

Children experience, express, and perceive emotions before they fully understand them. In learning to recognize, label, manage, and communicate their emotions and to perceive and attempt to understand the emotions of others, children build skills that connect them with family, peers, teachers, and the community. These growing capacities help especially young children to become competent in negotiating increasingly complex social interactions, to participate effectively in relationships and group activities, and to reap the benefits of social support crucial to healthy human development and functioning.

Healthy social-emotional development for children unfolds in an interpersonal context, namely that of positive ongoing relationships with familiar, nurturing adults. Young children are particularly attuned to social and emotional stimulation. Even newborns appear to attend more to stimuli that resemble faces (Johnson and others 1991). Responsive care giving supports early childhood in beginning to regulate their emotions and to develop a sense of predictability, safety, and responsiveness in their social environments. Early relationships are so important to developing children that research experts have broadly concluded that, in the early years, "nurturing, stable and consistent relationships are the key to healthy growth, development and learning" (National Research Council and Institute of Medicine 2000, 412). In other words, high-quality relationships increase the likelihood of positive outcomes for young children (Shonkoff 2004). Experiences with family members and teachers provide an opportunity for young children to learn about social relationships and emotions through exploration and predictable interactions. Professionals working in child care settings can support the social-emotional development of children in various ways, including interacting directly with young children, communicating with families, arranging the physical space in the care environment, and planning and implementing curriculum.

Brain research indicates that emotion and cognition are profoundly interrelated processes. Specifically, "recent cognitive neuroscience findings suggest that the neural mechanisms underlying emotion regulation may be the same as those underlying cognitive processes" (Bell and Wolfe 2004). Emotion and cognition work together, jointly informing the child's impressions of situations and influencing behavior. Most learning in the early years occurs in the context of emotional supports (National Research Council and Institute of Medicine 2000). "The rich interpenetrations of emotions and cognitions establish the major psychic scripts for each

child's life" (Panksepp 2001). Together, emotion and cognition contribute to intentional processes, decision making, and learning (Cacioppo and Berntson 1999). Furthermore, cognitive processes, such as decision making, are affected by emotion (Barrett and others 2007). Brain structures involved in the neural circuitry of cognition influence emotion and vice versa (Barrett and others 2007). Emotions and social behaviors affect the young child's ability to persist in goal-oriented activity, to seek help when it is needed, and to participate in and benefit from relationships.

Young children who exhibit healthy social, emotional, and behavioral adjustment are more likely to have good academic performance in elementary school (Cohen and others 2005; Zero to Three 2004). The sharp distinction between cognition and emotion that has historically been made may be more of an artifact of scholarship than it is representative of the way these processes occur in the brain (Barrett and others 2007). This recent research strengthens the view that early childhood programs support later positive learning outcomes in all domains by maintaining a focus on the promotion of healthy social emotional development (National Scientific Council on the Developing Child 2004; Raver 2002; Shonkoff 2004).

Interactions with Adults

The foundations that describe Interactions with adults and relationships with adults are interrelated. They jointly give a picture of healthy social-emotional development that is based in a supportive social environment established by adults. Children develop the ability to both respond to adults and engage with them first through predictable interactions in close relationships with parents or other caring adults at home and outside the home. Children use and build upon the skills learned through close relationships to interact with less familiar adults in their lives. In interacting with adults, children engage in a wide variety of social exchanges such

as establishing contact with a relative or engaging in storytelling with a care teacher. These interactions form the basis for the relationships that are established between teachers and children in the classroom or home and are related to children's developmental status. How teachers interact with children is at the very heart of early childhood education (Kontos and Wilcox-Herzog 1997).

Relationships with Adults

Close relationships with adults who provide consistent nurturance strengthen children's capacity to learn and develop. Moreover, relationships with parents, other family members, caregivers, and teachers provide the key context for children's social-emotional development. These special relationships influence the infant's emerging sense of self and understanding of others. Infants use relationships with adults in many ways: for reassurance that they are safe, for assistance in alleviating distress, for help with emotion regulation, and for social approval or encouragement. Establishing close relationships with adults is related to children's emotional security, sense of self, and evolving understanding of the world around them. Concepts from the literature on attachment may be applied to early childhood settings, in considering the infant care teacher's role in separations and reunions during the day in care, facilitating the child's exploration, providing comfort, meeting physical needs, modeling positive relationships, and providing support during stressful times (Raikes 1996).

Interactions with Peers

Through interactions with peers, children explore their interest in others and learn about social behavior/social interaction. Interactions with peers provide the context for social learning and problem solving, including the experience of social exchanges, cooperation, turn-taking, and the demonstration of the beginning of empathy. Social interactions with peers also allow older

children to experiment with different roles in small groups and in different situations such as relating to familiar versus unfamiliar children. As noted, the foundations called Interactions with Adults, Relationships with Adults, Interactions with Peers, and Relationships with Peers are interrelated. Interactions are stepping-stones to relationships. Burk (1996,) writes: We, as teachers, need to facilitate the development of a psychologically safe environment that promotes positive social interaction. As children interact openly with their peers, they learn more about each other as individuals, and they begin building a history of interactions

Relationships with Peers

Children develop close relationships with children they know over a period of time, such as other children in the family child care setting or neighborhood. Relationships with peers provide young children with the opportunity to develop strong social connections. Infants often show a preference for playing and being with friends, as compared with peers with whom they do not have a relationship. Howes' (1983) research suggests that there are distinctive patterns of friendship for the children age groups. But it vary according to age in the number of friendships, the stability of friendships, and the nature of interaction between friends (for example, the extent to which they involve object exchange or verbal communication).

Recognition of Ability

Children's developing sense of self-efficacy includes an emerging understanding that they can make things happen and that they have particular abilities. Self-efficacy is related to a sense of competency, which has been identified as a basic human need (Connell 1990). The development of children's sense of self-efficacy may be seen in play or exploratory behaviors when they act on an object to produce a result. Children may demonstrate recognition of ability through "I" statements, such as "I did it" or "I'm good at drawing."

Expression of Emotion

Even early in infancy, children express their emotions through facial expressions, vocalizations, and body language. The later ability to use words to express emotions gives young children a valuable tool in gaining the assistance or social support of others (Saarni and others 2006). Temperament may play a role in children's expression of emotion. Tronick (1989, 112) described how expression of emotion is related to emotion regulation and communication between the mother and infant: "the emotional expressions of the infant and the caretaker function to allow them to mutually regulate their interactions . . . the infant and the adult are participants in an affective communication system."

Both the understanding and expression of emotion are influenced by culture. Cultural factors affect children's growing understanding of the meaning of emotions, the developing knowledge of which situations lead to which emotional outcomes, and their learning about which emotions are appropriate to display in which situations (Thompson and Goodvin 2005). Some cultural groups appear to express certain emotions more often than other cultural groups (Tsai, Levenson, and McCoy 2006). In addition, cultural groups vary by which particular emotions or emotional states they value (Tsai, Knutson, and Fung 2006). One study suggests that cultural differences in exposure to particular emotions through storybooks may contribute to young children's preferences for particular emotional states (for example, excited or calm) (Tsai and others 2007).

Young children's expression of positive and negative emotions may play a significant role in their development of social relationships. Positive emotions appeal to social partners and seem to enable relationships to form, while problematic management or expression of negative emotions leads to difficulty in social relationships (Denham and Weissberg 2004). The use of emotion-related words appears to be associated with how likable preschoolers are considered by their

peers. Children who use emotion-related words were found to be better-liked by their classmates (Fabes and others 2001). Infants respond more positively to adult vocalizations that have a positive affective tone (Fernald 1993). Social smiling is a developmental process in which neurophysiology and cognitive, social, and emotional factors play a part, seen as a "reflection and constituent of an interactive relationship" (Messinger and Fogel 2007). It appears likely that the experience of positive emotions is a particularly important contributor to emotional well-being and psychological health (Fredrickson 2000, 2003; Panksepp 2001).

Empathy

Empathy is "knowing what another person is feeling," "feeling what another person is feeling," and "responding compassionately to another's distress" (Levenson and Ruef 1992, 234). The concept of empathy reflects the social nature of emotion, as it links the feelings of two or more people (Levenson and Ruef 1992). Since human life is relationship-based, one vitally important function of empathy over the life span is to strengthen social bonds (Anderson and Keltner 2002). Research has shown a correlation between empathy and prosocial behavior (Eisenberg 2000). In particular, pro-social behaviors, such as helping, sharing, and comforting or showing concern for others, illustrate the development of empathy (Zahn-Waxler and others 1992) and how the experience of empathy is thought to be related to the development of moral behavior (Eisenberg 2000). Adults model pro-social/empathic behaviors for children in various ways. For example, those behaviors are modeled through caring interactions with others or through providing nurturance to the children. Quann and Wien (2006, 28) suggest that one way to support the development of empathy in young children is to create a culture of caring in the early childhood environment: "Helping children understand the feelings of others is an integral aspect of the curriculum of living together. The relationships among teachers, between children and teachers, and among children are fostered with warm and caring interactions."

Emotion Regulations

Researchers have generated various definitions of emotion regulation, and debate continues as to the most useful and appropriate way to define this concept (Eisenberg and Spinrad 2004). The developing ability to regulate emotions has received increasing attention in the research literature (Eisenberg, Champion, and Ma 2004). As a construct, emotion regulation reflects the interrelationship of emotions, cognitions, and behaviors (Bell and Wolfe 2004). Young children's increasing understanding and skill in the use of language is of vital importance in their emotional development, opening new avenues for communicating about and regulating emotions (Campos, Frankel, and Camras, 2004) and helping children to negotiate acceptable outcomes to emotionally charged situations in more effective ways. Emotion regulation is influenced by culture and the historical era in which a person lives: cultural variability in regulation processes is significant (Mesquita and Frijda 1992). "Cultures vary in terms of what one is expected to feel, and when, where, and with whom one may express different feelings" (Cheah and Rubin, 2003). Adults can provide positive role models of emotion regulation through their behavior and through the verbal and emotional support they offer children in managing their emotions. Responsiveness to children's signals contributes to the development of emotion regulation. Adults support children's development of emotion regulation by minimizing exposure to excessive stress, chaotic environments, or over- or understimulation.

