

# Working Papers

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**Working Paper No. 06-16**

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**Center for Social Development**



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George Warren Brown School of Social Work

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**Abstract**

**Economic Empowerment as a Health Care Intervention among Orphaned Children in Rural Uganda**

This study evaluated an economic empowerment intervention to reduce HIV risks among orphaned children in Uganda. Children (n=97) were randomly assigned to receive an economic intervention or to a control arm. Data obtained at baseline and 12-month follow-up revealed differences on HIV prevention attitudes, educational plans, and child-caregiver relationship for intervention arm children relative to control children. Findings lend support to use of economic empowerment interventions for HIV risk reduction among orphaned children.

## **Economic Empowerment as a Health Care Intervention among Orphaned Children in Rural Uganda**

AIDS is a global public health issue, particularly for the people of sub-Saharan Africa. In Uganda—a country especially threatened by AIDS—over 1 million children have lost one or both parents due to the disease (UNAIDS, 2006). The numbers of these AIDS orphans are expected to increase by 50,000 annually (World Bank, 2000). Facing multiple problems, AIDS orphans in Uganda sorely need responsive interventions to help them prevent their own HIV infection and advance their educational and economic futures, despite their disadvantaged status. This study evaluated an asset-based family economic empowerment intervention for AIDS orphaned children in Uganda. Based on asset theory (Sherraden, 1990; 1991), the intervention employs such assets as savings accounts and scholarships for education to not only fight poverty, but also to promote health and social functioning.

### **Methods**

#### ***Study Design***

In an experimental design, 97 AIDS orphaned children from seven comparable primary schools in the Rakai district of Uganda were randomly divided into experimental ( $n=50$ ) and control ( $n=47$ ) arms. Each child assented to study participation, and had the informed consent of at least one parent or guardian. Children in the sample were primarily female (70%), had an average age of 14 years, and lived in an average household size of six people, including three children. Seventy two percent of children had no living father; 46% had no living mother and 39% were double orphans (with no living father or mother).

## Economic Empowerment as a Health Care Intervention

Experimental arm children received a family economic empowerment intervention, which included a Child Development Account (CDA) and six 2-hour classes on career planning, short-term and long-term career goals, and financial well-being. Held in the child's name in a bank, the CDA is funded by contributions from the child's family members or friends, with 2:1 matching funds from the intervention. Matching funds are provided by a consortium of institutions including Columbia University School of Social Work, Washington University in St. Louis, and the Friedman Family Foundation. Account holders may use the CDA only to pay their educational expenses or to invest in such income generating activities as raising livestock or starting a small business. Children in the control arm received usual care for AIDS orphaned children in Uganda that included peer counseling, health education, and scholastic materials.

### **Measurement and Analysis**

Outcome data were obtained through 1-hour assessments with each child, at their school. Interviews were conducted by a research assistant blind to study arm assignments, prior to intervention delivery and 12 months post-intervention. Evaluation measurement items, adapted for Ugandan children from previously tested scales (Fisher, Auslander, Munro, Arfken, Brownson, Owens, 1998; Cleary, Devanter, Rogers, et al., 1993; Paikoff, 1995; Slonim-Nevo, Auslander, Ozawa, 1995; Rotheram-Borus, Rosario, VanRossem, Reid, Gillis, 1995), included scales on HIV prevention attitudes, educational planning, and family cohesion. Changes in mean scores from baseline to 12-month follow-up between experimental and control arms were compared with multivariate analysis of variance on each outcome variable.

## Results

Children did not significantly differ between arms in their baseline scores on HIV prevention attitudes, educational plans (Figures 1 and 2), or the degree of child-caregiver communication. At 12-month follow-up, experimental arm children had improved their HIV prevention attitudes, whereas control arm children showed decreased scores relative to baseline measurement on this variable,  $F(1, 82) = 5.1, p < .05$ . Educational plan findings showed a similar pattern, ( $F(1, 81) = 5.6, p < .05$ ).

