Prioritized needs of community based orphan care programs in Malawi

BEARD, B.J.

Abstract

Significant numbers of children are being left as orphans in sub-Saharan Africa and their communities are trying to help both the children and the families in which they live. In Malawi, this model is called Community Based Orphan Care (CBOC). While studies have been conducted on the needs of both children and families, little is known about the needs of the community based programs. The purpose of this exploratory, descriptive field study was to examine the prioritized needs of 31 CBOC programs in Malawi. In focused group discussions, respondents identified their most important needs which include: food/water, supplies, buildings, transport, medicine, and programs. Needs were further delineated into those needed for children and families and those desired for the operation of the programs, themselves. Working through communities is the culturally appropriate way to reach families and orphans in Malawi and possibly all of sub-Saharan Africa.

Key words: Malawi, orphans, needs, Africa, community

Introduction

Malawi is a small, landlocked, densely populated country in southeastern sub-Saharan Africa. It is a physically beautiful nation with one of the largest freshwater lakes in Africa. Malawi is often called the "Warm Heart of Africa" because of the customary hospitality of its people. It is also one of the poorest countries in the world with more than 65% of its 11.5 million citizens living below the poverty line (National Statistics Office, 2001). Approximately 40% of the population is unable to satisfy their basic caloric needs and 55% of the rural population suffers chronic food insecurity (UNDP, 2001). There have been two recent, severe food crises, one in 2002 and another in early 2006. Over half of the population does not have access to safe drinking water.

In Malawi, life expectancy has decreased to 38 years of age (UNICEF, 2005). The prevalence rate for HIV/AIDS, one of the country's leading causes of death, is significant at 14.4% (Republic of Malawi, 2005). Most of the deaths occur in the population's reproductive age group (15-49 years). Since the fertility rate is 6.1% (UNICEF, 2005), this means that, after the deaths of their young parents, large numbers of children are being left as orphans.

An orphan is a child under the age of 18 years whose mother or father or both are dead (Subbarao & Coury, 2004; Ministry of Gender and Community Service, 2003) and the numbers of orphans are growing throughout sub-Saharan Africa. Estimates suggest that the number of orphans was 43.4 million (12.3 million due to AIDS) in 2003 (UNAIDS, UNICEF, &

USAID, 2004). In Malawi, there may be as many as 1 million orphaned children representing 14% of all children, 48% of these because of HIV/AIDS (UNAIDS, UNICEF, & USAID, 2004).

It has been said that, in Africa, there is no such thing as an orphan and that children belong to the whole community (Foster, 2003; Ayieko, 1997). There's a strong desire to care for one's own and to maintain the family. This makes people feel independent rather than dependent and provides the greatest opportunity for a child's social and spiritual well-being. A child feels a sense of belonging to a community.

In the past, the extended family system in Malawi provided a safety net for the small numbers of orphans in society (Maluwa-Banda & Bandawe, 2001). If the extended family was not available or able to care for them, other well-wishers would take them into their homes. Today, this safety net is stretched to its limits with the significant numbers of children who need homes. Orphans with no adult caregivers must fend for themselves as child-headed families. The emergence of so many child headed households is an indication that extended families are under stress. As extended families provide care for more children or as children manage families themselves, they are increasingly dependent on their communities for help and support. Families and communities are still the main caring environment for most children in Malawi.

Communities, faced with the large numbers of families who are caring for orphaned children, are coming together to formalize their responses. These grassroots groups grow out of concern by members of the communities who are motivated by a sense of obligation to care for those in need (Foster, 2002). In Malawi, when these groups organize, they are called Community Based Orphan Care (CBOC) programs (Beard, 2005). Keeping children in families within their communities is, by far, the preferred means for caring for orphaned children (Family Health International, 2001; Ministry of Gender and Community Service, 2003; Ministry of Gender, Youth, and Community Services, 1999; Republic of Malawi, 2005; UNAIDS, UNICEF, & USAID, 2004). It is also the most cost effective strategy (DeMarco, 2005; Desmond & Gow, 2001; Drew, Makufa, & Foster, 1998). The community, essentially, tries to provide the safety net for both the families and the children for whom they are caring. Finally, the U. N. Convention on the Rights of the Child addressed the rights that will help children to achieve the goals of childhood successfully. The UNRC declared: "The family, as the fundamental group of society and the natural environment for growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities in the community" (UNCRC, 1989). Malawi, along with all but two member nations, ratified this international statement.

