
# Can Global Development Dollars Do More to Improve Care for Orphans and Most Vulnerable Children (O/MVCs)?

**BACKROUND PAPER**

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**Abstract**

Current global donor trends geared toward funding care for orphans and most vulnerable children (O/MVC) in family and community care settings are inextricably linked to the HIV/AIDS pandemic, poverty alleviation, and a child rights framework historically focused on strengthening the family. Multilateral, bilateral, and private donors with limited resources are legitimately concerned with investing in cost-effective programs that provide the maximum impact per dollar spent – a goal that can sometimes come at the expense of providing long-term quality care to children most in need. The few cost comparison studies that have been conducted indicate that family and community-based care is more affordable and sustainable than institutional-based care, even when the cost of programs such as direct cash transfers or old-age pensions to vulnerable households are included. However, until these types of family-centered donor strategies become more widespread and sustainable, childcare settings by necessity must continue to be based on children's individual needs and rights, as well as the more pragmatic reality of which programs, facilities, and services are actually available in the communities in which they live. Three suggested steps for moving forward emerged from this review: 1) Donors must seek to improve local and national micro-caregiving environments through the integration of Early Childhood Development (ECD) strategies; 2) Using the momentum of the UN Guidelines for Alternative Care for Children, donors and governments should be encouraged to track and monitor O/MVC and improve the quality of care in all child care settings, with special focus on unregistered institutional settings; and 3) Donors, government institutions and civil society—including faith-based organizations—must improve their fiscal monitoring and evaluation systems while amplifying their commitment to accountability and transparency of O/MVC expenditures. The paper concludes with a call for more methodological, systematically rigorous studies in countries facing the greatest OVC burden. Moving beyond the traditional dichotomized choices of institutionalized vs. community care is necessary to promote and sustain the well-being of millions of children who will grow up and contribute to, rather than drain, a country's economy.

## Foreword

While the definition of "orphan" is hotly debated in development circles, the United Nations estimates (based on its definition) that there are between 143-163 million orphans who are in need of immediate care and support in order to survive.[1] Of this number, UNICEF conservatively estimates that two million children live in orphanages worldwide, a number based on 2007 UNICEF data provided by their country office reports. Millions of other at-risk children are assumed to be living with families, in community settings, in child-headed households, streets, railway stations, garbage dumps, brothels, and armies.

The issue of orphans and vulnerable children is increasingly a development problem, for which there needs to be a development solution. Around the world, parents explain that placing their children in institutional care will improve the child's material conditions. There is no question that severe poverty and the effects of disease, famine, civil unrest, war, and natural disaster limit many families' ability to meet even the most basic needs of their children. As a result, many donors and policymakers today argue – and several are investing in the notion – that if poor households were to receive support in any number of forms (i.e. cash transfers, old-age pensions, psychosocial counseling services, food donations, etc.), their capacity to provide for their children would improve dramatically and the need for orphanages would decrease. In this sense, the desire to improve care and protection of O/MVC is directly linked to national and global strategies to alleviate household poverty and other inequities, including gender, that often accompany it. However, until poverty reduction programs can realize their goals, millions of children are living as orphans in institutions or on the streets where donor resources aren't reaching them.

This paper by Miriam Zoll, commissioned by CGD, is the first to systematically document current public and private donor practices related to Orphans and Most Vulnerable Children (O/MVC) in developing countries. It's analytical focus it to identify and describe the central arguments, policies, and evidence fueling donor decisions to fund particular approaches to care for O/MVC, particularly in the context of the HIV/AIDS pandemic and its effect on children. This paper does not determine whether families, communities, or institutions do a better job of raising happy, healthy children who can mature into functioning and productive citizens. Rather, it explains how current donor trends prioritizing family and community care over orphanages came to be and suggests a way forward for donors to maximize the impact of their aid dollars for O/MVCs.

**Nandini Oomman**

[1] UNICEF, UNAIDS, and USAID, *Children on the Brink: A Joint Report of New Orphan Estimates and a Framework for Action*, 2004.

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## ACRONYMS

CBO: Community-based Organization
CEE/CIS: Central Eastern Europe and the Commonwealth of Independent States
CRC: Convention on the Rights of the Child
CSG: Child Support Grants
DFID: UK Department for International Development
ECD: Early Childhood Development
FBO: Faith-based Organization
HIV/AIDS: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IATT: Inter-agency Task Team
JLICA: Joint Learning Initiative on Children and HIV/AIDS
MAP: Multi-Country HIV and AIDS Program
NGO: Non-governmental Organization
OAC: Orphans and Abandoned Children
O/MVC: Orphans and Most Vulnerable Children
OVC: Orphans and Vulnerable Children
OVC RAAAP: The Rapid Country Assessment, Analysis and Action Planning Process for Orphans and Vulnerable Children in sub-Saharan Africa
UNAIDS: Joint United Nations Program on HIV and AIDS
UNDP: United Nations Development Program
UNFPA: United Nations Population Fund
UNGASS: United Nations General Assembly Special Session
UNICEF: United Nations Children's Fund
PEPFAR: US President's Emergency Plan For AIDS Relief
WFP: World Food Program

## 1. INTRODUCTION

*What Do Development Donors Have to Do with Orphans and Most Vulnerable Children?*

Current global donor trends geared toward funding care for orphans and most vulnerable children (O/MVC) in family and community care settings are inextricably linked to the HIV/AIDS pandemic, poverty alleviation, and a child rights framework historically focused on strengthening the family. Multilateral, bilateral, and private donors with limited resources are legitimately concerned with investing in cost-effective programs that provide the maximum impact per dollar spent—a goal that can sometimes come at the expense of providing long-term quality care to children most in need. The few cost comparison studies that have been conducted indicate that family and community-based care is more affordable and sustainable than institutional-based care, even when the cost of programs such as direct cash transfers or old-age pensions to vulnerable households are included. However, until these types of family-centered donor strategies become more widespread and sustainable, childcare settings by necessity must continue to be based on children's individual needs and rights, as well as the more pragmatic reality of which programs, facilities, and services are actually available in the communities in which they live.

What follows is an effort to document current public and private donor practices related to Orphans and Most Vulnerable Children (O/MVC) in developing countries. Its primary analytical focus is to identify the central arguments, policies, and evidence fueling donor decisions to fund particular approaches to care for O/MVC, particularly in the context of the HIV/AIDS pandemic and its effect on children. The paper aims to provide a historical and evidence-based framework that highlights why current donor trends prioritizing family and community care over orphanages have come to pass.

*Data Limitations and Methodology*

Data for this paper were drawn from the following sources: descriptive and analytical studies and reports from international donors, including annual reports, research documents and presentations; country reports generated by governments and United Nations agencies; website searches of national and international non-governmental organizations (NGOs), faith-based organizations (FBOs) and community-based organizations (CBOs); literature searches for formal and “grey literature” not formally published, including program and project reports, policy documents, conference abstracts, and news articles; and telephone and email correspondence with a range of organizations engaged in O/MVC affairs. This paper does not include direct field observations of orphanages or family and community-based programs.

It is important to note that a wide ranging number of children's rights and protection agencies around the world report regional and national shortages of accurate data assessing the population of children living in various care settings, and the strengths and

weaknesses of these living situations. These gaps are due in part to many governments' inability to prioritize complex, costly and time-consuming surveys pertaining to O/MVC care, or to support sustainable monitoring and evaluation systems and follow-up. The limited global data currently available about O/MVC is often retrieved via academia and government surveys, and/or initiatives sponsored by large children's organizations such as UNICEF and Save the Children. UNICEF very openly and cautiously acknowledges the limited nature of data collected through organizations, governments or its own country offices. In many cases, O/MVC estimates are derived from country data provided by national sources, such as Ministries of Social Welfare, UNICEF country offices, or country reports. In some global publications, such as *Progress for Children: A Report Card on Child Protection* (UNICEF 2009),[2] data was not available for South Asia and West and Central Africa.

## 2. CHALLENGES IN ASSESSING THE SCALE OF THE O/MVC PROBLEM

Efforts to ascertain the scope and degree of O/MVC globally are extremely difficult due in part to the absence of accurate data, as well as disagreement on the precise definition of an "orphan". While some countries have adopted the United Nations definition as "a child who has lost one or both parents," others have not, making it extremely challenging to target at-risk children or to identify their whereabouts in family and community-based care programs, or in residential institutions. Research has shown that some 88 percent of children designated as “orphans” by international agencies working to fight HIV/AIDS actually have a surviving parent.[3] The percentage of institutionalized children who are single or double orphans is not known; however, some studies indicate that a significant proportion of children living in orphanages have been placed there as a result of household poverty and natural disasters, not necessarily because of parental death(s).[4] In Afghanistan, Belarus, Bhutan, Kyrgyzstan, Nepal, Sri Lanka, and Tajikistan, for example, it is estimated that 80 percent or more of children residing in institutions have a living parent. The same holds true in Bangladesh, Bolivia, and Pakistan, where more than 50 percent of children living in institutions are believed to have a living parent.[5] A January 2009 study conducted by the Government of Ghana's Social Welfare Department showed that up to 90 percent of the estimated 4,500 children living in orphanages were not orphans.[6]

The term "most vulnerable children" evolved in policy language over the last two decades in an effort to protect children from the fierce stigma that often accompanies the label "orphan" and to balance the needs of *all at-risk children*, regardless of the causes of their vulnerabilities. Children fall into "at-risk" categories for a wide range of reasons, including poverty; separation from parents due to work migration, HIV/AIDS and other diseases; natural disasters; gender discrimination; and war and conflict. Stigma of orphans remains a particular concern in sub-Saharan Africa where upwards of 12 million

[2] UNICEF, *Progress for Children: A Report Card on Child Protection*, Number 8. September 2009.
[3] Sherr, L., et al, *A Systematic Review on the Meaning of the Concept “AIDS Orphan”: Confusion Over Definitions and Implications for Care*, AIDS Care, 20:527–536, 2008.
[4] UNICEF, *Progress for Children: A World Fit for Children*, Statistical Review, 2009.
[5] Better Care Network, *Global Facts About Orphanages*, UNICEF. July 16, 2009.
[6] WEST AFRICA: *Protecting Children from Orphan-Dealers*, Accra, Ghana, 27 May 2009 (IRIN)

children have been deemed single or double orphans as a result of the HIV/AIDS pandemic.

