

Orphan care: the role of the extended family in northern Uganda

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Abstract

This paper examines the traditional role of the extended family in orphan care in northern Uganda. The extended family provides much support in looking after orphans, but has been overburdened by the AIDS epidemic with the result that some care is being provided by the older orphans, who are too young for the responsibility. The main problems of orphans are lack of money, inadequate parental care and some mistreatment by the caregivers.

Orphanhood was predicted to increase in sub-Saharan Africa because of the AIDS epidemic (Petros-Barvazian and Merson 1990). The increase was also a result of wars and the poor state of the economy which exacerbated the spread of HIV in eastern Africa, according to Reining (1993), who stated that as many as 60 out of 1000 children were orphans. Data from five cities in the region showed that orphanhood increased by 46 per cent in 1992 in Lilongwe and Blantyre in Malawi, and more than doubled in Bujumbura in Rwanda, as a result of AIDS (Valleroy, Harris and Way 1993). The Mutale enumeration of 1995 in Zimbabwe revealed that orphans made up 14.7 per cent of the total children aged below 15 years (Foster *et al.* 1995, 1997; Urassa, Walraven and Boerma 1997). In Ethiopia, of 883 children under 15 years, 280 (31.7%) had lost one or both parents (Bedri, Kebede and Negassa 1995).

In Uganda, insecurity and civil strife during the 1970s and 1980s led to an increase in the number of orphans; this situation has been aggravated by the AIDS epidemic. The 1989-90 Medical Research Programme on AIDS in Masaka district revealed that 10.4 per cent of the children under 18 years were orphans, 13 per cent of whom were double AIDS orphans (Kamali *et al.* 1996). The 1991 census estimated that about 1.04 million children were orphans, who constituted 11.6 per cent of the children below 18 years; 9.3 per cent of the orphans had lost both parents (Republic of Uganda 1995). In urban areas like Kampala where AIDS was widespread, orphanhood had increased by 124 per cent in 1992 (Valleroy *et al.* 1993).

Studies in western and central Uganda by Hunter (1991) and Dunn (1992) found that orphanhood was highest in Rakai district (12.8%) in comparison to Luwero (5.6%), Masaka (5%) and Hoima (4.4%). More recent studies in some of these districts indicated an increasing trend in orphanhood. For instance the Semuto and Butuntumula study in Luwero reported that 20.8 per cent of the children were orphans (Shuey *et al.* 1996) and a survey in Masaka, a district heavily affected by AIDS, indicated an orphanhood level of 64 per cent in bereaved households (Ntozi 1997). The same studies observed that levels of double orphans had increased because of AIDS.

Orphans face several constraints especially when their parents have died of AIDS. In USA, AIDS orphans face an uncertain future regarding their custody and financial benefits (Levine 1995). The situation is worse in Africa where AIDS orphans have dropped out of school and been dispossessed of property (Webb 1995; Bedri *et al.* 1995). In South Africa

and Namibia where many marginalized orphans have been reduced to living on the street, the crime rate, prostitution and drug abuse are increasing (Webb 1995).

In Uganda, the main problems of orphans were found to be shelter, school fees and equipment, food, bedding, clothing, medical care and provision of care to younger siblings (Shuey *et al.* 1996). For example in Kampala, 47 per cent of the households assisting orphans lacked money for schooling compared to 10 per cent of those with no orphans to help (Muller and Abbas 1990). A study in Rakai by Barnett and Blaikie (1992) found that some orphans were stunted and malnourished because the extended family system could not cope with the high rate of orphanhood. In Masaka where AIDS is widespread, school attendance was lower for orphans (75.5%) than for non-orphans (83.6%) (Kamali *et al.* 1996).