Background

The literature is replete with research and opinions about the needs of children. There is limited literature about family needs and even less about the needs of the communities who are trying to provide supportive services to orphans and the families caring for them.

Needs of children

Knowledgeable judgments about the needs of orphaned and vulnerable children are offered in the literature. The latest collaborative project statement from UNAIDS, UNICEF, and USAID (2004) proposes a developmental approach for meeting the needs of orphans and vulnerable children. A child's age and stage of development will determine responses. The child's level of physical, cognitive, emotional, and psychosocial development denote the kinds of support and protection required.

According to this publication (UNAIDS, UNICEF, USAID, 2004, p. 16), for infancy and early childhood, needs include: care after the death of a parent; feeding; health care; growth monitoring and promotion; preserving sibling relationships; consistent and loving care-giving; and daycare and early learning options.

For children in middle childhood, needs include a focus on: education; nutrition; community participation; family connections; learning traditional skills and cultural behaviors; sibling relationships; recreation; caring adult relationships; and education about death and HIV/AIDS.

For adolescents, needs include: education and/or skills training; learning about adult roles; health care; education about HIV prevention; protection against exploitation; nutrition; peer relationships; and adult support.

At least two other reports agree with the developmental approach. Both Ruland et al. (2005) and Lyons (1999) believe that existing programs may not be meeting the needs of older and adolescent children. Programs may not be addressing the psychological, educational, sexuality and reproductive health, social support, and livelihood needs of orphaned adolescents.

Other authors encompass orphans of all ages when delineating their needs. Usually, these needs can be grouped together in the general categories of: physical, material, economic, educational, psychosocial, legal, safety, cultural, and spiritual needs (Phiri & Webb, 2002; Subbarao & Coury, 2004; Williamson, Cox, & Johnston, 2004). The need for psychosocial support and for a non-discriminatory environment has been especially singled out by authors as critical to an orphaned child (Grainger, Webb, & Elliot, 2001; Foster, 2002; Fox, 2002).

Several research studies have looked at the needs of orphans in sub-Saharan Africa countries. An early study in Uganda on the prevalence of orphans and the magnitude of their problems found that orphan needs were met and they were generally well looked after within their community (Kamali et al., 1996). The results of a study in Kenya (Lindblade, Odhiambo, Rosen, & DeCock, 2003) suggested that the health status of surviving orphans is similar to that of the non-orphans living in the same community. However, the authors recommend that longitudinal studies should be conducted to better determine the overall impact of orphan-hood on child health.

In most research studies conducted in sub-Saharan countries, there were differences in school enrollments, participation and attendance between orphans and non-orphans (Bicego, Rutstein, & Johnson, 2003; Ainsworth, Beegle, & Koda, 2005; Case, Paxson, & Ableidinger, 2004). In a study conducted in Zambia and Rwanda (Chatterji et al., 2005), there were no school enrollment differences. However, orphans were worse off with regard to possession of material goods and their health status was worse than non-orphans.

The main problems faced by orphans in Kenya were lack of school fees, food, and access to medical care (Nyambedha, Wandibba, & Aagaard-Hansen, 2003). In a qualitative study in Zambia, findings indicate that orphans' needs are basic and include: economic security, food, education, health care, shelter, and emotional health (Family Health International, 2005).