Emotion regulation skills are important in part because they play a role in how well children are liked by peers and teachers and how socially competent they are perceived to be (National Scientific Council on the Developing Child 2004). Children's ability to regulate their emotions appropriately can contribute to perceptions of their overall social skills as well as to the extent to which they are liked by peers (Eisenberg and others 1993). Poor emotion regulation can impair

children's thinking, thereby compromising their judgment and decision making (National Scientific Council on the Developing Child 2004). At kindergarten entry, children demonstrate broad variability in their ability to self-regulate (National Research Council and Institute of Medicine 2000).

Impulse Control

Children's developing capacity to control impulses helps them adapt to social situations and follow rules. As children grow, they become increasingly able to exercise voluntary control over behavior such as waiting for needs to be met, inhibiting potentially hurtful behavior, and acting according to social expectations, including safety rules. Group care settings provide many opportunities for children to practice their impulse-control skills. Peer interactions often offer natural opportunities for young children to practice impulse control, as they make progress in learning about cooperative play and sharing. Young children's understanding or lack of understanding of requests made of them may be one factor contributing to their responses (Kaler and Kopp 1990).

Social Understanding

During the childhood years, children begin to develop an understanding of the responses, communication, emotional expression, and actions of other people. This development includes children's understanding of what to expect from others, how to engage in back-and-forth social interactions, and which social scripts are to be used for which social situations. "At each age, social cognitive understanding contributes to social competence, interpersonal sensitivity, and an awareness of how the self relates to other individuals and groups in a complex social world" (Thompson 2006, 26). Social understanding is particularly important because of the social nature of humans and human life, even in early infancy (Wellman and Lagattuta 2000). Recent research

suggests that children's social understanding is related to how often they experience adult communication about the thoughts and emotions of others (Taumoepeau and Ruffman 2008).

Impacts of institutional care on social and emotional wellbeing of children

There are different international research findings related to institutional child care impacts on social and emotional aspects of development of children.

Historically, institutional care has been associated with regimented, depersonalized environments in which children have no opportunity to experience a caring family life. As a consequence, they often failed to acquire normal life skills and the capacity for independent thought and motivation. The condition of dependency and expectation that resulted became known as the Institutional Syndrome. In addition, institutionalized children commonly endured chronic abuse and emotional deprivation, which gave rise to a lasting inability to form loving and trusting relationships. These factors combined to make it difficult for children who experienced long term residential care to cope outside of the institutional environment, johnson, d. (1999). The realization that institutions had the capacity to cause permanent psychological and sociological damage led to the abandonment of this form of care in Western Europe and North America. Unfortunately, this enlightened approach has been slow to find acceptance in much of the developing world where old-style institutions remain a common care option.

When the AIDS pandemic generated an orphan crisis in East and Central Africa in the 1980's, well-meaning groups and individuals in the West responded by building orphanages to house these children. This trend alarmed international child welfare organizations. Following the lead

of the Save the Children Fund (UK), whose intervention in the early years of the pandemic in Uganda, was successful in closing down many of these new facilities, they developed strategies to promote community-based care which became accepted as the best option for children orphaned in the pandemic, Bukenya, S.(1999) & UNICEF,(2002). Institutions are now generally regarded as the last resort in the care of children orphaned by AIDS and many international funding agencies have made it policy not to support their construction or running costs.

Modern institutions have sought to correct many of the deficiencies of their predecessors by creating family units within the institutional environment. However, despite these improvements, institutionalization remains an inappropriate intervention in the African context of mass orphan hood. Their ability to provide care for only a small number of children at disproportionately high cost and their tendency to undermine traditional methods of care are common criticisms. More insidious is their propensity to alienate children from their extended families, communities and culture. This can have serious implications for the eventual re-integration of orphans into their communities and for their future happiness.

Attachment style and behavioral problems among institutional care children has been studied in Israel and this research has highlighted that the age a child is taken into care can have an impact on the long term effects of their mental health. Institutional Placement is the most common solution for abused and neglected children in Israel. In contrast, the USA places children in Institutional Care facilities because an adequate foster home cannot be found. Foster homes in Israel are used rarely or only in extreme cases (Shechory, 2007). The removal from the family home in itself will of course create an enormous challenge on a child's coping resources and the transition process will be an extremely stressful time for the child. The experience of

neglect or abuse will have a direct effect on the child's emotional and social development and this can extend long into adolescence and adulthood (Cicchetti, 1995).

In addition, studies have also shown that there is greater risk of developing psychological disturbances in later life for children who have experienced neglect or abuse. These psychological issues can include behavioural problems (anti-social or aggressive), learning problems and social adjustment problems (Barnow, 2001).

The damaging psychological consequences of institutional care have been written about for over 50 years. The publications of Goldfarb (1944; 1945) and Bowlby (1951) were particularly influential and highlighted a number of emotional, behavioral and intellectual impairments that characterized children who had been raised in residential care.

Children living in institutions without parents are reported to perform poorly on intelligence tests and to be slow learners with specific difficulties in language and social development, in comparison to children with foster parents. In addition, they had problems concentrating and forming emotional relationships, and were often described as attention-seeking. The lack of an emotional attachment to a mother figure during early childhood was attributed as the cause of these problems, which were considered to be long-lasting.

'Attachment theory' (Bowlby, 1969) emphasized the negative consequences of institutional care compared with family-based care and the importance of a primary care-giver for normal child development. This led to a decline in the use of institutional care or large children's homes in some parts of the English-speaking world. In other parts of world, child care policy has been less concerned with the psychosocial needs of children. Instead, an emphasis has been placed on the physical needs of children and controlling their environment. In these countries, this has led to

reliance on *institutions*, rather than on the development of substitute parenting, such as kinship care, foster care and adoption (Browne, 2002)

Adverse impacts of institutional care on social behavior and interaction with others

Of the 27 studies scientifically investigated by Johnson et al. (2006) concerning the development of children who have been raised in institutions, 17 studies measured social and behavioral problems that were more prevalent in residential care children compared with other children. Evidence of negative social or behavioral consequences for children raised in institutional care was reported by 16 (94%) of the studies, highlighting problems with anti-social conduct, social competence, play and peer/sibling interactions. In addition, one in ten children who spent their early lives in poor conditions, often deprived of interaction with others, were found to show 'quasi-autistic' behaviors such as face guarding and/or stereotypical 'self-stimulation/ comfort' behaviors, such as body rocking or head banging (Beckett et al., 2002; Rutter et al., 1999, 2007; Sweeny and Bascom 1995). However, the severity and duration of difficulties varied greatly across the studies, reflecting the different situations and experiences of the children studied in various countries.

Observations carried out in European residential care homes have since confirmed more stereotypical behavior in children who are under stimulated in institutions of poorer quality – after six months the young children were observed to have become socially withdrawn. As a consequence of failed interactive initiatives, young children learn *not* to be sociable, and visible efforts of a child to interact with others become rare due to unresponsive care-giving practices

(Nelson et al., 2007). This observation is particularly pertinent to children under three years of age where a six-month institutional placement represents a significant proportion of their early life experience.

Impacts of institutional care on the formation of emotional attachments

Johnson et al. (2006) reviewed 12 studies that specifically considered the formation of emotional attachments for children in institutions compared with other children. Only one study found no supporting evidence for greater attachment difficulties for children growing up in residential care. Nine studies report significantly more indiscriminate friendliness, over-friendliness and/or disinhibited behavior for children in institutions, suggesting 'disorganized attachment disorder' has greater prevalence among these children compared with children in families or children who were admitted to institutional care after the age of two years (Wolkind, 1974; Rutter et al. 2007).

In terms of emotional attachments, even apparently 'good quality' institutional care can have a detrimental effect on children's ability to form relationships throughout life. The lack of a warm and continuous relationship with a sensitive caregiver can produce children who are desperate for adult attention and affection. Superficially, the behavior of these children can appear 'normal' (or pseudo-secure), but their lack of discrimination in seeking affection is indicative of disorganized/disorientated or disinhibited attachment disorder (Zeanah, 2000; Rutter et al., 2007). The presence of attachment disorder is more common in children who have spent more of their infancy in institutional care (O'Connor et al., 1999, 2000). However, this pattern is not an inevitable consequence of early deprivation and there are mediating factors that can ameliorate

the negative effects, such as the child being a particular favorite of a residential care worker and receiving sensitive care giving.

Nevertheless, this is rare and children in institutional care clearly have limited opportunities to form selective attachments, compared with children in family-based care, especially where there are large numbers of children, small numbers of staff and a lack of consistent care through shift work and staff rotation.

CHAPTER THREE
3. RESEARCH METHODOLOGY

This chapter deals with the research design, description of target population, and sampling, procedures for data collection, variables considered, instruments used for data collection, procedures and results of pilot study, methods and the rational for selecting them.

3.1 Research Design

The study was informed by the mixed methods research methodologies which integrate qualitative and quantitative approaches (Johnson and Onwuegbuzie and Turner, 2007). The methods are employed concurrently and are used in this study because, the researcher wishes to use qualitative findings to help interpret or contextualize quantitative results. Weight is typically given to quantitative data and mixing of data occurs when the initial quantitative results informs the secondary qualitative data collection (Creswell, 2009). The mixing of data occurs during interpretation and discussion section. Thus, the two forms of data are separate but, connected.

3.3 Variable considered

Four variables were used in the analysis and they are: Age, gender of each child, social and emotional development which was using nominal scales.

In addition to the above statistical variables, the personal place of the child, child's social networks with significant people, the social structures were considered.

Dependent Variables:

Social development: It is a continuous variable obtained from the average score of the scales considered as social development.

Emotional development: It is a continuous variable obtained from the average scale scores considered as emotional development.

Independent Variables:

Out of several psychosocial variables, resilience, and material resources such as shelter, clothes, and socialization. They are multiple variables that predict the impacts.

