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THE IMPLICATIONS OF RESIDENTIAL CARE ON THE PSYCHOLOGICAL WELL-BEING OF ADOLESCENTS IN LUSAKA URBAN.

By

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DECLARATION

I Monica Mwenda-Jalasi declare that this dissertation

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ABSTRACT

Background: Residential Care (RC) is frequently used despite it being the last resort in the continuum of care for children and adolescents and evidence of its detrimental effects on the psychological well-being of children. RC is a type of care arrangement involving a group of more than ten children that is routine, impersonal and care is provided by a paid caregiver. Extreme poverty, family disintegration, parental death, HIV and AIDS, armed conflict, abuse, neglect and natural disasters are some of the main reasons why children end up in RC.

Methods: A cross sectional study using quantitative and qualitative methods was undertaken to investigate the implications of residential care on the psychological well-being of adolescents in Lusaka District. Eighty (80) adolescents were recruited comprising 40 (50%) males and 4IV0 (50%) females aged eleven (11) to sixteen (16) years from RC and Family Care (FC). Three (3) residential care managers were interviewed to collect information on the psychosocial services provided to adolescents. Focus Group Discussions (FDGs) were held with adolescents from RC to collect information on perceptions about their living environment. The Strengths and Difficulty Questionnaire Youth Version (SDQ-Y) self report was used to collect data on the adolescents' psychological well-being.

Results: The t-test revealed significant mean differences in psychological well-being between FC and RC adolescents on the SDQ-Y on Emotional symptoms, Conduct and Peer problems, $p<0.05$. The Two-way ANOVA revealed that the independent variable gender did not have a significant effect on Total Difficulties with $F(1, 79) = 0.71$, $p>0.05$. Both males and females in RC experienced psychological well-being to the same degree. The psychosocial services provided included counseling, talks and games which were incorporated with spiritual instruction. RC care service providers bemoaned the high cost of education and hiring professional staff such as psychologists and social workers to work with adolescents. Adolescents in RC were satisfied with the meeting of their daily basic needs but expressed dissatisfaction with recreation facilities. RC adolescents also expressed mixed feelings about family contact. RC adolescents showed low psychological well-being compared to FC adolescents.

Conclusion: The study suggests that residential care does not provide a nurturing environment for optimal social and emotional development of adolescents. This was attributed to inadequate skills and knowledge by caregivers, financial challenges and inadequate psychosocial programmes. The Government needs to allocate adequate resources to Social Protection to reduce poverty at all levels of development. RC service providers should provide sustainable and effective services for adolescents in care to promote positive psychological well-being.

DEDICATION

I dedicate this work to my family, my three beautiful children Chifuno, Chikondi and Neema, and my wonderful, loving husband and friend, Joseph Jalasi (Jnr) for the encouragement and support. Team Jalasi never gave up on me, thank you!!

I also dedicate this work to all the children living in residential care due to different circumstances, some of whom I have come to know personally and have grown to love!

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Special thanks go to all the management and staff of the residential care facilities and the schools for their support. Lastly, I want to extend a very special thanks to all the wonderful children that participated in the study, for being brave and sharing their experiences. It was really a pleasure to interact with all the beautiful children!

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
FC	Family Care
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
MCDMCH	Ministry of Community Development, Mother and Child Health
MGCD	Ministry of Gender and Child Development
OVC	Orphans and Vulnerable Children
PSS	Psychosocial Support
RC	Residential Care
SDQ-Y	Strengths and Difficulty Questionnaire-Youth Version
UN	United Nations
UNICEF	United Nations Children's Fund

CHAPTER ONE

INTRODUCTION

1.0 Background

Residential care implies an organised, routine and impersonal structure to the living arrangements for children with a professional relationship rather than parental relationship between the adults and children (Browne, 2009). This means that all children follow a daily routine that involves eating, toileting and sleeping at the same time. The caregiver is an adult who is paid to provide care for the children. According to the United Nations Guidelines on Alternative Care (2009), residential care is provided in a non-family based group setting and may include transit centres in emergency situations, places of safety for emergency care and long-term residential care facilities. Evidence suggests that the phenomenon of residential care across the globe has been growing in recent years due to a complex interplay of different factors (Mann, Long, Delap & Connell, 2012).

Globally it is estimated that the number of children in residential care is around eight million but this is just an estimate as there is inadequate monitoring by Governments (Mann et. al, 2012). According to the Zambian Ministry of Gender and Child Development, the number of adolescents in residential care in Zambia is estimated to be around 4, 500 (Child protection system mapping & assessment report, 2012). (It is also estimated that there are approximately 1, 200 Orphans and Vulnerable Children (OVC) and more than half, that is, around 690,000 have been orphaned due to AIDS (Child protection system mapping & assessment report, 2012).

It has been observed that there are various reasons why children and adolescents end up in residential care. AIDS and other diseases, armed conflict, natural disasters, forced

displacement and extreme poverty leave millions of children orphaned, separated, or on the brink of family breakdown (Williamson & Greenberg, 2010). Other reasons why children and adolescents end up in residential care include family disintegration, sexual and physical abuse, neglect and delinquency (Situation Analysis of OVC, 2004). In this situation, governments are obliged under the UN child protection systems to step in and ensure that the rights of children are protected.

It has been documented that residential care has devastating effects on the psychological well-being of children (Browne, 2009). Although research in many parts of the world has demonstrated that residential care can contribute to low psychological well-being of children, it is still a common practice. Adolescence is a transitional stage of human development that occurs between childhood and adulthood (Schaffer & Kipp, 2010). It is during this period that adolescents generally have a difficult time adjusting to the physical changes that their bodies go through and also seek autonomy from their parents resulting in conflict (Berry, Poortinga, Breugelmans, Chasiotis & Sam, 2011).

It has been observed that adolescents who lack a strong family and social network like those in residential care, often need supportive relationships and strategies to navigate their way through life (Bowyer & Wilkinson, 2013). However this is a challenge for adolescents in residential care because of the non-family based setting that residential care provides. Children and adolescents do not usually experience the continuity of care that they need to form a lasting attachment with an adult caregiver because of a high ratio of children to staff as well as high staff turnover (Williamson & Greenburg, 2010).

In order for adolescents to have positive psychological well-being, they need an environment that takes into consideration their individual needs. This however, is a challenge in residential care as the quality of care is compromised by the inadequate knowledge levels of the caregivers. According to Huppert (2009), psychological well-being is the combination of feeling good and functioning effectively and sustainable well-being does not require individuals to feel good all the time. What is critical is being able to manage the experience of painful emotions such as disappointment, failure or grief which is a normal part of life.

Psychological well-being is therefore compromised when negative emotions are extreme or last for a very long time and interfere with a person's ability to function effectively in his or her daily life. In this regard, psychological well-being is an essential component of general health of adolescents because if negative emotions last for a long time, this may cause other health problems such as extreme anxiety and stress. Children raised in residential care often show poor attention, hyperactivity, difficulty with emotion regulation, elevated levels of anxiety, increased rates of attachment disorders and indiscriminate friendliness (Bos, Zeanah, Fox, Drury, McLaughlin, Nelson, 2011).

Studies have also indicated that there are gender differences in psychological well-being among adolescents. Among the general population, gender differences in psychological functioning and health are well documented (Dekker, Ferdinand, Van Lang, Bongers, Ende, Verhulst (2007). During childhood, the prevalence of psychiatric disorders is significantly higher in boys, while in adulthood, women have twice the risk of depression compared to men (Strunk, Lopez & De Rubeis, 2006). In Africa gender plays an important role in the socio-cultural set up of families and communities. Parenting practices, socialization, roles and

expectations differ according to the sex of the child. This makes investigation into gender difference among children in residential care cardinal.

1.1 Statement of the Problem

While in many countries residential care has been found by some researchers to be undesirable and the least option in the continuum of care, it still remains in use (Makuyana & Kangéthe, 2014; Browne, 2009; Carter, 2005; Gearing, MacKenzie, Schwalbe, Brewer & Ibrahim, 2013). In Zambia there is limited research on the effects of residential care on the psychological well-being of adolescents. Most research has focussed on access to basic services such as health, education and nutrition. A study by Banda (2011) was undertaken to show prevalence rates of mental disorders in children that were living on the streets. In Zambia, residential care is provided within the confines of the- law through the Juveniles Act Chapter 53 of the Laws of Zambia. The Ministry of Community Development and Social Welfare (MCDSW) developed the Minimum Standards of Care for Child Care facilities as part of the implementation of the United Nations Convention on the Rights of the Child (UNCRC) provisions.

Minimum Standards of care are a set of guidelines which residential care service providers are supposed to adhere to in the process of implementation of different programmes for children (Ministry of Community Development & Social Welfare, 2014). Specifically, Article 3 (3) states that: "set standards of care for children should exist" (UNCRC, 1989). In addition, the Juveniles Act Chapter 53 of the Laws of Zambia states that "Juveniles' inspectors must ensure that standards of care in children's voluntary homes are observed" (GRZ, 2012). All these interventions are based on ensuring the protection of rights of children in care.

Despite the introduction of the standards, service delivery in residential care is marked by a number of flaws such as unqualified staff, inadequate caregiver/child ratios and inadequate rehabilitation programmes (Child protection system mapping & assessment report, 2012). The report also highlighted poor monitoring, legal loopholes and poor registration of care facilities by authorities charged with this responsibility within the child protection system.

It is important to note that adolescence is a challenging period of development for most children. Coupled with living in residential care, adolescents may face a myriad of problems thereby affecting their psychological well-being. Research assessing psychosocial functioning has revealed that many children and adolescents placed in residential care have mental and behavioural problems, including internalizing problems such as depression and anxiety and externalising problems such as rule breaking and aggression (Gearing, MacKenzie, Schwalbe, Brewer & Rawan, 2013).

While residential care may be beneficial to adolescents who have been abandoned for instance, it is important to note that existing literature suggests that residential care may not be the best option for children in need of care. Poverty, child abuse and neglect, AIDS burden, conflict, family disintegration and incapacitated extended family networks are some of the reasons why adolescents end up in residential care (Browne, 2009). Unless Governments invest in sustainable social protection programmes that address the needs of vulnerable families holistically, residential care of children and adolescents will continue to be used as the first option in the continuum of care.

1.2 Rationale of the Study

There has not been comprehensive research specifically on the impact of residential care on the psychological well-being of adolescents in Zambia as previous studies undertaken have mainly focussed on service provision in areas such as education, nutrition, health care and

psychosocial support. A study by Banda (2011) focussed on a broader component of mental health of street children in residential care. Residential care is the most frequently used among the other models of care even though the Zambian Government Policy regards it as a measure of last resort (National Child Policy, 2006). This is against the background that residential care deprives an adolescent of their natural family environment as well as a sense of identity. Further, there is evidence to suggest that early residential care is typically detrimental to all developmental domains of children (Mann et.al 2012).

This study is important because it focuses on a group that is particularly vulnerable. Adolescence brings with it physical and psychological changes and it is a very critical and important stage in the development of human beings. Most of the physiological, psychological, and social changes within an individual take place during this period of life (Rathi & Rastogi, 2007). During this period, there is more struggle, turmoil and challenges than in childhood (Schafer & Kipp, 2010). Adolescents have long been regarded as a group of people who are searching for themselves to find some form of identity and meaning in their lives (Erikson, 1968). However, living in residential care may pose other challenges due to inadequate consistent care and support from caregivers. It is therefore important that adolescents living in residential care get optimum benefits from tailor made services provided to them by service providers and other stakeholders.

This study is significant because Zambia is a signatory to the United Nations Convention on the Rights of the Child (UNCRC) and ratified the Convention on 6th December, 1991. Therefore as a signatory, the Government of the Republic of Zambia has an obligation to provide a protective environment for vulnerable groups such as adolescents in residential care. This is by ensuring that adequate child protection policies and legislation are developed and enacted respectively. The child protection system is managed by the Government through

various pieces of legislation and policies such as the Juveniles Act Cap 53 of the laws of Zambia, the National Child Policy and the National Social Welfare Policy. The NGOs also provide support to the child protection system through the provision of different services to children and communities.

Finally, it is hoped that this study shall provide the Government and its partners a basis for re-evaluating the role of residential care and its impact on the psychological well-being of adolescents. This is in light of concerns by the Government and its partners on the quality of interventions for adolescents in residential care. It is also endeavoured that the study shall provide knowledge that will stimulate policy direction to the Government as well as service providers of child and adolescent care services.

1.3 Aim of the Study

The aim of this study was to investigate the implications of residential care on the psychological well-being of adolescents.

1.3.1 Specific Objectives

The specific objectives of this study were:

i. To determine if there was a difference in the psychological well-being of adolescents in residential care and adolescents in family care.
ii. To investigate whether there was a relationship between gender, type of care and psychological well-being among adolescents in residential care and family care.
iii. To investigate the type of psychosocial services provided by residential care service providers.
iv. To examine the perceptions that adolescents in residential care have about their environment.

1.3.2 Objectives and Measures

The following were the objectives, measures and how they were achieved.

	OBJECTIVE	HOW IT WAS ACHIEVED	MEASURE
1.	To determine if there was a difference in the psychological well-being of adolescents in residential care and adolescents in family care.	By analysing the scores on the SDQ-Y	SDQ-Y
2.	To investigate whether there was a relationship between gender, type of care and psychological well-being between adolescents in residential care and family care.	By analysing the scores on the SDQ-Y	SDQ-Y
3.	To investigate the type of psychosocial services provided by residential care service providers.	By analysing the data provided by the managers in residential care.	Structured Interview Guide, Work plans. Annual reports
4.	To examine the perceptions that adolescents in residential care have about their environment.	By analysing the feedback from the FGDs with adolescents using thematic analysis.	Focus Group Discussions

1.4 Research Questions

This study addressed the following questions:

i. Is there a difference in psychological well-being of adolescents in residential care and family care?

ii. Is there a relationship between gender, type of care and psychological well-being among adolescents in residential care and family care?

iii. What type of psychosocial services do residential care service providers provide?

iv. What perceptions do adolescents in residential care have about their environment?

1.5 Hypotheses

It was hypothesised that:

i. There is a difference in psychological well-being of adolescents in residential care compared to the adolescents in family care. Adolescents in residential care would show low psychological well-being compared to adolescents in family care.

ii. There are gender differences in psychological well-being between RC and FC adolescents with boys in residential care scoring low psychological well-being.

1.6 Variables

The following were the independent and dependent variables used in the study:

1.6.1 Independent Variables

Gender, age, residential care and family care.

1.6.2 Dependent Variable

Psychological well-being.

1.7 Operational Definitions and Constructs

The following were the definitions of variables that were used in the study.

1.7.1 Adolescent: Any person aged eleven (11) to sixteen (16) years old.

1.7.2 Adoption: is a process whereby a child becomes a permanent, legal member of a family other than their birth family.

1.7.3 Alternative care: Includes formal and informal care of children outside of parental care and includes kinship care, foster care, and supervised independent and residential care.

1.7.4 Continuum of Care: involves an integrated system of care that guides and tracks children over time through a comprehensive range of care services.

1.7.5 Family care: Type of care provided in a family set up e.g. with parents, grandparents, uncles, aunts or any other family members.

1.7.6 Foster Care: is a situation where a child is placed by a competent authority (e.g. Child Welfare) for the purpose of alternative care in the domestic environment of a family other than the children's own family.

1.7.7 Gender: State of being male or female.

1.7.8 Kinship care: is family-based care within a child's extended family system or with close friends of the family known to the child and may be formal or informal in nature.

1.7.9 Residential care: type of care provided in a non-family based environment such as an orphanage where a group of children are looked after by a paid caregiver.

1.7.10 Psychological well-being: the degree to which a person functions effectively in their relationship with others**.**

1.8 Theoretical Framework

The examination of the implications of residential care on adolescents' psychological well-being was based on the ecological model of human development developed by Urie Bronfenbrenner. This is defined as:

> "the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this proves it is affected by relations obtaining within and between these immediate settings, as well as larger social contexts, both formal and informal, in which the settings are embedded" (Bronfenbrenner, 1977, p. 514).

Bronfenbrenner used this theory to explain how the environment has an impact on a developing child. In addition, the ecological theory conceptualized development as a multifaceted experience based on interaction between personal, situational and socio-cultural factors. The model proposes influences on development as a series of layers or ecological environments, namely the microsystem, mesosystem, exosystem, and macrosystem.

He describes the layers as a nested arrangement of concentric structures, a social web, mutually interacting and each contained within the next (Bronfenbrenner, 1979). Each layer has a resulting impact on the next layer, meaning there is constant interaction among the layers. The nested system operates in such a way that a child's behaviours and development are impacted by the behaviour and development of those with whom he or she interacts with in the social web. It is important to note that the interaction is reciprocal because the child's behaviours and development also influence those he or she interacts with. "The child not only influences the variety of settings he or she encounters, such as the home, day care centre, school, or playground, but he or she is simultaneously influenced by these environments" (Bronfenbrenner, 1989: pp 17). This theory is critical for this study because the home or family are a key component when investigating the development issues of a person or child, no matter what age they are.

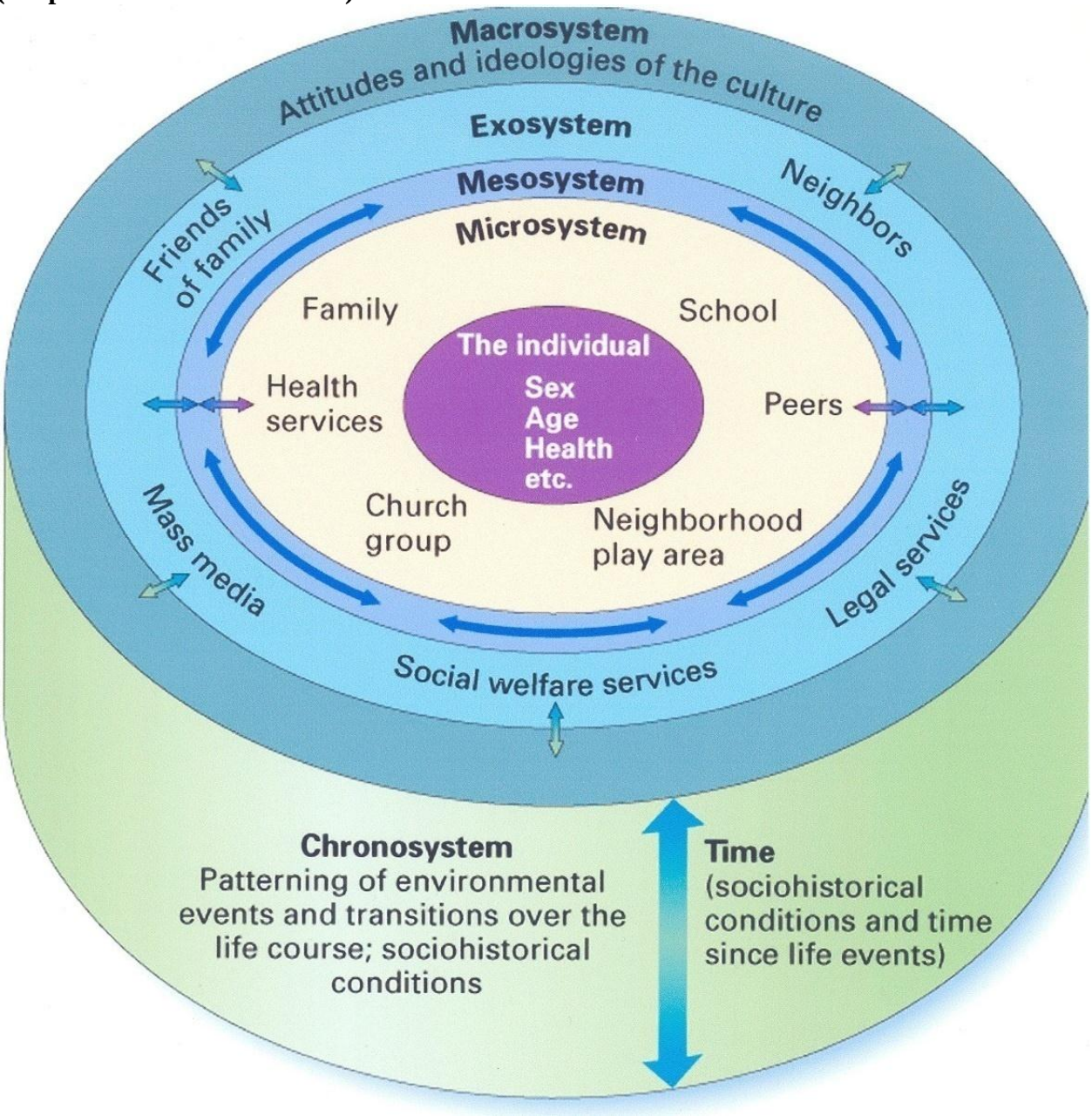
1.8.1 Microsystem

The microsystem is the closest layer to the child. According to Berk (2000), the microsystem includes the structures with which the child maintains direct contacts. The innermost layer represents the individual, who is then surrounded by differing levels of environmental influences (Bronfenbrenner, 1994). It contains the structures with which the child has direct contact such as the family, the school, friends and day care. Bronfenbrenner (1994) added that people in the microsystem influence the child and the child is also influenced by his environment.

Paquette & Ryan (2001) add that the relationships at this level are in two ways-from the child and towards the child and Bronfenbrenner called this bi-directional influence. Berk (2000) adds that in a microsystem, the bi-directional interactions are at their strongest and they have

the most powerful influence on the child. However a lot of influence still comes in from the other layers. Figure 1 illustrates the different layers of the ecological model.

Figure 1: Bronfenbrenner's Ecological Framework of child development (adapted from Santrock 2007)



During adolescence peer groups are an important aspect. A peer group comprises peers who interact regularly, have a sense of membership and formulates norms that specify how members are supposed to look, think and act (Schaffer & Kipp, 2010). The microsystem also entails relational factors that may be associated with psychological well being such as parenting style, family environment, family/household size and composition, social economic status, conflicts and domestic violence, social isolation and interactions among family members. Therefore the adolescent's roles, activities, and interactions on a face-to-face basis within specific settings form his microsystem.

1.8.2 Mesosystem

The second level is called the mesosystem and it affects the child directly. Mesosystems can be thought of as opportunities to build a bridge between two different settings, thereby providing consistency and familiarity in the child's life (Brofenbrenner, 1979). It comprises relations between home, school and neighbourhood and is made up of the more intimate relationships in the family, but also other significant social contacts of everyday life such as members of the extended family, neighbours and so on (Nabuzoka & Empson, 2010).

Thus the mesosystem deals with the interaction between two microsystems such as communication and the dynamics in the family either between parental figures or between parents and children. These factors may not directly lower psychological well-being but it is likely that they would contribute to negative patterns of family functioning that may contribute to heightened stress levels. For instance an adolescent who is in an abusive home may have heightened stress levels and similarly an adolescent in residential care may have high stress levels due to the unpredictability of the future in residential care.

1.8.3 Exosystem

There are some settings that greatly influence the child's socialization even though the child has no direct role in them. Bronfenbrenner referred to this context as the Exosystem. Although the exosystem has an indirect effect on the child, its influence usually impacts the child as it "trickles" down through other people in the child's life (Bronfenbrenner, 1979). Some of the things that may affect a child's life include new legislation and policy, government reform or social unrest. It is worth noting that even though the effect of the exosystem is indirect it can still be quite profound on the life of a child. Bronfenbrenner further states that like the Micro and Meso systems, the Exosystem effect on a child can be short term like a temporary change in work hours for a parent, or long term like the death of an extended family member.

Of particular interest is the fact that residential care systems operate within the Exosystem. Laws governing their operations and regulations also fall in this system. Therefore, a child who cannot live with their immediate family due to family disintegration, violence, death of parents or primary caregiver end up in the child protection system which comprises foster care, adoption or residential care within the exosystem. Examples of the exosystem include mass media, refugee centres, social agencies and Non-Governmental Organisations (NGOs), which together with the Department of Social Welfare play a key role in providing either permanent or temporal care to vulnerable children in difficult circumstances.