The needs of orphans in Malawi have been addressed in the literature (Republic of Malawi, 2005; Munthali, 2002; Chirwa, 2002; National AIDS Commission, 2003). These needs are basically the same as those identified in articles above related to orphans. In one paper, appraising the orphan situation in Malawi, the authors emphasize the importance of providing psychosocial care to orphans (Maluwa-Banda & Bandawe, 2001). This piece goes on to discuss other problems and needs of orphans which include: physical needs, education and vocational skills, loss of income, health care, stigmatization, socialization, exploitation, and emotional and psychological support.

In an early study in Malawi, adults and children differed in their identification of most important needs. While many of the adults identified material needs as most important, most of the orphans placed an equal or higher value on the "love" lost when a parent dies. The authors conclude that orphans have special psychosocial needs centering on grief resolution (Cook, Ali & Munthali, 1998).

In a study conducted in Malawi from 1998-2000 of 1106 surviving offspring of HIV positive mothers, neither maternal HIV status nor orphan-hood was associated with stunting, being

wasted, or reported ill health. The investigators suggest that, in terms of physical well-being, the extended family did not discriminate against surviving children whose parent had been ill or had died as a result of HIV/AIDS (Crampin, et al., 2003).

When Mann (2002) asked Malawian orphans and other vulnerable children to give their perspectives on their needs, they identified a need for love and forgiveness, need for freedom of expression, and freedom from discrimination and stigmatization. All children and young people who participated in this research agreed that orphans experience discrimination and harsh or cruel treatment within their households. Some orphans described having stones thrown at them, being insulted, or having less access, among other things, to food, material items (such as clothing, shelter, soap, pens, and notebooks), and school opportunities, due to lack of school fees and uniforms than the other children in the household. Aside from material and financial support, the two most important needs identified by adults in this study were: need for parental guidance and the need for love and support.

Finally, the Malawi Ministry of Gender and Community Services (2003) report that orphan care studies were conducted in 1993, 1994, and 1997. According to the Ministry, those studies showed that orphans that lose a mother have different needs than those who lose a father. Losing a mother is especially critical for orphans less than 5 years of age. Loss of a father has greater effects on the development and educational opportunities for older orphans. In 1998, the Malawi Ministry of Gender, Youth and Community Service conducted a conference on best practices in orphan care. During this conference, they identified six areas of psychological and health care needs of orphans. These include: identification of traumatized orphans; counseling; recreation; integration and re-integration in school and community; life skills training; and medication and use of traditional ways of healing (Ministry of Gender, Youth and Community Services, 1999).

Needs of families

While there is literature that includes both beliefs and research about the needs of orphaned children, there is less about the needs of families caring for children. International programs believe that family capacity represents the most important factor in building a safe, protective environment for orphans and one of the key strategies is to strengthen this capacity of families to care and protect orphans (UNAID, UNICEF, & USAID, 2004).

In a landmark article, Bhargava and Bigombe (2003) recommend a change in public policy to improve the financial situation of families caring for orphans. They contend that more families may be willing to care for orphans in their homes if financial incentives were provided to them since, without these incentives, they could not afford to support the extra children. Often, caregivers are grandparents and both they and their grandchildren suffer because of loss of social and economic support (Munthali, 2002). Subbarao and Coury (2004) have developed a list of interventions to improve the financial situation of families caring for orphans. Some of these include: labor sharing; communal gardens; agricultural assistance; microfinance; income-generating activities; and skills training.

The Malawi National AIDS Commission (2003) identifies multiple ways that households should be assisted as they care for orphans. The areas that need support include: food security, shelter, psychosocial, economic, and keeping families together. In a study of best practices on community based care for orphans, Malawi's Ministry of Gender, Youth and Community Service (1999) determined that the establishment of loan revolving funds was central to the improvement of the economic basis of families. An increasing number of families in Africa are in such poverty that basic needs cannot be met. A survey in Tanzania reported that 40% of families caring for orphans could not even cover basic expenses. The most common unmet needs were education (school fees and uniforms), food, medical care and clothes (Whitehouse, 2002).

