The Scale, Scope and Impact of Alternative Care for OVC in Developing Countries

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Executive Summary

Background and Objective

Over 145 million children worldwide have lost one or both parents due to various causes, 15 million of these are due to AIDS (1,2); and many more have been made vulnerable due to other causes. The global community has responded by putting in place various care arrangements for these children. However, the scale, scope and impact of these alternative care approaches have not been well summarized. The aim of this literature review is to synthesize and analyze available data on alternative care approaches and the impact of these placements on the lives of orphans and other vulnerable children. Both the short-term and long term wellbeing of a child depends a lot on where they live and the care they receive in those settings.

Methods and Definitions

This was a review of literature on alternative care arrangements for OVC from 1981 to June 2009, utilizing both electronic and manual search strategies, and including both published and unpublished literature. PEPFAR defines an OVC as a child, 0-17 years old, who is either orphaned or made vulnerable because of HIV/AIDS. A child is vulnerable because of any or all of the following factors:\(^1\):
- Is HIV-positive;
- Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);
- Lives outside of family care (e.g., in residential care or on the streets); or
- Is marginalized, stigmatized, or discriminated against.

Alternative care is defined in this document as all residential care (either formal or informal) provided outside of the parental home. Such alternatives include: the extended family, foster families, group homes, orphanages, and community-based care. Family-centered care initiatives include programs focused on preserving or strengthening the ability of extended or foster families to absorb and effectively care for OVC without compromising the economic viability of the household and the health and wellbeing of other resident family members. Community-based care refers to a variety of community initiated and/or community led interventions, including family-strengthening, psychosocial support, empowerment, economic development, cash assistance; all provided within child’s own community and within a family or family-like setting.

\(^1\) Tom Lantos and Henry J. Hyde re-authorization Act which although does not specifically define OVC, it refers to “Orphans and children who are vulnerable to, or affected by, HIV/AIDS.”
Key Findings

There is much we do not know about the scale, scope, and impact of alternative care for OVC. The gaps in knowledge severely undermine our ability to understand the magnitude of the OVC crisis and, therefore, the specific care needs and effectiveness of current care initiatives.

What We Do Know

Three things we do know for certain are that:

1. **Extended families are shouldering the burden of care:** Ninety percent of children in developing countries separated from their parents by reason of death or other causes are living under the care of the extended family (4-7).

2. **The family care safety net has been overburdened to the point of near rupture:** Increasing numbers of OVC, high dependency ratios, poverty and HIV/AIDS have put increased socio-economic strain on households that have absorbed orphans. This strain is manifested as reduced per capita income, reduced per capita income consumption, reduced household investments, and negative impacts on both the orphans taken in and the caretaker’s biological children (6-8, 18, 44, 46-55).

3. **Long term care of young children in large orphanages is associated with attachment disorders and developmental delays in social, behavioural and cognitive functions** (35, 36, 38, 40, 72, 73).

What We Do Not Know:

1. **Magnitude of the OVC crisis:** While UNAIDS (1) and UNICEF (2) have recorded, over time, a fair amount of data on numbers of orphans and children living with HIV in developing countries; we know little about the number of children who fall into the combined category of orphans and vulnerable children (OVC). Variations in definitions (and in some cases non-existence of definitions) of vulnerability make estimates of numbers of OVC within countries educated guesses at best and, at worst, impossible. For this reason, accurate comparisons of OVC prevalence between countries are also not possible. Available data show that in a number of countries about 41% (24-58%) of children 0-17 years are OVC (3); however this figure is still an underestimate of the true magnitude of the crisis.

2. **Number of children in residential care:** We found very limited data on numbers of children in residential care in developing countries. With the exception of the extended family, data from four countries shows that this form of care is the most common form of alternative formal care (9). The lack of data on the numbers or circumstances of children being cared for outside of their original families makes it difficult for local child welfare authorities to monitor progress in preventing separation, promoting re-unification and ensuring the provision of appropriate alternative care (76).
3. **Short-term effectiveness of community-based care:** Research evaluating the short-term effectiveness of community-based OVC interventions is often cross-sectional in design and focused on collecting qualitative information. While such information is useful for understanding in detail the situation and needs of OVC, their households, and communities, it does not allow us to assess a causal relationship between the intervention and an objectively defined outcome. Community-based programs have a key role in providing psychosocial support (PSS) to OVC, but studies to evaluate the effectiveness of various PSS programs are limited, and so are the tools to do so.

4. **Short term effectiveness of child-centered group homes:** While a large body of literature documents the negative impact of large orphanages that focus on fulfilling a child’s basic need for shelter, food, and guardianship, only a handful of studies assess the short-term effectiveness of small group homes that attempt to cultivate a familial atmosphere. These studies include several from Eritrea comparing various short-term outcomes and anecdotal observations from children placed in a variety of residential settings, including large institutions, small group homes, foster-families, and biological families. In general, these studies present a complicated picture, showing better outcomes for children in residential care in some areas and in others for those living in foster care or reunited with family members (42-45). Likewise, two studies from China report ‘better’ or ‘similar’ quality of life for orphans in group homes versus those under kinship care (27, 59).

5. **Long-term impact of various forms of Alternative Care placements and support interventions on OVC wellbeing:** With the exception of orphanages, there is a dearth of evidence on the long term impact of other alternative care arrangements on the wellbeing of OVC; partly because impact measures have not been well defined in a number of areas of OVC wellbeing and partly because longitudinal studies that aim to follow cohorts of children and measure the impact of various OVC interventions over time are scarce. For example, apart from few studies on short-term effect of community-based psychosocial support (PSS) interventions (62-64, 75); little research has been done to systematically measure the long-term impact of many potentially effective community-based interventions. Cash-assistance programs are currently being evaluated in Malawi and elsewhere with promising findings indicating that monthly infusions of small amounts of cash can lift families out of destitution, improving food-security as well as nutritional, educational, and health outcomes (66-70). While these findings are promising, longitudinal impacts remain to be seen. One study assessed the short-term cost-effectiveness of household economic strengthening interventions (71), but their long-term impact and sustainability has not been evaluated.
Recommendations

1. Definitions of vulnerability need to be standardized across countries and donors. Consistent definitions of both orphaning and vulnerability will allow for easier identification and tracking, allowing us to get a better sense of the magnitude of the OVC population.

2. Well-designed longitudinal cohort studies directly linked to various OVC programs providing reliable data for the improvement of the quality, scale and coverage of OVC programs are urgently needed. Where cohorts cannot be constructed for various reasons, all OVC programs should start with baseline data to allow for impact evaluation over time. To know if OVC interventions are making a real difference in the lives of the children we serve, we must measure not just the short-term effects of our efforts but the long-term impact on the children’s social and economic development as adults.

3. While the extended family remains the main form of support for OVC in developing countries unless governments and the donor community redouble their efforts to sustainably increase the capacity of this safety net the quality of life of the children in these households, both biological and fostered, is in danger of worsening in vulnerable households.

