

Full Length Research Paper

Risks, protection factors and resilience among orphan and vulnerable Children (OVC) in Ethiopia: Implications for intervention

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Downloaded 27 November, 2013; Accepted 24 February, 2014; Published March 2014.

The purpose of this study was to investigate risk, protective factors and resilience among orphan and vulnerable children (OVC) in Ethiopia. One hundred eighty two orphan and vulnerable children were randomly selected from 14 kebeles through simple random sampling technique. Data were collected by using self report questionnaire. The results show that most orphans and vulnerable children faced family, school and community related risks factors. Sizeable number orphan and vulnerable children faced community related problems including negative discrimination rejection and social isolation, social or cultural. However most of them failed to use protective factors to buffer these risks. Consequently, most were found to be less resilient to these adversities. Since the concepts of resilience and risks are broad, a more detail study shall be conducted for this study tries to assess only the general nature of the constructs.

Key words: risks, protective factors, resilience, orphan and vulnerable children.

INTRODUCTION

In Ethiopia, there has been a strong culture of caring for orphans, the sick, and disabled and other needy members of the society by the nuclear and extended family members, communities and churches. However, in the perception of the community, orphan and vulnerable children are not often considered to have asset to cope up adversity. As a result, no attention has been given to resilience ability of orphan and vulnerable children and thereby resilience or protecting abilities of orphan and vulnerable children has been ignored.

According to Margaret et al. (2001), people are born with resilient attributes. Margaret et al. (2001) added that people acquire resilience abilities that could be improved

through effective training and development. Similarly, Killian (2007) stated that people are naturally endowed with the ability to cope with adversity provided that they get nurturing and supportive environment.

Globally, about 145 million orphan children live in sub-Saharan Africa, Asia, Latin America and the Caribbean. In sub-Saharan Africa, where HIV has hit hardest, 12 of children were orphan (UNICEF cited in YLPB, 2009). Moreover, UNICEF (2012) estimated that about 5.5 million children in Ethiopia were orphan. This constitutes around 15% of the total child population. Of these, 16% lost their parents due to HIV/AIDS (UNICEF, 2012).

Despite serious hardships, many children overcome

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difficulties and grow up to lead productive lives and become resilient through protective factors. Some children have protective capacities that enable them to cope better with the ups and downs of life and become resilient (Killian, 2007).

The sources of resilience can be genetic, biological, psychological, and environmental factors (Margaret et al., 2001). Resilience is not static construct rather changes over time. Therefore, resilience needs to be viewed as positive adaptation over time, not at a single point (Margaret et al., 2001).

MATERIALS AND METHODS

Participants and Sampling

One hundred eighty two orphan and vulnerable children (OVC) participated in the study. Participants were randomly drawn using simple random sampling technique. The rationale to use simple random sampling technique was that it is best suited for such homogeneous and finite population and it gives equal chance for all orphan and vulnerable children to be considered in the study.

Instruments

The Connor-Davidson Resilience Scale was used to measure resilience of participants. The Connor-Davidson Resilience Scale is a 25-item scale that measures the ability to cope with adversity that respondents rate items on a scale from 0 (not true at all) to 4 (true nearly all the time) higher scores reflecting greater resilience (Campbell-Sills and Stein, 2007). In addition, checklists were used to measure risk and protective factors.

Pilot study was conducted so as to check reliability the tools. Some questions were discarded for low inter-item. Finally, the reliability of the risk, protective factor and resilience sub-measures were found to be 0.697, 0.590 and 0.773 respectively. The content validity of the items was also assessed by two Psychologists from Department of Psychology, University of Gondar.

Administration

Initially, orientation was given to assistant data collectors on how to handle and administer the questionnaires. In addition, participants were informed about the anonymity of their responses. Then, the questionnaires were distributed to those participants who can read and write in free rooms. For illiterate respondents, data collectors read the items to them and record their responses.

Analysis

In order to analyze data, different statistical techniques were computed using version 16. Percentages, mean, independent t-test and one way ANOVA were computed to analyze the data. Alpha value of 0.05 was determined for all significant tests.

RESULTS

Of the total 182 participants, 33.7% were orphan (lost both their mother and father). Others were vulnerable

children which consists 12.7%. Among the total 61 orphan participants, slightly above half (55%) participants were cared and supported by their grandparents. Even though small in number, the rest of the participants were cared by their relatives, brother, sister, uncle, aunt. Surprisingly, there were few children who were supporting themselves.