1.8.4 Macrosystem

Berk (2000) refers to the macrosystem as the outermost layer for the child and it is important because it refers to the culture, values and beliefs of the larger society within which the child lives. The macrosystem cannot be linked to any specific setting but could be seen as what builds the consistencies across the other systems. This therefore means that because of the

interconnectedness between these nested layers, any change in one layer would have an effect on the other layers. Bronfenbrenner's ecological model therefore offered a bridge between the fields of sociology and psychology by taking into consideration multilevel risks and protective factors right from the individual to societal levels. The practical implication of the ecological approach is that a person's development and behaviours, both normal and abnormal, evolve as a product of mutual and interconnected interactions taking place within a social world (Berk, 2000).

1.8.5 Chronosystem

The fifth layer in the ecological model in the Chronosystem. Bronfenbrenner (1994) included the chronosystem as part of this model to suggest that time was a key factor in a child's development. For instance important life events such as the birth of a sibling or the beginning of school, parent's divorce can modify existing relationships between children and their environments (Addison, 1992). It is suggested that as children get older, they may react differently to environmental changes and may be more able to determine more how that change will influence them. Berk and Levin (2003) state that changes and life events internal to the child such as the natural aging process result in the child modifying their own experiences, which in turn affects their development.

The theory further points out that if the relationships in the immediate microsystem break down, the child will not have the tools to explore other parts of his environment (Addison, 1992). For instance if a child loses his or her parents, they may not have the tools to explore the other parts of the environment if social support networks are not responding to the needs of the child. Addison further points out that children looking for the affirmations that should be present in the child/parent or child/other important adult relationship look for attention in

inappropriate places resulting in anti-social behaviour, lack of self-discipline, and inability to provide self-direction.

The underlying premise of the model is that adolescents do not develop in a vacuum but within the contexts of their families, communities and countries and are influenced by peers, relatives and other adults with whom they come in contact (Rice, 1996; Schaffer & Kipp, 2010). The motivation to use the ecological model emanated from existing research evidence that adolescents are affected by a number of factors before they eventually end up in residential care. These include poverty, divorce, marital conflict, abuse and neglect, death of parents, guardians, or primary caregivers. Other factors that affect adolescents include the school system, peers and the residential care, which operates within the exosystem. For instance, over time parents may divorce, the family constitution may change; the adolescent may change schools and neighbourhoods. This approach led to the search for risk factors in a child's environment, which would predispose a child to poorer outcomes, and protective factors which might buffer them.

What makes Bronfenbrenner's theory more useful is that, it focuses on ongoing interactions of an individual not only during early infancy and childhood, but looks at the individual throughout the life span. The theory also examines how a child develops over time and across different contexts. Bronfenbrenner believed that the way in which a child or adolescent develops is not only influenced by his or immediate environment, but also by things in their surrounding environment such as family, culture orientation and the government (Bee, 1992). The model also describes how an adolescent is in the centre of a number of activities in the home, community and larger part of the cultural system and how all these have an influence on the development of an adolescent.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section provides a review of literature on residential care and its implications on adolescents' psychological well-being. Studies have been cited from both developing and developed countries. Data sources included publications, in-country reports, theses, dissertations, the internet and books.

2.1 The Situation of Orphans and Vulnerable Children in Zambia

The problems that Orphans and Vulnerable Children (OVC) face are varied and depend on the circumstances. Of significance to this study is the fact OVC constitute part of the population of children found in residential care. OVC are a group of special children who are generally at risk of deprivation and prone to develop emotional and behavioural problems even when reared in a well run residential care facility.

According to the Zambia Central Statistics Report's Zambia Demographic and Health Survey (2013), orphaned children may be at greater risk of dropping out of school than children with biological parents. The report further highlights the inability to pay school fees, the need to help with household chores, or the need to care for sick parents or younger siblings as some of the reasons why OVC drop out of school. Another study undertaken in Zambia from five districts revealed that if both parents were dead and the children were not living with grandparents, they were less likely to be attending school (Akwara, Noubary, Ken, Johnson, Yates, Winfrey, Chandan, Mulenga, Kolker, Luo, 2010). The effects of parental loss have a profound effect on children resulting in grief, anxiety, fear, and hopelessness with long-term consequences such as psychosomatic disorders, chronic depression, low self-esteem, learning disabilities, and disturbed social behaviour (Smart, 2003).

Providing care and support for OVC is one of the biggest challenges Zambia faces today as the ever growing numbers overwhelm available resources (Situation Analysis of Women & Children, 2008). According to National Child Policy (GRZ, 2006), an orphan is a child below the age of eighteen who has lost one or both parents. It is worth noting that adolescents fall within this age group and definition. A vulnerable child on the other hand refers to a child below the age of eighteen years who has been or is likely to be in a risky situation where she/he is likely to suffer significant physical, emotional or mental stress that may result in the child's rights not being fulfilled (GRZ, 2006). These risk factors may be found in the home or the community the child is in.

In addition, AIDS, fuelled by high poverty levels, is the primary contributor to OVC incidence in Zambia; accounting for more orphans than all other contributing factors combined (Child Protection System Mapping & Assessment Report, 2012). According to the Situation of Women and Girls Report (2008) the onset of the HIV and AIDS pandemic has resulted in many families being strained by the added care responsibilities. It has been observed that grandparents particularly have stepped in to fill the parenting vacuum and to provide full time care of orphaned or abandoned children (Situation of Women and Girls Report, 2008).

One the outcomes of the AIDS pandemic has been an increased number of children who have been orphaned or whose social and economic vulnerability has increased due to the serious illness of a parent or other adult caregiver of a household. It has been noted that Zambia has the second highest number of Orphans and Vulnerable Children in Africa (National AIDS Council, 2011). The proportion of Zambian children under age 18 with one or both parents dead is 11 % and it has been revealed that orphanhood increases with children's age, from

2% of children under age 2 to 24% of children aged 15-17 (CSO, 2013). Further, the Zambia Demographic and Health Survey (ZDHS) revealed that the Copperbelt has the highest proportion of orphans (15%), while Eastern, Northern, North Western, and Southern have the lowest with 10%.

The number of children in residential care in Zambia is however expected to be much higher as there is no accurate system to track children in residential care by the Ministry of Community Development and Social Welfare (Child Protection System Mapping & Assessment Report, 2012). In Zambia residential care is considered as a measure of last resort in the care of vulnerable and orphaned children because it deprives children of their natural family environment (Situation Analysis of Women and Children, 2008: GRZ, 2006).

Therefore understanding the actual magnitude of the problem and socio-demographic characteristics of OVC can provide a solid foundation for designing appropriate programmes. Due to lack of a comprehensive registration system for birth and death statistics, an accurate estimate of the number of OVC in Zambia is not available.

2.2 Models of Care for Orphans and Vulnerable Children (OVC)

In Zambia the care of vulnerable children is provided through formal and informal arrangements. The UN Convention on the Rights of the Child (UNCRC) recognises that children have the best chance of developing their full potential in a family environment (Jini & Roby, 2011). However, some children may find themselves in alternative care due to poverty, neglect and death of parents or primary care giver. Alternative care is provided where the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child (Child Protection System Mapping & Assessment Report, 2012). The formal arrangements include adoption, both domestic and

international, foster care and residential care. The informal include kinship or family care, where child is cared for by members of the extended family or friends.

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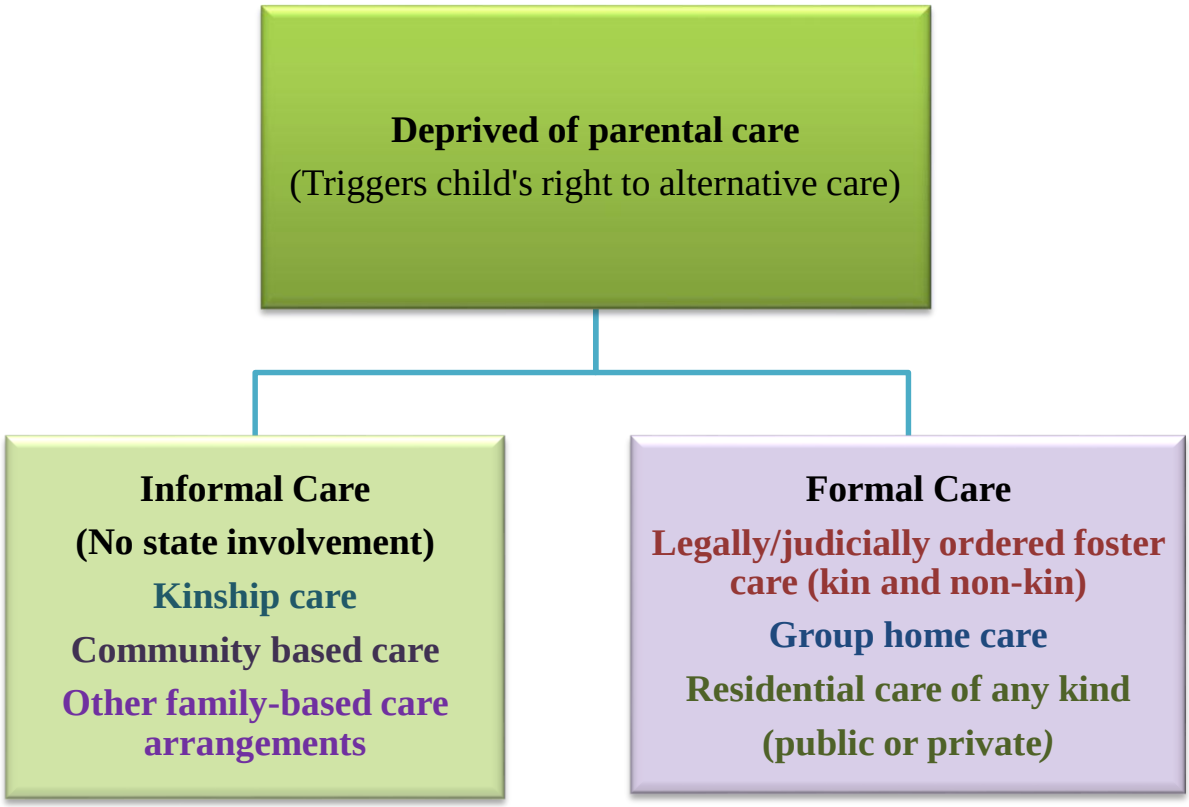
Figure 2: Forms of Alternative Care under the Guidelines for the Alternative Care of Children.



2.2.1 Foster Care

The terms "foster care" and "fostering" are used to refer to a variety of approaches to child care. Foster care arrangements provide safe and supportive homes for children who for various reasons are unable to live with their own families (Situation Analysis of Women and Children, 2008). Foster care in Zambia is in two types, formal and informal. The formal type is where the Department of Social Welfare commits a child into the care of another person other than the child's biological parents due to death or abuse (GRZ, 2004). This authority by the Department is vested in the legal system through the Juveniles Act Chapter

53 of the Laws of Zambia. However, the most widely practiced form is the informal foster care. This is when a child is taken care of by other family members such as uncles, aunts, grandparents or siblings. This is largely due to the cultural practice of the extended family system. Informal foster care is ideal because a child does not lose his or her sense of identity since they are under the care of the larger extended family.

In the United States and Europe, foster care generally describes the State-managed placement of a child with non-relatives who are both supervised and compensated by the State and is generally considered permanent though it may be long-term depending on the situation (Delap, 2011). Formal foster care is basically made use of until a child can be reintegrated with a parent, is adopted or reaches adulthood. In Western Europe and Scandinavia, foster care is long-term, resembling adoption. In situations of displacement or conflict, child protection agencies often arrange foster placements to ensure care for separated children and in such contexts there may be no government capable of overseeing the process (Williamson & Greenberg, 2010).

In some cases, concerned agencies and participating families assume that if tracing for a child's own family is not successful, the placement will become permanent. In others, placements are intended to be only temporary and there may be limited external support. The advantage of well planned and monitored foster placements is that they provide the cultural and developmental advantages to children of living in a family environment pending family reunification or long-term placement (Delap, 2011). From 2004 to 2010, over 1,000 children living on the streets in Zambia were reintegrated into families by the Africa KidSAFE Network in collaboration with the government (Africa KidSAFE Report, 2010).

As with other forms of alternative care, foster placements should be initiated with both the children's immediate and long-term protection and wellbeing in mind (Tolfree, 2004). Recent research in the United Kingdom (Berridge, Biehal, Henry, 2011) shows that children in stable long-term foster placements do as well as adopted children. This then provides a protective future for a child.

2.2.2 Kinship/Family Care

Kinship care is an alternative to institutional care that has good potential for being scaled up through adequate provision for social work services and the tracing and assessment of relatives. When a child's immediate family cannot or will not provide adequate care, the next option to consider is care by either legal or fictive kin. Legal kin are those relatives where there is a legal relationship based on blood ties, marriage or adoption (Williamson & Greenburg, 2010). Fictive kin are chosen "relatives" where there is a close bond that is treated by the child and family as if it were a blood relationship.

Kinship care is common in most societies, including wealthy ones; it is the most significant form of out-of-home care globally for children who are unable to live with their parents (Save the Children, 2007). In traditional societies, there are often clan or tribal systems that exist and these can be strengthened to ensure care for children without primary caregivers. In most situations it has been observed that a social worker was able to identify an extended family member who was willing to provide care when a parent became incapacitated to do so (Save the Children, 2007). There however seems to be a connotation of needing financial help every time a vulnerable child is taken in by a relative.

Generally, there is no direct governmental oversight of such placements especially if the child is in the extended family. These different forms of foster care vary significantly in terms of

what they describe and their respective strengths and weaknesses. In a particular context, it is important to be clear exactly how the term is understood and the safeguards included for children (Williamson & Greenburg, 2010). The most compelling reason to scale up kinship care is that living with immediate or extended family is often the preferred choice for children themselves in the event that parents are unable or unwilling to provide care (Donahue, Hunter, Sussman, Williamson, 1999). Further the report pointed out that in South Africa, Botswana and Zimbabwe, research revealed that the children's expressed preference for care was: immediate family and extended family followed by community members, foster care and care in a child-headed household, another family, irrespective of kinship bonds.

A report indicates that in nine West African countries, the percentage of households that included children not living with their parents ranged from 16 to 32 per cent, with an average of 24 per cent (Greenburg & Williamson, 2010). The report further highlights that the reasons for such placements can include parental illness, death, separation or divorce; mutual assistance or strengthening ties between family units; improved educational options for the child; and others.

2.2.3 Adoption

Adoption is one of the models of care that is used by governments to provide permanent care to vulnerable children. Unlike foster care, adoption is enshrined in the legal frameworks of countries. Adoption is a process whereby a person assumes the parenting for another and in so doing, permanently transfers all the rights and responsibilities, along with Adoption (Child Protection System Mapping & Assessment Report, 2012). In this case a child becomes a permanent, legal member of a family other than their birth family. Most governments have legislation that outlines specific steps that govern this process. Globally, most adoptions are

domestic; that is, the child and adoptive parents share the same nationality. A minority are international and inter-country, where the adoptive parents have a different nationality than the child (Williamson & Greenburg, 2010).

Although comprehensive statistics on domestic adoptions around the world are not readily available, the total number of international child adoptions has been approximately 40,000 per year, about one third the total of domestic adoptions each year within the United States alone (Lehalnd, 2009). In some developing countries, international adoption is more common than domestic adoption but it has been observed that the frequency of domestic adoption is increasing in many countries. In India, for example, local adoption was rare and faced certain cultural constraints. In 1989, India adopted national regulations specifying that at least 25 per cent of adoptions would be domestic, and the number of Indian children adopted has substantially increased (Williamson & Greenburg, 2010).

In Zambia, adoption is facilitated through the Adoption Act Chapter 54 of the Laws of Zambia. In 2006, there were 99 applications for adoption and 69 children were adopted (Child Protection System Mapping & Assessment Report, 2012). At the international level, Zambia has continued to facilitate international adoptions for Zambian children. The report however points out that that adoption is not a common practice. This has been attributed to culture, where the extended family looks after children who have lost their parents. Therefore families do not feel the need to legalise the relationship through the legal system because of the culture of a child belonging to everyone.

2.2.4 Residential Care

This is care provided in any non-family based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long term

residential care facilities including group homes (UN, 2009). By 2006 there were 101 homes providing residential care to 4, 592 children in Zambia (Child Protection System Mapping & Assessment Report, 2012). Residential care is administered through the Juveniles Act Chapter 53 of the Laws of Zambia. The National Child Policy has been drawn to guide and direct appropriate interventions for child survival, development and protection in Zambia. The National Child Policy (2006) clearly states that residential care should be the last option because it deprives a child of his or her natural family environment.

Research has shown that residential care is not only detrimental to a child's health but is also expensive to run. In family-type settings (the child's natural or extended family, foster care or adoption), is immeasurably better than life in even a well organised institution for almost all children (Carter, 2005). In addition the individual one-to-one love and attention that only parents (whether birth, foster or adoptive) can give, is extremely powerful and cannot be compared by institutional care in promoting the development of children. According to Carter (2005), on average, institutional care is twice as expensive as the most costly alternative community residential/small group homes; three to five times as expensive as foster care (depending on whether it is provided professionally or voluntarily); and around eight times more expensive than providing social services-type support to vulnerable families.

It should be pointed out that although residential care is not always the best option for care of children, sometimes it becomes the only option. Institutional care leaves a negative influence on the child's emotional development because it does not provide consistent deep emotional intimacy with at least one adult (Are, 2003). The interaction of different feelings with an adult is important for fostering healthy emotional well being. In order for a child to develop into a happy and healthy adult, the child needs love and a sense of security. However there

are cases when living in the biological family is harmful for the child (Williamson & Greenburg, 2010). In such cases, it is the duty of Government agencies such as the Department of Social Welfare to place a child outside the family environment. It is at this point when alternative care becomes critical for a child.

2.3 Reasons for Placement of Adolescents in Residential Care

The family is regarded as the most central institution of society where through which a child is socialised. The home ideally should be a source of security and stability in the life of children because it is from this basis that children develop their identity, physical, emotional and social well being is developed (United Nations Convention on the Rights of the Child 1989: Art 18). However there are children who find themselves in residential care for various reasons. Some families for instance are not able to provide basic needs for their and fulfil their needs. Such children eventually may then be removed from their parents' care through the child protection system and placed in residential care facilities until the family circumstances have improved. Children housed in residential care do face a number of challenges because they do not have an ever present parent or parental figure. However there are generally many socio-economic reasons why children are placed in residential care.

2.3.1 Economic Transition

It has been observed that residential care is increasing in countries where there is economic transition, because for many families and communities the changes have resulted in increased unemployment, migration for work, family breakdown and single parenthood (Carter, 2005; Tinova, Browne & Pritchard, 2007). In these countries, poverty seems to be the main underlying factor for placing a child in residential care, with single parents and parents with large unplanned families equally challenged by poverty and unable to cope (Sigal, Rossignol & Ouimet, 2003). This situation is further compounded by inadequately funded child welfare services which cannot meet the demands of the vulnerable families and communities. It has

been observed that most children in residential care come from poor families and some are discriminated against, although the link is not always straightforward (Csaky, 2009). In Sri-Lanka a survey involving 1, 836 children living in residential care for example, found that 40% had been placed into care due to poverty (Save the Children, 2006). These families gave up their children to institutions because they could not provide food or afford healthcare.

At national level, Zambia has seen an increase in the number of residential care facilities for adolescents and children. At present there are over 100 residential care facilities. Since the end of the one-party system in 1991 and subsequent introduction of the multi-party democracy, Zambia pursued a programme of liberalisation and private sector development. The closure of state-owned companies and the end of subsidies to agriculture created formal sector unemployment (Situation Analysis of Orphans and Vulnerable Children, 2004). During this political and economic transition, families became vulnerable due to unemployment leading to children and adolescents living on the streets to earn a living. At the same time HIV rates were at their peak coupled with non-availability of anti-retroviral therapy (NAC, 2006). It has been observed that HIV coupled with poverty puts additional stress on a household (Situation Analysis of Children & Women, 2008).

2.3.2 Poverty

Studies focusing on the reasons for residential placements for children and adolescents consistently reflect that poverty is often the driving force. According to the UN (2009), the vast majority of children in residential care globally are not double orphans. Poverty, not lack of caregivers, is often cited as the reason for placing children in residential care (Bilson & Cox, 2007). Poverty and deprivation have negative consequences on a child because this affects their ability to stay with their parents. According to Roelen and Delap (2012), children without parental care are at greater risk of discrimination, inadequate care, abuse and

exploitation. Without parental care children may make poor choices about their well-being and may end up abused, married off at an early age or infected with HIV. They also lack access to services such as education, health care and social support.

Case studies of Sri Lanka, Bulgaria and Moldova, poverty was found to be a major underlying cause of children being received into residential care (Williamson & Greenberg, 2010). The study also pointed out that a large proportion of children in institutional care had at least one living parent, but the parent had significant difficulty providing care or were unwilling or unable to do so (Williamson & Greenberg, 2010). In Sri Lanka, for example, 92% of children in private residential institutions had one or both parents living, and more than 40% were admitted due to poverty (Bilson & Cox, 2006).

In Zimbabwe, where nearly 40% of children in orphanages have a surviving parent and nearly 60% have a contactable relative, poverty was cited as the driving reason for placement (Powell, Chinake, Mudzinge & Mukutiri, 2005). According to a report by UNICEF in 2004 *Children Deprived of Parental Care in Afghanistan*, research implicates the loss of a father (which in many cases leads to exacerbated household poverty) as the reason for more than 30% of residential care placements. In Zambia, HIV and AIDS coupled with disease burden seem to be a leading cause of children being in residential care (Child protection system mapping & assessment report, 2012).

2.3.3 Conflict and HIV and AIDS

AIDS and conflict are fuelling a surge of institutional care in some developing countries particularly in Africa and Asia. In Liberia however, fuelled by conflict, the number of orphanages in Liberia increased from 10 in 1989 to 121 in 1999 and 25 of every 10,000

children are in orphanages (Green & Williamson, 2010). In Zimbabwe, 24 new orphanages were built between 1996 and 2006 (Powell et. al, 2005). In Sri Lanka, the Government counted 223 registered children's institutions in 2002, up from 142 in 1991 (Mariam & Dharshini, 2006).

During the civil war and increasing AIDS mortality in Uganda in 1992, it was found that approximately 2,900 children were living in institutional care and the survey also found that approximately half of these children had both parents living, 20% had one parent alive and another 25% had living relatives (Williamson & Greenburg, 2010). Similarly, a notable increase was observed in Europe. Following the war in Bosnia and Herzegovina in the mid-1990s, the number of residential institutions for children increased by more than 300% (Davis, 2006). Reports of an increase in the number of children in residential care were also reported in Central and Eastern Europe. According to Carter (2005) during the cold war in Central and Eastern Europe and the former Soviet Union, the percentage of children who were in institutions rose by 3%.

2.3.4 Proliferation of Residential Care Facilities

Globally the UN estimates that up to eight million children around the world are living in care institutions (Pinheiro, 2006). The actual figure is likely to be much higher, due to the proliferation of unregistered institutions and inadequate monitoring by authorities. According to Csaky (2009) many countries still continue to use residential care despite the recognition of the harm it causes on child development. Throughout central and eastern Europe and the former Soviet Union for instance, the rate of placement of children in institutions rose by 3% between 1989 and 2002 (Carter, 2005).

Another increase was observed in Sri Lanka, where the number of officially registered children's institutions increased from 142 in 1991 to 500 in 2007 (Save the Children, 2006). Csaky (2009) further adds that some of these increases are due to the persistent use of institutional care within the formal child protection system, while other increases are due to the proliferation of unregulated and unlicensed institutions. It has been observed that in the United States of America and Western Europe, the child protection systems have developed at a faster rate than family-based alternative care therefore when the legal system finds parents abusive, neglectful or due to inability to meet the basic and physical needs of their children, residential care is normally used as opposed to foster care or kinship care.