Orphan care by the extended family

Studies in Africa show that the extended family provided the basic care for the orphans (Burch and Dewit 1986; Mitchell 1989; Bedri *et al.* 1995; Foster *et al.* 1997) and the institutional response was only supplementary (Webb 1995). The grandparents were found to provide much of the orphan care in Zimbabwe and Uganda (Hunter 1991; Foster *et al.* 1996). However, the recent dramatic increase in the number of orphans due to the AIDS epidemic has threatened to break this major function of the extended family system. This is because the disease has compromised family income that has to be spent mainly on medical care (Urassa *et al.* 1997). As a result, AIDS orphans survive under difficult circumstances (Foster *et al.* 1996).

Studies by Hunter (1991), Ntozi and Mukiza-Gapere (1995) and Foster (1996) showed that because of AIDS, many people caring for orphans are either too young or too old to manage the task. Shuey *et al.* (1996) observed that orphan care is solely the task of surviving parents, mainly mothers, and that some family members assist when both parents are dead. It is also claimed that the kinship ties are no longer close enough to provide for orphan care (Carswell 1988).

With family support being reduced, institutional assistance to orphans is being used as an alternative. Orphanages and non-government organizations provide direct support for the basic needs and school fees for orphans (Urassa 1997). One such group is Caritas in Rwanda which provides home care and food, and purchases family houses for children orphaned by AIDS (Mody 1993). Orphans' programs in Masaka and Rakai districts provide education to AIDS-affected orphans (Sharpe 1993). However, institutional support by the state has been found inadequate and sometimes inefficient (Burch and Dewit 1986).

Data source

The data used in this paper were collected in the 1997 survey conducted in the districts of Arua, Soroti and Lira in northern Uganda. The survey of three districts was an extension of an earlier multiphase study in six districts in other parts of Uganda started in 1992. Both positive and random sampling designs were used in the survey which used a structured questionnaire to probe for information from 1206 households that had suffered a death since their formation. Eight modules of the questionnaire asked about background characteristics of the households, contribution of members of the household, mortality since the household was formed, orphanhood and caretaking arrangements, migration and behavioural patterns, patient care, attitude towards illness and death in the community, and fertility. This paper uses information collected from the module on orphan care arrangement.

Orphanhood in northern Uganda

Table 1 shows that the overall orphanhood prevalence rate for the sample districts was 35.6 per cent. Lira district had the highest proportion of orphans (42%) followed by Arua district (38%). Soroti district had the lowest percentage of orphans. The high level of orphanhood observed can be partly explained by civil wars and a high level of AIDS prevalence in the area, especially in Arua district as observed by Ntozi *et al.* (1998).

The table also shows that orphanhood increased with age up to age group 5-9, then dropped in the next age groups, which was contrary to an observation made by Foster *et al.* (1995). Though this pattern is similar to that observed by Ntozi (1997) in other districts in Uganda, the percentages are higher. The high percentages of orphans of school age, 5 and above, in northern Uganda suggest that many children have dropped out of school, as observed in Rakai and Masaka districts (Kamali *et al.* 1996). Fortunately the government of Uganda has started providing free universal primary education which is expected to benefit the orphans.

Table 1
Proportion of orphaned children by district and age

District	Total children	Orphans	Per cent orphans
Lira	2195	921	42.0
Soroti	2020	536	26.5
Arua	1732	662	38.0
Age Groups			
Infants	645	90	14.0
1-4	1454	469	32.3
5-9	1554	679	43.7
10-14	1578	596	37.8
15-17	727	285	39.2
All	5958	2119	35.6

Table 2 shows that the majority of the orphans in the area had lost a father (72%) while 26.3 per cent were motherless; only 1.7 per cent had lost both parents. While no double orphans were observed in Lira district, Soroti had the highest number, followed by Arua. It is further shown that 58.3 per cent of the orphans were very young, below age 10. The higher percentage of paternal orphans can be explained by civil wars in northern Uganda which have claimed more lives of males than of females. The double orphans on the other hand may be a result of AIDS which kills both parents, as earlier observed by Kamali *et al.* (1996) and Ntozi (1997).

