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Evaluation of a Community-Based Orphan Care Program in Uganda

Jini L. Roby & Stacey A. Shaw

ABSTRACT

In response to the orphan crisis in sub-Saharan Africa, the international child welfare community has agreed on a model that aims to increase the capacity of families and communities. Yet, little is known thus far about the service content and efficacy of programs based on the model. This project examined a community-based program in Uganda that provides support and assistance to families raising orphaned and other vulnerable children. Findings suggest that the households' need in certain categories, such as housing and food security, decreased significantly after services were received. Children's senses of belonging and permanency appeared promising. The program's strengths are discussed with recommended changes, as well as implications for policy, practice, and further research.

Globally, 148 million children have lost one or both parents, with 43.4 million orphans residing in sub-Saharan Africa alone. Poverty, conflict, and diseases constitute primary reasons for parental deaths, with 13 million children orphaned due to AIDS (UNAIDS, UNICEF, & USAID, 2004). Orphaned children endure more difficulties than their peers, in virtually every area of life—education, socialization, nutrition—and often face isolation, protection violations, abuse, child labor, prostitution, and increased risk of HIV infection (UNICEF, 2003, 2006). Many orphaned children also deal with depression, guilt, fear, and long-term mental health problems (Atwine, Cantor-Graae & Bajunirwe, 2005; Foster, 2002).

Extended families in sub-Saharan Africa have traditionally served as a safety net for orphaned children (Foster, 2002) and currently care for over 90% of orphaned children (International Social Service & UNICEF, 2004; UNICEF, 2003). However, few families can afford to support extra children (Bhargava & Bigombe, 2003), as more parents are dying due to HIV/AIDS (Monasch & Boerma, 2004). With the added strains (Joslin & Harrison, 2002; Oburu, 2005), families are less willing or able to take orphans, and some reportedly take advantage of or discriminate against them (Crawley, 2001; Wax, 2003). In some cultures, unequal treatment of kin children is tolerated due to traditional emphasis on inheritance lines and socially accepted family roles (Rutayuga, 1992). Some households are led by children, leading to additional risks (Foster, Makufa, Drew, & Kralovec, 1997; International Social Service & UNICEF, 2004; Roby & Cochran, 2007).

In Uganda, a country with over 27 million people, more than 50% of the population is under age 15 (World Fact Book, 2006). Over 2 million children are orphans or otherwise vulnerable, representing 14% of the nation's children (UNAIDS, UNICEF, & USAID, 2004). One in four households in Uganda fosters at least one orphan (Ministry of Gender, Labour and Social Development, 2004). Fostering by kin or community members is recog-

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nized as the best option for orphans (International Social Service & UNICEF, 2004; Williamson, 2004, 2005; World Bank, 2001), and the costs are far less than those of caring for children in orphanages (Peterson, 2002). Many programs in Uganda seek to support orphans and vulnerable children, in alignment with both international policy (UNAIDS, UNICEF, & USAID, 2004) and Uganda's national policy (UN IRIN, 2004; Sayagues, 2004). Although there is some research on the efforts to assist orphans in Uganda (Jacob, Smith, Hite, & Cheng, 2004; Lugalla & Kibassa, 2002; Morisky, Jacob, Nsubuga, & Hite, 2006; O'Hare, Venables, Nalubeg, Nakakeeto, & Kibirige, 2005; Oketch, 2004; Sayagues, 2004; Valadez, Kaweesa, & Mukaire, 2004; Witter, Calder, Ahimbisibwe, & Webb, 2004), few studies have been conducted to find out how programs impact families and orphaned children.

The program evaluated in this study, Action for Children (AFC) headquartered in Kampala, Uganda, was started in 1995 by Jolly Nyeko, a community leader and child welfare professional. In 2001 she joined efforts with Holt International Child Welfare Services (Holt)—a U.S.-based nonprofit child welfare and adoption agency started in the 1950s—to provide a family preservation program for at-risk families with children. Their goal was to enable orphans and other children at risk to be maintained within their family systems (B. Dahl, director, International Programs, Holt International, & J. Nyeko, president, Action for Children, Kampala, Uganda, personal communication, November 6, 2004).

Action for Children has several program sites throughout Uganda. The families are identified by community local council leaders, who target the poorest families who are struggling to meet basic housing, food, and child care needs. The families then move along a scale of eight indicators: housing, food security, children's education, health/hygiene, community participation, psychosocial support, income generation, and mentoring (or *atenge*).