A study in Uganda showed that adult caregivers have needs that must be addressed so that they can then support and prolong their capacity to care for orphans in their homes (Gilborn, Nyonyintono, Kalumbili, & Jagwe-Wadda, 2001). For instance, adults may have: critical health needs of their own; a need for help with psychosocial issues of their own and of orphans; and material needs. Study participants said that material support is what they need most.

Needs of communities

There is literature on both the needs of orphans and the families that care for them but very little about what their communities need, in turn, to provide support to children and families. Most African communities, caregivers, and grassroots organizations do not have the economic means to manage adequately (Phiri & Webb, 2002). In 1998, Hunter and Williamson suggested intervention strategies to help maximize the impact of local, community based responses, the first of which is to strengthen the capacity of families to cope with their problems.

But more recently, Chirwa (2002), in discussing orphan care in Malawi, declares that there has been a reduction in the capacity of communities as a result of the rapid increases in the number of orphaned children. Even so, the Malawi National AIDS Commission (2003) suggested that communities could provide support in the following areas: health care; material/financial; emotional, spiritual and social support; awareness and prevention.

While the literature discusses the importance of community support for family care of orphans, there has been no research published that has assessed what communities, themselves, need to do their work. In fact, most literature looks at what children need, deals somewhat with the needs of families caring for orphans, but does not deliberate at all about what communities need. As Foster (2002, p. 9) says, when referring to community responses and initiatives in orphan care, "they have been little studied or documented".

The inclusive purpose of this project (2001-2005) was to survey programs that care for orphans in Malawi to better understand community responses, capacities and needs. In the overall project, 71 programs were visited to determine: program features, budget/funding information, outcome measures and prioritized needs. The specific purpose of this report is to describe the needs of 31 community-based orphan care programs visited in 2003 and the identified priority of those needs by these community groups.

Methods

This exploratory, descriptive field study used qualitative methods to gather data and adopted a participatory approach to draw participation and experiences of key stakeholders. Quantitative methods were used to analyze the data. The sample was purposive. Social welfare workers guided us to community based orphan care programs in their areas.

The tool was developed by the researcher based on responses from programs in 2001. The visits in 2001 were part of an overall assessment of orphan care in Malawi (Beard, Beard, Dimmock, & Streshley, 2001) in which 16 programs were visited, 12 of which were CBOC programs. During those visits CBOC programs identified their needs as: funding, workers, medicine, supplies, programs, buildings, transport, and food/water. Funding was not included in the 2003 study since it was assumed that all programs would identify this as their first priority in order to support all other needs. Using the list of seven needs, along with an alternate option called "other", groups were asked to determine their 3 most important needs and to then prioritize these as #1, #2, and #3. For each need identified as a priority, they were asked to state what specific items were needed.

For this study, a focused group discussion was used. Group consensus was sought in a structured group interaction. Group based technique was used with the local social welfare worker providing instructions to participants in their native language. This method encouraged people to talk with one another and they could exchange ideas in their native language. Consensus based decision making is a feature of community initiatives so this method was appropriate for this study (Foster, 2002). Response time to the questions ranged from a low of 10 minutes to a high of 45 minutes. Most groups were able to complete the exercise within 20 minutes. Respondents were village orphan care committee members and leaders such as tribal chiefs and headmen. There were between 4 to15 adults in each group. No children were included as respondents in this project.

Programs were located in urban/suburban (15; 48%) and rural/remote (16; 52%) areas. In many cases, the programs in remote areas would have been impossible to find without the help of local social welfare workers. These programs were especially appreciative of visits from outsiders. All programs, however, were eager to respond to the interview questions regardless of program location. Seventeen (55%) were in the Northern region while 14 (45%) were in the Central region.

In terms of data analysis, frequencies and percentages were determined for each of the seven needs for all programs and then by program location. Program location was determined by whether the program was located in an urban/suburban area or in a remote/extremely remote area. For data analysis, prioritized needs were scored as: #1 priority (3 points); #2 priority (2 points); #3 priority (1 point) for all programs. Each program was allocated a total of 6 points. The numbers of programs were multiplied times the maximum number of points (6). This determined the weighted score. These weighted scores were then summed and percentages were determined (see Tables 2, 4, and 6).

