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ORIGINAL PAPER

Religion and Caregiving for Orphans and Vulnerable Children: A Qualitative Study of Caregivers Across Four Religious Traditions and Five Global Contexts

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Abstract

Studies of caregivers of orphans and vulnerable children (OVC) rarely examine the role religion plays in their lives. We conducted qualitative interviews of 69 caregivers in four countries: Ethiopia, Kenya, Cambodia, and India (Hyderabad and Nagaland), and across four religious traditions: Christian (Orthodox, Roman Catholic, and Protestant), Muslim, Buddhist, and Hindu. We asked respondents to describe the importance of religion for their becoming a caregiver, the way in which religion has helped them make sense of why children are orphans, and how religion helps them face the challenges of their occupation. Using qualitative descriptive analysis, three major themes emerged. Respondents discussed how religion provided a strong motivation for their work, reported that religious institutions were often the way in which they were introduced to caregiving as an occupation, and spoke of the ways religious practices sustain them in their work. They rarely advanced religion as an explanation for why OVC exist—only when pressed did they offer explicitly religious accounts. This study has implications for OVC care, including the importance of engaging religious institutions to support caregivers, the significance of attending to local religious context, and the vital need for research outside of Christian contexts.

Keywords Orphaned and vulnerable children · Caregivers · Religion · Religion and occupational well-being · International · Buddhism · Christianity · Islam · Hinduism

In this study, we look at religious commitments, beliefs, and practices as factors that are relevant to how caregivers of orphaned and vulnerable children (OVC) sustain their work over time. Despite their disfavor in the USA and Europe, institutions for

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OVC continue to anchor care in many countries. Current research shows that quality of care does not significantly differ between community-based, group-home, or institutional care situations (Whetten et al. 2014). What is clear, however, is that the quality of care OVC receive is critical for positive outcomes and also that caregivers of OVC in many countries face substantial physical and mental health challenges (Govender et al. 2012; Ice et al. 2010; Kidman and Thurman 2014; Kuo et al. 2012; Lv et al. 2010; Muliira and Muliira 2011). The well-being of children and caregivers alike makes it important to understand the factors that help caregivers thrive in their work.

The focus of this study is on religion, which we mean to encompass both individual and institutional "beliefs, practices and rituals that relate to the sacred" (Koenig 2009, p. 284). This definition is broad, but given the wide range of religious contexts under consideration, we felt it was necessary to draw upon a definition of religion that allowed room for a wide variety of practices and beliefs. While the importance of religion in community development is now widely accepted (Deneulin and Rakodi 2011) and the place of religion within nongovernmental organizations has been studied (Kniss and Campbell 1997; Schnable 2016), the role that religion plays in the lives of *frontline development workers*, in this case OVC caregivers, has received little attention. To our knowledge, only one study from Ghana has reported on the central role of religion in the lives of OVC caregivers (Darkwah et al. 2016). Other studies of caregiving occupations have investigated the role of religion, for example, nurses in Uganda (Bakibinga et al. 2014), caregivers of persons with schizophrenia in India (Gojer et al. 2017; Rammohan et al. 2002), and caregivers of older relatives among Mexican-American families (Herrera et al. 2009). In each of these cases, religion was revealed to play a constructive role in coping with the stresses of caregiving.

Existing work on religion and caregiving occupations is also limited because it often focuses on a single country and/or a single religion. There is a vital need for research that is both cross-national and cross-religious in scope. In this research, our goal is to elucidate the important role that religion plays in the lives of caregivers of OVC in five religious and geographic contexts.

Our work makes several contributions. First, this study is cross-national, drawing from five different international sites in four countries: Kenya, Ethiopia, India (Nagaland and Hyderabad), and Cambodia. To date, most studies have examined data from a single country, precluding cross-national analysis. Second, we look at multiple religious traditions: Christianity, Islam, Hinduism, and Buddhism. Most researches on the link between religiosity and caregiving have occurred in the USA, Europe, and majority Christian contexts, even though institutions for OVC are found globally in diverse religious contexts. Cross-national and cross-religious data allow us to offer a more complete picture of the role religion plays in the lives of OVC. And finally, because our data are drawn from in-depth interviews of caregivers of OVC, we are able to attend to the voices of the caregivers themselves.

Background and Theory

In this study, we draw from the large literature that has documented how many aspects of religion are positively related to physical and mental well-being, especially in the context of dealing with adversity (Blanchard et al. 2008; Ellison et al. 2001; Ellison and Levin 1998; George et al. 2002; Jarvis and Northcott 1987; Weaver and Flannelly 2004). We borrow heavily from the meaning-making model developed by Park (2005). The meaning-making model emphasizes the important role that religion plays in both how people make sense of life's circumstances and situations, and how religion can create the goals around which people orient their lives. The meaning-making role of religion may play an especially important role in helping people cope with situations that do not present easily solvable or explainable situations. The presence of OVC may raise difficult questions about why children are allowed to suffer, and religion may play a role in constructing narratives that help resolve this tension (Malhotra and Thapa 2015; Padmavati et al. 2005). Among caregivers who flourish, we also expect that religion will provide a strong motivation for their work. Research has shown that a sense of calling is important for people to thrive in caregiving occupations, especially because religion often provides a way to understand suffering and loss (Kotarba 1983). Religion may also be of particular importance for those working with OVCs because the primary texts of many religious traditions place a priority on caring for orphans.