To reach a level of sufficiency on these indicators, families are enrolled in various program components. The Community Child Care Counseling Component (C-5) uses volunteers who make home visits to assess the children's well-being and provide information to the caregivers on HIV/AIDS prevention, discipline and care of children, nutrition, economic enterprises, sustainable agriculture, malaria control, and child rights. The Grandparent Action Support (GAS) provides support and early childhood education to grandparents caring for young children (ages 0–8), most of whom (80%) are orphaned as a result of HIV/AIDS. Children's Brigades, neighborhood clubs of children and youth ages 8–24, provide health and reproductive education, as well as other life skills and social interaction. AFC also uses the Micro Enterprise Development Initiative (MEDI), which provides small loans to promote economic self-sufficiency, and the Child Helpline, a crisis intervention mechanism for children and adults experiencing abuse (Action for Children, 2005). The purposes of this evaluation were to determine the efficacy of the AFC program for the caregivers and children, and to provide participant input to the program.

AFC's family preservation program focuses on strengthening the capacity of existing nuclear and extended families, in harmony with the global model established in late the 1990s for dealing with the orphan crisis. This model, ratified by the United Nations General Assembly Special Session and adopted for standardizing orphan care approaches (UNAIDS, UNICEF, & USAID, 2002), encompasses five core principles on which programs are to be built: strengthening the capacity of families, mobilizing and strengthening community-based responses, ensuring access to essential services, strengthening government's role in protecting the children, and raising awareness (UNAIDS, UNICEF, & USAID, 2004). To be eligible for AFC programs, families must be in extreme poverty and raising young children. Children may be the family's own biological children, kin children, or unrelated children not living with their own families. It is not required that families take in orphaned children to receive assistance, although more than half of the children in participating families' homes are in substitute care.

AFC's program is also compatible with Uganda's Orphans and Other Vulnerable Children Policy, titled "Hope Never Runs Dry," launched in June 2005 (Ministry of Gender, Labour and Social Development, 2004). Developed in partnership with more than 20 public and private organizations (Okumu, 2003), the Ugandan policy aims to ensure that (1) orphans, vulnerable children, and their families have access to basic essential services; (2) resources are mobilized and efficiently used for orphans and vulnerable children; and (3) the capacity of essential service providers is enhanced (Ministry of Gender, Labour and Social Development, 2004).

Program Evaluation

Sample

Of the total of 331 caregivers being served by AFC's programs, 315 families (95.1%) participated in the research, conducted in Kampala and its surrounding areas, including Masindi, a town 120 kilometers north of Kampala. Those not interviewed were away from home despite three visits to reach them, or were too sick to be interviewed. A total of 527 children living in these households (in the 8- to 18-year age range) were also interviewed, representing a 60.2% response rate among the 874 children in this age range in the participating households. Those who were not interviewed were attending boarding schools, visiting relatives, or otherwise unavailable.

Instruments

The researchers constructed the survey instruments with input from AFC and Holt, and obtained all necessary human subjects' approval. First written in English, the instruments were translated to Luganda and Runyoro, languages spoken by study participants. Once the researchers arrived in Uganda, a local research advisory committee convened to provide a final check on relevancy and cultural sensitivity, and their input was incorporated. A team of Luganda-speaking local interviewers, all college graduates, were hired and trained with the input and assistance of a local social work colleague not affiliated with AFC.

Twelve surveys were conducted initially as a pilot to test the facial and cultural validity of the instrument. The instruments were then modified slightly and administered again to a different group, after which the instruments were finalized. Data from the pilot surveys were not included in the data set. Throughout the project, the project manager rotated among research assistants weekly to ensure standardized interview protocol. Three questionnaires were used: one for the caregivers, another for caregivers to provide information about the children, and the last for children, as further detailed in later sections. All questionnaires consisted of open-ended, Likert Scale, ranking, and Yes/No questions.

Caregiver's questionnaire. Questions sought the caregiver's perception of both the content and helpfulness of the program on AFC's eight indicators. The questions then sought information in other areas of need not being addressed by AFC. Interviewers examined relationships among family members and the extent of support caregivers received from extended family and community. In addition, caregivers were asked about their opinions of orphan care programs, child welfare options, and the responsibilities of various organizations in caring for orphans and families.

Caregiver's questionnaire on each child. The caregivers were asked to provide data on each child, ages 0 to 18, living in the household. Questions addressed the child's schooling, health, relationships with others in the family, and overall functioning. If the child was not the caregiver's biological child (son or daughter), questions were asked about the child's contact with their his or her parents.

Child's questionnaire. Each child in the 8 to 18 age range who was interviewed was asked about his or her living situation, schooling, health, and receipt of food and clothing compared to other children in the family. Orphaned children were asked about their family of origin. All children were asked about future hopes.