Out of the total 182 OVC respondents, 44.9% of them reported that they have ever experienced failure to promote to next grade level. Here, 48.6% participants witnessed that they had poor attachment with their schools and never obtained recognition for their achievements. Besides, in the social aspects, 39%, 22.5%, 31.8% and 25.8% participants faced negative pressure, social isolation from the society, social or cultural discrimination and rejection respectively. Moreover, 81.3% participants confirmed that they have lived with poor family. Finally, 23.6% participants reported that they had poor physical health.

Regarding protective factors, 69.2% respondents reported that they have social skills to communicate with others. The rest 30.8% did not have such skill. Besides, 65.4% participants reported that they have good attachment with their family or care givers whereas 34.6% did not have this close bond with their family or care givers. Moreover, 46.2% respondents were not successful in their academic performance. About 46.75% did not get care and support from their parents and care givers. Nearly half (46.75%) participants' parents were not employed. Surprisingly, 62.4% participants did not have access to social supports. Finally, 47.5% and 40.9% participants did not have community networks and participation respectively.

Among the total 182 OVC respondents, the mean resilience score was 40.13 with standard deviation of 9.87. The maximum and minimum scores were found to be 15 and 70 which shows a wide range. There was no statistically significant difference in average resilience scores between male and female OVC respondents ($t=0.112$, $p>0.05$). The mean resilience score of male and female participants were found to be 40.05 and 40.21 respectively. This is negligible difference. Besides, the mean resilience score of a respondent whose educational level ranges from grade one to grade four was 38.83 with standard deviation of 9.7. Finally, the mean resilience score of respondent whose educational level ranges from grade five to ten was 42.60 with standard deviation of 9.55. There was no significant difference in the resilience ability among illiterate OVC participants, participants whose educational level is between grade 1 to grade 4 and those whose grade is between grade 5 to grade 10 ($F=2.77$, $df=2$, $p>0.05$).

DISCUSSION

Some OVC in Chilga Wereda did not attend education

Table 1. Proportion of orphan and vulnerable participants.

S/N		Frequency	percent
1	Both parents alive	23	12.7
	Vulnerable Only mother alive	67	37
	Only father alive	30	16.6
2	Orphan Both parents died	61	33.7
	Total	181	100

Table 2. Types of Caregiver for orphans participants who lost both their parents.

S/N	Care givers	Frequency	percent
1	Grand parents	33	55
2	Relative	2	3.27
3	Brother	3	4.5
4	Sister	6	9.8
5	Uncle	5	8.2
6	Aunt	9	14.5
7	Self	3	4.5
	Total	61	100

Table 3. Proportion of respondents who faced risks.

S/N	Items	Yes		No	
		Frequency	percent	Frequency	percent
1	School failure	75	44.9	92	55.1
2	Negative peer group pressure	71	39	111	61
3	Poor attachment to school	86	48.6	91	51.4
4	Social isolation	41	22.5	144	77.5
5	Poverty	148	81.3	34	18.7
6	Social or cultural discrimination	57	31.8	122	68.2
7	Poor physical health	43	23.6	139	76.4
8	Peer rejection	47	25.8	135	74.2
9	Absence of positive parent- child interaction	60	33	122	67
10	Family conflict at home	63	34.6	119	65.4

which is basic right of each child. But, USAID (2008) report clearly states that a child who has access to education has a better chance to recover from the psychosocial impacts of their experiences and disrupted lives. Of the total 61 orphans, most of them (47.5%) were cared and supported by their grandparents. Since grandparents are likely to need supports of others, one may infer the amount and quality support given to orphans. The rest were living with their aunts, sisters, brothers, relatives, uncles. Though few in number, there were also orphan children who were living independently without the support of others. This shows that grandparents take the responsibility or burden to provide care and support to orphans.

When we come to school related risks, nearly half (44.9%) OVC in Chilga Wereda have ever failed to promote to the next grade at least once in their academic life. Besides, more than half (58%) had poor attachment with their schools and never obtained recognition for their achievements. This shows that considerable proportion of OVC in the Wereda were not successful in their academics which likely lead to susceptibility to adversity or bad life condition. Because, according to USAID (2008) report, accessibility to quality primary schooling helps children for better chance in life. In addition, there were some OVC who faced social problems like negative pressure, social isolation from the society, social or cultural discrimination and rejection. Moreover, the

Table 4. Protective factors that have been used by OVC.