Methods

This study employed qualitative descriptive analysis (Sandelowski 2000, 2010). Qualitative descriptive analysis is the appropriate method to use in situations where straightforward descriptions of the phenomena (i.e., the role of religion in OVC caregiving) are desired. Our goal in this analysis was not to present our findings in a highly abstract way, but rather to stay closer to the participant's voices.

Our research team included staff at four nongovernmental organizations (NGOs) that are devoted to the welfare of children, but which do not necessarily care for OVC themselves. These were in five locations: Hyderabad, India; Dimapur/Kohima in Nagaland state, India; Bungoma, Kenya; Addis Abba, Ethiopia; and Battambang, Cambodia. Methods were consistent across sites, with some minor variation in recruitment and participant compensation. It is important to note that the two sites in India were very different. Hyderabad is a large city in south-central India and majority Hindu. Nagaland, a province in the far east of India and is culturally distinct from much of India. The official language of Nagaland is English, and Christianity is the majority religion. Ethiopia and Kenya, while both in East Africa, have key religious differences. Ethiopia is a majority Christian-Orthodox country, while Kenya is dominated by Protestant and Catholic Christianity.

Because the data for this study were collected as part of a larger project that sought to understand the factors that allow OVC caregivers to thrive, only

caregivers with a reputation for excellence were recruited. In order to recruit participants, research staff at each NGO identified candidate OVC institutions in their geographic area. In Addis Abba, Bungoma, and Hyderabad, research staff initiated recruitment by asking the OVC institution director to identify caregivers with reputations for excellence in caregiving. Research staff contacted the caregivers by phone or in person and explained the study. In Nagaland, there were only a few OVC institutions, each of which employed one or two caregivers. Research staff in Nagaland called the institution directors, who were often also the institution's caregiver, and scheduled a time to visit in person. In Cambodia, research staff sent a letter to institution directors and, for those willing, met to discuss the study. At each institution, with the director's permission, research staff convened a meeting with all caregivers simultaneously and described the study. Caregivers were invited to decline participation and written informed consent was obtained from all participating caregivers at all sites.

Research staff collected a variety of data from caregivers. In this study, we analyzed in-depth interviews and reported basic demographics from a survey of these caregivers. The in-depth interviews were conducted in person, in a private location and recorded. Research staff were trained on a semi-structured interview guide so they understood conceptually the goal of each question, enabling them to generate follow-up questions during the interview until a full answer addressing the intent of the question was reached. A number of broad questions about religion and caregiving were asked. The questions directly addressing religion in the interview guide were the following (the full interview guide is available from the first author upon request):

- "Has religion had any influence or impact on you becoming a caregiver and caring for children in institutions? If so, please explain the relation between your religion and your work."
- "It can be very sad seeing children without parents who are able to take care of them. Why do you think this happens? Does your religion help you make sense of children being orphans? If so, how?"
- "What role does your religion play in allowing you to continue to be a caregiver even when there are big challenges?"

The interviews took 30–120 min to complete. Interviews were conducted in a language spoken by both the caregiver and interviewer. In Cambodia, all interviews were conducted in Khmer; in Ethiopia, Amharic; and in Kenya, Kiswahili. In Hyderabad, interviews were conducted in the participant's choice of Telugu or English. In Nagaland, all interviews were conducted in English, with some details asked in Nagamese for clarity. Following the interview, the interviewer transcribed the interview in the original language and then translated it into English. In the quotations below, we have tried to avoid altering the translations, except where absolutely necessary for clarity.

Following data collection, caregivers were compensated in ways consistent with their cultural norms and in-country ethics approvals. In Kenya, the institution received a gift (e.g., cooking oil, sugar, or soap worth $20 USD) to share

and the caregivers received a small gift (e.g., sugar, tea, soap, or talk time scratch cards worth $10 USD). In Nagaland, caregivers received a small gift of stationery sets. Monetary compensation was given to individual caregivers in Cambodia ($10 USD), Ethiopia ($13 USD), and Hyderabad ($8 USD).

Data were analyzed using a conventional content analysis, the appropriate approach when there is limited existing research on the phenomena (Hsieh and Shannon 2005). Following this approach, we collected data open-ended interviews, read the interviews word-for-word and then coded them to identify common themes. We used NVivo (QSR International, 2017) to organize and visualize in-depth interview data. Each site secured in-country ethics approvals and all procedures were approved by the Duke University Arts and Sciences Institutional Review Board. We describe our analytic process in detail below.