Procedures

AFC provided assistance by introducing the research team to the community zone leaders in each area of the project. *Zone leaders* are appointed by local councils to lead in social service and relief efforts. Zone leaders accompanied the interviewers to meet the families and introduced the project. An appointment was then set up with each family for an interview. On the day of the interview, the study was discussed in greater detail through the local research assistants, and if the caregiver felt comfortable participating, the consent form was signed (thumb prints were used where necessary), and the interview took place in a spot the caregivers chose, typically in or near their home. Interviewers followed a format of a written survey and wrote down the responses in English. At the conclusion of the interview, caregivers were asked to provide information on each child in the home. Children—biological children (sons and daughters of the caregiver), related children, and nonrelated foster children—between the ages of 8 and 18 were administered a separate questionnaire after signing consents and with the approval of the caregiver. Children were primarily interviewed during Children's Brigade meetings, when they gathered at a community center for activities. There, the children were pulled aside one by one to be interviewed. However, some children were interviewed in their homes, in a private setting.

Data Analysis

The data were entered and analyzed using the Statistical Package for Social Sciences (SPSS). Quantitative methods were used to analyze the level of need in the various categories before and after AFC services; participants' approval or disapproval regarding child welfare topics; and children's health, school attendance, and reported level of belonging or rejection. Qualitative analyses were used for organizing responses on caregiver's expressions of needs and opinions, and other more subjective items.

Program Evaluation Findings and Discussion

Sample Distribution

In all, 315 caregivers were interviewed, each the main caregiver for a household with children. Of those, 252 were from the four separate service areas (parishes) in Kampala (Kyanja 1, $n = 153$; Kyanja 2, $n = 42$; Kiwatule, $n = 48$; and Kiswa, $n = 9$) and 63 from Masindi. Nearly half of participants (48.6%) resided in the Kyanja 1 area. The next 30% resided in the remaining three areas of Kampala. The last 20% resided in Masindi.

Demographic Characteristics

The caregivers ranged in age from 17 to 100 years, with a mean age of 46; most, 89%, were women, and 11% were men. More than half ($n = 170$, 54%) had received some primary education, more than a quarter had received some secondary education ($n = 83$, 26%), and a small minority ($n = 5$, 1.6%) had received postsecondary education. Almost one fifth ($n = 57$, 18%) had received

no formal education. The average number of adults living in the household other than the caregiver was 1.37. The number of children in the household ranged from 0 to 19, with an average of 4.5 children per household and a standard deviation of 2.6. Family income ranged from $0 to $2,000 USD per year, with the mean income at 785,000 Ugandan Shillings per year, or roughly $454 USD based on July 2005 conversion rates. This income is in comparison to the mean per person GDP of Uganda per year of $1,700 USD (World Fact Book, 2006). The most common source of income was selling food (including produce from small gardens), charcoal, or other items at a small shop or roadside stall.

The families were included in the sample because they participated in one or more of the core family preservation programs: C-5 (n = 51, 20%), GAS (n = 116, 46%), and MEDI (n = 68, 27%). Only 5.2% (n = 13) of the caregivers participated in more than one of the three major programs.

Evaluation of Services Received

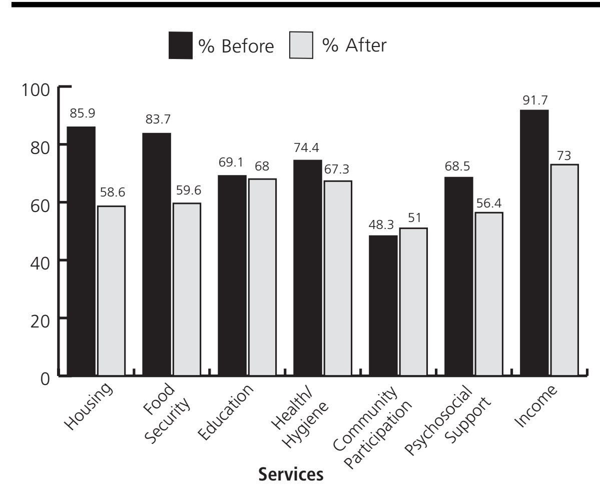
In each AFC program, participants are assisted on the eight indicators of self-sufficiency and permanence: housing, food security, education for children, income generation, health and hygiene, psychosocial wellbeing, community participation and finally an opportunity to mentor other families before exiting the program. This study asked caregivers to evaluate the effectiveness of the program on each of these indicators and to describe other services they felt were needed.