4. More emphasis should be placed on interventions that reduce household poverty and increase household investments, such as cash transfers which have been shown to have positive impacts on child level outcomes in education, health and nutrition in vulnerable households. With support, family centered care through own parents or the extended family remains the most viable and sustainable form of alternative care option for vulnerable children. If families are economically empowered they should be able to take care of most of the basic needs of the children like education, health and nutrition.

5. In situations where a vulnerable child cannot be absorbed into the extended family system, small family-like group homes such as the SOS children’s villages would be the next recommended alternative for vulnerable children; considering that formal adoption is rare in developing countries. Available data from this review shows that group homes offer acceptable quality of care and did not reveal the negative impact on the wellbeing of OVC associated with institutional care; although the evidence is limited in both design and sample sizes. In addition the cost-effectiveness of this form of alternative care has not been fully evaluated, and their capacity to care for all those in need is limited.

6. For some children, family placement is neither available nor the best option due to previous abuse, mental health, or other special needs. The literature does not provide any guidance on how to identify these children, screen them, and facilitate residential placements that can meet their needs. Exploratory research on the most common needs and characteristics of such children is needed, as is research looking at the care provided to such children in both residential facilities and families.
Conclusion

This review has shown that the extended family system, currently taking care of over 90% of OVC is under extreme pressure, and unless governments and international development partners redouble their current efforts to increase the capacity of the families to cope, the quality of lives of foster OVC and all children in vulnerable households remain in danger. Interventions aimed at preventing and reducing child vulnerability and those that aim to reduce household poverty and increase household investments will go a long way in reducing the numbers of vulnerable children.

The current research evidence is limited to cross-sectional designs and the few longitudinal studies that are limited in length of follow up and age coverage for robust evaluation of long term impact of OVC interventions. There is therefore need to design and conduct longitudinal cohort studies that ask different questions, measure various OVC care variables over time, and provide a continuous set of reliable evidence for improving the scale and effectiveness of OVC interventions. To know if OVC interventions are making a real difference in the lives of the children we serve, we must measure not just the short-term effects of our efforts but the long-term impact of programs on the children’s social and economic development as adults.
1.0 Overview

Globally, about 145 million children have lost one or both parents as a result of various causes; 15 million due to AIDS (1,2). In addition many more are vulnerable due to various causes. The international community has responded to this challenge by putting in place various alternative care interventions in support of the affected children and households taking care of them. International development partners and national government ministries responsible for the welfare of orphans and other vulnerable children (OVC) require comprehensive and accurate data on numbers of OVC receiving care under various arrangements to plan for and monitor the response at national level. Clear definitions of the various care arrangements and interventions are important for general program design, implementation and monitoring, but more importantly for measuring effectiveness and impact of the OVC programs. Of equal importance is the need to measure the short and long-term positive, negative, and unintended effects of interventions. In order to do this, clear outcomes need to be defined at both child and household levels. OVC program staff and key funding and government stakeholders need to know the extent to which their efforts are working, make necessary adjustments to improve benefits, and mitigate unintended negative consequences for children, care providers, and communities.

The primary objective of this literature review therefore is to summarize the evidence on the scale, scope and impact of alternative care on OVC in developing countries. To the extent possible, the review will document the numbers and proportions of OVC under various care arrangements; describe the various alternative care arrangements and the positive and negative outcomes on OVC wellbeing associated with each care arrangement. The review will define the parameters for future applied research on issues that have not been properly studied or that are absent from the literature. The paper will present key findings, discuss the policy, program and research implications of the findings, and make recommendations aimed at improving the evidence base for the effectiveness and positive impact of OVC programs.

2.0 Methods and Definition of Key Terms

2.1 Definition of OVC

PEPFAR\(^2\) defines an OVC as a child, 0-17 years old, who is either orphaned or made vulnerable because of HIV/AIDS. A child is vulnerable because of any or all of the following factors:

- Is HIV-positive;
- Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);

\(^2\) http://www.pepfar.gov/guidance/78164.htm
• Lives outside of family care (e.g., in residential care or on the streets); or
• Is marginalized, stigmatized, or discriminated against.

2.2 Definition of Alternative Care

Alternative care or alternative child placement is defined in this document as all residential care (either formal or informal) provided outside of the parental home. Such alternatives include: the extended family, foster families, group homes, orphanages, and community-based care. Family-centered care initiatives include programs focused on preserving or strengthening the ability of extended or foster families to absorb and effectively care for OVC without compromising the economic viability of the household and the health and wellbeing of other resident family members. Community-based care is a more general term comprising a variety of OVC interventions, including family-strengthening, psychosocial support, empowerment, economic development, and cash assistance; initiated and/or implemented by the local community.

2.3 Literature Search Strategy

We conducted a systematic review of literature utilizing both electronic and manual search methodology to access both peer reviewed published and unpublished (grey) literature. We supplemented our literature review with secondary analysis of Demographic Health Survey (DHS) data from PEPFAR supported countries, and other data from UNICEF and UNAIDS on numbers of OVC and children’s living arrangements. To identify relevant studies, we reviewed the following online databases from January 1981 through June 2009: Ovid/Medline, PubMed, African Journals Online, Africa-Wide NIPAD and African Healthline, Child Development and Adolescent Studies, PsychInfo, Published International Literature on Traumatic Stress (PILOTS), Rural Development Abstracts, Sociological Abstracts, Social Services Abstracts, Web of Science, Google search, Google Scholar, Popline/One Source, and Public Affairs Information Service Archive. No language restrictions were applied. We also searched the following sites: UNICEF, BETTER CARE NETWORK, ICH MACRO, Measure DHS, International Social Service (ISS), USAID Development Clearinghouse, UNAIDS, WORLD BANK, and PEPFAR-supported countries-specific websites. We also contacted experts in the field for relevant literature. The original pool of 875 potentially relevant citations was narrowed down to 77 sources for inclusion in the review on Alternative Care.

3.0 Findings

3.1 Scale of the Crisis

While there is a fair amount of data on numbers of orphans and numbers of children living with HIV in developing countries; we know little about the number of children who fall into the combined category of orphans and vulnerable children. Variations in definitions of vulnerability make it difficult to come up with accurate numbers of OVC. For example, DHS uses a different definition of OVC from the broader country definitions, with the result that country prevalence figures are not easily comparable.
For instance, the Zambia DHS (2007) defined a vulnerable child as child below age 18 who has a chronically ill parent (sick for 3 or more consecutive months within the last 12 months) or who lives in a household where an adult has been chronically ill or has died in the last 12 months preceding the survey\(^3\); whereas the Zambian Ministry of Community Development and Social Services has a wider definition which includes the DHS definition\(^4\).

The only available data on OVC that attempts to take into account the variability in OVC definitions is from a study by Vinod Mishra and Simona Bignami-Van Asche (3). Using Demographic Health Survey data, they provide estimates of the size and distribution of the OVC population in eight Sub-Saharan African countries\(^5\) with adult HIV prevalence greater than 4%. In Figure 1, we present a summary of the data.