Long-term research and data compiled by UNICEF indicate that orphans are more likely than non-orphans to miss out on schooling; to live in poor households that experience food insecurity and poor health; to suffer from anxiety, depression and grief; and to contract HIV infection.[7] Other studies have found that children who have lost their mothers are more likely to experience compromised educational outcomes than children who have lost their fathers,[8] and girls are often affected differently than boys.[9] For example, some studies have found girl orphans to be at greater risk than boys for HIV infection and other threats to their reproductive health.[10]

Much of the data referenced in this paper relies on the United Nations definition of "orphan" and its estimate that there are between 143-163 million "orphans" who are in need of immediate care and support in order to survive.[11] Of this number, UNICEF conservatively estimates that two million children live in orphanages worldwide, a number based on 2007 UNICEF data provided by their country office reports. However, other global children's organizations, such as Save the Children UK, estimate the number to be as high as eight million.[12] The lack of oversight, regulation, and reporting requirements makes verification of these figures difficult, as will be discussed later in this paper. Millions of other at-risk children are assumed to be living with families, in community settings, in child-headed households, streets, railway stations, garbage dumps, brothels, and armies. In 2007, the countries with the highest reported populations of orphans were India (estimate: 25 million), China (estimate: 17 million), and Nigeria (estimate: 9.7 million).[13]

## 3. REGIONAL O/MVC CONTEXT

A severe shortage of accurate mapping data makes it extremely difficult to assess the numbers of O/MVC and their living situations globally and regionally. While UNICEF country office reports and calculations are most commonly cited, UNICEF openly acknowledges that its estimates are likely to be conservative. National data gathered from household surveys or other mapping initiatives are available in some countries. In others,

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[7] UNICEF, *Africa's Orphaned and Vulnerable Generation*, New York, 2006.
[8] Case, A. and Ardington, C., *The Impact of Parental Death on School Outcomes: Longitudinal Evidence from South Africa*., Demography, Volume 43-Number 3, August 2006: 401-420; Sherr, L., *Strengthening Families through HIV/AIDS Prevention, Treatment, Care and Support – A Review of the Literature*, JLICA. 2008, referencing: Evans and Miguel, 2007; Bhargava, 2005; Ainsworth et al, 2005; Kamali et al, 1996; Yamano & Jayne, 2005).
Note: The literature review conducted by Lorraine Sherr encompassed 383 studies with keyword reference to "orphan" and "AIDS."
[9] *Orphanhood in Malawi*, The Government of Malawi and UNICEF, 2004-2006; Sherr, L. *Strengthening Families through HIV/AIDS Prevention, Treatment, Care and Support – A Review of the Literature*, JLICA. 2008.
[10] Gregson, S., et al., *HIV Infection and Reproductive Health in Teenage Women Made Vulnerable by AIDS in Zimbabwe,* AIDS Care, 2005. 22: p 759-766; Birdthistle, I., et al., *From Affected to Infected? Orphanhood and HIV Risk Among Female Adolescents in Urban Zimbabwe*, AIDS, 2008, 22: p. 759- 766; Cluver, L., Operario. D., *The Inter-generational Link Between the Impacts of AIDS on Children, and Their Subsequent Vulnerability to HIV Infection: A Study of the Evidence to Inform Policy on HIV Prevention and Child and Adolescent Protection*, JLICA 2008; Sherr, L., *Strengthening Families through HIV/AIDS Prevention, Treatment, Care and Support – A Review of the Literature,* JLICA, 2008.
[11] UNICEF, UNAIDS, and USAID, *Children on the Brink: A Joint Report of New Orphan Estimates and a Framework for Action*, 2004.
[12] Zoll, Miriam, Interview with Better Care Network, April 2010
[13] UNICEF, UNAIDS, and WHO, *Children and AIDS: Fourth Stocktaking Report*, 2009.

particularly those where birth and death certificates are difficult to access—such as Africa and Latin America—government surveys are not necessarily reliable.[14]

*Africa*

Approximately 15.2 million children under the age of 18 in the sub-Saharan African region have been orphaned or made vulnerable as a result of the HIV/AIDS pandemic,[15] and an additional 18.8 million are at-risk due to poverty, disease, gender inequity, famine, war, and/or regional instability. Orphanages are less common in Africa than in other parts of the world in large part due to a cultural tradition of extended family and community care giving in times of need, and the fiscal inability of many governments to support state run institutions. That said, anecdotal evidence from the field suggests a surge of new orphanages in some African countries. In Uganda[16] and Zimbabwe[17], for example, the number nearly doubled between 1998 and 2001. In Zimbabwe, UNICEF found that "the single most important factor contributing to the admission of children to orphanages was poverty."[18] Overall, however, the response by African citizens to the growing O/MVC crisis fueled by the AIDS pandemic remains rooted in the good will of family and communities to care for children in need, as they have done since the HIV virus first surfaced in the late 1980s. Research conducted in 2008 in sub-Saharan Africa suggests that the majority of O/MVC live in family settings—typically with a surviving parent or sibling, or with members of their extended family. [19]

Donor aid has predominantly been invested in HIV/AIDS treatment programs to expand care and medicine to the sick, including prevention of mother to child transmission, rather than specific programs for O/MVC.[20] National governments' efforts to provide basic living assistance to poor households, such as old age pensions or cash transfers that are known to improve O/MVC household security, remain extremely limited in about a dozen African countries.[21] Inadequate monitoring and evaluation of aid money on the part of governments and civil society, and a critical lack of transparency among donors, makes it extremely difficult to determine how much funding is actually being spent on O/MVC programs. National efforts to promptly respond to the O/MVC emergency are hindered in part due to the deaths of trained staff who have died from AIDS, a shortage of qualified replacement workers, and a range of additional infrastructure challenges.[22] As President Festus Mogae of Botswana expressed in a 2003 speech in Washington, DC:

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[14] *Progress for Children: A Report Card On Child Protection*, UNICEF, September 2008.
[15] UNAIDS and WHO, *AIDS Epidemic Update*, 2007
[16] *Uganda Country Report*, Ugandan Ministry of Labor, Gender and Social Development, 2001, p.197.
[17] Powell, G. et al, p. ii.
[18] Powell, G. et al., p. 25.
[19] Hosegood, V., *Demographic Evidence of Family and Household Changes in Response to the Effects of HIV/AIDS in Southern Africa: Implications for Efforts to Strengthen Families*, JLICA, August 2008.
[20] *U.S. Government and Partners: Working Together on a Comprehensive Coordinated and Effective Response to Highly Vulnerable Children,* Third Annual Report to Congress on Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, December 2009
[21] Adato, M., Bassett, L., *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates, Technical Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 1: Strengthening Families*, in Collaboration with the International Food Policy Research Institute, USA, 2008.
[22] *Executive Summary: OVC RAAAP Final Report, The Policy Project in Support of OVC RAAAP Initiative*, USAID, UNICEF, UNAIDS, WFP, January 2005

> *"It should be borne in mind that one impact of the epidemic has been to reduce our own capacity to deal with it, since many of our own people have died. We have recruited others. They too have died. And to the extent that we have suffered these losses, our management capacity to deal with HIV/AIDS has been diminished. And this is why we have done some things less quickly than had been intended or hoped."* [23]

On a positive note, over the last few years, with the infusion of technical support and funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the UK Department of International Development (DFID), many countries are now building and maintaining their own O/MVC databases. A majority of PEPFAR country recipients have also formulated and begun to implement national O/MVC strategies that dovetail with their overarching national HIV/AIDS plans. Of the 22 countries in the East and Southern Africa region, for example, 16 have made progress in developing a national plan of action to address the needs of children without parental care, and these plans target *all* orphans and vulnerable children, including those affected by AIDS.[24] As a result, there has been a marked improvement in O/MVC data collection in some countries, though many gaps still remain.

*Asia*

As in most other regions of the world, poverty is a driving factor behind family separation and children's placement into alternative care setting in Asia. Some parents who are unable to provide basic food, accommodation, education, and health care for their children look to institutional care as an environment where these needs will be met. Approximately one fourth of the world's child population lives in South Asia, comprised of India, Pakistan, Bangladesh, Nepal, Afghanistan, Sri Lanka, the Maldives, and Bhutan. Most of these countries lack widespread family support services and alternatives to institutional care—which is often viewed as the only recourse immediately available to children in need.[25] A 2006 study by UNICEF, however, concluded that no South Asian country had implemented a comprehensive system for monitoring institutional care.[26] In both East and South Asia—where an estimated 72 million children are living in institutional care settings[27]—governments often can and do support state-run orphanages for children. The Bangladesh government in 2003 supported the construction of 500 private homes for children,[28] and Nepal reported the construction of 81 new institutions between 2001 and 2005, though it is not clear if these orphanages were state funded.[29] With an estimated 8,000 children in institutional care in Afghanistan,[30] that country has experienced an "alarming increase in residential

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[23] Mogae, Festus*, President of Botswana Speech to CSIS Task Force on HIV/AIDS and Members of the Bush Administration,* Washington, DC, November 2003.

[24] Inter-Agency Task Team on Children and HIV and AIDS Working Group on National Plans of Action, 'National Responses for Children Affected by AIDS: Review of progress and lessons learned', IATT, New York, August 2008, pp. 11–13.

[25] UNICEF, UNAIDS, and WHO. Children and AIDS: Fourth Stocktaking Report. 2009.

[26] UNICEF, *Children Outside Parental Care*, 2006.

[27] UNICEF, Facts on Children, http://www.unicef.org/media/media_45451.html . Last accessed November 17, 2008.

[28] Dona, G., *Overview of the Conditions of Children Outside Parental Care in Institutions and Communities*, UNICEF, 2003.

[29] New Era and ORC Macro, *Study of Children in Children's Homes in Nepal*, USAID, 2005.

[30] Islamic Republic of Afghanistan Ministry of Labor and Social Affairs (MOLSA), National Strategy for Children 'At-Risk', 2006.

care," with numbers in some Kabul institutions doubling between 1998 and 2003.[31] A study supported by UNICEF in 2003 showed an annual doubling in that country of the number of children entering institutional care.[32]

As of 2003, more than 48 million of the estimated 584 million children in the South Asian region were reported as having lost one or both parents. Across South Asia, an estimated eight percent of the total population under 18 is classified as orphans, with national estimates ranging from approximately 6.5 percent (Pakistan and Sri Lanka) to 13 percent (Afghanistan).[33] In India, which is estimated to have 25 million orphans,[34] data from Kerala region suggests a population of more than 50,000 O/MVC living in 600 institutions.[35] In Sri Lanka, more than 50 percent of children in orphanages were admitted due to poverty,[36] and 20 percent of the children in institutional care in the North-East Province were placed with the hope of accessing education.[37] While government records showed 11,000 children to be living in institutional care nationwide, independent research indicates that there are close to 16,000 institutionalized children in just four of Sri Lanka's eight provinces.[38]

China's Ministry of Civil Affairs estimates that there are 712,000 at-risk children nationally, with approximately 90,000 living in child/social welfare institutions. The vast majority of O/MVC are thought to live in the community with guardians.[39] Another study, however, conducted with the same Ministry and the Beijing Normal University, estimates that there were 573,000 O/MVC, including 67,942 children living in child/social welfare institutions.[40]

In Cambodia, the number of registered residential care facilities rose in 2009 to a total of 224 with 11,029 child residents, representing a 14 percent increase since 2008, and a 51 per cent increase since 2005. Statistics are based on the 2008 annual statistical reports of the Ministry of Social Affairs. In 2009, the total number of orphanages rose to 257, with 21 state-run orphanages and 236 NGO orphanages, housing a total of 11,834 residents. Many orphanages in Cambodia are sponsored by overseas donors, many of them faith-based, such as the U.S. Four Square Church.[41]

*Central and Eastern Europe and the Commonwealth of Independent States*

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[31] See Country Reports to the Second International Conference on 'Children and Residential Care: New strategies for a new millennium,' Stockholm, 2003., p.6
[32] Islamic Republic of Afghanistan Ministry of Labor and Social Affairs (MOLSA) and UNICEF, 2003.
[33] *Child Care Policy/Country Reports: What You Can Do About Alternative Care in South Asia*, UNICEF, January 2008.

[34] UNICEF, UNAIDS, and WHO. Children and AIDS: Fourth Stocktaking Report. 2009.
[35] Government of India, , *Convention on the Rights of the Child: India - First Periodic Report*, Department of Women and Child Development, 2001.
[36] Save the Children, *Children in Institutional Care in Sri Lanka: The Status of Their Rights and Protection in Sri Lanka*, 2005.

