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Exploring the Caregiver-Child Relationship in Institutional Care Facilities in South Sudan

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**EXPLORING THE CAREGIVER-CHILD RELATIONSHIP IN
INSTITUTIONAL CARE FACILITIES IN SOUTH SUDAN**

A Masters Thesis

Presented to

The Graduate College of

Missouri State University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science, Early Childhood and Family Development

By

Jennifer Joy Telfer

August 2017

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EXPLORING THE CAREGIVER-CHILD RELATIONSHIP IN INSTITUTIONAL CARE FACILITIES IN SOUTH SUDAN

Childhood Education and Family Studies

Missouri State University, August 2017

Master of Science

Jennifer Joy Telfer

ABSTRACT

Institutional care for children separated from parents is expanding in Africa, but little research exists on caregiving at these institutions. This study explores the caregiver-child relationship in two residential institutions in South Sudan by investigating how caregivers experience their role and how children experience their lives in the institution. Semi-structured interviews assessed 14 caregivers' backgrounds, parenting experience, attitudes, education, and motivations. The Orphans and Vulnerable Children Wellbeing Tool (OWT) assessed 98 adolescent residents, who also gave feedback about their answers. Caregivers employ parenting styles used by their parents and report treating non-relative children the same as biological children. Children report relatively lower family and social wellbeing as compared with other domains of wellbeing, such as food, shelter, and spirituality. Despite disparities in caregivers' age, experience, and education between the two institutions, the adolescent groups at both sites report similar mean wellbeing scores, indicating the institutional framework may influence adolescent wellbeing more strongly than particular characteristics of the caregivers at those institutions. Future studies in South Sudan could compare adolescent wellbeing across a spectrum of alternative care settings (relative foster care, non-relative foster care, institutional care) to determine which form of alternative care provides the highest wellbeing for children.

KEYWORDS: caregiver-child relationship, caregivers, institutional care of children, orphans, Africa, South Sudan, orphanage, residential care, alternative care, caregiver attitudes, OVC, adolescent wellbeing, OWT

This abstract is approved as to form and content

Joan E. Test, Ed.D.
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August 2017

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In the interest of academic freedom and the principle of free speech, approval of this thesis indicates the format is acceptable and meets the academic criteria for the discipline as determined by the faculty that constitute the thesis committee. The content and views expressed in this thesis are those of the student-scholar and are not endorsed by Missouri State University, its Graduate College, or its employees.

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I dedicate this thesis to Isaac, Rebecca, and Isaiah.

May you rest in peace, rise in power, and may your memory live on.

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INTRODUCTION

Parent-child relationships are significantly related to a child's healthy social and emotional development (Bowlby, 1988). Parents provide this healthy formative relationship in a child's early years, but when children are separated from their parents by death or other factors, those children can suffer negative outcomes. In the absence of their parents, children may live independently, with their extended family, or be raised in alternative care environments, which take many forms. Forming a healthy relationship with a new adult caregiver can be a moderating factor to improve social and emotional development outcomes in those children (Bakermans-Kranenburg, Steele, Zeanah, Muhamedrahimov, Vorria, Dobrova-Krol, & Gunnar, 2011).

In South Sudan, the world's newest nation, many children have been separated from their parents. Civil society is responding to the needs of these children with charities, programs, and different forms of alternative care. I wonder how these children's new caregivers view their role in a child's life, and if they are managing to establish the kinds of attentive, reciprocal relationships that will help children to develop into healthy and well-adjusted adults.

The following chapter will serve to introduce the study through discussion of the problem and purpose of the study. A cursory overview will be given to the research questions, aims, and design. The significance of the study will be discussed as well as the assumptions and limitations of the study. Finally, terms to be used throughout this thesis will be defined.

Statement of the Problem

South Sudan is the world's newest nation, achieving independence from Sudan in 2011, after a protracted civil war for self-determination (Government of the Republic of South Sudan, 2015). Although the armed conflict between North and South Sudan ended with the Comprehensive Peace Agreement in 2005, unresolved historic conflicts and inequitable distribution of resources continued to result in occasional outbreaks of violence leading up to independence. After the 2011 independence, internal political power struggles led to the eruption of civil conflict in December 2013 in which an estimated 10,000 people were killed and 1.4 million South Sudanese displaced from their homes (The UN Refugee Agency, 2015). The general lack of stability and infrastructure in South Sudan continues to inhibit social services, make the daily tasks of life very time consuming, limit the efforts of civil society, and keep market prices unpredictable. The Government of South Sudan's Ministry of Gender, Social Welfare and Religious Affairs (2008) reports that education and healthcare continue to be inaccessible to many South Sudanese. In this context, many children have been separated from their parents by war, death by natural causes, neglect, abuse, and exploitation (GOSS, 2008). The South Sudan AIDS Commission and Ministry of Health (2015) report more than 70,000 orphans and vulnerable children in South Sudan. UNICEF (2014) estimates that 570,000 children, a much higher number, have lost one or both parents in South Sudan, and that an estimated 100,000 of those children have lost one or both parents specifically due to HIV/AIDS.

In response to great need, independent actors and community leaders in the civil sector established various forms of alternative care to provide for the needs of children

separated from their parents (Save the Children, 2013). Children's homes, children's villages, orphanages, drop-in centers, and other forms of alternative care facilities were established to meet these needs. A preliminary review of the terms "South Sudan" and "orphanage", "orphan", "children's home", or "children's village" on Google's search engine revealed 32 organizations which provide care for more than 1,500 orphans and children separated from their parents in 8 of the 10 states of South Sudan and in South Sudanese refugee camps in three nations bordering South Sudan (see Appendix A). The small number of children in alternative care centers, relative to the total estimated population of orphans or other children separated from their parents, indicates that the vast majority of these South Sudanese children are either living independently or living in the care of their extended families or communities under informal fostering arrangements (Ministry of Gender, 2008). However, the preliminary organizational review conducted by this researcher revealed that many alternative care facilities have been established since 2005. The establishment of new institutional care facilities in South Sudan is in keeping with a broader trend in African nations of expanding institutional child care (Powell, 2006). As the number of children served by institutional facilities increases, so increases the need to ensure these children are receiving appropriate care.

My personal interest in the wellbeing of South Sudanese children separated from their parents is related to the two years I worked as an administrator and case manager at a children's village in South Sudan before independence. While glad to participate in providing a home for children in challenging situations, I deeply regretted the fact that these children were not growing up in a family setting where they could receive more devoted attention from their caregivers. All of the kids in that alternative care center had

endured childhood trauma and loss. Some of them would eventually be reunited with extended family members or a living parent, but the majority of the children would be raised in the residential care environment until they completed secondary school. The caregivers at the children's village were mostly widowed women with children of their own. The institutional facility of 120 children was structured so that one or two caregivers shared a room with 8 to 16 children of different ages. The caregivers worked hard, spending their days caring for the youngest children and supervising the activities and normal household chores of the school-aged children. I observed what appeared to be differential treatment of the caregivers toward the children. Some children were treated with love, care, and kindness, while others seemed to be belittled and provoked, even deliberately overlooked on occasion. I observed that many children did not appear to trust and relate freely to their caregivers as I might have expected a child to relate to a parent. At times, children would disclose to me feelings of sadness or despair related to their lack of a mother. In the years since I finished working there, some who have left the facility to transition into life as young adults have confided in me about the challenges and fears they experienced in relating to the caregivers in the institutional setting.

The Government of South Sudan (GOSS) affirms every child's right to grow up in "a supportive, protective and caring environment", acknowledging that children living independent of parental care are at great risk of not developing to their full potential (Ministry of Gender, 2008). This position reflects the wisdom of attachment theory, which ties a child's social and emotional development directly to the strength of his or her early relationship with a primary caregiver (Bowlby, 1988). Although some research indicates there is a sensitive period between 8 and 12 months when children are best

disposed to form attachment patterns (Bakermans-Kranenburg, et al., 2011), even children separated from their parents at older stages of development can suffer adverse social-emotional outcomes if they do not maintain a strong relationship with an adult as they grow (Chikwaiwa, Nyikahadzo, Matsika, & Dziro, 2013). A child raised in an alternative care setting needs to be mentored in cultural and social wisdom to prepare for a successful transition into adulthood (Dziro, Mtetwa, Mukamuri, & Chikwaiwa, 2013).

Although international policy makers advocate for family-based care and the deinstitutionalization of children in institutional care where possible (UNICEF, 2004) and South Sudan's child welfare policy emphasizes family-based care (Ministry of Gender, 2008), studies reveal that raising children in both family-based and institutional forms of alternative care involves a complex interplay of many factors which can have positive, negative, and mixed outcomes for the children (Abebe & Aase, 2007; Freidus, 2010; Hermenau, Hecker, Elbert, & Ruf-Leuschner, 2014; Morantz & Heymann, 2010). Some literature indicates that the qualities of caregivers and the associated quality of child care is a more significant moderator of a child's healthy socio-economic development than the location of care (Nyamakupa, Gregson, Wambe, Mushore, Lopman, Mupambireyi, & Jukes, 2010; Whetten, Ostermann, Whetten, Pence, O'Donnell, Messer, & Thielman 2009). Some authors have recommended a focus on improving the quality of care across all forms of alternative care (Bakermans-Kranenburg, et al., 2011; Whetten, Ostermann, Pence, Whetten, Messer, Ariely, & Thielman, 2014), while many others emphasize the need for caregiver training in institutional care settings (Bettmann, Mortensen, & Akuoko, 2015; Morantz & Heymann, 2010). For this reason, I have chosen to investigate the caregiver-child relationship in an institutional care setting in South Sudan, hoping that

the data will be able to inform future trainings for caregivers serving children separated from their parents in South Sudan.

Purpose and Aim of the Study

The purpose of this study is to examine the nature and dynamics of caregiver-child relationships at *Urban Facility* (UF) and *Rural Facility* (RF) in South Sudan through semi-structured interviews with 14 caregivers and self-report wellbeing assessments of 98 adolescents in care.

My aim in this project is to identify key dynamics of the caregiver-child relationship as well as strengths and weaknesses in the relationship that can inform future caregiver trainings.

Research Questions

In examining the caregiver-child relationship throughout my study, I explored the following questions:

1. What are the caregivers' backgrounds and family narratives? How might the caregivers' relationship with their own parents and children inform how they understand their role as a caregiver to non-relative children?
2. What is the caregiver's experience of caring for children separated from their parents? What are their strengths and joys as caregivers? What are their challenges and struggles as caregivers?
3. How do caregivers feel about ethnic identity? How might this impact their care of children from different ethnic backgrounds?
4. What hopes and vision do caregiver's have for non-relative children in their care?
5. How do institutionalized children fare in different domains of wellbeing?
6. Do institutionalized children have contact with their biological family? Do they

maintain connection with their ethnic heritage?

7. Who do institutionalized children trust, and why?
8. How do institutionalized children perceive the staff and caregivers at their institution?

Research Design

I used a multiple methodology case study design to explore the caregiver-child relationship in institutional care in South Sudan (Gay, Mills, & Airasian, 2006), combining qualitative and quantitative methods of inquiry.

The qualitative inquiry followed the ethnographic tradition of extended observation on site and trust building with participants to develop deep understanding of a phenomenon occurring within a unique cultural context (Gay, Mills, & Airasian, 2006). I conducted semi-structured interviews with 14 caregivers, 7 caregivers at each research site, to hear their stories, beliefs, and behaviors explained in their own words. I administered the Orphan and Vulnerable Children Wellbeing Tool (Senefeld, Strasser & Campbell, 2009), a self-report quantitative measure of wellbeing for adolescent children, to 98 adolescent children at two institutional care facilities. During the assessment, many of the youth wanted to clarify their responses with comments and anecdotes, which were recorded as additional qualitative data.

Significance of the Study

This study may serve to inform future trainings of caregivers at institutional care facilities or future trainings for potential family-based caregivers in South Sudan. As there has not yet been any published research on institutional care in South Sudan, so this work may serve to inform interested parties about the nature and dynamics of

institutional care in this context. Foreign agencies and organizations interested in child welfare programming in South Sudan will be able to read about the quality and nature of the relationships children form with the staff and caregivers in the institutional care context. I hope this study will be useful for informing and improving child welfare interventions for children separated from their parents in South Sudan.

Assumptions. The following are some assumptions in the design of this study:

1. Caregivers and children spoke with me willingly.
2. Caregivers and children were honest.
3. My presence and observations did not fundamentally change the caregiver-child dynamic.
4. Children with secure attachment to a primary caregiver experience greater social and emotional health.
5. Caregivers are capable of moderating children's social and emotional development.
6. Caregivers have the capacity to provide adequate parental care for children.

Limitations. The following are some limitations in my study:

1. My white skin and American passport did not allow me to maintain a low profile in South Sudan.
2. Social desirability bias may have influenced the actions and responses of caregivers and children during my observations and interviews.
3. Instability in South Sudan during data collection impeded effective on-site collaboration with my Sudanese research partner.
4. Language and cross-cultural communication barriers.
5. There was no control study of the parent-child relationship in a family-based setting in South Sudan.
6. There was no control study of the caregiver-child relationship in a family-based alternative care setting in South Sudan.
7. What I do not know.

Definition of Terms

For the purpose of clarity, in this study, the term *alternative care* will be used to describe any form of care, either traditional or emerging forms, provided to a child who has been separated from his or her parents. *Family-based care* is used as a sub-category of alternative care to describe care offered within a nuclear family in the community, such as kinship or relative foster care, non-relative foster care, or adoption. *Institutional care* will also serve as a sub-category of alternative care to encompass all forms of organized residential care facilities for children separated from parents. Institutional care may take many structures, such as residential nurseries, orphanages, group homes, children's homes, or children's villages. Where I use the term *orphan*, I will be speaking of children who were separated by one or both parents through death. In place of the commonly used term, *orphans and vulnerable children* (OVC), I will speak of *children separated from their parents* and specify the form or reason for separation (i.e. death, displacement, abuse, neglect, abandonment) only if necessary for clarity or understanding. I reject the use of the term "OVC" (except in identification of Catholic Relief Services' research instrument, the OWT) because the term was developed for use by international organizations in their HIV/AIDS programming in Africa, is now also used by social scientists and international organizations to describe children in non-African developing nations, yet is not a term used by social scientists or child welfare advocates in the developed world (further detailed in Appendix B). Because using

“children separated from their parents” makes for difficult reading, when I use the term *children* in this paper, I am speaking of children who have been separated from their parents. I will not be addressing children in the care of their natural-born parents.

- Alternative Care – any form of care, either traditional or emerging forms, provided to a child who has been separated from his or her biological parents.
- Children Separated from Parents – self-explanatory term that I have chosen to use as opposed to the popular “orphans and vulnerable children” (OVC), for reasons explained in Appendix B. Children separated from parents is similar to the language used by South Sudan’s Ministry of Gender, Social Welfare and Religious Affairs in their Draft Child Policy on Children Without Parental Care (2008). Notably, a child ceases to be a child separated from parents when permanent caregivers are designated for the child.
- Family-based care – a sub-category of alternative care, used to describe care offered to a child separated from his or her parents which takes place within a nuclear family in the community, such as kinship or relative foster care, non-relative foster care, or adoption.
- Institutional Care – a sub-category of alternative care to encompass all forms of organized residential care facilities for children separated from parents. Institutional care may take many structures, such as residential nurseries, orphanages, group homes, children’s homes, or children’s villages.
- Intergovernmental Organization (IGO) – an international organization, such as the United Nations or World Bank, whose mandates are driven and funded by sovereign states who are members of the organization.

- Non-governmental Organization (NGO) – a non-profit organization that is not part of an established government.
- Non-Relative Foster Care – a sub-category of family-based care, care for a child by parents who are not biologically related to the child, may be temporary.
- Orphan – a child separated by death from one or both biological parents.
- Relative Foster Care – a sub-category of family-based care, care for a child within his or her extended, biological family.

LITERATURE REVIEW

The purpose of this study is to explore the caregiver-child relationship in children's homes in South Sudan. In the absence of a parent-child relationship, it is important for a child to bond with another adult caregiver to moderate for healthy social and emotional development (Bakermans-Kranenburg, et al., 2011). At the time of this writing, no scholarly literature has been published about alternative care or the caregiver-child relationship in South Sudan. To provide context for the study, this literature review begins by discussing the traditional and emerging forms of alternative care for children separated from their parents in Africa. My purpose in this review is not to advocate for or against traditional or emerging forms of alternative care in Africa, rather to emphasize the factors that strengthen child wellbeing outcomes and enhance caregiver-child relationships in any alternative care situation. Foundational research on alternative care and caregiver-child attachment was written in Europe and North America in the mid-twentieth century and has influenced the emerging forms of alternative care in Africa. So, this chapter will also review early literature on institutional care and patterns of caregiver-child attachment. After considering studies on child wellbeing outcomes in alternative care settings in Africa and listing various factors that influence child wellbeing, this chapter will narrow focus to qualities of caregiver-child relationships that directly impact children's social and emotional wellbeing. The summary brings all the information together to emphasize the importance of understanding and strengthening caregiver-child relationships in African institutional care environments, specifically South Sudan.

Traditional and Emerging Forms of Alternative Care in Africa

Historically, African families were large and connected, serving as a social safety net. Even when parents were living and healthy, African children were not socialized primarily by their parents, but by a group of peers, siblings, grandparents, and extended family members (Kayongo-Male & Onyango, 1984). When extended families lived far apart, it was not unusual for parents to send one or more of their children away to live with and be raised by an uncle for the purpose of strengthening kinship loyalty within the extended family or to an unmarried relative for the purpose of companionship and helping in the household duties. This kind of fostering of related children was traditionally a fixture of the African family structure, and children raised in this way were usually treated well, sometimes even preferentially (Kayongo-Male & Onyango, 1984). When children were orphaned or abandoned, traditionally these children would be absorbed into the extended family structure and raised by a relative (Abebe & Aase, 2007). Although fostering of non-relative children was also a common occurrence, it was generally not considered an avenue to create or expand the family identity. As compared with relative children, non-relative foster children were often treated poorly, vulnerable to abuse by the foster family, exploited as household laborers, and regarded as outsiders – not family (Kayongo-Male & Onyango, 1984).

At the rise of the global HIV/AIDS pandemic in the 1980s, governments and intergovernmental organizations (IGOs) began to discuss how to care for children being orphaned by the epidemic. Sub-Saharan Africa was particularly hard hit by HIV/AIDS, and in the ensuing decades, the orphan crisis grew to the extent that by 2007, 12% of Sub-Saharan Africa's children were orphaned (Bettmann, Mortensen, & Akuoko, 2015).

The reality was that although many children were being orphaned due to HIV/AIDS, these new orphans represented only a fraction of the total orphan population in Africa (UNICEF, 2014). Though large-scale orphanhood was not unfamiliar to Africa historically, a cumulative 30% increase in the orphan population over the course of several decades did strain the traditional systems of orphan care (Abebe & Aase, 2007). As Schenk and colleagues (2008) observed in Zambia, although orphaned children were traditionally taken in by the families of their paternal uncles, HIV/AIDS claimed millions of lives across one generation, leaving many aging grandparents as primary caregivers for their orphaned grandchildren without the support of extended family. The rising cost of taking on orphaned children care was such that many orphans were left to fend for themselves. The 1990s and 2000s saw a rise in orphan-headed households, where older siblings became the primary providers and protectors of their younger siblings, at great personal and psychological cost (Nyamukapa, et al., 2010; Schenk, et al., 2008). These orphan-headed households were vulnerable to food insecurity, illness, educational deprivation, and exploitation (Schenk, et al., 2008).

Health workers, faith-based institutions, and non-governmental organizations (NGOs), observing the impact of HIV/AIDS at the grassroots level, used international media to draw attention to the crisis. Media reports motivated international actors to engage the issue by funding institutional children's homes across Africa (Dziro, et al., 2013; Freidus, 2010). Although institutional care for children separated from their parents had already passed out of vogue in Europe and North America, many new institutional children's homes were established in Africa with funding from European and North American faith-based organizations, governments, and private donors during the 1990s.

Powell (2006) reports that 27 orphan-care institutions were built in Zimbabwe alone in the ten-year period from 1994-2004. While the newly developed institutional care facilities across Africa provided care for many thousands of children, the vast majority of orphaned children were still being absorbed into the traditional African system of orphan care – the extended family (Abebe & Aase, 2007; Powell, 2006).

The growing phenomenon of institutional care for children in Africa raised alarm among some observers who expressed concern about the outcomes for children being raised institutionally (Chikwaiwa, et al., 2013; Dziro, et al., 2013; Freidus, 2010; Powell, 2006). Much research had already been done outside of Africa that showed negative developmental outcomes for children raised institutionally, and that research has informed the emerging forms of alternative care in Africa.

Early Research on Institutional Care and Patterns of Attachment

Institutional care for children separated from their parents passed out of vogue in Europe and North America in the twentieth century, being replaced by forms of family-based care such as foster care and adoption. This transition was largely due to *attachment theory*, rising from John Bowlby (1952) and Mary Ainsworth's (1962; Bowlby & Ainsworth, 1953) early investigations of the effects of "deprivation of maternal care" on children's mental health.