Further, there has been emphasis of responding to orphans needs through residential care as opposed to family/kinship care. The criterion for assistance is often orphanhood, rather than other factors influencing protection and survival within families and communities (Save the Children, 2009). The potential for an inappropriate response to the orphan crisis was noted in Zimbabwe where a number of organizations were considering building new institutions in the absence of any official and enforced policy relating to orphan care (Williamson & Greenberg, 2010). This has resulted in proliferation of residential care without consideration of its implications on children. According to Save the Children (2009) the absence of guidelines has led to inexperienced organisations providing residential care operating without practice and policy. In Swaziland, 80% of children's homes were established between 2000 and 2004 and most of these are not registered and are externally funded (UNICEF, 2008).

In Zambia the Government in 2001 initiated the Child Care Upgrading Programme (CCUP), in partnership with UNICEF to raise the level of skills of caregivers in residential care. This was due to the proliferation of residential care facilities operating below the standards of care

(UNICEF, 2004). However, it has been noted that monitoring by the authorities in Zambia is still inadequate resulting in flaws in the child protection system (Child protection system mapping & assessment report, 2012).

Further the Minimum Standards of Care seem to focus more on the feeding and nutrition, bed space, facility space, child/caregiver ratio without much emphasis on emotional support to children. The Standards however state that new staff or caregivers must be trained in the following areas:- developmental stages of children, age appropriate activities for children; positive guidance and discipline of children fostering children's attachment; identity & self esteem; helping children overcome separation and loss of their parents; health and safety practices in the care of children; positive interaction with children; supervision of children and prevention of child sexual abuse; detection and reporting of suspected child abuse and neglect; psychosocial counselling on HIV; and Basic facility management (GRZ, 2014). While this information is provided in the standards, it is not known how many child care facilities actually train and orient new staff in these key areas.

The trend around the globe has revealed that poor caregiver-to-child ratio in many residential care facilities affects the way staff respond to children's needs (Csaky, 2009). In addition the different levels of skills and knowledge seem to also affect the caregiver's response to the needs of children. Browne (2009:1) states that "often the staff are inadequately trained and poorly supervised; making basic mistakes such as feeding a child who should be able feed himself on his back in a sleeping position as this leads to poor development." In addition the caregivers see their role as more related to nursing and physical care than psychological care (Nelson, Zeanah, Fox, Marshall, Smyke, Guthery, 2007). This therefore means that while

physical care may be provided, psychological needs are neglected leading to poor emotional development.

2.3.5 Inadequate Social Protection Systems

Social Protection refers to policies and practices that protect and promote livelihoods and welfare of people suffering from critical levels of poverty and deprivation and/or are vulnerable to risks and shocks (Ministry of Community Development & Social Welfare, 2014). Social Protection has become a top agenda for governments because it is recognised as a human right under the Universal Declaration of Human Rights (UDHR). According to the UDHR (1948), Article 25 states that:

> "Everyone has the right to a standard of living adequate for the health and well-being Of himself and of his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Therefore if Social Protection is a right, governments must ensure that they provide adequate social protection programmes to enhance the living standards of citizens. In addition, if these programmes do not meet the expectations of citizens, then it is considered a violation of human rights.

Social Protection according to the World Bank (2012) is a collection of measures to improve or protect human capital, ranging from labour marketing interventions and publicly mandated unemployment or old-age insurance to targeted income support. Further, the World Bank states that Social Protection interventions assist individual, households and communities better manage the risks that leave people vulnerable.

An investigation in Europe however, found an association reported between low community health and social services spending and high numbers of abandoned and institutionalised children. Furthermore, inadequate health and social services for parents (e.g. mental health and alcohol/drug addiction services) also means that children are likely to remain in residential care for longer periods of time (Browne et al., 2005b; 2006). However, the relationship between child poverty and institutional care is not very clear due to the fact that there are significant numbers of children who live in residential care facilities in economically developed countries. It has been observed that the need for comprehensive social protection has attracted greater levels of attention, particularly in developing countries (Situation Analysis of Women and Children, 2008). Although Social Protection may be implemented, it has to be child sensitive because most of the time, adolescents still remain poor and vulnerable even in households receiving support from empowerment programmes.

While social protection programmes target specific groups such as disabled persons, older persons, retirees and vulnerable children, the need is great and there are still vulnerable communities who are not reached due to limited coverage. According to Save the Children report *A Last Resort 2009*, social protection systems to support families facing vulnerable situations are failing resulting in many children growing up outside the family. This demonstrates that if social protection programmes are adequate and have good coverage, the number of children growing up outside the family can be significantly reduced. According to UNICEF (2008), a study of care services in southern Africa concluded that Social Protection schemes can reduce the need for alternative care and assist relatives to care for children where birth parents are unable to do so. Another challenge is that government ministries and departments responsible for child welfare are often underfunded and understaffed (Williamson & Greenberg, 2010). Social protection policies are an essential

element of realizing children's rights, ensuring their well-being, breaking the vicious cycle of poverty and vulnerability, and helping all children realize their full potential (International Labour Office, 2014/15). Despite the importance of these programmes coverage is particularly limited especially in low and middle income countries with large child populations (ILO, 2014/15).

In Zambia, the Social Protection Policy was developed in 2014 to coordinate the provision of social protection services in the country. In 2015, the Government through the Ministry of Finance and National Planning allocated a total of K1.3 billion towards Social Protection, with K805m towards the Public Service Pension Fund, K180.6m towards Social Cash Transfer and K50m allocated towards Food Security Pack (MOF, 2015). Although allocation for Social Protection allocation increased in the 2015 budget compared to 2014, high poverty levels remain a challenge (Policy Monitoring & Research Centre, 2015). Other Social Protection programmes that the Government is running in conjunction with donors and partners include the Social Cash Transfers and Public Welfare Assistance Scheme (PWAS). PWAS targets the poorest 2% of the population (UNICEF, 2008).

Social Protection programmes are very cardinal if poverty levels are to be reduced in any given society. This is because poverty has been cited as one of the reasons why children end up in residential care. Further poverty and deprivation are closely linked with exploitation of children. Social Protection can help reduce exploitation, neglect and abuse in the home and must therefore it must be a priority for policy makers (HelpAge & REPSSI, 2011).

2.3.6 Gender, Family background and Individual Characteristics

In some countries gender may have an influence with regards to residential care. Female children are more often abandoned into institutional care and international adoption. For

example, in 2007 the India Human Rights Commission reported that 90% of the 11 million abandoned or orphaned children in India were girls (Csaky, 2009). Although there is limited gender disaggregated data on the number of girls entering care, there is sufficient information to suggest that girls are more vulnerable than boys (MGCD, 2012). The CSO (2013) for instance suggests that female headed households are, for example, typically poorer than male-headed households. This means that if female children are present in this type of household they are likely to be married off or may end up in care.

An adolescent's characteristics such as disability may also increase the chances of residential care because of discrimination and negative social attitudes towards adolescents with physical and/or mental disabilities, children from ethnic minorities, illegitimate children and children from single mothers or broken families, all of whom are over-represented in residential care (Browne, 2009). Further, abuse and neglect also contribute to residential care of children compounded with other factors. According to the Central Statistical Office (2013) foster children and orphans are vulnerable because they may be at increased risk of neglect or exploitation when their mothers, fathers, or both are not present to assist them. The consequences of this usually results in institutionalisation. This means that an orphaned child is likely to be placed in residential care.

A study by Morantz, Cole, Ayaya, Ayuku & Braitstein, (2013) in Kenya on 462 children revealed that reasons for admission in to residential care included destitution (36%), abandonment (22%), neglect (21%), physical/sexual abuse (8%) and lack of caregiver (8%). In this sample, the most common reason for non orphans to be admitted was maltreatment at 90%, whereas for orphans, it was destitution at 49%.

2.4 Meaning of Psychological Well-Being

Psychological well-being is one of the most central ideas in counselling as it plays a cardinal role in theories of personality and development. It provides a baseline from which to assess psychopathology; it serves as a guide for clinical work by helping the counsellor determine the direction clients might move to alleviate distress and find fulfilment, purpose, and meaning; and it informs goals and objectives for counselling-related interventions (Christopher, 1999).

Psychological well-being is one of the most widely used constructs among psychologists and mental health professionals. However, there is still no consensus regarding the operational definition of this construct (Khan & Juster, 2002). Yet, many theories of well-being have been proposed and an extensive body of empirical research using different indices of this construct has been conducted. However, theorists have found that the concept of psychological wellbeing is much more complex and controversial because it serves as an umbrella term for many constructs that assess psychological functioning (Girum, 2012).

Ryff (1989) defined well-being as the optimal psychological functioning and experience. According to Shek (1992) psychological well-being is a state of a mentally healthy person who possesses a number of positive mental health qualities such as active adjustment to the environment and unity of personality. Dzuka and Dalbert (2000) defined psychological well-being as the overall satisfaction and happiness or the subjective report of one's mental state of being healthy, satisfied or prosperous and broadly to reflect quality of life and mood states. Therefore psychological well being has to do with a healthy mind which is defined by how a person behaves and interacts with others.

According to Huppert (2009) psychological well-being is about lives going well, feeling good and functioning effectively. Psychological well-being becomes compromised when negative emotions last very long and interfere with a person's ability to function effectively in their daily life. Managing negative or painful emotions is essential for long-term mental well-being. Ryff (1989) developed an alternative approach to well-being that she refers to as psychological well-being and this stemmed from synthesizing ideas from the personality theories of Malsow, Jung, Rogers, Allport, Erikson, Buhler, Neurgartens, and Jahoda. She constructed a measure of well-being around six subscales namely Autonomy, Environmental Mastery, Positive Relations with Others, Purpose in life, Personal Growth, and Self-Acceptance. According to Rathi & Rastogi (2007), adolescents who exhibit strength in each and every subscale will be in a state of good psychological well-being, while adolescents who struggle in these areas will be in a state of low psychological well-being.

Ryff (1989) further defines self acceptance as people having the ability to self actualise, to be optimal in their functioning, have a positive attitude towards themselves as well as their past. On the other hand Ryff defines positive relations with others as people having both warm and trusting relations and being able to identify with others as well as having the ability to be intimate with others. Ryff (1989) further defined autonomy as the ability to be intimate with others as well as learn from them. It is about people being independent and being able to regulate their behaviour within themselves.

According to Ryff (1989) environmental mastery is people's ability to choose and envision environments that suit them as a person. It also involves the ability to be flexible in different environmental settings. Another subscale that Ryff added to the definition of psychological well-being is purpose in life. It is essentially people's ability to have some sense of direction

in their lives and meaning. Finally, Ryff (1989) defines personal growth as people's ability to continue to develop their potential, and to grow as a person. The outlined domains are considered key components that makeup the definition of psychological well-being.

2.5 Psychological Well-Being and Adolescence

Adolescence is a very critical and important stage in the development of human being. Most of the physiological, psychological, and social changes within the person take place during this period of life (Rathi & Rastogi, 2007). Adolescents are continuously changing mentally, psychologically and physically, learning about the 'real world' and striving for autonomy from their parents and inclusion in social groups (Santrok, 2004). There are factors that affect adolescent's level of psychological well-being. These include quality of relationships within families; stress and parental involvement may lead to higher or lower psychological well-being. Adolescents who possess low psychological well-being or psychological distress may also exhibit characteristics of low levels of distress (Cripps & Zyromski, 2009).

An adolescent's level of psychological well-being is affected by a number of factors. Several studies have shown that the quality of relationship within families, especially with parents is a major determining factor of psychological well-being in adolescents (Shek, 1997; Sastre & Ferriere, 2000; Van Wel, Linssen & Abma 2000). In most circumstances adolescents in residential care have limited quality relationships with their parents. This is as a result of death of parents or primary caregivers, divorce and prolonged separation from primary caregivers. Another key factor that may contribute to a higher or lower level of psychological well-being in adolescents is stress (Siddique & D'Arcy, 1984), physical health (Mechanic & Hansell, 1987) and both popularity and intimacy in peer relationships (Townsend, McCracken & Wilton, 1988). Family interactions are particularly important for adolescents but being in residential care does not afford this opportunity.

Shek's (1997) study found that the rating of family functioning was significantly related to measures of well being, school adjustment and problem behaviour. His findings suggest an intimate link between family functioning and the psychosocial adjustment particularly of positive mental health of Chinese adolescents. The study by Siddique & D'Arcy (1984) conducted on Canadian adolescents revealed that stress may contribute to the psychological well being of adolescents. In this study it was found that stress in school, family and peer situations were all related to psychological well-being. This study is significant because it pointed out that stress in family had by far the most negative impact on an adolescent's psychological well-being (Siddique & D'Arcy, 1984). This therefore demonstrates that the family is a key component in the psychological well-being of adolescents.

The study by Mechanic and Hansell (1987) revealed that there was a correlation between both higher ratings of physical health and higher levels of psychological well-being. Therefore this shows that high psychological well-being is associated with good health. The study by Townsend et. al (1988), found that popularity and intimacy with respect to adolescent friendships had an impact on adolescent's psychological well-being. It was revealed that intimacy factor was more predictive. These studies demonstrate that psychological well being is a complex factor as there are a wide range of factors that may have an impact on it.

2.6 Psychological Well-Being of Children and Adolescents in Residential Care

A review of the literature reveals considerable evidence that mental disorders are significantly more common in residential care populations than in the general population (Richardson & Lelliott, 2003). Studies undertaken so far point to the fact that residential care has detrimental effects on children. In terms of knowledge about the implications of child development in residential care settings, René Spitz (1945) was one of the first clinical theorists to describe the emotional development of infants in the first year of life and the

emergence of what he called *anaclitic depression* in infants separated from their primary caregivers due to hospitalisation (Richter & Norman, 2010). He identified a high level of mortality of infants in institutional care, despite the availability of food, comfort and medicine. This was because the infants were isolated and did not receive stimulation and close contact with nursing staff. According to Thompson (2009), Spitz found that the high mortality was due to the absence of mothering and environmental stimulation, leading to susceptibility to disease, physical wasting and emotional withdrawal.

Further, Bowlby (1952) asserts that the formation of an ongoing, warm relationship was as crucial to a child's survival and healthy development as the provision of food, child care, stimulation and guidance. The innate ability to develop these attachments is universal in children, but the patterns of attachment depend on the relationship that each child develops with caregivers over time. Bowlby's work on the effects of institutional care on children in the 1940s led to his commissioning by the World Health Organization in 1951 to author *Maternal Care and Mental Health* on the mental health of homeless children in Europe after the Second World War (Williamson & Greenburg, 2010). This report was influential and changed policy with regards institutionalisation of children in Europe and the United States. In addition Mary Ainsworth's work on the significance of maternal sensitivity for children's well being also added to the body of research with regard to her work in Uganda and Baltimore in the United States.

Children who experience early deprivation and neglect have a significantly increased risk of a range of emotional and behavioural problems (Browne, 2009). This therefore means that children who are placed in residential care in the early years are likely to suffer from emotional and behavioural problems in future. This was emphasised by Cassidy and Shaver

(2008) who state that early interactions are very critical for later development. This is because the early interactions determine how a child's behaviour shall be shaped in future. Residential care of children is a critical way in which to understand the impact of neglect and child development (Bos et. al, 2011).

There have been several studies on the impact of residential care on the psychological well-being of adolescents. Padmaja, Sushma and Argawal (2014) undertook a study in India on psychosocial problems and well-being in 116 institutionalised and non-institutionalised children aged 12 to 15 years using the Strengths and Difficulty Questionnaire. The aim of the study was to determine the role of institutionalisation on psychosocial problems and to determine the role of type of care and gender on internalizing and externalizing problems and well being in children. According to Padmaja et.al (2014), the study found that the adolescents under institutional care had higher levels of externalising problems than those under home based care. The study also revealed that there was no significant interaction on type of care (institutional or home based) and gender with $F(1,112) = 2.562$, $p > 0.05$.

Detrimental effects of residential care were documented in a study by Banda (2011) in Zambia. The aim of the study was to explore the mental health problems/disorders of street children in residential care and to examine the service response to their mental health needs. The involved 74 children in residential care aged between 7 to 17 years revealed that the most frequent mental health problems/disorders were behavioural and emotional problems. The findings from the self rated SDQ indicated that on average, 17 children (27.0 %) scored in the 'abnormal range' with regards to the total difficulties score, 30 (47.6 %) scored in the emotional problems category, 10 (15.8%) scored in the conduct problems category, 29 (46.0 %) scored in the peer 27 problems category and 2 (3.2 %) scored in the pro-social problems

category (Banda, 2011). The findings concluded that children living in residential care have higher levels of mental health problems than those living with their families.

In Bangladesh a study was undertaken by Rahman, W, Mullick, Pathan, Chowdhury, Shahidullah, Ahmed, Roy, Mazumder & Rahman, F., in 2012 on 342 children aged 6 to 18 years. The objective of the study was to find out the prevalence of the behavioural and emotional disorders among children in residential care and to assess the possible factors associated with the presence of disorder in this population. The Development and Well-Being Assessment (DAWBA) was used for the assessment of psychopathology. The findings of the study revealed that overall prevalence of behavioural and emotional disorders were 40.35%, in which behavioural disorder was 26.9%. Emotional disorder was at 10.2% and both emotional and behavioural disorders were 3.2% (Rahman et. al, 2012). Other factors associated with behavioural and emotional disorders included higher length of stay in residential care and low level of education of foster mother. These factors were associated with psychiatric morbidity of the respondents.

It is important to understand a child's background as they are admitted in residential care. This is because there may be factors that may make residential care even worse for a child with a traumatic background. Chipping (2012) undertook a study in the United Kingdom to explore how children that had been taken into residential care were affected socially and emotionally. She pointed out that consideration should be made that abuse and neglect prior to being taken into residential care will have an effect on a child's emotional and social stability. The study revealed that living in residential care could further damage a child's emotional well-being.

Further this seemed to be dependent on a child's age at the time of admission as well as their personal resilience (Chipping, 2012). Therefore resilience has a large part to play in how each child copes in different situations. This is also supported by Gearing et.al (2013) who states that maltreated children face simultaneous traumas, including not only the experience of the abuse but also ruptured ties to their families and communities leading to heightened levels of emotional and behavioural disorders. It has been observed that any amount of orphanage experience is harmful for a child; the damage is greatest during the first year of life and increases dramatically with the length of stay in an institution (Mushtaq, Margoob, Rather, Khan., Singh, & Malik, 2006).

Another key observation made by Goodwin (1994) is that individuals who were institutionalised at early age are at risk of living in poverty, developing psychiatric disorders, difficulties with interpersonal relationships and have serious difficulties parenting their children. This statement is also supported by a joint report of 2004 by the United Nations, *Children on the Brink,* which pointed out that:

> "Long-term institutional care was particularly inappropriate for infants and young children because the healthy emotional, cognitive, and even physical development of children in this age group requires that they have at least one consistent and loving caregiver with whom they can form a bond." (UN, 2004. p.15)

Therefore early institutionalisation and duration of stay are key factors to consider in terms of residential care of children.

A study by Gearing et. al (2013) was undertaken in Jordan. The aim was to establish the prevalence rates of mental health and behavioural problems among 70 adolescents aged 11 to

18 years in residential care. The Child Behavioural Checklist was used to collect data on the adolescents. The results of the study revealed that 53% of the adolescents were identified as experiencing mental health problems, and 43% and 46% had high internalising and externalising scores respectively. Gender was found to be a significant predictor in most models used by researchers with males scoring worse, with males scoring high on externalising disorders such as aggression and rule breaking (Gearing et. al, 2013). Notable in Gearing's study however was that unlike previous studies, he found that males scored higher on both externalising and internalising behaviours. The results revealed that in the regression models for pathways into care, number of transfers and length of stay were found to be significant predicators of mental health functioning (Gearing et. al, 2013). In contrast, findings by Padmaja et.al (2014) found that in a sample of residential care adolescents aged 12 to 15 years, girls had higher externalising problems than boys.

Although most researchers have found higher levels of emotional and behavioural problems in adolescents in residential care, Whetten, K., Ostermann,. Whetten, P, & Donnell (2009), found a different scenario. The study found that due to a huge orphan burden in five countries selected for the study, the orphans in residential care scored higher on intellectual functioning and had fewer social and emotional difficulties compared to family care orphans. According to Whetten et. al. (2009) the differences were more pronounced when comparing those institution based children with only community based children not cared for by their biological parents. This study therefore did not support the hypothesis that institutional care is systematically associated with poor well being.

2.7 Psychosocial Support in Residential Care

Children and adolescents in residential care require age appropriate, gender and culturally sensitive interventions to enable them cope with the challenges of losing parents and being

separated from their siblings and family. In this vein Psychosocial Support (PSS) is essential in ensuring that children and adolescents maintain high psychological well-being. Psychosocial support is about helping children, families and communities to improve their psychosocial well-being by encouraging better connections between people, and building a better sense of self and community (Morgan, 2012). According to Richter, Foster & Sherr (2006), there is global consensus that the best psychosocial care and support for children orphaned and made vulnerable by HIV and AIDS is provided through everyday interpersonal interactions that occur in caring relationships in homes, schools, and communities. This therefore means that caring relationships have to be established in order for children to experience love and care and to enable them cope through difficult times.

PSS services therefore may range from providing specialised services like counselling and therapy, to providing basic services like food, shelter, health and education and also speaking with kindness, and listening with care to what children and their caregivers have to say (Morgan, 2012). However of significance is the fact that when PSS is provided, it means that children and communities are treated with dignity, respect, and are acknowledged as agents of their own decisions and future. Further Richter et.al (2006) add that such services and interventions enable children to form a sense of self-worth and belonging and are key to learning, developing life skills, participating in society, and also importantly having faith in the future.

The overall function of PSS interventions is to address the needs and rights of children and youth in a holistic manner by incorporating psychological and social aspects of support within the other service delivery and developmental contexts such as education. PSS interventions help children and adolescents live and cope with life and its stressors and helps

build resilience. According to the United Nations Convention on the Rights of the Child (UNCRC), meeting the psychosocial needs of children is not only a privilege but also a right of the child. The fundamental principle is "in the best interests of the child." This principle is based on the understanding that children's vulnerability requires special support in order to enable them enjoy human dignity. Therefore it is not enough to provide basic needs alone but emotional and social needs of children have to be taken into consideration and should have prominence.

A review of literature indicates that providing PSS services is a challenge in residential care. According to Williamson and Greenburg (2010), a study by UNICEF in 2007 in Sri Lanka found that out of 488 voluntary residential homes, only 2% were compliant with standards relating to the individual care of children. This means that if these residential homes were not compliant with minimum standards, of which PSS is a component, it is questionable if any PSS programmes were provided. Further, another assessment in Liberia in 2008 found out of 114 orphanages, only 28 met the minimum standards of care (Ryan, 2009). It is important to note that while Minimum Standards of Care have been developed in Zambia, service delivery has remained poor (MGCD, 2012). Among the challenges that residential care facilities face in delivering quality services to vulnerable children include inadequate funding, lack of trained caregivers, mismatch between child and staff ratios and inadequate knowledge about the well being of children (Csaky, 2009). These two factors make it difficult for residential care facilities to provide quality care to children and adolescents.

It has been observed that in general, PSS services in residential care are almost non-existent and are somewhat veiled in general services. Orphanages are too frequently promoted as offering more, in a material sense, than some families are able to provide, without

recognizing the vital role that emotional and social relationships play in a child's development (Faith to Action Initiative, 2014). A study by Thembela (2007) in South Africa on the evaluation of a PSS intervention found positive outcomes in both caregivers and vulnerable children in a community hit by HIV and AIDS, violence and poverty. The key finding of this study showed that after training in PSS, caregivers were better able to understand the needs of the children and therefore they responded appropriately to their needs. This demonstrates that once caregivers are equipped with knowledge and skills, children and adolescents can have better outcomes.

Another study by Selvi (2014) on fifteen (15) adolescents in Thiruvallar District of India sought to explore the problems of adolescents in residential care. Apart from being dissatisfied with physical aspects of care, the adolescents cited lack of emotional support from caregivers and family. The study revealed that although PSS was a key component in the development of children, residential care facilities seemed to focus more on the provision of basic needs and other physical aspects. Rutter et.al (2007) argues that lack of positive adult interaction from consistent carers can limit children's ability to develop personal confidence and key social skills, including those necessary for positive parenting. While meeting basic needs is cardinal, neglecting emotional and social needs poses serious long term negative consequences for adolescents.