3.5 Target Study Population

The participants involved in this study were 160 children. Eighty institutionalized children were compared with equal eighty comparison children residing with their parents/relatives. From the researcher's experiences, majority of those children under institutional care are because of one or both of their parents was affected by HIV/AIDS and most of them are from poor family background. Likewise, the comparable groups are also from poor family background and they have relatively similar but not identical background with independent group. Both groups are attending school. Therefore, to the best of researcher's knowledge, both groups are relatively from similar family background.

3.6 Sampling Method

The sampling techniques used to select children respondents in institutional facilities were through stratified sampling method. On the other hand, the schools are selected availability through their proximity and the purpose of the study. And also the comparable groups, children in the schools are selected through purposive sampling technique.

3.7 Sampling procedure

In the first place, the complete list of institutional child care centers was found from Adama town women and children affairs office. Besides, a complete list of school was found from Adama town education office. Accordingly, from the total number of ten institutional cares centers, the researcher has taken nine institutional care centers for investigation through purposive sampling technique. Furthermore, four schools were also taken through purposive sampling method through Adama education office suggestion and researcher's research objective. On the other hand, the participants from institutional care were selected via stratified sampling technique. And also, participants from home based cares were selected through purposive sampling method.

3.8 Method of data collection

Each method of data collection has its weaknesses and strengths and this is why researchers often apply two or more methods in a study. Esterberg (2002) claim that studies that use multiple/complimentary methods tends to be the strongest. Therefore, theoretical, methodological and data triangulation were relevant in this study. Triangulation is used to obtain confirmation of the data that has been collected. Validity was presumed on the basis of having been previously established of the studies the statements were taken from.

3.8.1 Primary data sources

Questioners

The main data-gathering instrument in this study is questionnaire which was adopted from Janus, M., Brinkman, S., Duku, E., Hertzman, C., Santos, R., Sayers, M, et al. (2008), McMaster University, Offord Centre for Child Studies scales (see appendix A). The scales

comprise of forty three items and are composed of two subscales and accompanied by demographics questionnaire. Out of these, 21 items was targeted to measure the social development dimension and 22 items were constructed to measure the emotional development aspects. Each item has five- response categories-"Never at all", "rarely", "sometimes", "always", and "often". The first subscale, the social development categories, consists of 21 items and the emotional development subscales, consists of 22 items.

Observation

On the other hand, in addition to the above statistical technique, observations of children living at care setting and in the home with their guardians were conducted to scale up the reliability and validity of the study. Observation assumes that people's behavior is purposeful and can express deeper values and beliefs. What people say they do and what they actually do can be two very different conditions.

Observation can thus be a valuable tool in order to supplement other methods and checking the validity of a study. Observation is very useful when dealing with children because it may reveal patterns of behavior the children themselves are unaware of or cannot describe to a satisfactory degree (Kitchin and Tate, 2000). Even though observation is a good method in addressing certain issues, there are some problems connected to it. The presence of the researcher as a stranger may also influence the behavior of people. People act more as expected or what they believe is expected too when they are overtly observed by a stranger. There are different ways of conducting observation; participant and non-participant and overt and covert. Overt non-participant observation was used in this study, because of the limited time frame. The purpose of observations was to look at both the material and social structures and supplies at the children's homes which my in one way or another have impacts the children's SED. The social structures

are important in order to give a broader impression. The researcher used a check list when doing observations (see Appendix B). Things that were of importance for the observations were the physical surroundings at the homes, the children's personal place and the social interaction, such as the child-child and child-staff interaction.

To supplement the observations the researcher took photos at all the children's care center. This was to document the material structures of the homes, like the bedrooms, the bathrooms, toilets, the compound and all material structures that might exist.

Semi Structured Interviews

The aim of an interview is *"not to be representative but to understand how individual people experience and make sense of their own lives"* (Valentine in Flowerdew et al, 2000:111). *The advantage of this approach is that it is sensitive and people-oriented, allowing interviewees to construct their own accounts of their experiences by describing and explaining their lives in their own words"*, (Valentine in Flowerdew et al, 1997: 111). Feminist scholars claim that interviews are a very good way to study marginalized groups, such as children, because it allows them to tell their stories in their own words. It is valuable as a method because it allows the researcher to obtain the children's own perspectives (DeVault, 1999 and Reinharz, 1992 in Esterberg 2002, Grieg et al, 2007).

Children, both as individuals and as a social group, are potentially more vulnerable to the power-imbalance between the adult researcher and the child informant (Punch, 2002; Barker, 2003; Hood et al. 1996). The data collected from interviews can also be difficult to organize and analyze. This is because this type of interview can become less systematic and comprehensive. When interviewing children it is important to take their age and level of maturity into consideration. As the age of the children interviewed varies from 10 to 19 years old, there is a

big difference in their ways and abilities of expressing themselves, hence the length of the interviews and the "depth" of the information gathered vary. The children's ability of expressing themselves is not only dependant on their age, but also on their individual level of maturity, their personality and their cognitive abilities and the level of stimulation they are exposed to. The researcher used a semi structured interview guide during the interviews (see appendix A). This gives the researcher freedom and flexibility to explore issues more deeply as they came up during the conversation. The use of semi-structured interviews as opposed to a more rigidly structured interview was useful in this study because what is considered a good and healthy social and emotional development is very much an individual experience which is dependent on both personal preferences and level of comparison. The children were given the opportunity to rise issues that where important to them in the interviews. Themes that were discussed during the interviews with the children where; the children's social networks, the children relationship with others children and staffs, personal place and life at the children's home in general. But, interview were conducted with only adult children with the age ranges of 10-19 because, young children cannot express themselves fully.

3.8.2 Secondary data sources

To supplement the primary data, the researcher used information from various secondary sources. These include national program of action on women and children, UN guideline on alternative child care, national standard service delivery guidelines for orphan and vulnerable children's care and support programmes were also used to shed some light on these issues. The secondary sources also include documents obtained from children's care center. These were monthly records kept for the children concerning their psychosocial support, health, education and social interaction with the other children and staff. This was very valuable because it allowed

the researcher to answer the existing policies and legal frame work which protect children and promote their positive and healthy interaction of social relations and emotional stability.

3.9 Data Gathering Procedures

When working with children, it is important to go through the proper channels and the managers and directors were the authority figures with the power to give permission to contact with the children. The children are the primary source of the data in this study and the managers at care centers and directors at schools were sources of access to the children. Researcher meets with groups of participants in each setting. After the consent was explained, researcher passed out research packets. The questioners is administered to the selected sample groups in each institutional child care centers and schools by taking appointment from them at the time convenient for them. Furthermore, interviews were conducted at the various children's homes in a place where none of the other children or the staff could hear the conversation. However, sometimes the children became concerned and almost looked over their shoulder before answering some of the questions. The average interview took about 15-25 minutes.

3.10 Method of Data Analysis

The data analysis of this research was based on both quantitative and qualitative methods. For the purpose of the quantitative data analysis, descriptive statistics measures- mean and standard deviation were used to see the general patterns of subjects of both comparable groups in terms of age, gender, ethnicity, religion, child's parent's/guardians the academic status of the parents/guardians. To examine the significance of differences in terms of social and emotional development; independent sample t-test was employed.

Furthermore, qualitative method was used that are based on simple observation and semi-structured interview with the children.

3.11 Pilot Study

Even though, the selected quantitative instruments have already been standardized, and their reliability and validity have been established by their authors, the period, environmental context and situation under which they were standardized were different from the environment and situation here in Ethiopia. Hence, pilot study was believed to be important to check the reliability of the instrument in Ethiopian context. The scales were administered to sampled 36 equally to both children at care centers and schools.

According to the results of pilot study, the reliabilities of the scales to measure social and emotional development were confirmed through Cronbach's Alpha. Accordingly, the inter-item reliability of the social and emotional development was assessed by calculating Cronbach's Alpha (α) coefficients for each of the forty three components of social and emotional development separately. Appendix C shows the results of this analysis.

3.12 Ethical Consideration

Research ethics is *"concerned to which extent the researcher is ethically and morally responsible to his/her participants, the research sponsor, the general public and his/her own beliefs*" (Kitchin and Tate, 2000). *Anonymity and confidentiality* are important issues here. When it comes to children, the ethical and moral aspects are especially important to bear in mind (Scott in Christensen and James, 2000). The issues of ethics are very often thought to be the imperative difference between research with adults and research with children. This is because children are a group that are more vulnerable and in more need of protection than adults. The information the researcher was seeking touches parts of the children's lives in the most intimate ways. These children come from difficult backgrounds and might still live under unfavorable conditions. In this study the researcher got informed consent from the manager at each child's home/institutions, who all received a letter in English describing the purpose of the study.

3.13 Validity and Reliability

Validity *"concerns the soundness, legitimacy and relevance of a research theory and its investigation or practice"* (Kitchin and Tate, 2000). In other words validity is the truthfulness of the data collected or how relevant the data is for the research questions. Since every method of data collection has its shortcomings the researcher chose to apply complementary methods to ensure the validity of the study. Mikkelsen argues that *"biases do not disappear, but the use of triangulation for crosschecking information enhances the validity of research results*" (Mikkelsen, 1995).

Several factors influences the validity of the data collected. It is important that the subjects understand the purpose of the study and for what purpose the collected data will be used. Therefore researcher made it clear at all times during the data collection that I was a student from ASTU and I also carried with me a letter of support from ASTU explaining the purpose of the study. The amount of privacy provided ensuring the respondents feeling comfortable, is of vital importance to the validity of a study.

The researcher also made sure the questions being asked were not misleading and that the language was not difficult to comprehend, both because the whole questioners translated to local language, Amharic. The potential problem of validity due to the cultural differences was solved because of the researcher's previous contact and experience with both staff members of institutional care and school setting. To avoid misunderstandings respondents were asked to explain issues and statements that were unclear to them. The setting and the theme are sensitive and demanding. Nevertheless, the information gathered is reasonably valid.