\textit{Figure 1: Percentage of children aged 0-17 years who are OVC in 8 Sub-Saharan African Countries}

This data shows that in these countries, using a broad definition of OVC\(^6\) and cognizant of the differences in definitions and years of estimations\(^7\), on average 41% of all children aged 0-17 years may be considered as OVC (median 39.2%); ranging from 24% in Kenya to 58% in Lesotho. Our own analysis

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\(^5\) Cameroon, Cote D’voire, Kenya, Lesotho, Malawi, Tanzania, Uganda and Zimbabwe  
\(^6\) Broad definition of vulnerability: Children who are orphans or live with chronically ill parents or adults, or live in households with HIV-infected adults, or live in households where an adult has recently died due to chronic illness, or live in households with no adults, or live in households with orphaned children.  
of DHS data from six additional countries where data was available reveals that the percentage of all children who are orphans ranges from 11% in Haiti to 21% in Rwanda (average: 14.4%, median: 15%); while that for OVC in five countries, using a narrow DHS definition of OVC\(^8\), ranges from 19.2% in Zambia to 29% in Rwanda (average: 23.7%; median: 26.2%).

The second source of data comes from UNAIDS and UNICEF. According to UNAIDS the number of children living with HIV (a category of vulnerable children) has been increasing exponentially between 1990 and 2007; and estimates are that globally 2 million children under the age of 15 years are living with HIV. During the same period, while there is an overall global stabilization of the HIV and AIDS pandemic, the number of orphans due to AIDS has exponentially increased, with current global estimates at 15 million (low estimate = 13 million; high estimate = 19 million). The number of orphans due to all causes is currently reported to be 145 million (1). Data on number of all categories of OVC by geographic area, age, gender, and care placement are not available.

**3.2 The Scale of Alternative Care**

Data on numbers of OVC in need of care, and numbers and/or proportions being reached with basic services is scarce. We also found little information measuring the scale of alternative care in terms of numbers of OVC under various care arrangements or placements.

Available data shows that over 90% of OVC in developing countries is taken care of by the extended family (4-7); and even when one or both parents are alive, a fair number of vulnerable children live with other members of the extended family.

We carried out secondary analysis of DHS data from ten PEPFAR supported countries between 2004 and 2008 on OVC living arrangements to get a sense of the scale of alternative care in terms of placement (Figure 3). Although living arrangements may evolve for many reasons, such data does give an indication of the numbers and/or proportions of children not under the care of their parents (i.e. under alternative care); cognizant of the fact that up to two-thirds of these children in some countries may be vulnerable (8). The limitation of DHS data is that it does not capture OVC under alternative care placements outside of households (i.e. those in children’s villages, other group homes, and orphanages). The data shows that, irrespective of OVC status, on average, only 56% of children live with both their parents; ranging from as few as 25.8% in Namibia to 89.4% in Mozambique (median=58%). The proportion of children not living with either parent ranges between 5.6% in Rwanda and 23.7% in Namibia, even though both parents are alive (median=10.7%). Data from three countries shows that on an average 22% of children do not live with their biological parents (Haiti 11.4%; Zambia 19.2%; Namibia 36.4%). The proportion of children not living with either parent because both were dead ranged from 1.2% in Tanzania to 3.8% in Rwanda.

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\(^8\) Narrow definition of vulnerability: A vulnerable child is one who is below 18 years who has a chronically ill (sick for 3 or more consecutive months the last 12 months) parent or who lives in a household where an adult has been chronically ill or has died in the last 12 months preceding the survey.
Belsey (8), in an analysis of national DHS data and data from Multiple Indicator Cluster Surveys in 34 sub-Saharan countries from 1995 to 2003, found the percentage of children living with both parents to range from 28% to 78% (mean 64%). In a study to evaluate the capacity of Malawi, South Africa, Swaziland and Zambia to manage alternative care systems for children, Dunn and Parry-Williams report that the proportion of children who live with both parents ranges from 62% in Zambia to 22% in Swaziland; with only 3-6% living with their fathers alone (9). On average, 22% of children in Zambia and Malawi and 38% in South Africa and Swaziland live with their mother headed households. The proportion of children living with neither parent varied from 12% in Zambia to 34% in Swaziland. According to the report, between 8.1% (Zambia) and 24% (South Africa) live elsewhere even though both parents are alive. The same study reports that ‘much remains unknown about the number of children in residential care in Sub-Saharan Africa because estimates are available for only a limited number of countries.’ The study found no system to collect data on either the number of children in formal residential care or on the proportion of children receiving informal care from non-relatives. From available data, the authors found that Residential Care was the most common form of alternative formal care in the four countries; with 396 registered children’s homes in addition to numerous unregistered homes which received no state oversight.
According to another UNICEF report (7) there were 7,500 children in residential facilities in Liberia and 5,000 in Zambia. These figures are based on government estimates and it is not clear whether the estimates are based on registered facilities or include some known unregistered institutions. In Zimbabwe between 1994 and 2004, 24 new institutions were built and the number of children in residential care doubled (Powell et al, 2005). In a survey of 329 institutions taking care of OVC in Central, Southern, Western and North-East provinces of Sri-Lanka, Save the Children found 15,068 children in institutions in four provinces alone (10). The institutions included remand homes, receiving homes, detention homes, schools, training centers, and voluntary homes. The report found that only 8% of children in voluntary, often labeled ‘orphanages’, were without both parents; and 50% of admissions to institutions were due to poverty. Another study by Save the Children found that 80% of children in non-state institutions/orphanages had at least one living parent (11). In Zimbabwe a cross-sectional survey involving administration of survey questionnaires to managers of all institutions, complemented by focus group discussions and in-depth interviews reveals that only 0.3% of the estimated 900,000 orphans at that time were cared for in institutions; 98% were cared for by their extended families and communities (5). Fifty-six children’s institutions had a registered capacity of 3,279 children and had 3,013 children in care at the time; over 50% of the institutions were dormitory style. The study also records that the number of institutions and institutionalized children had doubled over the ten years preceding the study. It is also important to note that 39% of the children had one or both parents and 59% had contactable relatives.