Results

How programs operate and what they do for children and families

The 31 CBOC programs included in this analysis are caring for 31,838 orphans. Programs stated that they were also providing support to 13,960 other vulnerable children for a total of 45,798 children. Twenty (65%) of the programs have activities that are held 5-6 days each week while 4 programs meet 3 days or less. Seven programs do not formally meet but are either providing services out in the community or planning to hold formal activities in the future. Most programs (24; 77%) try to provide at least one meal per day for children with one program being fully focused on this goal. Nine (29%) programs are providing school fees for orphans but only 51 children are receiving these fees (range: 2-14; mode: 6) due to lack of available funds. Five programs said that their dream is to provide school fees. One program said: "This is a big problem facing us".

Fifteen (48%) of the programs have onsite community based child care centers. These are preschool programs intended to not only prepare young children for primary school but to also offer the children a meal which may be their only meal of the day. One of these schools was located outdoors under a tree. Nine (29%) of the CBOCs have Saturday programs. One was a "youth club" for 10-18 year olds focusing on recreation and skills training. Skills training were included in two other Saturday programs. Most (6) programs tried to provide one basic meal. Other components of Saturday programs included: recreation (soccer), language (English) lessons, singing and music, religious training, spiritual and other counseling, and teaching about HIV/AIDS. Four programs conducted clubs or after school programs for youth. These were

usually for older children and included snacks, recreation, skills training, counseling, and teaching about HIV/AIDS.

Eighteen (58%) of the programs included skills training for youth. Skill training for orphans is important since youth have lost their fathers, the ones from whom they were supposed to learn a profession or trade. Programs are providing the following training experiences: tailoring/sewing/knitting (9); carpentry and wood working (9); tinsmithing (6); indigenous skills such as making mud bricks, mats, clay pots and gardening (5); cooking and baking (2); bicycle repair (2); and, finally, poultry farming (2). Skill training provides income opportunities not only for the orphans but also for families and the organization itself as the products of the training programs are often sold. Twenty (65%) programs provide language education, most often in English, and 20 (65%) programs include religious or spiritual guidance. While 8 (29%) programs said that they have "medical care" onsite, this care consisted mostly of first aid kits and, in one instance, of only a small number of analgesics. The chairperson of one program is a nurse and one program was located near a district health care sub-center. During a visit to a remote program, a young child was found very ill with what appeared to be malaria. We had a supply of anti-malarial medicine with us which we gave to the village committee members to use as needed. Gardens were an important component for 14 (45%) programs and a source of great pride for community members. Crops raised include: maize, vegetables, soy, and ground nuts. One program had a maize garden but it was swept away in a torrential rain and now the area was suffering from a drought. Three programs have secure facilities. Three other programs have guards or night watchmen. Security is of particular concern for programs in urban areas but of increasing concern in rural areas as poverty levels deepen. Nine programs said they have facilities for hygiene or sanitation. Two said that hygiene and sanitation were not sufficient for the child care centers, in particular. Twelve of the programs are offering formal education or support for adults. Seven of the programs offer training or support related to finances. Four programs give business management training seminars for guardians. Four programs have formal loan programs (also called micro loans) for guardians. One of these, a "revolving fund" gives loans worth 1000MK (about USD 12) to guardians. These guardians then set up small businesses selling products such as cassava, scones, vegetables, or sugar. Three programs hold discussion groups for widows and grannies. The purpose of these is to not only provide social support but to also give guidance about "property grabbing" by relatives. Spiritual support and encouragement with the "Word of God" are components of two of the programs. Finally, teaching about child development and nutritional needs of young babies and children are included in four of the programs. Ten of the programs provide outreach to families in their homes. Most often, this includes food (7) or second hand clothes (6) but can also include medicine, when available, and soaps. Counseling and information about HIV/AIDS is also done by two programs.