Table 2
Age distribution of orphans by dead parent and district

Districts Age groups	Lira			Soroti			Arua			All
	F	M	B	F	M	B	F	M	B	
Infants	73.0	27.0	0.0	71.0	29.0	0.0	63.6	36.4	0.0	4.2
1-4	76.8	23.2	0.0	65.3	31.4	3.3	79.4	19.9	0.7	22.1
5-9	68.5	31.6	0.0	62.8	31.7	5.5	78.6	20.5	0.9	32.0
10-14	74.3	25.7	0.0	63.1	29.8	7.1	76.8	22.2	1.0	28.1
15-17	76.2	23.8	0.0	64.6	26.6	8.9	68.4	31.6	0.0	13.4
All	73.3	26.7	0.0	64.2	30.2	5.6	76.6	22.7	0.8	100.0

F = father, M = mother, B = both parents

Causes of orphanhood

The age distribution of orphans by cause of death of parents is presented in Table 3. The table shows a high rate of AIDS orphans in Lira district (40.8%) followed by Arua (39.6%). Soroti district had the lowest percentage of the AIDS orphans, 22.8 per cent. The table further shows that AIDS accounted for 35.9 per cent of all orphanhood causes. It is also shown that the percentage of AIDS orphans rose with age from infancy (24.4%) until it peaked at age 14 (39.8%) before falling to 37.9 per cent in the highest age group. This pattern is expected because high AIDS mortality resulting from infected mothers affects younger more than older orphans; and sexually active adolescent orphans themselves die of AIDS. These age-specific rates and the overall orphanhood due to AIDS are however lower than those observed in other areas (Ntozi 1997).

Table 3
Age distribution of orphans by cause of death of parents and district (%)

District Age Group	Lira		Soroti		Arua		All	
	AIDS	Non-AIDS	AIDS	Non-AIDS	AIDS	Non-AIDS	AIDS	Non-AIDS
Infants	27.0	73.0	22.6	77.4	22.7	77.3	24.4	75.6
1-4	31.9	68.1	26.4	73.6	37.6	62.4	32.2	67.8
5-9	39.2	60.8	20.1	79.9	42.4	57.6	35.6	64.4
10-14	47.5	52.5	23.4	76.6	41.2	58.8	39.8	60.2
15-17	49.2	50.8	21.5	78.5	35.5	64.5	37.9	62.1
All	40.8	59.2	22.8	77.2	39.6	60.4	35.9	64.1

Orphan care

Table 4 shows that surviving parents provide most of the care (29.5%) followed by grandparents (21.6%), older orphans (19%), uncles (13.3%) and step-parents (11%). Aunts and other relatives provide the least care. However, the table shows that care by grandparents, step-parents, other relatives and friends, and aunts of AIDS orphans was more than that of all orphans put together. Care of AIDS orphans by grandparents was observed in other areas of Uganda (Hunter 1990, 1991) and in Zimbabwe (Foster *et al.* 1996).

Deeper analysis shows that surviving fathers provide more care than mothers, perhaps because the fathers have more means, and the husband's relatives often deny the widows the opportunity to look after the orphans. This is reflected in the substantial assistance from uncles and step-parents for paternal orphans. In the absence of fathers, uncles were found to provide assistance as expected, since children belong to their father's lineage. However, the support was high for non-AIDS orphans, perhaps because some of the widows were inherited by their brothers-in-law who had to care for them and their children (Harley 1940; Lawrance 1957; Southall 1970; Kisekka 1989). In contrast, grandparents provided more care for maternal orphans, perhaps to help the widowers.

No relatives other than the aunts and uncles provided care to double orphans. The older orphans provided more care to themselves and the younger orphans, who are mainly female non-AIDS orphans. Hunter (1990) observed similar care by older orphans in Rakai district in Uganda, as did Foster (1996) in Zimbabwe.