3.1.3 Scope of Alternative Care

The scope of alternative care for OVC is very wide and is defined and described differently by various authors under different contexts. In spite of the wide scope covered in the literature the various types of care arrangements or placements may be divided into three categories that are not mutually exclusive:

- Family-centered care
- Residential or institutional care
- Community-based care

a) Family-Centered Care

Although various authors use different terms, and we did not find one standard definition, the literature is full of the terms ‘family-centered’ or ‘family-based’ care (12-15) as the most preferred option for the alternative care of OVC. For the Joint Learning Initiative on Children and HIV/AIDS (JLICA), ‘families are social groups connected by kinship, marriage, adoption, or choice. Family members have clearly defined relationships, long-term commitments, mutual obligations and responsibilities, and a shared sense of togetherness.’ And the family-centered approach is a ‘comprehensive, coordinated care that addresses the needs of both adults and children in a family and attempts to meet their health and social care needs, either directly or indirectly through strategic partnerships and/or linkages and referrals with other service providers’. JLICA does not, however, specifically define the family in the context of alternative care for OVC nor what constitutes
‘family-based’ or ‘family-centered’ care in an OVC programming context. JLICA also reports that there is a dearth of literature and respondents who either defined family-centered care, a strategy for family-centered care, or offered a model of a family centered approach. Both the Framework for Protection, Care and Support of OVC and the UN Draft Guidelines on Alternative Care refer to ‘family-based’ care, but do not define it; the latter also refers to ‘family-like care placements,’ which may refer to small group homes or children’s villages (see later). Despite the lack of a standard definition, it appears clear that family-centered alternative care includes any of the following:

- Kinship/Extended family care
- Foster care
- Supported child-headed households
- Adoption

Family-centered care includes the following categories of care that Belsey refers to as ‘non-parent-headed family household’ (8):

- Kinship-based foster care;
- Non-kinship-based foster care;
- Kinship-based adoption;
- Non-kinship-based adoption;
- “Grandparentalized” families (grandparent-headed family households);
- “Parentalized” child-headed families (child-headed family households)

**Foster Care, Kinship Care, Extended Family Care**

The terms *foster care*, *kinship care*, and *extended family* are defined differently by different authors, but on the whole they are used interchangeably in literature. According to the Better Care Network, the term *foster care* is used in a variety of ways, and, consequently, it often causes confusion and miscommunication. In industrialized countries, it refers to formal, temporary placements made by the state with trained, monitored and compensated families. In many developing countries, it is kinship care or other informal placement with a family; in most cases not regulated by the state; although it may be formal, typically provided by adults who are not related to the child, but may include formalized kinship care. Kinship care refers to the full-time care of a child by a relative or other member of the extended family; and hence is essentially synonymous with the term ‘extended family care;’ and is usually arranged without formal legal proceedings. In most developing countries, it is essentially the only form of alternative family care available on a significant scale (Better care Network). Kinship care has also been defined as ‘a form of alternative care that is family based, within the child’s extended family or with close friends of the family known to the child (16). According to Meintjes kinship care may be court-ordered or formal (17).

The DHS literature from the 1990s defines foster children as ‘children under the age of 15 years, living in households with neither their mother nor their father present.’ Madhavan in a paper

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9 http://www.measuredhs.com/pubs/pdf/FR106/02Chapter02.pdf, Ghana DHS 1998, table 2.3 foot note 1, same definition used for all DHS done around this time in various countries
entitled ‘Fosterage patterns in the age of AIDS,’ examines literature on child fostering and uses it to highlight some understudied aspects regarding the care of children orphaned by AIDS in South Africa (18). The author distinguishes crisis-led from voluntary fostering. The latter referring to arrangements made between biological and foster parents in line with cultural norms about child rearing; while the former refers to fostering done in response to death or economic hardship, as is the case with children orphaned by AIDS and other causes. Formal adoption, the author notes, is not as common as fostering in Africa. Although some literature regards fostering as distinct from extended family care (19) most foster parents are part of the extended family and may range from aunts to uncles and grandparents; with the latter taking care of 50% of orphans (20, 21).

Desmond et al, describing the situation in South Africa, distinguish between formal or statutory fostering and informal or non-statutory fostering (22). In the latter case, a member of the extended family or the community assumes the responsibility of caring for vulnerable children. Children cared for in this approach are external to any welfare support or system; they are not placed in homes with a court order and the caregivers do not receive a place-of-safety grant or foster care grant. Caregivers are motivated by kinship obligations, community preservation and a sense of personal calling. This form of care is very common in rural areas where access to services is more difficult than in urban areas. Formal fostering on the other hand refers to a situation where the child is committed by court order to the care of a foster parent who may or may not be a relative.

**Children’s Villages and Children’s Homes**

The literature is mixed in its categorization of children’s homes, group homes, and children’s villages. Some view them as part of institutional care, while others appear to consider them as part of family-centered approaches.

One of the examples of children’s villages is the SOS children’s village model. According to the SOS-Kinderdorf International (23, 24) the SOS village concept is a family-based approach, built upon the vision that ‘every child grows up in a family, with love, respect and security,’ aimed at building families for children in need; caring for children who are orphaned, abandoned or whose families are unable to care for them. The model is based on four key principles:

- Child has a caring parent - The Mother,
- Family ties grow naturally - The Brothers and Sisters
- Each family creates its own home - The House
- The SOS Family is part of the community - The Village.

The literature source reports that in each village there is a designated ‘mother’, who builds a close relationship with every child entrusted to her, and provides the security, love and stability that each child needs. Girls and boys of different ages live together as brothers and sisters, with natural brothers and sisters always staying within the same SOS family. These children and their SOS mother build emotional ties that are intended to last a lifetime. The children freely interact with other children in the community, they live according to their own culture and religion, are helped to recognize and
express their individual abilities, interests and talents; and further assisted with educational skills and vocational training.

We were however unable to obtain literature on turnover rates for the ‘SOS mothers,’ neither were we able to get any evidence of long-lasting relationships between the SOS children and their ‘SOS mothers.’ Considering that SOS villages are usually separated by a security fence, there is no data on how well the children are integrated into the community around them.

A different concept of children’s villages is the ‘Watoto’ village. These are clusters of homes served by schools, a medical clinic, a church and community hall, a clean water source, roads and electricity. Watoto is a church-based organization in Uganda that cares for orphans and widows (25, 26). Watoto places the most vulnerable children into new families. Each family consists of 8 children and a mother who cares for them. It supports the living relatives of orphans such as grandparents, uncles or aunts, by ensuring the children receive food, clothing, and education, while living under the protection of their own family.

Children’s Group Homes are similar to the SOS Children’s Villages. According to Zhao et al, group homes are based in the community, managed by ‘house parents,’ and house four to six orphans in a family-like structure; hence the orphans would call the house parents ‘father’ and ‘mother’ and call each other ‘brother’ and ‘sister’ (27).