The qualitative analysis team included authors with backgrounds in social work, psychiatry, theology, sociology, and global health. One of the analysis team members helped conduct caregiver interviews in Ethiopia. Once the interviews were completed and transcribed, two members of the research team (both with a background in social work) read five interview transcripts and developed an initial set of data-driven codes (e.g., "motivation for caregiving," "religious practices"). They met to review their codebooks and create a harmonized preliminary codebook. Once the preliminary codebook was agreed upon, the original five interviews were assigned codes from the harmonized codebook. The two researchers then met and discussed each section of text for which they did not assign the same code and discussed those instances until they agreed on the appropriate code or refined the definition of the code. Once the codebook was finalized, the two researchers coded 10 of the same transcripts and followed the same process, reviewing and discussing the text for which they did not assign the same code until they agreed on the code. Then, five researchers used this improved codebook to code the remaining transcripts. When data did not fit with the codes, new codes were created or existing codes refined. In addition, the team member assigned to coding a transcript wrote a memo to summarize the interview. These memos included a synopsis of the information learned and identified any emerging themes or patterns.

Once coding was complete, we then proceeded to define common themes across the interviews. Because this study sought to understand the role of religion in the lives of OVC, we identified all of the quotations from all of the sites that were coded with a religion-related code. We then extracted these quotations and sufficient context from the interviews for thematic analysis. From this limited set of quotes, the first and second authors independently read these interviews and identified key emergent themes. They then met to share identified themes and resolved differences until they reached consensus. These themes were then discussed with authors from participating host institutions for review and iterative feedback. Themes were only finalized when agreement from all the participant sites on the appropriateness of the themes was obtained. After the analysis was completed, it was clear that there were more commonalities across sites in the role of religion among OVC caregivers, and we organized our data thematically rather than by site. When quotations are provided, the country and religion of the caregiver are provided.

As is common in qualitative descriptive analysis, we also included a short closed-ended survey along with the open-ended interview. This survey collected basic demographic characteristics to better help understand the similarities and differences between the contexts. We calculated means, standard deviations, and proportions (where appropriate) for the demographic variables by site and for the overall sample.

Results

A total of 69 caregivers participated in in-depth interview data collection, six from Nagaland, nine from Hyderabad, twelve from Ethiopia, eighteen from Cambodia, and twenty-four from Kenya. In Table 1, we provide basic descriptive statistics for each site and for all the sites combined. Not surprisingly, most of the variation in religious identity was between sites. Hindu caregivers were found exclusively in Hyderabad and Buddhist caregivers only in Cambodia. All of the caregivers in Ethiopia and Nagaland identified as Christian. There was one Muslim caregiver in Hyderabad, with the remainder in Kenya. Most caregivers attended religious services or observances at least weekly, except in Cambodia, where few reported regular attendance. Prayer followed a similar pattern. Most caregivers in Nagaland, Ethiopia, and Kenya reported praying at least daily. Caregivers in Hyderabad were more diverse. Cambodia had the largest proportion of respondents who reported prayer "a few times a year" or "never." Overall, reading religious scriptures was less common. All or most of the caregivers in Nagaland and Ethiopia reported reading scriptures only a few times a year. Half of the caregivers in Cambodia reported never reading scriptures (the only country where "never reading" was reported).

Turning to the in-depth interview data, the findings showed that most OVC caregivers drew on religion in vital and variable ways to interpret and to sustain their caregiving work. Several major themes arose from the qualitative descriptive analysis of these transcripts.

Religion and Motivation for Caregiving

Many caregivers drew upon religion to describe their motivations for caring. This applied across most of the countries and particularly among those who were Christian and Muslim; this theme was less prominent among caregivers in Cambodia. Many caregivers spoke of how their religion encouraged them to work with OVC. Caregivers invoked religion both to account for how they understood the moral status of OVC and why they were motivated to care in five overlapping ways.

First, many caregivers, especially Christian caregivers in Kenya, invoked the recurrent admonitions of the Hebrew Bible (e.g., Ps. 82:3, Is. 58:7) and the Christian New Testament (e.g., James 1:27) to extend hospitality to "orphans, widows, and the poor" as an intrinsic reason to care for OVC. One Catholic Christian caregiver in Kenya stated that "*Religion teaches us love and care for others, especially the less fortunate orphans and abandoned children"* and that *"God is always on the side of*

Table 1 Descriptive statistics of OVC caregivers in five sites and four countries