Institutional group homes and residential nurseries were common forms of alternative care for children separated from their parents in Europe and North America when Bowlby (1952) began his investigations. In those environments, too many children received too little caregiver attention, and Bowlby (1952) noted that this was especially

detrimental in infancy. The younger the age at institutionalization, the longer the length of institutionalization, and, perhaps most significantly, the greater the level of maternal deprivation negatively influenced the development of children in institutional care (Bowlby, 1952). Children's physiological development was not impacted as negatively as was their speech, understanding, and capacity to express themselves (Bowlby, 1952), showing that the developmental delays in institutional care were primarily cognitive, social, and emotional. Bowlby (1952) said cases of institutionalization before the age of six and institutional neglect resulted in the worst child outcomes.

This early research on institutional care led Bowlby (1952) to propose *attachment theory*, stating that healthy development requires an infant to form a strong relational bond with his or her primary caregiver, optimally a biological parent, during infancy. This primary relationship acts as a "secure base" and provides the growing child with a sense of safety, security, ability to face the unknown, and capacity to form a healthy self-concept and lasting future relationships (Bowlby, 1988). A child who fails to develop a secure attachment with a primary caregiver in the first year of life may struggle in the future to regulate his or her emotions, form relationships with adults, confidently interact with peers, face and overcome adversity, develop intimate relationships in adulthood, or form healthy parent-child relationships with their own children (Bowlby, 1988). Complete deprivation of maternal care, where a child formed no relational attachment, as Bowlby (1952) observed in the worst forms of institutional care, could lead to lifelong disability and mental illness. Bowlby (1952) warned that institutionalization of a child younger than six years old could have disastrous long-term developmental implications if

that child could not successfully bond with a stable, primary caregiver during the critical, early years.

Bowlby's early investigation of institutional care in Europe and North America, his resulting *attachment theory*, and Mary Ainsworth's (1964) labeling of attachment styles led to further research on child-caregiver attachment in institutional care around the world. Mary Ainsworth (1967) tested the theory through longitudinal observations of the mother-child attachment relationship in Africa. Ugandan mothers' physical proximity, responsiveness, and availability to infants during their first years of life led to the formation of a secure attachments (Ainsworth, 1967).

Further attachment studies in China, Chile, Greece, Japan, Portugal, Romania, Russia, the United Kingdom, and Ukraine looked at patterns of child-caregiver attachment in institutional care as compared with family-based care (Bakermans-Kranenburg, et al., 2011; Lionetti, Pastore, & Barone, 2015). Of four attachment patterns (secure, insecure-avoidant, insecure-anxious, and disorganized/cannot classify), secure attachment is the healthiest pattern (Lionetti, et al., 2015). Insecure-avoidant and insecure-anxious are not ideal, but they are adaptive and functional patterns. Disorganized and cannot classify, however, are dangerous because children with this classification are not forming any pattern of attachment with others, which can result in lifelong social isolation, problems in emotional regulation, dissociation, stressful feelings, and disruptive caregiving behavior in adulthood (Lionetti, et al., 2015).

Although disorganized attachment is rare in the general population, it was commonly observed in institutionalized toddlers (Bakermans-Kranenburg, et al., 2011). When disorganized attachment is observed in the general population, it is primarily

observed in children whose parents were neglectful or abusive in early parenting (Bakermans-Kranenburg, et al., 2011). The large percentage of institutionalized children exhibiting disorganized attachment points to widespread neglect of children in institutional care. Because many institutions have low caregiver to child ratios, children may receive little reciprocal interaction through play and conversation with caregivers. Such non-attentive or neglectful care is significantly related to disorganized attachment in young institutionalized children (Bakermans-Kranenburg, et al., 2011).

Although vastly higher percentages of children in institutions demonstrated disorganized attachment patterns than in the general population, the studies reported significant variability between institutions (Bakermans-Kranenburg, et al., 2011; Lionetti, et al., 2015), indicating that some institutions provide better care than others. Although Bakermans-Kranenburg and colleagues (2011) present family-based care as the preferred form of alternative care, they emphasize that sensitive, responsive, and stable institutional caregivers should be able to form secure attachment bonds with children provided they have a favorable and consistent environment in which to do so. It is possible that disorganized attachment in children growing in institutional care is more closely related to the low quality of the caregiver-child relationship than to the location of care.

Based on his early observations of institutional care, Bowlby (1952) recommended never institutionalizing a child under the age of 6, structural and staffing changes in institutional care to facilitate more nurturing caregiver-child relationships, a shift away from institutional care as the first or only alternative care option, and an ultimate goal of permanent family-based care for children separated from their parents.

The research on *attachment theory* and Bowlby's recommendations in the mid-twentieth century have affected policy, public perception, and funding for alternative care around the world (Bakermans-Kranenburg, et al., 2011). The United Nations Committee on the Rights of the Child (1989) called for institutional care to be a last resort for children separated from their parents, with family or community-based care as the preferred means of alternative care. Now, where institutional care is still common, there is a push for deinstitutionalization and family-based care as the preferred means of alternative care (Lionetti, et al., 2015). The United Nations' standards have been applied to policy in some African nations, including South Sudan (Powell, 2006; Ministry of Gender, 2008), however, as explained earlier in this review, the traditional African systems of alternative care are strained under the weight of the increasing orphan population (Abebe & Aase, 2007). That phenomenon, combined with many African governments' limited capacity for funding social programs (Kayongo-Male & Onyango, 1984), creates an unfunded mandate for alternative care programming in many African countries. The need for alternative care is being met increasingly by international donors and NGOs who choose to establish more institutional care facilities, often with permission of local governments (Powell, 2006). The good news about emerging forms of institutional care in Africa is that many of these facilities have adopted the structural changes recommended by Bowlby (1952), but do these facilities create good outcomes for the children in their care?

Studies on Child Outcomes and Factors Influencing Alternative Care in Africa

Comparative studies on the attachment of children to their caregivers revealed a stark disparity in attachment patterns for children in institutional care as compared with children living in family-based care. Although no studies have been published on child-caregiver attachment in African alternative care, researchers have examined African children's wellbeing outcomes in both institutional and family-based alternative care. The results are mixed, showing different child outcomes for material, emotional, and social wellbeing across forms of alternative care. These outcomes are attributed to different factors, which interact differently to affect children's wellbeing, and will be further discussed in this section.

Material Wellbeing. A comparative study, done by an American student of public policy, compared the material wellbeing of Tanzanian children in orphanages to children in foster homes in three Tanzanian communities (Zimmerman, 2005). The author investigated the material wellbeing (clothing, lodging, school supplies, health care, and food) and living situation of the children. Zimmerman (2005) provided rich descriptions of the living environments of both groups of children, painting a happy picture of content children living in an orphanage while other children languished in foster homes without access to adequate food, housing, or education. According to Schenk, et al. (2008) and Kayongo-Male and Onyango (1984), African foster children often do face a harsh reality, but Zimmerman's (2005) polarized descriptions of institutional versus family care based on material wellbeing alone is not the full picture. Zimmerman (2005) paints what would seem a very beautiful picture of institutional care and recommends building more orphanages to increase capacity to provide institutional

care to foster children in the community. The valid point I see in her study is that some foreign-funded orphanages in Africa are able to provide a level of material care above the capacity of the surrounding community. Material wellbeing, however, is only one factor that can affect a child's overall wellbeing.

Social Wellbeing. Another American researcher, an anthropologist, did an ethnographic study of children raised in institutional care in Malawi (Freidus, 2010). Her study pushes back against the implicit assumptions in Zimmerman's (2005) study that material provision for the needs of a child separated from his or her parents represents the whole of adequate care. Freidus (2010) found that Malawian children raised in orphanages have varied outcomes. Most of the children living in the three orphanages she studied had extended family living in the surrounding community, but were living in institutional care because the institution could provide more for them than their families of origin. Some unintended consequences of this situation for the child are increasing social ostracization and alienation from the child's extended family and culture. In one interview, a young adult raised in the institution said that institutions gave children "an artificial life" while breaking their kinship ties to their home villages and affiliations (Freidus, 2010, p. 300). Others reported unintended consequences arising from institutional care include community jealousy leading to increased stigma for being an orphan and a youth's disillusionment upon re-integration to society that he or she is unable to maintain a certain standard of living (Freidus, 2010).

Charles Dziro and his colleagues in the University of Zimbabwe's school of social work (2013) conducted a qualitative study about children's ability to re-integrate into society after being raised in institutional care in Zimbabwe. In the foreign-managed

institutional environment, Dziro (2013) observed African children losing contact with important aspects of their ethnic heritage. Africa is a diverse land with many languages and cultures (Kayongo-Male & Onyango, 1984), but without extended exposure to their unique traditional dances, dramas, and storytelling, institutionalized children are not socialized to their broader culture or unique ethnic identity (Dziro, et al., 2013). The children in this study reportedly struggled to develop socially in step with their community-based peers, and they often come out of institutional care ‘half-baked’ (Dziro, et al., 2013, p. 125). This posed serious problems for their future. For example, not knowing their family *mutopo* or totem, could prevent a young Zimbabwean person from marriage (Dziro, et al., 2013). Yet, over the course of institutionalization, children often lose contact with their living family members and their tribal language (Powell, 2006). Cut off from fully participating in a social network, those children grow up with anti-social tendencies (Dziro, et al., 2013).

Emotional Wellbeing. Zimbabwean social work professors conducted a comparative quantitative study on the intrapersonal wellbeing of children in institutional and family based care (Chikwaiwa, et al., 2013). The authors used the term *intrapersonal wellness* as a measure of emotional wellness, examining joy/happiness, hope for the future, and self-esteem/confidence. Chikwaiwa and colleagues (2013) administered the *Psychosocial Well-being Quality Assessment Tool* to a probability sample of 204 children separated from their parents in three Zimbabwean communities. The study found that high psychosocial and intrapersonal wellness was directly and significantly related to living in family-based care and having a good relationship with an adult (Chikwaiwa, 2013). Chikwaiwa’s (2013) study tells us that children separated from their parents in

those Zimbabwean communities generally have higher emotional wellbeing when they live in a family and have a good relationship with an adult.

Interaction of Material, Social, and Emotional Care. Having considered studies addressing material, social, and emotional wellbeing separately, we must now consider how they interact to influence a child's overall experience of alternative care. Institutional care may provide high levels of material wellbeing, but does that moderate for the social isolation a child may experience in institutional care? Consider that Zimbabwean children living in family-based care feel great psychological stress when they do not have access to adequate food and education (Nyamukapa, et al., 2010). And yet, while children growing up in institutional care in Botswana were not stressed about their material needs, they did report a sense of isolation from the community and ambivalence toward their caregivers, evidencing significant challenges to social and emotional development within institutional care (Morantz & Heymann, 2010). We see that living in family-based care does not rule out poverty or ensure social and emotional wellbeing, even as having one's material needs fully met in institutional care does not ensure social and emotional wellbeing.

Abebe and Aase (2007) studied Ethiopian extended families caring for children orphaned to HIV/AIDS. Through qualitative interviews with 42 orphans, 12 social workers, 18 heads of households; 8 focus groups with orphans and 6 focus groups with elders and community leaders; and story-writing by 140 children in primary school, Abebe and Aase (2007) discovered that extended families have differing capacities to provide care for children along a spectrum of capacity. Economic (or "material"), social, and emotional care were the factors which emerged in the research as indicators of a

family's capacity to care for children. Abebe and Aase's (2007) spectrum of capacity had four family profiles ranging from *capable* to *adapting* to *transient* to *rupturing*. Although Abebe and Aase (2007) did not explicitly define their spectrum, I inferred from the family profiles in the narrative that a capable family is able to provide adequate material, social, and emotional care relative to the community standards. An adapting family adequately provides in two areas or evidences ongoing improvement in the three areas. A transient family provides adequate care in one area, but evidences great internal stress and strain along with child deprivation in the other two areas. A rupturing family exhibits a failure to meet any of the children's basic needs. In Ethiopia, there are more capable families in the rural environment than the urban, and, overall, there are more capable families than rupturing families (Abebe & Aase, 2007). Abebe and Aase (2007) advocate for greater use of family care as opposed to institutional care, and instead of institutionalizing children living in rupturing or transient families, he encourages social supports to strengthen the families.

From the small-scale, local studies we've reviewed so far, the traditional African form of family-based care seems to be better than institutional care when considering children's social and emotional development. However, we also learned that extreme poverty leads some families to be unable to meet the needs of foster children. Internationally funded institutions in impoverished communities provide better material and educational benefits than children separated from their parents would be able to access otherwise. Freidus (2010) says that institutionalized children are sacrificing their social and emotional development for the sake of food, education, and material benefits. Is that assertion broadly defensible?

The largest and most comprehensive comparative study of child outcomes in alternative care measures four areas of child-wellbeing in institutional and family-based care in five low-income nations (Whetten, et al., 2009; Whetten, et al., 2014).

Hypothesizing that children in institutional care in poor countries would have worse overall wellbeing than their counterparts in family-based care, the *Positive Outcomes for Orphans Team* from Duke University designed an ongoing longitudinal study to test 1,357 institutionalized children and 1,480 family-based children's physical and emotional health, growth, cognitive development, and memory in 83 different institutions and communities in Cambodia, India, Ethiopia, Kenya, and Tanzania (Whetten, et al., 2009; Whetten, et al., 2014). The institutions studied were across a wide spectrum of institutional forms, ranging from large, internationally-funded children's villages to small, local, community-initiated and managed group homes. In the baseline study, Whetten and colleagues (2009) found that the assessment evidence disproved their hypothesis. Institutionalized children in the lowest income nations showed no worse outcomes than children living in family-based settings. When the data was controlled to distinguish between children living institutionally, children living with extended family, and children being fostered in non-relative families, the children in non-relative foster families had the lowest wellbeing. This provides a balancing perspective to the observations made by Zimmerman (2005) in Tanzania. The tests in Whetten's (2009) study had high sensitivity, showing outliers who scored very high and very low in both institutional and family-based settings. The authors were surprised by their findings and encouraged a more nuanced examination of what makes for good child outcomes in each form of alternative care. In the follow up study with the cohort of children 36 months

later, the original hypothesis was again disproven (Whetten, et al., 2014). The institutionalized children had outpaced their counterparts in health and height-for-age outcomes. Although children in institutional care were reported to have more emotional difficulties than children in family-based care, the differences were small. All other measurements were not significantly different. When the results were controlled for analysis by country, Kenyan children were more likely to have their basic needs met in an institution than in family-based care. Kenyan children in family-based care faced more poverty, educational deprivation, stigma, and exposure to physical and sexual violence than their counterparts in institutional care (Whetten, et al., 2014). These results should not be interpreted to say that institutional care produces the best outcomes for African children separated from their parents. When the results were controlled for comparative analysis between institutions, Whetten and team (2014) observed great variability of child outcomes between institutions, confirming that some institutions provide better care than others. This study also does not indicate that institutionalized children will successfully be able to transition out of institutional care, and it has not addressed the “unintended consequences” of institutionalized care as highlighted by Freidus (2010) or Dziro (2013). The study’s value lies in emphasizing that child outcomes in institutional care in poor countries is comparable to outcomes in family-based care in those settings.

Factors Influencing Child Wellbeing Outcomes in Alternative Care. In this review of child outcomes in alternative care in Africa, we’ve seen that a number of factors influence child wellbeing, including:

- Provision of material needs and access to education (Zimmerman, 2005; Chikwaiwa, et al., 2013; Nyamukapa, et al., 2010)

- Child's ability to maintain a connection to his or her tribal/clan identity (Freidus, 2010; Nyamukapa, et al., 2010; Dziro, et al., 2013)
- The quality of relationship with an adult or primary caregiver (Chikwaiwa, et al., 2013)
- Structure/design of alternative care (Zimmerman, 2005; Abebe & Aase, 2007; Whetten, et al., 2014)
- Quality of care provided (Abebe & Aase, 2007; Bakermas-Kranenburg, et al., 2011; Whetten, et.al., 2014)

All of these factors are significant moderators of child wellbeing. Notably, social and emotional wellbeing outcomes tend to be weaker in institutional care than material wellbeing outcomes. Since social and emotional development is related significantly to a child's relationship with his or her caregiver (Bowlby, 1952; Chikwaiwa, et al., 2013), the remainder of this literature review will emphasize quality of care and narrow in on what has been written on the nature of the caregiver-child relationship in African institutional care.

Caregiver-Child Relationships in Institutional Care Settings in Africa

Developing secure attachment with a caregiver occurs less frequently in institutional care than in family-based care (Bakermas-Kranenburg, et al., 2011), but these results are believed to be dependent on the age of the child and the quality and consistency of care more than where the care takes place (Bakermas-Kranenburg, et al., 2011; Whetten, et al., 2014).

Unlike the European institutions that Bowlby (1952) observed, caregivers in institutional settings in Africa often live at the institution, providing care for groups of 8-12 children in a single dwelling which makes part of a larger “village” of caregiver-child dwellings (Freidus, 2010; Zimmerman, 2005). This “children’s village” model was recommended in Europe by Bowlby (1952) and by policy advisors in Africa (Powell, 2006), and has been implemented extensively as a form of institutional care in Africa. The idea of many homes gathered into a larger unit is reminiscent of the traditional home structures of Africa’s pre-colonial past (Kayongo-Male & Onyango, 1984), and the consistency of a live-in caregiver provides more potential for relational stability and reciprocal interactions than was possible in “dormitory style” European orphanages with shift-working caregivers (Bakermas-Kranenburg, et al., 2011; Bowlby, 1952).

Regardless of form of alternative care, African children have higher social and emotional wellbeing when they have healthy relationships with adults (Chikwaiwa, et al., 2013; Abebe & Aase, 2007). Zimbabwean orphans said that living with a relative was important, but more important was living with someone who would not mistreat them (Nyamukapa, et al., 2010). In a Kenyan study, although children separated from their parents emphasized their need of material provision, they expressed more concern about living in the care of someone who loved them and honored the memory of their parents (Mears, Singletary, & Rogers, 2011). Although many caregivers agree their job is to give children love and support, they are not always able to articulate what that looks like (Bettmann, Mortensen, & Akuoko, 2015). A sample of institutionalized Botswanan children reported not feeling a sense of connection with their caregivers, and children in

Botswana and Zambia reported verbal and physical abuse by their institutional caregivers (Morantz & Heymann, 2010; Hermenau, et al., 2014).

A recurring theme in the literature was that the majority of caregivers in African institutional care settings lack training (Morantz & Heymann, 2010). Bettmann, Mortensen, and Akuoko's (2015) study of staff attitudes at institutions in Ghana revealed that although caregivers have a basic understanding of children's needs, they sometimes lack the training or support to attend to those needs. There is also a dearth of caregiver education on human attachment and emotional development. When questioned about children's relational needs, 28 caregiving staff out of 92 interviewed did not mention that a child needed either parents or caregivers, and only slightly more than half of those interviewed acknowledged that separation from a parent can have adverse effects on a child (Bettmann, Mortensen, & Akuoko, 2015).

Ghanaian caregiving staff expressed a desire for training on basic first aid, nutrition, medication, behavior management, and how to relate to children (Castillo, Sarver, Bettmann, Mortensen, & Akuoko, 2012). Specifically, the staff requested on-site training that fit the challenges they were facing at the time (Castillo, et al., 2012).

Summary and Direction

Alternative care for children in the African context is complex with a long history and challenging present. Traditional African forms of childcare seem rooted in healthy parent-child attachment, and modern research on *attachment theory* has gained from observing African mothers (Ainsworth, 1967). Yet, in much of Africa, foreign-funded organizations are responding to child welfare concerns that local governments are unable

to adequately address (Zimmerman, 2005). Is the care they provide leading to positive outcomes for the children being served? The research shows mixed outcomes, especially where social and emotional wellbeing is concerned. However, both social and emotional wellbeing can be strengthened by injecting positive relationships into a child's life, as mentors, caregivers, or examples (Bakermas-Kranenberg, et al., 2011; Dziro, et al., 2013).

Since studies show that children's social and emotional wellbeing is significantly related to positive relationships with adults (Chikwaiwa, et al., 2013), how might the caregiver-child relationship in institutional care contribute or detract from a child's social and emotional growth? What important knowledge should children learn from parents and mentors, and are institutional caregivers providing these types of experiences for children? What have caregivers learned that they have found useful and would be willing to share with other caregivers? These kinds of questions are important if institutions are to become more intentional in strengthening caregivers to actively influence or moderate children's social and emotional wellbeing.

Research has only briefly considered how African children and institutional caregivers understand their relationships, and I believe there is much more to learn about the caregiver-child relationship in institutional care in Africa. Although Bettmann (2015) and Castillo (2012) explored caregiver attitudes toward attachment and emotional development in Ghana, I found no other research on this topic in Africa. Specifically, I found no research on institutional care in South Sudan. Since improving caregivers' relationships with children in an alternative care setting should strengthen children's

social and emotional wellbeing outcomes, I propose to explore the caregiver-child relationship in children's homes in South Sudan.

METHODS

The purpose of this study is to explore the nature and dynamics of caregiver-child relationships at two residential institutions for children in South Sudan, *Urban Facility* (UF) and *Rural Facility* (RF). In this chapter, I will introduce my research design, sites of the study, participants, ethical considerations, data collection procedures, my role as a researcher, and how I have analyzed the data.