[37] *Home Truths: Children's Rights in Institutional Care in Sri Lanka*, Save the Children in Sri Lanka, p. 12.
[38] Jayathilake, R. and Amarasuriya, H., *Home Truths: Children's Rights in Institutional Care in Sri Lanka*, Save the Children in Sri Lanka, 2005.
[39] *Cost of Care of Orphans*, China Ministry of Civil Affairs and UNICEF, 2009.
[40] *Situation Analysis on Kinship Care of Orphans in China,* China Ministry of Civil Affairs, Beijing Normal University, Save the Children, 2005.
[41] Zoll, Miriam, Interview with Better Care Network, April 2010

The CEE/CIS region has a strong tradition of state involvement in child protection, inherited from its Soviet past. UNICEF estimates that there are more than 800,000 to one million children in institutional care in the region, and that the rate of children in formal care today has risen since the transition from the Soviet period.[42] Ironically, findings from a survey of 42 European countries found that some CEE and South Eastern European states may now have more up-to-date child protection laws than many of the more affluent states in Western Europe. This shift reflects the political attention to and increased awareness of the crucial efforts required to improve the situation of children in residential care in many of the states of the former Soviet Union.[43]

In CEE/CIS the proportion of all children who are in institutions has increased, according to research by the UK-based organization EveryChild. While the total number of children living in orphanages is estimated to have decreased by over 100,000,[44] the birth rate in the region has also fallen dramatically, and in many of the region's countries the proportion of children in orphanages has actually increased.[45] Part of this increase is due to parental migration to Russia in search of work. As in Asia and Africa, research from Eastern Europe has shown that material poverty at the household level is one of the key motives for placing children in orphanages.[46] In Bulgaria, the number of children in orphanages increased by more than 20 percent from the early 1990s to the end of the decade, as living conditions deteriorated.[47]

*Caribbean and Latin America*

Relevant data on O/MVC in the Caribbean and Latin America region was more difficult to locate than data for other regions. While data in Spanish was available in many countries, researchers for this particular paper were not able to access or easily translate reports and country surveys.

UNICEF estimates that 1.3 million at-risk children in the Latin American and Caribbean region do not have proper birth certificates or documentation, making it difficult for them to access state social services and anti-poverty benefits.[48] A useful 2007 report on children in the Caribbean estimated that over 6000 children were living in institutional care, excluding Haiti where the estimate was as high as 50,000.[49] Reports from Trinidad and Tobago, Guyana, and Jamaica show that institutional care is still being utilized in many cases as a first resort; that children are staying well beyond a temporary stay; and that standards within institutional care are generally absent or not in compliance with the

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[42] *The Institutional Care of Children*, UNICEF, New York, January 2008 (internal document)
[43] Guðbrandsson, B., *Rights of Children in Institutions: Report on the Implementation of the Council of Europe Recommendation Rec(2005)5 on the Rights of Children Living in Residential Institutions*, Council of Europe, 2009, pg. 2-3.
[44] Carter, R., *Family Matters: A Study of Institutional Childcare in Central and Eastern Europe and the Former Soviet Union*, Every Child, 2001, p. 16.
[45] UNICEF, *Innocenti Social Monitor 2006: Understanding Child Poverty in Southeastern Europe and the Commonwealth of Independent States*, UNICEF Innocenti Research Centre, 2006, p 62. Available at http://www.unicef-icdc.org/publications/pdf/ism06_eng.pdf
[46] *Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children*, accessed on the Better Care Network website, http://www.bettercarenetwork.org
[47] Gantcheva, R. & Kolev, A., *Children in Bulgaria: Growing Impoverishment and Unequal Opportunities*, Innocenti Working Paper Series No. 84, UNICEF, Florence, January, 2001, p. 35.
[48] UNICEF, *A Report Card on Child Protection*, 2009
[49] Lim Ah Ken, Patricia, *Children Without Parental Care in the Caribbean: Systems of Protection*, UNICEF, November 2007.

Convention on the Rights of the Child. In Trinidad, the majority of children have been in residential care for over two years and many have stayed for longer than six years.[50] According to the report, only Belize, Jamaica, Grenada, and Barbados have established legal regulations governing residential care institutions. UNICEF reports that civil society organizations in Suriname and Trinidad have begun to establish their own independent standards. In Guyana, UNICEF has facilitated a partnership between residential care institutions and the government to elaborate a set of best practice standards.[51]

In 2001, 180 million people in the Latin American region—about one-third of the population—were estimated to be living in poverty with incomes under US$2 per day. Brazil, Colombia, Mexico, and Argentina have the highest levels of HIV/AIDS infection among adults and more vulnerable children as a result.[52] An estimated 36,000 children under the age of 15 in Latin America are thought to be HIV positive.[53] Seventy percent of the region's poor live in the seven largest middle-income countries— Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico, and Uruguay.[54] Poverty is a particular problem in rural areas and among the indigenous populations; children constitute a particularly vulnerable group with up to 40 percent living in poor households. In Brazil, it is estimated that 24 percent of children and adolescents living in orphanages are there due to poverty.[55]

Research suggests that some form of child-conditioned income transfers, support for maternal employment, and early childhood programs are key to reducing both child poverty and enhancing child development (along with sanitation, water, and shelter).[56] Broadly speaking, many Latin American countries have pioneered successful anti-poverty programs—some of which are now being replicated in Africa and Asia—that have helped to improve the lives of poor children, most notably cash-transfer and social pension programs.[57] In September 2009, the Organization of American States launched the Inter-American Social Protection Network. U.S. Secretary of State Hillary Clinton hosted the launch, expressing the U.S. government's commitment to supporting best practices in social protection in Latin America. In particular, she noted conditional cash transfer programs and their positive impact on health and education outcomes for children.[58]

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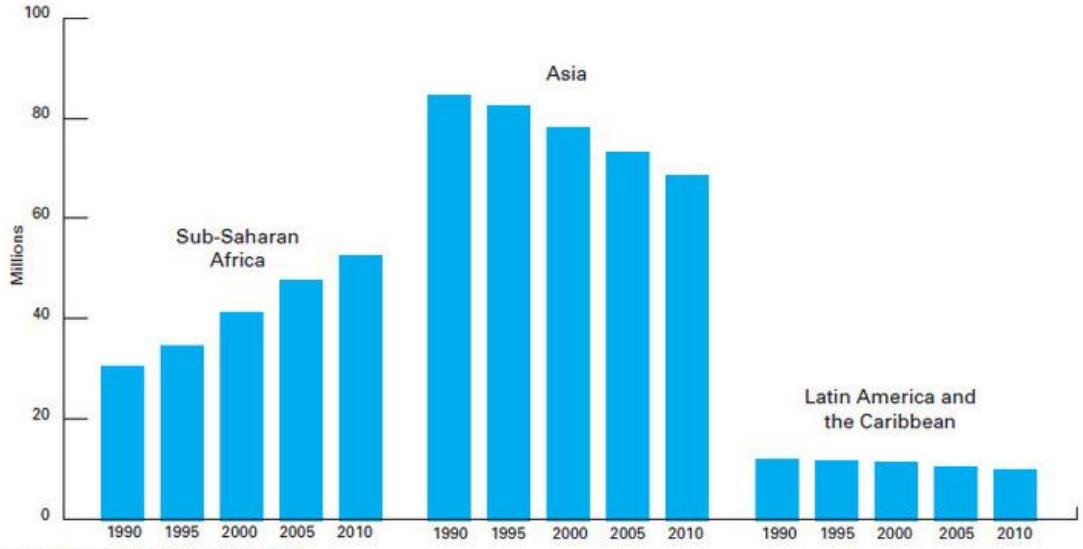
[50] Ibid.
[51] Magda Wills, F., *Assessment of Procedural and Physical Standards in Children's Residential Care Institutions in Guyana*, UNICEF: Guyana, 2007.
[52] Abreu A. G., Noguer I., Cowgill K., *HIV/AIDS in Latin American Countries,* The World Bank, 2003.
[53] UN Economic Commission for Latin America and the Caribbean - www.eclac.org
[54] Gordon, D., Shailen Nandy, Christina Pantazis, Simon Pemberton, and Peter Townsend, *Child Poverty in the Developing World*, Bristol, England: University of Bristol, Policy Press, 2003.
[55] *O Direito à Convivência Familiar e Comunitária: Os Abrigos Para Crianças e adolescents no Brasil*, The Research Institute of Applied Economy (IPEA) and the National Council of the Rights of the Child and Adolescent (CONANDA), Brasília, 2004, p. 56.
[56] Kamerman, Sheila B. (2003) " Child Well-Being, Family Allowances and Social Services in Latin America" in ISSA, Social Services and Family Allowances: Social Security for Everyone Geneva: ISSA
[57] Adato, M., Bassett, L., *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates, Technical Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 1: Strengthening Families*, in Collaboration with the International Food Policy Research Institute, USA, 2008.
[58] *U.S. Government and Partners: Working Together on a Comprehensive Coordinated and Effective Response to Highly Vulnerable Children,* Third Annual Report to Congress on Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, December 2009

FIGURE 1.1: Number of orphans ages 0–17, by region, 1990–2010




**Source**: UNAIDS and UNICEF estimates, 2006.

* Unless otherwise indicated, the figures on orphans in this document include orphans from all causes.

## 4. HISTORICAL CONTEXT OF DONOR TRENDS TOWARD O/MVC PROGRAMS.

It is difficult if not impossible to discuss current donor trends for O/MVC without discussing the global HIV/AIDS pandemic and the historical context of donor responses to that ongoing emergency. The *daunting* numbers of O/MVC in sub-Saharan Africa alone—an estimated *34 million*—are heart wrenching and overwhelming. Regional data available for the year 2008 indicates that of the estimated 143 to 163 million orphans globally, 55.3 million–33.9 percent–live in sub-Saharan Africa,[59] and an estimated 10.7 percent (17.5 million) have lost one or both parents due to AIDS.[60]

Over the last three decades, the devastating presence of AIDS has galvanized billions of dollars in international aid and forced governments and the global community to examine more closely the need to fund and sustain child development programs as well as children's material needs, such as food, shelter, and clothing. Since AIDS first emerged as a public health issue, African governments and global donors have shied away from expensive institutional care settings (hospitals or orphanages) and relied instead on more affordable voluntary care provided by families and communities (see page 24 for costing data).[61] Today the voluntary care of infants and children is still most often delivered by women between the ages of 20 and 50 who work to ensure that O/MVC[62] receive basic essentials for survival, as well as consistent emotional ties with a caregiver. The current

[59] UNICEF, UNAIDS, and WHO, *Children and AIDS: Fourth Stocktaking Report,* 2009.
[60] UNAIDS, *Report on the Global AIDS Epidemic*, 2008.
[61] Executive Summary, *OVC RAAAP Initiative Final Report, Rapid Country Assessment, Analysis, and Action Planning (RAAAP) Initiative On Behalf of Orphans and Other Vulnerable Children in Sub-Saharan Africa*, Prepared by POLICY Project In Support of the OVC RAAAP Initiative, USAID, UNICEF, UNAIDS and WFP, January 2005.
[62] Budlender, Debbie, for the Huairou Commission, *Compensation for Contributions: Report on Interviews with Volunteer Caregivers in Six Countries*, New York, USA: The Huairou Commission, 2010.

trend among donors to invest in programs that strengthen families and communities' ability to comprehensively care for O/MVC is directly linked to Africa's unique and extremely challenging public health and economic circumstances. It is also linked to a long history of combining global child protection with children's rights, efforts to achieve gender equity, and programs designed to alleviate household poverty.