Table 4
Orphanhood care by identity of dead parent, sex and cause of death (%)

Carer	Male orphans			Female orphans			AIDS orphans			Non-AIDS orphans			All AIDS orphans	All orphans
	F	M	B	F	M	B	F	M	B	F	M	B		
Parent	27.3	39.3	0.0	28.4	31.0	0.0	25.9	27.7	0.0	28.9	41.0	0.0	26.5	29.5
Uncles	16.1	6.1	0.0	14.7	9.1	7.1	12.0	5.1	100.0	17.1	9.9	0.0	9.9	13.3
Aunts	3.4	1.5	50.0	1.9	4.8	7.1	3.0	3.9	0.0	2.6	2.5	23.8	3.3	3.0
Step-parents	11.6	6.1	0.0	13.8	7.5	0.0	15.0	6.9	0.0	11.5	6.7	0.0	12.3	11.0
Grand-parents	18.9	33.8	0.0	16.8	31.0	0.0	19.7	38.5	0.0	17.1	30.7	0.0	26.4	21.6
Older orphans	19.5	10.2	50.0	22.3	13.4	85.7	20.5	11.3	0.0	21.0	12.3	76.2	17.5	19.0
Other relatives	3.1	2.3	0.0	3.9	4.8	0.0	3.9	4.8	0.0	2.0	1.1	0.0	4.1	2.6

F = father dead, M = mother dead, B = both parents dead

Orphan care decision-makers

Table 5 shows orphan care decision-makers by identity of the dead parent according to the sex of the orphan and the cause of orphanhood. The table shows that clan members made most of the decisions about orphan care, especially for AIDS orphans, followed by surviving parents and older siblings. The influential role of grandparents as orphan care decision-makers was more pronounced among AIDS orphans in Rakai and Masaka districts (Hunter 1991). Uncles and other relatives made few decisions about orphan care, probably because many of them had died.

As expected, surviving fathers were more important in decision making than mothers irrespective of the orphans' sex and cause of orphanhood. Clan members took most of the care decisions on paternal and double orphans, probably because the fathers were dead and women are rarely allowed to make decisions when there are male relatives to do so. Where the father had died of AIDS the mother could be sick with AIDS and therefore unable to give care while for the double orphans clan members made decisions since children belong to their father's lineage. Percentages of decisions by grandparents were also high among double orphans, especially the boys, probably because grandsons are considered more important than grand-daughters since they are expected to continue the family lineage.

Table 5
Orphan care decision-maker by dead parent, sex and cause of death

Decision maker	Male orphans			Female orphans			AIDS orphans			Non-AIDS orphans			All AIDS orphan s	All orphan s
	F	M	B	F	M	B	F	M	B	F	M	B		
Parent	20.1	36.3	0.0	21.4	21.9	0.0	20.0	28.3	0.0	21.1	30.3	0.0	22.7	22.7
Older siblings	11.5	11.6	8.3	12.5	13.1	21.4	8.3	10.0	0.0	16.7	14.2	16.0	8.9	13.5
Uncles	3.6	1.2	0.0	4.7	3.1	0.0	4.8	2.7	0.0	3.8	1.5	0.0	4.1	3.5
Clan	51.3	39.8	58.3	49.3	47.6	71.1	56.1	42.5	100.0	47.5	44.4	64.0	51.6	48.8
Grand-parents	6.3	9.2	33.3	7.3	8.3	7.1	9.7	11.4	0.0	5.4	6.5	20.0	10.2	7.5
Other relatives	3.4	2.0	0.0	4.9	6.1	0.0	1.1	5.0	0.0	5.6	3.1	0.0	2.4	4.0

F= father dead, M = mother dead, B= both parents dead

Effects of orphanhood

The main effects of the death of parents on orphans were categorized in four groups: lack of parental care; lack of money both for domestic and educational use; mistreatment of orphans whose property was seized or who were forced into marriage at early ages; and no effect.