Research Design

The overall approach for my study of the caregiver-child relationship in institutional care in South Sudan was a multiple methodology study, employing quantitative assessment, using the Orphans and Vulnerable Children Wellbeing Tool (Senefeld, Strasser & Campbell, 2009), and qualitative methods, using semi-structured interviews for content and observational elements of an ethnographic case study to provide context (Gay, Mills, & Airasian, 2006). The rationale for the study was based on the need to understand how South Sudanese caregivers at these residential institutions relate to the non-relative children in their care. Because children who have healthy relationships with adults have better social and emotional wellbeing (Chikwaiwa, et al., 2013), with deeper understanding of the relationships between caregivers and children in the South Sudanese institutional care environment, it may be possible to consider methods of fostering better caregiver-child relationships to improve children's social and emotional wellbeing. Although research suggests that the caregiver-child relationships in African institutional environments could be improved (Bettmann, Mortensen, & Akuoko,

2015; Morantz & Heymann, 2010; Nyamukapa, et al., 2010), no study has been done on the caregiver-child relationship in institutional care in South Sudan. Qualitative research focuses on understanding (Gay, Mills, & Airasian, 2006), making this an appropriate method to explore the current reality of the caregiver-child relationship and attitudes of the caregivers and children as an important first step in considering how to improve these relationships in the future.

Ethnographic research involves extended observation on site and trust building with participants to develop deep understanding of a phenomenon occurring within a unique cultural context (Gay, Mills, & Airasian, 2006). As an American female who lived and worked in South Sudan for two years (from 2008 to 2010), has maintained contact with South Sudanese, and has made multiple visits back to South Sudan in the years since (2011, 2012, 2014, and 2016), I have learned that it is best for me to gain understanding of the local environment through multiple ways of knowing. Questions and discussions with South Sudanese are enlightening, to be sure, but they may not reveal the full picture to my mind. To come closer to understanding the reality as the South Sudanese experience it, knowledge must be gathered in multiple ways. Gay, Mills, and Airasian (2006) call the process of gathering knowledge in multiple ways to confirm or crosscheck other information *triangulation*, an important principle in ethnographic data collection. An ethnographic case study provided me with a research framework from which to gather data about a specific phenomenon through observation in the natural setting, to triangulate and not depend entirely on data reported from any one interview, and to integrate the reality of culture into all of the work. I believed an ethnographic case study was the best way to develop understanding of the attitudes, values, concepts, beliefs

and practices of caregiving shared by the caregivers at this institution in South Sudan (Gay, Mills, & Airasian, 2006).

My ethnographic case study entailed observations of caregiver and child interactions in their natural setting to provide context; semi-structured interviews with the caregivers to provide content; quantitative assessment and qualitative feedback from adolescents to use in triangulation of the caregiver interviews.

Sites of the Study

Data collection took place at *Urban Facility* (UF) and *Rural Facility* (RF) in the Republic of South Sudan from June until August 2016. The sites are vastly distinct because of physical structures, geographic location, and surrounding communities. These differences caused me to expect significantly different wellbeing outcomes, with adolescents in RF scoring relatively higher in wellbeing due to their environment.

UF lay on a property of approximately 1 hectare on the outskirts of an urban area in South Sudan. The property was fenced and enclosed by security gates with added corrugated metal to provide privacy. The property was also guarded around the clock, as it was located in a community where theft and occasional armed violence occurred. The property, inclined on a slope, housed a row of organizational offices for administration, housing for staff, a kitchen, several outdoor gathering spaces, some gardens, and an inner chain-link fence within the larger outer fence. Within the inner fence lay the alternative care facility, which, for the purposes of this research, I call UF. This inner fenced area contained an outdoor shelter, a dormitory, a playground, a bathing and latrine shelter, a kitchen, dining room, television room, and library. The outdoor shelter (*payat*) was where

children assembled for morning prayers, caregivers had meetings, or people relaxed in the shade, gathered to eat, made crafts, or enjoyed a myriad of other activities. The dormitory had 8 rooms, including 5 bedrooms, 2 bathrooms with indoor plumbing, and a storage room. Each bedroom had three sets of bunk beds. Six to eight children stayed in each room along with a caregiver. The facility housed 43 children, ranging in age from 1 year to young adults finishing secondary school. Drinking water flowed to taps in the kitchen and bathrooms from large black water tanks, which were refilled regularly by water trucks. Electric lights illuminated the property at night, powered by city power or solar panels.

Although there were several tall buildings and some new development occurring on the unpaved road where UF is located, just a short walk across a small creek from the facility, the community was impoverished and undeveloped. Many people moved transiently through the neighborhood by car, on motorcycles, on foot, or driving their cattle through to the cattle camp. Only a short walk from the facility was a slum that had grown up in the middle of a cattle camp and on the edges of a cemetery. The roads were unpaved and the structures where people lived were not permanent structures, built of tarps, metal sheets, wood, reeds, and scavenged materials. Permanent structures, like concrete walls surrounding the cemetery, were marked with violent language, imagery, and gang graffiti. There were not adequate sanitation facilities in this community, leading to poor hygiene and frequent illness. These homes often flooded during heavy rains, putting occupants out of the house. When rains came at night, people in this community migrated to sleep on the streets or along the verandas in the marketplace. Many of the children in UF came out of this community from situations of neglect or abuse. In this

community, many earned their livelihood by brewing and selling homemade alcohol, begging in the market, working as day laborers, tapping their social networks for basic needs, or poverty-driven prostitution.

Business thrived in markets not far from UF with goods imported over land from other East African nations. Educated professionals found employment in international non-governmental organizations or local non-profits, schools, and government agencies. The city was an administrative center of governance. Police, military, and security personnel were active in and around the city with a large military base located on the outskirts of the city. Government and IGO/NGO workers earned high wages and lived in relative luxury with a wide gap between the rich and the poor.

RF lay on a property of 40 hectares, or approximately 100 acres. It shared this land with a church and a primary school that serves approximately 500 local primary students, including primary students who lived in the care of the children's village. The church was a circular, concrete structure that comfortably seated 120 people. The school was composed of 10 buildings, which included one administrative office building, seven classrooms, and two latrines. There were also two boreholes (wells) on the property that served the school, local community, and occupants of the institutional facility. An inner chain-link fence separated the residential children's facility from the rest of the property. The inner fence contained children's dwellings, a kitchen, latrines, storage buildings, outdoor shade structures, 1 borehole, administrative buildings, and housing of administrative staff. The children's dwellings are large single rooms, built of concrete blocks with corrugated metal roofs. Each dwelling was equipped with bunk beds, a table, a bathing room, and solar powered lighting. The dwellings housed 8-16 children and one

or two live-in caregiver staff. The kitchen shelter was built of concrete and corrugated metal roofs, and the cooking was done over large versions of the local charcoal stoves. The pit latrines were dug and then enclosed either by metal-framed, concrete-brick structures or in the local style of wood-framed, mud-brick structures. There were 120 children housed in nine dwellings, aging from preschoolers to young adults in secondary school.

The community surrounding this facility was rural and agrarian. The neighbors made their living primarily through subsistence farming of maize, millet, sorghum, sweet potatoes, and other vegetables. In addition to a plot of land for cultivation, some families had small herds of goats and chickens. Neighbor families were generally large where a mother and father are both present. Some of the neighbors were single mothers or widows who lived with or without children. The home structures surrounding the facility were mud brick rooms with thatched roofs. The rooms were separate dwellings for maturing daughters and sons and occasionally for multiple wives and their children. Cooking was done outside over charcoal burning stoves or open fires, and water was fetched from the borehole at RF or from the small stream running through the community. Many homes had pit latrines for sanitation. The topographical scene was generally flat with some hills and valleys shaped by rivers, streams, and a large marsh which irrigated the land, lending to the green landscape. The standing water in the marshland served as breeding ground for mosquitoes, and malaria was a common ailment. On the horizon were rock face mountains jutting out of the land, usually one or two together, but not in ranges.

In addition to agriculture, local neighbors were entrepreneurial. Cash income came through selling extra produce or meat in the local markets; small scale production and sale of charcoal or mud bricks; resale of goods such as soft drinks, cellphone credit, matches, candles, kerosene, and cookies; and services as varied as motorcycle taxis, vehicular repair, day labor, cooking, and tailoring. Business thrived in the market in a town center several miles from RF with goods imported over land from other East African nations. Educated professionals found employment in local non-profit organizations, schools, and government agencies. The nearby town was a state center of governance, when the state boundaries were changed in 2016. Police, military, and security personnel were active in and around the town with a military base several miles outside the town in the opposite direction of RF.

The traditional inhabitants of these regions were ethnically distinct with a common linguistic origin. Different dialects were spoken by the various ethnic or tribal groups. Although communication and intermarriage across linguistically-related ethnic groups was typical, relations between linguistically-diverse ethnic groups were strained. During the colonial period and post-colonial conflict, due to the military, business, and government activity in these regions, other ethnic and linguistic groups came to settle here. Nepotism in local and central government, economic or market disparity between native and migrating ethnic populations, land disputes, and crime along ethnic lines were causes of occasional conflict.

Sudan gained its independence from Great Britain in 1956, but that same year, a civil war erupted as South Sudan battled for self-determination and independence from the centralized government in the north. Civil war raged from 1955-1972 and reignited

from 1983-2005 when the Comprehensive Peace Agreement was signed. South Sudan established an interim government that ruled South Sudan in collaboration with the government of Sudan until South Sudan's independence was secured through a popular referendum in 2011 (Government of the Republic of South Sudan, 2015). In December 2013, South Sudan became embroiled in a civil conflict. The conflict was primarily a political and power-based struggle between the two largest ethnic groups in South Sudan, the Dinka and Nuer. A peace and power-sharing agreement between President Salva Kiir of South Sudan and Riek Machar, the leader of the opposition rebels, was signed in August 2015 and lasted until July 2016, when civil war resumed while I was collecting data in South Sudan. The larger context of this nation cannot be ignored in the investigation of the caregiver-child relationship, as violence has been the backdrop of the caregivers and children's lives.

Participants

The population for my study was caregivers and adolescent children at UF and RF in South Sudan.

I chose UF and RF as my population and sample because my relationships at these facilities provide me with ease of access, convenience sampling. Because of the years I spent working at that site, I had already established good relationships with staff and residents, which could guarantee more trust and open communication in my interactions with caregivers and children. At both UF and RF, I interviewed 7 caregivers, for a total of 14 caregivers. See Table 1 for caregiver demographic information.

Table 1

Caregiver Demographic Information

	Variable	<i>n</i>	Valid Percent
Age			
	20-29	5	35.7
	30-39	1	7.1
	40-49	4	28.5
	50-59	3	21.4
	60-69	1	7.1
	Total	14	100.0
Religion			
	Christianity	14	100.0
	Total	14	100.0
Marital Status			
	Single	6	42.8
	Widowed	2	14.2
	Separated	6	42.8
	Total	14	100.0
Education in Years			
	0-8	4	28.5
	9-11	2	14.2
	12 or certificate	2	14.2
	>12	2	14.2
	No Response	4	28.5
	Total	14	100.0
Languages Spoken			
	One	0	.0
	Two	7	50.0
	Three	4	28.5
	Four +	3	21.4
	Total	14	100.00

Note. Ethnic groups represented in this sample include (in alphabetical order) Acholi, Baganda, Baka, Bari, Kakwa, Kuku, Lugbara, Madi, Mundari, and Pojulu.

At both UF and RF, I assessed the wellbeing of children older than 12 years. The assessment was voluntary, and I assessed 98 of the 99 adolescents at the two locations.

Not all of the adolescents responded to the questions in every domain. Two adolescents were no longer in school because of academic struggles, and they did not report on the educational domain. This is why the results report only 96 valid responses in that domain.

Ethical Considerations

A danger I saw in studying the caregiver-child relationship as an ethnographic case study was that focusing my observations and research at one facility carried inherent risks to the organization, caregiving staff, and children. In describing the research settings with descriptive field notes, I may have revealed distinguishing features of the facilities to those who already know a lot, or would take the effort to know more, about institutional care settings in South Sudan. Because I desired to maintain confidentiality for children, caregivers, and the facilities themselves, I took care to discuss these concerns with the administration of these organizations when we met to discuss the informed consent. They did not seem concerned about the implications when we talked, but they were pleased that I agreed to write my thesis without identifying their organizations by name. After defending my thesis, I plan to share the document with them at which time the directors will tell me agree whether or not they would like me to attach the name of their organizations to the study.

According to the Children Without Parental Care policy of South Sudan, each organization working with children is responsible to institute procedures for reporting any allegation of misconduct toward children, defined as “abuse, neglect, exploitation, extreme forms of labour or risk of abandonment” (Ministry of Gender, 2008). As a researcher, I held myself to the same standard of professionals working with children in

South Sudan. I asked both facilities about their child protection policies and what their abuse reporting measures were, and I informed both the administration and participants in my study that I would follow those reporting procedures if I heard allegations of abuse or observed abusive behavior.

Before conducting my research, I obtained general informed consent from both UF and RF administration to make observations at the facility, interact with the staff and children, interview caregivers, and assess adolescent children for my research. The general informed consent form used is included in Appendix C. Additionally, I sought and obtained the children's assent to participate in the research as well. I did this verbally with the children. The adult (ages 18+) participants gave verbal consent to participate in my study after an overview of an informed consent document before I interviewed them, observed them, or documented them for use in this project. In the informed consent document for young adults and caregivers, I explained my commitment to ensuring participant confidentiality in my research and my responsibilities as a mandated reporter. Informed consent documentation is included in Appendix D and E. These documents were given to participants to read. Illiterate participants had the form read to them or explained to them in a language they could understand. Each participant was given an opportunity to ask clarifying questions, and was assured that they could discontinue participation at any time without any repercussions, even after signing an informed consent document.

Although I speak both English and Juba Arabic, the common trade languages of South Sudan, I chose to partner with a trustworthy translator from outside UF and RF for the sake of aiding me in translation or consultation regarding meaning of Juba Arabic and

colloquial English terms and phrases. I found a translation assistant who agreed to maintain participant confidentiality during the course of our work together. Although the violence that erupted in South Sudan during my time there interrupted the times that the translator had agreed to work with me, I was able to consult him via phone about linguistic challenges I faced. I compensated the research assistant for his work with me.

In addition to submitting an application for research for approval by Missouri State University's Internal Review Board (IRB, approved April 26, 2016, study 16-0411), I consulted with social workers in South Sudan to see if there was an IRB process or committee from whom I needed to gain permission to conduct my study in Central Equatoria State. Despite my search, I did not find any IRB process in South Sudan.

During my fieldwork in South Sudan and after returning to the USA, I kept the interview recordings and transcripts secure. In writing my results and cross-checking my data with participants after data collection, I took precautions to prevent identification of any individual participant whom I quote in the study. I have aggregated demographic data in tables and eliminated personal identifiers as much as possible so as not to reveal identifying information of individual staff and children.

Data Collection Procedures

My data collection consisted of field notes from observations and reflections on caregiver-child interactions in the institutional settings; audio recordings and transcripts of semi-structured interviews with the caregivers; quantitative responses from adolescents to the OWT and their qualitative feedback during and after assessment.

Gay, Mills, and Airasian (2006) recommend taking clear, extensive, and detailed field notes from observations. I took notes throughout my time at UF and RF about the environment, happenings, and specific caregiver-child interactions observed. I wrote detailed descriptions of actions and interactions I observed, only describing and not interpreting the actions. After observation, I reread the field notes and added *reflective field notes* or *observer comments* (Gay, Mills, & Airasian, 2006).

I conducted audio-recorded, semi-structured interviews of 14 caregivers, 7 caregivers at each research site. The interviews were conducted in English or South Sudanese Arabic, which I speak. Before interviews, I explained the informed consent document to each caregiver and acquired their verbal consent to participate in the study. All of them gave verbal consent. The interviews lasted between 20 minutes and 2.5 hours, depending on how much the caregivers chose to share. Most caregiver interviews lasted approximately 1 hour.

I assessed 98 adolescent children using the OWT (Senefeld, Strasser & Campbell, 2009). Before assessing any of the adolescents, I explained the purpose of my study and the nature of the assessment. They all gave their verbal assent before I administered the assessment. Only one adolescent living at the two facilities opted not to be assessed, so I assessed 98 of 99 adolescent children present at the two facilities. Their assessments lasted between 15 minutes and 1.5 hours. Most assessments took between 20 and 30 minutes to complete, but a number of the adolescents wanted to tell me more. I did not audio-record the adolescent children's assessments, but I took descriptive notes about the stories and made notes of specific language the adolescents used to qualitatively describe their experiences living in institutional care.

Instrumentation. Below, I will describe the qualitative and quantitative instruments I used in data collection.

Semi-structured, Caregiver Interviews. To gain a deeper understanding of the caregiver's background, thoughts, and attitudes, I developed some questions for use in conducting semi-structured interviews with caregivers at UF and RF. The five loci of those questions, which formed the common structure of the interviews, were: the caregiver's personal background, the caregiver's parenting knowledge, the caregiver's experience as a caregiver, the caregiver's vision for the children in her care, and the challenges and opportunities facing the caregiver. Below are the specific topics of conversation in which I engaged and more specific questions which I introduced of some of the semi-structured conversations with caregivers at the research sites:

- What is the caregiver's background and family narrative?
 - Where did your mother and father come from?
 - What languages did they speak?
 - Where were you born?
 - What was your first language?
 - Do you speak other languages?
 - What is your ethnic/tribal identity?
 - Are your parents still living? Brothers? Sisters? Husband? Children?
- What are the caregiver's understanding and beliefs about parent-child relationships?
 - What do children need to grow up well?
 - What is the role of a parent?

- Who is someone in your life that was a good mother? What does her life teach about motherhood?
- What did you learn about being a parent from your parents?
- How long have you been a mother?
- What did you learn about being a parent from your children?
- Did you ever receive any training on how to be a parent? If so, what training and from whom?
- What is the caregiver's experience of caring for children separated from their parents?
 - How did you come to work at PCF? How long have you been working here? Did you work somewhere like this before?
 - What is it like to care for children in the children's home?
 - How is caring for these children different from caring for your own children? Please tell me some stories.
 - What do you do well in caring for these children? Please tell me some stories.
 - What makes you happy working with these children?
 - What is difficult working with these children?
- What is the caregiver's vision for these children?
 - What are your hopes for these children in the future?
 - What do you think will happen to these children in the future?
- What challenges and opportunities do caregivers face?
 - What challenges do you face as a caregiver?
 - What sort of training would you like to receive?
 - What caregiving skills and knowledge are you willing to teach others?

I audio recorded all of the interviews and took notes during the interviews to help me ask follow up or clarifying questions.

I believe semi- and unstructured interviews lend themselves more to relaxed conversation and opportunities where the caregiver could take the lead as the expert teaching me. Although I had a list of questions, I did not raise every question with every caregiver. I allowed the caregiver to lead the conversation, and I introduced questions that fit the direction the caregiver was taking the conversation or when the caregiver was unwilling to respond at length, which rarely occurred. When I was able to follow caregivers' lead and go with the flow of their conversation, it allowed caregivers more autonomy to share and focus on what they felt was important. I believe semi- and unstructured interviews better fit the natural flow of conversation than a structured interview would have. Conforming myself to the natural movement of South Sudanese conversation style was important to maintain trust and diminish observer effect (Gay, Mills, & Airasian, 2006).

Wellbeing Assessment of Adolescent Children. To gain a general understanding of wellbeing of the children in care at the research sites, I assessed 98 adolescent children using the OWT (Senefeld, Strasser & Campbell, 2009). Catholic Relief Services (CRS) developed this 36-question assessment as a rapid wellbeing assessment for “orphaned or vulnerable” children, aged 13 to 17. Because many programs serving children in need focus evaluation on the nature and quantity of services provided, not the feedback of the child beneficiaries, CRS developed the OWT to elicit the voices of their programs' child beneficiaries, allowing them to express their own perceptions and sense of wellbeing.

The OWT has been validated cross culturally (Senefeld & Perrin, 2014); has been used in Ethiopia, Haiti, India, Kenya, Malawi, Rwanda, Tanzania, Vietnam, and Zambia (Senefeld, Strasser & Campbell, 2009); is easy to administer; and is simple to score. It assesses the *holistic* wellbeing of a child across the following ten domains of wellbeing: food and nutrition, shelter, protection, family, health, spirituality, mental health, education, economic opportunities, and community cohesion. The OWT is a rapid assessment tool, used to measure patterns of child wellbeing in programs that serve them; it was not intended to be used as an in-depth individual assessment (Senefeld, Strasser & Campbell, 2009).

Before using this instrument, I worked in consultation with a Sudanese research assistant to translate the OWT into South Sudanese Arabic, following the translation guidelines in the OWT User Guide (Senefeld, Strasser & Campbell, 2009). We discussed each domain and each question, taking care to translate the questions dynamically, not literally word for word. After completing our joint translation, the assessment was reverse translated by a Sudanese professional living in Juba, South Sudan. His back translation gave some ideas for clarification needed on a number of the questions. Final changes were made, and the instrument was used to assess children in the two research sites.