2.8 Adolescents and Perceptions of Residential Care.

Living in residential care is a challenge for many adolescents because care arrangements in care differ significantly with family care. Thus adolescents undergo a major shift in care when they move to residential care from a family set up. In addition, residential care accommodates children and adolescents from diverse backgrounds and cultures, therefore it

is not easy for any child or adolescent to fit in and conform to the rules and regulations of residential care.

According to Kang'ethe and Makuyana (2014), orphans and vulnerable children in institutions do not receive adequate personal care, attention, affection and stimulation. Studies on what adolescents perceive about their environment in residential care have revealed mixed findings. In Ethiopia for instance, a study undertaken on 60 adolescents by Tadesse, Dereje and Belay (2014) revealed that most of the adolescents reported that they led a better life than before because they received basic needs such as food, clothing, shelter, medical care and education. This demonstrates that these particular adolescents did not have access to basic needs before they entered residential care. However, what is questionable is the quality of services provided to them.

A study undertaken in Zimbabwe however, found contrasting findings. Powel, Chinake, Mudzinge & Mukutiri (2005) undertook a study in Zimbabwe on 189 adolescents in residential care whose objective was to determine their response to residential care and their psychosocial well-being. A key finding of the study indicated that most of the adolescents felt abandoned by their extended families (Powel et.al, 2005). This was because they had no contact with extended family members. This finding is consistent with a study by Cluver and Gardner (2007) in South Africa who explored the perceptions of orphaned children, their caregivers, and care professionals about factors contributing to well-being in orphaned children. According to Cluver and Gardner (2007) the children in care reported missing family, felt separated and sent far away. The researchers therefore concluded that immediate and extended family contact was perceived as protective.

Further on family contact, a contrasting finding was found by Berrige, Biehal and Henry (2010) in the United Kingdom on a study of young people in residential care. The purpose of the study was to provide an insight into the characteristics and circumstances of the young people who lived in them. The study indicated that although the majority of children had regular contact with parents, residential care staff rated this contact as "mainly positive" in 38% of the cases out of the 70% of children (Berrige et. al, 2010). This was because it elicited mixed feelings on half of the young people who saw their parents. This may be linked to the circumstances under which the young people they left their homes and also the kind of relationships they had with their parents and guardians.

According to the UN (1989), the Convention on the Rights of the Child in Article 31 states that "a child shall have full opportunity for play and recreation." This right is also enshrined in the Zambia Minimum Standards of Care for Child Care Facilities to ensure that service providers provide adequate and age appropriate recreation facilities for children under their care. Despite recreation being a right, residential care facilities have continued to provide inadequate and poor services to children (Zambia Ministry of Gender & Child Development, 2012). Tadesse et. al (2014) in Ethiopia found inadequate recreation and entertainment services for adolescents in two centres. Recreation is an essential component in child development and it promotes physical and mental well-being. The researchers found that children spent their spare time wandering within the care facility with no visible engagement in activities and the children pointed out that they wished to play guitar, piano, football and singing (Tadesse et. al, 2014).

A similar finding was found by Mushtaq, Margoob, Rather, Khan, Singh & Malik, (2006) in Kashmir among adolescents in residential care. The purpose of the study was to explore the

nurture, nature and needs of the children. The study found that loneliness was associated with poor recreational facilities. The children in this particular study were not engaged in any form of activities hence contributing to high levels of loneliness thus leading to poor mental health.

2.9 Summary of Literature Review

It is without doubt that residential care of children is detrimental to child health and development. This is evidenced by studies by Gearing (2013), Banda (2011) and Bos et. al (2011). Living in residential care and being an orphan further puts a child at risk of more psychological problems, unless interventions within the care system are provided. Sometimes children may then be removed from their parents' care and be placed in residential care facilities until the family circumstances have improved through the child protection system.

Among the reasons why children and adolescents find themselves in residential care include poverty and economic transition, conflict, disease burden such as AIDS, family disintegration, abuse and neglect. The child protection system favours other models of care for children and adolescents such as adoption and foster care. It is argued that residential care should be the last option in the continuum of care. Although other models of care such as foster care and adoption seem to favour the psychological well-being of children, residential care is still widely used in many countries especially in emergency situations.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section focuses on the methodology that the researcher used in the study and includes the research design, the study participants, sample size, procedures of data collection, data collection tools, pilot study, ethical considerations and finally the data analysis.

3.1 Study Design

The study used a cross sectional study employing both quantitative and qualitative methods. Cross-sectional research involves using different groups of people who differ in the variable of interest but share other characteristics, such as socioeconomic status, age, educational background, and ethnicity (Hennick, 2014). In this study the two groups were children from different settings, that is residential care and family care.

Quantitative methods involve either identifying the characteristics of an observed phenomenon or exploring possible correlations among two or more phenomena (Leedy & Omrod, 2005). It employs measurable data to formulate facts and uncover patterns in research. On the other hand, Qualitative research is concerned about the world we live in and how things are the way they are. Qualitative data studies behaviour in natural settings and uses people's accounts as data and, there is no manipulation of variables **(**Hancock, Ockleford & Windridge, 2007).

3.2 Study Participants

The participants in this study were adolescents from residential care facilities and family care in Lusaka District in the age range of 11 to 16 years. A matched sample consisting of school

going adolescents in family care was part of the study population and was used to show comparison.

3.3 Study Setting

The study was undertaken in selected residential care facilities providing services to adolescents in Lusaka District. Based on the Information Directory of Service providers, the care facilities were recommended by the Department of Social Welfare in the Ministry of Community Development and Social Welfare to have adolescents within the age range and gender specified for the study. Lusaka was an ideal location because of the high number of residential care facilities with fifty-eight (58) followed by Copperbelt and Southern Provinces (Child Protection System Mapping & Assessment Report, 2012).

The school sample consisted of adolescents from two Government schools, a primary and a secondary school. The two schools were selected following recommendation from the office of the Lusaka District Education Board Secretary (DEBS), under the Ministry of Education. The two schools were also within the proximity of the residential care facilities and matched the characteristics of the sample required for this study such as age and gender. In addition, the schools were also easily accessible by the researcher.

3.4 Sample Size

The sample comprised a total of eighty-three (83) participants. The sample was broken down as follows; Forty (40) adolescents in residential care, with 20 males and 20 females and forty (40) school going adolescents in family care with 20 males and 20 females. Three (3) residential care managers were also part of the sample, comprising 2 males and 1 female. This sample size was considered representative taking into consideration the time frame and the available resources to undertake such a study.

3.5 Ethical Considerations

Before the study was undertaken ethical approval was obtained from the University of Zambia Research Ethics Committee. Further, authority was granted from the Ministries of Health; Community Development and Social Welfare; Education and Home Affairs. In addition all adult individuals involved in the study were provided with a Participant Information Sheet, which contained information of the purpose of the study, the need for their involvement, what their participation would entail and issues pertaining to ethics and confidentiality. The following research ethics were considered in this study: *permission, informed consent, confidentiality, voluntary participation and anonymity.*

3.5.1 Permission

For purposes of this research, formal permission was sought from the Ministry of Community Development and Social Welfare and the Ministry of Education as this study involved adolescents from schools and residential care facilities.

3.5.2 Informed Written Consent

Informed Written Consent was obtained from all adults or caregivers participating in the study. The children and their caregivers were debriefed about the study and their role. With regards the adolescents in school, the school management were informed of the study and its purpose. If they agreed to take part in the study, they were provided with a written consent and requested to sign it on behalf of the adolescents. The adolescents were required to provide written assent if they agreed to participate in the study.

3.5.3 Confidentiality

Participants were given an assurance of confidentiality and a description of the intended use of the data. All the data obtained was kept under strict confidence. Data obtained in soft copy was password protected by the researcher. The data obtained in hard copy was kept under

lock by the researcher and was only accessed by the researcher to ensure the highest level of confidentiality.

3.5.4 Voluntary Participation

The participants were informed that participation in the study was at no cost and that they were free to withdraw at any time during the research without providing a reason.

3.5.5 Anonymity

Codes as opposed to names were assigned to all participants and organisations to protect personal and organisational identity.

3.5.6 Referral

Arrangements were made by the researcher to refer any adolescents in family care or residential care for professional services if need arose. However, during the study no serious issues arose. Therefore the residential care staff continued to provide support within the facilities. The guidance and counselling teachers in the two schools were also on hand to assist if any such issue arose.

3.5.7 Logistics

The study was conducted within the school time for adolescents in school. The adolescents were provided with refreshments after completion of the SDQ-Y. With regards family care adolescents, refreshments were provided only after the all the children completed the SDQ-Y within the residential care facilities.

3.5 Data Collection Procedure

3.5.1 Residential Care Adolescents

The researcher first recruited adolescents from residential care. The purpose of the study was explained to the heads of the facilities. If they agreed to take part in the study, they were

given participant information sheets and consent forms to sign on behalf of the adolescents. The researcher then provided participant information sheets and explained the purpose of the study to the children and their expected role. The researcher with the help of the caregivers screened the children using the Inclusion and Exclusion Criteria. A list was then generated for those who met the requirements. If the children agreed to take part, they were provided with a written Assent form to sign (see Appendix 8) and invited to take part in the study. This process was done through six facilities until an equal number of females and males were reached.

The residential care facility selected for the Focus Group Discussions (FGDs) was purposively sampled. This was because the facility contained the maximum number of participants required for a FGD, which is 10. In addition, the facility accommodated both males and females, as this was critical for the researcher to obtain data from both sexes. The adolescents taking part in the Focus Group Discussions (FDGs) were also purposively sampled with help from their caregivers.

3.5.2 Family Care Adolescents

The family care adolescents were recruited from two Government schools. The researcher first explained the purpose of the study to the Head teacher and the role of the participants at the first school (School A). After agreeing to take part in the study, the researcher provided a Participant Information Sheet and a Consent form.

The researcher was then provided with a list of Grade 8 learners from the Guidance and Counselling Department. The researcher with the help of the guidance teacher used the inclusion and exclusion criteria to screen the adolescents on the list. After screening the researcher generated a list of 49 learners comprising 21 females and 28 males. These were provided with participant information sheets, letters and consent forms to take to their parents

and guardians. Only adolescents whose parents provided consent were allowed to participate and in turn the learners had to provide written assent by signing an Assent form. A total of twenty-one (21) adolescents comprising 13 males and 8 girls were given consent by their parents and guardians. Therefore a total of 28 adolescents refused to be part of the study.

At the second school (School B), the school management was debriefed about the purpose of the study and their role. The researcher provided the Participant Information Sheet and Consent Forms. After school management agreed to take part in the study, the researcher was then taken to a Grade 8 class where the purpose of the study was explained to the learners. Those aged 11-16 (n=35) were provided with letters, consent forms and Participant Information Sheets to take to their parents and guardians. Only adolescents whose parents provided consent were allowed to take part in the study. A total of 25 children provided consent from their parents, comprising 14 girls and 11 boys. Ten (10) refused to take part in the study. A list was generated for boys and girls and the researcher used simple random sampling from the list of boys and girls to achieve the required 20 girls and 20 boys for the whole study. Every alternate participant was selected and provided with assent forms.

3.5.3 Residential Care Managers

The study used purposive sampling for the managers in residential care. Purposive sampling allows the researcher to choose participants who will be most useful in providing the information required and are chosen for a particular purpose (Leedy & Omrod, 2005). Three managers were sampled to take part in the study. Of the three, two were male and one was a female. Purposive sampling was used because the managers were expected to provide information on the adolescents under their care bearing in mind that they interacted with the adolescents on a day-to-day basis.

With regards the adolescents in residential care and family care, the sampling frame was generated through consultations with the administration and school management respectively. This involved selecting participants based on the age and sex and those falling outside the age range of 11 to 16 were excluded from the study. A list comprising the participants falling in the required age range was generated with an identity number. The second part of the sampling involved simple random sampling and every alternate participant was chosen for the study until the required sample size of 80 is achieved. If for any reason, parents or guardians did not provide consent, the researcher used the same sampling frame by using simple random sampling in order to reach the targeted sample of 80.

3.6 Pilot

A pilot is a miniature study or a small-scale version of the full study that will be performed later (Wheeler, 2010). For purposes of this study, a pilot involving four (4) adolescents drawn from the community matching the socio-demographic characteristics of the residential care sample was undertaken. The aim of the pilot study was to gain familiarity and expertise in the use of the instruments and specifically to test if the adolescents easily understood the questions.

After the pilot study, the researcher decided to alter a word on the SDQ-Y, which the respondents could not understand. Notably the word 'squirming' appearing on statement 10 of the SDQ-Y (see Appendix 1) was replaced by its synonym 'fidgeting.'

3.7 Data Collection Tools

3.7.1 Strengths and Difficulty Questionnaire-Youth (SDQ-Y) Version

The Strengths and Difficulties Questionnaire (SDQ)-Y was used to assess psychological well-being in adolescents for the study. This is a brief screening measure that is increasingly being used for the purpose of identifying behavioural and emotional problems in children and

adolescents (Menon, 2014). It was developed by Goodman (1997) and is used to measure the mental health status and behavioural problems in children and adolescents. The 25 items in SDQ-Y are divided into five subscales comprising of 5 items each, generating scores for conduct problems, hyperactivity/inattention, emotional symptoms, peer problems and prosocial behaviours. The items are scored on a 3-point scale with 0 = not true, 1 = somewhat true, and 2 = certainly true.

The subscale scores can be calculated by summing up the scores on relevant items (after recoding reversed items) range of the scores 0-10. This means that a higher score on the prosocial subscale for instance reflects strength, whereas higher scores on other subscales (conduct problems, hyperactivity/inattention, emotional symptoms and peer problems) indicate difficulties. A total SDQ-Y score is derived from 20 items (emotional symptoms, conduct problems, hyperactivity and peer problem subscale), excluding the prosocial subscale. Scores for total difficulties range from 0 to 40, with higher scores indicating more mental health problems.

It has been observed that the SDQ-Y has demonstrated both good reliability and validity for use in this study because it has been used before in forty (40) countries with similar settings to Zambia including Ghana to assess children's psychological outcomes (Menon, 2014). In Zambia for instance, Menon (2008) used the SDQ-Y to determine the emotional well-being of HIV positive adolescents. The findings of these studies indicated that the instrument could be effectively used to screen for psychological well-being of adolescents in residential care. In a study by Menon (2014), Cronbach alpha co-efficients for the SDQ total and sub-scale ranged from good to low, internal consistency for total SDQ Score ($\alpha = 0.66$) emotional

problems scale (α = 0.55) was good and for hyperactivity scale peer relations and conduct problems scale was low.

3.7.2 Focus Group Discussion (FGD)

The adolescents who took part in the Focus Group Discussion (FGD) were recruited from residential care. FGDs allow a researcher to get more in-depth information, perceptions, insights, attitudes, experiences, or beliefs (Patton, 2002). In addition, they are useful to increase the validity of data as part of the mixed method approach. According to Hennick (2014), Focus Group Discussions are essential because they help to identify a range of perspectives on a research topic and to gain an understanding of the issues from the participants themselves in a group environment. Purposive sampling was used to arrive at 10 adolescents who participated in the FGD. As this was a mixed methods study, FGDs were used to ensure depth of information on the topic at hand. This was aimed at exploring the adolescents' views on their perceptions about their environment. The researcher audio taped the FGDs.

3.7.3 Structured Interview with Residential Care Managers

In order to examine the service provision for adolescents in residential care, interviews were conducted with three residential centre managers. The purpose of the interview was to get information on the psychosocial support services provided by the facility and how these services if any, were accessed by the adolescents. The researcher also examined work plans, annual reports and any other documentation that was useful to gain insight into the facility's programmes and services for the adolescents.

3.7.4 Socio-Demographic Questionnaire

The Socio-Demographic questionnaire was used to capture general and demographic information of the participants. The adolescents filled in the questionnaire with assistance from their caregivers and teachers.

3.7.5 Training of Research Assistants

Two research assistants were recruited for this study, one male and one female. Their role was to facilitate the FGD that was held for the adolescents in residential care. They were oriented for one day in residential care practices, policies around child protection, FGD guide and ethical practices when dealing with children in care. The research assistants had prior experience of working with young people, as they were members of a youth-based Non-Governmental Organisation (NGO) that provided leadership skills to vulnerable youth.

3.8 Inclusion and Exclusion Criteria

3.8.1 Inclusion Criteria for Residential Care Sample

Adolescents with the following characteristics were included:

i. Adolescents aged 11 to 16 years
ii. Adolescents who had been in residential care for at least six (6) months or more at the commencement of the study.

3.8.2 Exclusion Criteria for Residential Care Sample

Adolescents with the following characteristics were excluded:

i. Adolescents with a special need e.g. Down's syndrome as provided by information from caregivers and adolescent case files.
ii. Adolescents whose caregivers did not provide consent.
iii. Adolescents who did not provide assent.

3.8.3 Inclusion Criteria for the Family Care Sample

Adolescents with the following characteristics were included in the study:

i. Adolescents aged between 11 and 16 years.
ii. Adolescents who were living with parents or guardians from the extended family e.g. grandparents, uncles, aunts etc.

3.8.4 Exclusion Criteria for Family Care Sample

For purposes of this research, adolescents with the following characteristics were excluded from the study:

i. Adolescents with special needs e.g. intellectual disability as provided by information from the school management.
ii. Adolescents whose parents or guardians did not provide consent.
iii. Adolescents who did not provide written assent.

3.9 Data Analysis

3.9.1 Quantitative Data

The quantitative data was analysed using the statistical software package, Statistical Package for Social Sciences (SPSS) version 20. A total of eighty (80) questionnaires were completed for data analysis representing a 100% response. Descriptive Analyses was used to obtain means and standard deviation for the independent and dependent variables and to summarise the data. Chi- Square was used to check for relationship between the demographics and psychological well-being.

3.9.2 The Independent sample t- test was used to determine whether there were significant mean differences in psychological well-being between residential care and family care adolescents on the SDQ-Y subscales and Total Difficulties.

3.9.3 Two-way Analysis of Variance (ANOVA) was computed to determine the effect of gender and type of care on psychological well-being between residential care and family care adolescents.

3.10 Qualitative Data

Qualitative data collected through FGDs and Interviews was analysed qualitatively using thematic analysis. This involved transcribing and familiarisation with the data, reading and re-reading. The data was then categorised according to emerging themes.

3.11 Data Management

Data collected was checked for completeness and inconsistencies at end of each data collection day. Any inconsistencies noted were corrected immediately. The data entry, cleaning and analysis was done by using Statistical Package for Social Sciences (SPSS) version 20.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the findings of the current study. The findings were discussed according to objectives of the study. These included the demographical data, i.e. gender, age, educational level and parenthood status; psychological well-being of adolescents in residential care and in family care; gender differences in psychological well-being of residential care and family care adolescents; psychosocial support services provided by the residential care service providers and finally, the perceptions of adolescents in residential care about their environment.

4.1 Demographical Data

4.1.1 Gender

The study targeted a total of eighty-three (83) participants. Of these, 80 were adolescents with 40 (50%) representing residential care and 40 (50%) from family care. The study also targeted three (3) key residential care managers, which included two (2) males and one (1) female. The adolescents recruited from selected residential care facilities in Lusaka consisted of 20 (50%) females and 20 (50%) males. The family care adolescents also comprised 20 females (50%) and 20 males (50%). A summary of the distribution is illustrated in Table 1.

4.1.2 Age

The target group for the adolescents was 11 to 16 years. The participants were divided into two age groups 11-13 years and 14-16 years to assess the age distribution in both FC and RC adolescents and across gender. The adolescents aged 11-13 were 36, representing 45%, while those aged 14-16 were 44, representing 55%. In the 11-13 group, 24 were female representing 66.7% and 12 were male, representing 33.3%. In the 14-16 group, 16 were

female, representing 36.4% and 28 were male representing 63.6%. The data revealed that there were more males in the 14-16 year age group compared to females, and more females in the 11-13 year age group compared to males. A summary of the demographic characteristics of the participants is shown in Table 1.

4.1.3 Educational Level

From the sample of 80 adolescents, only 2 adolescents were not in school representing 2.5% and these were from residential care. Adolescents between Grades 2 to 4 were 15 (18.8%); those in the Grades 5 to 7 were 11 (13.8%). The Grade 8 to 10 category had 52 (65.5%). The data revealed that there were more adolescents from residential care in the lower grades, that is Grades 2 to 4 with 15 (18.8%) as compared to family care which did not have any adolescents in the lower grades with 0 (0%). This scenario was the same in the Grade levels 5 to 7, which had no adolescents from family care accounting for 0 (0%) while for residential care the total number of adolescents was 11 (13.8%). A summary of these findings is illustrated in Table 1.

4.1.4 Parenthood Status

From the eighty (80) adolescents sampled in the study, 4 (5%) were maternal orphans, (having lost a mother) with one (1) from family care and three (3) from residential care. A total of thirteen (13) adolescents (16.3%) were paternal orphans (having lost a father). Of these, four (4) were from family care and nine (9) from residential care. The double orphans (having lost both father and mother) were thirteen (13) representing 16.3%, with two (2) from family care and eleven (11) from residential care.

The data revealed that there were more double orphans in residential care than in family care. The non-orphans accounted for 58.8%, with a total number of forty-seven (47), with thirty-three (33) from family care and fourteen (14) from residential care. The children whose

parents' whereabouts were unknown accounted for 4% with none (0) from family care and three (3) from residential care. A summary of the findings is displayed in Table 1.

Table 1: Demographics and SDQ-Y Total Difficulties

		Residential Care		Family Care			Total Difficulties	
Variables		**n**	**%**	**N**	**%**	**Total (n)**	**Chi-square $\chi 2$**	**Significance p**
Gender	Male	20	50	20	50	40		
	Female	20	50	20	50	40	28.01	0.08
	Total	40	100	40	100	80		
Age	11-13	18	45	22	55	40		
	14-16	22	55	18	45	40	19.10	0.45
	Total	40	100	40	100	80		
Educational Level	Grade 2 – 4	15	37.5	0	0	15		
	Grade 5 – 7	11	27.5	0	0	11		
	Grade 8 -10	12	30.0	40	100	52	75.17	0.054*
	Not in School	2	5.0	0	0	2		
	Total	40	100.0	40	100	80		
Parenthood Status	Maternal orphan	3	7.5	1	2.5	4		
	Paternal Orphan	9	22.5	4	10.0	13		
	Double Orphan	11	27.5	2	5.0	13	95.93	0.061
	Non-Orphan	14	35.0	33	82.5	47		
	Unknown Whereabouts	3	7.5	0	0	3		
	Total	40	100.0	40	100.0	80		

4.2 Relationship between Demographics and SDQ-Y Total Difficulties

A chi- square test was used to show whether there was any association with the demographics gender, age, educational level and parenthood status between family and residential care adolescents. The findings revealed that significant levels were reached on the demographic Educational level and Total Difficulties with ($\chi 2 = 75.17$, $p<0.05$). This was because 65% of the adolescents in residential care were between Grades 2-7. With regards family care, all (100%) of the adolescent were in Grade 8. A summary of the findings is illustrated in Table 1.

The other demographics gender, age and parenthood status all did not reach significant levels with gender ($\chi 2=28.01$, $p>0.05$), age ($\chi 2=19.10$, $p>0.05$) and parenthood status ($\chi 2=95.93$, $p>0.05$). This therefore shows that the sample of adolescents from residential care and family care did not differ in terms of demographic characteristics.

4.3 Psychological Well-Being of Residential and Family Care Adolescents on SDQ-Y Subscales.

The psychological well-being of RC and FC adolescents was computed using the scores on the four of the sub-scales of the SDQ-Y. The sub-scales included Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems and Prosocial Behaviour. These four sub-scales make up the Total Difficulties Score. The means and standard deviations of the two groups were also computed using descriptive statistics. The hypothesis was that RC adolescents would show low psychological well-being in comparison to FC adolescents.

In order to achieve this, an Independent sample t-test was used to test if there were any significant differences in psychological well-being of FC and RC adolescents on the five named sub-scales of the SDQ-Y.