Housing. Of the 315 families, 198 (63%) had received housing-related assistance in the form of mattresses and blankets (n = 122, 62%), containers for water and food storage (n = 33, 17%), iron sheeting (n = 10, 5%), or more than one category of these items (n = 21, 11%). According to participant responses, this housing-related assistance had been "very necessary" for 170 families (86%) and "necessary" for 18 families (9%) (Figure 1). Further assistance in housing was deemed "very necessary" by only 116 families (59%) and "necessary" by 44 families (22%). Thus, it appears that housing-related services are moving families out of the most desperate circumstances at a significant level ($t(197) = –6.99$, $p < .001$).

Despite these findings, 81% of the respondents who had received assistance described additional help as either "very necessary" or "necessary." The 115 families who had not yet received housing help are presumably in desperate need. Indeed, we saw evidence of such need: families living in shacks with leaks, inadequate sleeping space for all members of the household, and insufficient bedding and storage containers for water and food.

Food security. Fewer than half of the families (n = 141, 45%) had received food assistance by the time of the study. Of the families who had received assistance, they had received food (i.e., beans, posho, maize; n = 103,

FIGURE 1. *Degree of need before and after receiving services.*



73%), seedlings (n = 16, 11%), training on growing vegetable gardens (n = 12, 8.5%), and gardening tools (n = 4, 3.5%). Actual commodity assistance is typically reserved for families who are unable to raise or buy food for themselves, such as children living on their own or aged grandparents who are not able to work. The families who had received the help said that it was "very helpful" (n = 96, 68%) or "helpful" (n = 22, 16%). Some said it was "fair" (n = 21, 15%), and one family felt it was not helpful at all. Overall, those who had received food assistance said that the assistance was "very necessary" (n = 118, 84%) or "necessary" (n = 17, 12%) before their involvement in the program. At the time of the study, continued food assistance was considered "very necessary" by 84 families (60%) and "necessary" by 36 families (26%). Again, the data show a significant number of families moving out of the most desperate category, indicating that caregivers are less likely to need additional help after receiving services ($t(138) = –4.72$, $p < .001$), although most families (86%) reported needing continued assistance.

Education. Only 97 families out of 315 had received school-related assistance by the time of the study. Of those, 50 families (52%) had received school supplies, 12 (12%) had received help to pay school fees, 14 (14%) had received general educational support, 9 (9%) had received day care/nursery school services, and 4 had received assistance with food at school. Remaining families (n = 3, 3%) had received other assistance related to children's education.

The before-and-after comparisons in this area were not as encouraging (see Figure 1). Before AFC services, educational assistance was rated "very necessary" (n = 67, 69%) or "necessary" (n = 13, 13%), and after receiving services the assistance was still "very necessary" (n = 66, 68%) or "necessary" (n = 21, 21%). Therefore, it would appear that after the services begin, more families feel they need educational assistance than before. This could be due to children's growing up and reaching school age,

or to other factors. For example, we noted that there is a tendency for parents and guardians of school-aged children to favor sending children to private boarding schools, which are relatively expensive but believed to offer a better educational environment than the public schools. Further, even though Uganda waived school fees for children attending public primary and secondary schools in 1997 (Deininger, 2003), there are related costs for uniforms, books, and supplies, and sometimes boarding school tuition. Also, as school fees were only eliminated for four children in each family, many children, especially orphans and girls, do not have government assistance for paying school fees (Kirungi, 2000).

Additionally, food and housing assistance often takes the form of onetime distributions that help families become more comfortable and self-sufficient immediately. Educating children, by contrast, requires long-term funding and years of effort. Caregivers' assessment of their need for continued assistance in educating children reflects the long-term nature of this effort.

Health and hygiene. On this indicator, 199 families had thus far received medical treatment (n = 83, 42%), including medications or injections (n = 56, 28%), sanitation training (n = 35, 18%), and household hygiene items (n = 18, 9%). Most caregivers found the services "very helpful" (n = 114, 78%) or "helpful" (n = 27, 14%). Only 8 (4%) felt the services were "fair," and 3 found the services "unhelpful" (n = 3, 1.5%). Here, there was significant improvement in the before (n = 148, 74%) and after (n = 134, 67%) reports by families who found these services "very necessary." After receiving services, caregivers found their need for additional services in this category to be less necessary ($t(193) = -3.52$, p = .001). The combined group of families who said they needed services at the "very necessary" and "necessary" levels also showed modest improvement, at 91.1% before and 85.4% after services had been received.