Role of the Researcher. Gay, Mills, and Airasian (2006) define three types of participant observers. In this study, I played the role of a privileged, active observer. I returned to a place where I was known and where I worked previously. Because of my historical relationships in these research sites, I was treated preferentially. Because of my active involvement in many areas of life during my years working at these facilities, I was invited to actively participate in any activity, while being expected to participate in

nothing. This was the paradox of my position as a privileged, active observer. Because of my former position (two years providing administrative assistance and case management), the heritage of colonialism (where foreigners, especially White foreigners, were treated well, but not trusted), and the time that passes between my visits back to South Sudan, I was welcomed as an honored guest. The senior staff at the two facilities, with whom I had day-to-day interaction in the past and with whom I maintain regular contact, welcomed me to observe and take notes without hesitation. They opened the entire compound to me without question: welcoming me into staff meetings, allowing me to observe the gamut of daily life experiences, even inviting me to participate and facilitate programming with the staff and children. From an observer standpoint, I was free to observe and take notes without question.

In qualitative studies, the researcher is the instrument. Therefore, I must acknowledge the limitations to trust building inherent in the complex historical relationship between White people and South Sudanese. Because of historical mistrust of outsiders, developing trusting relationships is a time-consuming process. I had already invested years of my life into relationships with individuals at these facilities, but some caregivers and children were new since my latest visit. Still, I had a good reputation among staff and children that preceded me. However, because of an unspoken norm at one of the facilities (which children had explained to me in the past) that the children and caregivers should keep secrets from the white people, I knew I would need to tread carefully and conduct myself in such a way that I did not raise suspicion, but exhibited unconditional positive regard toward all caregivers and children.

Because of my prior experience at these locations, observer effect and observer bias were real concerns for collecting data at these locations. I hoped that observer effect would be diminished in some way because of my past experience, as I have already worked through trust issues with some of the study participants, however, because of my past experience, I thought there may also exist many unspoken expectations that caregivers and children would have toward me when I returned. To mitigate these expectations, I made clear to the caregivers and children when I arrived that I had come this time to learn from them. I was intentional to exhibit gratitude, honor, and reciprocity toward the caregivers and children by assisting the caregivers in their duties, offering administrative assistance to the staff, and leading activities for the children. All participants were very generous toward me in sharing their experiences and knowledge, as well as opening their home to me.

I initiated this study because of my own desire that the children at these facilities be well prepared to transition into society as socially and emotionally healthy young adults. Some of the young adults who have already transitioned out of these facilities have spoken with me about their memories and concerns about the caregiver-child relationships in these settings. I occasionally observed troubling cues from caregivers during my time in South Sudan, but I did not know what to do about what I believed I was observing. Because of my past experience, observer bias was an obvious pitfall for which I had to continually be vigilant in my field notes and reflections. I needed to remind myself that I had not come to evaluate, but to observe and document what I saw. As an observer, I reflected on my affective responses and attitudes to keep them in check and continually realigned myself to the position of an observer. By positioning myself to

learn from the caregivers and children about South Sudanese cultural expectations of parents and caregivers, I hoped to see from their perspective. I intentionally looked for the strengths and assets of the caregivers in their own experience of parenting and in their work as caregivers for these children. I both endeavored to learn from them and affirm in them their own capacity to prepare these children for a good future.

Gathering valid data through semi-structured interviews with caregiving staff was a significant concern for me going in, for reasons of communication, trust, social desirability bias, and observer bias. I attempted to moderate these concerns through translation assistance (from phone consultation with a Sudanese research assistant as I analyzed my data); cross-checking and triangulation of data using caregiver interviews, child feedback, administrative input, field notes, and photos; protracted observation and relational interaction with caregivers and children; intentional reciprocal actions (like working alongside the caregivers in providing childcare or supervision, doing chores alongside the children, and picking up administrative tasks to assist wherever I could); and my own vigorous self-reflection and course-correction.

Data Analysis

After concluding on site observations, I reviewed my field notes and crosschecked my initial observations and the general themes emerging from the data with staff and administration of the children's homes, providing an opportunity for them to directly address any concerns they had or objections to the initial findings before I left the research settings. Upon return from the research sites, I began to listen to the caregiver interviews, score the wellbeing assessments, and immerse myself in my data.

Qualitative Analysis. I began by translating the interviews conducted in Arabic. When I struggled with the translation of a word or phrase, I contacted my Sudanese research assistant by phone to help me understand what the caregiver was trying to express in that segment. As I listened to and translated the interviews from Arabic, I took notes on large pieces of paperboard, mapping out the flow of the interview, noting important points and phrases, summarizing stories, and writing specific quotes and time stamps from the audio recording. I proceeded to do the same with the audio recordings of interviews of caregivers conducted in English (see Appendix F).

When I had taken extensive notes on all of the 14 interviews, I met with my thesis advisor. We discussed the themes that were emerging from the interviews and created several categories for coding. Creswell (1998) recommends broad coding at the beginning of qualitative analysis, leading to a deepening cycle of reflection, deeper analysis, further reflection, and deeper analysis of the data. I returned to my notes and began to highlight parts of the interview related to the codes we had established. Visually, I could now see a representation of the different themes, which were as follows:

- Experience of being parented or experience of parenting
- Extended family relationships
- Attachment
- Things the caregiver wanted to teach the researcher about children and/or caring for children
- Demographics
- Further training the caregivers desired or would be willing to provide to others
- Judgment statements or empathy statements (to infer caregiver values)

- Challenges, concerns, or questions the caregiver has about the children's care, the institution or work environment, or children's future wellbeing

After coding all 14 interviews in those categories, I met again with my thesis advisor to discuss what I had discovered. At this juncture, I began to return to each individual caregiver to begin mapping out the caregiver's individual approach to caregiving, related to personal experience, values, demographics, training, etc. I built a profile for each caregiver, condensing the themes and information that emerged from individual interviews. I then compared the caregiver profiles between one another to explore for any emerging patterns.

Creswell (1998) recommends that a researcher reduce the data to 5 or 6 themes to use in writing the narrative. As these key themes emerge from the field notes and interview data, a researcher can relate the themes and develop ways of organizing and summarizing the data, using codes, categories, charts, and visual images (Creswell, 1998). At this point in analysis, I began to write up the themes and patterns that I had seen emerge in the caregiver group as a whole. I cross-examined those results for validity in field notes I had written and the qualitative feedback I had recorded from the children. I also began to compare the caregivers' emphases to the wellbeing domains of the adolescent assessments.

Quantitative Data. During my days in South Sudan, I transferred the OWT data for the 98 adolescents from my field notebook into an excel spreadsheet. After returning to Missouri State University, I met with Dr. Todd Daniels, a statistician at Rstats, to transfer my data into an SPSS file and write the syntax for scoring the total wellbeing assessment and the ten domains of wellbeing. We analyzed the wellbeing scores using descriptive analyses and independent *t* tests to answer questions comparing groups.

RESULTS

The observation of caregivers and children, caregiver interviews, and adolescent wellbeing assessments in the two research sites provided ample data. In this chapter, I will report on themes that emerged from the qualitative data, namely information about the caregiver's personal backgrounds, their caregiving knowledge and values, and their experience as caregivers in these institutional settings. I will also report my analysis of the adolescent children's wellbeing assessments and their qualitative feedback. All of these results will paint a picture of the nature and dynamics of the caregiver-child relationship in these institutional care settings in South Sudan.

Caregiver Backgrounds

In my interviews with the caregivers, I was welcomed into the rich life stories of fourteen women. All of these stories disclosed difficult childhood experiences, yet most caregivers (11) reported overwhelmingly positive experiences of being parented. This section summarizes these caregivers' childhood backgrounds and their experiences of being parented.

Childhood. All of the caregivers interviewed reported difficult childhood experiences that varied in nature, but related to the themes of loss, trauma, and poverty. Most of the caregivers (12) were raised in the context of war in South Sudan and northern Uganda, so these difficult experiences played out against the background of civil conflict. Eight of the caregivers mentioned life during wartime or explicitly told me stories of their war experiences, and four of the caregivers talked about life as a refugee. Other

caregivers told me about difficult childhood experiences and losses within their families. I did not explicitly ask to hear about difficult childhood experiences, but these significant events were told to me when I asked caregivers to tell me about themselves and their families of origin.

Loss. Ten of the fourteen caregivers experienced loss or separation from one or both of their parents as a child. These losses were due to parental death, abandonment, or migratory employment. In most cases, they were taken in by relatives or continued to receive parental care from the remaining parent, but two of them were left fully orphaned without helpful relatives nearby, and were very vulnerable during their late childhood and adolescence. One such caregiver described her experience like this, “My parents didn’t raise me. They died early, and I grew alone.”

Those who received care from their relatives and remaining parents generally spoke very positively about their experience of being parented, as I will report later. Even in the presence of a loving caregiver, the loss or absence of one or both biological parents was a significant marker of their childhoods. One caregiver said it this way,

From the age of three, I lived with my auntie... I’ve grown up with friends who talk about their mothers. I just don’t feel it in me. You know, I cannot just tell somebody about my mother... Sometimes I feel like nobody was there for me. But my auntie was there for me. She was my father. She was my mother. Everything. She was my everything.

Another loss that some caregivers experienced was the loss of their childhood homes during internal displacement or refugee migration. One caregiver described her family’s early morning flight in these words,

At dawn, around five, that is when the bullets started... the moment my mom heard the bullets, she was up, and she started packing things that we would need... Mom said, “Ok, you children first hide here. Let me go ahead and find for us another place.” So, she would go check for a safer space, and then we would

all go and run there... all six of us ran.

Several of the older caregivers described multiple refugee migrations during their lifetimes. They ran first to Uganda or the Democratic Republic of Congo, returning back to South Sudan when war erupted in their host nations. Due to the outbreak of violence in South Sudan during this data collection in July 2016, many of these caregivers have made yet another refugee migration to Uganda.

Trauma. Five of the fourteen caregivers told stories of childhood trauma. One orphaned caregiver described being abandoned by her extended family when they ran as refugees during the war. She remained behind in Sudan, alone, where she was vulnerable to abuse and was eventually taken into a forced marriage. In her words, “An old person and neighbors looked out for me, but I found all my food. A man took me when I was 15 years [to become his wife]. There was no family to arrange a good marriage for me. He was a drunkard and beat me.”

Another caregiver retold the trauma of regularly witnessing her alcoholic father beating her mother. She explained, “My father was educated, but he drank a lot. My mother suffered a lot with violence in the home... We all suffered... I never wanted my children to suffer like that.”

Several caregivers retold war stories, especially about their escape from soldiers when they ran as refugees. Although one caregiver laughed as she told me that she and her siblings all survived, she talked about the lingering trauma of the war, “During the liberation struggle, there was a lot of looting, killing, rape. Yeah... I can’t deny that the trauma is not there. The trauma is there.”

Another caregiver retold a story about running away from home because her uncle was physically abusing her. She told how running from the abuse brought problems in her family for many years, but she thought it was important for me to know that she has since mended the relationship with her uncle and his family, “As an adult, I reconciled with them. I don’t refuse them.”

One caregiver described being emotionally abused and neglected by her parents. She explicitly drew connections between her own childhood experience of abuse and neglect and her ability to relate to the children in her care, saying,

I advise the kids about their parents – “You should love your mother and father because without them, we wouldn’t be here talking. You must respect them.” They say, “Even I’m ashamed of them!” I say, “No, no, no. It’s not your fault. You can tell them to change, but you cannot change them... never be ashamed of your parents. I’m not ashamed of my parents. I just do not like what they do.”

Poverty. Four of the fourteen caregivers told me that they grew up in poverty as children. They classified poverty as not having enough food or access to education. “I grew up in the mud, like the poor kids in the slums today,” One caregiver said, “My mother suffered with us a lot, which is why I didn’t finish my education.”

If lack of access to education is an indicator of poverty, however, it is possible that more caregivers experienced childhood poverty than those who explicitly said so. In addition to those who stated that they experienced childhood poverty, two more caregivers stated that they received no education whatsoever and others stated that they were unable to finish their education.

Being Parented. The fourteen caregivers were raised by a variety of caregivers. Most of them were raised by their biological parents (7), but nearly as many were raised by their relatives after being separated from their biological parents (5). Two of the

caregivers were orphaned and spent their late childhood and adolescence largely responsible for themselves, without parental care. From their interviews, I drew out three categories of their experiences of being parented. Most of the caregivers (11) reported overwhelmingly positive parenting, although two reported negative parenting, and one reported ambiguous parenting.

Positive Parenting. Eleven of the fourteen caregivers reported positive childhood experiences of being parented. The most common parenting experiences that the caregivers related to me were role modeling life skills, providing resources, teaching values, encouraging education, and emphasizing faith.

Role Modeling Life Skills. Eight caregivers spoke at length of important role their parents played as teachers. They attributed their life skills and character traits to the role modeling of their parents during their childhoods. One caregiver captured the prevailing sentiment when she stated, “My parents taught me everything. I just copied them.”

Parents taught their children to do the necessary tasks of life, including farming, housework, cooking, and childcare. One caregiver stated, “My mom was a good example of a mom. She taught me housework, not to be lazy, to wash, to cook, to dig [farm]. She said, ‘If I ever die, you’ll have nobody,’ so she prepared me to work hard – to do all her work.”

Other caregivers affirmed that tasks were taught to them through role modeling by their parents, adult relatives, or older siblings. One caregiver explained that her widowed father taught her how to farm, while her father’s sisters taught her household tasks, like cooking and cleaning.

Another caregiver explained that her parents role modeled life tasks to her as the firstborn child; then, as she grew, she took over the tasks from her parents and provided role modeling for her younger siblings. Another firstborn caregiver expressed the process of role modeling in this way:

The child is being trained. When the parent asks them to bring water, then the child obeys and brings water. Or the parent tells the child to go and wash clothes for her. Or, sometimes, the child has watched the parent mix up some porridge, and mom invites the child to try to make porridge too. The child has been observing how mom does these jobs. So, now the child goes and brings a pot and starts the fire and puts the pot on to boil and mixes the porridge and puts it into a cup to share with his brother or mother. This is the work that the child is learning.

Life skills and life characteristics were almost always linked to modeling as the teaching method. Even the caregivers who did not have strong relationships with their biological parents spoke of learning life and parenting skills from someone else. One caregiver, who was orphaned and grew up without direct caregivers, spoke of the challenge she had when she gave birth to her first child. Because she had never lived with someone who role modeled caring for a child, she did not know what to do for a baby. Her mother-in-law took over the caregiving for her firstborn child. When this caregiver gave birth to her second child, she became the primary caregiver because she had learned to care for babies through the role modeling of her mother-in-law.

Provision. Caregivers related how their parents or caregivers provided them with shelter, food, protection, and clothes. One caregiver waxed poetic as she remembered how her mother tenderly provided for her, “My mother held me from the time I was small. I drank from her breasts. From childhood until I was grown, I always opened my eyes to see her there. She made my clothes, and she dressed me tenderly. She held me

until the time when I held her. I knew her from birth. She called me her child. She was my mother.”

The caregivers described provision of basic needs as the evidence of love. One caregiver described her uncle’s love for her in this way:

We ate 3 meals a day. He would work. In the morning, we’d have tea, then go to school... We will come back from school and find the lunch ready... So, after that, we will make the supper. Then we will eat. So, he’s always ok in terms of food, education, dressing, and in terms of school. He’s always the best. I learned love and care from my uncle. He always loved us, and he gave us that attention of being children. And he provided everything.

Even when resources were scarce, the caregivers indicated that their parents provided everything they possibly could. One caregiver described her mother’s efforts in face of intractable poverty in these terms, “My mother had nothing to give us, but at least she would cook food for us. She would find a way to get food for us to eat, even if we didn’t have school fees... At least we would eat one meal a day.”

When it was impossible to provide something the child needed or desired, many parents would explain the situation to the child in terms they could understand. One caregiver recalled her aunt communicating openly with her about their financial situation, “I knew my auntie inside and out. I even knew how much money she would get and how she would divide it... She was very open with me. She would say, ‘This and this is going to happen. You will do this, and you will see that the money is over. We remain with nothing, so it means we have to be very careful.’”

Several of the caregivers noted selfless acts of love that parents or caregivers made to provide for the children’s needs. One caregiver reminisced, “My mom put us as first priority in such a way that she would go for a year without any new clothes or any new shoes, but making sure that we all had new things... she always put us first.”

Teaching Values. Caregivers spoke of important values that their parents taught them, including respect of elders, hard work, hospitality, equity, and love for others.

Almost every caregiver mentioned respect of adults and elders being an important value in their childhood home. Some caregivers used the term “fear” of parents and adults. Other caregivers spoke about how, as children, they had to listen, obey, and not ask questions. These important behaviors belie the importance of children respecting their elders. However, lest the readers assume these parents were cold and exacting, many of the caregivers described their parents as caring disciplinarians who warmly and patiently taught their children good behavior.

Many of the caregivers told stories about how their parents would discipline them when they were disrespectful or disobedient. Four of the caregivers mentioned their parents “caning” them (striking them with a small stick), but two of those emphasized that their parents rarely caned them and only did so as a last resort after a child’s repeated, stubborn, and intentional disobedience. One caregiver explained it like this:

My mom caned me. You know, that’s just the way of disciplining. My mom is someone who – you do something and she keeps quiet. Then she talks to you. The second time you misbehave, she talks again. Until, maybe the seventh time. She piles up all your mistakes [laughter]. Finally, the last one is when some very serious discipline!

Two of the caregivers said that their parents never caned them at all, simply threatening caning or preferring to reason with the child. One caregiver explained that her mother would never beat her, but instead, beat her “with her mouth,” which sounds like threatening corporal punishment. “[Mother] didn’t insult us. We didn’t know insults. She would say she would beat us when we were not behaving, but she never did. She just beat

us with her mouth... If we did something bad, she would say, 'I will beat you,' but she never actually used a stick."

When it came to discipline, another caregiver said that her auntie reasoned with her, asking good questions and turning the locus of responsibility on the child to help her understand and take responsibility for her behaviors:

She was very tough. [She would ask,] "So, you did this? Do you think it was good?" Even when she knew it was wrong! [Then my auntie would ask me,] "So, what should I do to you?" You know, it's hard sometimes if your parent asks you that. So, I would tell her, "Cane me." And she would say, "I'm not going to cane you. Look for another one..." I would ask her, "Why are you making this long?" And she would say, "Because I want you to *understand*. You must understand why what you did was wrong."

Hard work was another shared value in many of the caregivers' childhood homes. Several of the caregivers insisted this was one of the most important values that could be transmitted to a child. One caregiver described "hard work" as the primary thing that her mother taught her, saying:

If my mother would have been a lazy woman, we would have all died in my family. She would go to the woods to collect firewood to take to the market. She'd sell them. Buy food. Come back and cook for us. She went to people's gardens and worked [as a day-laborer]... I adopt that motto of hers... Nothing is to be gained without sweat.

Hospitality was a value that several caregivers emphasized in their interviews, telling how their parents opened their homes to relative children, neighbors, and visitors. One caregiver said the most important thing for a child to know was how to greet a visitor properly, while another talked for nearly twenty minutes on the importance of sharing food with neighbors.

Equity in sharing resources emerged as a common value that caregivers emphasized about their parents. Especially when parents cared for both biological

children and relative children, caregivers saw this value when their parents were equitable in distributing food and other provisions. One caregiver, raised by her aunt, mentioned how her aunt always divided the food equally among her own biological children and the relative children in her care.

One caregiver, raised alongside her cousins by her own mother, remembers distinctly that her mother emphasized that all children would be treated fairly. There was no preferential treatment for biological children over the cousins. They were all family. They all shared alike. There was also no preferential treatment for male children over female children:

[My mother] took us all equally... She would not differentiate, saying, “This is a boy. This is a girl.” The work girls did, the boys had to do. In most African cultures, they say a boy is not supposed to cook – a boy is not supposed to fetch water or things like that. But when a visitor comes, whether you’re a boy or a girl, my mom says you have to go down on your knees and show respect. In some families, you find that boys do not kneel down. But with my mom, even the boys had to. So, there was a lot of equality growing up.

Love of others was another important value, emphasized by several caregivers and defined as practically meeting the needs of others. One caregiver commented on how her aunt and uncle taught her how to love other people by loving her so well:

I didn’t grow up in the hand of my mother; I was raised in the hands of others. They loved me and taught me to love everyone as my family... Accept everyone as your family. Don’t divide. When someone is tired, help them. When their clothes are dirty, wash them. When they visit you, give them water... God loved me, and my aunt’s husband taught me to love others.

Another caregiver, whose mother raised her alongside her cousins, talked about the ways her mother’s love impacted her. “Despite the fact that my cousins were related to us, they were not our real, real, real siblings – yet, my mom was able to care for them... When you grow up in a very loving family, you also tend to love.”

Education. I have already mentioned above that not all of the caregivers received education. The older caregivers struggled to access education because of financial barriers and social instability during their childhoods. However, the younger caregivers who were able to attain an education were supported by their parents or relatives to go to school. Even several of the older caregivers who did not manage to finish their educations mention that their parents encouraged them to pursue an education, as evidence that education was highly valued by parents whether or not they had the means to enroll their children.

Faith. All of the caregivers identified themselves as Christians, and many of them mentioned faith playing an important role in their family lives. Two caregivers said their parents raised them to believe that faith was the most central part of their lives. In one of the two homes where faith in God was said to be “the first thing,” the caregiver directly associated her mother’s faith with the family’s rejection of division and verbal abuse:

From birth, I never knew insults or quarreling... Mom told us, “You should love church. Church will teach you...” When you’re in church, you won’t develop an insulting or abusive mind. Quarreling won’t be in your mind because this church is teaching not to quarrel – to be united – bringing anyone together. You see someone and know they are your brother. This is your sister. Your father. Your mother. This church brings everybody together into one.