4.3.1 Emotional Symptoms

On the Emotional symptoms scale, there was a significant difference in the mean scores for RC adolescents (M= 4.58, SD= 2.14) and FC adolescents (M=3.50, SD=1.66); t (78) = -2.51, *p<0.05* as shown in Table 2. In the current study residential care adolescents experienced more emotional problems than the family care adolescents.

4.3.2 Conduct Problems

There was a significant difference in the mean scores for RC and FC adolescents on the Conduct Problems subscales with RC adolescents (M=2.98, SD=1.78) and FC adolescents (M=1.88, SD=1.30), t (78) = -3.23, *p<0.05.* The residential care adolescents experienced more conduct problems compared to the family care adolescents as shown in Table 2.

4.3.2 Hyperactivity

Further on the Hyperactivity scale, there was no significant difference in the mean scores for RC adolescents (M=2.95, SD = 1.91) and FC adolescents (M=2.45, SD=1.55), t (78) = -1.29, *p> 0.05*. The results are tabulated in Table 2.

4.3.4 Peer Problems

The Peer Problems Sub-Scale showed significant difference in the mean scores for RC adolescents (M = 2.88, SD = 1.54) and FC adolescents (M= 1.63, SD=1.08), t (78) = - 4.21, *p<0.05* as shown in Table 2. The adolescents in residential care experienced more peer problems as compared to the family care adolescents.

4.3.5 Prosocial Behaviour

The results on the Prosocial scale did not show any significant difference in the mean scores with RC (M=7.95, SD=1.58), FC (M=8.43, SD=1.28), t (78) = 1.48, *p>0.05* as shown in Table 2.

Table 2: Independent Sample t-test between RC and FC adolescents on SDQ-Y Subscales

	Residential Care	Family Care		
SDQ-Y Subscale	M (SD)	M (SD)	t	*p*
Emotional Symptoms	4.58 (2.14)	3.50 (1.66)	-2.51	0.014*
Conduct Problems	2.98 (1.78)	1.88 (1.30)	-3.23	0.002**
Hyperactivity	2.95 (1.91)	2.45 (1.55)	-1.29	0.202
Peer Problems	2.88 (1.54)	1.63 (1.08)	-4.21	0.016**
Prosocial behaviour	7.95 (1.58)	8.43 (1.28)	1.48	0.144
Total Difficulties	13.38 (5.73)	9.45 (3.06)	-3.82	0.001**

*Significant at 0.05 level

** Significant at 0.01 level

4.4 Psychological Well-Being of RC and FC adolescents on Total Difficulties Score.

The Independent sample t-test on the Total Difficulties Score (sum of emotional symptoms, conduct problems, hyperactivity and peer problems) revealed that there was a significant difference in the mean scores between residential care and family care adolescents as shown in Table 2. The RC adolescents scored (M=13.38, SD=5.73) and FC adolescents (M=9.45, SD=3.06); t (78) = -3.82, $p<0.05$.

This study hypothesised that would be a difference in psychological well-being of adolescents in RC compared to the adolescents in FC. The hypothesis was confirmed as the results of the t-test showed a significant difference in the total difficulties scores for RC and FC adolescents. Residential care adolescents showed low psychological well-being compared to family care adolescents.

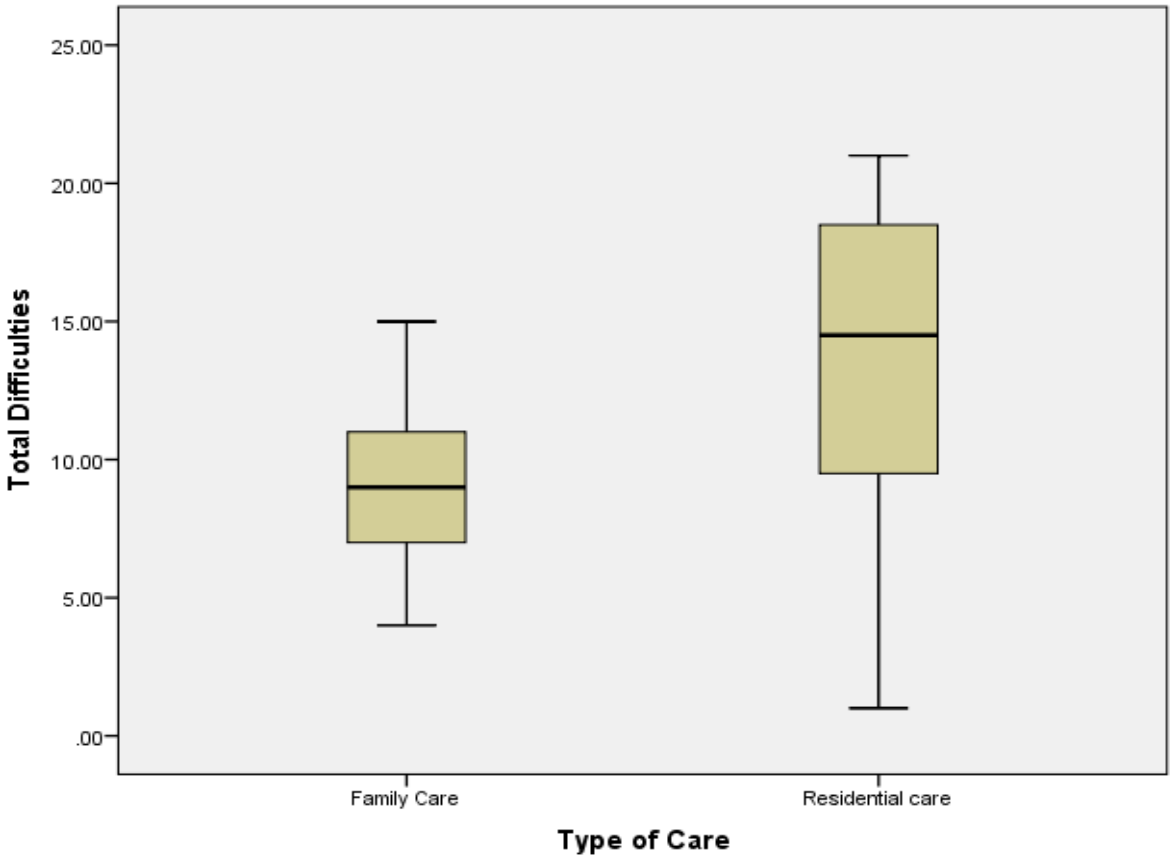
4.5 Relationship between Gender, Type of Care and Psychological Well-Being (Total Difficulties) between Family Care and Residential Care Adolescents.

The current study also investigated the interaction of the independent variables gender and type of care on the dependent variable psychological well-being. In order to achieve this, a two-way ANOVA was computed to compare the effect of the two independent variables, on the dependent variable, psychological well-being in residential and family care adolescents. The data was examined to assess whether it met the conditions set to conduct the Two-Way ANOVA.

The dependent variable Psychological Well-Being (Total difficulties) was measured at a continuous level. The independent variables Gender and Type of Care each had two categorical groups with gender broken down as male and female. The independent variable, type of care was categorised as residential care and family care. Further the data had an independence of observations because there was no relationship between the observations in each group or between the groups themselves.

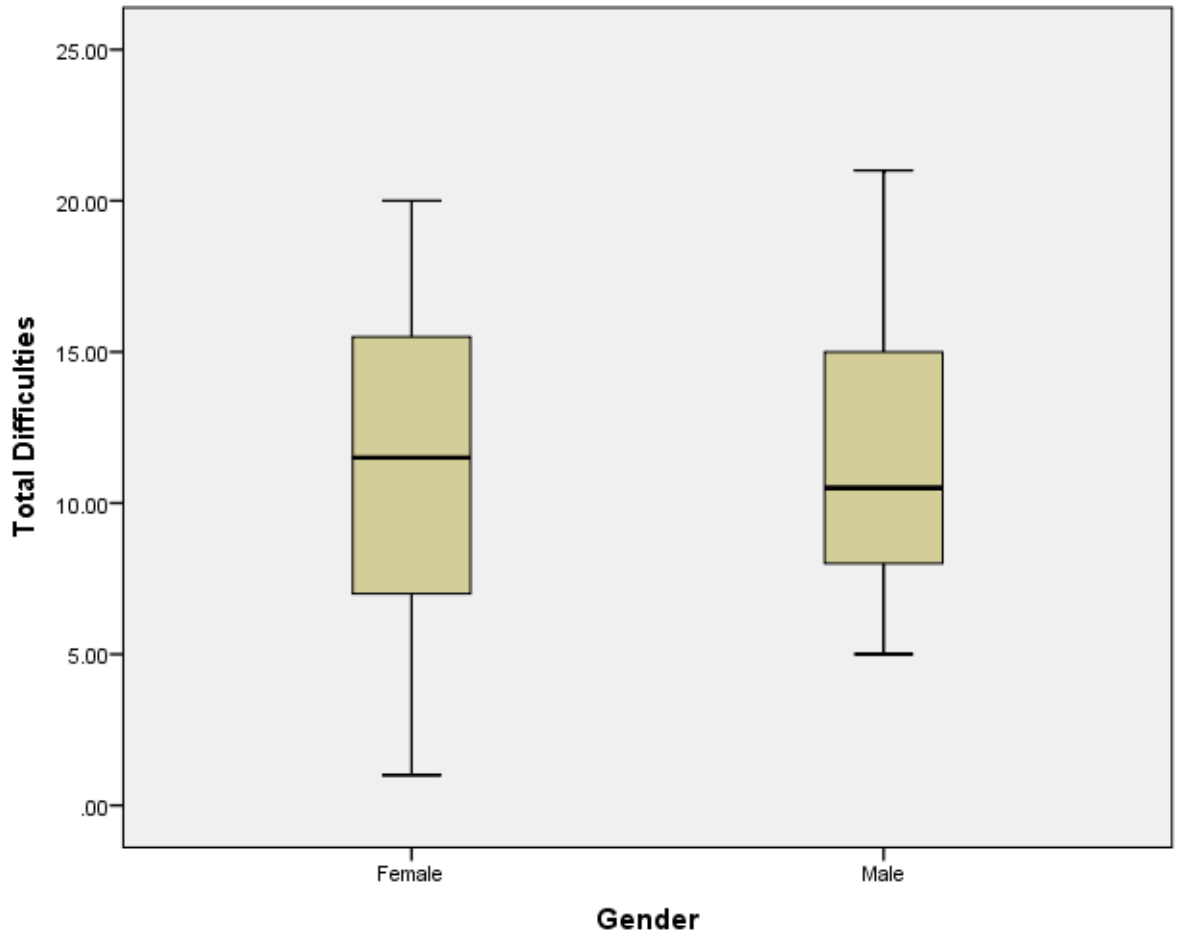
The data was checked for significant outliers as shown in the Box plot in Figure 3. As can be observed from the Box plot, the dependent variable Psychological Well-Being (Total Difficulties) had no significant outliers in both Family Care and Residential Care adolescents.

Figure 3: Box Plot showing Total Difficulties and Type of Care



Further, the data was checked by gender and psychological-well being (Total Difficulties). The Box plot showed that there were no significant outliers in the sample. The mean for FC and total difficulties score was 4 to 15 and for RC and total difficulties it was 2 to 21. The graphical representation is shown in Figure 3.

Figure 4: Box plot showing Total Difficulties and Gender



The data was also checked for normality and this was achieved by employing the Shapiro-Wilk test. The two categories of the variables gender and type of care were computed against Total difficulties to determine if they were normally distributed. The results revealed that Psychological Well-Being (Total Difficulties) was normally distributed for females with $p > 0.05$. However for males, the data was not normally distributed with $p < 0.05$. The results are presented in Table 3.

Table 3: Tests of Normality Gender and Total Difficulties

	Gender	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	Df	Sig.	Statistic	df	Sig.
Total Difficulties	Female	.113	40	.200*	.959	40	.154
	Male	.172	40	.004	.918	40	.007

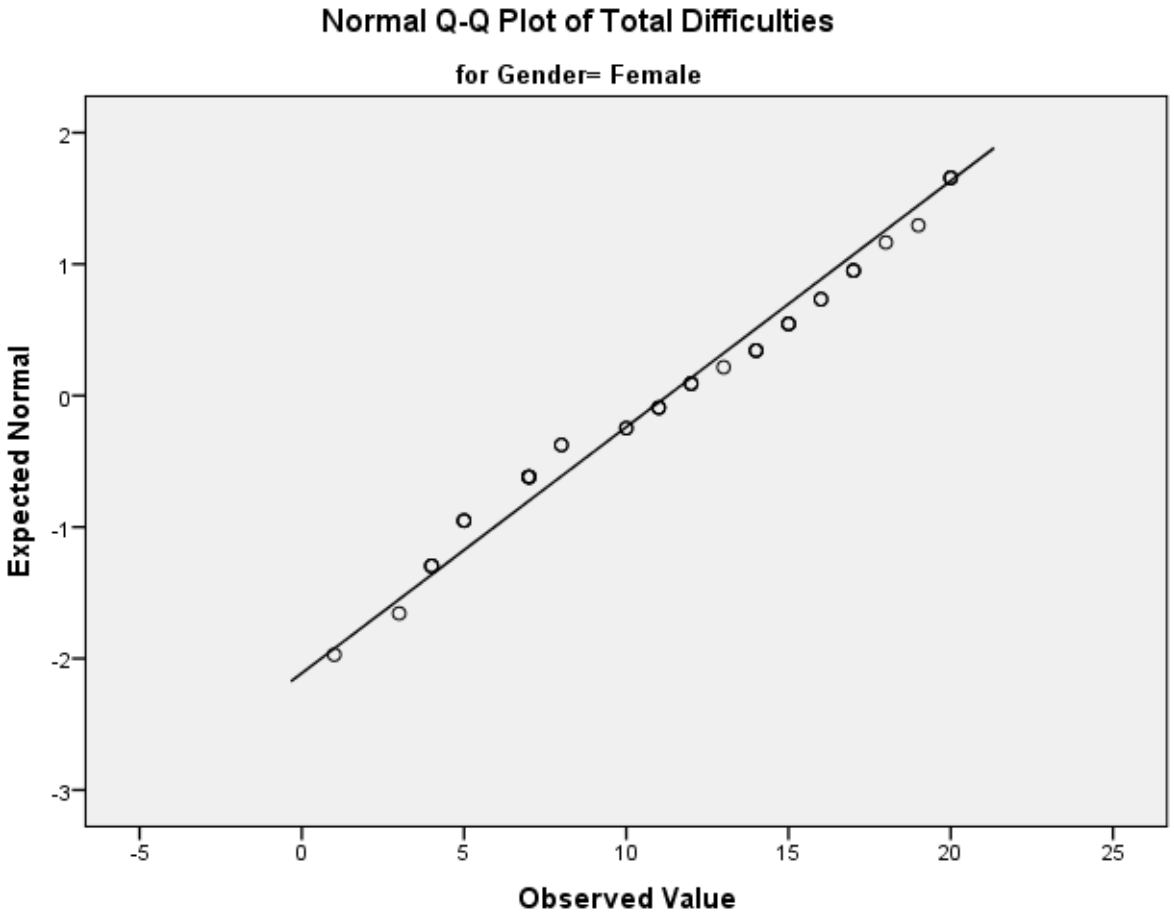
The data was also checked for normality with Total Difficulties and Type of care. From the results, the data was not normally distributed with $p<0.05$ for both Family care and Residential Care adolescents as tabulated in Table 3.

Table 4: Tests of Normality Type of Care and Total difficulties

	Type of Care	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Total Difficulties	Family Care	.113	40	.200	.943	40	.043
	Residential care	.136	40	.059	.924	40	.010

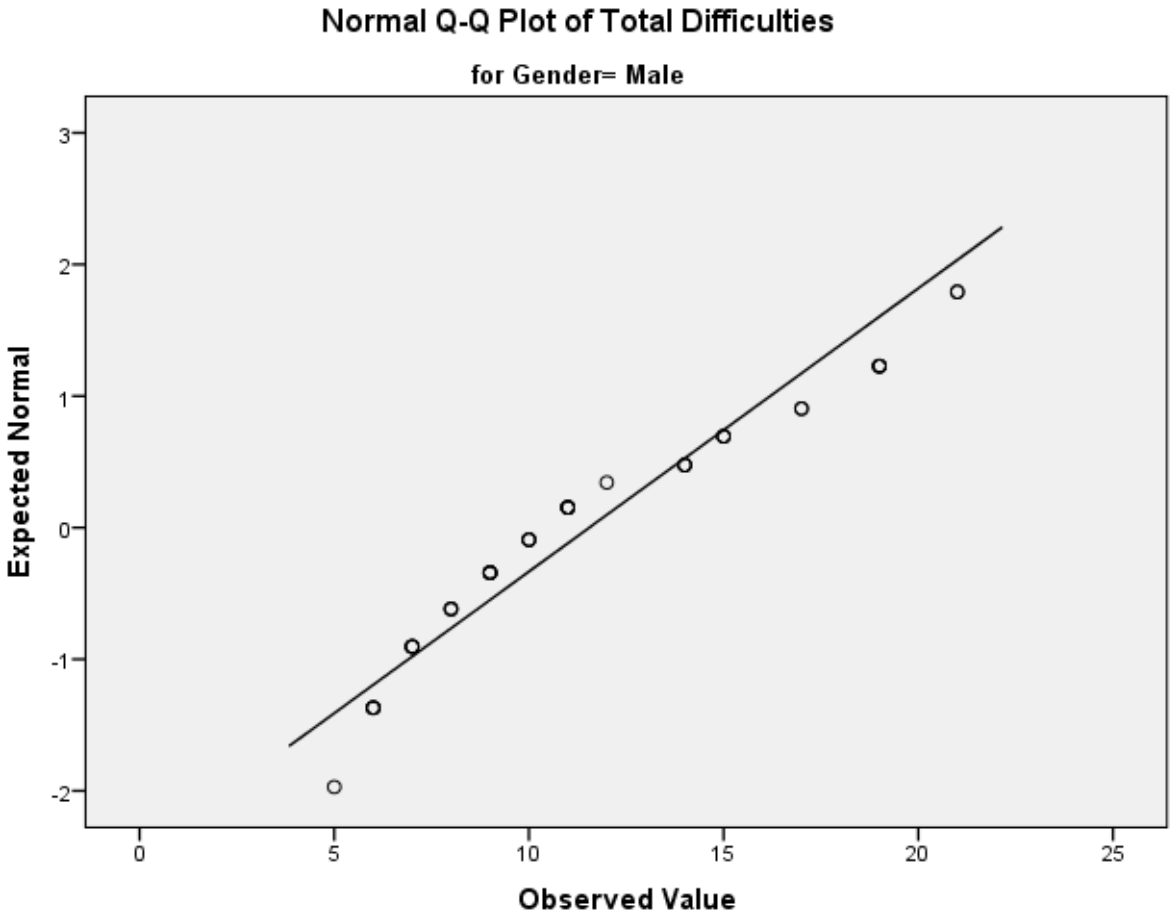
As numerical analysis revealed that the data was normally distributed in other categories of the independent variables, and where not normally distributed, the graphical method was employed. A visual inspection of the Q-Q Plot for gender and total difficulties revealed that the data points were close to the diagonal line indicating an approximately normal distribution as shown in Figure 5. The Q-Q plots for males also revealed that the data was approximately normally distributed as the data points were close to the diagonal line.

Figure 5: Normal Q-Q Plot of Total Difficulties, Gender = Female



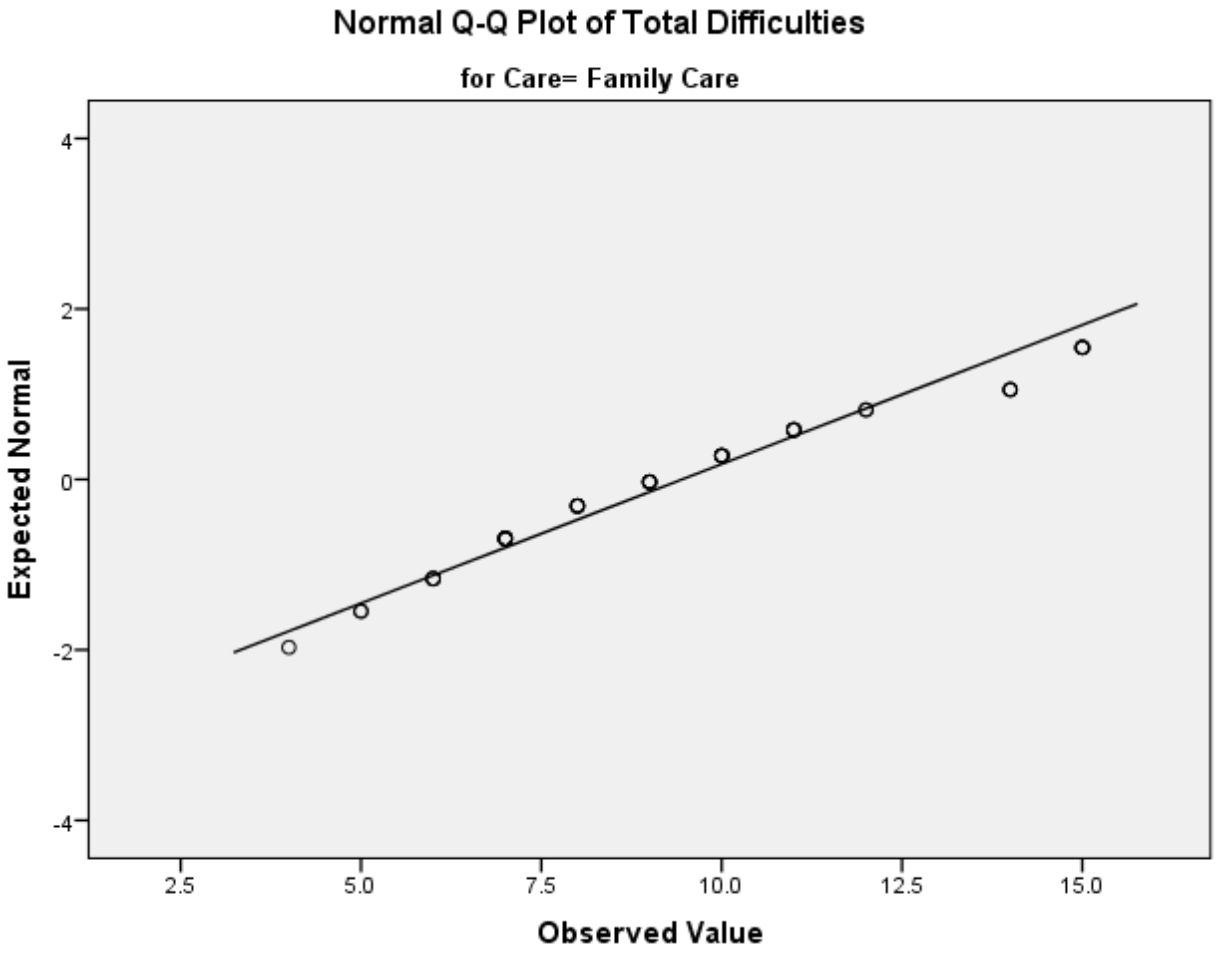
A visual inspection of the Q-Q plot for males and Total difficulties revealed that the data was approximately normally distributed as the data points were close to the diagonal line.