What programs need

To fully understand what the programs said they needed, and their priorities for these needs, it is important to understand the operation of these programs as they try to do their job, as identified in the section above. Nearly all (94%) of the programs identified food and water as a priority need (Table 1). Only two programs, both located in urban/suburban areas, did not identify a need for either food or water (Table 5). In terms of water, boreholes (6) were needed by six programs and one program would like a tap into the city pipeline. Programs identified needs for food for children and families. Specific food identified included: maize (corn), likhuni phala (high protein porridge blend of maize and soya), ufa (maize flour), rice, sugar, beans, groundnuts, soya, lactogen, baby formula, oil, salt, meat, relish (vegetables; meat), milk, and nsima (thick porridge made from maize, cassava or other starchy flour).

Supplies were identified as a need by 58% of the programs (Table 1). They were the second most important need for programs in rural/extremely rural areas (Table 4) but the third most

important for all programs (Table 2) and for programs located in urban/suburban areas (Table 6). Supplies that programs listed that they need for their own operation include: teaching/learning materials such as blackboards, chalk, exercise books, books, pens; cooking pots, pans, utensils, plates, cups, spoons; toys and soccer balls; bicycles; ambulance bicycle; seeds, fertilizer, and pesticides; soaps; skills training materials. Supplies that programs said they need for families and children include: used clothes (2nd hand); warm clothes; soaps; home based care kits; mosquito nets, blankets, bedding and sleeping mats.

Buildings were needed by 48% of the programs (Table 1). These buildings include: nursery schools (community based child care centers) (5); multipurpose buildings (4); administration buildings (2); primary school (1). When weighted, buildings became the second most important need for all programs and for those located in urban/suburban areas (Tables 2 and 6). Buildings were the third most important need for programs located in rural/extremely rural areas (Table 4).

Transport was identified as a need by 48% of the programs and was weighted as the fourth most important need for all programs and for those in rural/extremely rural locales (Table 4). Transport was identified as important by 56% of programs in rural/extremely rural areas (Table 3) and by 40% in urban/suburban locations (Table 5). Modes of transport needed include: motorcycles (11); bicycles (9); money for minibuses.

Nine programs (29%) identified medicine as a need (Table 1) but medicine was identified as a more important need by programs in urban/suburban areas (Tables 5 and 6) than those located in rural/extremely rural areas (Tables 3 and 4). One program said they want a "drug revolving fund". Medicine and health related needs include: anti-malarial drugs; analgesics, including chewable analgesics for children; cough medicine; iodine; aspirin; band aids; gloves; iodine; anti-retroviral medicine for orphans living with HIV/AIDS; and anti-diarrhea medicine.

Programs, or education, were identified as a need by 7 programs (23%; Table 1). Programs identified include: life skills for orphans; training for committee members, teachers, volunteers, and executive committee members; HIV/AIDS counseling; record keeping; skills training; and nutritional programs. None of the programs listed "workers" as a need and none of the programs chose the option called "other" to identify additional needs that were not on the list.

There were multiple limitations to this study. This study was limited to one country in Africa, Malawi, and the sample was purposive, chosen primarily by district social welfare workers. Most respondents were not recipients of program activities although some were guardians of orphans. Respondents did not include children, the primary beneficiaries of orphan care programs.

Table 1
Programs prioritizing needs (N = 31)

	need	number of programs	% of total programs
1	food/water	29	94%
2	supplies	18	58%
3	buildings	15	48%
4	transport	15	48%
5	medicine	9	29%
6	programs	7	23%
7	workers	0	0

Table 2

Weighted measure of points given to prioritized need by all of the programs (N = 31) (186 total points)*

	need	points	% of total points
1	food/water	54	29%
2	buildings	41	22%
3	supplies	37	20%
4	transport	25	13%
5	programs	15	8%
6	medicine	14	8%
7	workers	0	0

* each program ranked top 3 needs as:
#1 (3 points) #2 (2 points) #3 (1 point)
Total points per program = 6
31 programs x 6 points = 186 total points