Site:	Hyderabad	Nagaland	Ethiopia	Kenya	Cambodia	Overall
n	9	6	12	24	18	69
Male (%)	6 (66.7)	3 (50.0)	1 (8.3)	6 (25.0)	0 (0.0)	16 (23.2)
Age (mean (sd))	36.11 (14.34)	33.17 (4.88)	42.17 (9.27)	36.42 (10.44)	45.78 (14.42)	39.54 (12.20)
Years being a caregiver (mean (sd))	4.44 (4.22)	6.83 (4.26)	13.50 (8.68)	6.90 (4.25)	9.64 (6.26)	8.44 (6.29)
Married (%)	3 (33.3)	4 (66.7)	5 (41.7)	18 (75.0)	12 (66.7)	42 (60.9)
Have biological children (%)	3 (33.3)	3 (50.0)	6 (50.0)	23 (95.8)	13 (72.2)	48 (69.6)
Highest education attained (%)						
Less than high school	5 (55.6)	0 (0.0)	6 (50.0)	11 (45.8)	14 (77.8)	36 (52.2)
High School	2 (22.2)	1 (16.7)	2 (16.7)	12 (50.0)	4 (22.2)	21 (30.4)
University Grad	2 (22.2)	5 (83.3)	4 (33.3)	1 (4.2)	0 (0.0)	12 (17.4)
Religion (%)						
Hindu	8 (88.9)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	8 (11.6)
Muslim	1 (11.1)	0 (0.0)	0 (0.0)	7 (29.2)	0 (0.0)	8 (11.6)
Buddhist	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	18 (100.0)	18 (26.1)
Christian	0 (0.0)	6 (100.0)	12 (100.0)	17 (70.8)	0 (0.0)	35 (50.7)
How often do you attend religious services? (%)						
More than once a day	3 (33.3)	1 (16.7)	6 (50.0)	8 (33.3)	0 (0.0)	18 (26.1)
About once a day	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	12 (66.7)	12 (17.4)
A few times a week	0 (0.0)	1 (16.7)	1 (8.3)	1 (4.2)	0 (0.0)	3 (4.3)
About once a week	3 (33.3)	0 (0.0)	0 (0.0)	3 (12.5)	4 (22.2)	10 (14.5)
About once a month	2 (22.2)	2 (33.3)	4 (33.3)	8 (33.3)	2 (11.1)	18 (26.1)
A few times a year	1 (11.1)	2 (33.3)	1 (8.3)	4 (16.7)	0 (0.0)	8 (11.6)
How often do you pray? (%)						
More than once a day	1 (11.1)	0 (0.0)	1 (8.3)	1 (4.2)	1 (5.6)	4 (5.8)

Table 1 (continued)

Site:	Hyderabad	Nagaland	Ethiopia	Kenya	Cambodia	Overall
n	9	6	12	24	18	69
About once a day	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (16.7)	3 (4.3)
A few times a week	4 (44.4)	0 (0.0)	2 (16.7)	1 (4.2)	6 (33.3)	13 (18.8)
About once a week	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	3 (16.7)	4 (5.8)
About once a month	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	2 (11.1)	3 (4.3)
A few times a year	2 (22.2)	6 (100.0)	9 (75.0)	22 (91.7)	0 (0.0)	39 (56.5)
Never	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (16.7)	3 (4.3)
How often do you read scriptures? (%)						
More than once a day	2 (22.2)	0 (0.0)	0 (0.0)	4 (16.7)	3 (16.7)	9 (13.0)
About once a day	4 (44.4)	6 (100.0)	9 (75.0)	4 (16.7)	4 (22.2)	27 (39.1)
A few times a week	1 (11.1)	0 (0.0)	1 (8.3)	8 (33.3)	1 (5.6)	11 (15.9)
About once a month	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (5.6)	1 (1.4)
A few times a year	1 (11.1)	0 (0.0)	1 (8.3)	8 (33.3)	0 (0.0)	10 (14.5)
Never	1 (11.1)	0 (0.0)	1 (8.3)	0 (0.0)	9 (50.0)	11 (15.9)

the poor and misplaced." A Christian caregiver in Nagaland stated that "*God said that we have come to serve the poor and unwanted, those who have nobody."*

Second, caregivers across religious traditions voiced that service to OVC was a way to serve God, such that they served God by serving OVC. A Muslim caregiver in Kenya stated, "*Islam teaches service to others, especially to the poor and less privileged in order to serve Allah…and sharing the little you have with less fortunate."* A Hindu caregiver in Hyderabad stated, "*Doing service to orphan children is serving God. So that is the motivation* [for caregiving]." A Protestant Christian caregiver in Kenya stated, "*My religion motivates me, knowing that I am able to serve God even if it's in a small capacity of taking care of others."*

Third, many Christian caregivers cited the example of Jesus as a motivation for caregiving:

> *It's through religion that I learned that being a Christian one must be someone who shows love and this love comes from Jesus Christ Himself, that He Himself loved us and that He taught us to love others. In that case, through the word of God I've learned that it's good to take care of orphaned children, widows and the poor and vulnerable….* – Christian caregiver in Kenya

> *If I look back to the religion…then it inspires me with life stories about Jesus Christ. When he was on this earth he was for the people…to serve but not to be served. He became a real human being and that's how he tried to live with poor people, he tried to restore sick people, and that's how I try to act. I get a good example from Jesus Christ and it really motivates me and try to follow the good examples of what he did when he was on this earth.* – Christian caregiver in Nagaland

Though not as prominent, and often more diffuse, Buddhist caregivers also cited the Buddha as a moral example for caregivers. For example, a Buddhist caregiver in Cambodia wrote:

> *The Buddha didn't force us to believe him and he guided us to do only good things. He guided to love and care for each other, and he taught us about the dharma that…it is difficult for me to say, I cannot remember it. Honestly my heart loves and respects it.*

Fourth, across religious traditions, but especially in Islam, caregivers cited divine command as a reason for caregiving:

> *Yes [religion] has an influence. I would like to tell you something. Allah is the ultimate, he will send us where we have to go and what we have to do, we only have to follow his instructions. I believe in that concept. Not everyone will get a chance to do this kind of work. Whoever has been loved by Allah will get an opportunity through him to do this kind of work. That's why whenever we do some work we used to say Bismaillah. That means remembering him who gave us a chance to do.* – Muslim caregiver in Hyderabad