Figure 6: Normal Q-Q Plot of Total Difficulties, Gender = Male



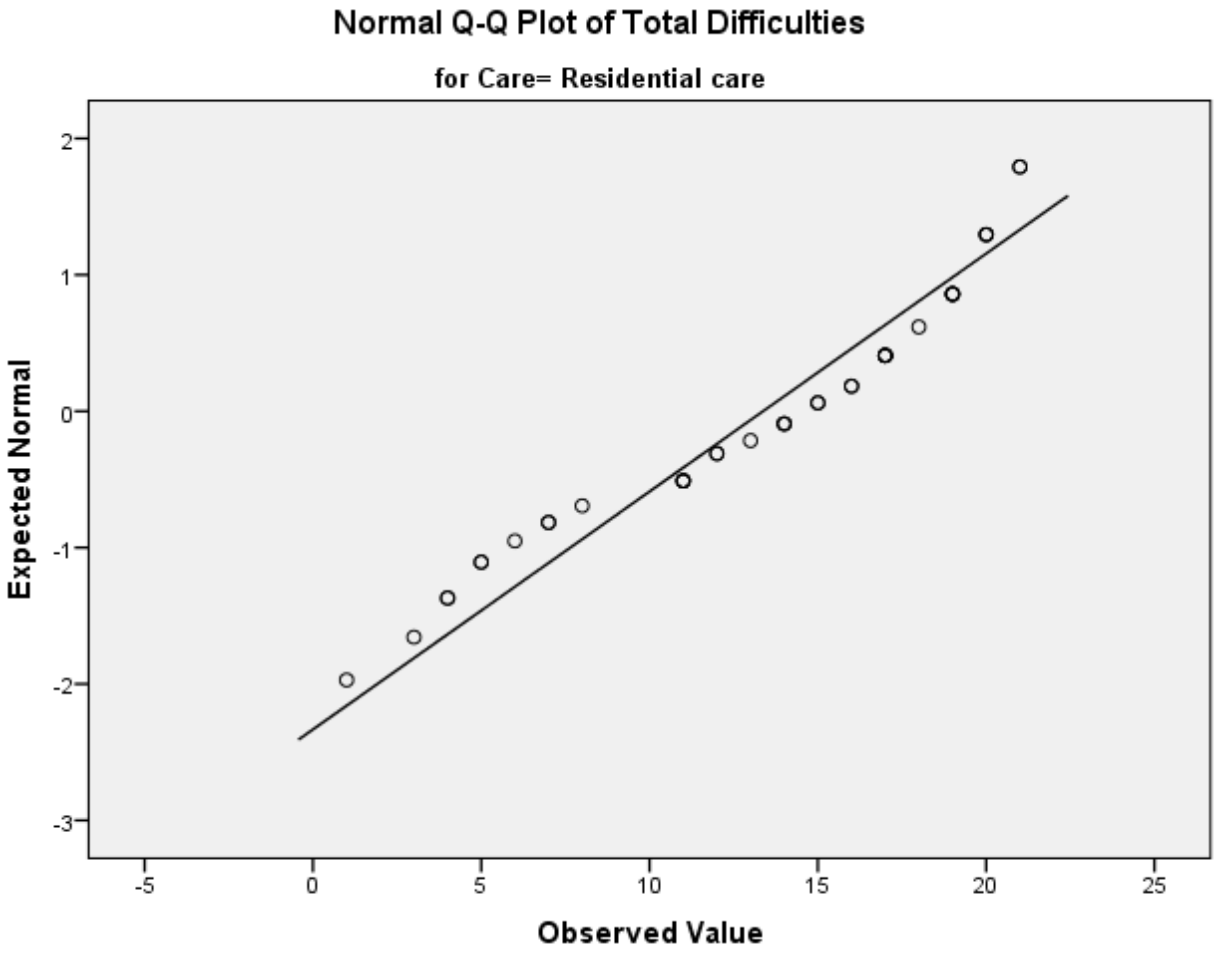
Further the data was checked for normality of distribution by the variables type of care and total difficulties. A visual inspection of the data revealed that the data was normally distributed for family care and total difficulties as the data points were close to the diagonal line in a non-linear pattern as shown in Figure 6.

Figure 7: Normal Q-Q Plot of Total Difficulties, Family Care.



The data was also examined for residential care and total difficulties. A visual inspection revealed that the variable total difficulties were approximately normally distributed as the data points were close to the diagonal line. This is demonstrated in Figure 8.

Figure 8: Normal Q-Q Plot of Total Difficulties, Residential Care.



The results of the two-way ANOVA revealed that there was a statistically significant interaction between the effects of type of care and psychological-well being (Total Difficulties), F (1, 79) = 14.36, $p < 0.05$. Adolescents in residential care and family care experienced psychological well-being at different levels, with adolescents in residential care showing lower well-being compared to family care adolescents. The results are tabulated in Table 5.

There was no significant mean difference between the interaction of gender and type of care with F (1, 79) = 0.071, $p > 0.05$. The study hypothesised that there would be gender differences in psychological well-being between females and males in residential care, with

males showing low psychological well-being compared to females. The results are presented in Table 6. The interaction of gender and type of care on psychological well-being did not yield a statistical mean difference with F (1, 79) = 0.714, *p> 0.05.*

Table 5: Two-way ANOVA Dependent Variable: Total Difficulties

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	324.938[a]	3	108.313	5.049	0.003
Intercept	10419.613	1	10419.613	485.688	0.000
Gender	1.512	1	1.512	0.071	0.7901
Care	308.113	1	308.113	14.362	0.000*
Gender * Care	15.313	1	15.313	0.714	0.401
Error	1630.450	76	21.453		
Total	12375.000	80			
Corrected Total	1955.388	79			

a. R Squared = .166 (Adjusted R Squared = .133)

The gender difference was not significant between residential and family care adolescents. The mean for females was M=11.28, and males M = 13.95. The results are tabulated in Table 6.

Table 6: Descriptive Statistics for Total Difficulties, Gender & Type of Care

Gender	Type of Care	Mean	SD	n
Female	Family Care	9.75	3.61	20
	Residential care	12.80	6.37	20
	Total	11.28	5.34	40
Male	Family Care	9.15	2.46	20
	Residential care	13.95	5.11	20
	Total	11.55	4.65	40
Total	Family Care	9.45	3.06	40
	Residential care	13.38	5.73	40
	Total	11.41	4.98	80

4.6 Type of Psychosocial Services Provided

4.6.1 Demographics of the Residential Care Managers

The three residential care managers selected for the interviews were purposively sampled. This depended on their availability and willingness to participate in the study. The participants included (2) males and one (1) female. Two out of the three managers/coordinators had College Diploma as their highest qualification, while one participant had a University Degree. A summary of the demographics of the managers is provided in Table 5.

Table 7: Demographics of Managers and Characteristics of Residential Care Facilities

Characteristics	**Care Facility 1**	**Care Facility 2**	**Care Facility 3**
Educational Level of Head	Degree	Certificate	Diploma
Gender	Male	Female	Male
Number of years served (yrs)	10	20	8
Target Group (Gender)	Boys & Girls	Girls only	Boys only
Age at admission (yrs)	6	0	8
Admission Capacity	25	30	25
Year of Registration	2002	1995	2003

4.6.2 Characteristics of the Residential Care facilities

Facility 1 targeted both female and male children from as young as six (6) to adolescents up to the age of eighteen (18). Facility 2 targeted girls only from infancy to the age of nineteen (19). Facility 3 targeted boys only from the age of eight (8) to eighteen (18). All facilities had been in operation for at least ten years and more. In addition, all three facilities were run by a group of individuals through a Board. On average, each facility admitted at least twenty (20) to twenty (25) children and adolescents with an average capacity of 30 children. All

three facilities indicated that they employed permanent staff as well as volunteers. A summary of the characteristics of the residential care facilities is illustrated in Table 7.

4.7 Emerging Themes from Interviews with Managers

Interviews were conducted for key residential care managers/coordinators on a one to one face interaction using an interview guide. The researcher analysed the data from the interviews thematically and categorised the data into emerging themes. The emerging themes were then broken down into various sub-themes and are tabulated in Table 8.

Table 8: Themes and Sub-themes from Interviews with Residential Care Managers

	Main Theme	Sub-Theme
1.	General Services	1.1 Psychosocial Services
2.	Knowledge levels	2.1 Training
3.	Challenges to service delivery	3.1 Inadequate financial resources 3.2 Minimum Standards of Care

4.7.1 Theme 1: General Services

This theme highlighted the general services that the residential care facilities provided. All three residential child care facilities sampled indicated similar purposes, that is, to provide support to Orphans and Vulnerable Children (OVC) through the provision of basic needs (food, shelter and clothing) as well as other social services such as education, health care, counselling, life skills, reintegration and recreation. When asked about the general services they offered to the children, one female manager had this to say:

"This organisation started 20 years ago. We target girls only because they are more vulnerable than boys. We have three boys who are now in college; these are the last boys we

admitted, they came here when they were very young. The services we provide include education, shelter, food provision, counselling, life skills and health care."

Mrs. C, female facility manager.

Another male manager had this to share:

"This organisation was founded on the premise of providing support to children both boys and girls who are orphans or vulnerable and have no one to take care of them. This was in 2002. We provide shelter and care, food, education support, health care, counselling and skills training."

Mr. B, male facility manager.

Another male manager shared how his organisation provided general services.

"This organisation started in 2003. We look after boys only here, we feel that boys are sometimes left out but they are equally vulnerable. We provide education, health care, counselling, food, shelter and recreation. These children come from all walks of life, some have very poor parents and others have just been neglected."

Mr. K, male facility manager.

4.7.2 Psychosocial Services

When asked on whether the facilities provided psychosocial services, all three residential care managers reported in the affirmative. A general observation made was that two out of the three facilities provided psychosocial support and had minimal records of on-going activities, although these were more group focussed with no specific outcomes for individual children. However, one facility did not have anything on record to suggest that psychosocial services were being provided to the adolescents.

One manager emphasised the importance of psychosocial support during the interview. He had this to share:

"This service (psychosocial support) is very important because most of these children have gone through a lot of challenges. Some were abandoned, neglected and have no idea where their families are. Through counselling, we are able to help them heal."

Mr. K, Manager

4.7.3 Summary

From the above findings, it was evident that all three residential care facilities provided similar services, which included education, health care, food and shelter, counselling and recreation to vulnerable children. It was however observed that there were varying levels in the provision of psychosocial services.

4.7.4 Theme 2: Knowledge Levels of Psychosocial Support

The main thrust of the above named theme was the knowledge levels of the managers in psychosocial support. It further highlighted what the managers benefited from training. Two out of the three managers clearly indicated that it was not enough to just feed the children but empower them with knowledge, show them love and care. One manager had this to share:

"These children come from different backgrounds and some have similar reasons that led them to come here. We try to help them by talking to them and intervening through counselling until we reach a point where we feel we have helped the child. That is why psychosocial support is very important."

Mr. K

Another manager reported that they provided talks especially when they noticed bad behaviour in the children.

"*We provide talks for the children. The frequency depends on the need at the particular time. Especially when we realise children are not behaving well, we have talks and we also involve volunteers to talk to the children."*

Mrs. C

4.7.4.1 Training

The managers were asked if they had undergone any training in psychosocial support and if they found the training helpful. All three managers indicated that they had undergone training in psychosocial support in the last three to four years. Of the three, two managers indicated that the training was helpful in their daily interaction with children. The two further indicated that they had been equipped with probing skills, which helped them to investigate matters concerning adolescents further. The third manager did not indicate whether the training was helpful or not.

One residential manager reported that:

"The training was very helpful because I learnt probing skills. This has helped me and the other caregivers to deal with issues in a more exploratory manner especially if we suspect that children are not telling the truth."

Mr. B

4.7.4.2 Summary

From the findings, the managers indicated that psychosocial support was very cardinal in the lives of the adolescents under their care. In addition, all three had undergone training in psychosocial support. One general observation was that psychosocial services were offered in a general manner with no specific outcomes for each child.

4.8 Challenges to Service Delivery

This theme highlighted the challenges that the residential care facilities faced in service delivery in various aspects. All three residential care providers indicated that they faced numerous challenges in delivering services to children. The most common challenges cited by the managers were inadequate human and financial resources, which in turn negatively affected their service delivery. On implementation challenges, the Minimum Standards of Care were cited as a challenge.

4.8.1 Inadequate Financial Resources

4.8.1.1 The Cost of Qualified Personnel

All three residential care managers reported that they had challenges in employing qualified professional staff to care for the children. It was observed that the caregivers were recruited based on each institution's capacity to pay them and not as stipulated by the Minimum Standards of Care. The common challenge expressed by the three residential care facility managers was that they were unable to meet the salary expectations of qualified professional personnel. Therefore, they resorted to employing persons who had minimum skills and were willing to do the job. One manager reported this:

"*I know that as a facility, we are required to employ a psychologist. Looking at the present day salaries, we cannot afford one because they require a huge salary. So we have ended up employing caregivers who have some minimum skills of what the job is about."*

Mrs. C

4.8.1.2 High Cost of Education

All three staff interviewed reported that costs related to education had proved to be a challenge. Despite the Free Education Policy for primary school education, children still

required school requisites such as shoes, uniforms and books, which were not free. One male manager reported that:

"Unless books, uniforms and shoes are provided, education is not free. We struggle to provide these things for all our children. This situation will continue to deprive children in orphanages access to education."

Mr. B

4.8.2 Minimum Standards of Care

The managers were asked if they were aware of the existence of the Minimum Standards of Care for Child Care Facilities developed by the Zambian Government. All three replied in the affirmative. In addition, the three managers agreed that the standards were a good initiative in ensuring protection of children in care and were a good guide for them. One manager indicated that his staff in the residential care facility had difficulties implementing the guidelines because the policy makers did not provide them with sufficient feedback after monitoring visits. The manager had this to share:

"The Department of Social Welfare comes from time to time to monitor how we operate. In the past, after monitoring, we were told to work on the problem areas. But now they just come, do the monitoring and they don't tell us where we need to improve. It's a challenge to us as an organisation."

Mr. B

4.8.3 Summary

From the findings, it was evident that a lot more effort needs to be put in place by both the policy makers and implementers to ensure provision of quality services in residential care. Residential care providers seemed to attribute funding challenges to the provision of quality services, which is the basis of the Minimum Standards.

4.9 Perceptions of Residential Care Adolescents about their Environment

4.9.1 Characteristics of Participants

A total of ten (10) children participated in the FGD. These included four (4) males and six (6) females. All the ten children were enrolled in school. These were aged between 11 and 16. Of the 10 adolescents, 3 were orphans and 7 were non-orphans. With regards their reasons for entry into residential care 2 adolescents indicated poverty, 3 cited neglect, 2 reported abuse, 2 reported abandoned and 1 reported lost. Out of the ten adolescents, four had family contact and 6 did not have any family contact. With regards duration of stay in care, 4 had been in care for 8 years, 3 had been in care for 5 years and 3 had been in care for less than 2 years. A summary of the characteristics of the respondents is shown in Table 9.

Table 9: Characteristics of FGDs Participants

Characteristic		**Female**	**Male**	**Total**
Gender		6	4	10
Age	11-13	4	2	6
	14-16	2	2	4
Orphan hood Status	Orphans	3	0	3
	Non- orphans	3	4	7
Family Contact	Yes	2	2	4
	No	4	2	6
Reason for Entry	Poverty	2	0	2
	Abuse & Neglect	2	3	5
	Abandoned & Lost	2	1	3
Duration in Care	<4yrs	1	2	3
	5-7yrs	3	0	3
	≥8 yrs	2	2	4

The themes and sub-themes that resulted from the data processing were grouped into six themes and twelve sub-themes. The researcher arrived at this by using thematic analysis and then categorising the data into emerging themes.

4.9.2 Thematic Analysis from Focus Group Discussions with Adolescents

The main themes identified by the researcher during the FGDs included: Daily Life in Residential Care, Perceptions of the Community towards Children in Residential Care and lastly, Family Contact. These were further broken down into the following sub-themes: Relationship with Caregivers and Needs, Peer Relations, Recreation and Entertainment; School System - Teachers, School system - Peers; Family Contact, Feeling Isolated and Missing Parents. A summary of the themes is highlighted in Table 10.

Table 10: Themes and Sub-Themes from FGDs

Theme	Sub-theme
1. Daily Life in Residential Care	1.1 Relationship with Caregivers and needs 1.2 Peer relations 1.3 Recreation and entertainment
2. Perceptions of community towards children in residential care	2.1 School system-teachers 2.2 School system-peers
3. Family Contact	3.1 Family contact 3.2 Feeling isolated and missing parents

4.9.2.1 Theme 1: Daily Life in Residential Care

This theme focussed on the daily routine of the children in the facility, how they interacted amongst themselves, their caregivers and how their basic and social needs were met by the care facility. It was observed that the children mainly had three points of contact beyond the facility. These were school, church and health centre. The centre was mainly for shelter and other needs, the church for spiritual needs and the health centre, when they required medical attention.

The children talked about engaging in chores such as cleaning, homework, reading the Bible and gardening. Prayer seemed to come out strongly amongst all the children as they indicated that they always started the day with prayer and then other chores such as cleaning and preparing for school followed. Four (4) boys in particular indicated that their male caregiver often read the Bible to them before they went to sleep. One male participant had this to say:

"*Before we sleep every day, our uncle reads a Bible passage for us. We discuss the word of God and he explains some things if we are not clear. After that we pray together as a family. I enjoy this very much."*

Male participant aged 12

4.9.2.2 Relationship with Caregivers

When asked about their relationships with their caregivers, all the children said their relationships were generally good. Six (6) out of the ten (10) children responded that their caregivers treated them like their own biological children and corrected them when they were wrong. The caregivers disciplined them and provided them with their daily needs. The girls in particular referred to their female caregiver as "mother." The boys however referred to their male caregiver as "uncle" and the female caregiver as "mother." In addition, some of the children mentioned that they depended on their mother for other things such as sewing their clothes. One girl had this to share:

"Our mother takes care of us. She provides us soap for bathing and sanitary needs. Even when we don't have schoolbooks, she provides them for us together with the Director. When we are sick, she takes us to the clinic and gives us medicine. Our mother knows how to sew; she sews on a sewing machine. When our clothes are torn, or maybe you need a button to be put in place, we take them to her and she sews for us."

Female participant aged 16

4.9.2.3 Peer Relationships

When asked about their interpersonal relationships amongst themselves, the children mentioned that they got along fairly well and they did not indicate any serious challenges in this area. They seemed to have formed strong friendships, as some were siblings and the older ones tended to look after the younger ones. The younger ones also seemed to depend on their older brothers and sisters for help with schoolwork and taking care of them when sick. In addition, the older siblings seemed to exercise a level of authority over the younger ones and corrected them when they misbehaved. One of the girls had this to say:

"I depend on the older girls very much. They correct me when I do wrong things. They advise me to stop doing bad things because they say other people won't like me. They tell me to be good to other people so that other people can also be good to me."

Female participant aged 11

Another boy shared how he depended on his elder sister for many things. He specifically shared how he depended on his sister for help when he fell sick. He had this to say:

"Sometime last year, I got sick. I had malaria and I couldn't do some things for myself because I was too sick. My sister would help me with fetching water for bathing; she would also wash my clothes because I was too weak to do anything. When I get homework she also helps me because she is very good at maths."

Male participant aged 12

4.9.2.4 Recreation and Entertainment

Seven (7) out of ten (10) children expressed dissatisfaction with the manner in which the care facility was providing services. They felt that the facility needed to do more in this particular area. They highlighted inadequate recreation facilities in their facility. One female participant had this to share:

"We don't have much to do over the weekend. We wake up, clean our rooms and the outside, then we watch tv. There is no specific time for us to do certain things. Each person takes a bath at his or her own time. We would like to go out and see interesting places, and perhaps even buy some good food from there."

Female participant aged 12

4.9.3 Theme 2: Perceptions of Community towards Children in Residential Care

This theme basically highlighted the reaction of the community towards the adolescents in residential care. The community is this sense was the school, church and the community surrounding the care facility.

4.9.3.1 Reaction from School System: Teachers

The children gave three main responses on the reaction of their teachers after they discovered that they lived in residential care. The first response was that some of the teachers showed the children extreme pity, over protection and treated them differently from their friends who were in family care. The second response was that some of the teachers showed special treatment but in a subtle way. The third response was that some of the teachers did not show special treatment but in fact treated them more or less like the children from family care.

One girl recalled how her teacher showed extreme feelings of pity upon discovering that she lived in an orphanage. The girl had this to share:

"When I was in Grade four, my teacher was something else. She would ask me so many questions when she discovered I was living in an orphanage. She would ask me questions like, how many are you? How do you live? Do they treat you well? She would ask so many questions and I found it very irritating and annoying. "Chifundo china chilamo" (The feelings of pity were too much). She was showing me too much pity and I didn't like it. I just wanted to be treated like a normal child."

Female participant aged 16

One boy whose teacher showed subtle treatment had this to share:

"My teacher treats me well and she understands where I come from. When we have to make contributions towards things like cobra for cleaning the class or other contributions, she doesn't make me pay; instead she pays for me."

Male participant aged 14

One girl aged 12 revealed that her teacher did not give her special treatment but was actually hard on her.

"My teacher treats me well, when I don't do well in class, she encourages me to work harder. She is very hard on me but she shows genuine love and my performance has improved. She just wants the best for me and wants me to grow up well and have a good education and future."

Female participant aged 12

4.9.3.2 Reaction from School System: Peers

The children indicated two main responses when asked what the reaction of their friends was with regards their stay in residential care. The first response was that they were treated well

and also protected from other children who tried to pick fights with them. However, three (3) children indicated that their friends did not know that they lived in an orphanage. Two (2) children reported that some of the children at school were curious to know where they lived and asked if they could visit.

One girl shared that their friends from school and other children treated them well and protected them from the bad children.

"Our friends treat us well. Even the ones who are not our friends but know where we come from are also good to us. When some of the naughty children at school try to fight with us, they come and defend us. They tell the bad children to stop bothering us."

Female participant aged 12

The other response was that their friends just wanted to come and see where and how they lived. One girl aged 14 share had this to share.

"My friend at school asked me if she could come and visit, so I said yes. She came here and we played. She wanted just to know where I lived. She is the only one at school who knows that I live here because she is my friend."

Female participant aged 14

4.9.3.3 Summary

This theme discussed the reaction of teachers and peers towards the adolescents in care. It was evident that the school system played a key role in shaping the behaviour of the adolescents. This is so because some of the adolescents felt that their teachers and peers were giving them special treatment. However, some of the adolescents did not reveal to their peers that they lived in a residential care facility possibly due to fear of being stigmatised.

4.9.4 Theme 3: Family Contact

The theme discussed the impact of family visitations on both adolescents with and without family contact. It also described how the adolescents felt isolated and abandoned by their families. Out of the ten (10) adolescents sampled for the FGD, (4) had family contact, whereas six (6) did not have family contact.

4.9.4.1 Family Contact

Both groups of adolescents with and without family contact indicated some level of stress associated with family visitations. The children who were visited indicated that they wished they could be with their families and felt sad when their parents and guardians had to leave. The children without family contact had two responses. Four adolescents without family contact reported that they did not know how they would react if their parents and guardians visited them. These were the adolescents that were neglected by their parents and guardians. Two (2) adolescents reported that they would be very happy if their parents visited them. Family contact seemed to elicit mixed emotions in the adolescents. This may be because some adolescents did not experience a good exit with their families. One boy without family contact shared this:

"I feel very sad when I see my friends' parents visiting them. I ask myself why my parents don't come. They have never come to see me since I came here, I don't know why. I really miss them. Sometimes I feel like going back to the house where we used to live but I can't remember exactly where the house is. It has been too long."

Male participant aged 12

In addition, the children whose parents and guardians had visited them also shared the feelings of stress.

"*When my mother comes to visit, I feel very happy. But when it is time for her to go, I feel very sad because I want to be with her. I miss her and my brother very much."*

Male participant aged 12

Another child whose mother maintained contact expressed hatred for her father because she felt that he was responsible for her and her sister to be in residential care.

"*I think my father didn't want me, he didn't care for me and didn't love me. I think he didn't want me to be his child. My mother is just okay because she visits my sister and me. My father has never visited us since my sister and I came here in 2009. He has never done anything for my sister and me. I hate him."*

Female participant aged 12

4.9.4.2 Missing Parents and Feeling Frustrated

The children also reported feeling frustrated because of missing their families. This happened as they interacted with other children at school. They expressed being frustrated when their peers talked about their families and what their mothers did for them in their day-to-day interactions. Notably, the girls particularly experienced this.

A female participant had this to share:

"Sometimes my friends at school will start talking about what their mothers did for them maybe over the weekend. I just keep quiet because I have nothing to say about my mother. I haven't seen her since 2007 so what is there to say? I just listen to my friends' stories about their families or I just walk away. It is very hard and I become very upset."