Community participation. This indicator is designed to assist the family in getting involved in the community, both in terms of receiving and giving mutual assistance. At the time of the study, 143 families had been involved in this indicator. The major activity for those who were participating was to engage in gardening with community members (n = 59, 41%), often sharing a plot of land. Some (n = 24, 17%) participated in cleaning the community center, helping to build their own or others' homes with members of the community (n = 20, 14%), volunteering as individuals or as a team member in helping others who are needy (n = 10, 7%), or obtaining community training (n = 5, 3.5%). A sizable group (n = 19, 13%) engaged in other activities. Most families thought that community activities were "very helpful" (n = 75, 52%) or "helpful" (n = 35, 25%), and 24 (17%) caregivers thought they were only "fair." Although statistically there was no significant difference in the numbers of families who had moved from "very necessary" and "necessary" to other categories, the data suggest that more caregivers feel a need to be involved with the community as they progress in the program. Therefore, the slight increase in neediness may in fact imply a positive movement toward community cohesion.

Psychosocial support. Within this category of the program, 165 participating families received training in family care (n = 57, 35%), health and income training (n = 56, 34%), counseling services (n = 24, 15%), self-maintenance training (n = 18, 11%), and other related services (n = 8, 1%). The families found these services "very helpful" (n = 127, 79%) or "helpful" (n = 28, 17%). As shown in Figure 1, many families rated their initial psychosocial services as "very necessary" (n = 20) and afterward felt less need for additional services, although overall, approximately the same numbers of families remain in the combined "necessary" and "very necessary" categories.

Income generation. On this indicator, 230 families reported that they had been helped through the microcredit program, in which families receive small loans to start a business. Of those who received the loans, 101 (44%) received business loans of $18 USD or more. Another 42 families (18%) received loans of less than $18 USD, and 49 families (21%) received an unspecified amount. The remaining 17% of the participants received various small amounts of money for home use. Among those who had received help, 147 (64%) felt that it was "very helpful," and 31 (14%) felt it was "helpful." Surprisingly, 38 families (16.5 %) expressed that the help was only "fair," mostly citing that the small amount did not make a lasting impact. The remaining 14 families stated it was not helpful (n = 7) or did not reply (n = 7). For 211 families the help was "very necessary" before program participation, and for 168 families it was still "very necessary," a reduction of 20% (see Figure 1). However, as in most areas of the program, help is still needed by similar numbers of families (220 before intervention vs. 209 after).

Mentoring (*atenge*). Mentoring is the stage when families have reached all other indicators and are able to formally mentor other families. Only seven families had reached this stage, and three were currently mentoring other families. They all had positive responses to their involvement in mentoring. For most families, however, *atenge* was a far-off goal.

Other services needed. Caregivers were asked to identify additional desired or necessary services for themselves, their children, and the households. For themselves, the caregivers' top items were income-generating opportunities and loans (n = 120, 38%), housing and household items (n = 65, 21%), food (n = 26, 8%), health services (n = 12, 4%), and training (n = 12, 4%). A few mentioned educational costs for children (n = 11, 3.5%), and some listed more than one of the above items (n = 36, 11%) (Figure 2). As to the additional assistance the children

FIGURE 2. *Services necessary for caregivers.*

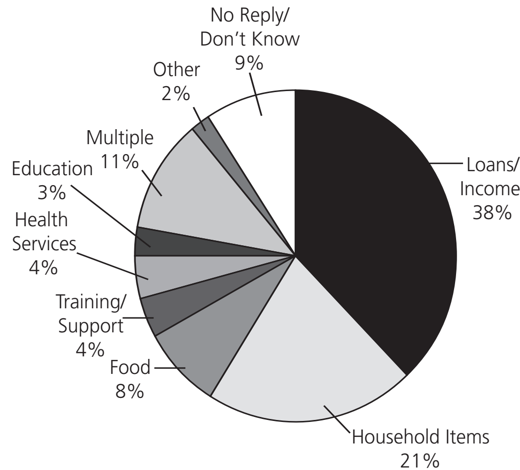


TABLE 1. *Cost Estimates in Uganda Shillings*[a]

INDICATOR	PER FAMILY	PER CHILD
Housing	300,000	
Food security	50,000	
Education for children		50,000(term)
Health/hygiene		80,000(annual)
Community participation	60,000	
Psychosocial support	10,000(month)	
Income	50,000(cycle 1)	
Children's Brigades	20,000(month)	

[a] *$1USD=1,756 Uganda Shillings (as of Dec. 19, 2006).*

needed, half of the caregivers (49.5%) indicated that children had multiple needs such as school-related fees and supplies, clothing, and health needs. More than a third (n = 117, 37%) listed school-related assistance as the top item. For the households, a third (n = 104, 33%) listed household items such as iron sheeting, bedding, saucepans, jerry cans (plastic containers used to carry water), latrines, water, and clothes. A total of 71 caregivers (22.5%) indicated that they needed a house, followed by other needs such as food/medication (n = 24, 8%), training/support (n = 8, 2.5%), education for children (n = 5, 1.6%), or multiples of the above (n = 27, 8.6%).