Fifth, for some caregivers, the promise of a divine reward for their work with OVC provided a motivation for caregiving. A Christian caregiver from Kenya stated,

"*When I explain patience, it tells me to be patient, even if I don't get paid here, God will pay me for the work that I have done here."* A Hindu caregiver from India stated, "*My guru advised me to do service to children to get rid of my sins or mistakes, knowingly or unknowingly committed. It is not my own idea or knowledge but on the advice of my known person I have chosen to serve the children without parents."*

Other Sources of Motivation

Not all caregivers used religious language to describe their motivation for caregiving; a small minority actively rejected religious accounts. Most Buddhist caregivers and some Hindu caregivers did not appeal to religious concepts to explain their motivations. In the transcripts from the interviews in Cambodia, religion was never advanced as a motivation for caregiving. Most caregivers in Cambodia appealed mainly to pragmatic concerns—for example, earning an income—as their primary motivation for caregiving. When asked, "What motivated you to work with children in institutions / orphanages?" a Buddhist caregiver from Cambodia responded, "*Because I didn't have [a] job to do."* Another Buddhist caregiver in Cambodia said, "*It was not so hard as selling the bread, selling the bread in the sunlight…but working here I could have enough food to eat and it was easy to work in the shade."* One Hindu caregiver from India even went out of the way to state that religion did not motivate their caregiving work. When asked, "Do you connect your motivation for being a caregiver to your religion?*"* This respondent replied, "*No, I do not relate this to religion."*

In addition to religion, three other sources of motivation emerged prominently in the caregivers' responses. First, as noted above, many caregivers viewed caregiving as a way to earn a living. Second, many caregivers expressed that they were motivated by seeing children succeed. A Kenyan Christian caregiver said, "*It's priceless to see a child whose world was shattered when abandoned at a very young age grow, mature and excel in their studies.*" A Hindu caregiver from Hyderabad stated,

> *The children who lived here and got married, now they become mothers of children. When they inform me about giving birth to a child, it makes me feel so happy that I have become a grandparent. Sometimes children call me after a long time and I feel so happy that they still feel I am their family member. It's a very great feeling.*

Third, several caregivers spoke of being moved to caregiving when they encountered the suffering of OVC. A Protestant Christian caregiver from Kenya stated, "I love children and was concerned with abandoned children, especially those left at our church's door step, they were suffering and was asking myself, 'How do you abandon your child?'" An Ethiopian Orthodox Christian caregiver spoke similarly of a particular encounter with a child:

> *When a baby girl came to this institution, I was here. When the person who brought her left, the girl ended up with me. She hugged me tight and asked, "would you be my mother moving forward?" She was about 4 years old when*

she came. [Interviewer notes that the caregiver tears up while trying to continue explaining.] *And I said to her, "Yes, don't worry, I will be your mother." I was on a day shift and I had to leave clandestinely. She was following me. I left clandestinely and they told me that she asked my whereabouts and cried. When I got here the following day, she said 'My mom is here.' After that, even when I have days off, she doesn't want me to leave. I would talk to her on the phone, from home.* [Interviewer notes that the caregiver tears up and sits in silence for a minute.] *These kind of experiences make me want to stay here.*

Religious Resources for Caregiving

Beyond simply citing religion as a motivating factor, caregivers frequently named particular resources within their religious traditions that they understood as helpful for sustaining the work of caregiving.

Prayer. Many respondents spoke of the importance of prayer for overcoming the challenging situations that they faced in their chosen occupation. This theme was pervasive across countries and religious traditions. Prayer was understood as a source of strength and also as a way to bring about a solution to a difficult problem:

When I meet the difficulties, I just wish to the Buddha for helping me. And it can help me realize that other people are having more and stronger difficulties and they can live with them, why cannot I? So I must work hard for my life. -Buddhist caregiver from Cambodia

I believe God is there and He works because at certain times in the institution when we lack something and we tell God to make a way, He provides, and He gives us the mind… The mind that even if you were not thinking of something, you will find that thing. I also believe that when you take your needs before God, He works. – Christian caregiver from Kenya

I get courage. When we pray god will help us, he will take care of us and solve every problem. Whenever a child gets sick or I am worried about children I go to the Saibaba Idol and offer prayer and then I get relief. It gives peace of mind. The day I don't do prayer feels like something is missing. Performing prayer and Bhajan will keep the children peaceful and happy. -Hindu caregiver from India

In some cases, when caregivers were experiencing conditions of scarcity or significant need, prayer functioned as a lens though which what followed was received in gratitude as God's provision:

I was just angry wondering what I was going to do and where I was going to get funds or resources. I was asking myself many questions on what do? And I just prayed and said, "God, open ways and please answer my prayers." And that period was the same time that the former teacher came and brought us the food donations. Wonderful, God is a living God." -Catholic caregiver from Kenya.