*Convention on the Rights of the Child*

One of the most important legal human rights instruments for children is the 1989-1990 UN Convention on the Rights of the Child (CRC) that established children's civil, political, economic, social, and cultural rights, and reinforced the notion that the family unit is the best environment for children to thrive.[63] While 193 countries ratified the CRC in November 1989, some governments still have not built in provisions to their legal and child welfare systems to enforce it. The four core principles of the CRC are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. The preamble to the CRC contains succinct pro-family language that has undoubtedly influenced donor-funding patterns toward family and community-based care, and has helped create a movement among child welfare systems globally to deinstitutionalize children and integrate them into community and family care settings.[64]

> *"Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community…Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding…"*
>
> *Preamble to the United Nations Convention on the Rights of the Child*

*2001 UNGASS Declaration of Commitment on HIV/AIDS*

A decade later, a unified global effort to assist the millions of O/MVC specifically affected by the HIV/AIDS pandemic in sub-Saharan Africa (and Asia) began to materialize. In September 2001, 50 countries signed the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, which included a core set of indicators applicable to orphans and other vulnerable children (OVC). Basic OVC care and support services may include medical support, socioeconomic support such as clothing, food parcels, financial support, and shelter, and psychological support such as counseling and spiritual support. Specifically, the language of the UNGASS goals reinforced the pro-family theme of the CRC and renewed donor

[63] Kang, Kris, *What You Can Do About Alternative Care in South Asia: An Advocacy Kit*, Better Care Network, UNICEF, Katmandu, Nepal, 2008, pg. 13
[64] Richter, L., Foster, G., Sherr, L., *Where the Heart Is: Meeting the Psychosocial Needs of Young Children in the Context of HIV/AIDS*, The Hague, Netherlands, Bernard Van Leer Publications, 2006.

commitment toward strengthening the capabilities of families, communities, and governments to provide adequate support and care to vulnerable children:

> *"By 2003, develop, and by 2005 implement, national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;*
>
> *Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;*
>
> *Urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programs to support programs for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa."*

*Inter-Agency Task Team on OVC and Global OVC Partners Forum*

That same year, the UNAIDS Committee of Cosponsoring Organizations called for the creation of an Inter-Agency Task Team (IATT) on OVC. In August 2001, UNICEF convened the first meeting comprised of UNAIDS co-sponsors and key partner organizations.[65] Those in attendance included representatives from UNICEF, the UNAIDS Secretariat, UNDP, UNFPA, the World Food Program (WFP), Save the Children Alliance/Hope for African Children Initiative, USAID, USAID/Displaced Children and Orphans Fund, and the International Federation of Red Cross and Red Crescent Societies. Two years later, in 2003, UNICEF convened a broad coalition of stakeholders through the IATT to reach consensus on a set of ten core indicators to measure national progress toward improving the welfare of children in need. It is not clear from research conducted for this report if a unified body of representatives from the institutional care sector participated in any of these meetings. At the First Global OVC Partners Forum, held in October 2003, an agreement was reached for greater collaboration to rapidly scale up and improve the quality of response to orphans and other vulnerable children. The significance of the ten percent O/MVC earmark for African countries receiving aid from the then brand new PEPFAR program was highlighted and celebrated during this forum.[66] Today, PEPFAR remains the largest donor to O/MVC programs in the world.

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[65] Second Meeting of the Inter-Agency Task Team on Orphans and other Vulnerable Children, Report of Meeting on 12 November 2002.

[66] *Executive Summary: OVC RAAAP Final Report, The Policy Project in Support of OVC RAAAP Initiative*, USAID, UNICEF, UNAIDS, WFP, January 2005

*OVC RAAAP*

Subsequently, USAID, UNICEF, UNAIDS, and the WFP outlined a desire to conduct a massive rapid assessment exercise as a preliminary step to scale up their response to the growing O/MVC crisis in Africa. By 2003 it had become clear that the head on collision of ineffective prevention and treatment, infringements on women and children's human rights, deepening poverty, and crippled public health infrastructures now constituted a major natural disaster for children and families that needed to be evaluated and assessed in a more comprehensive manner.[67] From 2003 to 2005, USAID, the UN, and Futures Group International conducted an unprecedented investigation of children's policies and programs in 17 sub-Saharan African countries that has since become a baseline for measuring progress in this arena. The multi-year initiative was known as the *Rapid Country Assessment, Analysis and Action Planning Process for Orphans and Vulnerable Children in sub-Saharan Africa* (OVC RAAAP). Initially, the study targeted Botswana, Central African Republic, Cote d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. The final report indicated that most governments did not have specific policies in place to assist vulnerable children and their families, and that most governments and donors were not able to track how funds were being distributed to at-risk children.[68] Similar studies were subsequently conducted in Asia and the Caribbean.

*The Framework*

In July 2004, while the OVC RAAAP was underway, UNICEF and UNAIDS joined with a broad range of multi-sectoral representatives to solidify the *Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS.*[69] Those engaged in this worldwide endeavor were donor and government agencies, FBOs, NGOs, academic institutions, the private sector, and civil society representatives. It is not known if institutional care facilities participated in discussions and the formation of policies for vulnerable children. The five tenets that comprise the *Framework,* first presented in UNICEF's *Children on the Brink* in 1997,[70] represent a pro-family agenda that has since been adopted by numerous donors and other stakeholders to support and mobilize family and community-focused responses to the pandemic rather than institutionalized care. These include but are not limited to: DFID, the Global Fund, the Bernard Van Leer Foundation, CARE, Family Health International, Columbia University's Mailman School of Public Health, and the WFP.[71] The tenets of the *Framework* are as follows:

- #1 Framework Strategy: Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial, and other support.

[67] Ibid
[68] Ibid

[69] www.unicef.org/aids/files/Framework_English.pdf
[70] Williams, John, *Strategic Action Developed for Children and Their Families*, 2003
[71] *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS*, UNAIDS and UNICEF, July 2004.

- #2 Framework Strategy: Mobilize and support community-based responses to provide both immediate and long-term support to vulnerable households.
- #3 Framework Strategy: Ensure access for children in need to essential services, including education, healthcare, and birth registration.
- #4 Framework Strategy: Ensure that governments protect the most vulnerable children through improved policy and legislation, and by channeling resources to communities.
- #5 Framework Strategy: Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.[72]

*UN Guidelines for the Alternative Care of Children*

Throughout many regions of the world, ministries charged with children's welfare often lack the capacity to effectively implement laws protecting children, or to gather information to determine whether O/MVC's basic needs, such as food, shelter, clothing and healthcare, are being met. Many child welfare officials are unaware of how many institutional facilities or family and community-based care programs exist within their borders, who funds them, or how many at-risk children are receiving care and services.[73] These serious gaps in information pose a primary concern for children's vulnerability to child trafficking, illegal adoption, prostitution, child labor, violence, and abuse. In an effort to close these gaps and to reinforce prevention of family separation, the UN General Assembly in 2009 passed by consensus the *UN Guidelines for the Alternative Care of Children*, an important document aimed at improving the safety and security of children living in alternative settings outside of parental care. Though there is no way to enforce the standards outlined in the *Guidelines* the very existence of the document itself sends a strong child protection message to governments.

"Alternative care" refers to the spectrum of care settings and services available to children whose parents are no longer able to provide adequate care for them. This includes but is not limited to: statutory residential care, adoption and foster care, infant centers, children's homes, children's villages, traditional foster care, crisis care, community family models, cluster foster care, community-based support, and home-based support (See Annex B). The *Guidelines* provide urgently needed guidance for applying a child rights approach to alternative care. They emphasize prevention of separation and family strengthening efforts, promote family reunification, and highlight the obligation to provide suitable alternative care.[74] The document discusses universal placement practices and standards, and stipulates the need for individual placement plans that best meet the needs of each child and his/her circumstances. Most importantly for the context of this paper, it reinforces the CRC and the *Framework's* focus on a *child's right* to be raised in a loving family environment rather than an orphanage.

*"Guidelines for the appropriate use of alternative care should establish clear*

[72] UNAIDS and UNICEF, *Children on the Brink 2004: Strategies to Support Children Isolated by HIV/AIDS*, New York, 2004.
[73] *Missing: Children Without Parental Care in International Development Policy*, Every Child, November 2009.
[74] http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/11/L.13

*priority, in line with the CRC and international best practices, for family and community-based placements over institutional care, for permanent over temporary placements, and for domestic (national) solutions rather than international ones."*

*..."A fundamental shift away from over-reliance on institutional care can be supported by actively discouraging the creation of institutional care facilities. International experience demonstrates that once an institution is built it will be filled, irrespective of children's needs."*

*Anti-Poverty Programs and O/MVC*

The links between poverty, gender inequity, loss of parental care, and children's vulnerability have drawn global attention to the need for specific child-sensitive social protection strategies.[75] A comprehensive study commissioned by the Joint Learning Initiative on Children and HIV/AIDS (JLICA) in 2008 reviewed over 300 documents describing and evaluating income transfer programs in middle and low income countries globally.[76] The study showed that some regional anti-poverty programs utilizing cash transfers—particularly those that originated in Latin America and are now being applied in Africa and Asia—have successfully improved many vulnerable families' ability to provide and care for their children, or children in their extended families and communities.

Cash transfers are targeted programs—usually by geographic area and income level—and often incorporate monitoring and evaluation from the outset. Pilot and more well established programs have been shown to have a significant impact on childhood, and likely intergenerational, poverty.[77] These conditional and unconditional fiscal schemes provide a package of interventions aimed at increasing children and families' wellbeing by placing money directly in the hands of the poor.[78] In some programs, transfers are contingent upon families using a percentage of the funds to buy food or pay for school fees or medical treatment. Mexico's rigorously evaluated *Oportunidades* program, for example, sets three conditions for receiving income transfers: children's regular school attendance, routine visits by family members to health clinics, and participation in an improved nutrition program.[79] Another example is Mexico's PROGRESA program that provides $13 per family per month (equal to 20 percent of mean household consumption).[80] This successful program has helped to reduce headcount poverty by 17

[75] *Missing: Children Without Parental Care in International Development Policy*, Every Child, November 2009.
[76] Adato, M., Bassett, L., *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates, Technical Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 1: Strengthening Families*, in Collaboration with the International Food Policy Research Institute, USA, 2008.
[77] *Making Cash Count: Lessons from Cash Transfer Schemes in East and Southern Africa for Supporting the Most Vulnerable Children and Households*, HelpAge International, Institute of Development Studies, Save the Children-UK, 2005.
[78] JLICA, *Home Truths: Facing the Facts on Children, AIDS, and Poverty*, Joint Learning Initiative on Children and AIDS, 2009.
[79] Adato, M., Bassett, L., *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates, Technical Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 1: Strengthening Families*, in Collaboration with the International Food Policy Research Institute, USA, 2008.
[80] Schady, N., *Conditional Cash Transfer Programs: Reviewing the Evidence.* Paper presented at the Third International Conference on Conditional Cash Transfers, Istanbul, Turkey, 2006; Skoufias, E., *PROGRESA and Its Impacts on The Welfare of Rural Households In Mexico,* Washington, DC: International Food Policy Research Institute, 2005.

percent and the severity of poverty by 46 percent.[81] A study of a cash transfer program in Mozambique also found reductions in the headcount of poverty and poverty severity.[82]

The evidence in favor of cash transfer programs suggests that both unconditional and conditional cash transfer programs are effective in reducing poverty.[83] In terms of unconditional programs, a 2004 South African study[84] found that Child Support Grants (CSG) helped reduce the incidence of poverty by eight percent and the severity of poverty by 20 percent in a study among HIV-affected households. The program was also effective in improving children's access to education, nutrition, and health, and was associated with an 8.1 percent increase in school enrollment among six year-olds and a 1.8 percent increase among seven year-olds.[85] The study suggests that families receiving CSG in South Africa prioritize school attendance for their children over those who do not receive grants.