Table 6 shows that the main effect on orphans was lack of money (36.6%) followed by lack of parental care (29.2%) and mistreatment (21.6%). A substantial percentage (12.6) of the orphans were not affected by the death of their parents. The problem of lack of money was common in Arua and Soroti districts; this problem alone accounted for more than half of the effects in Arua district. Lira district reported lack of parental care as the most common effect on orphans. There was a higher percentage of mistreatment of orphans in Soroti than in the other districts. For unknown reasons as many as 21.5 per cent of the orphans in Soroti were not affected by orphanhood compared to 11.1 per cent in Lira and 7.9 per cent in Arua.

The distribution of orphans by problems in each age group shows that the two main problems of infants were mistreatment and lack of parental care while other children suffered most from lack of money. The problem of money among orphans of school age is expected since they need school fees and equipment, which are hard for the carers to provide. The infants and those aged 15-17 years were reported as being less affected by lack of money than those in the other age groups, perhaps because the infants were not aware of the problem and the 15-17 year-olds were mature enough to fend for themselves. It is curious that for all age groups a similar level of mistreatment (20.3 -22.5%) was reported, except in the case of infants who were reported as the most mistreated group (31.1%). This is probably because the infants could not complain about mistreatment. Perhaps those who reported on their behalf exaggerated the problem because of family wrangles.

Table 6
Per cent distribution of problems of orphans by age and district

District	Lack of		Orphan	
	parental care	money	mistreated	not affected
Lira	38.8	28.4	21.7	11.1
Soroti	21.3	31.9	25.4	21.5
Arua	22.2	51.7	18.3	7.9
Age Group				
Infants	28.9	22.2	31.1	17.8
1-4	32.4	35.5	21.1	11.1
5-9	28.7	38.0	20.3	13.0
10-14	28.0	38.1	22.5	11.4
15-17	27.4	36.5	20.4	15.8
All	29.2	36.6	21.6	12.6

The effect of the death of a parent on orphans is indicated by the percentage distribution of problems of orphans by age group and sex of orphans displayed in Table 7. The table shows that more boys than girls had problems of lack of parental care. This pattern is further confirmed by higher percentages of orphan girls than boys who were not affected by their parent's death perhaps because girls are more compliant than boys.

According to age, all orphan girls except those aged 10-14 years suffered more than boys from mistreatment; this is not surprising because mistreatment of young females in Africa is

not new. For instance, girls are often forced into marriage (Akingba 1974; Alabi 1990), dispossessed of property (Olunloyo 1993), sexually abused (Mati 1989; Abdool-Karim *et al.* 1992; Adepoju 1994; Esiet 1996) and denied equal educational opportunities with boys (Atai-Okei 1994; Makinson 1994; Meekers and Meekers 1995; Okwabi 1995). As a result many young girls have married or migrated to towns where they serve as housemaids and prostitutes (Rajani 1995).

Table 7
Per cent distribution of orphans according to problems by age and sex

Age Group	Males				Females			
	Lack of		Orphan		Lack of		Orphan	
	care	money	mis- treated	not affected	care	money	mis- treated	not affected
Infants	29.5	22.7	27.7	20.5	28.3	21.7	34.8	15.2
1-4	32.5	38.2	20.5	8.8	32.3	32.3	21.8	13.6
5-9	30.2	38.5	19.4	11.9	26.9	37.3	21.4	14.3
10-14	31.4	33.3	24.8	10.6	24.6	43.0	20.1	12.3
15-17	26.5	40.4	16.6	16.6	28.4	32.1	24.6	14.9
All	30.5	36.7	21.0	11.8	27.7	36.5	22.2	13.7

Per cent distributions of orphans according to problems by caretaker can be seen in Table 8. The table shows that the orphans who were most affected by lack of money (55%) were those cared for by aunts. Orphans cared for by grandparents had fewer financial problems than those assisted by other members of the family, who perhaps had their own children to look after, whereas grandparents own most of the property and have few or no children to look after.