Scripture and sacred texts. Many caregivers also found resources for caregiving in sacred texts of their traditions. Caregivers turned to sacred texts both as sources of strength and guidance and for their prosocial teachings:

> *Epic stories I have read [have] influenced me to choose this type of work and also the mindset to do service. What I have read in Bhagavad Gita where Lord Srikrishna quoted that, "I exist in everything in the universe. If you serve them it means you served me. If you help the needy it means you served me." There is a saying in it, "Service to humankind is service to the God." I believe in that. Treat every human being equal; that will create wisdom.* – Hindu caregiver from Hyderabad

> *Of course, [my religion] has helped me. I believe that words from the Bible teaches people to be righteous. Therefore, I refer to the Bible to give advice to others in difficult situations. And it has worked for me so far.* – Protestant Christian caregiver from Ethiopia

Meditation. Caregivers also described value in meditation as a way of centering themselves. A Catholic Christian caregiver from Nagaland, for example, stated that "*usually towards the evening I just meditate, think back on my daily activities, looking back into my day's activities and I meditate myself, and it refreshes me and it helps me, gives more strength to overcome my shortcomings, how I felt and from there draw positive things to improve more again*."

Religious communities. In at least two different ways, caregivers spoke regularly of the importance of their religious communities to their caregiving work. First, for some caregivers, religious communities were the context where they first learned of the situation of OVC, and these communities served as institutional gateways for the work of caregiving:

> *Since my childhood my uncle (father's brother) was high devoted. He used to read a lot of devotional books, so when I was 6 years old I started reading Ramayan and Mahabharth, ethical and moral story books. Later when I was in 10th standard I was attached to a voluntary organization where I have learned about helping the poor and disadvantaged people. After that I joined RSS* [Rashtreeya swayamsevak sangh, a large Hindu national volunteer organization] *and started doing service to the community. Whatever is in my mind to do service is being fulfilled by joining this institution.* – Hindu caregiver from Hyderabad

> *I personally love staying with children. In the beginning I was a Sunday school teacher, it happened that I loved children's company very much and my interest grew more and more. I began taking care of orphan children. I saw that this institution was providing care for orphans and abandoned children so I was encouraged to come and be a part of this group who dedicates their efforts in caring for the less privileged in our society in a volunteer capacity and later hired as a caregiver.* – Protestant Christian caregiver from Kenya

I developed a heart for children at young age. I loved kids and so when I went to Bible College, while studying there, I started caring for a group of children known as chokoraa (street children). *I later learned about the plight of orphan children who were deserted and abandoned and had no one to care for them and I then asked for a job at the children's home.* – Christian caregiver from Kenya

Second, for many caregivers, religious communities were sources of strength, conveyers of purpose and meaning, and sites of support, protection, and belonging. A Catholic Christian caregiver from Kenya stated, "*Our religion supports us like giving us tasks at the church. They can take children who are older who have finished studies and train them in catering, tailoring and pottery. My religion supports me*." A Protestant caregiver from Kenya stated,

People from the church, … we share the challenges that we face and they said that they will support us. … We also shared about the parents who threaten and things like that, and they addressed it. … Also, biblically we need to have hope, so from that day we shall not have any more threats, we shall be OK from that day. I now knew that there are no more problems that we shall face…church people have also agreed to support us. We saw that we are no longer alone. We are surrounded by a certain team that supports us in prayers, too. – Protestant caregiver from Kenya

I grew up in an orphanage. I grew up with a lot of children here and then you know my family was running [the orphanage], so I used to see lot of children here. And then when I grew up along with them, I slowly realized that they were so happy. Outside during daytime and all, they would be working so hard and then they would be tired and frustrated, [but]then they would come inside the devotion, because in those days also we had morning devotion and evening devotion. And during those evening devotion[s], they used to come and sing their full heart and then it was such a joyful time we got to spend together in the evening devotion. So … then you know, I started thinking religion can be something which umm . . . how do I say, that is the reason why [actually I am a theologian] and that is the reason why I made a decision in my life that I should do all these things and it should start with religion. – Christian caregiver from Nagaland

It should be noted that one caregiver cited religious community as a model for what *not* to do related to caring for OVC:

Once I have visited Saibaba Temple, there people were distributing food, but what I have observed there is food is being offered to the rich people, not to the poor and needy. Anyway rich people have something to eat; poor people who are begging outside temple are not offered food. So I have learnt that not like them, [I] need to work for the poor and needy. – Hindu caregiver from Hyderabad

Religion and Understanding Why Children are Orphans

In order to investigate whether caregivers used religion to interpret or to explain the context of OVC, we asked caregivers to tell us why children are orphaned. In their responses, several caregivers appealed to pragmatic and proximate explanations that did *not* involve religion. For instance, when asked why children are orphans, one Christian caregiver in India responded, "*Parents are HIV infected, poverty, both parents committed suicide, father murdered mother, so these are the reasons for the children to become orphans*." Even when pressed by the interviewer to describe whether religion helps them make sense of children being orphans, this respondent said, "*No, religion [has] not helped me to understand orphaned children*." A similar theme was heard from another Hindu respondent in India,