According to Beard, the word ‘orphanage’ is never used in Malawi; instead the terms ‘children’s home or children’s village’ are used (28). The homes try to emulate a normal family and community environment for orphans by grouping them as family units under the care of a paid guardian or ‘mother.’ The family units are grouped in clusters surrounded by a security fence.

b) Institutional Care

During our review, we came across various types of institutional or residential care for orphans and vulnerable children. The main form of institutional care are orphanages, although as stated earlier some authors categorize small family-like children’s homes and children’s villages as institutional care. On the whole, institutional arrangements all tend to fall into two legal categories: registered and not-registered or statutory and non-statutory.

c) Community Based Care

It is not possible to separate community-based care from other care placements because all other forms of alternative care operate in communities. In spite of this difficulty, however, community-based care is an entity that requires separate discussion because of the key role it plays in supporting all types of care arrangements. In the context of care for OVC, community-based care has been defined by some authors as care provided to children by responsible adults within their own communities and within a family or family-like setting (29). The idea is that the community takes responsibility for children and oversees their care and well-being in essentially all aspects: shelter,

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10 Watoto is a Swahili name meaning ‘child.’
protection, food and nutrition, psychosocial, education, and health. The support may be direct to the child or indirectly through support to the care-giver. In terms of specific community responses, the scope of community-based care for OVC varies a lot in structure and function, ranging from specific community-based facilities built and managed by the community for the care of OVC to social support networks, providing psychosocial and material support to OVC. According to Mathambo and Richter, there is no commonly accepted definition of community responses as they are diverse (30). The authors identify six types of community responses: Food support, financial support, caring for care-givers, psycho-social support, education, and informal transfers. Informal transfers involve transfer of goods and services between households and may take the form of cash, material goods, child care, cooking etc. In Malawi, Beard identified community-based child care centers (CBCC), feeding and nutrition centers, skills-training centers, and multi-purpose community buildings (28). Community-based child care centers are sometimes called day care centers and provide education, food and nutrition, and recreation services (28). In general the type of support given varies according to areas of comparative strengths of particular community groups. For example, in a study of 505 faith-based organizations, Foster found that over 90% of them provided religious education and spiritual support to vulnerable children, followed by school assistance (73%) and material support (62%) (31). Tolfree defines community-based care as a range of approaches which are designed to enable children either to remain with their own (or extended) families and to prevent the need for separation, or to be placed with an alternative family, if possible within his/her community (32). Tolfree points out that the community has a great role to play in preventing the separation of children from their parents or other close family members because the vast majority of children in institutional care have families; what is needed is to support these families. He then lists a number of strategies to support families and prevent separation of children. These include material support, provision of day care centres, educational support, and resources targeting single mothers and other families who are likely to place their children in residential care. Tolfree was quick to point out the challenge of sustaining such interventions, and suggests that household economic strengthening interventions such as loans for micro-enterprise may be more sustainable than any form of welfare benefits.

Key to the effectiveness and sustainability of community support to OVC and their households are voluntarism, innovation, local leadership, and various safety nets enshrined in communities (30). Community safety nets are resilient and provide coping mechanisms within communities, mainly through various voluntary associations like self-help groups, grain loan schemes, savings clubs, etc. Foster refers to voluntary associations as ‘poor people’s insurance policies’ whereby relatives and friends provide support to the vulnerable on assumption of reciprocity in time of need in the future. Communities are resourceful, and with effective mobilization and support, they provide the best sustainable safety net for the care of orphans and other vulnerable children. Germann et al evaluated the effectiveness of mobilizing and strengthening community care groups through Community Care Coalitions (CCC) in 4 different countries: Ethiopia, Mozambique, Uganda, and Zambia (33). The aim of the study was to identify strengths and weaknesses of community care groups and coalitions to inform and guide World Vision and its partners’ on how to mobilize and strengthen these community based OVC programs. The researchers identified five domains important for an effective community-based program:
• Community mobilization
• Community structure
• Community capacity
• Resource mobilization
• Linkages

We are of the view that these are important areas that need to be emphasized for any organization that aims to strengthen community OVC support.

3.3 Effect and Impact of Various Alternative Care Arrangements on OVC Wellbeing

Apart from institutional care, there is little documented impact of various care arrangements on the long term wellbeing of orphans and vulnerable children.

3.3.1 Institutional Care and Child Wellbeing

For over 60 years now, various studies have demonstrated disturbances in growth, attachment, cognitive development, language and behavior associated with institutionalization; from Provence and Lipton (34) to the latest results from the Bucharest Early Intervention Program (BEIP) (36). One of the most condensed pieces of literature we found on this subject was a comprehensive review of literature by Johnson et al. In a systematic review of literature to gather research evidence on the impact of institutional care on brain development, attachment, social behavior, and cognitive development, the authors found that children placed in residential care were at risk of harm in terms of attachment disorder and developmental delays in social, behavioural, and cognitive functions if they were not moved to a family-based care by the age of 6 months (35). The most recent data comes from the Bucharest Longitudinal trials in Romania. Zeanah et al randomly assigned 52 children, 6-30 months old, to care as usual (institutional) and 59 children removed from institutions to foster care (36). The two groups were compared to 59 children who had never been institutionalized. At 54 months they examined the children for psychiatric disorders, symptoms, and co-morbidity. The authors found that children with any history of institutionalization were twice more likely to develop psychiatric disorders than those without such history (53.2% versus 22.0%); and children removed from institutions into foster homes were only one-half as likely to have internalizing disorders as those who continued to live in institutions (22.0% versus 44.2%). Apart from the limitation in age coverage and the small sample sizes, an important caveat to this evidence base is that this research tends to focus on large government institutions that prioritize physical care (shelter and food) over emotional attachment. The generalizability of these findings to smaller scale group homes with lower child to caretaker ratios that attempt to cultivate a family-like atmosphere is therefore questionable. A study of a cohort of 325 HIV-infected Romanian children by Ferris et al (37) found no significant difference in disease progression between children who resided with their biological families and those who resided in "family home"-style institutions. Although the study is also limited by a small sample size, the authors report that children who resided with their biological families were more likely to experience disease progression through either death or CD4 decline than were children in institutions.
Another study by Zeanah et al, evaluating attachment in 95 institutionalized and 50 never institutionalized children aged 12-31 months, shows that children raised in institutions exhibit serious disturbances of attachment as assessed by various measures (38). Ghera et al, in a study of an equal number (n=68) of previously institutionalized children placed in foster care (FC) and institutionalized children (IC), aged 6-30 months, found that children in FC demonstrated significantly higher levels of positive affect at 30 months (p<0.001) and 42 months (p<0.001) of observation compared to the IC group (39); though there was no significant effect between the two groups in terms of negative affect. The FC children also displayed significantly higher levels of attention than IC children at 42 months (p=0.01).

In a study comparing outcomes for 124 institutionalized children aged 5-31 months who had resided in institutions for varying lengths of time and 66 never-institutionalized children, Smyke et al report that children raised in institutions demonstrated marked delays in cognitive development, poorer physical growth, and marked deficits in competence (40). Data comparing 133 institutionalized and 72 never-institutionalized children aged 5 to 31 months showed a pattern of increased low-frequency (theta) power in posterior scalp and decreased high-frequency (alpha and beta) power in frontal and temporal electrode sites in the former group; reflecting a maturational lag in the nervous system or tonic cortical hypo-activation (41).