Reliability *"is the extent to which a method of data collection yields consistent and reproducible results when used in similar circumstances by different researchers or at*

different times" **(Hay 2000). Kumar, (1999), claims that it is not possible to control the factors affecting the reliability of a study in research. Such factors can include the respondent's mood, the nature of interaction, wording of questions and the physical setting. It is possible that how the respondents presented the aim of this study and my presence at the children's homes for the children, affected their answers and behavior. To confirm the reliability of rating scale pilot study was done and confirmed through cronback alpha and hence, the items are reliable.**

CHAPTER FOUR

4. DATA ANALYIS AND INTERPRETATION

In this chapter the results obtained from both employed statistical and qualitative method are presented in tables followed by verbal descriptions. First, results of descriptive statistics are presented and then comparison of general backgrounds (Age and Gender) of mean score of differences between institutional care and home based care are presented. Furthermore, results from qualitative method employed were presented through verbal expressions.

Table 1: List of institutional care centers with their children population

S.No	Name of Institutions	No. of children
1.	Bethel children's home association	14
2.	Kids care children's home association	8
3.	Kingdom Vision International	10
4.	My father's home	9
5.	Nejashi social development center	20
6.	Noble action holistic development	11
7.	Selam children's development center	11
8.	Xuwarina degaf yatu yemebetochinna yelejoch bet	4
9.	Yoseph yelejoch bet	13
	Total	**100**

Source: Adama city women and children's affairs office

N.B The No. of participants from home based care is not listed because of purposive/judgmental sampling.

4.1 Mean and standard deviation of backgrounds of respondents

These measures of descriptive statistics were believed to give an overview of general patterns of backgrounds of the subjects for both independent groups. Table 2 presents these measures.

Table 2: Means and standard deviation of backgrounds of respondents

Categories/groups	Variable lists considered as backgrounds	N	Mean	Std. Deviation
Institutional care	Age of child	80	1.70	.461
	Gender		1.36	.484
	Total	80		
Home based care	Age of child	80	1.44	.499
	Gender		1.25	.436
	Total	80		

As depicted in table 2, children's from institutional care have high score mean as compared to children's family based care in terms of their age and gender.

Accordingly, as depicted in table 2, children's from institutional care have high score mean as compared to children's home based care in terms of their age which are 1.70 and 1.44 respectively. Similarly, the mean score of gender of the institutional based children is higher than their counterparts of home based care children which are 1.36 and 1.25 correspondently.

In terms of standard deviation, institutional care group has high score both in terms of age and gender than those of home based care.

4.2 Differences in terms of both Social and Emotional Development Aspects

Differences in both social and emotional development aspects variables are were seen to know the overall mean differences of both variables of the groups.

Table 3: The mean and standard deviation for social and emotional development variable

Variable	Care Arrangements/approaches	N	Mean	Std. Deviation	Std. Error Mean
Social and Emotional Development	**Institutional care**	80	2.88	.501	.056
	Home based care	80	3.05	.518	.058

The above table 3 represents the descriptive statistics output which provides the sample sizes (N), means, standard deviations, and the standard error of the separate for both groups. Accordingly, there were 80 children being in institutional care in the sample with average 2.88, with standard deviation and standard error of the mean of .501 and .056,respectively. Similarly, there were 80 children being in home based care with an average of social relations and emotional stability of 3.05 with a standard deviation and standard error of the mean of .518 and .058, respectively.

Table 4: Independent Samples Test for Social and Emotional Development variable

		t- Test for equality of means t-test for Equality of Means						
		T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
Social and Emotional Development		-2.176	158	.031	-.175	.081	-.334	-.016

The above table 4 depicts the independent samples t-test statistic (t = -2.176) for the equality of means in terms of both social and emotional development of children being in institutional care and children from home based care falls within the 95% confidence interval of differences.

The significance value (p = .031), being less than .05, shows that there is significant difference between the means of the two groups. The data have produced a t_{obs} of -2.176, with df=158, p = .031.

Taking all of this statistical information into consideration, and given that the means of the social and emotional development are significantly different, there is reasonable certainty that there is significant differences, in care approaches of home based and institutionalized children with regard to .social and emotional development variables. Because .031 is less than .05, we can't conclude that the average social relations and emotional stability was statistically significant. Therefore, the researcher rejects the null hypothesis since the p-value is ≤ 0.05. At the, $\alpha = 0.05$ level of significance, there is enough evidence to conclude that the mean indexes are not the same for the two areas.

4.3 Differences in terms of Social aspects of development

The Independent sample t-test for sub- scale social development variable between the two groups was calculated in the following manner.

Table 5: Descriptive statistics for social development variable of the groups

Variable	Care Arrangements/Approaches	N	Mean	Std. Deviation	Std. Error Mean
Social Development	Institutional care	80	3.12	.709	.079
	Home based care	80	3.57	.809	.090

The above descriptive group statistics on table 5 shows the sample size, means, standard deviations, and the standard error of the mean for each group. As far as the social development variable is concerned, the sample size for both group is equal, which 80 participants for being in institutional care and 80 participants for being home based care. The mean, standard deviation and standard error mean for institutional care are 3.12, .709 and .079 respectively. Likewise, the mean, standard deviation and standard error mean for participants under family care are 3.57, .809 and .090 respectively.

Table 6: Independent Samples Test social development variable

	t-test for Equality of Means						
	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Social Development	-3.714	155.329	.000	-.446	120	-.684	-.209

The above table 8 clearly depicted t-test for mean differences in terms of social dimensions of development of participants of both institutional care and home based care. A significance value of .000 (less than .05) indicates that there is significant difference between the two group means.

Furthermore, the confidence interval for the mean difference does not contain zero within its range which is -684 to -290. This also indicates that the difference is significant.

Based on the results of independent t-test (p = .000 is less than .05), we reject the null hypothesis (Ho). Therefore, it can be concluded that there was significant difference between institutional care and home based care in terms of social development aspect.

4.4 Differences in terms of Emotional development variable

Table 7: Description of statistics for Emotional development sub-scale variable

Variable	Care arrangements/approaches	N	Mean	Std. Deviation	Std. Error Mean
Emotional Development	Institutional care	80	2.65	.554	.062
	Home based care	80	2.57	.506	.057

The above table 7 descriptive statistics displays the number of participants, mean value of emotional development, standard deviation, and standard error for the test variable(s) within categories defined by the grouping variable (Institutional care and home based care). Accordingly, the numbers of participants are 80 for institutional care and home based care, respectively. The mean value, standard deviation and standard error for institutional care are 2.65, .554 and .062, respectively. On the contrary, the mean value, standard deviation and standard error for home based care is 2.57, .506, and .057, respectively.

Table 8: Independent sample t-test in terms of Emotional development variable

	t-test for Equality of Means

	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Emotional Development	.996	158	.321	.084	.084	-.082	.249

Table 8, table represents the results of the groups means in terms of emotional development. Therefore, t statistic, df, and Sig. (2-tailed) identified to determine if there was a significant difference between the means of the samples with respect to emotional development aspect. Since, .086 is greater than .05; it is possible to conclude that the average emotional development was statistically insignificant in terms of emotional state.

Qualitative Results

Through observation checklist it was tried to look at if the personal place of each children may impacts the child's social relationship and emotional regulation. From existing divide of personal place was supported by each of the institutional care and the children's caretakers, hence the home supports the existence of inequality or equality among the children concerning personal place which also impacts the children's social and emotional development. During the weekends the children's free time is quite open with just some chores and church. All through the week the children are mostly free to engage in activities of their own choosing, like playing soccer, watching TV, hang out with friends or just rest. The children move freely between the different bedrooms and on the compound.

The researcher observed some fights and quarrels among the boys and the older boys seemed to use their physical advantage to dominate the younger ones. This could indicate that there exists a hidden social hierarchy among the children based on age and physical strength; however it difficult to confirm or reject this because, there is no enough data.

Results obtained from semi-structured interview are analyzed and interpreted verbally in the following manner. Semi-structured interview is conducted only with children of 13-15 because of the children at early childhood period cannot respond to the interview question properly. This part of analysis, love and belonging, the children-staff relationship, relationship among children, social networks like friends, relatives and community are considered.

4.5 Love and the children's feeling of belonging towards the home

Having a fundamental feeling of belonging towards the home is positive for aspects of children's social and emotional development. It provides the children with a safe base from which they can explore the world. It will provide them with a sense of identity that children raised in residential care facilities often do not have due to the lack of significant contact with others.

"I don't like it here! The biggest problem is that I want to leave here. I don't want to stay" (Girl 14, institutional care). She went on saying that she would leave institutional care center with anyone that would take her. When I asked if there is anything she likes about living at care center she just shook her head. The wish to leave the home was also expressed by other children:

"If I get the chance I'll move out. Not only me. We are many. We want to move out from this orphanage. […] I don't feel like staying in this orphanage" (Boy 15, institutional care)

*"It has been very good growing up here. [...] Here (the home) can not be separated from my future" (*boys 15, institutional care*).*

From the above interviews, in a situation where many children feel they live in an unsafe and unstable environment, close and loving bonds between the children and the staff are more likely to be the exception, than the rule.

For many children this means that once they leave the home, they might not have any adults to turn to for support. Even though the children expressed that they liked some staff members, the child-staff relationship was for the most part referred to in negative terms. This creates an environment where the children feel unsafe, unloved and unwanted, which can lead to nervousness, anxiety, fear, depression and a low self-esteem in turn negative social and emotional development.

The impacts of child care…

In some institutional care, there is undoubtedly care center with the best child-staff relationship. The children used very positive terms when describing the staff and drew the image of an environment where they felt safe, well taken care of and where they truly believed that the staff had their best interest in mind which impacts the children's in fundamental way. This gives the children a broad social network that will affect aspects of their social and emotional development in positive manner.

On the other hand, the children talked about the home based care as something that would always be a part of their life. Even when they talked about moving out and making a life of their own, they talked about the home as a "family" they always could return to; *"It has been very good growing up here. [...] Here* (my home) *can not be separated from my future"* (Boy 14, Home based care). The image drawn was of home based care as a base from which the children go out and explore the world. Thus, when the children move out, the home will always be there as a safety-net which the children can go to for support.