Negative Parenting. Two of the fourteen caregivers reported overwhelmingly negative childhood experiences of being parented. These two caregivers reported parents who quarreled a lot and did not provide for their children’s basic needs. The marriage relationships in these two families experienced domestic violence, alcoholism, and adultery. One caregiver reported arbitrary violence, stating, “Mom beat me when I made a mistake.” Another caregiver reported parental neglect and a fearful home environment, describing her experience in these words:

Nobody was there for me... You can have parents, and they can be very useless. Sometimes it's not easy to say, but it's true. Because they are not helping you at all. They're just there. I can't say they were poor. No. They had what was needed to put me in school – to provide everything I needed – but they did not. They kept on quarreling. I feared even sometimes to go home. I even said that I hate that I was born to that family.

Ambiguous Parenting. One of the fourteen caregivers alternated between phrases like, “All mothers are good” and “I grew alone, and I’m still alone,” when the researcher asked about her parents. She did not disclose any stories about her parents and very little information about her childhood, making it difficult for the researcher to classify her experience as positive or negative.

Caregiver Values and Knowledge

When I interviewed the caregivers, I postured myself as one who had come to learn how to care for children. I asked them to share with me their understanding and experience of how to be a good caregiver. In response, the caregivers shared what they learned in their experience of becoming parents and what they thought all children need to grow up well.

Becoming Parents. Of the fourteen caregivers, eight are mothers of their own biological children. Although the other six caregivers have never given birth to children, four of them voluntarily took on responsibility for orphaned relatives or non-relative children in need before coming to work as caregivers in an institutional setting. When I interviewed these women, some of them told me what they had learned in becoming parents and how it applies to caring for children in the institutional setting. I have classified this knowledge in five themes: teach children what you were taught (12); be selfless and do whatever it takes to meet the children's needs (9); be gentle with children

and they will behave better (9); treat children fairly (6); and you need God's help to be a good parent (3).

Teaching. Almost all of the caregivers (12) emphasized teaching as the primary role of a parent.

A number of caregivers explicitly stated that a parent is responsible to teach children what they had learned from their parents. One caregiver told me, "Teach the kids what you learned growing up," and another said, "Teach kids exactly what your parents taught you."

Caregivers listed behaviors and skills that parents ought to teach their children, including the following life skills: farming, cooking, cleaning, washing clothes, and housework; and the following character traits: respect, hard work, obedience, generosity, hospitality, and good manners.

Most of the caregivers said that a parent should teach by role-modeling skills and behaviors that a child should learn, which is almost directly in line with the way these caregivers reported being parented. One caregiver told me, "Children follow their parents' examples. [You must] demonstrate for them how to live," and another stated, "Advise them what to do," and "Model good behaviors."

Selflessness. Nine of the biological mothers emphasized the importance of being selfless as a mother and "doing whatever it takes" to provide for the children in one's care. Notably, these four were all single mothers due to death or separation from their husband. One of them told me the story of how she often went hungry to provide food for her biological children and her orphaned nephews. She said,

When my nephews were left in my care, after their father died, it was a very difficult time. We didn't have enough food for all of us – so I had to be

hungry so they could eat. I would leave the house early in the morning, leaving the children there. I told them to look after the house. I would go and look for food. I would farm all day, then bring home food for them. They would eat. I would not. I was *so* hungry during that time, and we were staying so many of us in one room.

Many caregivers are living selflessly in the way they cater for their children's needs. Of the eight caregivers who are biological mothers, four of them have already raised their children to adulthood. The remaining four are single mothers, actively supporting their children with the wages they earn as caregivers. Three of those four caregivers are separated from their biological children while they work in the institutional care setting. They send money home to support their children and see their children only on holiday visits back to their home villages.

One of them told me that as a single woman in South Sudan, to provide for herself, she would have to either "marry from husband to husband," at the risk that a future husband may reject her children, or "work in pain." Instead of seeking provision for herself at the risk of her children's security, she chose the difficult path of working to provide for herself and her children alone. "So, that is why you see me here [working at the institution]," she explained, to "extend my own kids in their education."

Three caregivers extended this selflessness in caring for their own children to their work caring for non-relative children, talking about how they persist in their job when it gets difficult for the sake of the kids. One of them said she chose to do the hard chores during the school week so the "kids would have no worries" and would be able to focus on their studies.

Gentleness. Nine caregivers emphasized the importance of being gentle with children, especially when they were upset, misbehaving, or in conflict with another child.

One caregiver said that she was taught to always be gentle with her own children, and that the same rules apply when caring for children who are not related to her in the institutional setting. She said,

If they insult you, don't insult them back. You stay quiet... When their hearts are still hot, they will not accept to speak with you. They are still upset and the situation will intensify... You speak to them gently. If you speak harshly, it is very bad. If you quarrel with them, their brains will break and they will begin to think about their mother and father who are not present with them... they are looking for peace... So, take care of them gently so they will be well and smile and obey without quarreling or worrying... This is how you take care of orphans.

One caregiver put the locus of responsibility on caregivers to control their own behaviors when children are misbehaving, "Being with the kids, you will learn a lot. You learn how to control yourself in terms of the behavior of the kids." Another caregiver added, "Calm yourself when you're angry. Kids won't hear you if you're angry." She also drew a connection between a caregiver's response to a misbehaving child and the child's behavior improving, "Talk to a child gently and the child will improve what he or she is doing bad. The child will improve."

Several caregivers emphasized that they would not use corporal punishment to address misbehavior, but said reasoning with the child would be more effective. One of them said, "There is no way to *make* a child behave. Just talk to them." One of them did not rule out corporal punishment, but suggested, "Talk and talk and talk before spanking." Two caregivers suggested that asking children questions and listening to them could help them discover new ideas and try new behaviors.

Fairness. Six of the caregivers emphasized the importance of treating children fairly. This was described in tangible terms, such as providing equal servings of food, and the understanding of "fairness" extended across biological and even tribal boundaries.

Whether the child was their own biological child or they were caring for someone else's child, these caregivers said they would provide no different care. One caregiver advised me, "See them the same as your own children," while another said, "Teach orphans the same as kids from your own womb." One caregiver said of herself, "I treat these kids the same as I treat my own."

Several caregivers mentioned that a child's ethnic background had no bearing on how they parented the children in their care, which is important in South Sudan, which has experienced significant tribal conflict historically and in recent years. The fourteen caregivers were ethnically diverse, coming from ten different tribes, although several of those tribes shared a common language group. One caregiver emphasized that a child's ethnic background should make no difference in the care provided, "For me, I cannot concern myself with those things. I don't even consult [the kids] are from where. We are all human beings and we speak a common language." Another explained how she has cared for children from tribes that have historically been at odds with her tribe, "I would even carry children [from the other tribe] on my back. I would bathe them. Clean them. Feed them porridge." Her advice is to "love all children. See every child as your brother, as if you had the same parents. Don't make division."

While caregivers emphasized the importance of treating children fairly, two caregivers simultaneously acknowledged the complexity of providing fair treatment. They explained that fair treatment may not always be equal treatment, since children will not always need the same treatment because they have different backgrounds, personalities, and needs. Those two caregivers were advocating equitable treatment, and encouraged me to "treat them uniquely, according to their needs."

God's Help. Three of the caregivers emphasized that they were incapable of providing good care for children without God's help. One of them told me, "Without prayer, you'll have no peace to parent." The others mentioned situations where children's behaviors would test their patience and push them to the end of their own internal resources. In those moments, they advised turning to prayer. One said,

[When children are very difficult], you should pray. You should call out to God. I say, "Lord! The kids here, some don't listen. Some insult. Some quarrel. But, Lord, hold my heart. Don't let bad words come out of my mouth." That's what I say to God. "Give me a good heart and good words!" You must cry out to God. You ask for strength from God.

Children's Needs. In my interviews, each caregiver told me the things that they believed were vital for children to grow up well, which I believed would reveal their emphasis as caregivers. After describing the things they emphasized, I will relate their responses to the 10 domains of wellbeing that were measured on the OWT.

Caregiver Emphasis. When asked what children need to grow up well, most caregivers emphasized children's needs of food, hygiene, and healthcare. Many caregivers also emphasized the importance of children being educated, not only formally in a school setting, but in life skills, good behavior, and traditional values. Caregivers also mentioned children's need for discipline and structure to guide them.

Most caregivers from *Rural Facility* (RF) emphasized children's basic needs and one or two other needs. Caregivers from RF mostly emphasized physical needs, but they also emphasized chores and discipline. Three RF caregivers said that children needed "good words," "understanding," and "freedom from worry."

Caregivers from *Urban Facility* (UF) emphasized children's basic needs as well as quite a developed list of psychological and social needs. UF caregivers added needs

such as “a safe place to play,” “the language of their tribe,” “culture and traditions,” “someone to listen to them,” “routine,” “to be with their family,” “comfort,” “good advice,” and “time with adults who will love them long term.”

Notably, twice as many caregivers in the UF mentioned the need for child protection and shelter as did the caregivers in the RF. This may be because caregivers in the rural setting take protection and shelter for granted, as their location is typically safer, whereas child protection concerns and lack of proper shelter are more prevalent in the urban environment. Also notable is that the caregivers in the urban setting created more extensive lists of children’s needs than did those in the rural facility. This may be related to the fact that the caregivers in the urban facility have received more formal training than those in the rural facility, or it could be that the rural environment and mindset is less complicated and more matter-of-fact. The rural caregivers mentioned discipline more often than did the caregivers in the urban setting.

OWT Domains. To relate the caregiver’s lists of children’s needs to the wellbeing domains in the assessment (OWT) that I administered to 96 adolescent residents of these institutions, I have created a visual representation to display the 10 domains of wellbeing in the assessment as well as how many of the caregivers listed needs from those wellbeing domains in their interviews (See Table 2). This can provide a representation of which domains of wellbeing the caregivers find especially noteworthy, and which domains of wellbeing are more-or-less taken for granted, or perhaps, less esteemed.

Table 2

Children's Needs as Reported by Caregivers (n = 14) in Interviews

Reported Needs	Number of Caregivers Who Reported			
	Urban Facility	Rural Facility	Total	% of Total
Food and Nutrition	6	6	12	86
Health	6	4	10	71
Education	5	4	9	64
Protection	6	3	9	64
Mental Health	5	3	8	57
Shelter	5	2	7	50
Economic	5	2	7	50
Family	3	3	6	43
Community	3	3	6	43
Spirituality	3	2	5	36

Caregiving Experience in the Institutional Setting

In the following pages, I will report what caregivers shared about their experience providing non-relative children with care in their current institutional settings. I will report on their motivation to take and keep the caregiving job, their self-identified caregiving strengths, the struggles they experience, training they have received and desire, their joys in caregiving, and their hopes and dreams for the children in their care.

Motivation to Work. During the course of the semi-structured interviews with the caregivers, thirteen of the fourteen women disclosed some of their motivations for working as caregivers in an institutional setting. I categorized those motivations into the following categories: sponsoring the costs of education (9), pursuit of a dream (9), lack of

options (5), financial support for biological children (4), internal motivation to care for children in need (4), enjoy working with children (3), and a desire to “pay it forward” (2).

Costs of Education. Nine of the caregivers said that they support someone’s education, whether their own children, younger siblings, a nephew, or a non-relative child. In South Sudan, school fees are required every few months, whenever a new school term begins. The continual financial need to sponsor children’s education is a strong incentive for these caregivers to remain employed.

Pursuit of a Dream. Nine of the caregivers mentioned dreams that they have for their own futures. Two of them want to be able to repay those who cared for them as children, by buying a car for an uncle and building a house for an aunt. Two of them would like to save money to go back to school for further studies. Two of them want the children in their care to speak well of them in the future. One desires to buy a plot of land and build a house. One hopes to start her own business. One hopes that the children currently in her care will support her financially one day; she hopes this job will provide her with future economic security if these kids will do well and remember her.

Supporting Children. Four of the women said they needed financial support for their own children. One had already signed custody of her children over to the institution and decided to seek employment there to be near them. One may have considered leaving the job, but needed the income and medical assistance that was provided for her child.

Lack of Options. Four of the caregivers expressed that they were in a crisis when they took this job. They felt they had a lack of options, but they took the caregiving job because it was available.

Two women were in desperate financial need when the opportunity became available. One of them was running from an abusive husband and learned of the job when she was trying to escape domestic violence. She said, “[My boss] invited me to come here to work so I wouldn’t be at risk of my husband.” The facility was a safe space; the job was a means for her to secure her independence and to provide for her children. One said she had “nowhere else to go.”

Concern for Children. Four of the caregivers expressed an internal motivation to serve the wellbeing of the children in their care. One caregiver stated, “I don’t want these kids to experience the same thing as their parents,” while another caregiver hopefully proclaimed, “Kids wounded hearts can be healed.”

Enjoy Working with Children. Three of the caregivers expressed a deep love and enjoyment of children since their own youth. They said they enjoyed working with children and liked the job.

Pay it Forward. Two of the caregivers mentioned how they had been helped in their childhood and spoke of a desire to reciprocate and serve others. One of them used the phrase “pay it forward.”

Strengths. Not all of the caregivers spoke of their strengths, though each caregiver was evidently strong in many ways. I am reporting only what they told me in our interview times. Three caregivers said they were good cooks and could train the children in their skills. One caregiver said she had knowledge of child development from her studies and work experience, which she was willing to share with other caregivers. One of the caregivers said she was good at “being with the kids,” which I also observed in her interactions with them. Another caregiver said she was gifted in helping children

resolve their conflicts. One caregiver said she was good at teaching the children right from wrong. And one caregiver said she was good at empathizing with the kids and understanding the situations from which the kids came.

Struggles. The caregivers reported nine areas of struggle, as follows: children's behavior (8), caregiver exhaustion (6), children's backgrounds (5), a sense that caregivers' best efforts fall short of what the children need (3), worry for caregivers' own children (3), institutional structure (3), uncertainty about children's future (2), sickness (2), security (1), and government corruption (1). Two caregivers said that they had no struggles or concerns.

Children's Behavior. The most prominent struggle that caregivers experienced was in regard to the children's behaviors. Caregivers specified different behaviors that they found challenging, including quarreling, disrespect, complaints, carelessness, school difficulties, and immaturity.

The most prominent complaint, made by six caregivers, was about quarreling of children amongst one another and quarreling between the children and the caregivers. When children disagree with one another, it changes the dynamic of the caregivers' work environment. Some caregivers commented on how children's quarrels cause them to feel lack of peace inside themselves. While some caregivers move toward the conflict to engage children in discussions and negotiation about the core issues of the conflict, other caregivers simply try to stop the acts of quarreling, i.e. "Stop the shouting." One caregiver told me that she gets so upset when some children quarrel with her that she stops talking to the child and leaves to find an administrative or supervisory staff person

to handle the conflict, mentioning fear of her own responses to the child when her emotions are running high. That caregiver explained,

The kids in my room are bad. They complain and fight, and they are the worst. So, when I say anything small, they insult me or refuse so that I complain to them... If they don't listen, I call [my boss] to sit with them and each one will give his or her side of the story. Then [my boss] will identify what happened and the problems and tell them what to do.

Some caregivers mentioned that quarreling between the children occasionally escalates to violence.

Four caregivers cited the children's disrespect of caregivers as a significant struggle for them. Several of them mentioned how some of the children will insult the caregivers when they are angry. "[The children] are rigid and they don't obey fast," one caregiver explained. When the caregivers press them for obedience, the children respond disrespectfully. "They talk back. They lack respect. They use abusive language," said one caregiver. She continued, "Not all the kids disrespect me, but some are very difficult... I can't blame them. They are not kids who grew up in a normal situation. They cannot reform in a day. It will take time for them to become real human beings." Another caregiver explained the children's disrespectful behavior in this way, "Some kids are created with stubborn personality and nothing will change."

Three caregivers said that the children's complaints were a significant challenge for them. "These kids work together in groups, and still they complain about their chores," said one caregiver.

One mentioned that the children are very careless with their belongings, often losing or damaging things. This caregiver mentioned that the institution is spoiling them and teaching them to remain careless by replacing what is lost or damaged.

One caregiver mentioned the difficulties that the children face in school as being a particular challenge for her. The children will come to her after being beaten by a teacher and tell her about the difficulties they are facing at school. She tries to listen to the children, but encourages them to behave. “I have ever been a child. I would tell my mom, ‘The teacher beat me for no reason,’ when I was knowing the reason. So, I don’t take the child’s side. I encourage them to behave and obey the teacher.”

One caregiver mentioned that some children “never grow up.” She was frustrated by adolescent children who are not behaving as responsibly as she would expect them to behave. Some of the residents at the institution are still there after turning eighteen because they have not yet completed their secondary studies. She says of those children, “[They’re] growing up and they need to be independent, but they still call themselves children after 18 years!”

Caregiver Exhaustion. Six caregivers expressed their exhaustion in the work of caring for children in the institutional setting. Two of them specifically mentioned the heavy workload, while the other four spoke of general exhaustion from constant caregiving and behavior management. The models of care between the two institutions are slightly different, but in both locations, caregivers carry responsibility for a group of 4-12 children of different ages. They also share shift duties like cooking, washing clothes, and supervising the children. “[These kids] make me suffer so much... [they] give me gray hair,” said one caregiver, commenting on how tired she was of raising her voice to get the children to obey.

Children's Backgrounds. Five of the caregivers said that the children's backgrounds and families of origin provided ongoing challenges in the caregiving environment.

Several caregivers were concerned about the situation of children who were separated from living biological parents. Some children living in institutional care were orphaned and have no living parents. Other children were taken into institutional care because of abuse, neglect, or because their parents are indigent. "Some [of those children's] parents are still keeping [other] kids on the street," a caregiver explained. Children in care often remember their living parents and siblings in the communities, miss them, and worry about them. "Kids need their parents," one caregiver told me.

Some parents brought their children to institutional care on false pretenses (i.e. stories of the child being orphaned) in the hope that an institutional care setting would provide education and a future that the parents feared they could not provide. Those parents, a caregiver explained, "Are still destroying their children's lives."

One caregiver drew a connection between the children's backgrounds and the children's behaviors, saying, "If a mother is diligent, her child is diligent. If a father is lazy, his son is lazy." While some caregivers indicated that a child could unlearn bad behaviors, other caregivers believed that behaviors and character traits were fixed in children based on their parents and their family of birth.

One caregiver was concerned about forced marriages. She referenced a situation where a family member of a child in care had come to the institution to demand that the girl be married. In South Sudan, forced marriages sometimes occur, where a woman or a girl is sold to be someone's wife. Although the situation the caregiver referenced ended

without the girl being taken from the institution, this caregiver was concerned that other families of origin would return and take girls from the institution for the money they could make from an early forced marriage.

Best Efforts Fall Short. Three of the caregivers spoke of discouragement they face in this work when they feel they are inadequate in their service of the children. Two expressed inadequacy in helping the children feel loved, and one expressed inadequacy in helping the children change their behaviors.

Two caregivers were concerned that the children were not feeling loved. One caregiver emphasized multiple times in our interview that one of the most important things children need is “love and care,” but she feels that despite her love and care for these children, her love is unable to meet the need the children have. In her words,

However much we try to give love to the kids – ok – they will get the love, but you cannot compare with the child who has grown at home with normal parents, like blood parents... the parental love, they *need* that, you know? That natural love is not there... I am trying to give them all the love and care, but for the child, they know that they are here because their parent cannot care for them. It can affect them. They might say, “Ah – if not for my parent being poor or not having a proper house – or things like that – I would have been with my parent.” You know, a child can think things like that.

Although many caregivers expressed frustration with the behaviors of some children, only one caregiver verbalized a sense that her best efforts to help the children change were failing. Several caregivers stated that children are unable to change – they simply have good character or bad character. Other caregivers stated that change took time. The caregiver who expressed frustration about her ability to help children change also mentioned wanting to get further education to learn how to be more effective.

Worry for Her Own Children. Three of the caregivers mentioned struggling with their separation from their biological children. To work this job, some caregivers are

separated from their own biological children. They send money home to their children, call them regularly on the telephone, keep tabs on them through family and neighbors, and visit home whenever they can, but the caregivers' work schedules and their children's school schedules make these visits brief. In the struggle to push their own children ahead, they cannot be with them. One of them explained,

I am worried for myself because of my kids. The time that we have together is really very small... So, it's a challenge to me that I cannot read their behaviors. So, this is a big challenge... The moment when they have gone home, I have to talk to them [on the phone]. Everyday, I have to call them. I need to know from my neighbors. I have to talk to my neighbors to watch them. This is what I am doing now. Sometimes, it makes me to think so much. I need to take time to be with my kids, otherwise, they will not see me like a mother.

Institutional Structure. Three caregivers expressed concerns about the structure of the institutions where they worked.

One caregiver stated that the nature of an institution slows down the process of providing attentive care to each child because children's needs must be filtered through a process. She told me that in a home with proper parenting, the parent would immediately respond to a child's request or explain to the child why the need cannot be met. But, in this setting, the caregiver must take the request to the administration. She said, "The kids will sit and call me, saying, 'I have an issue,' but I cannot solve it. I just send it ahead to the administration." The administration can take a week or longer to respond to requisitions from the budget. The process can be long and discouraging for the child, who feels the caregiver is unresponsive to his or her needs. This caregiver felt that needs were better met and caregiving was more responsive in a home, as opposed to an institution.