But the evidence assessing the effect of placements in various types of orphanages/group homes is not entirely negative. We found five studies conducted in Eritrea between 1990 and 2002 that assessed behavioral characteristics and cognitive performance of children orphaned by war in a variety of residential care situations. Between 1990 and 1992, they compared wellbeing of children aged 5-7 living in Solomuna Orphanage, an institution housing over 500 children, before and after the model of care was shifted to be more child-centered (42). The authors report that two years after the orphanage was restructured the emotional state of the orphans had improved dramatically as indicated by reduced frequency of serious behavioural symptoms and improved socio-emotional relationships with peers and adults. They then compared the behavior and cognitive abilities of 74 of the children living in Solomuna to refugee children (age 4-7) living with at least one parent in the local community (42). The Solomuna orphans displayed more behavioural symptoms of emotional distress, but performed at a more advanced level on cognitive and language performance measures. Solomuna orphans experienced significantly more enuresis and impaired relationships with adults and peers; although children living with their families had significantly more phobias. These behavioral differences were only significant in younger children (age 4-5). In 1996, they compared the psychosocial well-being of children age 5-17 living in two smaller orphanages with different care models, one more child-centered than the other where children mixed with different age groups and experienced lower child/caretaker ratios (43). They then compared longitudinal behavioral symptoms and cognitive performance of the Solomuna children (age 9-12) after five years living under the child-centered care model with those living in the two smaller orphanages (44). Orphans in settings where staff fully-participated in decision making and children were encouraged to be more self-reliant through personal interactions with staff, showed significantly fewer behavioural symptoms of emotional distress than orphans who lived in a setting where the director made all the decisions and children had to follow strict rules and schedules. The authors conclude that when orphanages are the only means of survival, a group setting where
staff shares in the responsibilities of child management, is sensitive to the individuality of the children, and establishes stable personal ties with the children, serves their emotional needs and psychological development better than a more authoritative style management with strict rules and schedules. Finally, in 2002, they compared 10-13 year old children living in orphanages or group homes to those who were reunified with family or living with their biological parents (45). Orphans reunified with extended families had greater adaptive skills than institutional orphans but as many signs and symptoms of emotional distress as orphanage children. Group home orphans had fewer signs and symptoms of emotional distress and greater adaptive skills than either re-unified or institutional orphans, and had fewer symptoms of emotional distress than children raised by their own parents in their own home.

3.3.2 Foster Care / Extended Family / Kinship Care and Child Wellbeing

Despite the fact that the extended family takes care of most of the OVC, it receives very little support (6). For example, in Funam, Cambodia, more than 90% of orphans are supported by the extended family; three quarters of these receive no support. In Rwanda, 37% of all households are caring for orphans, but only 0.2% received the full package of care and support.

The challenge revealed by the literature is the reduced capacity of the extended family safety net to care for the increasing number of OVC (6-8, 18, 44, 46, 46-55). As UNICEF acknowledges, ‘this traditional support system is under severe pressure-and in many instances has already been overwhelmed, increasingly impoverished and rendered unable to provide adequate care for children (6, 7). Households with orphans are more likely to become poorer, mainly due to high dependency ratios (6, 7, 49). In 2002 in Uganda, households with orphans had earned 25% less (per capita income) than those without orphans and the per capita income was 31% less in Zimbabwe (6). In a cross-sectional survey to explore barriers and incentives to orphan care in Zimbabwe, Howard et al. interviewed 371 adults caring for children about the well-being, needs, resources, and perceptions on orphan care (56). Ninety-eight percent of the respondents said they were willing to foster orphans but poverty was the primary barrier to fostering and struggling families lacked external support. The authors recommend that incentives for sustainable orphan care should focus on financial assistance.

Without support, the extended family system will continue to suffer, with negative consequences on the lives of children. In a survey of 400 households with orphans in Mwanza, Tanzania, almost 40% of the households could not cover basic expenses (6). The most common unmet needs were education, food, medical care and clothes. The same source also reports that surveys in 8 other countries showed similar results. A study from Botswana that focused on foster care found that working families that took care of orphans in addition to their own children were more likely to have difficulty in meeting child needs, reduced time for own family, difficulty meeting overall responsibilities at home, and unable to find reliable child care, than families not caring for orphans (46). Deininger et al (48) found that foster children had significantly less access to all three types of health services measured in their

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11 Health services measured: vaccination against measles; vaccination against diphtheria; vitamin A supplementation.
study compared to those that lived with their biological parents, although there was no difference between the two groups in terms of school enrollments.

There is one study however that identified various levels of extended family resilience to the increasing numbers of OVC. Abebe and Aase, in a seven-month period of child-focused, qualitative research fieldwork involving observations; in-depth interviews with orphans, social workers and heads of households; focus group discussions with orphans, elderly people and community leaders; and story-writing by children in school contexts; explored the trade-offs and social dynamics of orphan care within extended family structures in Ethiopia (57). The authors report that there are multiple layers of resilience by the extended families in coping with the increasing numbers of orphans and identified a continuum of four profiles of families in Addis Ababa and Gedeo: rupturing, transient, adaptive, and capable families. Ten families in the study were in extreme forms of impoverishment and destitution (rupturing), failing to provide for the basic needs of the children. Ten other families represented the transient category, living in relative poverty and at high risk of ‘sinking into’ deprivation. These families are characterized by lack of a principal adult breadwinner, and include child-headed and grandparent headed households. Adaptive families on the other hand are well-functioning, with relative economic security, general level of wellbeing; but ‘less-than-average’ family circumstances. Capable families have viable material and social capacities, even without external material support. According to the authors, good care for orphans depends on reciprocity, willingness and the capacity of care-givers to avail the necessary resources for the children. They identify three types of capacity: economic, emotional, and social, respectively representing capability to provide basic material and other resources for the children’s wellbeing; willingness and ability to offer psychosocial and emotional support; and ability and willingness to socialize orphans with social and cultural skills necessary for present and future life. Overall, however, the authors describe families as economically ‘struggling’ to care for the increasing numbers of orphans and point out that many of the hurdles that orphans face are poverty-related.

A cross-sectional study from Eritrea looking at war orphans compared behavioral characteristics of 40 orphans in each care setting: reunified with extended family, group home, and orphanage. The findings showed that orphans reunified with extended family had greater adaptive skills than institutional orphans but as many signs and symptoms of emotional distress as orphanage children (45). Orphans reunified with extended families rated themselves lower than those in group homes on overall personal adjustment, self-reliance, and relationship with a parental figure; but placing orphans in small group homes was far more expensive than reunifying them with extended families.

Zimmerman conducted a qualitative study among 50 orphans in Malawi assessing the characteristics of orphans living with extended family or in foster homes (58) and those in what is being referred to as ‘Orphanages’ but are actually children’s villages or as they’re termed in Malawi, ‘children’s homes’ (28). The study depicted the poor living situation faced by orphans in foster homes and found that Malawian orphans placed in children’s homes had an advantage over those placed in foster homes in terms of quality of shelter, food security, and school enrollment. The results of this study must however be interpreted with caution considering that an average household in Malawi is very poor; we cannot compare orphans in donor-funded children’s homes with those in locally supported foster homes.
A cross-sectional study from China looked at the difference in perceived life improvement and life satisfaction among AIDS orphans in kinship households, orphanages, and group homes (27). The sample comprised of 176 double orphans living in orphanages; 30 double orphans living in group homes; and 90 double orphans living in kinship. The results of the study indicate that orphans living in kinship households had the lowest scores in perceived life improvement and life satisfaction when compared to orphans living in orphanages and group homes. Zhao et al. found that children in group homes and orphanages reported that their overall quality of life in their current situation was “same” or “better;” than their previous living situation. Children living in Kinship care were significantly less enthusiastic about their quality of life, rating it as “same” or “worse” than their previous situation (27).