Some families were receiving only partial services from AFC, and others had received assistance but would have liked additional help in these areas. These families looked mostly to AFC for these needs, as 82% (n = 257) reported that AFC was their own source of help. The other 14% (n = 45) reported receiving additional help, and the remainder (n = 13, 4%) did not reply.

Cost Considerations

The cost of the program varies according to the extent of need for each participating family, and there is no standard rate per family. The cost analysis was therefore approached with a per-family estimate for the first seven indicators (the last indicator, mentoring, costs nothing). In addition, the Children's Brigade has been added as a separate cost analysis item. As can be seen in Table 1, some of the indicators (e.g., housing) target a certain level of sufficiency, at which time the assistance stops. Other indicators (e.g., education) require repeat intervention for the duration of the family's participation in the program. Based on the figures presented in Table 1 (given by Nyeko, AFC chairperson), the onetime cost of assisting a typical family of five children—for 3 years—would be estimated at $285 USD for housing, food, community participation, and psychosocial support. Microcredit loans would be additional and would depend on how many loan cycles the family uses.

The more expensive items include $295 USD for Children's Brigade, about $2,000 USD for three years of school-related costs for all five children, and $660 for health and hygiene needs. If microcredit costs were to be estimated at $100 per family, the total costs would add up to $3,340 for 3 years for a family with five children. That is a rate of about $93 USD per month, for providing all basic safety-net services, counseling, children's activities, education assistance, and most important, keeping this family together. In our opinion, that is an extremely good value (see Table 1).

Geographical Region Comparison

When comparing households in Kampala to those in Masindi, a more remote location in Western Uganda, few significant differences were apparent. The households had similar mean numbers of children and expressed similar average degrees of need before and after receiving services. However, some Masindi households expressed a lower degree of need after receiving services, showing a lesser degree of ongoing need in the education category ($t(305) = -3.17$, $p < .005$). Income in Masindi was also significantly less ($t(276) = 4.05$, $p < .001$) than in Kampala. Caregivers in more remote areas were less positive in their ratings of how well AFC helped their families ($\chi^2(9) = 20.08$, $p < .05$).

Child-Related Findings

The analysis of the eight indicators provides a glimpse at the first part of the AFC mission—"rescuing children from immediate danger" (Action for Children, 2005). It would appear that the program is generally succeeding at moving many families from the most desperate to less desperate categories, hopefully moving them away from immediate danger through the provision of improved health care and economic opportunities for the family.

However, the latter part of the mission, "giving [children] an opportunity to develop a purposeful future," is more difficult to document, as evaluating those would entail some measurement of the children's psychological and emotional well-being. Further, the question needed

to be explored in context of the overall missions of the funding and implementing agencies. Holt International Child Welfare is dedicated to helping children have a permanent, loving family (Holt International Children's Services, 2003). Certainly, we concluded, that question would entail an opportunity for permanency with the family, as well as a sense of belonging that children currently feel. We went about this in two ways: first we interviewed caregivers about each of the 1,484 children in their care. Next, we interviewed all children ages 8 to 18 years (*n* = 527) who could be contacted, reaching more than 60% of them. We have made a detailed report of findings of these issues elsewhere (Shaw & Roby, in press), and thus this section is a summary only.

Children ranged from 0 to 18 years, with the heaviest concentration in the 5- to 7-year range. The gender distribution was 49.5% (*n* = 734) female and 50.5% (*n* = 750) male. Fewer than half (*n* = 618, 42%) were sons and daughters of the caregivers. A slightly larger number of those who were not sons and daughters were the caregivers' grandchildren (*n* = 633, 43%), followed by nieces and nephews (*n* = 129, 9%), step-relatives (*n* = 28, 2%), brothers or sisters (*n* = 25, 2%), great-grandchildren (*n* = 11, 0.7%), and other relatives (*n* = 2, 0.1%). Another 32 children (2.2%) were not related to the caregivers.