> *I heard from the children that due to economic problems, parents committed suicide. One of the children's father had a health problem, two kidneys failed - he is on dialysis. They were in a good financial position before father got sick, due to a health problem they ended up spending lot of money, got into financial trouble. After spending so much money, the child's father expired. Some children had a single parent, some don't have both parents."*

Similar themes emerged from Christian caregivers in Ethiopia and Kenya:

> *It could be HIV or it could be a financial problem where the parents are not capable to raise the children. Then, the children go to some of their relatives, their aunt or uncle where they may be forced to overwork. As a result, they leave their kindred home and go out on the street. Then, the police find them on the street and bring them here. It is to say that the children are in the institution due to different problems."*

> *It happens because there are parents who have children but don't have that heart to take care of them or they are not able (they are helpless). So, they abandon them, majority of orphans have been abandoned. People get children but they don't love them so they abandon them. Because if a parent loves their children, they can never throw them away or abandon them. Some parents die of HIV and HIV related illness and kids are orphaned by the relatives.*

In a minority of responses, caregivers offered a partial religious account for the status of orphans, as when one Protestant Christian caregiver from Kenya, stated, "*God said to the Israelites, if you sin I will make an orphan, I will cut off all my protection as your father."*

Caregivers from Cambodia, all of whom identified as Buddhist, were generally reluctant either to attribute religious motivations for caregiving or to invoke religious explanations for the status of orphans. If the interviewer pressed them to provide a religious explanation for orphans, they would eventually offer karmic explanations for OVC's status:

> *They* [OVC] *used to do bad sin in past life, they separated, even a small bird, from their family. For example, they saw chicks and they took them*

home and fed them, they didn't care about the mother bird's heart that lost her chicks, and even they fed the chicks at home, it was not as well as with the mother bird. So it affected the next life, they could not live with harmony. – Buddhist caregiver from Cambodia

I think they did a lot of sins in past life: that's why this life, they become orphans. But it is good for them to stay in the institution because there are the director and caregivers who advise them to be the good people, to not to have this [bad] karma…. – Buddhist caregiver from Cambodia.

But, this karmic view took a great deal of coaxing and it seemed when pressed, they simply recited the religious line. It is important to know that karma was not endorsed by one of the Cambodian caregivers, a former orphaned child. He, like many others, focused on proximate, rather than supernatural, reasons for why children become OVC.

I never think about this reason [religion] because I am also an orphan. I just know that children living were abandoned by their parents, some are single orphans, and some are double. I feel that I likely pay more attention to the double orphaned ones because we have the similar story. I never think or analyze about the reason why they are orphaned and I just think that they are orphaned like I am. – Buddhist caregiver from Cambodia.

Discussion

Caregiving for OVCs is a challenging occupation, and it is important to understand what factors are related to thriving in caregivers. Despite the fact that many OVC caregivers work in contexts where religion is a central part of life, few studies have examined the ways in which caregivers think about the relationship between religion and their work. We offer three observations about the role religion plays in the lives of OVC caregivers.

First, in this study, we found that many caregivers appealed to religion as a key motivation for choosing to work with caregivers. Many spoke of their decision to pursue caregiving as a career or as a calling. For some, their involvement with a religious institution opened up caregiving for OVCs as a viable career. While less pervasive, respondents also stated that the promise of divine reward helped them continue in their work.

It might be tempting to conclude from these data that religion provides a strong motivation for why OVC caregivers do their work and gives them energy to continue in their work. While that is one possible explanation of these data, there is another equally plausible mechanism at work. It is possible that OVC caregivers employ religion after the fact to explain their motivations, employing what Swidler (1986) calls the "toolkit" approach. Swidler argues that motivations are difficult to discern, and rather we should think of people employing religious "tools" from their cultural "toolkits" to construct meaning post-hoc. Thinking about religion in this way may also help to explain why religion was employed in different ways in Christian, Muslim, Hindu, and Buddhist

societies. Christianity and Islam have many direct texts and teachings that speak to the importance of caring for OVCs. This means these caregivers had narrative tools readily at hand to construct meaning around their actions. We noted that across countries and across religious traditions, caregivers tended to draw on their religious traditions in ways that did not perpetuate stigma against OVCs, highlighting instead the way that particular traditions describe caring for OVCs as a divine command and a privilege, and decentralizing religious explanations for why children are orphaned that assign causal responsibility to OVCs themselves. In the Buddhist context, where religious explanations for orphanhood can center on individual culpability due to actions in a past life and therefore add to possible stigma of OVCs, caregivers were much more reluctant to use religion to explain why they are OVC caregivers or how religion sustains their work. In other words, religion was most salient when it was consonant with other commitments.

Second, it was clear in our study that caregivers' referenced religious practices, and not only religious beliefs, were important to the caregivers for sustaining their work. Prayer, meditation, and the reading of sacred texts were frequently cited as important ways that caregivers respond to difficult and challenging situations. In this light, it is clear that in addition to providing a narrative context for caregivers to interpret their work, religious traditions offer caregivers concrete, practical, behavioral strategies that they employed regularly to sustain the work of caregiving. Participants frequently reported turning to prayer, singing religious songs and meditation in response to difficult situations. Even though research has demonstrated that religion does not always play a positive role in helping people cope with stressful or difficult situations (Ano and Vasconcelles 2005), in our study, respondents consistently reported that engaging in religious activities helped to ameliorate the burden of their work (Brewer-Smyth and Koenig 2014; Faigin and Pargament 2011). This was much less the case in Cambodia, where caregivers (all self-identified as Buddhist) rarely mentioned religion as a resource for coping with demanding situations. The difference in Cambodia suggests that religion's role in caregiving cannot be considered in the abstract; religion is grounded in lived religious experience, that is, belief and practice as they are manifested in particular social and cultural contexts.