In another study, Zhao and others asked children to assess improvements in their current mood and peer relations in comparison to their experience prior to their parents’ death (59). The responses of children living in group homes, orphanages, or with kin were then compared. Children living in group homes reported the greatest improvement in both categories, followed by those living in orphanages. Children living with kin reported the lowest levels of improvement. These differences were statistically significant.

There was only one study that evaluated the long term impact of a form of alternative care for OVC. This study by Pittacher et al focused specifically on SOS children’s villages and was set up to evaluate the experiences of adults who lived in SOS Children’s Villages (60). The study, code-named “Tracking Foot Prints,” was a retrospective cohort conducted between 2002 and 2003, covering 20 countries from Africa, Central and South America, Asia and Europe. The results show that 60% of adults who had lived in SOS children’s villages reported being married, with 85% satisfied with their marriage and 70% satisfied with their current living conditions. Reflecting on their lives immediately after admission to the villages, 70% of the respondents described it as a period of “love, security, feeling at home, happiness.” The remaining 30% fell into a broad category of negative experiences that ranges from loneliness to feelings of abandonment and violence. Approximately one-third of SOS Village adults felt that integration into the community was a challenge, with 21% of Kenyan alumni adults and 37% of Honduran adults stating that they had felt inferior to other children. The process of becoming independent was also stressful; 40% of Salvadoran and 70% or Southern and Western Latin American respondents admitted to feeling pressured. In terms of self-worth, however, three-quarters of respondents from 3 of the twenty countries studied felt that they were supported and taken seriously by caretakers. The limitation of this study however is that there was no comparison group, making it difficult to attribute any of the outcomes, negative or positive to having been in children’s villages.

### 3.3.3 Community-Based Care and Child Wellbeing

An evaluation study in Uganda examined a community-based program that provides support to families in extreme poverty raising OVC (61). This is a family preservation program implemented by Action for Children (AFC). Components of the program included counseling, education, and micro-finance support. A total of 315 families participated in the study with 527 children being interviewed. The researchers calculated the households’ degree of need before and after receiving the services from AFC over a period of four years (Baseline in 2001; Evaluation in 2005). Findings suggest that the
households’ need in certain categories, such as housing and food security, decreased significantly after services were received and that children’s sense of belonging and permanency appeared promising. The need for housing decreased from 85.9% to 58.6%; that for food security from 83.7% to 59.6%; that for psychosocial support from 68.5% to 56.4% and need for income from 91.7% to 73%. Germann et al. (33) evaluated the effectiveness of mobilizing and strengthening community care groups through Community Care Coalitions (CCC) in 4 different countries: Ethiopia, Mozambique, Uganda, and Zambia. The aim of the study was to identify strengths and weaknesses of community care groups and coalitions to inform and guide World Vision and its partners’ on how to mobilize and strengthen these community-based OVC programs. Results of the study indicate that community-led child care programs that were well networked and established through a strong community mobilization process are sustainable mechanisms for enhanced child wellbeing at the community level. The authors also note that the quality of care was dependent on the quality of home visitors and the frequency of ongoing visits. High levels of volunteerism are key to sustainability of community-based programs. Additional factors that must be improved to increase sustainability include improving vertical linkages to government, involving community leadership to increase community demand for home visitor services and support, increased investment in home visitor training, and improved ability of CCCs to access national and international funding.

One of the key areas of focus for community-based programs supporting OVC noted in the literature is psychosocial support (PSS). In Zimbabwe, researchers found that males who participated in a PSS program were more likely to report “self-confidence” when compared to the comparison group (85% vs 77%) (62). In Uganda, a cluster randomized trial evaluated the effect of PSS involving peer support group among 159 orphans age 10-15 versus 167 orphans of the same age in the comparison group (63). The results indicated that peer group support may decrease psychological distress, particularly depression and anger associated with adolescent AIDS orphans. A study from Rwanda tested a model of adult mentorship and support to improve psychosocial outcomes among youth headed households (64). The pre- and post- cross sectional study among 832 youth headed households up to 26 years of age showed that mentoring from adults within the community can measurably mitigate adverse psychosocial outcomes among male and female youth headed households. Youth who participated in the mentorship program reported significant decrease in feelings of marginalization and decrease in depressive symptoms. Youth who did not participate in the intervention reported a significant increase in feelings of grief.
4.0 Discussion: Policy, Program and Research Implications of the Findings and Recommendations

The aim of this review was to summarize evidence on the scale, scope and impact of various alternative care arrangements for OVC. In terms of scale, where possible, the review aimed at documenting total numbers of OVC, numbers in need of care, and numbers under various care arrangements. However there is a dearth of evidence in all these areas. Part of the challenge is lack of internationally agreed definitions of categories of vulnerability. Cognizant of the different cultural and contextual issues in various countries across the globe, we are aware of the difficulties of coming up with one definition. However, we are of the view that it is possible to come up with a generic definition that encompasses most categories and indicators of vulnerability. Consistent definitions of both orphaning and vulnerability will allow for easier identification and tracking, allowing us to get a better sense of the magnitude of the OVC population.

There is strong evidence that the capacity of the extended family to adequately care for orphans and vulnerable children is highly constrained (46, 48, 58, 65). Unless governments and the donor community redouble their efforts to sustainably increase the capacity of this safety net, the quality of life of the children in these households, both biological and fostered, is in danger of worsening in vulnerable households. More emphasis should be placed on interventions that reduce household poverty and increase household investments. Two examples of interventions that have been shown to work are the administration of social cash transfers (SCTs) to poor and vulnerable households and the training in savings and internal lending committees (SILCs). A number of studies have shown that administration of social cash transfers is associated with increased household income with positive impacts on health, education, food security and nutrition (66-70). A study by Measure Evaluation and Tulane University School of Public Health in Kenya showed that training in SILCs can lead to reductions in food insecurity at a low cost of only $1.61 per beneficiary (71). With support, family centered care through own parents or the extended family remains the most viable and sustainable form of alternative care option for vulnerable children. If families are economically empowered they should be able to take care of most of the basic needs of the children like education, health and nutrition.