One caregiver said there were too many children per caregiver. She was concerned that caregivers could not meet the children's needs adequately.

One caregiver expressed concerns about the purpose underlying the institutional structure. Before her work at this institution, she believed that institutions for children existed to provide temporary care for children before reuniting them with their families. After working here for several years and seeing the children remain here long-term, she is confused about the purpose and goals of the institution.

Uncertainty About Children's Future. Two caregivers expressed concerns about the future of the children in their care.

One was concerned about what will happen to the children with disabilities when they have grown up. She expressed doubts that the institution would remain open indefinitely or that it would continue to care for adults with disabilities. She said her only hope for the child in her care was that another institution would open to take care of adults with disabilities.

One caregiver expressed concerns that the children were being set up for failure. Instead of being raised for independence, she felt the children in care were relying too heavily on resources that would one day dry up. She described the children as “spoiled,” because they were given everything they needed and were not held accountable to be responsible, productive, or independent. She felt there was no adequate plan for reintegrating them into the communities, but she said she would not ask the administration about that because she wanted to keep her job. In her own words, “Bringing children from [bad situations] and building them here – sometimes I am so confused. I don’t know what is the end of these kids later... when they are brought here, some of them have their fathers and mothers... I don’t know the end of these kids because I don’t know the plan. “

Sickness. Two caregivers stated that sickness on the compound was a concern.

Security. One caregiver said that she was concerned about people breaking into the institutional compound and robbing them.

Government Corruption. One caregiver mentioned her concerns about government corruption in South Sudan. Her concern was that government employees would corrupt justice for children if they received pressure from powerful people or bribes.

Training. When caregivers were asked about trainings they had received, they mentioned trainings on child protection (4), case management (3), trauma training (1), hygiene and safety (1), psychosocial support (1), and gender based violence (1). One of the institutions had provided significantly more trainings than the other. Caregivers at the urban institution reported receiving multiple opportunities for training on many occasions, while caregivers at the rural institution reported receiving far fewer opportunities for training.

When asked if there was any training they would like to receive, caregivers from both institutions named further trainings they desired. They named the following trainings: counseling, mental health/mental illness, anger management, how to care for children with special needs, and how to teach kids.

Joys. I asked caregivers what brought them joy in their work with the children. Caregivers mentioned taking delight in the funny things that children say. Two caregivers said they are joyful when the kids behave well. One caregiver mentioned taking joy when the kids are healthy. One said she was joyful when the kids confide in her. One of the

caregivers mentioned that she was very happy because of her employer, “Our boss provides for all of us like her children. We have no worries.”

Hopes and Dreams. Caregivers discussed their hopes and dreams for the children in their care, which fell into the following categories: to have good families (10), to do well (10), to get good jobs (7), to finish their studies (6), and to be people of faith (3).

Good Family. When the caregivers discussed the good families that they hoped the children in their care would attain, they described these realities in different ways. Their understanding of “good family” had different emphases. Some caregivers were child focused, describing the needs of a new family unit that the child would form. Other caregivers were family focused, emphasizing the future of the child’s biological and institutional family as it exists today. And, some caregivers were community focused, viewing the children’s future families as conduits of community transformation.

Child focused caregivers described “good family” as children being able to “find love,” “get married,” “own homes,” have “good relationships,” and “make better families than the ones from which they came.”

Family focused caregivers described “good family” as children growing up to “remember me,” “help their caregivers,” and “visit me and I visit them.”

Community focused caregivers described “good family” as children becoming adults who “serve their communities,” “lift their communities out of poverty,” and “follow our footsteps” opening children’s homes “if worse comes to worse” and the need for institutional care is not eradicated.

Do Well. Ten caregivers expressed general sentiments that the children would “do well.” Some specific statements under this general theme included that “good things will

happen” for the children and that they would “be responsible for themselves,” “know how to behave,” and “fulfill their dreams.” Two caregivers focused on health and wellbeing of children with disabilities, saying that they hoped the child would “be all right,” noting that they were uncertain about the future of children who would likely never become independent.

Good Jobs. Seven caregivers mentioned hopes that children would grow up to get good jobs. Several caregivers listed the jobs they hoped for, which included: doctors, social workers, lawyers, teachers, drivers, and “big people.” One simply stated that she hoped the children would find good jobs so they could “be independent.”

Finish Studies. Six of the caregivers mentioned hopes that the children would finish their studies. Not all of those caregivers mentioned what level of education they hoped the children would attain, but several of them stated that they hoped the children would finish secondary school or even university if they were able.

People of Faith. Three of the caregivers mentioned their hope that the children in their care would always be people of faith. These caregivers were also those for whom faith was emphasized as a number one priority in their own childhoods.

Adolescent Children’s Wellbeing Assessments

Ninety-eight adolescents from the two institutional settings were assessed with the Orphan and Vulnerable Children Wellbeing Tool (OWT). In this section, we will review the results of the wellbeing assessments (see Table 3), with the goal of understanding in which wellbeing domains the children in these settings are doing better or worse. We will examine the data to see if UF and RF have similar wellbeing scores, or if children in one

setting have significantly better wellbeing than those in the other. We will also see if the data support that boys and girls do equally well, or if one gender has higher wellbeing. Finally, this section reports back the qualitative feedback that adolescents offered while taking the wellbeing assessments, giving some qualitative richness to the quantitative wellbeing scores.

Table 3

Adolescents' (n = 98) Wellbeing Scores by Domain

Wellbeing Domain	Mean	<i>SD</i>	Min	Max
Shelter	2.6837	.34639	1.67	3.00
Food	2.6190	.36136	2.00	3.00
Spirituality	2.6105	.42874	1.00	3.00
Education	2.6031	.31538	1.80	3.00
Protection	2.3997	.38290	1.50	3.00
Mental Health	2.3291	.38726	1.25	3.00
Health	2.3240	.39322	1.00	3.00
Economic	2.1105	.45906	1.00	3.00
Community	2.0986	.42057	1.33	3.00
Family	1.8767	.49282	1.00	3.00
Total Score	23.6283	2.03407	1.00	3.00

Note. Each wellbeing item was scored on 3-point Likert scale, where 1 = none of the time, 2 = some of the time, and 3 = all of the time.

Wellbeing Scores by Location. An independent samples *t* test was conducted to determine whether adolescent residents at UF had similar scores as adolescent residents at RF, based on the wellbeing assessments conducted of children at both institutions (see Table 4). Data screening showed that scores in each group met the assumptions of normality. The assumption of homogeneity of variance was tested using Levene's test,

$F(1,14) = .27, p = .60, ns$; indicating that the assumption of homogeneity of variance had not been violated. Therefore, the pooled variance independent samples t test was used. The groups did not differ significantly, $t(94) = -.541, p = .59, d = .56, 95\% \text{ C.I. } [-1.41, .81]$. The mean wellbeing score for the adolescents in UF ($M = 23.38, SD = 2.36$) was not significantly different than the mean wellbeing score for adolescents in RF ($M = 23.68, SD = 1.98$). The Cohen's d effect size was $-.15$, a small effect size (Cohen, 1988). These findings do not support the idea that the adolescents in one institution are doing better than another.

Table 4

Wellbeing Scores by Location

	<i>N</i>	Mean Score	<i>SD</i>
Urban Facility	16	23.3760	2.36123
Rural Facility	80	23.6788	1.97517

Note: Highly desirable scores are 25 or above. 23 has been observed to be common among groups of vulnerable children, indicating room for improvements in certain domains. Nearing 22 or below may indicate deficits in domains, and scores below 15 require immediate intervention (Senefeld, Strasser, Campbell, 2009).

Wellbeing Score by Gender. Another independent samples t test was conducted to determine if adolescent boys in care of these institutions had similar wellbeing scores as adolescent girls in care of these institutions (see Table 5). Data screening showed that scores in each group met the assumptions of normality. The assumption of homogeneity of variance was tested using Levene's test, $F(1,14) = .036, p = .85, ns$; indicating that the assumption of homogeneity of variance had not been violated. Therefore, the pooled variance independent samples t test was used. The groups differed significantly, $t(94) =$

5.37, $p = .000$, $d = .38$, 95% C.I. [1.27, 2.77] . The mean wellbeing score for the male adolescents ($M = 24.89$, $SD = 1.73$) was significantly higher than the mean wellbeing score for the female adolescents ($M = 22.87$, $SD = 1.83$). The Cohen's d effect size was 1.13, a large effect size (Cohen, 1988). These findings tell us that a typical male adolescent in care at these institutions will score higher on this wellbeing assessment than 84.13% of the female adolescent respondents.

Table 5

Wellbeing Scores by Gender

	<i>N</i>	Mean Score	<i>SD</i>
Males	36	24.8931	1.72538
Females	60	22.8694	1.82601

Note: Highly desirable scores are 25 or above. 23 has been observed to be common among groups of vulnerable children, indicating room for improvements in certain domains. Nearing 22 or below may indicate deficits in domains, and scores below 15 require immediate intervention (Senefeld, Strasser, Campbell, 2009).

To ensure that there was no distinct difference between the wellbeing of female adolescents in UF and RF, we split the data by gender and ran an independent samples t test by location (see Table 6). Data screening showed that scores in each group met the assumptions of normality. The assumption of homogeneity of variance was tested using Levene's test, $F(1,14) = 3.04$, $p = .49$, ns ; indicating that the assumption of homogeneity of variance had not been violated. Therefore, the pooled variance independent samples t test was used. The groups did not differ significantly, $t(58) = 1.145$, $p = .257$, $d = .54$, 95% C.I. [-.47, 1.71] . The mean wellbeing score for the female adolescents in UF ($M = 23.34$, $SD = 2.44$) was not significantly different than the mean wellbeing score for

adolescents in RF ($M = 23.71$, $SD = 1.57$). The Cohen's d effect size was .34, a small effect size (Cohen, 1988). These findings do not support the idea that female adolescents in one institution are doing better or worse than the female adolescents in another.

Adolescent Voices. Some of the adolescents volunteered more information to clarify their responses as I assessed them during the wellbeing assessment. To add depth to the quantitative data, I will report their feedback below in line with the ten domains of wellbeing from the OWT.

Table 6

Female Wellbeing by Location

	N	Mean Score	SD
Urban Facility	15	23.3356	2.43835
Rural Facility	45	22.7141	1.57496

Note: Highly desirable scores are 25 or above. 23 has been observed to be common among groups of vulnerable children, indicating room for improvements in certain domains. Nearing 22 or below may indicate deficits in domains, and scores below 15 require immediate intervention (Senefeld, Strasser, Campbell, 2009).

Family. Adolescents from these two institutions had the lowest mean wellbeing score in the family domain. During this part of the wellbeing assessment, many of the adolescents shared about their families. Some of them have living parents and siblings, some are orphaned but maintain contact with relatives, while others were orphaned and have lost contact with their extended families.

While a few of the adolescents expressed that they consider their caregivers and the other children at the institutions as their new family, a larger number of adolescents told me that they do not view the institution as their family at all. Instead of viewing

themselves as vulnerable children who need families, many of the adolescents described themselves as children who have been given an opportunity for education. One adolescent explained it this way,

The culture [of this place] is that this is our home where we can gather in the future. But, to be completely honest, we are not family. We are like people staying in a hotel, renting from a different tribe, but you go home and you don't know yourselves. It's like a boarding school. You come together from different places and tribes, but when you leave – you don't know each other. Just schoolmates. That's what this place is like.

One of the questions in this section of the wellbeing assessment asks the adolescent if he or she has someone at home who will take care of them if they are hurt or sad. Children frequently became morose when I asked them that question.

Of the caregivers at the institution, one child said, "I have taken problems to the adults, and they don't take it serious." Another adolescent said cynically, "If you trust people, they return back to you problems."

Several teenagers said they were in contact with their biological family members and would reach out to them when in trouble. One girl said that her uncle is the person she would trust to take care of her. Another adolescent said, "I talk to a leader here [at the institution] or my sister in the nearby neighborhood." Another girl mentioned, "I talk to my great aunt [who lives outside the institution]."

During this section of the assessment, some adolescents were clearly grieved by the separation from or loss of their family. "Sometimes, the picture of my mom comes to me, and I cry. I worry about her. I just want to go see her."

One indicated that she wished her siblings were able to live with her. "I worry about my family," she said. "It is very important for brothers and sisters to be together –

to live somewhere – and Mom visits them.” It seemed this child did not anticipate being reunited to live with Mom, but wished that all the siblings could live together.

Some children indicated that the institution where they live does not allow them to see their families. This problem seemed to have arisen when the administration tried to deinstitutionalize many of the children in care to live with family members. Children who received regular visits from family members were the first to be sent back to live with their families, however those children returned to homes where there was poverty and inadequate resources to support them. One adolescent explained,

Most parents don’t visit here anymore. They had been coming, but then [the administration] said the kids would be sent home [if they had families that could care for them]. Some kids sneak to see their families. Some kids refuse to see their families... they won’t visit their parents, for fear of being sent home. Some kids even deny their parents. The fear is being sent home without a way of being supported.

Older teenagers especially expressed their concern with the lack of family relationships. Another adolescent explained the situation this way, “We aren’t allowed to see our parents – unless [the administration] wants to chase us home. If we went home to stay with our parents, they couldn’t take care of us well. The school fees aren’t there, and we would be hungry. So, up to now, as big as I am, I don’t know my parents at all.”

One boy’s eyes overflowed with tears as he told me, “I am very bitter with [the administration] for refusing that I can visit my family.”

A number of the adolescents expressed that they do maintain contact with their extended families or living parents, indicating that they visit their families regularly in the local community or occasionally “meet them accidentally,” though they do not necessarily feel close to their relatives. Some of the teenagers suggested that the administration could consider sending the kids home to visit their parents during school

holidays or hosting a family day, where all their family members could come and reconnect with them. One adolescent argued that it was very important for children to maintain relationships with their families as it would motivate them to do their best in school and grow into good adults, recalling how one boy had been impacted after a visit with his family, “[One of the boys] changed after going to visit his family. He changed totally after seeing the way his family is. They told him to put energy into his studies. Now he’s not lazy or stubborn, but putting all energy. He doesn’t complain. He knows where he came from and understands everything.”

Sadly, it seems that some of the children who came into institutional care as young children or who have been institutionalized far from their birthplaces have completely lost contact with their relatives, original languages, and cultural customs. This disconnection from family has profound consequences. As one adolescent told me,

In this culture of South Sudan, families are important. If you ask these kids, some don’t even know their families. They don’t know the place [where their families live.] ... If [this facility] was ever closed, these kids will end up all in the street because they don’t know where to go... These kids grow up not knowing their family, village, culture. [One of the adolescents who finished secondary school] struggled to get her national documents because she couldn’t answer questions about her family, tribe, home area. Her saving grace was speaking the tribal language. [But, some of these children] don’t know their language, don’t know their culture, don’t even know their real names.

One girl told me that she has forgotten her language and has no contact with her family. One boy told me he was very afraid that he would not be able to reunite with his family after he grows up. He feels alone and isolated in the world, and he fears what will happen when he finishes school because he does not think he could manage to remember where his family lives. “I only worry about my family. They forgot about me.”

Community. During this section of assessment, some of the adolescents (mostly girls) mentioned that they had little interaction and no relationship with people in the community. Another adolescent said that community members have advised her to use her stay in the institution to make a future for herself, “This is a golden chance that you have got. Don’t lose it.”

Some adolescents mentioned being insulted by people in the community, who called them “orphans” and “compound kids.”

From their comments, it seems like the male adolescents had more favorable interactions with members of the local community than girls. The boys occasionally go into the community to help their neighbors farm. “Sometimes they thank me or give me money,” one boy told me. Community members also occasionally advise the teenagers to obey the rules and “stay well” at the institutional facility.

The teenage boys also interact with the local community through sports. “In football, if I injure myself, someone from the community could carry me on motorbike. But if we defeat the neighbors on the soccer field, we are fearing fights later.”

When asked if they felt “welcome to attend religious services,” the adolescents who responded negatively commented on the institutional administration and not on the surrounding community. “Sometimes I have no interest in going to church, but they force me to go,” said one teenager. In response to this question, another young person said, “Children have no rights here. [The administration] may force you to do what you don’t like.” And another adolescent stated, “If I want to go to another church, they don’t allow,” indicating that children were required to attend services at a particular church.

Economic. Adolescents expressed some confusion about the questions in this domain. “Do you want to know if my family at home has money to care for me?”

Many of the kids commented on the poverty they experienced at home, often explaining to me how they could not return home because their parents cannot afford to take care of them. “My dad has no work,” one adolescent told me, while another commented, “Poverty is the reason I am here. My family is poor.” Another adolescent told me how, before coming to live at the institution, she was responsible for bringing in income for her family.

When I asked one young person about the family having enough money to buy the necessities, this adolescent told me, “I was instructed by my family that I should not talk about this one.”

Health. In the health domain, young people mentioned the kinds of ailments that worried them, including heartburn, headaches, stomachaches, coughing, flu, malaria, typhoid, infections, eye pain, eczema, acne, and menstrual problems. One young person told me, “My buttocks is paining, and I am remaining short.”

Larger than any of their specific health concerns was the concern that a few children expressed, that the caregivers, staff, and administration of the institution were generally unconcerned about their health.

“They will ask symptoms, but don’t give malaria tests,” said one young person, “They just give us [malaria] medication when it might not be malaria.” Another adolescent expounded,

When you are sick, it’s hard to be sent to the doctor or hospital. Paracetamol [similar to Tylenol] is the normal one they give when you have a stomachache or something, but it’s hard to go to the hospital until it’s very bad.

They accuse the kids of pretending when [we say we are sick] and send us to school.

“They don’t respond as soon as is needed,” one of the children stated, and another expressed this sentiment, “Sometimes I get malaria and fear I’ll end here.”

Mental Health. Many of the adolescents don’t feel like they have anyone to trust at the institutional facilities. One adolescent told me, “There’s totally no adult I can trust. I don’t tell [caregivers] if I have a problem. I just keep it inside my heart.”

Some of the kids named caregivers or staff with whom they felt comfortable talking, however, many children felt betrayed when those individuals shared their secrets with the administration. One adolescent said, “Sometimes I can talk to [a certain staff,] but she doesn’t keep secrets. That can become a problem.”

One told me a story of his disappointment when he requested something he needed and nothing was ever provided. His request was continually referred to other staff, but never fulfilled. Since then, he feels ignored and frustrated. “I have no adults I can trust.”

Reflecting, after completing the wellbeing assessment, one of the youth said this,

If I could change anything, it would be an adult that I could trust. You cannot find an adult you can trust because they are coming and going. At school, I can’t find someone I can trust because they are all listening to one person about how we behave. The head teacher says we are doing like this and this... Important for an adult I can trust is to keep my secret... Why can I not trust the [caregivers]? One day I told something to one of them, and she went and told all of the other [caregivers]. It made my heart to pain. That is why I don’t trust any adult. She said she will not tell anyone, but afterwards, all the [caregivers] knew.

Many of the adolescents identified “quarreling” and false accusations as a problem at the institutions, mentioning their sadness when they are caught up in a conflict

or accused of something they did not do. “I get sad when people complain and bring problems about me.”

The environment of secret-telling, conflict, and accusation has caused a number of the youth to internalize their worries. “I keep quiet and work things out myself,” said one girl. Another adolescent said she occasionally confides in friends, but, “Sometimes I cry alone.”

Protection. In this domain, many of the adolescents reflected on their own privilege relative to the kids living around them in the neighboring community. “We are loved well here,” said one youth, “Not like the neighbor kids.” One of the girls said that the difference between her and children living in the surrounding community is a “good difference. We have school fees, books, pens, and clothes.” Another young person acknowledged, “We have needs provided for us that outside kids don’t get.”

Some of the young people did not compare themselves favorably in relation to the neighbor kids. One expressed sadness that the caregivers “don’t look at us as their own children,” feeling the absence of parental love that the neighbor kids presumably experience. Another young person said, “[The administration] is harsh with us when we make mistakes.”

In this domain, many of the girls mentioned being afraid of the neighbors in the community if the neighbors had been drinking alcohol. The girls spoke of walking quickly and in groups to avoid encountering a drunk person. “When I run into drunkards on the way, sometimes they chase us and we run back to the compound. If I see a soldier with a gun, I fear.” One young person added, “This time of war, I’m fearing rebels. We can’t move freely.”

Education. Some students reported being treated differently from their classmates at school, describing the difference as either a “good difference or a bad difference” depending on the day or the situation. Sometimes, out of fear of retribution from the staff at the institutions, the teachers would avoid caning the students, but one student complained that teachers ridiculed students, calling them names and attacking them for their living situations. In her words, “[Teachers] have problems with us. They separate us. We are doing well, and still they hate us. They call us ‘[name of institution] children.’ I like to learn, but sometimes I don’t like school because of the teachers.”

Other adolescents reported getting beaten by their teachers at school. Ridicule and beatings were both reasons other students reported disliking school.

When it came to supplies, for the most part, kids reported having all the school supplies they needed. “If I need any supplies for school, and it’s there, I just have to ask. They will give it to me,” one boy explained.

Spirituality. While some of the children complained about being forced to go to church in the community domain of the wellbeing assessment, most of the children responded very positively to the questions about their personal spirituality. One boy said, “Before I came to this compound, I didn’t know about God. But, now, my life is different in a good way.”