Third, this study highlights the important role that religious institutions play in caregivers' lives above and beyond the material support they may provide to institutions that care for OVC. Religious institutions serve as sites of awareness of the lived experience of OVC and also as gateways for people to learn about the possibility of employment in this field. Religion was important for many caregivers because it provided the doorway into caregiving as an occupation. In the realm of religion and caregiving, research often focuses on the impact of religious beliefs and practices on caregiving. However, our research points to the important role that religious institutions, especially churches and mosques, play in creating places for caregivers to work and as places where caregivers are recruited and trained.

Limitations

There were several limitations of this study. Although this study was designed to investigate the experiences of caregivers recognized for the excellence of their work, the small number of caregivers at institutions in Nagaland and the way that caregivers were identified in Cambodia limit this assumption for these two sites. Second, asking specific questions about religion in in-depth interviews may have primed participants to discuss religion more favorably or in greater detail than would have been the case had the interview questions not mentioned religion. Third, in cultural contexts where religious practices and beliefs are widespread, we cannot rule out the possibility that religious attitudes and dispositions may have contributed to institution directors' perceptions that these participants were excellent caregivers, potentially weighting the pool of participants with more religiously observant caregivers. Fourth, this study was restricted to OVC caregivers with a reputation for excellence. It is possible that if we had included caregivers with a different reputation the relationship between religion and caregiving may have differed. While none of these considerations invalidate these participants' responses, they provide caution against generalizing these responses to all OVC caregivers.

Additionally, because our study asked respondents to assess the role of religion in their caregiving, we were unable to assess whether the religious commitments of caregivers were beneficial to those receiving care. It is possible that caregivers see religion as a positive influence, but that religious ideas lead OVC caregivers to provide suboptimal, or even harmful, care. Future research could explore how religion is manifest in the caregiver–receiver dyad.

Conclusions and Implications for the Care of OVC

In the development landscape, religion and religious institutions are often treated instrumentally, that is, they are valuable in so far as they allow access to communities that are geographically remote or otherwise inaccessible to non-religious groups (Deneulin and Rakodi 2011; Deneulin and Zampini-Davies 2017). In this study, we took a different approach to exploring the role religion plays in organizations that care for OVC. Instead of looking from an outsider perspective - that is, how outside groups might use religion and religious organizations to advance their missions - we examined the role religion plays within local organizations that are providing care to OVCs. We found that in most cases, religious beliefs, religious practices, and religious organizations were important for how caregivers described their path to becoming OVC caregivers, how they made sense of the situation of orphans, and how they coped with considerable challenges. For many, religious beliefs, practices, and communities provided narrative frameworks that guided caregivers' self-understanding.

This study has several implications for the care of OVC, both from the perspective of groups that support organizations that provide care to OVC and from

inside OVC-care organizations. OVC benefit when they receive quality care and when there is continuity in their caregivers. In this study, caregivers spoke to the many and myriad ways in which religion helped them flourish in their careers. This suggests supporters of institutions that provide care to OVC must be aware of the religious contexts of the communities in which the institutions are located and would be wise to seek the guidance and experience of local religious partners when developing and sustaining programs. Religious practices and communities may be particularly important for enabling caregivers to sustain their work over time. This study also affirms the importance of attending to the local religious context. In our research, there were major differences between Christian/Muslim, Hindu/Buddhist contexts. While working through churches and mosques in Christian and Muslim settings to support and recruit caregivers is obvious, this approach is not feasible in Buddhist, and to a lesser extent, Hindu, contexts, which lack similar congregational expressions of religion.

This study suggests parallel implications for organizations that provide OVC care. First, given the self-identified importance of religious practice for caregivers, we suggest that OVC institutions should make space for personal religious observances by caregivers in the context of their work, even if the institutions are not themselves religiously affiliated. In many of the settings we explored, religion was the primary frame through which caregivers understood their work. Providing on-site support for caregivers to engage in religious practices and giving caregivers (especially those who live at the institution) time off to engage in religious practices may facilitate the well-being of caregivers. Given that many caregivers spoke of the importance of singing religious songs as ways to cope with stress, caregivers may benefit from the incorporation of music into meetings and the daily rhythm of life of the residential care organizations. Engaging with local clergy and having them visit caregivers of the same religious background has the potential to help sustain the work of caregivers. Second, given that religious communities and congregations can sometimes function as institutional gateways to caregiving, our study suggests that OVC institutions may benefit from partnering with local congregations to raise awareness of the situation of OVC and possibly to recruit future caregivers.

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Compliance with Ethical Standards

Conflict of interest The authors whose names are listed immediately below certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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