Table 3

Rural/extremely rural programs prioritizing needs (N = 16)

	need	number of programs	% of total programs
1	food/water	16	100%
2	supplies	10	63%
3	transport	9	56%
4	buildings	8	50%
5	programs	3	19%
6	medicine	2	13%
7	workers	0	0

Table 4

Weighted measures of rural/extremely rural programs (96 total points)*

	need	points	% of total points
1	food/water	31	32%
2	supplies	20	21%
3	buildings	20	21%
4	transport	15	16%
5	programs	7	7%
6	medicine	3	3%
7	workers	0	0

* each program ranked top 3 needs as:
#1 (3 points) #2 (2 points) #3 (1 point)
Total points per program = 6
16 programs x 6 points = 96 total points

Table 5
Urban/suburban programs prioritizing needs (N = 15)

	need	number of programs	% of total programs
1	food/water	13	87%
2	supplies	8	53%
3	medicine	7	47%
4	buildings	7	47%
5	transport	6	40%
6	programs	4	27%
7	workers	0	0

Table 6
Weighted measures of urban/suburban programs (90 total points)*

	need	points	% of total points
1	food/water	23	26%
2	buildings	21	23%
3	supplies	17	19%
4	medicine	11	12%
5	transport	10	11%
6	programs	8	9%
7	workers	0	0

* Each program ranked top 3 needs as:
#1 (3 points) #2 (2 points) #3 (1 point)
Total points per program = 6
15 programs x 6 points = 90 total points

Discussion

Families in Malawi are mostly impoverished and are straining to meet not only their own needs but also those of the orphans who have come to live with them. They are relying more and more on their local communities for help. Communities are organizing into CBOC programs with the intention of helping to meet the needs of their citizens. CBOC programs, themselves, are now the focus as they find that they, themselves, have needs of their own.
As this report shows, CBOC programs are trying to meet the needs of children and their families by providing a number of services directly to them. Some of these include: food, medicine, soaps, school fees, used clothes, and micro-loans. Many of the CBOC programs have more formal components which include: Saturday and after-school programs; skills training classes; education about HIV/AIDS and family finance; discussion groups; legal advice; communal gardens; feeding schemes; on-site child care centers and preschools; language education; spiritual/religious guidance; and counseling.

Awareness of what CBOC programs are doing, in their work, helps gives insight into the results of this study. The programs have identified their needs as they provide direct support to children and families but also as they try to function as a group and manage their more formal, organized programs.

For instance, the first priority for nearly all programs is food/water. This was not a surprising finding as both food and water are basic needs for all people. This means that they want to provide food directly to families but they also need food for children in the preschool and child care centers. The six programs that identified boreholes as important intend to put those boreholes near the child care centers or the multipurpose buildings so that all community members would benefit.

The same is true with supplies. Programs are providing, or would like to provide, supplies directly to families including clothes, soaps, blankets, mosquito nets and bedding. But they also identify that they need supplies to run components of their formal programs. These components include the preschools or child care centers, skills training classes, and communal gardens. Supplies are needed to run all of these elements and include such things as teaching/learning materials, food preparation items, garden supplies, and recreation equipment. During the data gathering time in this study, several of the programs said that they hesitated to include recreational supplies such as soccer balls and toys among their list of needs. They were concerned that this answer might be misconstrued as their not being serious about their work. They were reassured by both the social welfare workers and the researcher that including these items was appropriate to the intent of the study. Again, identification of supplies as a need was not an unexpected finding.

The programs prioritize both "transport" and "buildings" as important. While these do not directly benefit children, they are important to the administration and operation of the programs themselves. Without transport, community members might find it difficult to travel far distances to deliver supplies and food to families, even if these became more available. Buildings identified as important included child care centers and multi-purpose buildings. In Malawi, these multipurpose buildings are usually centrally located and can have many uses. Often they have a small, secure area used to store cooking materials, food, and supplies. The building is used as a child-care center or preschool and as a gathering place for community activities such as adult education classes. To generate income useful for maintaining the building, it may be rented out to community members for celebrations such as weddings. Since the building is seen as integral to community life, theft and damage from trouble-makers is rare.