Another young man reflected on who God was to him, “When people are hungry, God gives them food. When people are thirsty, God gives water. When their leg is broken, God fixes it.”

Some of the children seem to have turned to spirituality in the face of a lack of certainty and a lack of trustworthy confidantes in their lives. One such adolescent said, “I never trust anyone. I trust God alone.”

Another young person described her experience in these words, “I don’t waste time telling people here [about my problems.] Sometimes I ask if I need something, and they give what I need. But I worry... Sometimes I miss my family and don’t feel good. I just talk to God. I pour it all out there.”

One adolescent spoke of turning to prayer when she felt depressed to experience a sense of escape from her sadness, “When I’m in a dark place, I call on God, and I’m out of here. When I’m sad, I see myself in an empty box. When I’m happy, I’m in a candy brain. My brain is so sweet. In the dark box, sometimes I see a light, but the dark closes it out. If I call on Jesus, the light comes and takes me to the candy of the brain.”

Food. Although most of the adolescents responded that they ate at least two meals a day and had adequate food, a number of young men and women reported going to bed hungry on the occasions when they came home late from school after the food had been served. A few youth also said that they went to bed hungry on occasions when they didn’t want to eat the meal that had been prepared.

Shelter. Although a majority of the adolescents responded that they always had a safe place to sleep and always felt secure in their neighborhood, a large group of adolescents wanted to talk about why they *didn’t* feel safe where they live.

“I’m fearing the adults,” one child said, and another expounded, “I fear [the caregivers.] If you do bad to them, they curse you. They will say, ‘If you argue with big people, this thing will stay in your life forever.’”

One child mentioned that there was “fighting on the compound,” speaking of quarreling between the children and administration. “When we quarrel, I fear someone will beat me.”

Another child mentioned that those kids who misbehaved were labeled problem children and could not get free from that designation, “Sometimes the director and [caregivers] see some of us kids as good and others as bad.”

Another adolescent stated that caregivers often exhibit prejudicial judgment toward children from different parts of South Sudan, “The caregivers separate us kids. If a child urinates or steals something, they blame those kids who came [from far away.]”

“The [staff] are always crying or criticizing us all over the compound for small things. The [caregivers] do the same,” said another adolescent.

One young woman explained, “Sometimes we quarrel here, but when there are no problems, I am safe.”

Not all the comments about feeling safe at the facilities were negative, however. One adolescent said, “This place is awesome. We do special activities. It’s too much fun,” and another adolescent said, “I think it’s good for kids to grow up in a place like this. We sleep well and eat, and also playing is allowed. That is good for the children. When we do bad, they talk to us. They don’t beat us like at home with my uncle. If we keep doing bad, they give us punishment to teach us.”

One girl explained how she oriented new arrivals to the home. She advises younger children that they can really enjoy their lives at the institution if they follow the rules. She tells them, “Behave well. Respect [caregivers]. No fighting or abusing brothers

and sisters. Go to school and come back all together. If the [caregivers] ask something for you to help – do it. Be happy all the time, even while you’re sleeping.”

DISCUSSION

The purpose of this study was to examine the nature and dynamics of caregiver-child relationships at institutional facilities in South Sudan through observations of caregiver and child interactions, semi-structured interviews with caregivers, and wellbeing assessments of the adolescent children in care. This section will discuss how the results reported in the last chapter answer the research questions listed in the methodology section. We will examine caregivers' and children's understandings of the purpose and nature of their relationship as well as the children's needs and wellbeing, before discussing the strengths of this study, its limitations, and recommendations for further analysis and future research.

Purpose and Nature of Caregiving Relationship

In the interviews, caregivers disclosed their backgrounds and family narratives. The majority of caregivers spoke very positively of their parents and their experiences of being parented. The positive parenting behaviors that the caregivers' parents employed in raising them are very similar to the behaviors that caregivers employ in raising their own children, and those they report employing in care of non-relative children. See Table 7 below for side-by-side display of reported parenting behaviors for comparison.

Many of the caregivers emphasized that they provided the same care for institutionalized children as they would provide for their own children. The children, however, did not all perceive that to be true of caregivers. One child said that the caregivers "don't look at us as their own children," and many adolescents expressed a

sense of lack of family ties, emphasizing that their relationships with caregivers did not replace or satisfy their desire for familial relationships.

Table 7

Parenting Behaviors Reported by Caregivers

Caregivers' Parents' Parenting Behaviors	Caregivers' Own Parenting Behaviors
Role Modeling	Teaching
Life Skills:	Life Skills:
Farming	Farming
Housework	Housework
Cooking	Cooking
Childcare	Cleaning
	Washing Clothes
Teaching Values:	Character Traits:
Respect	Respect
Hard Work	Hard Work
Hospitality	Hospitality
Equality	Generosity
Love of Others	Good Manners
	Obedience
Resource Provision	Selfless Provision
Encouraging Education	Gentle Discipline
Emphasizing Faith	God's Help

Note. Behaviors of caregivers' parents and caregivers themselves are lined up to display similarities and differences in the parenting behaviors reported.

When asked about their own tribal affiliation, many of the caregivers emphasized that tribal or ethnic classification made no difference to them and had no impact on the care they provided to the children. The children, however, did not all perceive that to be true. Several children reported perceived differential treatment from caregivers because of where they came from. One child said that the experience of living in the institution

was like, “renting from another tribe,” indicating that this adolescent felt tribal difference was significant in relationship to the experience of being raised in institutional care. Some caregivers acknowledged that traditional values and culture are important to them, indicating that their own cultural beliefs and values are emphasized in their parenting style. It is therefore likely that those caregivers’ particular culture may impact children from diverse ethnic and tribal backgrounds by emphasizing certain values, expressions, or traditions while deemphasizing others.

One caregiver reported that tribal languages were not used in the institution, mentioning only the use of the “shared language” or trade languages of English and South Sudanese Arabic. Practices like these, intended to unify the caregivers and children and to create a fictive family, have the additional impact of raising children in an environment where they lose access to their particular language and culture. During wellbeing assessments, the older adolescent children commented that their years in the institution had led to the loss of their tribal languages and sense of ethnic identity. Some of them were worried about how that loss would impact them in their future beyond the institution, sharing anecdotes of how it had already affected others. Ethnic and cultural losses as a result of institutional care have been reported and observed in other African nations (Dziro, 2013).

In interviews with caregivers, they disclosed a variety of motivations, joys, and struggles in their work. However, there were some strong shared themes that emerged regarding their hopes and dreams for the children in their care. Caregivers most wanted the children to grow up and build good families, and many of those caregivers spoke of the institutionalized children as part of their own fictive families, expressing desire that

their relationship with the children would last throughout the remainder of their lifetimes. However, not all the children perceived a fictive family relationship with their caregivers. Rather, the children spoke of their purpose at the institution being related to getting their education and launching them into a successful future.

The more I listened, the more it became apparent that the caregivers and children do not perceive their relationship in the same light. It is possible that, due to observer effect, the caregivers reported their beliefs and actions in what they thought would be a more favorable light. Perhaps the caregivers do hold conscious biases against certain children which they were unwilling to admit. However, if I assume the caregivers reported attitudes and behaviors that they do consciously hold and proactively attempt to enact, it could be that caregivers experience some level of cognitive bias and unknowingly fail to express their attitudes, beliefs, and behaviors in ways that effectively communicate their care to the children.

I believe the difference in perspectives between the caregivers and children represents an important hurdle for these caregivers to bridge with the children in their care. Chikwaiwa and colleagues (2013) advised that programs serving children must be “child-focused” and work to provide children with mentors in whom they can confide. Further caregiver training may be helpful in equipping caregivers with the strategies and skills necessary to understand, respect, and value the perspectives of children in their care. The adolescent feedback in my study expressed recurring disappointment and a lack of trust in caregivers. Staff emphasis on simple things like honoring one’s word to children (or not making promises which cannot be kept), soliciting children’s input and feedback in situations that affect them, and validating the children’s experiences may go

a long way in helping these children feel heard and valued. These behaviors may build an environment in which children begin to regain trust for the adults in their lives.

Although a caregiver may wish to serve as fictive family, that caregiver will never be able to replace the mother that gave birth to the child. In the case of children who have been orphaned, their grief should not be downplayed or mocked, and efforts should be made to maintain connections with their extended families and tribal group. In the case of children who have been separated from living parents, the pain of that separation should also not be downplayed or mocked, and the administration should build in opportunities for the child to maintain contact with his or her family and tribal heritage. The children themselves made suggestions on how that could happen, recommending family visits during school holidays or regularly scheduled “family days” where relatives could come to see the children at the institution. Family certainly should not be undermined or forgotten by the adults responsible for the children’s care.

Children’s Needs and Wellbeing

When discussing what children need to grow up well, caregivers most emphasized the material needs of children, such as food, hygiene, medication, education and safety. Adolescents in the two institutional care facilities reported their highest wellbeing scores (>2.6) in the shelter, food and nutrition, and spirituality domains. It’s notable that adolescent children report highest wellbeing in domains related to their material needs, particularly shelter and food. This corresponds with earlier studies on institutional care in Africa (Zimmerman, 2005). A number of adolescents acknowledged that they felt a sense of privilege to be living in institutional care because their material and educational needs

were met. This privilege was mentioned relative to the children living in the surrounding communities. Such relative privilege may explain why friendly community members advise institutionalized children to behave well and use the “golden chance” they have, while unfriendly community members reportedly mock and ridicule institutionalized children, perhaps out of jealousy. This also may explain why institutionalized children would be afraid to leave the institution, despite a deep feeling of loss at the separation from family members and a longing to maintain familial connection. Although the children’s comments and wellbeing scores indicate that living in an institution provides a sense of security for their material needs, their sense of social wellbeing is lower. Table 8 ranks the caregivers’ emphasis of children’s needs alongside the children’s mean wellbeing scores by domain.

Table 8

Caregiver Emphasis of Child Needs and Child Wellbeing Scores in Ranked Order

Caregiver Emphasis	Mean Wellbeing Scores
1. Food	1. Shelter
2. Health	2. Food
3. Education	3. Spirituality
4. Protection	4. Education
5. Mental Health	5. Protection
6. Shelter	6. Mental Health
7. Economic	7. Health
8. Family	8. Economic
9. Community	9. Community
10. Spirituality	10. Family

Note. This table displays which needs of children caregivers most emphasized alongside adolescents’ mean wellbeing scores, ranking the domains from highest mean wellbeing score to lowest mean wellbeing score.

Adolescents reported their lowest wellbeing scores (1.87 and 2.09 respectively) in the family and community domains. Unsurprisingly, the family and community domains of wellbeing were much less emphasized by caregivers in their discussions of children's needs. Although most caregivers who emphasized children's material needs reported that children received very good care at the institution, several caregivers expressed concerns that the institutional environment made caregiving less attentive and responsive than caring for a child in a home environment. Many of the adolescents reported that they had been disappointed when approaching caregivers or institutional staff about their physical or emotional needs, only to be, as they perceived it, ignored or put off. A sense that their voices were not heard or valued by the administration of the children's home emerged in many of the adolescent comments. This sense of disappointment that children reported frequently led to children adopting a learned sense of distrust of caregivers and administration. Some children's comments reflected feeling betrayed or unloved, and one child stated, "I have no adults I can trust." This distrust of adults is a significant detractor to adolescents' social and emotional wellbeing, since, according to Chikwaiwa (2013), the quality of a child's relationship with an adult directly influences child wellbeing.

In the interviews, caregivers least emphasized spirituality in their discussion of children's needs. This is notable, because spiritual wellbeing scored as one of the children's highest domains of wellbeing. When speaking about spirituality, the children very often connected their relationship with God directly to their sense of a lack of family or the lack of an adult that they could trust. Children very often reported turning to God to satisfy their need for someone trustworthy to listen to them.

Although the Urban and Rural Facilities provide care in different environments, are structured differently, provide different training for their caregivers, have caregivers from different generations and educational backgrounds, it is interesting to note that children's mean wellbeing scores were not significantly different across the institutions. It's also interesting to note that children's wellbeing was relatively higher in material wellbeing and lower in social and emotional wellbeing, corresponding with findings from past studies of African institutional care (Friedus, 2010; Morantz & Heymann, 2010; Zimmerman, 2005).

It appears evident that the needs most emphasized by caregivers relate positively to the children's mean wellbeing in the emphasized area. When most caregivers emphasize material needs, the children's material wellbeing scores reflect that. This is good, as it indicates the caregivers' corporate ability to influence child wellbeing in these domains.

However, the influence may not only be that of the caregivers. If all of the caregivers at these institutions suddenly desired to emphasize the social and emotional wellbeing of the children in their care, would they be able to do so? Some caregivers expressed concerns that the institutional structure itself was problematic and detrimental to child wellbeing as it created an environment where, by nature, caregiving was less attentive, less responsive, and more bureaucratic. Those concerns align with children's feedback about their social and emotional needs being ignored.

So, does the structure direct the caregiving or do the caregivers define the structure? One caregiver reflected on how she did not know what the purpose of the institution was. Although she felt confused and wondered how this facility was helping

children prepare for independence and healthy adulthood, she chose not to raise her concerns with the administration for fear of losing her job.

Cause and effect is difficult to tease apart in a complex institutional environment. Perhaps that complex nature is reason enough to advocate for family-based care of children separated from their parents. In keeping with South Sudan's draft policy on children without parental care (Ministry of Gender, 2008), institutional care settings should be the last resort for children separated from their parents. However, like Abebe and Aase (2007) described, family-based care in which material needs are unmet is no better than institutional care in which social and emotional needs are unmet. Organizations and governments can work to equip and strengthen families in poverty and to support children's educations while keeping children in family-based care. In cases where children are institutionalized, the administration should structure the facility to cater for children's social and emotional needs. This may mean hiring more caregivers to ensure a favorable caregiver to child ratio, designing the institutional setting to closely mimic the nature, size, and permanence of a family home, and to make child-centered decisions that prioritize attentive and responsive care. Caregivers in such institutions should be trained to understand diverse human needs, with a special emphasis on children's social and emotional wellbeing. Caregivers primarily emphasized the same things that their parents emphasized in raising them. They spoke of learning to be parents by observation and mimicking their parent's behaviors. Caregiver education should involve role-modeling and must be applicable to the felt needs of caregivers. Some of the trainings which caregivers at these institutions requested include: counseling, mental health/mental illness, anger management, how to serve children with special needs, and

how to teach the kids. Because caregivers mentioned many of their own childhood traumatic experiences and requested trainings to help them learn about mental health and emotional regulation, I believe institutions would benefit by providing trauma counseling and psychosocial education to caregivers for their own wellbeing. Caregivers' mental health is a direct moderator of the mental health and development of the children in their care (Howard, 2017), and greater mental health among caregivers could lead to caregivers' greater emotional availability to the children in their care. Caregivers also spoke of their own exhaustion and experiences of overwork. Administration of these institutions should take care to protect and invest in the wellbeing of caregivers by encouraging appropriate cycles of rest and self-care, while limiting the intake of new children if caregivers are overburdened. If at all possible, institutions should not be permanent placements for children, but children should be given permanent placement in families with adequate support.

Strengths

This study revealed how caregivers and children experience two institutional environments in South Sudan, and notably, how they experience it differently. This is an early study of institutional care in South Sudan (the researcher has not found any other academic studies on care of children in South Sudan), and it contributes to the literature on forms of alternative care for children separated from their parents in Africa. This study can educate the administration of these two institutions on the ways caregivers and children experience institutional care. It may serve to help the administration and caregivers improve or transform the model of alternative care, make efforts to strengthen

children's wellbeing in family and community domains, and inform future trainings for caregivers on how to better relate to the children in their care.

Limitations

One limitation of this study is that the results are not broadly generalizable, although they do paint a picture of the caregiver-child relationship at two particular institutions in South Sudan.

Another limitation is that the wellbeing assessments were only conducted at the institutional care facilities. There is no meaningful baseline data of this assessment conducted on South Sudanese children living with their parents in good homes or of South Sudanese children separated from their parents in other forms of alternative care. For this reason, we cannot know if the children assessed are doing better or worse than other children within the South Sudanese context; we can only determine in which areas of wellbeing they are doing better.

Civil war erupted in South Sudan during the data collection period. It is impossible to know, but the conflict may have influenced the data collection process in ways of which I am not aware. I was occasionally surprised at the candor of the participants, and I wonder if the volatile environment and the emotional toll it was taking on us all caused them to open up more than they otherwise would have done. Other participants maintained a closed posture and emotional distance. They also may have been coping with their stress. Children and caregivers may have responded to interview questions and wellbeing assessments differently under the stress of the conflict than they would have done had they responded in a different climate.

Further Analysis

Further analysis of my data set could look at the relationship between children's wellbeing scores and their total years of institutionalization, children's wellbeing scores and their age at assessment, and children's wellbeing scores and their age of intake at the institution. This analysis investigates the hypotheses that children who have been institutionalized longer have lower wellbeing, that age at assessment may influence wellbeing, or that adolescents institutionalized before the age of six may have lower wellbeing than adolescents who were institutionalized later as John Bowlby (1952) predicted.

Future Studies

Future studies on the topic of alternative care in South Sudan could be conducted using the OWT. A baseline wellbeing assessment could be conducted on a sample of South Sudanese children being raised by their parents in good homes. The assessment could also be conducted on children in different forms of South Sudanese alternative care (such as relative foster care, non-relative foster care, adoptive homes, or orphan headed households), to see which forms of alternative care for children separated from their parents leads to greatest child wellbeing. This rapid assessment could be conducted annually on any of these populations (including my study population) to map the change in child wellbeing over time and to continually elicit valuable feedback from the children themselves about their experiences and to improve forms of alternative care for children.

Further studies could also look at interventions in institutional care settings to educate and equip caregivers to meet children's social and emotional needs. Is the

education effective? What caregiver behaviors change after the training? Is the behavior sustained? Does it impact child wellbeing?

Any structural or programmatic changes that are made in institutional care settings, such as instituting annual family visits on school holidays, could be monitored and evaluated for their effectiveness and impact on children's wellbeing.

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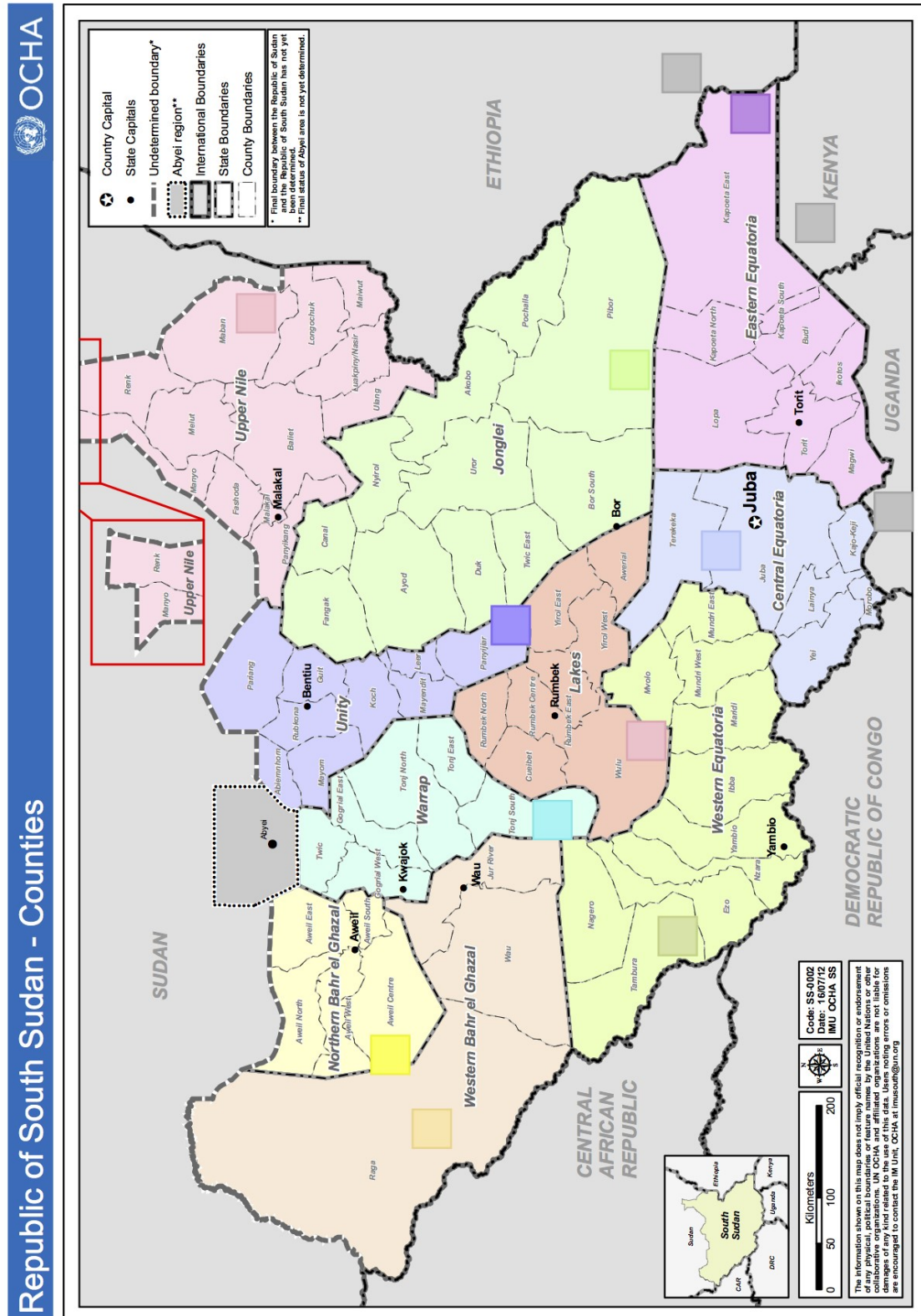
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APPENDIX A