S/N	Items	Yes		No	
		Frequency	percent	Frequency	percent
1	Social skills	127	69.2	55	30.8
2	Attachment to family/ caregiver/	119	65.4	63	34.6
3	Successful achievement in school	97	53.3	84	46.2
4	Parent/caregiver care and support	98	53.8	84	46.2
5	Parental job/employment/	97	53.3	85	46.7
6	Access to support services	68	37.6	113	62.4
7	Positive school climate	116	64.3	65	35.7
8	Sense of belongingness	119	65.7	61	33.7
9	Community networking	95	52.5	86	47.5
10	Participation in the community	107	59.1	74	40.9

Table 5. Independent t-test on gender difference in resilience.

Sex	Mean	t	Sig
Male	40.05	0.112	0.119
Female	40.21		

Table 6. Independent t-tests on resilience by age.

Age	Mean	t	Sig
4-12 years	38.8		0.02
13-17 years	42.2	2.3	

Table 7. Descriptive statistics on Resilience by Educational Level.

Educational level	N	Mean	Standard deviation
Illiterate	21	39.7143	10.77
Grade 1 -4	103	38.8350	9.7
Grade 5-10	58	42.6034	9.55

majority (81.3%) of children were conditions. All these show that, most orphans and vulnerable children in Chilga Wereda were suffering family, school and community related factors risks.

Regarding protective factors to buffer risks, more than half (69.2%) had social skills to communicate with others. Similarly, 65.4% had good relationship with their family or care givers whereas 34.6% did not have this close bond with their family or care givers. However, nearly half (46.2%) OVC were not successful in their academic performance. Besides, 46.75% did not get care and support

from their parents and care givers. Moreover, 46.75% OVCs' parents or care givers were not employed. Most OVC (62.4%) did not have access to social supports. Finally, nearly half (47.5%) and 40.9% OVC did not have social networks and participation in the community. This implies that substantial number of OVC in Chilga Wereda did not use protective factors to cope up with risks. This might be due to lose relationship between children and their parents or care givers. In addition, the society may not give equal opportunity to such children. The other possible explanation for failure to employ protective factors may be absence of educational opportunity for some OVC. Because, as to USAID (2008), a child who has access to education has a better chance to recover from the psychosocial impacts of their experiences and disrupted lives.

Coming to resilience, resilience score of OVC ranges from 10 to 17 with the mean score of 40.13. About 62 % OVC scored above half of the total score. But, 38 % OVC participants scored below half on Davidson's resilience measure. Though there is no clear cut point to determine resilience, the higher the score, the higher resilience ability of children. Based on the findings, we may at least infer that some OVC who scores below half were not resilient. This could be due to inability to use protective factors.

When we see resilience across sex and, was no statistically significant difference in resilience between male and female OVC respondents ($t=0.112$, $p>0.05$). The mean resilience score of male and female participants were almost equal (40.05 for males and 40.21 for females). However, there was statistically significant difference in resilience between OVC participants whose age ranges from 4 to 12 years and 13 to 17 years ($t=2.30$, $p<0.05$). The mean resilient score of young OVC (ranges from 4 to 12 years) was 38.8 and the mean resilience score for older OVC (13 to 17 years) was 42.2. This implies that young OVC are less resilient than older ones. Similarly, Luthar (2007) stated that resilience can also change over time based on the child's developmental

Table 8. One way ANOVA on resilience of OVC across educational level.

Source of Variation	Sum of Square	Mean Square	df	F	Sig
Between groups	531.207	265.603	2		
With in groups	17128.359	95.689	179	2.776	.065
Total	17659.566		181		

stage and subsequent experiences. Therefore, this difference could be due to effect development and as age of child increases, he or she become better in physical and mental maturity.

Finally, there was no significant difference in the resilience ability of among OVC with different educational status (illiterate OVC participants, participants whose educational level is between grade 1-4 and those whose grade is between grade 5-10) ($F=2.77$, $df=2$, $p>0.05$). The mean resilient score of illiterate OVC and those whose education ranges from grade 1-4 is almost equal which were found to be 39.7 and 38.8 respectively. But OVC whose level of education is between grade five and ten score slightly higher than others. The difference may be due to the effect of education. Similarly, According to Margaret et al. (2001), stated that people acquire resilience abilities that could be improved through effective training and development.

Implications for intervention

OVC need psychosocial training so as to use protective mechanisms and for positive adaptation. Intervention should strive to reduce modifiable risks to promote protective factors and ultimately to develop resilience.

It is important to increase awareness of parents, care givers and the community about risks facing OVC.

Conflict of Interests

The author(s) have not declared any conflict of interests.

ACKNOWLEDGEMENT

First, we would like to thank Mr. Nega Gidey, OVC Project Coordinator in Chilga Woreda, for his support during data collection. Last but not least, we are indebted to all volunteer OVC workers in Chilga Woreda for their co-operation and assistance in collecting data.

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