Some children also talked about how they wanted to get their education and come back and work for home based care, so they could give something back.

One boy (age 15) said that he preferred living at home, as compared to leaving his family even though his family's life is hand to mouth. He pointed out that life at the home was easier in that the he got what he needed for survival, such as food, clothes, and love which emanated from his home.

4.6 The children and staff/relatives

One boy (age 15, institutional care) said it quite blunt: *"They hate us!"* These are very strong words for a child to use when explaining how he believes his caretakers feel about him. When remembering that a child's caretakers are supposed to be his/hers strongest support and defense in this world, one can only speculate about the kind of pain and disappointment hidden behind such a statement. One child did not want to answer any questions about the staff. Most children divided the staff into the ones they liked and the ones they did not like at all;

"Some are good, some are not good. […] They shout at you, hit you, and insult you" (Girl 14, years old).

"Just like a small mistake and they will be shouting at you and they start insulting you" (Boy 14, years old).

"If you don't treat us well, how can I treat you well? That's the thing" (Boy 13, institutional care).

The lack of respect and trust between the children and the staff is clearly illustrated by these statements. When the children are shown little or no respect from the staff, this is what the children give back and this pushes the staff-child relationship deeper into a negative cycle.

Some children also said that they were more or less ignored by certain staff members. That some staff members does not bother to check on all the children sends a signal that some staff members does not consider all the children to be of equal importance. Some children are simply not worth the effort and attention.

On the other hand, "I like my home and the atmosphere their" (Boy 13, Home based care). *"They* (the relatives) *are doing very well in order to make everything possible. A very happy home"* (Boy 15, Home based care).

One thing that differs from the institutional care is that guardians of children home based care are the close relatives or their biological parents of children. This will undoubtedly create a stronger feeling of belonging for both the family's and the children. It is likely that the families will care much more about their life.

4.7 The relationship among the children

The manager's hope that the children would see themselves as siblings is not consistent with the image drawn by the children themselves in the interviews. One girl (age 13) said that she does not like any of the other children because: *"They are all bad".*

The children did not express having any close ties to each other. Instead, the fighting and stealing from each other where pointed out as the most typical feature of the relationship between the children among some of the care facilities. Some of the older boys would insist that there were no fighting amongst the children, something that was not consistent with my observations and interviews;

"Sometimes the oldest kids will beat us" (Boy 14, care center)

Information derived solely from my interviews might give the impression that some of the children have friends and that none of them get along. To draw such a conclusion would be to oversimplify the truth. The children do play together and seem to have their friends, but it is striking that when asked it is the negative aspects that were always emphasized.

On the other hand, the children from home based care seemed to get along well. This was confirmed by interviews and when asked about this issue, one children answered;

"[we get along] *like brothers and sisters. We we'll have the fights, but have the good times as well. [...] It's the same as any family"* (Girl 13, Home based care).

"We are good friends, but sometimes not that good. Sometimes it will be a bit trouble with some of us [...] We love each other" (Boy 14, Home based care).

The children from home based care illustrated and described a nuanced image of the relationship among the children, as they viewed it as basically good, but with occasional problems and conflicts, as would be the case in most sibling-relationships.

4.9 Social networks

Friends

Having friends is important to the children's development of social skills**.** Having friends at the residential care can undoubtedly be a huge positive experience for the children. Friends that have the same experiences as themselves are very valuable, as they are able to truly understand the daily struggles and frustrations. Most of the children know that they are at institutional care has been there for most of their childhood and are most likely to live there until they are 18 years old.

However, a social network only consisting of friends from the institutional home, will undoubtedly narrow the children's perspectives and experiences in a significant degree. Having friends that live outside the care center is equally important for the children's development. A social network where people have different experiences and backgrounds will undoubtedly enrich the children's lives.

The impacts of child care…

At some institutional care, many of the children have more or less grown up together and thus one should think that they have had the opportunity to form strong bonds. But, interviews with the children indicate that the home has not been entirely successful with this.

The following statements illustrate the lack of close bonds between the children in institutional care. *"They are all bad"* (Girl 13, care center, when asked how she felt about the other children living at institutional care.

In contrast to the above statements there where one girl (age 14) that said that she liked all the other children. These contrasting experiences between the children could be a result of a social hidden hierarchy where the children that claimed they did not like any of the others, are at the bottom of the hierarchy and have been exposed to picking, bullying and abuse or it could be a result of fear of the consequences of saying something bad about the others.

"We are good friends, but sometimes not that good. Sometimes it will be a bit trouble with some of us [...] We love each other" (Boy 15, care center).

"Sometimes we fight about little things, like choosing a play ground, but we get over it" (Girl 12, care center)

But, all children interviewed said that they had friends outside the care home. The children that are old enough to attend school are naturally the ones with the most friends outside the care center.

On the contrary, interview with children from home based care relatively have so many friends as compared to institutionalized children as illustrated by:

"I have many friends at neighbor, school and the surroundings" (Boy 12, Home based care).

From the above Interviews with the children indicate that the home care has been entirely successful with this.

Relatives

Even though some of the institutional cares centers actively encourage or work to maintain ties between the families and relatives, some children do not have any relatives or it has proven impossible to locate them. In some cases, the children do not want to have any contact with their families and conceals information of their whereabouts. Especially children who join the care center from street. This may be because the children have been mistreated, neglected and/or abused and are afraid they will be sent back.

One such example is a girl (age 13, institutional care) that was living with an aunt before she arrived at care center. She does not want to go back because she was mistreated and refuses to give any information about her aunt. She also conceals information about the rest of her family for the same reason.

On the other hand, children from home based care are having high possibilities and close ties with their relatives. *"My families allowed me to ask the rest of relatives during the weekends" (Girl 14, Home based care),* which encourages children's social relationships with significant others.

The local community

The local community represents strong resources and possibilities for the children. It can provide broader and stronger networks which increases the chances of succeeding as positive and

productive adults. It provides a network to draw benefits from when they leave the homes, such as job opportunities, marriage, friends, and an active life.

The main social arena for the children at care center is participating in the local community where the schools, but some boys said they had friends they would visit outside the home. The girls did not go of the home by themselves. This was based on fear of being assaulted. Thus, there is a difference in how boys and girls are able to participate in the local community. At all the homes the children participate in some sort of activities with the local children outside school, such as visiting and playing football, but school remains the main social arena in this regard. Contact with the local community enforces the feeling of belonging and social identity. On the other hand, children from home based care have a natural bond to the local community as many of them have close relatives and they spend most of their leisure time in the surrounding community.

One boy (Age 15) pointed to the fact that his family comes from the neighboring village and that he for that reason is good friends with the children in that village.

CHAPTER 5
5. DISCUSSION, SUMMARY, CONCLUSION AND RECOMMENDATIONS AND IMPLICATIONS

5.1 Discussion

In this section the results reported in chapter four are interpreted and discussed in light of purpose of this study. Accordingly, the results of independent sample t-test of combination of social and emotional variables are first discussed. This is followed by the differences of independent sample t-test of social development and emotional developments were separately discussed. This is followed by discussion of results from observation and semi-structured interview.

5.1.1 Child care Impacts on Social and Emotional Development

As revealed by the independent sample t-test (Table 2), there is no significant difference in terms of overall social relations and emotional stability between groups being cared in care arrangements between institutional care and home based care ($t_{-2.176}$= 031, P >.05). This shows that the observed social and emotional development mean scores difference between children of institutional care and home based care(Table 2) is not enough to enable one to look at the significance of differences the social and emotional condition of the target groups. The results suggests that children being from institutions and home based care are nearly similar in state of their social relations and emotional stability, and as a result it is unlikely to differentiate between institutional and home based care on the bases of the combination of social and emotional variables. This implies that being cared children in institutions has no significant influence on social and emotional development of children and hence, it is unlikely to bring significant change on overall social interactions and emotional stability.

The result is relatively consistent with a recent study by a group led by Kathryn Whetten, that suggested that institutional care may be as good or better than family care for orphaned and abandoned children in the age range of 6 -12 years. In five countries it compared orphaned and abandoned children in residential care with children of similar background living in families, but those in families were not necessarily benefitting from any sort of assistance, while children in orphanages presumably received food, education, and psychosocial services these facilitates provided. Using several measures, the Whetten *et al.* study compared the wellbeing of children in orphanages and families at a single point in time; it did not address, however, the critical longer term challenges of those who seek to reintegrate in society after growing up in an orphanage. A longitudinal study comparing young people who had been assisted in family care who had lived in institutions could be quite useful.

However, the result is inconsistent with theoretical reasoning of Psychodynamic approach and attachment theory which stresses the importance of the fundamental need of emotional care between the child and the primary care giver. For example, in 1951, John Bowlby's findings on the long-term negative impacts of institutional care on children which was published by the World Health Organization helped most of the child welfare policy and practice to shift from institutional care for separated and orphaned children towards family care. The findings also contradicts the 27 studies scientifically investigated by Johnson et al. (2006) concerning the development of children who have been raised in institutions, 17 studies measured social and behavioral problems that were more prevalent in residential care children compared with other children. Therefore, as his evidence the negative social or behavioral consequences for children raised in institutional care was reported by 16 (94%) of the studies, highlighting problems with anti-social conduct, social competence, play and peer/sibling interactions. In addition, one in ten

children who spent their early lives in poor conditions, often deprived of interaction with others, were found to show ‘quasi-autistic’ behaviors such as face guarding and/or stereotypical ‘self-stimulation/ comfort’ behaviors, such as body rocking or head banging (Beckett et al., 2002; Rutter et al., 1999, 2007; Sweeny and Bascom 1995). However, the severity and duration of difficulties varied greatly across the studies, reflecting the different situations and experiences of the children studied in various countries. Similarly, twelve studies conducted by Johnson (2006) that specifically considered the conditions of emotional attachments for children in institutions compared with other children has shown that, only one study found no supporting evidence for greater attachment difficulties for children growing up in residential care. studies report significantly more indiscriminate friendliness, over-friendliness and/or disinhibited behavior for children in institutions, suggesting ‘disorganized attachment disorder’ has greater prevalence among these children compared with children in families or children who were admitted to institutional care after the age of two years (Wolkind, 1974; Rutter et al. 2007).