Female participant aged 16

The adolescents also indicated that they missed their parents more when they saw other children with their families. This happened when they interacted with the community around them, like at church or at the health facility or even walking home from school. One female participant had this to share:

"I miss my family and my mother. I miss them more when I see people walking as a family. I envy that a lot. I wish I could just be with my family. I miss my sister very much."

Female participant aged12

Another male child without family contact indicated that there were certain days when he woke up feeling sad because he missed his parents and siblings.

"Sometimes when I wake up, I remember my mother and my sisters. I have all these thoughts all the time. Sometimes I wake up upset and sometimes happy. I just want to see them but I don't cry. I just try to forget about it."

Male participant aged 14

4.9.4.3 Summary

This theme compared the different reactions to family contact. It was evident that family contact was an advantage to some adolescents in the sense that family ties were maintained, therefore, this served as a protective factor. However for some of the children, family contact seemed to elicit feelings of abandonment and resentment. In addition, some of the children were not sure how they would react if their parents and guardians visited them.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter represents a discussion of the findings of the study based on the objectives. This includes psychological well-being of adolescents in residential care and family care; the relationship between gender and type of care on psychological well-being; the type of psychosocial services provided by service care providers and lastly the perceptions of the adolescents about their environment.

5.1 Psychological Well-Being of Adolescents in Residential Care and Family Care

The current study found that adolescents in residential care experienced higher levels of emotional symptoms, conduct problems and peer problems compared to adolescents in family care. The reasons advanced for this difference included the fact that residential care did not provide a conducive environment for child development due to high numbers of children against a smaller number of caregivers. Further, inadequate and lack of individualised psychosocial programmes to deal with various needs of children in residential care could have contributed to low psychological well-being in the residential care adolescents.

Evidence from the current study has been found to be consistent with previous studies undertaken by various researchers who have indicated an association between residential care and low psychological well-being. For instance a study conducted in Jordan by Gearing et. al (2013) revealed that there were high levels of mental health needs among institutionalised youths compared to youths who were in family care. At least 53% of the youths were found to have mental health problems. Another study by Caman & Ozcebe (2011) found a higher

prevalence of psychological symptoms in adolescents living in orphanages than in the general adolescent population.

In addition, the low psychological well-being experienced by residential care adolescents could be attributed to poor coping methods with regards their emotions. The adolescents in residential care reported using methods such as "bottling up feelings" when they were angry or sad. Nirmala & Mary (2007) add that bottled up emotions increases frustrations and stress. Although the adolescents in residential care explained that they had a caregiver whom they called "mother," it was evident that the interactions they had with her was more for help with basic necessities like school requisites and toiletries. It was evident that the adolescents had limited interactions with an adult figure and resorted to bottling up of emotions resulting in low psychological well-being.

The current study also revealed that adolescents in care experienced low psychological well-being because they did not have an adult figure to talk to. The adolescents who participated in the FGD talked about experiencing various emotions such as sadness and anger but had no one to talk to within the care facility. They seemed to rely more on each other as peers. Larson & Brown (2007) assert that children's interactions with their caretakers provide a matrix of affective experiences that shape their early emotional development. Therefore if these interactions are missing in the lives of adolescents, this will impact negatively on their psychological well-being.

According to Csaky (2009) a lack of positive adult interaction from consistent carers can limit children's ability to develop personal confidence and social skills. If children are not always talked to or heard, their emotions may not be well understood by those entrusted to

look after them. In short, children develop social skills as they interact with adults consistently. However, in the current study the adolescents in residential did not have an opportunity to talk to adults as frequently as they should. The lack of interaction with a consistent carer does not provide children to develop social skills which are very cardinal for development.

The adolescents in family care and residential care did not differ much on the hyperactivity and prosocial scales. The adolescents from residential care went to several government schools within their neighbourhood. In addition, all the children in residential care had at least another child from residential care in their class therefore no residential care child was isolated in a class at their school. The interactions with family care children within the school system could be the reason for improved prosocial behaviour.

Although research has demonstrated that there are high levels of hyperactivity among residential care children, the current study did not find significant mean differences between residential and family care adolescents on the t-test. However, a study by Padmaja et.al (2014) in a sample of 40 institutionalised children and 76 family care children found higher levels of hyperactivity in the institutionalised children.

A study by Whetten et.al (2009) however revealed contrasting findings. The study compared 1,357 orphans and abandoned children in institutional care and 1,480 community care aged 6 to 12 years old. According to Whetten et.al (2009), there was more variability among children within care settings than among care settings type. They argued that in countries facing a high orphan burden, some of the institutions were able to provide basic needs to poor

children hence improving their well being. The children in community care did not access any basic services and therefore were stressed and had low psychological well-being.

Bronfenbrenner's theory, on the other hand, focuses on how the environment influences behaviour (Bronfenbrenner, 1979; Bronfenbrenner, 1989). In the current study, the adolescents in residential care experienced low psychological well-being compared with adolescents in family care. The nature of residential care is impersonal and does not provide a nurturing environment because care is provided by a paid caregiver. It has been stated that caregivers often see their role as providing basic needs and not emotional support. Therefore the inadequacy of psychosocial support in the environment may have resulted in low psychological well-being in the residential care adolescents.

Further, Bronfenbrenners's ecological model states that the relationship is bi-directional. This means that while the environment has an impact on adolescents, they (adolescents) also contribute to the shaping of the environment. From the results, some of the adolescents in residential care reported "bottling their emotions" because they had no adult figure to talk to. This clearly demonstrates that the environment contributed to low psychological-well being. Further, the microsystem is the most influential as it affects a child directly. During the FGDs, all the children interviewed revealed that they all came from a family but due to various factors, such as death of parents, divorce, neglect and abandonment, they ended up in residential care.

5.3 Relationship between Gender, Type of Care and Psychological Well-Being on RC and FC adolescents.

The current study also investigated the relationship between gender, type of care and psychological well-being between residential care and family care adolescents. The study hypothesised that boys in residential care would score high on Total difficulties as compared

to girls in residential care. The results of the two-way Anova revealed that there were no significant gender differences between males and females in residential care. Gender did not have a significant effect on psychological well-being. This means that being male or female did not have any significant effect on psychological well-being.

Gender differences between males and females in RC were not observed from the current study sample. A general observation was that PSS services were very limited and poorly planned. The researcher came to the conclusion that the residential care facilities did not implement any comprehensive gender specific PSS programmes to address specific needs of the adolescents. However, type of care showed a significant interaction with psychological well-being. Therefore adolescents in residential care showed low psychological well-being compared to family care adolescents. This finding is consistent with Gearing et. al (2013). Other studies however have found gender differences in psychological well-being. Gearing et. al (2013) found that males scored higher in both externalizing and internalising domains compared to females.

Gender differences were not observed in the current study and this was attributed to inadequate gender specific psychosocial support services. In Gearing's study (2013) the boys experienced low psychological well-being because of inadequate psychosocial support. This clearly demonstrates that the environment is critical in shaping the emotional well-being of a child. According to Bronfenbrenner (1979), the environment that children grow up in has a greater role to play in a child's adjustment process during stressful life periods. Therefore without an adequately resourced environment, adolescents may grow to be deficient in psychological well-being as evidenced from the results.

5.4 Psychosocial Support Services provided by Residential Care Facilities

The current study revealed that there were a number of services offered to children in residential care which included education, health care, shelter, life skills, counselling and nutrition. The findings revealed that all three residential care facilities did provide psychosocial services but in an adhoc manner. The management of residential care facilities needed to prioritise the provision of psychosocial support services in order to improve the psychological well-being of the adolescents. Residential care in most cases emphasises mainly on the provision of basic needs such as food, clothing and shelter at the expense of key areas such as psychosocial support. Although all three facilities sampled did indicate some activities in psychosocial support, these were inadequate and were poorly planned with no specific outcomes for each child.

This finding was consistent with a study undertaken in Botswana. According to Maundeni (2009), one of the gaps in service delivery identified is the tendency for human service professionals, including social workers, to focus more attention on addressing clients' basic needs as opposed to or inclusive of psychosocial support. Therefore, while these basic needs are important and must be met, neglecting the emotional and psychological needs of children in residential care may be a potentially harmful practice.

Further, the study found that all three residential care facilities experienced financial challenges. In the absence of a sound financial base, service delivery is affected. A study analysing the costs of residential care was undertaken in Romania, Ukraine, Moldova and Russia. The findings suggested that residential care was expensive to run. According to Csaky (2009) the cost-per-user for residential care was six times more expensive than

providing social services to vulnerable families or voluntary kinship carers. Therefore family based alternatives such as foster care and adoption should be encouraged.

As evidenced from the results, psychosocial support services were poorly planned and inadequate. The Minimum Standards fall within the framework of the ecological model, specifically in the exosystem. According to Bronfenbrenner (1979) some of the things that may affect a child's life include new legislation and policy. From the findings in the current study, residential care facilities did not implement psychosocial support programmes because of various reasons such as inadequate human resource and capacity, including inconsistent inspections by policy makers. All these factors trickled down to the adolescents not being provided with adequate care resulting into low psychological well-being. This "trickle down" effect demonstrates that policy and legislation matters affected the adolescents but had no control over them.

5.5 The Perceptions of Adolescents about their Environment.

The current study found that the most common cause of children being in residential care was abuse and neglect. Poverty and delinquency were also cited as reasons why children found themselves in care. This finding was consistent by studies by Csaky (2009) who stated that poverty and social exclusion are two main reasons why children were unable to live at home. She further pointed out that that some parents placed children in care to ensure their basic needs were met and they got educated.

It should be noted that the factors that push children to be in residential care depend on the family dynamics are not caused by a single factor but by an interaction of different factors. This is also supported by Bronfenbrenner's Ecological model. The underlying premise of the

model is that adolescents do not develop in a vacuum but within the contexts of their families, communities and countries and are influenced by peers, relatives and other adults with whom they come in contact (Rice, 1999; Schaffer & Kipp, 2010).

The model also states that the way in which a child or adolescent develops is not only influenced by his or immediate environment, but also by things in their surrounding environment such as family, culture and the government (Bee, 1992).The findings of the study indicate that all the children sampled from the FGDs came from a family background but along the way, risk factors pushed them out of their homes into residential care. These included poverty, abandonment, neglect and abuse. Before the children ended up in residential care, they passed through a number of institutions such as Social Welfare, the police and family.

A key finding in the FGDs was that the adolescents generally felt neglected as some of them still had surviving parents who had never visited them from the time they entered care. This finding was consistent with a study undertaken in Zimbabwe on 189 youth from residential care. Powel et. al (2005) found that many children in care institutions felt abandoned by their extended families. Further the children expressed dissatisfaction on certain aspects of care, particularly social needs. This seemed to hinge on two factors, lack of adequate finances to provide quality services and inadequate skills of caregivers to provide programmes and activities beneficial to the development of children. The residential care managers in this study cited financial challenges which in turn affected their service delivery.

A similar finding was found in Botswana in a study by Morantz and Heymann (2010). The researcher examined the stories of children in a residential care facility. The finding was that

the children described being separated from siblings, missing their families and feeling disconnected from the community at large. This finding is consistent with the current study.

Another key finding was that people in the community reacted differently to children living in residential care. Some of the children indicated extreme feelings of pity, subtle ways and no reaction at all. Children generally cited having friends from three main points, school, church and within the facility. They reported that they did not socialise with children in the neighbourhood because they were not allowed to do so. A study by Tolfree (2004) suggests that physical separation of institutionalised children from communities has been justified on the basis of enhancing their safety and protection. However Csaky (2009) argues that this separation of children encourages their stigmatisation and ostracisation by community members. The inadequate interactions with other children and community members could be the reason why some of the children were seemingly overprotected and possibly stigmatised particularly in the school system.

Family visitations were also a key finding in this study. Generally, there were mixed feelings among adolescents who were visited and those who were not. Children who were visited by parents or family members reported feeling stressed because they missed home and wished to be with their parents. The children who were not visited expressed mixed feelings in the sense that while one group expressed that they would be happy if they too could be visited, the other group of children were not sure of what their reaction would be if they were visited.

This finding was similar to a study in the United Kingdom by Berrige et. al (2010) on children's residential care homes. The study indicated that although the majority of children had regular contact with parents, residential care staff rated this contact as "mainly positive"

in less than half of the children. This was because it elicited mixed feelings on half of the young people who saw their parents.

Further interactions with the children on their future seemed very positive. Some of the children reported feeling confident about their future while others chose to focus on immediate short term goals such as getting educated. Others expressed their desire to be with their parents after they completed education. A contrasting finding was found by Powel et. al (2005) in Zimbabwe where the majority of youth in care were worried about their future after exit from care. However the finding was attributed to the fact that the care institution's level of preparedness was low. In this case we could conclude that the children may have been or were being prepared adequately about their future, hence the positive response about their dreams and ambitions. The children also addressed a very important area of social protection. They asserted that the Government must put in place measures to assist poor people with access to education, health care and housing.

The family is the basic unit of society. According to the findings, the family visitations were received with mixed feelings. Generally this theory is consistent with the findings of this study because the home and family are critical in investigating the development of adolescents. They are critical in the sense that any influences or any changes in the environment affected the adolescents. For instance the inadequate psychosocial services in the residential care facilities may have resulted in low psychological well-being in the adolescents.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter constitutes a summary of the findings of the study, limitations and recommendations for future research. The conclusion represents the findings of this study as well as reviewed literature.

6.1 Summary of Research Findings

The aim of this study was to investigate the psychological well-being of adolescents in residential care and family care; gender differences in psychological well-being between family care and residential care adolescents; the type of psychosocial social services provided by residential care service providers and to examine the perceptions of adolescents about their environment. The study's thrust was based on Bronfenbrenner's ecological model, stating that adolescents were influenced by many events in their lives as they moved from one setting to another such as school, family, legal system and so on. In addition, adolescents also influenced their environment around them.

The current study found that there were significant differences in psychological well-being between family care and residential care adolescents, with residential care adolescents showing low psychological well-being. Emotional symptoms, conduct problems and peer problems were three of the subscales that showed significant differences in psychological well-being between residential care and family care adolescents. Further, no gender differences in psychological well-being were reported in this sample despite other studies indicating differences in gender and psychological well-being. The psychosocial support

services provided by residential care service providers included counselling, talks, games and these were incorporated with spiritual instruction. It was revealed that psychosocial support was provided in an uncoordinated manner based on each facility's capacity, with no specific outcomes for each child. The residential care service providers bemoaned the high cost of hiring professional staff such as psychologists and social workers to work with children.

With regards perceptions of their environment, residential care adolescents expressed satisfaction with meeting of their basic needs but expressed dissatisfaction with recreation facilities. Residential care adolescents expressed mixed feelings about family contact, while others appreciated the contact; other adolescents seemed not to be sure of their reaction if their family members visited them. Other adolescents felt stressed by family visitations because they missed their parents and guardians after they left. While adolescents in care appreciated the fact that being in care enabled them access social services such as education and health and counselling, there was unanimous agreement among them, preferring family care than residential care.

6.2 Conclusion

When compared to the general adolescent population, adolescents living in residential care are disadvantaged. Comparative studies of children living in residential care and those in family care have consistently demonstrated that RC adolescents have low psychological well-being. This has been attributed to the nature of residential care being impersonal. It has been observed generally that children have inadequate consistent care from a consistent caregiver thereby making children unable to form strong bonds with adults.

Residential care service providers face human and financial challenges thereby affecting service delivery to the adolescents under their care. This affects the quality of service delivery and undermines the rationale of the Minimum Standards of Care. Even though

residential care is not the best option, children in care may benefit from psychosocial support. However, although guidelines for mainstreaming psychosocial support are in place, there are no "stand alone" guidelines for the provision of psychosocial services in residential care. Further, the Minimum Standards of Care do not cover psychosocial support comprehensively. Consistent and comprehensive psychosocial services for children in residential care may help improve their well-being and perhaps reduce the inadequacy caused by long stay in care.

This study suggests that RC may not be the best model of care for adolescents because of the evidence of detrimental effects on the psychological well-being of adolescents. Although comprehensive studies in Zambia have not been undertaken, the current study found consistent results with research that has been undertaken in various parts of the world to demonstrate that RC may not be the best model of care.

6.3 Recommendations

1. Strengthening Social Protection

The study revealed that some children placed in residential care did not need to be in care. Too frequently, residential care has been used as a first resort and not the last in the continuum of care for vulnerable children.

a) Therefore, the Government and its collaborating partners need to increase the resource base for social protection programmes in order to capture as many vulnerable families and communities as possible. This will help reduce the number of children in care and also prevent more children ending up in residential care.

b) Strengthen systems to identify families and children at risk of entering the care system by equipping vulnerable communities with sustainable empowerment programmes and basic social services.

2. **Guidelines for provision of Psychosocial Services**

   Interviews with key staff in residential care facilities revealed that psychosocial support was an important area which was not well understood. Although the Government developed the Minimum Standards of Care for Child Care Facilities, the standards generally describe the essential requirements of care but do not provide comprehensive information on psychosocial support. Therefore, there is need to develop guidelines for psychosocial support that will help service care providers to provide quality care to children in residential care.

3. **Promotion of family based care models**

   The Government must promote and strengthen the use of family based care models such as adoption, foster care and kinship care to ensure continuity of the family ties.

4. **Professional bodies to Provide Services**

   Professional bodies for Social Workers and Psychologists should provide services to needy communities and children to help cushion the high cost of hiring professionals in child care.

6.4 Recommendations for Future Research

Research across the globe has shown that residential care causes a degree of psychological harm to children. The current study focussed on the psychological well-being of adolescents in residential care. It is therefore recommended that:

1. Research on the long-term effects of residential care on children and adolescents must be undertaken in Zambia in order to assess the psychological well-being of children and adolescents after leaving care.

2. A large scale study at country level or selected provinces could be conducted to assess the influence of other factors such as culture on psychological well-being of adolescents in care.

6.5 Implications

Residential care still remains the first option in the continuum of care for children and adolescents in need of care and protection despite it being a measure of last resort. This is because it is the easiest way of ensuring that adolescents who require immediate shelter and protection are assisted. However, research has suggests that residential care may cause psychological harm to children because of the lack of a consistent caring adult with whom children can form an emotional bond. This study has documented that adolescents living in residential care have low psychological well-being compared to adolescents in family care. Therefore there is urgent need for advocacy to spearhead the promotion and use of other forms of alternative care such as foster care, kinship care and adoption to ensure that adolescents are placed in family care options rather than residential care.

Reintegration of children with their families must be a top agenda for policy makers. However, there has been inadequate documentation in this area. A structured and well organised supportive system must be in place to ensure that children and families are ready for this process. It takes resources, political will, skilled and well-equipped care workers and most importantly, child participation to ensure a smooth implementation of such programmes.

Although Zambia is a signatory to the UN Convention of the Rights of the Child, the domestication of the Convention into national laws, policies and guidelines has lagged behind. However, there has been significant progress to ensure that residential care services for children in need of care are provided within the set international and national standards.

To this end, there has been a development of the Minimum Standards of Care for Child Care Facilities by the Government of the Republic of Zambia. These are a set of guidelines that residential care providers are supposed to adhere to in the implementation of programmes and services to children. Monitoring of the residential care facilities however remains inadequate and irregular due to administrative and geographical challenges.

Furthermore, there seems to be a relationship between social protection and residential care. Inadequate Social Protection programmes have resulted into adolescents being placed into residential care. Some of the adolescents in the current study reported a lack of basic social services such as education, health and food within their family environment. There is need to reorganise the Social Protection system to ensure that coverage is increased and re-assess the current targeting of vulnerable families and communities. Social Protection is very critical because its inadequacy results in a myriad of problems at household, community and national levels, one of which is adolescents being placed in residential care.

6.6 Limitations and Strengths of the Study

6.6.1 This study had the following limitations:-

1. The SDQ-Y was a self report. Therefore it was possible that the participants (adolescents) could have under reported or over reported the symptoms.
2. The ages of the children in residential care could not be validated by birth records; therefore accuracy of age was based on the information provided by the caregivers and in some instances the children themselves.

6.6.2 Strengths of the Current Study

1. A major strength of the current study was that the SDQ-Y has been documented to have good reliability and validity as a data collection tool.

2. The current study focussed on adolescents, a group were data is usually not readily available. A previous study on mental health in residential care settings sampled children between 7 to 17 years. The current study targeted the adolescent group from 11 to 16 years old.
3. The current study also used a comparison sample, that is, adolescents living with their families unlike previous studies at national level which focussed on children in residential care only.

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APPENDICES

Appendix 1: STRENGTHS AND DIFFICULTY QUESTIONNAIRE- Youth Version

For each item please tick the box for not true, somewhat true, or certainly true. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your number…….....Male / Female……..

Date of birth…….

		Not True	Somewhat True	Certainly True
1.	I try to be nice to other people. I care about their feelings.			
2.	I am restless; I cannot stay still for long.			
3.	I get a lot of headaches, stomach-aches or sickness.			
4.	I usually share with others, e.g. CDs, games, food.			
5.	I get very angry and usually lose my temper.			
6.	I would rather be alone than being with friends of my age.			
7.	I usually do as I am told.			
8.	I worry a lot.			
9.	I am helpful if someone is hurt, upset or feeling ill.			
10.	I am constantly fidgeting			
11.	I have one good friend or more.			
12.	I fight a lot. I can make other people do what I want.			
13.	I am often unhappy, depressed or tearful.			
14.	Other people my age generally like me.			
15.	I am easily distracted, I find it difficult to concentrate.			
16.	I am nervous in new situations, I easily lose confidence.			
17.	I am kind to younger children			

18.	I am often accused of cheating			
19.	Other children or young people pick on me or bully me.			
20.	I often offer to help others (parents, teachers, children)			
21.	I think before I do things.			
22	I take things that are not mine from home, school or elsewhere.			
23.	I get along better with adults than with people of my age.			
24.	I have many fears, I am easily scared.			
25.	I finish the work I am doing. My attention is good.			

Appendix 2: SOCIO DEMOGRAPHIC QUESTIONNAIRE

Topic: The Implications of Residential Care on the Psychological well being of Adolescents in Lusaka Urban.

Name of Researcher:.....

Date of Interview:.....

Place of Interview.....

My name is **.....**You are being asked to join a research study. The goal is to determine the **implications of residential care on the psychological well-being of adolescents.** First, you need to know all about this study and what you will need to do if you join this study. We will answer any questions you have. After we have told you everything and you understand, you can decide if you want to join or not. If you agree to join, you will need to sign. You can keep a copy and we will keep a copy here.

Information sheet

It is your choice to join this study.

You may choose not to join the study.

If you choose to join the study, you can leave the study at any time.

If you choose to join the study, you do not have to answer any questions that you do not want to. If you choose to join the study, no information about you will be given to anyone.

Part A: Background Information

Direction: please indicate your answer by making (✓) in the box that corresponds to your answer or to write the correct answer on blank space.

1. Code Number:**.....**
2. How old are you (Age)**.....**
3. Sex a. Male**.....**b. Female**.....**
4. Are you in school at the moment? (Please tick)

a. Yes ( )

b. No ( )

5. If yes, what is your present grade?

.....

6. Are your parents alive? Please tick in the ( )

a. Mother Yes ( )

b. Father Yes ( )

c. Mother No ( )

d. Father No ( )

Part B (Caregivers to assist)

6. When did adolescent come into your care**?.....**

.....

7. What was the reason/s for adolescent coming into your care?

.....
.....
.....

8. How long has child been in your care?

.....

9. Does adolescent have siblings in this facility? Please tick

Yes**.....**No**.....**

10. If yes, how many? **.....**

11. How is the child's general behaviour**?.....**

.....

12. Does the child's family visit him or her**?.....**

Thank you.

Appendix 3: INTERVIEW GUIDE WITH RESIDENTIAL CARE MANAGERS

Interview guide for residential centre managers/staff

Designation of respondent……Male/Female.....

Name of Centre…….....

Date of Registration.....

Location…….....

Target Group.....

Total Number of Children.....Boys.....Girls.....