With regard to institutional care, the results of this review have underscored the findings of earlier publications showing the deleterious effects on child wellbeing (72, 73). Well supported extended families therefore remain the best option for OVC care in developing countries. In situations where a vulnerable child cannot be absorbed into the extended family system, small family-like group homes such as the SOS children’s villages would be the next recommended alternative for vulnerable children; considering that formal adoption is rare in developing countries. Available data from this review shows that group homes offer acceptable quality of care (27, 45) and did not reveal the negative impact on the wellbeing of OVC associated with large institutional care facilities; although the evidence is limited in both design and sample sizes. In addition, the cost-effectiveness of this form of alternative care has not been fully evaluated and their capacity to care for all those in need is limited.
For some children, family placement is neither available or the best option due to previous abuse, mental health or other special needs. The literature does not provide any guidance on how to identify these children, screen them, and facilitate residential placements that can meet their needs. Exploratory research on the most common needs and characteristics of such children is needed, as is research looking at the care provided to such children in both residential facilities and homes. The challenge in the case of children who need specialized residential care lies in identifying such children and in making careful decisions about long-term care placements that will meet their needs and not create further trauma.

The role of the community in OVC-care cannot be over-emphasized; especially in providing support to families taking care of OVC. The current review has identified various community-based initiatives and strategies in support of OVC in form of provision of basic necessities of life like food, shelter and clothing as well as psychosocial support. We clearly see the role of the community in support of a family preservation program called Action for Children (AFC) in Uganda, with demonstrable positive benefits for households caring for OVC (61). We also see the role of the community in providing psychosocial support to OVC in a study of over one thousand adolescent OVC in Zimbabwe by Gilborn and others (62), demonstrating that males who participated in community PSS programs were significantly more likely than their comparison group peers to report self-confidence (85 percent vs. 77 percent, adjusted OR: 1.85, CI: 1.03–3.33, p < 0.05). In addition, we see the important role played by the community in the two programs evaluated by Kidman and others in Botswana (74). However, such studies that evaluate the effectiveness of community-based programs in meeting the needs of OVC are limited, and the impact of community-based programs on OVC overall wellbeing and long-term development have not yet been conducted. The reviewed literature points to at least eight key important issues that must be considered in the design and implementation of community-based programs: the role of the local leadership, effective community mobilization, capacity building, community structure, resource mobilization, effective linkages, and community ownership of the programs. However, only one study specifically described the value or contribution of these factors (33). Although the literature indicates that these ingredients are important for the effectiveness and sustainability of community-based programs, the evidence does not yet support these conclusions. We found four cross-sectional studies assessing the impact of psychosocial support (62, 64, 75); but no longitudinal cohort studies; therefore, ‘cause and effect’ conclusions cannot yet be drawn. The variability in the outcome measures and the general lack of standard indicators of performance for PSS programs also makes it difficult to compare studies, let alone allow for synthesizing quantitative results across studies through meta-analysis. Similarly, the definition of “PSS” is too fluid and will need to be revisited and agreed upon among researchers and programmers. Currently, the PSS literature indicates that the term means different things to different people. However, despite definition and methodological differences in the literature reviewed, appreciable evidence shows an encouraging association between peer and adult mentoring programs and improved psychosocial wellbeing of OVC (62, 64).

It is clear from the foregoing that well-designed longitudinal cohort studies directly linked to various OVC programs providing reliable data for the improvement of the quality, scale and coverage of OVC
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programs are urgently needed. Where cohorts cannot be constructed for various reasons, all OVC programs should start with baseline data to allow for impact evaluation over time. To know if OVC interventions are making a real difference in the lives of the children we serve, we must measure not just the short-term effects of our efforts but the long-term impact the children’s social and economic development as adults.

The finding that in some cases a large proportion of children in institutions has either living parents or traceable relatives (5, 10, 11), has important policy and program implications. First, policy makers need to ensure that all institutions taking care of children are duly registered; secondly, the criteria for admissions to these facilities should be clearly stated, and thirdly a robust monitoring system, that is backed by an up-to-date data base of all registered institutions should be put in place, where none exists. The data base should include, among other things, data on the four core indicators for monitoring children in Formal Care (UNICEF/Better Care Network (76). Careful assessment of the situation of children in residential care and their family links will enable Ministries responsible for vulnerable children to decide on placements that are in the best interest of these children; which may include the option of re-unifying them with their relatives.

This review found few studies that have followed OVC in various care arrangements and evaluated their wellbeing overtime over any long period of time. Pittracher et al. (60) traced and interviewed adults who had lived in SOS Children’s Villages and reported psychosocial characteristics of their current lives, but they do not compare these findings to baseline data; neither do they compare the characteristics to adults who have had no prior history of institutionalization. The research by Wolff et al. on orphans in post-conflict Eritrea living in a number of different institutional settings and family care settings does attempt to provide a picture over time of behavioral symptoms and cognitive performance (42-45). However, the highly mobile nature of this population appears to render strict longitudinal cohort study impossible. The Bucharest early intervention trials are well designed and robust, but so far we have evidence only in early infancy and childhood.

Finally, the need to narrow the gap between evidence and implementation is urgent. We have observed from our review of the literature that there were no studies that dealt with how best to translate available evidence into practice and that most of the research has focused on providing evidence, but the area of knowledge translation and management appears inadequate. For example, ten studies dealt with extended family support for OVC, and findings emphasize that with increasing numbers of OVC, this support system has seriously weakened and requires more support to be sustained (46, 48). However, few studies evaluated different strategies of supporting families caring for OVC (61). We observed the same pattern with regard to studies on community/home based care. Out of sixteen studies on community and home-based care of OVC, none dealt with issues of scale-up of community-based models known to work. All the publications on cash transfer focus on the effect of this strategy on household poverty and socio-economic wellbeing of vulnerable households, but none evaluated delivery mechanisms and/or sought evidence on cost-effectiveness or long term

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12 Formal Care Core Indicators: children entering formal care; children living in formal care; children leaving residential care for a family-based care; Ratio of children in residential care versus family-based care.
sustainability of cash transfers. Out of all the studies reviewed only two evaluated the cost-effectiveness of various OVC models (71, 77), and none studied costs and outcomes or costing models. While keeping in mind that there is no ‘one size fits all’ strategy for the care of OVC, the research community must continue to provide context-specific robust program-linked evidence through basic program evaluations (BPEs), ongoing operations research, and/or studies on the costs of provision of services.

6.0 Conclusion

This review has shown that the extended family system, currently taking care of over 90% of OVC is under extreme pressure, and unless governments and international development partners redouble their current efforts to increase the capacity of the families to cope, the quality of lives of foster OVC and all children in vulnerable households remain in danger. Interventions aimed at preventing and reducing child vulnerability and those that aim to reduce household poverty and increase household investments will go a long way in reducing the numbers of vulnerable children.

The current research evidence is limited to cross-sectional designs and the few longitudinal studies that are limited in length of follow up and age coverage for robust evaluation of long term impact of OVC interventions. There is therefore need to design and conduct longitudinal cohort studies that ask different questions, measure various OVC care variables over time, and provide a continuous set of reliable evidence for improving the scale and effectiveness of OVC interventions. To know if OVC interventions are making a real difference in the lives of the children we serve, we must measure not just the short-term effects of our efforts but the long-term impact of programs on the children’s social and economic development as adults.
7.0 References