This contradiction between the results of present study and the established theoretical conceptualization of institutional care could be explained by different factors. One explanation could be the shortage of time to look at the social relations and emotional stability of institutionalized children because; outcomes of institutionalized children have been proven to be worse than those placed in family care, through longitudinal studies such as the Bucharest early intervention program. Another possible reason is the comparable groups; children from family based care have relatively similar backgrounds with their counterparts, institutional care. Another possible reason for the incompatibility of the result of this study with the theoretical reasoning about the institutional care impacts may relate to validity of the used scale. The scale employed in current study adopted from other countries which is relatively differs from the study

areas context even though; the desirability of scale can be altered according to a particular culture (Mehren and Lehmen, 1969). The target groups of the same setting of this study are since children, as a result they may respond to items reflecting behavior that is negatively evaluated by the society socially acceptable ways. Such possibility might have confounded the present study.

5.1.2 Differences in terms of Social Development

Table 4 clearly presented the independent sample t-test of the target groups in terms of their social development sub-scale variable. The results shows that, the institutionally cared children has statistically significant mean score as compared to its counterparts, family based care children, which enable ones to predict social development variable of the target groups($p = .000$ is less than .05). This implies that children from institutional care have adverse impacts in terms of emotional development.

This finding is consistent with the findings of several researchers and child development specialists, who have recognized that residential institutions consistently fail to meet children's developmental needs for attachment, acculturation and social integration, Williamson, Jan, 2009. These children have difficulty forming and maintaining relationships throughout their childhood, adolescence and adult lives. In addition, studies have also shown that there is greater risk of developing psychological disturbances in later life for children who have experienced neglect or abuse. These psychological issues can include behavioral problems (anti-social or aggressive), learning problems and social adjustment problems, Barnow, 2001. The removal from the family home in itself will of course create an enormous challenge on a child's coping resources and the transition process will be an extremely stressful time for the child. The experience of neglect or abuse will have a direct effect on the child's emotional and social development and this can

extend long into adolescence and adulthood (Cicchetti, 1995). For instance, the realization that institutions had the capacity to cause permanent psychological and sociological damage led to the abandonment of this form of care in Western Europe and North America.

5.1.2 Differences in terms of emotional development

One of the questions of this study was to describe the impacts of children care on emotional aspects of development. As the result of independent sample t-test (Table 7 and 8) portrayed, there is no significant difference between subjects of institutional care and home based care in terms of these variable. The inequality of the groups in emotional stability with no significance difference in the independent sample t-test might be attributed to the fact that the age of the children. The presence of attachment disorder is more common in children who have spent more of their infancy in institutional care (O'Connor et al., 1999, 2000). However, this pattern is not an inevitable consequence of early deprivation and there are mediating factors that can ameliorate the negative effects, such as the child being a particular favorite of a residential care worker and receiving sensitive care giving. Nevertheless, this is rare and children in institutional care clearly have limited opportunities to form selective attachments, compared with children in family-based care, especially where there are large numbers of children, small numbers of staff and a lack of consistent care through shift work and staff rotation. Studies in Israel for example has found that, attachment style and behavioral problems among institutional care children has highlighted that the age a child is taken into care can have an impact on the long term effects of their mental health. The age of the child and their previous attachment to family members has a huge impact on their behavior and mental health once living within care and often this will follow them into their adulthood.

The result is consistent with research findings by several researchers (Kaler and Kopp 1990), which back up that group care settings provide many opportunities for children to practice their impulse-control skill which helps them adapt to social situations and follow rules.

The children and the staff/relatives relationships

The children from institutional care were the ones that expressed having poor relationships with staff. The main issues were concerned with unfair treatment, being ignored, abuse (verbal and physical) and a prevailing negative attitude towards the children. The unequal treatment can contribute to envy and quarrels between the children, diminishing aspects of the psychosocial development of those that feel unfairly treated. In a situation where many children feel they live in an unsafe and unstable environment, close and loving bonds between the children and the staff are more likely to be the exception, than the rule. For many children this means that once they leave the home, they might not have any adults to turn to for support. Even though the children expressed that they liked some staff members, the child-staff relationship was for the most part referred to in negative terms. This creates an environment where the children feel unsafe, unloved and unwanted, which can lead to nervousness, anxiety, fear, depression and a low self-esteem.

As compared to institutionally reared children and staff relationship, the children cared by families/relatives are undoubtedly with the best child-relatives relationship. The children used very positive terms when describing the guardians and drew the image of an environment where they felt safe, well taken care of and where they truly believed that the guardians had their best interest in mind The bonds seemed to be much stronger, than as compared institutionalized children. Hence, the children's own homes and its guardians create structures that impact aspects of the children's social and emotional development in a very fundamental way.

The relationship among the children

The impacts of child care…

This feeling of having a basically good relationship to the other children will affect aspects of their social and emotional development in a very positive way. It gives the children a broad social network that will affect aspects of their social and emotional development in the present, but it could also prove valuable later in adult life.

The findings from interview shows high tendency of the adverse impacts of institutional care which impacts the psychosocial development of children adversely. This finding is consistent with global evidence demonstrating serious developmental problems associated with placement in residential care, Ainsworth, M., et al., and 1999. A research by Save the Children (SAVE) established that institutional care often causes serious and negative impacts on the development and rights of children, (Mulungeta, 2003). Children living in residential child care facilities often have trouble adjusting to adult life when they move out and it undermines the traditional family and community responsibility for orphans and vulnerable children (Foster, 2005; Tolfree, 1995 and 2003). Institutional care is associated with negative consequences for children's development (Carter, 2005; Johnson, Browne and Hamilton-Giachritsis, 2006).

Children's t interviews suggested that children experienced social difficulties, including tendencies to withdraw or avoid peers and siblings. This is consistent with children tend to avoid social interactions, indiscriminate friendliness is also commonly reported in studies of institutional children (Chisholm, 1998; Chisholm, Carter, Ames, Morison, 1995; Tizard & Hodges, 1978; Zeanah, 2000). One explanation offered to account for such inappropriate social behavior is that institutionally cared children lack awareness of interpersonal boundaries. In support of this view, O'Connor et al. (1999) note that these indiscriminately friendly interactions are often superficial, impersonal, rarely reciprocal, and are maintained into adolescence.

One of the research question raised at the beginning of this study is to look at how the current policies and legislations protect children in need of care and in turn ensure their social and emotional development. Data gathered from secondary sources from National guideline of alternative child care and Standard Service delivery guideline for orphan and vulnerable children shows that there is current policies and legislations to secure alternative quality child care at all levels for orphan and vulnerable children. But, there is a gap on implementation of these policies and standard service for orphan and vulnerable children. This may impact the positive and healthy development of children adversely.

5.2 Summary

In this study attempts were made to find the impacts of child care on social and emotional development of children of residential care and home based care. The care approach impacts both on social and emotional variables were looked comparing institutionalized children and home based children.

As indicated in chapter three, the target populations of the study were sampled from 9 institutional child care centers and the comparable groups also were sampled from primary and junior schools in Adama city, oromia region. The subjects from institutional care were sampled through simple systematic sampling method. Similarly, subjects from home based care were selected through judgmental/purposive sampling.

Rating scales which measure the social and emotional development were used as instruments of data collection. Furthermore, observation, semi-structured interview, and sources from secondary data were employed as tool of data collection. After translating into Amharic language, the rating scale instruments were tried to see their reliabilities in Ethiopian context.

The statistical methods employed were descriptive statistics and independent sample t-test. On the bases of carried out data analysis, the results of this study are summarized in the following manner.

With regard to differences in both social and emotional development, the t-tests conducted have depicted non-significance differences between institutionally grown children and family based children in terms of combination of these variables.

But, in terms of social development as a single variable, there is a statistically significant difference in care arrangements of both groups of children.

With regard to qualitative aspects employed, even though some differences exist in terms of age of children, there is a detrimental impact of institutional care which adversely impacts the social and emotional development of children.

5.3 Conclusions

The main aim of this study was to investigate how the child care approaches impacts the social and emotional development dimensions of children in institutional care and home based care in Adama. The study revealed that the institutional care have relatively an adverse impacts on social development all the children in this study, which affects their socialization process. Using the theories of psychodynamic, attachment, and behaviorist, as a framework, the institutional cares are an organization that represents sets of structures that both limit and enables the children social and emotional development. The social-emotional development and institutional care are interrelated and all contribute to reinforce or restrict each other. This means that the way the institutions care children, reinforce each other and also affect other needs, such as, love and belonging and social networks. The institutional care of children at children's home, non-

governmentally owned institutional care in Adama have relatively a difference as compared to children's cared by their biological parents or close guardians by their social interaction and emotional stability. A deprived physical environment, overcrowding and poor salaries also creates unmotivated staff members that are unable or less willing to give the children the care they need. Relatively speaking, children care centers, in this study come from difficult backgrounds and most likely need more support from their adult caretakers than biologically or by guardians supervised children would. This means that these are vulnerable children made even more vulnerable due to a deprived physical environment and lack of proper care. Children institutional care, are in a position where they on several areas experience social exclusion. The children experience this both from lack of close contact with their relatives, the local community and having few close friends, both inside and outside the home. Hence, the socio-material conditions are strongly structuring their life conditions.

In contrast to institutional care, home based care cover the children's basic needs in a very similar way that reflects positively on aspects of the children's social and emotional development. Children under home based care in most aspects have a situation where the children feel more safe, loved, cared for and wanted, than what is the case at home based care which reflects their social interaction. Institutional care structures and relations are mostly focused on distrust and insecurity. The lack of close bonds with adult caretakers curbs the children of valuable life experience and support.

5.4 Recommendations

This research has made evident that there exist some inequalities in how the institutional child care are able to care for the children in a way that improve aspects of their social and emotional development as compared to parentally cared children.