Based on research for this report, there appears to be limited quantitative evidence regarding the benefits of cash transfers on children's health. However, preliminary qualitative analyses of many cash transfer programs, such as Concern Worldwide's Dowa Emergency Cash Transfer project in Malawi, show that individuals receiving cash transfers had better access to health care in addition to increased ability to cover transportation and medication expenses.[86] Several studies have also suggested that cash transfers have generated increased spending on food, allowing for greater consumption and improved nutrition.[87] An evaluation of Zambia's Social Cash Transfer Scheme, for example, suggested a reduction in the percentage of individuals having only one meal a day from 19 to 13 percent and a decrease from 56 to 34 percent in individuals reporting daily hunger pains.[88] Other studies have documented the positive impacts of the South African Old Age Pension on children's growth in recipient households, particularly for girls. Results from several countries confirm that pension recipients increase spending related to children's welfare, for example on food or healthcare. Both Botswana and Lesotho have recently introduced national old age pension schemes, joining a growing

[81] Skoufias, E., *PROGRESA and Its Impacts on The Welfare of Rural Households In Mexico,* Washington, DC: International Food Policy Research Institute, 2005.
[82] Datt, G., Payongayong, E., Garrett, J.L., & Ruel, M.T., *The GAPVU cash transfer program in Mozambique: An assessment* (Food Consumption and Nutrition Division Discussion Paper No. 36), Washington, DC: International Food Policy Research Institute, 1997.
[83] Kim, Jim, et al, *The Implementation Gap in Services for Children Affected by HIV/AIDS: Supporting Families and Communities in Caring for and Protecting Vulnerable Children*, Learning Group 3 Draft Report, Joint Learning Initiative on Children and HIV/AIDS, François Xavier Bagnoud Centerfor Health and Human Rights, Harvard School of Public Health, 2008.
[84] Booysen, F., *Social Grants As Safety Net For HIV/AIDS-Affected Households In South Africa*, Journal of Social Aspects of HIV/AIDS Research Alliance, 1(1), 45-56, 2004.
[85] Samson, M., Lee, U., Ndlebe, K., MacQuene, K., van Niekerk, I., Gandhi, V., et al., *The Social and Economic Impact of South Africa's Social Security System: Final Report,* Cape Town, South Africa: Economic Policy Research Institute, 2004.
[86] Devereux, S., Mthinda, C., Power, F., Sakala, P. & Suka, A., *An evaluation of Concern Worldwide's Dowa Emergency Cash Transfer Project (DECT) in Malawi,* Lilongwe: Concern Worldwide, 2007.
[87] Case, A., *Does Money Protect Health Status? Evidence from South African Pensions*, Princeton, NJ: Woodrow Wilson School of Public and International Affairs, Center for Health and Wellbeing, Princeton University, 2001; Samson, M., Lee, U., Ndlebe, K., MacQuene, K., van Niekerk, I., Gandhi, V., et al., *The Social and Economic Impact of South Africa's Social Security System: Final Report,* Cape Town, South Africa: Economic Policy Research Institute, 2004.
[88] MCDSS/GTZ, *Evaluation Report: Kalomo Social Cash Transfer Scheme,* Lusaka: Republic of Zambia Ministry of Community Development and Social Services and German Technical Cooperation, 2006.

number of sub-Saharan African countries that have such programs in place, or are considering them.[89]

This wide body of evidence-based analysis suggests that most developing countries can afford some form of social protection services for O/MVC affected by HIV/AIDS or extreme poverty. In 2005 the International Labor Organization estimated the cost of a social protection package targeting low-income African countries. The package consisted of a small universal old age pension, universal primary education, free primary health, and a child benefit of US$ 0.25 per day—at between 1.5 and 4.5 percent of Gross Domestic Product.[90] In South Africa and Namibia, pensions given to older family members are often used to effectively sustain entire extended families[91] that may consist of a grandmother caring for upwards of a dozen or more grandchildren or other relatives. Such transfers are generally low cost and affordable: Lesotho, Mozambique, Botswana, Mauritius and Nepal all have universal old age pensions which cost no more than 2 percent of their GDP.[92] In Zambia, calculations from a pilot social cash transfer scheme indicate that costs for all destitute families would come to around 0.5 percent of the country's GDP.[93] Despite such economic calculations, there is still a considerable underinvestment in these kinds of proven social protection measures.

## 5. O/MVC CARE SETTINGS AND IMPLICATIONS FOR CHILD DEVELOPMENT

*Where Do Orphans and Most Vulnerable Children Live?*

Donors have certainly taken note of the pro-family sentiments in the CRC, the *Framework*, and the *Guidelines*. The intent and language of these global agreements were influenced to some extent by the large cache of child development research purporting that a stable home environment and the existence of a primary caregiver is a key factor in the healthy psychological development of children.[94] Given the surging numbers of at-risk children globally, a wide range of care options, in addition to family settings, must be taken into account and considered. Some of these care environments are formal institutions, most often built by governments or churches, which an estimated 2 to 8 million children call "home." Others are family-like settings—such as SOS Villages—where many O/MVC unrelated by blood live might live together and function as a "family" or "children's village" under the auspices of a foster mother or family. Some children live in child-headed households with no adult supervision, or in packs that roam the streets of urban centers and rural areas. But extensive research conducted by JLICA

[89] Adato, M., Bassett, L., *What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates, Technical Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 1: Strengthening Families*, in Collaboration with the International Food Policy Research Institute, USA, 2008.
[90] Pal, K., et al, *Can Low-Income Countries Afford Basic Social Protection? First Results of A Modeling Exercise*, International Labor Organization, Issues in Social Protection, Geneva, 2005.
[91] HelpAge International, *Age and Security: How Social Pensions Can Deliver Effective Aid to Poor Older People and Their Families*, London, 2004.
[92] JLICA, *Home Truths: Facing the Facts on Children, AIDS, and Poverty*, Joint Learning Initiative on Children and AIDS, 2009.
[93] *Making Cash Count: Lessons from Cash Transfer Schemes in East and Southern Africa for Supporting the Most Vulnerable Children and Households*, HelpAge International, Institute of Development Studies, Save the Children-UK, 2005.
[94] Adam, E.E., *Beyond Quality: Parental and Residential Stability and Children's Adjustment*, Current Directions in Psychological Science, 13 (5), 210-213, 2004.

in 2008 revealed that the vast majority of O/MVC – particularly those affected by HIV/AIDS – live in extended or foster care family systems.[95]

A rather passionate and sometimes contentious debate exists between family and community-based care advocates and those who believe that more orphanages should be built. While a large scope of research has found that children raised in institutional care suffer serious emotional dysfunction, the same can be said for children living in family or community-centered environments wracked by abuse, violence, or the perils of chronic poverty. Since as early as the 1950s, a large number of child development researchers have consistently reported findings about the detrimental impact of institutional care on infants and children up to six and eight years old. In December 2008, however, a highly controversial study released by Duke University raised public attention to the fact that in some countries, children aged 6-12 in orphanages may fare better than or equal to children living in family and community-based settings.[96]

The Duke study was conducted in five countries in Asia and Africa – Cambodia, Ethiopia, India, Kenya and Tanzania – with researchers visiting 83 institutions from May 2006 to February 2008. They studied 1,357 orphans aged 6 to 12 living in institutions, and 1,480 living in homes in their communities. On average, the orphanages—some of which were family-like in structure – housed 63 children each. Twenty-eight percent housed 20 or fewer children and 17 percent housed 100 or more. Community-based care situations housed far fewer children in more family-like settings. The researchers assessed children's physical and mental health, behavior, physical growth, and intellectual functioning. The findings revealed much greater variability among children within care settings than among care settings type, reinforcing previous research pointing to the micro-care environment as a source of benefit or detriment to children in any number of care settings.[97] Researchers recommended that methodologically rigorous studies be conducted in those countries facing mounting orphan and abandoned children (OAC) populations in order to understand which characteristics of care promote child wellbeing. Such characteristics, researchers suggest, may transcend the structural definitions of institutions or family homes.[98]

Around the world, a common reason often cited by parents for placing their children in institutional care is to improve their material conditions. In some situations, orphanages may be better equipped than families to feed, clothe, and shelter children, and to ensure school attendance. There is no question that severe poverty and trauma caused by disease, civil unrest, war, and natural disaster compromise many families' ability to raise happy, well adjusted, and well cared for children. However, donors and policymakers today both argue—and many are investing in the notion—that if poor households were to receive support in any number of forms (i.e. cash transfers, psychosocial counseling, food

[95] Foster, G., Deshmukh, D., Adams, A., *Inside-Out? Strengthening Community Responses to Children Affected by HIV/AIDS,* Synthesis Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 2: Community Action, 2008.
[96] Whetten, K., et al., *A Comparison of the Wellbeing of Orphans and Abandoned Children Ages 6–12 in Institutional and Community-Based Care Settings in 5 Less Wealthy Nations,* PLoS ONE 4(12): e8169. doi:10.1371/journal.pone.0008169, 2009.
[97] Smyke, A.T., Koga, S.F., Johnson, D.E., et al, *The Caregiving Context in Institution-Reared and Family-Reared Infants and Toddlers in Romania,* Journal of Child Psychology and Psychiatry, 48(2), 210-218, 2007
[98] Whetten, K., et al., *A Comparison of the Wellbeing of Orphans and Abandoned Children Ages 6–12 in Institutional and Community-Based Care Settings in 5 Less Wealthy Nations*. PLoS ONE 4(12): e8169. doi:10.1371/journal.pone.0008169, 2009.

baskets, etc.), their ability to provide for their children would improve dramatically and the need for orphanages would decrease. In this sense, the desire to improve care and protection of O/MVC is directly linked to national and global strategies to alleviate household poverty and other inequities, including gender, that often accompany it.

The task of creating loving homes and reliable safety nets for an estimated population of 143 to 163 million O/MVC is daunting economically, logistically and spiritually. Based on the research conducted for this paper, it is clear that O/MVC care settings must be varied, based in part on children's individual needs and rights, but also on the more pragmatic reality of which programs, facilities, and services are actually available in the communities in which they live. In a study about children's resilience to severe challenges, such as the death of parents due to AIDS, a South African study recorded children's views about safety and security. The places children said they felt most safe were at home, school, and in the community. The findings support existing literature that suggests that an aspect of "belonging" or "connection" to a person or social structure includes identifying physical spaces that create a feeling of security, which in turn enhances children's resilience to circumstances beyond their control.[99]

In cases where children are completely abandoned and no foster or community programs exist, state or church-operated orphanages may be the only available alternative. The most common type of alternative care provided by the state is institutional care, particularly in countries of the former Soviet Union and in Asia. Throughout South Asia, for example, institutional care is often the only option formally supported and recognized by the government.[100] That said, in many developing countries institutional facilities often operate below government radar screens. A large number of residential facilities in Asia, Africa, and Latin America, for example, are not officially registered with appropriate social or child welfare ministries, nor is their quality of care monitored or evaluated. This is especially true of church-funded orphanages that are exempt by law from reporting donations and providing annual data about the numbers of children served or the kinds and frequency of services provided. These critical data gaps make it extremely difficult for child protection agencies nationally and globally to assess or improve the quality of care received by children, or even to determine if certain facilities are engaging in practices such as child trafficking, slavery, or illegal international adoptions.

*Child Development Research Findings*

Developmental child psychology reveals that children's earliest experiences and social attachments to others form the backbone of their ensuing learning, setting the stage for their ability to cope with challenges later in life. Their relationship to others, and especially to loving and attentive primary adult caregivers, is among the most important factors in healthy psychological development.[101] Extensive research from various

[99] Rochat, T., Hough, A., *Enhancing Resilience in Children Affected by HIV/AIDS: Children's Views and Experiences of Resilience Enhancing Family and Community Practices, Child, Youth, Family and Social Development*, Human Sciences Research Council, July 2007.
[100] *Child Care Policy/Country Reports: What You Can Do About Alternative Care in South Asia*, UNICEF, January 2008.
[101] Vygotsky, L.S., *Mind and Society: The Development of Higher Mental Processes*, Cambridge, MA: Harvard University Press, 1978.

countries confirms that O/MVC between the ages of 0 and 8 who have experienced serious emotional trauma early in life are more likely to suffer from depression and other mental health conditions later in their lives.[102] In societies with a high burden of HIV/AIDS and poverty, for example, children are more likely to be exposed to factors that detrimentally impact their cognitive development and future psychosocial and physical health. These factors might include chronic malnutrition, lack of education and healthcare, compromised care giving behaviors in institutional or family/community settings, the early death of a parent, caregiver illness, and exposure to exploitation and violence. Such stresses are known to disrupt brain chemistry and lead to impaired learning, memory, and social development, and to greater susceptibility to physical illnesses as an adult.[103]

A wide array of empirical and theoretical analyses reveals that the primary, loving relationship between a caregiver and a child carries critical implications for children.[104] For example, in a study of 19 countries in sub-Saharan Africa, at-risk children living in a household headed by a relative were worse off than those living with a parent, and children living in households headed by non-relatives were less likely to be enrolled in school.[105] Serious emotional attachment difficulties have also been consistently observed and reported throughout all regions of the world among institutionalized children.[106] A wide scope of research data spanning the last 50 years confirms time and again the troubling child development outcomes of many institutionalized children, particularly those in the 0 to 6 age range. Many of these findings indicate that it is the *quality* of the micro-caregiving climate (and the lack of consistent cognitive and physical stimulation) within the care environment that influences children's emotional and physical wellbeing the most.[107] Even in orphanages with caring staff, the child-adult ratio is often low, and staff rotation patterns and high turnover rates frequently reduce children's ability to bond with a caring adult.[108] Children housed within same-age groups also lack the benefits provided by the presence of older peers.[109] Additional research suggests that the higher the rating of psychological deprivation experienced by children in orphanages, the lower the IQ scores are—independent of malnutrition status.[110] A study on institutions in Europe found that young children (0-3 years) placed in residential care institutions were at higher risks of attachment disorder, developmental delay, and neural atrophy in the

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[102] Segendo, J, and Nambi, J., *The Psychological Effect of Orphanhood: A Study of Orphans in Rakai District*, Health Transition Review, 7:105-124, 2002.
[103] *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, Center on the Developing Child at Harvard University, 2007.