For children who were not the biological sons and daughters of the caregivers, questions were asked regarding the children's parents and other relatives. The caregivers' responses show that 22% (*n* = 328) of the children's mothers and 34% (*n* = 497) of the fathers had died. The largest number of mothers had died of AIDS (*n* = 255, 78%) (Figure 3). The fathers had also died primarily due to AIDS (*n* = 375, 65%) and accidents (*n* = 78, 13%) (Figure 4). Many children living in substitute care in these homes had living parents who were not willing or able to care for them. Regarding the possibility of other relatives' caring for orphaned children, the caregivers reported that there were no other relatives to care for the vast majority (73%) of the children in their care. Only about one quarter (*n* = 68, 27%) of the children have contact with other relatives. These data suggest that the extended family network is in fact weakening, and the once-strong system of kinship is no longer the reality for these children.

To assess the children's own sense of being loved, belonging, and permanency, we interviewed 527 of the children in the 8 to 18 age range. Their numbers mirrored the figures from each of the five districts in which their families live, with the greatest number coming from Kyanja 1 district, followed by Kiwatule, Masindi, Kyanja 2, and Kiswa districts. The majority of the children were 13 years or under, with 32% in the 8 to 10 age range and 34% falling in the 11 to 13 range. The gender distribution was 51% female and 49% male. The vast majority (*n* = 423, 90%) reported that they were attending school, whereas 10% (*n* = 54) were not. Most (*n* = 289, 74%) were in primary school, while only 17% (*n* = 90) were in secondary school. About half (51%) of them reported participating in the Children's Brigade program.

The question of how to measure sense of belonging and being loved became a challenge. An exhaustive literature review did not result in any cross-culturally reliable instrument to measure such intangible factors. Thus, we turned to the local people and children in the community, and learned that children often feel loved and a sense of belonging if they feel they are not overworked compared to other children in the family and if they feel they receive comparable quality and quantity of food. In our study, only 175 (33%) children and youth answered the question asking how much more or less they work than other children in the home. Of those who answered, 19% (*n* = 34) reported that they work "much more," and 49% (*n* = 85) answered that they work "more." Only 29% felt that they worked the same, and 5 children (0.3%) felt that they worked less than other children. It would be expected that older children would work harder, but controlling for age, this pattern was not apparent. Controlling for biological or nonbiological status showed

FIGURE 3. *Causes of maternal death.*

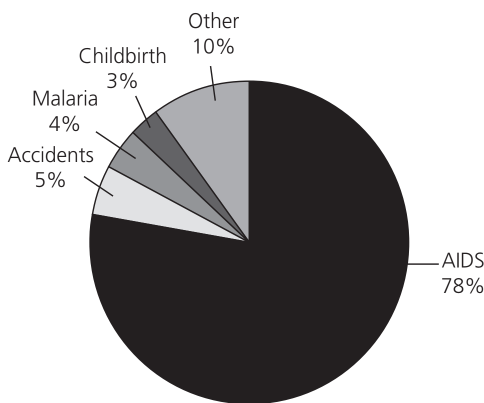
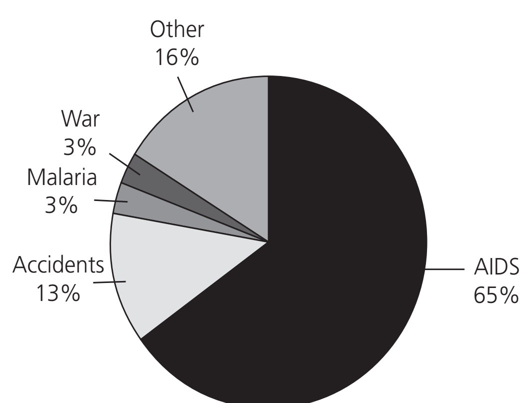


FIGURE 4. *Causes of paternal death.*



no significant difference. The questions on food produced similar results. Thus, based on those two factors at least, orphaned children seem to feel an equal sense of belonging and love with their biological counterparts.

For the most part, the children were happy with the adults with whom they lived; 69% ($n = 363$) reported that they were "always" happy, and 22% ($n = 117$) reported they were "often" happy with them. Only 7% reported being "sometimes," "rarely," or "never" happy. Participating children and adolescents were even more satisfied with the children in the family, with 76% ($n = 401$) being "always" happy with the children they live with, followed by 18% ($n = 95$) being "often" happy, and only 4% ($n = 22$) being "sometimes" or "never" happy.

And here is perhaps the most important indicator of the children's sense of permanency: An impressive 94% ($n = 495$) stated that they expected to live with their current family until they grew up. A small percentage ($n = 25$, 5%) stated that they did not expect to live with their current family, but 12 of these expected to live with another relative. We did not explore the reason behind their uncertainty; perhaps they expected that their caregivers would die from old age or sickness. Overall, however, these data are an encouraging sign of stability and permanence in the lives of these children.