[INSERT FIGURES 1 and 2 ABOUT HERE]

Findings on the degree of child-caregiver relationship revealed a similar pattern for differences between arms,  $F(1, 69) = 3.6, p < .05$ . The mean level of child-caregiver communication reported by children in the experimental arm increased from 2.2 to 2.5 from baseline to 12-month follow-up. Children in the control arm decreased their mean level of child-caregiver communication, from 2.4 to 2.2 from baseline to 12-month follow-up.

## Discussion

These data suggest that AIDS orphaned children can benefit from family economic empowerment interventions. Representing a departure from micro-level programs focused on behavioral risks for HIV infection, macro economic interventions may effect change by giving children a means to improve their lives in tangible and rewarding ways. Whatever the mechanisms for change, family economic empowerment programs warrant further investigation as a way to reverse the disquieting trajectory of HIV infection in sub-Saharan Africa.

## Economic Empowerment as a Health Care Intervention

Not without flaws – including a relatively small sample size, self-report measures, and a relatively short follow-up period – this study is nonetheless the first of its kind to examine economic empowerment for at-risk African youth. Future work might profitably involve larger clinical trials and appropriate behavioral outcome measures to determine whether economic interventions can address the seemingly intractable problems of HIV infection and AIDS in sub-Saharan Africa.



Figure 1. HIV prevention attitudes

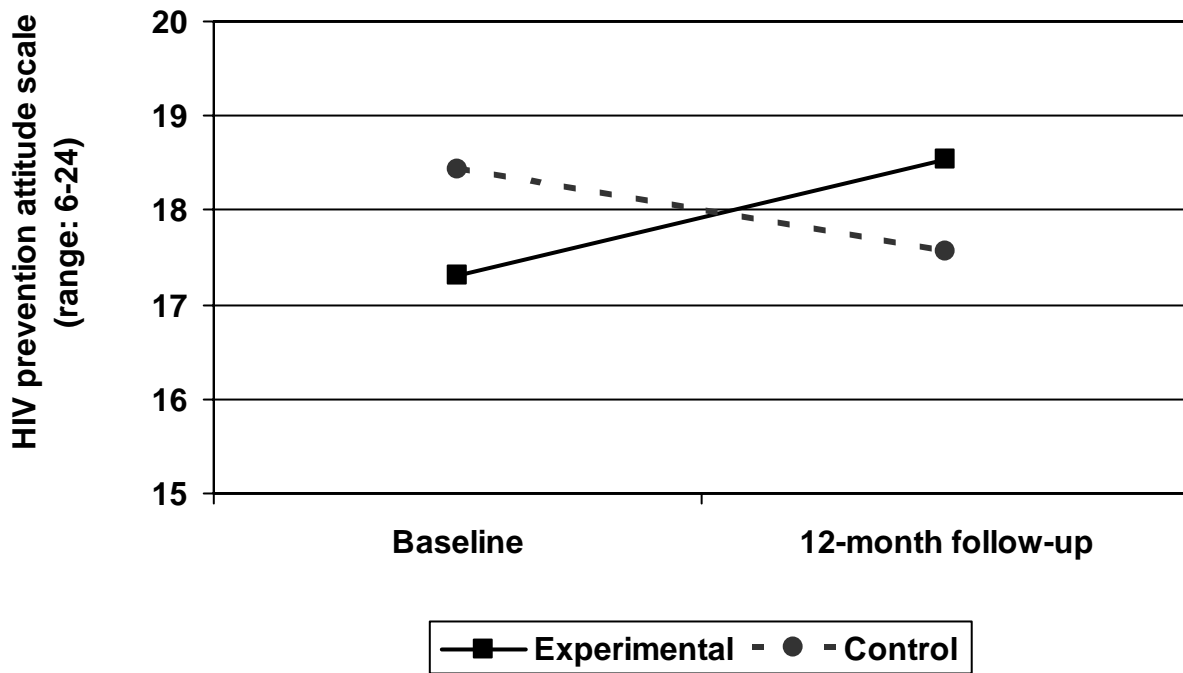
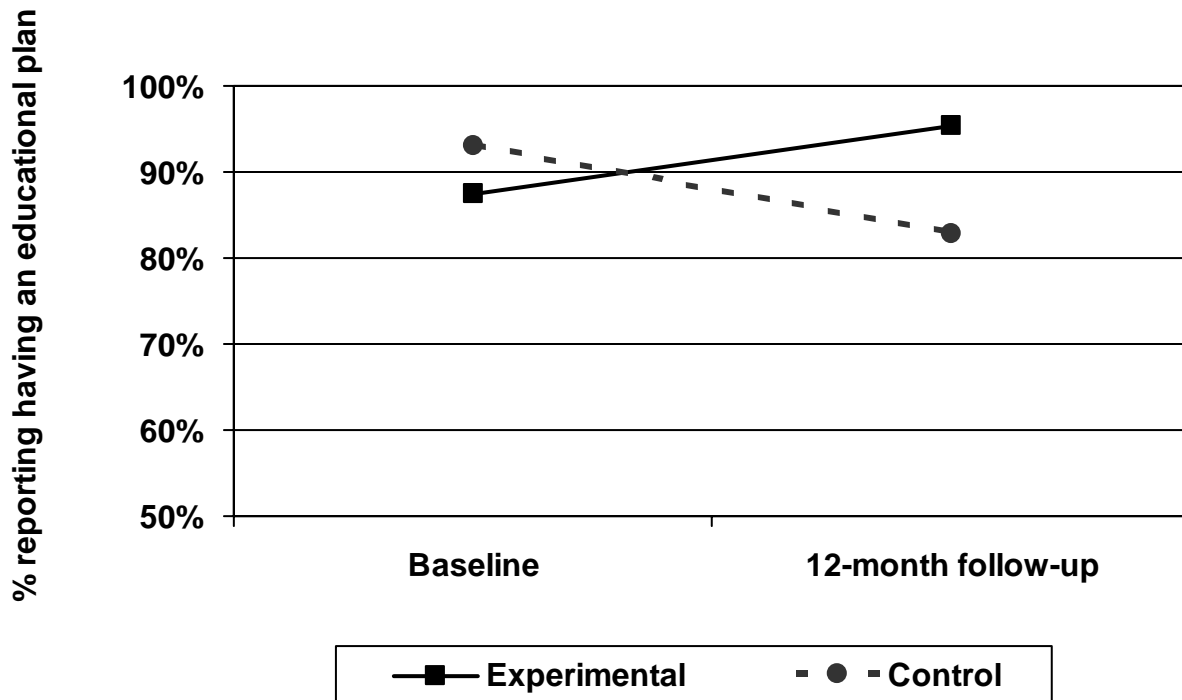