[104] Government of Malawi, UNICEF, Orphanhood in Malawi, 2004-2006.
[105] Ibid.
[106] Vorria, P., Papaligoura, Z., Sarafidou, J., Kopakaki, M., et al, *The Development of Adopted Children After Institutionalized Care: A Follow-Up Study*, Journal of Psychology and Psychiatry, 47 (12), 1246-1253, 2006.
[107]Smyke, A.T., Koga, S.F., Johnson, D.E., et al, *The Caregiving Context in Institution-Reared and Family-Reared Infants and Toddlers in Romania,* Journal of Child Psychology and Psychiatry, 48(2), 210-218, 2007
[108] Camras, L.A., Perlman, S.B., Wismer Fries, A.B. & Pollack, S.C., *Post-institutionalized Chinese and Eastern European Children: Heterogeneity in the Development of Emotion Understanding*, International Journal of Behavioral Development, 30 (3), 193-199, 2006.
[109] Vygotsky, L.S., *Mind and Society: The Development of Higher Mental Processes*, Cambridge, MA: Harvard University Press, 1978.
[110] Castle, J., Groothues, C., Bredenkamp, D., Beckett, C., O'Connor, T., & Rutter, M., *Effects of Qualities of Early Institutional Care on Cognitive Attainment,* E.R.A. Study Team, English and Romanian Adoptees. American Journal of Orthopsychiatry, 69 (4), 424-37, 1999.

developing brain.[111] These challenges have been documented to persist long after children leave orphanages and are associated with other behavioral problems, particularly attention difficulties.[112] In addition to factors that affect psychological development, other evidence suggests that in many institutional settings, low standards of safety, hygiene, nutrition, and health care are frequently the norm. According to a report on institutional care in Afghanistan, for example, children are frequently sick, lack access to health care services, and often leave institutions in search of food.[113]

Early Childhood Development (ECD) refers to a combination of programs and policies aimed at improving the nutrition, health, cognitive and psychosocial development, education, and in some situations, social protection, of young children. Delivered at home, community day care programs, schools, or institutions, ECD methods are known to strengthen at-risk children's chances of survival and academic success to the point that they have been integrated as a strategy for achieving the eight Millennium Development Goals—all of which are linked to children's rights and improvement of their care and support.[114] The 2007 *Education For All Global Monitoring Report* highlighted that disadvantaged children benefit the most from ECD interventions because they actually *"compensate for young children's negative experiences as a result of conflict (within family, society or institutions) and nutritional or emotional deprivation."*[115] ECD initiatives offer cost effective opportunities to target and deliver integrated services to a broader number of children at once while also helping to build the capacity of caregivers (and parents) to facilitate children's developmental needs. These interventions are known to improve health and socioeconomic outcomes in adulthood, especially for at-risk children in resource-poor settings.[116] Some long-term benefits of experimental ECD programs include improved school achievement, a reduced risk of emotional and behavioral problems, fewer high-risk behaviors, and positive economic outcomes.[117]

## 6. COMPARING COSTS OF VARIOUS CHILD CARE SETTINGS

Around the world, families, communities, faith-based organizations, governments, and donors are developing creative responses and interventions to protect and care for vulnerable children. Because they differ in scope, type of care, assistance provided, and quality of services delivered, it is very difficult to pinpoint accurate cost norms for the many different kinds of programs that exist throughout the world today. Based on the very few cost effectiveness studies that have been carried out, however, the general

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[111] *Mapping the Number and Characteristics of Children Under 3 in Institutions Across Europe At-risk of Harm,* EU Daphne Programme 2002-2003, WHO, Copenhagen, Denmark 2004.
[112] MacLean K., *The Impact of Institutionalized Care on Child Development,* Development and Psychopathology, 15, 853-884, 2003.
[113] *Study of Children in Children's Homes in Nepal*, USAID, 2005; *Children Deprived of Parental Care in Afghanistan: Whose Responsibility?,* Islamic Republic of Afghanistan Ministry of Labour and Social Affairs and UNICEF, 2003.
[114] *Promising Practices: Promoting Early Childhood Development for OVC in Resource Constrained Settings: The 5x5 Model,* CARE, USAID and Hope for African Children Initiative, 2007
[115] *Education for All Global Monitoring Report: Strong Foundations, Early Childhood Care and Education*, Paris, UNESCO, p. 109, 2007.
[116] Hawkins, J. D., Kosterman, R., Catalano, R. F., Hill, K. G., & Abbott, R. D., *Promoting Positive Adult Functioning Through Social Development Intervention in Childhood: Long-term Effects from the Seattle Social Development Project* (Vol. 159, pp. 25-31), 2005.
[117] Reynolds, A. J., & Temple, J. A., *Extended Early Childhood Intervention and School Achievement: Age Thirteen Findings from the Chicago Longitudinal Study*, Child Development, 69(1), 231-246, 1998; Schweinhart, L. J., Montie, J., Xiang, Z., Barnett, W. S., Belfield, C. R., & Nores, M., *Lifetime Effects: The High/Scope Perry Preschool Study Through Age 40*, (Monographs of the High/Scope Educational Research Foundation, 14). Ypsilanti, MI: High/Scope Press, 1993.

consensus is that community-driven interventions at the household level appear to be the most cost-effective while formal orphanages appear to be prohibitively expensive.[118]

A 2001 South African study described cost-effectiveness analysis as being concerned with assessing the type of service likely to be the most beneficial and appropriate given the resources available in any given setting.[119] Comparing six models of care, it discussed variables in both the quality of care offered and the cost of providing it. The six models studied were:

1. Statutory Residential Care
2. Statutory Adoption and Foster Care
3. Unregistered Residential Care
4. Home-Based Care and Support
5. Community-Based Support Structures
6. Informal Fostering/ Non-Statutory Foster care (See ANNEX B)

The cost analysis was conducted using two effectiveness measures: the cost of care *per month* per child and the cost of providing a *minimum standard of care per month* per child in each of the six models. These measures were added due to the different levels in *quality* of care delivered. The cost of providing minimum care allowed for comparison between models that provided less than the minimum of care and those that provided more.[120] The results revealed high costs associated with formal models of care, as well as the challenges associated with providing care through informal models that lacked adequate resources. In the final analysis, researchers concluded that community home-based care was the most cost-effective option.

There is no doubt that the voluntary nature of many family and community-based care programs significantly reduces overhead for both the state and donors. In many poor regions of the world, families and communities are delivering services previously provided by the state, prior to the era of privatization and structural adjustments in the 1980s and 1990s. Many of these policies mandated that governments privatize formal health and social service sectors that traditionally served the poorest and most vulnerable citizens.[121] Though state services often ran inefficiently in the sub-Saharan African region, for example, they did in fact provide some relief to the poor and generated jobs for primarily female health and social service workers.[122] In Ghana, for example, after privatization of the 42 largest state enterprises between 1984 and 1991, 150,000 workers lost their jobs.[123] These cutbacks in public sector employment disproportionately affected women who traditionally held positions such as clerical workers, cleaners, nurses, or teachers. In Ghana, the least skilled women working in the public sector lost job

[118] Subbarao. K., Coury, D., *Reaching Out to Africa's Orphans: A Framework for Public Action*, The World Bank, Washington, DC, 2004.
[119] Desmond, C. and Gow, J., *The Cost Effectiveness of Six Models of Care for Orphans and Vulnerable Children in South Africa*, University of Natal, Durban, South Africa, Prepared for UNICEF South Africa, 2001.
[120] Ibid.
[121] Sparr, P., *Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment*, Zed Books for the United Nations, pg. 214, 1994.
[122] Bangura Y., *Public Sector Restructuring: The Institutional and Social Effects of Fiscal, Managerial and Capacity Building Reforms*, United Nations Research Institute for Social Development, pg. 53, Geneva, 2001.
[123] Ibid.

protection, security, and benefits as a consequence of policies aimed at increasing efficiency, while others lost employment altogether.[124] It is important to note that today, in some regions of Africa, caregiver networks are organizing more formally in an effort to solicit compensation, whether through salary, stipend, trainings, or in-kind donations, for their caring labor.[125]

Based on research conducted for this paper, there appears to be a shortage of data comparing the costs of various O/MVC care settings within countries and within regions of the world. Perhaps because of the international donor and policy focus on sub-Saharan Africa's severe O/MVC crisis, more data was readily available for this region than any other. While data for Asia, some parts of Europe, and Latin America may be available, it was not accessible at the time of this study and is therefore excluded from this paper's analysis.

*Africa*

- A 2005 report prepared by Futures Group and UNICEF assessed costs of community-based care for OVC in sub-Saharan Africa alone.[126] The authors estimated that US$4billion would be needed annually by 2010, depending on whether support is provided to all orphans living below the poverty line or just those in most need. Unit cost data for O/MVC services were collected from 364 organizations in 22 African countries. The typical costs per child were $480 for children aged 0-4, $690 for children aged 5-9, and $830 for children aged 10-17. The unit costs varied with the quality and intensity of services. For example, in Zimbabwe the cost of providing the grain required for a simple porridge meal to school children 200 days a year is only $11 a year, while providing dry food for 2100 calories per day can cost up to $75 per person per year. Prepared meals can cost much more.[127]
- A World Bank study found that the annual cost for one child in residential care in the Kagera region of Tanzania was more than US$1K—almost six times the cost of supporting a child in a foster home.[128]
- Maintaining a Malawian child in an SOS Children's Village may cost up to US$2,400 a year. The high cost reflects in part the exceptionally comfortable environment in which children are raised compared to their peers. It is likely that costs could be lowered by adapting standards to those of nearby communities.[129]
- A study conducted in Zimbabwe showed that family-type home care settings were

[124] Sparr, P., *Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment*, Zed Books for the United Nations, pg. 214, 1994.
[125] Budlender, Debbie, *Compensation for Contributions: Report on Interviews with Volunteer Caregivers in Six Countries*, New York, USA: The Huairou Commission, 2010.

[126] Stover, John, et al, *Resource Needs to Support Orphans and Vulnerable Children in sub-Saharan Africa*, Draft Report, Futures Group/UNICEF, 2005.
[127] Ibid.
[128] Over, M., Ainsworth, M., *Coping with the Impact of AIDS in Confronting AIDS: Public Priorities in a Global Epidemic*, World Bank, Oxford University Press, 1997, p. 221.
[129] Bhargava, A., and Bigombe B., *Formulating Policies for Orphans of AIDS and Vulnerable Children in African Countries: Report from a Mission to Ethiopia, Malawi, and Tanzania*. World Bank, Washington, DC, 2002.