Limitations

This study was planned and closely collaborated among the funding, implementing, and researching entities. Although the study was set in Uganda, the language barriers were minimized by highly educated bilingual local research assistants. The ample time on location allowed for surveying nearly all families who participated in the program, although we chose not to include the Apache location, which serves 20 families, and a few families in the covered areas were never located. The limitations, therefore, tend to be more subtle in nature. For example, although we consulted with local academics and practitioners, we still question how culturally effective our questionnaires were in eliciting accurate responses from the participants. In addition, since we relied solely on the children's self-reports about their feelings of belonging and permanency, there may be questions regarding the reliability of those findings.

Another possible worry is that when outsiders ask questions, there may be a cultural tendency to provide the answers that may be perceived as being more desirable to put a positive spin on either the participants themselves or the program. Thus, some of the more positive findings may have been influenced by such cultural patterns. In this case, our worries are somewhat balanced by experiences of researching elsewhere in the region, where families receiving assistance tend to exaggerate, not minimize, their problems and needs.

Implications

The AFC program is a prototype of family preservation that focuses on strengthening the family and providing community-based services, foundational pieces in the newly developing international models for addressing orphan care. The findings of this study are thus among the first empirical evidence of the efficacy of that model and have implications for research and practice. In terms of research, a follow-up study of these same families and children in a few years would provide longer-term perspective, particularly with regard to permanency and emotional and psychological health of the children as they mature into adulthood. Further, a study on the saturation level of extended families should be done with a larger sample, as this program serves a small minority of all families at risk of disintegration. This study suggests that kinship networks are indeed struggling and need more support to survive. As similar programs and methods expand to different regions in Africa, it will be important to study how the program might be modified to meet local needs.

In terms of practice, it appears that AFC's program is quite effective in moving families out of the most critical stage of need to a safer level. However, more effort should be focused on longer-term sustainable self-sufficiency efforts such as literacy and education, reliable food production, AIDS education, and access to more microcredit financing. A broader funding base, including multinational, nongovernmental organizations (NGOs), and government agencies should support such efforts.

Conclusion

Through this evaluation, AFC showed many strengths as well as program areas needing improvement. The program is significantly helping families move out of the most desperate ("very needy") category, particularly in the most immediate needs areas such as housing and food security. These tend to be short-term, cost-effective services rather than long-term, sustainability-building services. AFC's challenge is to move families to greater and longer-lasting self-sufficiency. Recommended methods include increased assistance with longer-term microcredit projects and sustainable food production. Adult literacy and education for all children should also be included among the longer-term goals for AFC.

AFC is not able to serve all families who are eligible, and many families must wait for services. The families are least satisfied with AFC assistance in the education category. Although Uganda has eliminated public school tuition, families struggle to send their children to school due to related costs. Holt and AFC may consider setting up a separate fund to provide educational assistance or searching for additional education funding sources.

Where AFC is able to provide basic services, it is reasonably cost-effective. We did not seek access to all of the program's financial records, but based on program outcome and numbers of families served, we believe the program is a good investment in keeping families together by meeting basic needs.

The most promising findings were the indication of long-term permanency and relative happiness expressed by both children and caregivers in these households. There is a strong sense of commitment on the part of caregivers to raise the children in their care to adulthood. Likewise, the children almost unanimously expect to grow up until adulthood in their current homes. In addition, children report being happy and well adjusted in their current family environments. There was no significant difference between the positive feelings expressed by children who lived with their biological parents and others. However, AFC currently does not provide any counseling services to children who may have experienced trauma and loss in the process of being orphaned. While the long-term effects are not known, we would encourage that such services be provided, particularly for children who live with relatives other than their grandparents or with nonrelated families. Additionally, we would recommend that the psychoemotional health of the children be included as one of the major indicators of the program.

Finally, based on our experiences in other sub-Saharan countries, we believe that this program represents an excellent prototype for the family- and community-based approaches being advocated by the international child welfare community. With adequate resources and with adjustments for local needs, the program should be successful in other parts of the sub-Saharan region.

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Jini L. Roby, JD, MSW, MS, is associate professor in the School of Social Work, Brigham Young University. **Stacey A. Shaw**, MSW, is employed with International Rescue Committee, Salt Lake City, UT. Ms. Shaw was the project manager throughout the on-location data collection process. Correspondence regarding this article can be addressed to the first author at jiniroby@byu.edu or BYU School of Social Work, 2166 JFSB, Provo, UT 84602.

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