Even though the ultimate goal of institutional care is to reintegrate children to the wider societies and to make children's homes redundant, it is unlikely that this is possible in the near future. Hence, some steps should be taken in order to improve the social and emotional development of the children living in children's homes have and also to avoid that children are placed in residential child care facilities unnecessary.

Governmental control of child care facilities

Even though majority of the institutional child care facilities in Adama operates with form of governmental control, guidance and support, there is an immediate need to ensure that the existing children's home comply with the standards for care children which was already supplemented by ministry of women, and children affairs known by the name Guideline for orphan and vulnerable children.

Educational programs for staff members

As many staff members working in direct and daily contact with the children have little or no formal education it is important to focus on educational programs concerning basic child care, child development, child psychological support. Through such educational programs it is also important to focus on the value and importance of caring for these children.

Cooperation with the local community

Institutional cares are to various degrees closed environments and they have physical boundaries separating them from their surroundings. Children's homes should therefore aim to work closely with the local community to make sure that children don't loose their connection to their home community. One way to achieve this is to open services, such as healthcare and education, to the local community. These way children's homes can become what people perceive as a positive element in the community. A close connection with the local community will also benefit the children when they move out of the homes as they are likely to have better knowledge of the "outside" world and also to have broader social networks to rely on. It can also help reduce the stigma and discrimination that often follows children living in residential care settings

Prevention of family disintegration

The root causes for why parents and families send their children to children's homes need to be identified and properly addressed. According to the information from Adama city women and children affairs office, poverty and HIV/AIDS has been identified as the number one reason for child abandonment in Adama. Children's homes are often wrongly perceived as being more capable of caring for children than the biological family, as the children will at least receive regular meals, clothes and have better chances of receiving a basic education. Poverty reduction programs are important in order to empower families to care for their children.

5.4 Implications

An implication of this study includes using the most child care approaches focus on the physical treatment and material facilities and teach theory about child development and child-raising. They do not address psychosocial aspects of child development and most do not provide any practical experience. Even though, the statistical results part portrays that there are no social and emotional development differences between care arrangements of institutional and home

based care, the verbal opinion, expressions, and feelings of the participants shows there is a difference in care arrangements.

Another implication is that child welfare laws and regulations are also based on guideline standards of childcare for orphan and vulnerable children which were also stressed by this study. Child welfare workers need to be trained on psychological issues that they may not be aware of with this population. While it is not feasible to expect to change the welfare laws and regulations, it is feasible to train the welfare workers to work more effectively with this care institution.

An understanding of the impacts of child care on social and emotional development may also help the residential managers, caregivers and staff and intact families to understand and help children in care arrangements. Being able to understand the issues of impacts child care of children, may help to inform potential foster parents or relatives taking care of their children about what to expect as they take care of the children as well as deal with their behavioral or emotional issues. It can also be used to inform potential caregivers of what services and resources they will need to be able to care for these children.

The knowledge gained from this study can be used to better design residential care facilities so that social and emotional development is taken into account. Furthermore, it can also help to better inform childcare workers who work with this population.

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APPENDICES

Instruments of data collection

Consent

Dear Respondents,

This research project has focused on the topic entitled as, **"The Impacts of Institutional Care on Social and Emotional development of children: Institutional Child Care Centers in Adama Town in Focus" w**hich is done for the Partial Fulfillment of the Requirements for the Degree of Masters in Social Psychology. The questioners are prepared to assess **The Impacts of Child Care on Social relations and Emotional stability of children at child care centers in Adama town.** The research is done only for Academic purpose. Therefore, any data you provide for the researcher is kept confidential. Your accurate and kind response will make the whole research complete. "Thank you in advance for your cooperation"

General Instructions:

- ✓ Mark '**X**' to show your response for the general background of the child in the box.
- ✓ Please Read each question carefully and **tick one** that you think can express the child's social relations and emotional stability out of the **five** alternatives for the **rating scale.**
- ✓ Each general background and rating scale was prepared for a single child.
- ✓ Please don't write your name.

Appendix A

General Background of the child/Respondents

1. **Age** ---------Years
2. **Sex**: Male ------ Female --------

Scores

Never: 0 **Rarely: 1** **Sometimes: 2** **Often: 3** **Always: 5**

S. No.	List of statements that describe some of the feelings and behaviors of children within the past six months to be answered by respondents at child care centers/Teachers	Rating Scales scores				
		Always = 5	Often = 3	Sometimes = 2	Rarely = 1	Never at all = 0
I.	**How would you rate the following child's social development/Social relations?**					
1.	Plays and works cooperatively with other children					
2.	Able to play with various children					
3.	Follows directions, rules and instructions					
4	Respects the property of others					
5	Takes things that do not belong to him/her					
6.	Has difficulty awaiting turn in games or groups					
7.	Offers to help other children who have difficulty with a task					
8.	Demonstrates respect for adults					
9.	Demonstrates respect for other children					
10.	Accepts responsibility for actions					

11.	Works independently					
12.	Takes care of school materials					
13.	Works neatly and carefully					
14.	Curious about the others					
15.	Eager to play a new game					
16.	Able to solve day-to-day problems by him/herself					
17.	Spontaneously helps to pick up objects which another child has dropped.					
18.	show tolerance to someone who made a mistake (e.g., when a child gives a wrong answer to a question posed by the care givers or teachers)					
19.	Seem too friendly with Strangers					
20	Shows self-confidence					
21	know about acceptable behavior					
II.	**How would you rate you self in the following the Emotional development dimentions**					
22	Demonstrates self-control					
23	upset when left by parent/guardian					
24	Able to adjust to changes in routines					
25.	Laughs at other children's discomfort					
26.	Able to deal with feelings at the age- appropriate level					
27.	Empathic, response to other people’s feelings					
28.	Able to follow class routines without reminders					
29.	Answers questions showing knowledge about the world					

30.	If there is a quarrel or dispute I will try to stop it					
31.	Will invite bystanders to join in a game					
32.	Kicks, bites, hits other children or adults					
33.	Is disobedient					
34.	Has temper tantrums/anger					
35.	Impulsive, acts without thinking					
36.	Unhappy, sad, or depressed					
37.	Became fearful or anxious					
38.	Appears worried					
39.	cries a lot					
40.	Nervous, easily upset, or tense					
41.	Is shy					
42.	Sucks a thumb/finger					
43.	Can't sit still, is restless					

Appendix B

Observation Checklist

1. **Care center/provider's name**----------

2. **The physical surroundings**

   - Neighborhood

   - Compound

   - Playground

   - Rooms for social recreation.

   - Sanitary facilities

   - Electricity, running water

   - Food

3. **The children's personal place**

   -Bedrooms – condition of bedrooms, beds and other furniture?

   -How are the bedrooms used by the children? Just for sleeping or as a social arena?

4. **Social interaction**

   - Among the children

   - The children and the staff (relatives for home based children)

   - The children and relatives

Appendix -C

Semi-structured interview with the children

Background information

- Name (will be kept confidential in the study)
- Age

Friends

- Friends outside the home
- Friends at the home.
- What is his/her the relationship with the children like?

Staff

- Likes and dislikes about the staff. How do they treat you?
- The relationship between the staff and the children

Life at the institutional /Home

- Positive things about living here
- Negative things about living here
- What is the biggest problems in your life and how do you deal with this?
- How would you describe your life at institutional/ home care?
- If you could; what would you like to change in your life?

Appendix D

Computation of reliability coefficient of social and emotional development by Cronbach's Alpha

	Mean	Std. Deviation	N of Items
Part 1	67.7778	17.33883	22[a]
Part 2	54.7222	11.81430	21[b]
Both Parts	122.5000	23.49894	43

a Social development measurement

b Emotional development measurement

Case Processing Summary

		N	%
Cases	Valid	36	100.0
	Excluded[a]	0	.0
	Total	36	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Part 1	Value	.929
		N of Items	22[a]
	Part 2	Value	.830
		N of Items	21[b]
	Total N of Items		43

Correlation Between Forms		*.273*
Spearman-Brown	*Equal Length*	*.429*
Coefficient	*Unequal Length*	*.429*
Guttman Split-Half Coefficient		*.406*

a. The items are: 1-22

b. The items are: 22-43

	Mean	*Std. Deviation*	*N*
Item 1	*3.6389*	*1.29069*	*36*
Item 2	*3.6667*	*1.19523*	*36*
Item 3	*3.2222*	*1.14919*	*36*
Item 4	*3.4722*	*1.02779*	*36*
Item 5	*2.8056*	*1.21466*	*36*
Item 6	*3.0000*	*1.21890*	*36*
Item 7	*2.6944*	*1.00909*	*36*
Item 8	*3.2222*	*1.41646*	*36*
Item 9	*3.3056*	*1.23796*	*36*
Item 10	*3.0278*	*1.20679*	*36*
Item 11	*2.9722*	*1.31987*	*36*
Item 12	*2.8056*	*1.30536*	*36*
Item 13	*2.8889*	*1.38930*	*36*
Item 14	*2.7500*	*1.27335*	*36*
Item 15	*3.1111*	*1.50765*	*36*
Item 16	*2.3889*	*1.17784*	*36*
Item 17	*2.9444*	*1.11981*	*36*
Item 18	*3.0278*	*1.25325*	*36*
Item 19	*3.5278*	*1.23024*	*36*
Item 20	*3.1111*	*1.14087*	*36*
Item 21	*3.2222*	*1.31173*	*36*
Item 22	*2.9722*	*1.25325*	*36*
Item 23	*2.6667*	*1.24212*	*36*
Item 24	*2.9722*	*1.08196*	*36*
Item 25	*2.6389*	*1.19888*	*36*
Item 26	*2.9722*	*1.18288*	*36*
Item 27	*2.9167*	*1.13074*	*36*
Item 28	*2.8611*	*1.24563*	*36*
Item 29	*2.9167*	*1.13074*	*36*
Item 30	*2.6111*	*1.27117*	*36*
Item 31	*2.8889*	*1.16565*	*36*
Item 32	*2.5833*	*1.38099*	*36*
Item 33	*2.3889*	*.93435*	*36*
Item 34	*2.9167*	*1.22766*	*36*
Item 35	*2.8056*	*1.09073*	*36*
Item 36	*2.6389*	*1.35547*	*36*
Item 37	*2.4444*	*1.27491*	*36*
Item 38	*2.3333*	*.92582*	*36*
Item 39	*2.1389*	*.93052*	*36*
Item 40	*2.4167*	*1.22766*	*36*
Item 41	*2.6111*	*1.31535*	*36*
Item 42	*1.6944*	*1.14191*	*36*
Item 43	*2.3056*	*1.19090*	*36*