14 times less expensive than institutions.[130]

- In South Africa, the monthly cost of statutory residential care can be approximately six time more expensive than providing care to children living in vulnerable families, and four times more expensive than statutory foster care or adoption.[131]
- In Eritrea, the average economic cost for one child in residential care averaged about $1,900 and in Benin about $1,300. The corresponding cost of a child's integration into a family in Eritrea was about $100.[132]
- A cost comparison in East and Central Africa by Save the Children UK found residential care to be ten times more expensive than community-based forms of care.[133]
- A 2004 World Bank study concluded that regardless of conditions, keeping a child in an institutionalized environment is financially unsustainable because of the long-term heavy burden it places on the organizations running them. The costs per child per year range from US$5,403 (with donated food) in Rwanda to $698 in Burundi and $1,350 in Eritrea. Placing one percent of the 508,000 Burundian orphans in such institutions would cost $3.5 million each year. For most poor countries of Sub-Saharan Africa, this level of cost per child rules out institutional care as the preferred option for scaling up.[134]
- High costs were also associated with formal models of care in a 2002 study of South African O/MVC care settings[135] that also found that informal care approaches often lack the resources needed to meet children's most basic needs.

*Central and Eastern Europe and the Commonwealth of Independent States*

- In the CEE/CIS region, orphanage care is twice as expensive as the priciest alternative (small group homes), three to five times more expensive than foster care, and approximately eight times more costly than providing family and community support services to vulnerable families.[136]
- A study of residential care in Moldova by the EveryChild Consortium found that "residential care is expensive, easy to access, ineffective in providing for a child's proper development and, in large measure, an overreaction to the problems facing children and their families."[137]

As mentioned earlier in this section, there is a dearth of systematic research comparing the costs of various childcare settings regionally and globally. That said, it is important to

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[130] Powell, G., *SOS in Africa: The Need for a Fresh Approach,* University of Zimbabwe Medical School, Harare. Unpublished paper, 1999.
[131] Desmond, C. & Gow, J., *The Cost-Effectiveness of Six Models of Care for Orphans and Vulnerable Children in South Africa*, University of Natal, Durban, South Africa, Prepared for UNICEF South Africa, p. 37, 2001.
[132] Menahem, P., Coury, D., Gebremeskel, F., Hounsounou, G., and Kielland, A., *Costs of Projects for Orphans and other Vulnerable Children: Case studies in Eritrea and Benin*, World Bank, July 2004, p. 1.
[133] Swales, D.M., *Applying the Standards: Improving Quality Childcare Provision in East and Central Africa*, Save the Children UK, p. 108-110, 2008.
[134] Subbarao. K., Coury, D., *Reaching Out to Africa's Orphans: A Framework for Public Action*, The World Bank, Washington, DC, 2004.
[135] Desmond, Chris, et al, *Approaches to Caring, Essential Elements for a Quality Service and Cost-Effectiveness in South Africa*, Health Economics and HIV/AIDS Research Division, University of Natal, Natal, South Africa, 2002.
[136] Save the Children UK, *Protection Fact Sheet: The Need for Family and Community-based Alternatives to Children's Homes*.
[137] Larter, D. & Veverista, E., *Capacity Building in Social Policy Reform in Moldova*, EveryChild Consortium, October, p.13, 2005.

note that existing data on this topic has consistently concluded that family and community-based care settings are by far the most cost effective. In combination with policy trends favoring families and communities over institutions, this evidence—while lacking in scope—has no doubt also influenced donors' attitudes and funding decisions.

## 7. DONOR SUPPORT FOR O/MVC PROGRAMS

In CEE/CIS and parts of Asia, many orphanages are supported by the state. In other regions, however, institutions are usually funded by private philanthropy, most often in the form of faith-based organizations that have a long tradition of building orphanages and establishing missions overseas. According to the Faith to Action Initiative, an arm of the global Better Care Network, many self-identified Evangelical Christian groups and congregations in the United States sponsor orphanages in Africa and Asia. Some of these churches are non-denominational mega-churches engaged in the social justice movement and are comprised mostly of Baptists, Presbyterians, and Methodists.[138] Many new orphanages being built in Cambodia, for example, are linked to funding provided by a specific U.S. affiliated church group known as the Four Square Church.[139] During the last several years, however, more churches have begun to shift their financial support to family and community-based care rather than institutional care.[140]

Research shows that faith-based organizations have unparalleled reach, well-established networks, and staying power in sub-Saharan Africa, and appear to enjoy high levels of approval and trust among the people they serve.[141] According to a Tearfund survey, faith-based groups provide on average 40 percent of the healthcare in many African countries, while up to 97 percent of congregations across six African countries surveyed are caring for OVC.[142] In 2005 there were more than a quarter of a million congregations in the AIDS belt of East and Southern Africa alone—more than enough to support the regions' then 12 million and more orphans. Kenya alone has 80,000 congregations; if each cared for 20 orphans, all the country's orphans would receive some kind of church-sponsored community, family, or residential support.[143] The fiscal contribution of faith-based volunteers throughout Africa alone is enormous. In a 2006 study, the number of donated hours to communities and families in need, including O/MVC, was conservatively estimated to be valued at US$5 billion per annum—an amount similar in magnitude to the *total* global funding provided for HIV and AIDS by all bilateral and multilateral agencies.[144]

The large volume of community and family-based programs that exist globally—particularly in HIV/AIDS devastated Africa—depend primarily on funding from community residents, national governments, philanthropic organizations, and the top three global O/MVC donors: PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and

[138] Zoll, Miriam, Interview with Amanda Cox, Faith to Action Initiative, Better Care Network, April 2010.
[139] Ibid.
[140] Ibid.
[141] Foster, G., Deshmukh, D., Adams, A., *Inside-Out? Strengthening Community Responses to Children Affected by HIV/AIDS,* Synthesis Report, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 2: Community Action, 2008.
[142] Teddington, *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa*, UK: Tearfund, 2006.
[143] Foster, G., *Religion and Response to Orphans in Africa*, Chapter in Foster, G., Levine, C., Williamson, J, *A Generation at-risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children*, Cambridge University Press, New York, 2005.
[144] Teddington, *Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa*, UK: Tearfund, 2006.

Malaria, and the World Bank's Multi-Country HIV and AIDS Program (MAP) for Africa.

All three of these large global donors actively acknowledge—and their funding streams reflect—the importance of mobilizing and supporting family and community-based responses to assist children in need, including boosting support for anti-poverty programs at the household level. These fiscal trends mirror the global consensus to provide for children's wellbeing by prioritizing families and communities over institutions, as stated in the CRC, the *Framework* and the *Guidelines*. They are also based on evidence derived from child development research conducted over the last 50 years that repeatedly found cognitive, emotional, and physical deficits among children raised in institutions, and from cost-effectiveness studies that routinely found institutional care to be cost prohibitive. This does not necessarily mean, however, that some of these donors' funds do not reach institutional care settings. Some may, but an overwhelming lack of transparency in donor data continues to obscure funding channels, making recipient identification extremely difficult to track and decipher.

*US President's Emergency Plan for AIDS Relief (PEPFAR)*

In his January 2003 State of the Union Address, U.S. President George Bush announced the creation of the US$15 billion PEPFAR fund that targeted 15 high priority countries, the majority in sub-Saharan Africa.[145] Since its inception, Congress has mandated that ten percent of all PEPFAR monies be earmarked for O/MVC programs and services. Unfortunately, challenges in tracking and monitoring actual disbursements make it difficult to determine the quantity and quality of services being delivered. PEPFAR was reauthorized for a further five years through the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008.[146] The passage of the act authorized up to $48 billion for fiscal years (FY) 2009-2013. Today, 33 countries in Africa, Asia, Eastern Europe, the Caribbean and Central America receive funding for prevention, treatment and care.

By 2008 PEPFAR reported having provided US$328 million in specific funding for O/MVC activities in the countries completing Country Operational Plans, representing 9.5 percent of total PEPFAR funding for HIV prevention, care, and treatment.[147] PEPFAR's *Third Annual Report to Congress* highlighted the central importance of preserving families, and strengthening their capacity to protect and care for O/MVC. The report did not appear to mention investments made to institutional care facilities, though some may or may not have been administered. In 2008-2009 PEPFAR provided funds for treatment to prolong the lives of parents and caregivers, build skills and resources to address the needs of children affected by HIV/AIDS, improve economic strengthening of OVC households, and bolster interventions that enabled young people to meet their own

[145] Petrow, E., *Are Orphans the Orphans of the Global AIDS Response? An Analysis of the Constraints Affecting the Global Response to Children Affected by HIV/AIDS*, Thesis Submitted to the Faculty of the Department of Population and International Health, Harvard School of Public Health, May 2005.
[146] Tom Lantos and Henry Hyde United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008.
[147] *U.S. Government and Partners: Working Together on a Comprehensive Coordinated and Effective Response to Highly Vulnerable Children,* Third Annual Report to Congress on Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, December 2009, pg. 7

and their families' needs. The report also highlighted PEPFAR's investments in community efforts to create greater social safety nets for OVC and their caregivers, and to develop strategies to strengthen more formal systems of on-going support. Research about PEPFAR's policies conducted by JLICA in collaboration with Family Health International in 2008 found that PEPFAR's family and community-based care investments were small-scale rather than large-scale. Researchers claim this was due in part to a persistent uncertainty about what resources family-centered policies and programs actually require in practice.[148]

*The Global Fund*

The Global Fund is an international financing institution that does not implement programs directly and therefore has no way of tracking where funds disbursed for OVC programming are eventually spent. The Global Fund's work is based on the concept of "country ownership", whereby governments are responsible for allocating Global Fund money toward national programs benefiting O/MVC. Governments determine if Global Fund monies will be distributed to orphanages, family and community-based programs, or both.[149] In the 2008 reporting cycle for 426 active grants, the Global Fund's Enhanced Financial Reporting System under the service delivery category "Care and Support: Support for Orphans and Vulnerable Children" reported cumulative spending of US$80.3 million.[150]

*The World Bank's Multi-Country HIV and AIDS Program (MAP) for Africa*

Since 1999, the World Bank has invested US$1.8 billion for HIV/AIDS programs in 30 countries hardest hit by the pandemic. It launched the Multi-Country HIV/AIDS Program for Africa (MAP) in 2000 with a plan to invest funds nationally and locally over 15 years to support government and civil society responses to the pandemic and accompanying O/MVC crisis.[151] Working in close partnership with UNICEF and other partners, the World Bank estimates that close to two million O/MVC have received some kind of service through the MAP. As with other large donors, no specific data about disbursements for at-risk children's programs were readily available for this report.

Through the MAP, the World Bank has worked with partner governments to build greater political commitment toward the pandemic and assisted them to begin implementing decentralized multi-sectoral national programs while strengthening institutions and accountability. Specific development objectives of each individual country project, as stated in their national HIV/AIDS strategic plans, provide the basis for the MAP program and are agreed upon at the time of appraisal of the national projects. The MAP has contributed to health systems strengthening, catalyzed several sub-regional projects to address at-risk populations, and helped increase access to treatment. MAP reports having

[148] Wakhweya A., Dirks, R., Yeboah K., *Children Thrive in Families: Family-Centered Models of Care and Support for Orphans and Other Vulnerable children Affected by HIV and AIDS,* Technical Report, Joint Learning Initiative on Children and HIV/AIDS, Learning Group 1: Strengthening Families, in Collaboration with Family Health International, 2008.
[149] Zoll, Miriam, email correspondence with Marcela Rojo, Media Officer, Media Relations Team, Communications Unit, the Global Fund to Fight AIDS, Tuberculosis and Malaria, April 2010.
[150] Ibid.
[151] The World Bank - www.worldbank.org

funded over 50,000 NGO, faith-based, and community-based subprojects, many at the grassroots level. MAP-supported subprojects cover prevention, care, treatment, mitigation, capacity development, and monitoring and evaluation. Under MAP, partnerships, consortiums, and networks of special interest have been encouraged to address capacity weaknesses and other challenges to scaling up national AIDS programs. As a result, civil society engagement is now considered a crucial part of a national response.[152]

## 8. NEXT STEPS FOR DONORS

While the random circumstances of life that contribute to children's vulnerability are often beyond the control of any one entity, a collective response is not. Children's wellbeing and happiness hinge on a range of economic, environmental, and political variables that government and civic structures can to some degree contain and manipulate. Each of the estimated *143-163 million at-risk children* in the world today has a unique set of material, intellectual, and spiritual needs that must be met if they are to mature into functioning citizens of the global community. As the CRC and the *Guidelines* state, adults charged with caring for children—whether they reside within a family system or in the Ministry of Children's Affairs—must choose the option most appropriate for that particular child. In some cases where there are extended family and kinship networks, every effort must be made to support and strengthen their ability to care for the child. But what happens when there is no extended family to step in and raise the child? In those situations, alternative care options—ranging from orphanages to foster care to SOS Villages—must be identified, monitored, and supported in ways that best protect and nurture children.