Another remarkable result shown in Table 8 is that orphans caring for themselves complained less of lack of parental care than did those assisted by uncles, grandparents, step-parents and other relatives except aunts and living parents. Possibly, this is because left to themselves they have accepted the reality and are determined to succeed. It is also a reflection of increasing self-reliance by the orphans in the face of the breakdown of the extended family system.

Surprisingly, a higher percentage of orphans cared for by living parents (29.9%) and grandparents (25.9%) reported mistreatment as the main problem, possibly because the respondents mistook parental discipline for mistreatment. Other caretakers may have been more reluctant to discipline the orphans than their parents. Mistreatment could also arise from the extensive care required for AIDS patients, in cases where the living parent is sick with AIDS.

Table 8
Per cent distribution of orphans according to problems by caretaker

Caretaker	Lack of parental care	Lack of money	Orphan mistreated	Not affected
Living parent	21.2	40.3	29.9	8.6
Uncle	37.4	42.0	14.1	6.5
Aunt	16.7	55.0	20.0	8.3
Step-parents	37.0	36.6	15.7	10.6
Grandparents	34.4	30.2	25.9	9.4
Orphans themselves	29.9	37.9	18.9	13.3
Other relatives	43.1	39.2	19.8	7.8
All	30.0	37.9	22.5	9.6

Table 9 shows increases in the problems of orphan caretakers, especially problems of money. Relative to other problems, this increased for all orphans except those cared for by aunts. The orphans most affected by financial problems were those cared for by other relatives, uncles and living parents. The problem of money may be large for AIDS orphans being looked after by other relatives and uncles, perhaps because they have their own children to look after. Those cared for by surviving parents may have money problems due to past heavy expenditure on treating the deceased parent, and some surviving parents being too sick to earn money.

Table 9 also shows that AIDS orphans cared for by grandparents, older orphans and other relatives lacked parental care more than the rest: their parents were dead, or the surviving parent was too sick to provide care. Mistreatment of AIDS orphans by aunts, living parents, grandparents and uncles was more than that by other caretakers. However, mistreatment by aunts and living parents was exceptionally frequent, probably because aunts are traditionally known to be disciplinarians, while living parents may have been too sick to offer enough parental love. Grandparents on the other hand may have been too old to provide the expected assistance as observed by Hunter (1990) and Foster *et al.* (1996). It should be noted that fewer AIDS orphans were reported as not affected by orphanhood; this suggests that AIDS deaths of parents seriously affect orphans.

Table 9
Per cent distribution of AIDS orphans by caretaker

Caretaker	Lack of parental care	Lack of money	Orphan mistreated	Not affected
Living parent	23.8	45.9	25.4	4.9
Uncles	23.2	49.3	21.7	5.8
Aunts	26.1	34.8	30.4	8.7
Step-parents	29.1	44.2	19.8	7.0
Grandparents	36.2	31.9	24.9	7.0
Orphans	36.9	37.7	15.6	9.8
Other relatives	37.9	51.7	10.3	0.0
All	30.6	40.8	22.6	6.6

Conclusions and recommendations

There is a high rate of orphanhood in northern Uganda. The high proportions of AIDS orphans observed in Lira and Arua districts indicate the devastating effect of AIDS. The cessation of civil wars and a reduction of AIDS in these areas would drastically reduce orphanhood in northern Uganda. The role of the extended family in caring for the orphans is important despite the numbers involved. In a few cases, the older orphans assisted in looking after their younger siblings. The main problems for orphans were inadequate financial support, lack of parental care and mistreatment. It is therefore important that alternative means of orphan care should be explored to supplement the extended family before it is overwhelmed by the problems of orphans. Financial assistance to the family will greatly enhance the capacity of the family to continue coping with orphans.

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