Figure 2. Educational plans



References

- Cleary PD, Devanter NV, Rogers TF, et al. Depressive symptoms in blood donors notified of HIV infection, *Am Journal Public Health*. 1993;83:534-539.
- Fisher EB, Auslander WF, Munro JF, Arfken CL, Brownson RC, Owens NW. Neighbors for smoke free north side: Evaluation of community organization approach to promoting cessation among Americans. *Am Journal Public Health*. 1998;88:1658–1663.
- Joint United Nations Programme on HIV/AIDS (UNAIDS), *2006 report on the global AIDS epidemic*. UNAIDS; May 2006.
- Paikoff RL. Early heterosexual debut: Situations of sexual possibility. *American Journal of Orthopsychiatry*. 1995;3(65):389-401.
- Rotheram-Borus MJ, Rosario M, VanRossem R, Reid H, Gillis R. Prevalence, course and predictors of multiple problem behaviors among gay and bisexual male adolescent; *Development Psychology*. 1995;31:75-85.
- Sherraden M. Stakeholding: Notes in theory of welfare based on assets. *Social Service Review*. 1990;64(4):580-601.
- Sherraden M. *Assets and the poor: A new American welfare policy*. New York: M.E Sharpe; 1991.
- Slonim-Nevo, Auslander WF, Ozawa MN. Educational options and AIDS-related behaviors among trouble adolescents, *J. Pediatr. Psychol*. 1995;20:41–60.
- World Bank, *Helping the children, World Bank directory of HIV/AIDS intervention in Africa*. Washington, DC: World Bank; 2000.