None of the programs chose "workers" as a need. Nearly all CBOC programs are run by volunteers. Sometimes the programs will pay a nominal stipend to a cook, guard, or one of the preschool teachers, but this is rare as financial resources are in short supply. The spirit of voluntarism and caring for members of one's family and community is still strong in Malawi in spite of the deepening poverty levels for all people. It is easy to find volunteers as the unemployment level is so high.

What seems to be missing is a fuller focus on the psychosocial needs of children and their families. Psychosocial needs of children are most often neglected in designing programs (Phiri & Webb, 2002) yet just as important as material needs (Grainger, Webb, & Elliott, 2001). Some of the CBOC programs include counseling in their Saturday or after-school programs but, on the whole, psychosocial needs are only addressed in a limited way by most programs. For instance, maintenance and stabilization of sibling relationships and grief counseling for children are critical to both short and long term healthy adjustment of orphaned children. One recent research study suggests that program developers must develop reliable methods to measure the psychological status of orphans and determine their psychosocial needs (Chatterji et al., 2005). Since the literature addresses this need for psychological support as essential to the life of a child, CBOC programs should give significant attention to this component in the future.

A simple way to view the findings in this study would be to think of the orphaned child in the center of a circle. Surrounding that circle is a larger one that includes the family and encircling both the family and the child is the community. In thinking about needs, the child has its own

needs. The family tries to meet the needs of the child by providing such things as shelter, food, and clothing. But the family has additional needs, such as income, to support that child and supportive education about family financial budgeting and childcare issues. The community surrounds the family and child and is the safety net for all of them. The community attempts to help those families that are caring for orphans by providing them with food and material goods such as used clothes, school fees, medicines, skills training, daycare, and education. But the community has additional needs of its own, as evidenced by the results of this study. The community needs food, water, supplies, medicine, buildings and transport in order to succeed in their work. But, as simple as these findings seem to be, they are significant as they represent one of the first attempts to focus in on the needs of community-based programs themselves.

Conclusion

Outside of the three central circles of the child, the family, and the community lay all other services. Governments, nations, non-governmental organizations (NGOs), and donors are all supportive to the community.

There is always the danger that external initiatives, as well meaning as they are, can undermine local community capacity for coping with their problems (Foster, 2003). Navigating through the layers of community and family may seem time consuming and not as straightforward as outsiders would like. Sometimes peripheral agencies will go directly to the child or family to provide services, ignoring the community, often duplicating services already provided by the community itself. Large amounts of donations may come in from the global community with insufficient understanding of where to direct these resources.

The orphan care predicament belongs to the affected communities and they are the ones who know best what they need to deal with this problem. They are the experts and they will willingly articulate their perspectives, if asked, as they were in this study. Building the capacity of communities will, in turn, strengthen both families and the children for whom they care.

None of the programs visited in 2003 identified themselves as associated with COPE (Community-based Options for Protection and Empowerment) of Save the Children (US) in Malawi (Mann, 2002). COPE has developed strategies for assisting communities to respond to the needs of children, families and communities affected by HIV/AIDS. This is the first proposed partnership program in sub-Saharan Africa to try to move to a national scale to meet the needs of children affected by HIV/AIDS. Partnerships such as this (COPE) demonstrate sensitivity and respect for the views of the local community and, in the end, have better chances for success and sustainability of efforts.

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Author note

Betty J. Beard
Eastern Michigan University
School of Nursing
311 Marshall
Ypsilanti, Michigan 48197
USA
Mailing Address:
140 N. Grand Pte.
Brooklyn, Michigan 49230
USA
Phone: 734-487-2341
Fax: 517-592-2808
E-mail: Betty.beard@emich.edu
E-mail: Jbeard140@aol.com