N.B. Mean and standard deviation of each item

አዳማ ሳይንስና ቴክኖሎጂ ዩኒቨርሲቲ

የሳይኮሎጂ ትምህርት ክፍል

የተከበራችሁ ቃለ መጠይቅ የተደረገላችሁ መላሾች፤

የዚህ ፕሮጀክት ጥናት ዋና ትኩረት ፡በአዳማ ከተማ ውስጥ በሚገኙ የህጻናት ማሳደጊያ ማዕከላት የህጻናት ክብካቤና አያያዝ በማህበራዊና ስሜታዊ ዕድገት ላይ ያመጣው ተጽዕኖ፤ በሚል ርዕስ ላይ ያተኮረ ሲሆን ጥናቱም በማህበራዊ ስነ ልቦና ለማስተርስ ዲግሪ ማሟያነት የሚደረግ ነው፡፡ ጥናቱ የሚውለው (የሚያገለግለው) ለአካዳሚክ አገልግሎት(ጥቅም) ብቻ ነው፡፡ስለሆነም ለጥናት አድራጊው የሚሰጠው የትኛውም መረጃ ምስጢራዊነቱ የተጠበቀ ነው፡፡የርስዎ ትክክለኛና ቅንንት የተሞላው ምላሽ ጥናቱን የተሟላ ያደርገዋል፡፡ ስለ ትብብርዎ በቅድሚያ እናመሰግናለን፡፡

አጠቃላይ መመሪያ

- አጠቃላይ የህጻናቱን ታሪክ በተመለከተ ለምትሰጡት ምላሽ /X/ምልክት በሳጥኑ ውስጥ ያድርጉ፤
- ጥያቄዎን በጥንቃቄ ካነበቡ በኃላ ስለህጻኑ ባለፉት ስድስት ወራት ውስጥ ያለውን ማህበራዊ ግኑኝነቶችና ስሜታዊ መረጋጋት ካሉት አምስቱ አማራጭ የክብካቤ አገልግሎቶች አንዱን ምልክት ያድርጉበት፡፡
- አጠቃላይ የህጻኑን ታሪክም ሆነ የእድገት መለኪያ የተዘጋጀው ለእያንዳንዱ ህጻን ነው፡፤
- ስምዎን መጻፍ አያስፈልጉዎትም፡፡

የህጻኑ/ኗ/ን አጠቃላይ ታሪክ በተመለከተ

- ዕድሜ ----------ዓመት
- ጾታ፡ ወንድ ☐ ሴት ☐

- ሃይማኖት፡

  - ኦርቶዶክስ ☐
  - ፕሮቴስታንት ☐
  - ካቶሊክ ☐
  - ሙስሊም ☐
  - ዋቄፈታ ☐

- ❖ ሌላ ☐

- ብሔር፡
  - ❖ ኦሮሞ ☐
  - ❖ አማራ ☐
  - ❖ ትግሬ ☐
  - ❖ ጉራጌ ☐
  - ❖ ሌሎች ☐
- የህጻኑ(ኗ) የወላጅ ሁኔታ
  - ❖ አንድ ወላጅ ብቻ ☐
  - ❖ ሁለቱም በህይወት የሉም ☐
  - ❖ ሁለቱም አሉ ☐
- የወላጅ የትምህርት ሁኔታ፤
  - ❖ ማንበብና መጻፍ ☐
  - ❖ አንደኛ ደረጃ ☐
  - ❖ መለስተኛ 2ተኛ ደረጃ ☐
  - ❖ ሁለተኛ ደረጃ ☐
  - ❖ ሰርተፊኬት ☐
  - ❖ ኮሌጅ ዲፕሎማ ☐
  - ❖ ዲግሪና ከዚያ በላይ ☐

የነጥብ መመዘኛ

ፈፅሞ(በፍፁም)=1 እጅግ በጣም ጥቂት, = 2 አልፎ አልፎ(አንዳንድ ጊዜ) = 3 ብዙ ጊዜ= 4 ሁልጊዜ =5

ተ.ቁ	በህጻናት ማሳደጊያ/በመምህራን/ የሚሞላ ላለፉት ስድስት ወራት ህጻናት ስሜታቸውና ባህሪያቸውን በተመለከተ ገላጭ ሆኖ የቀረበ መለኪያ ዝርዝር (በመላሾች የሚሞላ/	የመመዘኛ ነጥብ ውጤት				
		ሁልጊዜ	ብዙጊዜ	አልፎ አልፎ(አንዳንድ ጊዜ)	እጅግ በጣም ጥቂት,	ፈፅሞ(በፍፁም)
	ቀጥሎ የተዘረዘሩትን የህጻኑን/ህጻኗን/ማህበራዊ ግኑኝነቶችንና ዕድገት እንዴት ይገመግሙታል/					
1	ከሌሎች ህጻናት ጋር ተቀራርቦ አብሮ መስራትና መጫወት					
2	ከተለያዩ አይነት ህጻናት ጋር መጫወት መቻል					
3	ትዕዛዞችን፤ ህግና ደንቦችን መከተል /መጠበቅ/					
4	የሌሎችን ንብረት ማክበር/አለመንካት/					
5	የራሱ/ሷ/ ያልሆነውን ንብረት መውሰድ					
6	በግልም ይሁን በቡድን በሚደረጉ ጨዋታዎች ተራን የመጠበቅ ሁኔታ ያለበት/ባት/ ችግር					
7	ችግር ያለባቸውን ህጻናት በስራ ማገዝ					
8	ለአዋቂዎች የሚሰጠው/የምትሰጠው/ ክበሬታ					
9	ለሌሎች ህጻናት የሚሰጠው/የምትሰጠው/ ክበሬታ					
10	አንድን ተግባር ለመፈፀም ኃላፊነትን መውሰድ					
11	ራስን ችሎ መስራት					
12	የትምህርት ቁሳቁስን በአግባቡ መጠበቅ					
13	በጥንቃቄና በንጽህና መስራት					
14	ስለሌሎች ጥንቃቄ ማድረግ					
15	አዲስ ጨዋታ ለመጫወት የሚያሳየው/የምታሳየው/ ጉጉት					
16	በየዕለቱ የሚገጥመውን/የሚገጥማትን/ ችግሮች በራስ ለመፍታት ያለው/ያላት/ብቃት					
17	በድንገት ሌላው ህጻን የጣለውን ዕቃ በፍጥነት በማንሳት ማገዝ					
18	አንድ ህጻን በሌላ ሰው ላይ ስህተት ሰርቶ ሲገኝ ለሌላው ለመከራከር የሚያደርገው/የምታደርገው/ እገዛ ለምሳሌ አንድ ህጻን ከሞግዚትም ይሁን ከመምህሩ ለተሰነዘረ ጥያቄ ትክክለኛ ያልሆን ምላሽ ሲሰጥ/ስትሰጥ/					

19	ከእንግዳ ጋር የቅርብ ጓደኛ መስሌ መቅረብ					
20	በራስ የመተማመን ሁኔታን ማሳየት					
21	ተቀባይነት ያላቸውን ባህሪያት ላይ ያለው/ያላት/ እውቀት					

	ቀጥሎ የተዘረዘሩትን የህጻኑን/ህጻኗን/ማህበራዊ ግኑኝነቶችንና ዕድገት እንዴት ይገመግሙታል/	የመመዘኛ ነጥብ ውጤት				
		ሁልጊዜ	ብዙ ጊዜ	አልፎ አልፎ(አንዳንድ ጊዜ)	እጅግ በጣም ጥቂት,	ፈፅሞ(በፍፁም)
22	ራስን በመግዛት ረገድ የሚያሳየው/የምታሳየው/ መልካም ባህርይ					
23	በወላጅ/በክብካቤ ሰጪው በኩል ሲረሳ/ስትረሳ ተስፋ መቁረጥ					
24	በመደበኛነት ለለውጦች ራስን ለማስተካከል ያለው/ያላት/ችሎታ					
25	በሌሎች ደስተኛ ባልሆኑ ህጻናት ላይ መሳቅ/ማፌዝ/					
26	እንደየዕድሜ ለሚከሰቱ ስሜቶች ተመጣጣኝ ምላሽ የመስጠት ችሎታ					
27	ለሌሎች ሰዎች ስሜት ግልጽ ምላሽ መስጠት					
28	ያለአንዳች አስታዋሽ በክፍል ውስጥ የሚሰጡ የዘወትር ተግባራትን መፈፀም					
29	ስለአለማችን ያለውን ዕውቀት ምላሽበመስጠት ረገድ					
30	ጥል ወይም ግጭት ሲከሰት ለማስቆም ያለው/ያላት/ብቃት/					
31	በጨዋታዎች ተመልካችን መጋበዝ					
32	አዋቂን ወይም ሌሎች ህጻናትን መምታት፤መንከስ ወይም መግጨት					
33	አለመታዘዝ					
34	ግልፍተኝነት፤ ተናዳጅነት፤ ቁጠኛነት					
35	መቸኮል፤ ሳያስብ/ሳታስብ/ ድርጊትን ማከናወን					
36	ደስተኛ አለመምሰል፤ማዘን፤ መጫጫን					
37	ፈሪ ወይም የተሸበረ መምሰል					

38	የተጨነቀ መምሰል					
39	አብዝቶ መጮህ/ማልቀስ/					
40	መደናገጥ፤ በቀላሉ መበሳጨት ወይም መጨነቅ					
41	ራስን ማግለል					
42	አውራ ጣትን ወይም ሌሎች ጣቶችን መጥባት					
43	መቀመጥ አለመፈለግ ወይም መቅበጥበጥ					