2015 Map of South Sudan and Researcher Notes



Researcher Notes
on Institutional Care Facilities in Different Regions of South Sudan,
from 2015 Internet Search (page 1 of 2)

Western Bahr el Ghazal:

- Good Shepherd Home -Kids Alive International - Wau "family style setting" 12 (Canada)

Northern Bahr el Ghazal:

- Aweil Bible College (ABC) - plan to build orphanage on 360 acres in 2011, Malek
- New Life Ministry - Nyamlell (Border of Darfur), funding from Make Way Partners, James Luall** 450+

Warrap:

- Nyuol Gidbuong Helpinghand Charity - Turalei**
Manute Bol and widow, education, 37 kids in community care

Unity: None Found

Upper Nile:

- SOS Children's Village - Malakal (families) 140 // RELOCATED TO JUBA
- The Good Shepherd Orphanage Project - Jikao/Jikow (founders Dukan Diew and Kong Toang)**
- ASAH - Duk Payuel, 4

Jonglei:

- Deng Opportunities Foundation, Sudanese Diaspora sponsoring orphan education**
- Bor Orphanage and Community Education Project (BOCEP): Australian sponsored project, feeding project and eventually an orphanage (fundraising now) - partnering with Anglican church? 44+

Lakes:

- In 2001, 3,500 child soldiers demobilized to Rumbek by UNICEF and then reintegrated to their families
- South Sudan Orphan Education program - Abiyei Achok, Cueibet County, Australia funding **

Western Equatoria: None Found

Researcher Notes
on Institutional Care Facilities in Different Regions of South Sudan,
from 2015 Internet Search (page 2 of 2)

Central Equatoria:

- New Generations Dreamland Yei, Sudan for Christ Ministries - 120, Pastor Stanley LoNathan**
- SOS Children's Village - (families) 110 (30 fled north) // Relocated from MALAKAL
- Friends of Juba Orphanage - 78, started by foreigners, run by Sudanese, gov't, <http://jubaorphanage.org/>
- Confident Children out of Conflict - Juba 40+
- Harvesters - Terekeka (50)
- Harvesters - Yei (100) govt donated land
- Grace Home for Children - Yei UMC
- Yei Children's Village - IrisSouthSudan(130)
- Greenland Home for Children - Kenyi UMC
- St. Bartholomew's Orphanage - Kajo Keji, Canadian started, 150+
- Jalimo Orphanage Primary School - Jalimo/Kajo Keji/Kanyapo II Payam, 72

Eastern Equatoria:

- Angels of East Africa -Children's Village - Nimule, Magwi (MGP, Sam Childers) 200+
- Cornerstone Children's Home - Nimule, 80+
- IrisSouthSudan- Chukudum, 26
- Hope for South Sudan-MakeWayPartners (borderofuganda)
- Social Action Orphanage Organization (SAOO) - Kapoeta ** 104

Ethiopia Refugee Camps:

- *Gambela (South Sudan Gospel Mission Alliance)
- *Matar
- *Roaring Lion Orphanage - Matar** 80+? 3,800? Stephen Chambang, 712-730-1432 Stephen@RoaringLion.info
- *Gambella - Jing of Hope**

Kenya Refugee Camps:

- African Soul American Heart (ASAH) - Kakuma, 8

Ugandan Refugee Camps:

- ASAH- Moyo, 29

*As of 2015 internet search, website indicated these institutions were still in development.

**As of 2015 internet search, website indicated these institutions were founded, operated, and/or funded by South Sudanese citizens, or South Sudanese in the diaspora.

APPENDIX B

Inequity in Terminology

A vital question with which practitioners and researchers have wrestled is how to operationalize the word *orphan*. The generally accepted definition, popularized by the United Nations, is that an orphan is a child (0-17 years old) who has lost one or both parents (UNICEF, 2014). However, many international non-governmental organizations and local organizations in Africa provide funding and programming, not only for orphans, but other vulnerable children as well. The World Bank (2005) introduced the term *orphans and vulnerable children* (OVC) when they released a toolkit to advise their staff on development projects in Africa. The term orphans and vulnerable children has been adopted by many researchers and organizations concerned with child welfare in Africa and developing nations, and the definition of “vulnerability” has been critically evaluated by some (Schenk, et al., 2008).

As explicated by the World Bank (2005), vulnerability is a conflation of risk factors. Being orphaned, defined as the loss of one or both parents; separation from living parents; parental neglect; food insecurity; educational deprivation; abuse; discrimination on the basis of tribe, background, or gender; sexual or other exploitation through child labor; or the abduction or conscription as a child soldier are all categories of vulnerability wherein African children may be categorized. But, the term itself, “orphans and vulnerable children”, raises fundamental questions about disparate terminology in international research and geographically differential responses to child welfare in our globalized 21st century.

In September 2015, I searched multiple journal databases (PsychINFO, Academic

Search Complete, SocINDEX, Social Work Abstracts, and ERIC) using the term “orphans and vulnerable children”. I found 172 scholarly articles. 137 of these articles were written about OVC in Africa, 21 were written about OVC in Asia (China, Cambodia, Indonesia), 11 were international studies written about OVC in low-income nations, and 3 were written about OVC in North America (Haiti and Mexico). These articles discussed OVC in the context of HIV/AIDS, poverty, rural contexts, immigration, and the drug war. The term has been used exclusively to describe children and youth in the global south or developing world. In the United States, I have never heard this term used to describe a foster child, a transgender youth, a hungry neighbor, or a child growing up in a single-parent home. Would it be a good idea for me to label those young people orphans and vulnerable children?

I am glad that language is dynamic. However, when I see terms being coined by powerful, native English speakers and operationalized specific to class or geography, I wonder why. Language can be used to give dignity, or it can be used to sideline and ghettoize. I have chosen not to adopt the term “orphan and vulnerable children” for my writing about African children because I would not use this term in writing about American children or youth. Mine concern is for social justice in my use of language.

APPENDIX C

General Organizational Informed Consent

Consent to Participate in a Research Study Missouri State University College of Child and Family Studies

Exploring the Caregiver-Child Relationship at an Institutional Care Facility in South Sudan Dr. Joan Test and Jennifer Telfer

Introduction

Your organization has been asked to participate in a research study. Before you agree to participate in this study, it is important that you read and understand the following explanation of the study and the procedures involved. The investigator will also explain the project to you in detail. If you have any questions about the study or your role in it, be sure to ask the investigator. If you have more questions later, Dr. Joan Test, the person mainly responsible for this study, will answer them for you. You may contact the investigators at:

Jennifer Telfer - Jen86@live.MissouriState.edu

Dr. Joan Test - JoanTest@MissouriState.edu

You will need to sign this form giving us the organization's permission to be involved in the study. Taking part in this study is entirely your choice. If you decide to take part but later change your mind, you may stop at any time. If you decide to stop, you do not have to give a reason and there will be no negative consequences for ending your participation.

Purpose of this Study

The reason for this study is to learn about the relationship between caregivers and children separated from their parents in South Sudan. Because your institution has been providing care for children separated from their parents since 2006, the caregivers and children here are experts on this topic. There is much I can learn from them.

If the administration of this facility is willing to welcome me, I would like to learn from their stories and experiences through observations of caregiver-child interactions, relaxed conversation with caregivers and children, and by administering a simple assessment of children's wellbeing (using Catholic Relief Services' Orphan and Vulnerable Children Wellbeing Tool).

If you agree to be part of this study, you will permit the facility's children and staff to participate in the study, including the following:

1. Permitting the researcher to:
 - a. Observe and participate in day to day life at this children's home
 - b. Work alongside and interview the caregivers, to observe and learn from them
 - c. Administer the Catholic Relief Services' Orphan and Vulnerable Children Wellbeing Tool (OWT) to the adolescent children in care
 - d. Make notes, take photos, and make audio recordings
 - e. Review case files and organizational documents as a method of crosschecking and verifying information gathered in interviews and observations
2. Work with Jennifer Telfer and her local research assistant throughout the course of the study
3. Allow the researchers access to the facility during the month of July 2016
4. The study is not expected to take the caregivers away from their normal duties, as the researcher will come alongside them in their routine tasks for observation and conversation. Orally administering the OWT will require 15-20 minutes per child.

Before leaving your organization, at the end of my time, I will share with administration the main themes I have observed or learned during my observation and data collection.

What are the risks?

Risks associated with this study include any discomfort or stress the caregivers and children may feel by the investigator's presence or questions. If any form of abuse is disclosed to the investigator, the investigator will report the abuse according to the organization's child protection policy, or in absence of a child protection policy, to the relevant authority in the Ministry of Gender, Social Welfare, and Religious Affairs, according the Children Without Parental Care policy of South Sudan.

What are the benefits?

Your facility may not benefit directly from this study. However, the information from this study may help me and others to care for children who are separated from their parents. I hope, but cannot promise, that what I learn will be helpful in designing future trainings for caregivers at your institution if desired.

How will my privacy be protected?

If your organization agrees to this study, but later decides to withdraw that agreement, the investigator will stop the study. Caregivers and children do not have to spend time with the investigator, and even if they choose to spend time with the investigator, they do not have to answer any question asked. If caregivers or children choose not to spend time with the investigator or not to answer any question, there will be no problem and no consequence from the investigator.

To prevent any unanticipated backlash against caregivers or children, the investigator will not share the information that any individual discloses directly with your organization's administration, other children, or other caregivers and staff. Written results of the study will aggregate the data to prevent identification of any participants. The final thesis will not reveal participants' names, and the investigator will work hard to maintain confidentiality of the caregivers, children, and your organization, should you require that. I will store the information shared with me on a password protected computer. Before publishing my paper, I will crosscheck the information with your administration to ensure validity, to give you the first look at my results, and to allow you the choice of whether or not to publish the thesis with your organization's name associated.

The raw data of this study (field notes, photos, audio recordings, individual responses to wellbeing assessment) are confidential and only the investigators will have access to the information which will be kept in a password-protected computer and a locked facility at the University. The data will be aggregated so the identities of the caregivers and children will be protected and remain confidential in published reports of this research. The name of your organization will not be disclosed unless you wish to be associated with the finished thesis and any subsequent published reports of this research.

Consent to Participate

If your organization wants to participate in this study, **Exploring the Caregiver-Child Relationship at an Institutional Care Facility in South Sudan**, you will be asked to sign below:

I have read and understand the information in this form. I have been encouraged to ask questions and all of my questions have been answered to my satisfaction. By signing this form, I agree voluntarily to participate in this study. I know that I can withdraw from the study at any time. I have received a copy of this form for my own records.

Signature of Director of Participating Organization

Date

Printed Name of Participating Organization

Signature of Person Obtaining Consent

Date

APPENDIX D

Assent for Child Residents

ORAL ASSENT KIDS

At my university, I am studying to learn good ways to care for children separated from their parents. I can learn a lot from you because you know what it's like to live in this place. I would like to learn from you by asking you questions about your life and watching your relationship with the mamas who care for children here.

When I go back to the USA, I will write a paper about what I learned here.

You don't need to answer my questions if you don't want to. It won't affect you badly if you don't want to talk to me.

To protect your privacy, I won't tell the mamas, staff, or administration who told me what, and I won't use your name when I write the paper for my university.

Do you have any questions about this now?

Will you let me learn from you?

If you have questions about this after I leave, you can have staff get in touch with me or contact me directly on Facebook or email.

(share contact information)

Script in Local Arabic of South Sudan:

Fi jama tai, ana b'agara teriga ta ainu wara iyal al ma be geni ma abu wo uma toumon. Ana bagder alimu min itum hajat ketiir ashan itum aruf kways geni hini kafe le itum. Ana der alimu min itum be asalu itum asila ---?--about your life--?--- wo be ainu.....your relationship with the mamas who care for children here. (still needs final translation and back-translation)

Can ana rija wara fi America, ana be katifu waraga le jama bi tai an hajat al ana elimu hina.

Inta ma jobu suwal tai can inta ma der. Ma be augu inta can inta ma der wunso le ana.

Ashan be hami neksia taki, ana ma be worii le iya staff ou mama jena yato wunso de wo amulu de, wo ana ma be katifu issimat takum can ana be wodii waraga de le jama tai.

Inta indu ye suwal?

Intum be sibu ana elimu min intum?

Can intum indu suwal badin, asal takum. Au can intum indu suwal bad ana rua, intum bo worii le staff cali worii le ana – au intum be worii le ana. Yao de malumat tai ou bi ta jama tai.

APPENDIX E

Informed Consent for Caregivers

ORAL INFORMED CONSENT

Script in English:

At my university, I am studying to learn good ways to care for children separated from their parents. I can learn so many things from you because you care for these children every day. I would like to learn from you by working with you, watching you care for children, and asking you questions. I might take notes, pictures, or record our conversations to remember what I am learning. I would love to understand more about how and why you care for the children.

When I go back to the USA, I will write a paper for my university about what I learned here. What I learn might help other people to care for children better, and it might help me learn what kinds of trainings are good for people doing this job.

If you don't want me to watch you caring for children, you can ask me to leave, and I will leave. If you don't want me to take notes, photos, or record a conversation, you can ask me not to, and I won't. Also, you don't need to answer my questions if you don't want to. It won't affect you badly if you don't want to talk to me.

To protect your privacy, I won't tell any of the staff or administration which mama said or did anything, and I won't use your name when I write the paper for my university.

Do you have any questions now?

Will you let me learn from you?

If you have any questions later, please ask me. Or if you have questions after I leave, you can have staff get in touch with me or contact me directly. Here's my contact information and the contact for my university.

(share contact information)

Script in Local Arabic of South Sudan:

Fi jama tai, ana b'agara teriga ta ainu wara iyal al ma be geni ma abu wo uma toumon. Ana b'alimu min itum hajat ketiir ashan itum b'ainu wara iyal de kulu yom. Ana der alimu min itum be shokul ma itum, be ainu hajat al itum be amulu, wo be asalu itum asila. Itimal ana be katifu, shilo shuwar, wo be sejiil hajat al niina be wunso ashan ana be zekhiire tamam. Ana der afamu ketiir an le wo kafe intum be ainu wara iyal.

Can ana rija wara fi America, ana be katifu waraga le jama bi tai an hajat al ana elimu hina. Hajat al ana be elimu de miken be saidu bagi nus ashan ainu wara iyal kways, wo miken be saidu ana be elimu de yato derassa kways le nus al be amulu shokul de.

Can intum ma der ana ainu itum ainu intum, intum bagder turiju ana, wo ana be rua. Can intum ma der ana katifu au souru au sejiil mukalamat ta niina de, intum be worii le ana wo ana ma be amulu. Kaman, inta ma jobu suwal tai can inta ma der. Ma be augu inta can inta ma der wunso le ana.

Ashan be hami nehsia taki, ana ma be worii le iya staff de mama yato wunso de wo amulu de, wo ana ma be katifu issimat takum can ana be wodii waraga de le jama tai.

Inta indu ye suwal?

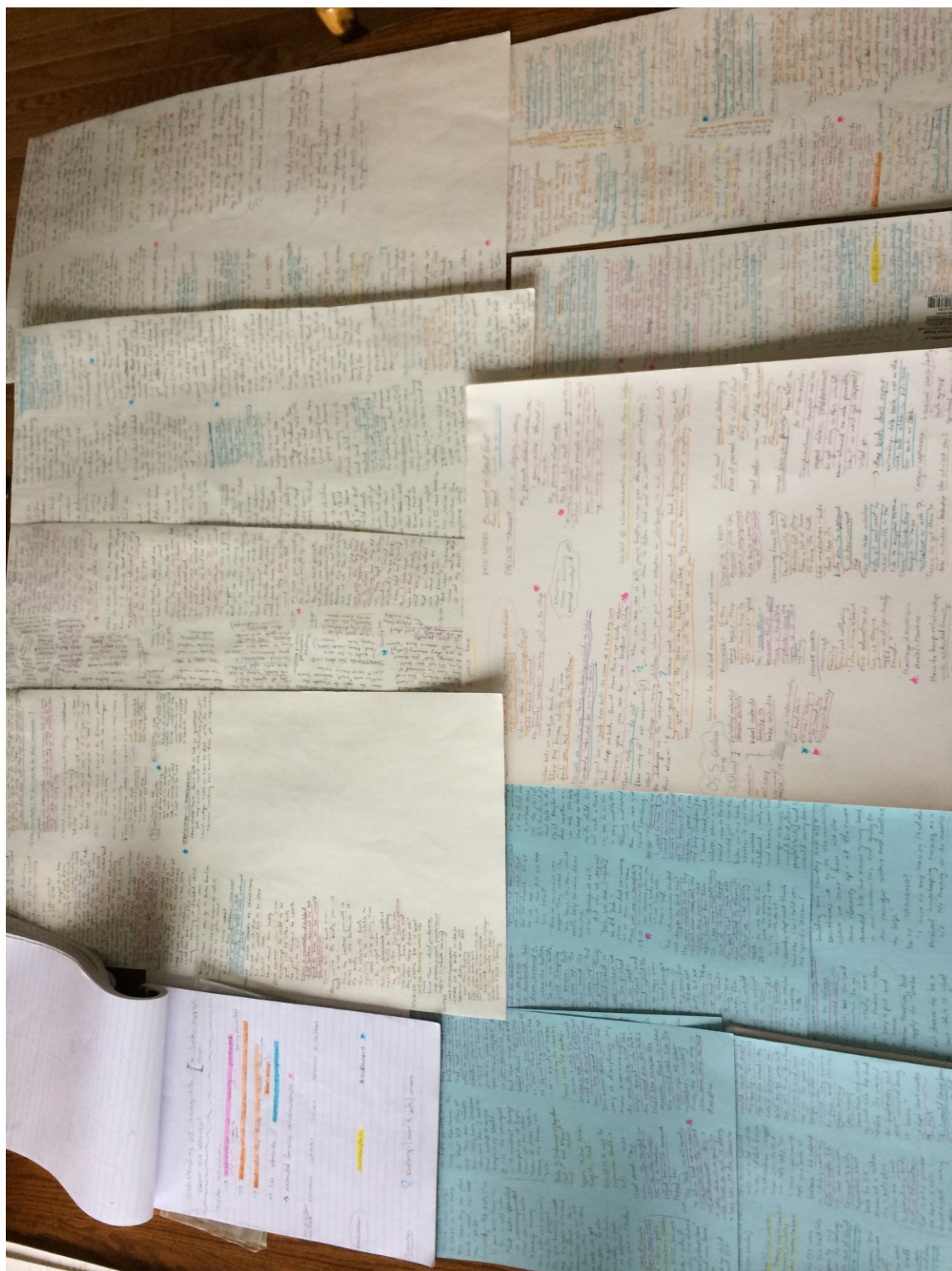
Intum be sibu ana elimu min intum?

Can intum indu suwal badin, asal takum. Au can intum indu suwal bad ana rua, intum bo worii le staff cali worii le ana – au intum be worii le ana. Yao de malumat tai ou bi ta jama tai.

APPENDIX F

Data Analysis Exhibit

Some of the translated caregiver interviews, with coding.



Field Notebook:

Scoring OWT and recording adolescent qualitative feedback during assessment.

1. 3	35. 2	shake head - then nodded.
2. 3	34. 1	"I don't know how to answer that question"
3. 1	35. 3	"I think these are important questions about how I am doing here."
4. 1	36. 3	"If I could change anything, it would be an adult that I could trust. You cannot trust an adult you can trust because they are coming and going."
5. 2		"At school I can't find someone I can trust because they are all listening to one person about how we behave."
6. 2		"The head teacher says we are doing like this and this..."
7. 2		"I like to learn, but sometimes I don't like school because of the teachers."
8. 2		
9. 3		
10. 2		"Important for an adult I can trust is to keep my secrets and that she or he can help me."
11. 2		"Sometimes people outside throw stones inside the compound when drunk."
12. 1		"I have only one friend at school. I didn't ask her if she has adults."
13. 1		"She can trust. I'm going to ask her."
14. 1		"Why cannot trust the aunties? The day I told one of the aunties she went and told all of the aunties. It made my heart to pity. That is why I don't trust any adults as said she will not tell anyone, but afterwards all the aunties know."
15. 1		
16. 1		"(one no other CCC children) teachers say we kids use medicine of witchdoctor to ward smart."
17. 2		"yes, in a good way."
18. 3		"you think you'll leave because you stay with white people. You think they'll take you somewhere, but they'll never take you anywhere in your life. Next year, I don't want to go back to that school. I don't know why they treat us differently - maybe jealousy - because their children aren't here (CCC), they begin abusing us - calling us 'you street children' this and this..."
19. 1		
20. 2		
21. 1		
22. 3		
23. 2		"when I'm sick, there is a nurse here."
24. 1		"not at all."
25. 1		
26. 1		"sometimes they visit - only my grandmother, but the rest can not."
27. 3		
28. 2		
29. 2		"sometimes I can think it's good, but I don't know it's bad."
30. 2		
31. 2		
32. 2		