1. What services does your facility provide for children and adolescents?
…….....
…….....
…….....
…….....
2. What psychosocial support services/activities do you provide?
……..
.....……
…….....
3. How often are these services provided?

.....
.....
4. Do you engage other people to assist you with PSS? If yes provide details.
.....
.....
.....
8. What is your level of Education?

.....

9. How long have you worked here**?.....**

10. Have you or any other caregivers received training in psychosocial support? Yes/No
.....

11. If yes, when was the training undertaken**?.....**

12. How did you find the training (was it useful, has it helped you in your work)? If yes provide specific examples.

.....
.....

13. Do you have guidelines from Government on how to run your facility?
Yes.....No.....

If yes provide additional information
……..
……..
……..
……..

14. What challenges does the institution face in delivering services to adolescents?
……
……
……
……
……

15. What are some of the ways in which these challenges can be addressed?
.....
.....
.....
.....
.....

Signature ……..

Date……..

Thank you very much for your help

APPENDIX 4: FOCUS GROUP DISCUSSION GUIDE FOR ADOLESCENTS IN RESIDENTIAL CARE.

Research Topic: The Implications of residential care on the psychological well-being of adolescents: A case of Lusaka Urban.

Date of group discussion.....

Time.....

Place.....

Number of participants.....Boys.....Girls.....

Moderator/s.....

Facilitator's welcome, introduction and Instructions to Participants

Welcome and thank you for volunteering to take part in this focus group. You may have been asked to participate as your point of view is important. I realise you are busy but I appreciate your time.

Introduction

This focus group discussion is intended to examine the perceptions of adolescents about their environment. May I tape the discussion to facilitate its recollection? (If yes, switch on the audio recorder).

Anonymity

Despite being taped, I would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the FDG will contain no information that would allow individual subjects to be linked to specific statement. You should try to answer and comment as accurately and truthfully as possible. I and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you wish to answer or participate in, you do not have to do so; however please try to answer and be as involved as possible.

Ground Rules

i. The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.

ii. There are no right or wrong answers

iii. You do not have to speak in any particular order.

iv. When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you.

v. You do not have to agree with the views of other people in the group and it is important that I obtain the views of each of you.

vi. Does anyone have any questions? (answers)

vii. OK, let's begin

Warm Up

Can you tell me about yourself? How old you are and what your favourite colour is.

Part 1 Introductory Question

1. Do you have friends? Would you like to tell me who they are?
2. Who is the most important person to you in this place?
3. How did you find yourself here?
4. Could you tell me what it is like to be here with your friends and caregivers?

   Probe: What do you do? Playing?

5. How is your relationship with your friends and caregivers?
6. Could you tell me about your friends at school? How do they treat you? What about your teachers and the neighbourhood here?
7. Who do you go to when you need help?

   Probe: Your friends? Your caregivers? Your teachers?

8. How do you feel about being in this place?

   Probe: Do you miss your family?

9. What do you think is the best place for a child to be raised in?

10. What concerns do you have for this place? Any suggestions for improvement of the facility?

Concluding Question

Of all the things we've discussed today, what would you say are the most important issues you would like to express?

Conclusion

- Thank you for participating. This has been a successful discussion.
- Your opinions will be a valuable asset to the study.
- We hope you have found the discussion interesting.
- If there is anything you are unhappy with or wish to complain about, please contact me later.
- I would like to remind you that any comments featuring in this report will be anonymous.
- Before you leave, please hand in your completed **personal details questionnaire. (attached as Appendix 2, part A)**

APPENDIX 5: INFORMATION AND ASSENT FORM FOR YOUNG PEOPLE (<16 YEARS)

What is the title of the research?

The Implications of Residential Care on the Psychological Well-Being of Adolescents in Lusaka Urban.

What is research?

- Doing research helps us find out new things about the way the world and people work.
- It also helps us find answers to problems facing us, peoples' feelings, thoughts, experiences, and things they like and don't like.
- Research also helps us find better ways of helping all kinds of people who may not be feeling so well.

These are some important things to know about research:

- You can say YES or NO about taking part in research
- You should have a chance to say YES! I want to take part, or NO! I don't want to.
- Some people may need more time to make a choice about taking part in research. They may take all the time they need.

Saying YES or NO:

- The researcher must go through this form with you to see if you want to take part in the research.
- This form helps you understand how your words will be used in the research.
- Then you can say if it's ok or not for us to use your words
- This is called giving your permission
- Another word for permission is consent.

Who is doing the research?

- I am the researcher. My name is Monica Mwenda-Jalasi. I come from **University of Zambia**
- I am trying to find a way for you to have your say, and for more people to listen to your words
- I am also trying to find a way to help you better, especially about issues of learning, your psychosocial needs, school and general relations with peers and others.

What is this research project all about?

- This research is about finding ways to help you

- One way of doing this is to listen to you; and listen to anything you want to talk about.
- I would also like to hear about how you live here, how you cope with daily challenges, what you think about things and how you feel about things.

Why have you been invited to take part in this research?

- I need people to help me with our research
- You can help me because you are a person who is living in residential care
- You have experiences about this that nobody else does.

What will happen to you in this study?

- This research is also about finding ways to help you or other people like you in the future.
- To do this I need to find out some things about you.
- We can make appointments to meet one another when it is a good time for you, or we can talk now.
- I will listen to anything you want to share with me
- I will talk to you about the things you want to talk about
- Together we will make sure that you are happy with your words
- I will only share the things you tell me with other people that I work with.
- I might need to talk to other people who will help and support you
- This is to make sure you are getting help from people who can support you the best
- But you can tell me if there are people that you do not want me to talk to about your words.

Can anything bad happen to you?

- I will try very hard to make sure nothing bad happens to you
- Some of the things you talk about could make you sad or angry, or remind you of sad things, or things you don't want to think about.
- I will try my best to listen about your sadness, or tell you about other people that can maybe help you.

Can anything good happen to you?

- I hope that you will like talking with me
- I hope that something good can happen to you, but I am not sure what that will be yet
- This is why I would like to do the research – so I can find out how to help you and other people like you

Will anyone know you are in the study?

- I will not tell anyone your name
- I will not give information about you to anyone else

- I will only use your words for my information
- I will not out your name with your words
- But I will ask you before I let anyone else see your words
- Your words will be kept safe in a special file with a number on it. Not your name.
- Your file will be locked away safely
- I will keep a copy of this form
- If you want to see your information, you can ask me

Who can you talk to about the study?

- You can talk to someone you trust about getting involved in the research
- This could be a friend, a care worker, teacher, another staff member, or a family member. Is there someone like this?
- This person should check that you understand what your words will be used for
- This person will be called your witness
- Your witness will sign to say that he or she has helped you understand about getting involved
- He or she will help you understand what you are giving consent for

What if you do not want to do this?

- You do not have to take part in the research if you do not want to
- This will not impact negatively on your life in any ways
- You can ask me at any time to stop using your words
- If you ask me, I will not put your words on paper or record them
- Even if you said yes in the beginning, you can change your mind to no
- You will not be doing anything wrong if you want to stop
- You will not get into trouble
- You can tell me if you have any questions about your information
- Remember, you can say YES or No about taking part. It's up to you.

What if you have any questions or complaints?

- If you have any questions now or during the interview, please feel free to ask me anything.
- If you have any questions after me and my colleagues have left your community, you can contact the lead researcher:

Mrs. Monica Mwenda-Jalasi

Address: P.O. Box 51009 RW, Lusaka.

Phone #: 0977 808958

Email: monica.jalasi@gmail.com

- If you have any complaints about the researchers or the research, you can contact you can contact the Ethics Committee, or the Director of Research at University of Zambia:

  Chairperson, Humanities and Social Sciences, Research Ethics Committee

  Address: University of Zambia, Great East Road Campus, P.O. Box 32379, Lusaka

  The Director, Directorate of Research and Graduate Studies

  Address: University of Zambia, Great East Road Campus, P.O. Box 32379, Lusaka

  Phone #: +260-211-290 258

APPENDIX 6: WRITTEN ASSENT FORM

Young People (<16 years)

Title of Research: The Implications of Residential Care on the Psychological Well-Being of Adolescents in Lusaka Urban.

The participant should complete the whole of the sheet himself/herself, please circle your answer.

1. Have you read and understood the information sheet? YES/ NO
2. Do you understand this research study and are you willing to take part in it? YES/NO
3. Do you have any questions about the research? YES/NO
4. Did the researcher answer all your questions? YES/NO
5. Do you understand that you can stop being a part of the study at any time? YES/ NO

If you agree to take part in the study, please sign below:

Signature:_____

Name (In Block Letters):_____

Date:_____

(Participant)

I have explained the study to the above participant and he/she has indicated his/her willingness to participate.

Signature:_____

Name (In Block Letters):_____

Date:_____

(Researcher)

APPENDIX 7: APPLICATION FOR ETHICAL APPROVAL

UNZAREC

FORM 1

The University of Zambia

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Telephone: 290258/291777 P O Box 32379

Fax: +260-1-290258/253952 Lusaka, Zambia

E-mail drgs@unza.zm

Your Ref:

Our Ref:

APPLICATION FOR ETHICAL APPROVAL FOR PROPOSED RESEARCH INVOLVING HUMAN PARTICIPANTS

1. **TITLE OF STUDY**:

An exploratory study on the implications of residential care on the psychological well-being of adolescents: A Case of Lusaka Urban District.

2. Principal Investigator:

Name: **Monica Mwenda-Jalasi** Qualifications: **Master of Communication for Development (MCD), Bachelor of Arts with Education (Special Education).**

Present Appointment/Affiliations: **Student, Master of Arts, Child & Adolescent Psychology, University of Zambia**

3a. **OTHER INVESTIGATORS**:

Name: **N/A** Qualifications: **N/A**

Present Appointment/Affiliations: **N/A**

Name: **N/A** Qualifications: **N/A**

Present Appointment/Affiliations: **N/A**

(Other names to be included on a separate page)

3b. **SUPERVISORS**:

Name: Dr. Anitha J. Menon **Qualifications**: PHD, Health Psychologist

Present Appointment/Affiliations: Lecturer, Psychology Department, School of Humanities and Social Sciences, UNZA. Chairperson, UNZA Committee on HIV and AIDS, 2008 till present.

Name: N/A Qualifications:N/A

Present Appointment/Affiliations:**N/A**

3c. Co-Supervisor/Mentor in Zambia (This section is for all researchers outside Zambia)

Name: **N/A** Qualifications: **N/A**

Present Appointments/Affiliations:

Name: **N/A** Qualifications: **N/A**

Present Appointments/Affiliations:

---

4. SUMMARY OF PROPOSED RESEARCH

A summary of the project proposal should include background to the study, aims and objectives, participants to be studied and research methods to be used. Technical terminology should be avoided as much as possible.

(Use not more than one additional A4 sheet if necessary)

---

5. ARE THE PARTICIPANTS DEPENDENT ON ANY OF THE INVESTIGATORS

As students: Yes ☐ No ☐ As employees: Yes ☐ No ☐

As patients: Yes ☐ No ☐ In other ways: Yes ☐ No ☐

If 'Yes' to any of the above, give details

N/A

N/A

6. POSSIBLE BENEFITS TO PARTICIPANTS:

The benefit to participants will be indirect and will hinge on the cardinal role of policy makers, implementers and planners. Therefore, it is expected that policy makers will begin to implement policies in the best interests of children and regulate service providers so that they provide care and support within the required standards of care. This in turn will have a positive impact on the overall well being of children.

7. POSSIBLE RISKS TO PARTICIPANTS

It is likely that the participants (adolescents) may be distressed due to separation through death or abandonment of their parents or primary caregivers.

8. **POSSIBLE BENEFITS TO THE COMMUNITY**

It is expected that the study will promote community based care of vulnerable and orphaned adolescents as opposed to residential care, thus promoting the important role the family plays in the development of a child. In addition, it is expected that the cultural role of the extended family shall be promoted and acknowledged. Further, psychological well being of adolescents is enhanced by strong family ties, therefore positive mental health will result in reduced crime, burden of care and increased family interactions.

9. **BUDGET**

(a) Financial support (requested or granted): Yes ☐ No ☐
SPONSOR SELF

(b) Are there costs which will be carried by other institutions Yes ☐ No ☑

(c) Are there costs which will be carried by the participants involved (e.g. travel, accommodation, meals, treatment)? Yes ☑ No ☐

If 'Yes' to any of the above, give details:

Participants may require transport and meals in order for the researcher to meet them in a central place. In addition, since the target group are children, they will need to leave the school for instance later than usual due to this exercise and may require food and transport to ease their burden of getting to their various homes.

---

10. **SUBMISSION (**Please take note of UNZAREC Forms1a and 1b**)**

A. **For Normal Review** at regular monthly meetings**,** attachments should include:

(i) 5 copies of Full Protocol Yes ☐ No ☐

☐ ☐

(ii) 15 copies of Summary of Protocol Yes ☐ No ☐

(iii) 15 copies of Questionnaire and/or interview schedules Yes ☐ No ☐

(iv) 15 copies of Information Sheet Yes ☐ No ☐

(v) 15 copies of Consent Form Yes ☐ No ☐

(vi) 15 copies of letter approving of or giving ethical clearance to the project proposal if it is a sponsored research related to another University Yes ☐ No ☐

(vii) 15 copies of Budget

(viii) 15 copies of Time Line

B. For Expedited Review, attachments should include:

(i) 5 copies of Full Protocol (to include the following): Yes ☐ No ☐

(ii) 8 copies of Summary of Protocol Yes ☐ No ☐

(ii) 8 copies Questionnaire and/or interview schedules Yes ☐ No ☐

(iii) 8 copies of Information Sheet Yes ☐ No ☐

(iv) 8 copies of Consent Form Yes ☐ No ☐

(v) 8 copies of Letter approving the project proposal if it is a sponsored research related to another University Yes ☐ No ☐

(vi) 8 copies of Budget Yes ☐ No ☐

(viii) 8 copies of Time Line Yes ☐ No ☐

11 DECLARATION

I……**MONICA MWENDA-JALASI**……

(Full Name) Apply to the Humanities and Social Sciences Research Ethics Committee of the University of Zambia for approval of the above research proposal involving human participants, as conforming with recognized ethical standards and as not impinging on the rights of the individuals.

Signed:…….Date: ……...

PRINCIPAL INVESTIGATOR

Contact Address:

P.O. Box 51009 RW,

LUSAKA.

Telephone No: …**N/A**……Fax No: **N/A**…….

Cell phone No: **0977 808958 or 0966 808958**

…….

E-mail address: **monica.jalasi@gmail.com**

……

Full name and address of Local Co-Supervisor/Member (if applicable):
N/A……...

……
…..……..
……

Signed: ……N/A…… Date: ……...

Full name and address of Head of Department or Head of relevant Organisation:

Dr. Hateembo Mooya

Psychology Department,

School of Humanities and Social Sciences,

P.O. Box 32379,

LUSAKA.

Signed: …….. Date: ....……..

Full name of Dean (if proposal from Head of Department):

…N/A…….
…….....

Signed: … N/A…….Date: ……....

APPENDIX 8: PARTICIPANT INFORMATION SHEET UNZA REC FORM 1a

UNZAREC FORM 1a

THE UNIVERSITY OF ZAMBIA

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: 290258/ P O Box 32379

Fax: +260-1-290258/253937 Lusaka, Zambia

E-mail drgs@unza.zm

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

PARTICIPANT INFORMATION SHEET

TITLE OF RESEARCH:

The implications of residential care on the psychological well-being of adolescents in Lusaka Urban.

PURPOSE OF THE STUDY:

The aim of this research will be to investigate the implications of residential care on the psychological well-being of adolescents.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT:

The study will be undertaken in Lusaka in selected residential care facilities, basic and high schools. It is a mixed methods study employing both quantitative and qualitative methods. Adolescents aged 11 to 16 years will be eligible to participate in the study. Their caregivers will also be targeted for the study.

CONFIDENTIALITY:

The information collected in this interview will be kept strictly confidential.

VOLUNTARY PARTICIPATION AND WITHDRAWAL:

Your participation in this research is entirely voluntary, i.e. you do not have to participate if you do not wish to. If you decide to take part, you are still free to withdraw at any time without penalty or loss of services and without giving a reason for your withdrawal.

RISKS AND BENEFITS:

The participants are likely to experience distress because they have experienced loss and separation from the primary caregiver. With regards the benefits of the study, it is expected that policy makers will begin to implement policies in the best interests of children and regulate service providers so that they provide care and support within the required standards of care. This in turn will have a positive impact on the overall well being of children.

CONTACTS FOR QUESTIONS (Names, addresses and phone numbers of the following):

1. Principal Investigator
   Monica Mwenda-Jalasi
   P. O. Box 51009 RW
   LUSAKA.
   Tel: 0977 808958

2. Chairperson,
   Humanities and Social Sciences,
   Research Ethics Committee
   University of Zambia.
   LUSAKA.

3. The Director,
   Directorate of Research and Graduate Studies (DRGS)
   UNZA, **LUSAKA.**
   Tel: +260-211-290 258

APPENDIX 9: UNZA REC Consent form

UNZAREC FORM 1b

THE UNIVERSITY OF ZAMBIA

DIRECTORATE OF RESEARCH ND GRADUATE STUDIES

Telephone: 290258/

P. O. Box 32379

Fax: +260-1-290258/253937 Lusaka, Zambia

E-mail drgs@unza.zm

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

CONSENT FORM

(Translated into vernacular if necessary)

TITLE OF RESEARCH: The Implications of residential care on the psychological well-being of adolescents in Lusaka Urban.

REFERENCE TO PARTICIPANT INFORMATION SHEET:

1. Make sure that you read the Information Sheet carefully, or that it has been explained to you to your satisfaction.

2. Take note of whether tape or 'audio' recording will be used.

3. Your participation in this research is entirely voluntary, i.e. you do not have to participate if you do not wish to.

4. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled.

5. If you decide to take part, you are still free to withdraw at any time without penalty or loss of services and without giving a reason for your withdrawal.

6. You may choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

7. The information collected in this interview will be kept strictly confidential.

8. If you choose to participate in this research study, your signed consent is required below before I proceed with the interview with you.

1. ----------

VOLUNTARY CONSENT

I have read (or have had explained to me) the information about this research as contained in the Participant Information Sheet. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.

I now consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature below says that I am willing to participate in this research:

Participant's name (Printed): …….....……

Participant's signature: …… Consent Date…….....

Researcher Conducting Informed Consent (Printed) **Monica Mwenda-Jalasi**…

Signature of Researcher: ……..…….. Date: ……

Signature of parent/guardian: ……. Date:.....

THE UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND GRADUATE STUDIES
Telephone:260-211-280258/293937 P O BOX 32379
Telefax:260-211-280258/293937 LUSAKA, ZAMBIA
E:mail: drgs@unza.zm
IRB 00006464
IORG: 000376

==========

17th November 2014

Monica Mwenda-Jalasi
P. O. Box 51009 RW
LUSAKA

Dear Mrs. Jalasi

APPLICATION FOR ETHICAL APPROVAL OF STUDY

Reference is made to your application for ethical approval for your study entitled "***An exploratory study on the implications of residential care on the psychological well-being of adoscents: A case of Lusaka Urban District***".

As your research does not contain any ethical concerns, you are hereby given an exemption from full ethical clearance to proceed with your research.

ACTION:	**APPROVED**
DECISION DATE:	**17th November 2014**
EXPIRATION DATE:	**18th November 2015**

Please note that you must also obtain written authority from the Permanent Secretary, Ministry of Health before conducting your research. The address for Permanent Secretary, Ministry of Health, Ndeke House, P O Box 30205, Lusaka: Tel+260-211-253040/5 Fax: +260-211-253344.

Finally, please also note that you are expected to submit to the Directorate of Research and Graduate Studies a Progress Report and a copy of the full report on completion of the project.

Dr. Augustus Kapungwe
CHAIRPERSON, HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

Cc Director, Directorate of Research and Graduate Studies
Assistant Director, Directorate of Research and Graduate Studies
Assistant Registrar (Research), Directorate of Research and Graduate Studies

All Correspondence should be addressed to the Permanent Secretary
Telephone: +260 211 253040/5
Fax: +260 211 253344

In reply please quote

MH/101/17/6
No......

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

NDEKE HOUSE
P. O. BOX 30205
LUSAKA

11th December, 2014

Ms. Monica Mwenda-Jalasi
P.O. Box 51009 RW
LUSAKA.

Dear Ms. Mwenda-Jalasi,

Re: Request for Authority to Conduct Research

The Ministry of Health is in receipt of your request for authority to conduct a study titled **"An Exploratory Study on the Implications of Residential Care on the Psychological Well-Being of Adolescents: A Case of Lusaka Urban District.".** I wish to inform you that following submission of your request to my Ministry, our review of the same and in view of the ethical clearance, my Ministry has granted you authority to carry out the above mentioned exercise on condition that:

1. The relevant Provincial and District Directors of Health where the study is being conducted are fully appraised;
2. Progress updates are provided to MoH quarterly from the date of commencement of the study;
3. The final study report is cleared by the MoH before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the MoH, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

You are advised to also ensure that assent and consent for minors is given.

Yours sincerely,

Dr. D. Chikamata
Permanent Secretary
MINISTRY OF HEALTH

Cc: District Medical Officer

All correspondence should be addressed
to the District Education Board Secretary
Telephone: 0211-240250 / 240249 / 0955 623749
E-mail: desbsisk@yahoo.co.uk

In Reply pleas

No:.....

REPUBLIC OF ZAMBIA

DEB/LSK/101/1/1

MINISTRY OF EDUCATION, SCIENCE, VOCATIONAL TRAINING AND EARLY EDUCAT

DISTRICT EDUCATION BOARD SECRET
P.O. BOX
LUS

27th January, 2015

The Headteacher
Chelstone Secondary School
LUSAKA

RE: RESEARCH: MS. MONICA JALASI

This serves to inform you that permission has been granted for Ms. Monica Jalasi do her research project at your school.

Grace N. Banda (Ms.
DISTRICT EDUCATION BOARD SECRETARY
LUSAKA DISTRICT

All correspondence should be addressed to the District Education Board Secretary
Telephone: 0211-240250 / 240249 / 0955 623749
E-mail: desbsisk@yahoo.co.uk

In Reply please quote

DEB/LSK/101/1/1.....

REPUBLIC OF ZAMBIA

MINISTRY OF EDUCATION, SCIENCE, VOCATIONAL TRAINING AND EARLY EDUCATION

DISTRICT EDUCATION BOARD SECRETARY
P.O. BOX 50297
LUSAKA

27th January, 2015

The Headteacher
Chakunkula Primary School
LUSAKA

RE: RESEARCH: MS. MONICA JALASI

This serves to inform you that permission has been granted for Ms. Monica Jalasi do her research project at your school.

Grace N. Banda (Ms.
DISTRICT EDUCATION BOARD SECRETARY
LUSAKA DISTRICT

DSWHQ/9/7/1

14th January, 2015

J.A. Menon PhD
Department of Psychology
University of Zambia
P.O. Box 32379
LUSAKA

RE: PERMISSION TO ACCESS RESIDENTIAL CHILD CARE FACILITIES BY MRS. MONICA JALASI

The above subject matter refers.

The Office of the Commissioner for Juvenile Welfare is in receipt of your letter in which you requested for permission for the above named student to carry out research in Child Care facilities in Lusaka Urban.

The Department of Social Welfare has no objection to the student conducting the research, on condition that issues pertaining to ethics and confidentiality are observed. You are further urged to ensure that written consent is obtained from all the individuals participating in the research. In the event that the individual is a minor, consent should be obtained from parents or guardians of the children. Kindly note that police clearance will be required particularly because the research involves vulnerable children.

By copy of this minute, the District Social Welfare Officer for Lusaka is urged to assist and guide you, where necessary, as you embark on your study. This office would also like to be availed a copy of the final report once completed.

S. Michelo
COMMISSIONER FOR JUVENILE WELFARE

cc. The Provincial Social Welfare Officer- Lusaka
cc. The District Social Welfare Officer – Lusaka
cc. Ms. Monica Jalasi