*Suggested Next Steps for Donors Concerned with O/MVC*

*1. Donors must support the improvement of O/MVC micro-caregiving environments by integrating Early Childhood Development (ECD) strategies, training, and programming into national OVC action plans and family, community, and institutional care protocols.*

For O/MVC interventions and care to be successful, they must address the myriad, interdependent needs of very young children, many of whom have been traumatized by circumstances resulting in the death of their parent(s) or separation from their family. Numerous research findings have shown that the physical, cognitive, and socio-emotional stages of children's development—whether they live in family, community, or institutional settings–-are interrelated and interdependent. “Physical” stages refer to children’s gross fine motor development, “cognitive” includes language and sensory development, and “socio-emotional” addresses psychological and emotional development. Research from Bangladesh has found that psychosocial stimulation is equally as important for motor skill development as good nutrition,[153] and physical growth after the age of six has been shown to be highly dependent upon hormonal

[152] Ibid.
[153] Hamadani, J., Huda, S., Khatun, F., Grantham-McGregor, S., *Psychosocial Stimulation Improves the Development of Undernourished Children*, The Journal of Nutrition, Oct: 136, 10, 2006.

secretions triggered by affection and social interaction.[154] Targeted studies have found that younger children in a variety of settings benefit the most from ECD interventions, with those between the ages of 0 and 36 months representing a highly critical window of development opportunities and vulnerabilities.[155]

Comprehensive ECD programs are known to reduce childhood mortality, increase children's access to education and health care, improve the economic security of households, and build the capacity of parents and other caregivers (institutional or community-based) to respond to the needs of at-risk children.[156] World Bank research has found that the presence of ECD helps increase and stabilize household financial earnings. Mothers who can access affordable schools and community care facilities for their children often experience an increase in earnings while members of the community care for their children.[157] In its *State of World's Children's 2001* report, UNICEF asserts that ECD should include all interventions directed at children or their caregivers, preferably integrated as a package of services that support the holistic development of the child and the wellbeing of its family. Community-based services that meet the needs of infants and young children are vital, and ECD programming should include health, nutrition, and educational components, as well as water and sanitation in homes and communities.[158] *In a World Fit for Children,*[159] UNICEF's outcome document from the UN General Assembly's Special Session on Children in 2003, 180 countries agreed that every child should have a nurturing, caring and safe environment to survive and be physically healthy, mentally alert, emotionally secure, socially competent, and able to learn.

Noting the value of ECD in accomplishing these goals UNICEF, UNAIDS, and the World Bank in 2003 published an important document recognizing the critical need to prioritize and mainstream ECD programming into existing HIV/AIDS prevention and care programs. The *Operational Guidelines for Supporting ECD in Multi-Sectoral HIV/AIDS Programs in Africa*[160] stresses that ECD must become an essential component of any well-designed, integrated HIV/AIDS treatment and care program and that it must be incorporated through broad-scale interventions to assure the healthy physical, emotional, and cognitive development of young children. The document highlights the economic value and benefits of ECD as a preventative strategy to help minimize a host of related social problems that may emerge later in children's lives. These may include teen pregnancy, social and/or sexual violence, increased risks of HIV/AIDS, drug use, juvenile delinquency, and chronic poverty.[161] Overall, the World Bank, UNICEF, and

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[154]Zeanah, C., Smyke, A., Koga, S., Carlson, E., *Attachment in Institutionalized and Community Children in Romania*, Child Development. September/October: 76(5): 1015-1028, 2005; Fox, N., D. Johnson, et al., *Findings from the Bucharest Early Intervention Project,* Presented at the Better Care Network Symposium January 2007, Washington DC, George Washington University. Urban slum in Nairobi, Master's Thesis, Emory-Rollins School of Public Health, 2007.

[155] Zeanah, C., et al, 2005.
[156] *Promising Practices: Promoting Early Childhood Development for OVC in Resource Constrained Settings: The 5x5 Model*, CARE, USAID and Hope for African Children Initiative, 2007.
[157] Ibid.
[158] *The State of the Word's Children 2001: Early Childhood*, New York, 2001.

[159] *A World Fit for Children*, Outcome Document 2003 UNGASS Meeting, UNICEF, New York, 2002.
[160] *Operational Guidelines for Supporting ECD in Multi-Sectoral HIV/AIDS Programs in Africa,* The World Bank, UNICEF, UNAIDS, 2003.
[161] *Operational Guidelines for Supporting ECD in Multi-Sectoral HIV/AIDS Programs in Africa,* The World Bank, UNICEF, UNAIDS, p. 3, 2003.

UNAIDS advocate for integrating ECD into national multi-sectoral HIV/AIDS programs and linking them to other national development efforts aimed at intersecting ECD and HIV/AIDS prevention, treatment and care for the entire family.

2. *Use the momentum of the UN Guidelines for Alternative Care for Children to encourage donors such as PEPFAR and the World Bank, as well as governments, to track and monitor O/MVC, and to improve the quality of care in child care settings, with special focus on unregistered institutional settings.*

Monitoring and evaluating O/MVC programs in institutions or communities is critical for being able to measure how many at-risk children are receiving essential services and to assess the quality of their care. Routine monitoring and evaluation is fundamental for child protection initiatives, particularly in countries with large numbers of unregistered residential care facilities and high incidences of illegal adoption or child trafficking. Donors can fund capacity building and training that will enhance O/MVC providers' micro-care-giving capabilities, as well as governments' and communities' monitoring and evaluation capabilities.

Since the *Guidelines* were passed in late 2009, several African countries have already begun to bolster regulations pertaining to institutions that house children. In Liberia, for example, all alternative care facilities will be required to register with the Ministry of Health and Social Welfare starting in 2010. An independent team comprised of representatives from the government, UNICEF, and civil society organizations are planning to carry out a detailed assessment of each institution before recommending it to the Ministry for accreditation.[162] Sierra Leone's Ministry of Social Welfare, Gender and Children's Affairs is also strengthening orphanage standards and auditing orphanages nationwide, which has forced many to close.[163] In Eastern Europe, Georgia has begun investigating ways to improve foster care placement systems and prevent infant abandonment,[164] while Azerbaijan has also begun exploring ways to improve gate keeping processes in its child welfare system.[165] The government of Guyana in the Caribbean has also taken a strong, proactive stance of reforming its child welfare system, assessing procedural and physical standards of institutional care settings, and establishing foster care and institutional care standards and procedures.[166]

3. *Bilateral donors, governments, and civil society, including faith-based organizations, must improve fiscal monitoring and evaluation of O/MVC expenditures, and become more transparent in disclosing expenditures and sharing data with each other and taxpayers.*

While aid specifically earmarked for O/MVC services may actually be expended, in many instances there is no evidence or follow-up to determine how that money has been

[162] UNICEF Liberia Press Release
[163] http://bettercarenetwork.org/bcn/details.asp?id=15202&themeID=1003&topicID=1022
[164] http://bettercarenetwork.org/bcn/details.asp?id=15202&themeID=1003&topicID=1022
[165] http://bettercarenetwork.org/bcn/details.asp?id=19732&themeID=1003&topicsID=1022
[166] Assessment of Procedural and Physical Standards in Children's Residential Care Institutions in Guyana: Summary and Recommendations, Better Care Network, 2010

spent or how many O/MVC have benefited.[167] In other cases, OVC funds are not earmarked specifically but are merged into much broader aid categories such as HIV/AIDS or youth, making it difficult or impossible to identify its end point. Complicating fiscal tracking matters, faith-based organizations that provide billions in aid and in-kind donations annually are exempt by law from having to report fiscal expenditures. These unique circumstances makes it extremely difficult if not impossible to measure the impact of church contributions on communities and families working to keep O/MVC populations alive.

Knowing how much O/MVC funding is being provided, what it is being spent on, and what it aims to achieve is vital for enabling researchers and policymakers to study what interventions and funding levels are most appropriately reaching children in need. It allows child protection officers and O/MVC program managers to tailor and improve at-risk children's access to essential services–-such as food, counseling, health care, or education—across a broad geographical spectrum. Aid transparency is vital for improving governments' ability to plan and manage their national response to O/MVC, and for accelerating citizens' comprehension of how the aid their country is receiving or giving is being utilized. The more educated the public is about how its government spends taxpayers' money, the less opportunity there is for incidences of corruption, duplication, or waste.

## 9. SUGGESTIONS FOR FURTHER RESEARCH

*Donors and governments must prioritize more research to assess the impact of how anti-poverty strategies, including compensation to O/MVC caregivers through direct cash transfers or old-age pensions, can improve quality of life for O/MVC and their families.*

The controversial issue of compensating unpaid family caregivers and community health workers—either through salaries or direct cash transfers to households—is one of the most critical issues linked to sustained care for O/MVC, particularly in Africa.

Caregivers are the most critical bridge in the chain of links and referrals sustaining family and community-centered O/MVC responses. They are the eyes and ears of community-based social and public health service systems, and serve as counselors and spiritual mentors to traumatized children suffering from enormous grief about their past and fear about their future. As stated earlier in this report, since the 1980s donors and governments have typically relied on an informal female volunteer force to deliver a diverse range of health care and social services formerly subsidized by the state before the era of structural adjustment.[168] Though extended-family volunteerism remains a strong tradition in African culture, the HIV/AIDS pandemic – coupled with insufficient national and global responses to it – has eroded critical social and economic structures within families and communities.[169] The burden of care on unpaid females has exacerbated poverty at the household level and interrupted many women's ability to work

[167] *Executive Summary: OVC RAAAP Final Report, The Policy Project in Support of OVC RAAAP Initiative*, USAID, UNICEF, UNAIDS, WFP, January 2005
[168] Sparr, P., *Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment*, Zed Books for the United Nations, pg. 214, 1994.
[169] Zoll, Miriam, *The Compensation Debate*, MIT Research Fellow, Program on Human Rights and Justice, 2005.

for pay outside the home. Direct cash transfers, old age pensions, and child welfare grants for families are one way of staving off deeper family financial crises and preventing burnout among family-based caregivers who are essential lifelines to vulnerable children in need.

The compensation debate is argued on both sides by governments, donors, NGOs, communities and families. Proponents argue that payment—even small amounts or in-kind support such as transportation or food vouchers—can do much to sustain worker/volunteer motivation and help offset unpaid care workers' household poverty. Those arguing against it caution that payment will erode community volunteerism and program ownership that is both a traditional aspect of African culture and a necessary means for providing long-term care during the duration of the pandemic, whether funding is available or not.[170]

It is important to keep in mind the gender dynamics at play in this ongoing debate. Because so many poor caregivers are female, governments and donors often assume that women and girls are innately inclined to nurture and care for the sick and vulnerable and that compensation of any form – salary, old age pension, or child welfare grants – is therefore unnecessary.[171] Pat and Hugh Armstrong of York University and Carlton University in Canada have investigated divisions of labor according to gender roles and between the state and families. In *Thinking it Through: Women, Work and Caring in the New Millennium,* they write:

*"There is very little that is "natural" about women's work in general or their caring work in particular. …Women's caring can be understood only within unequal relationships, structures and processes that help create women as carers and undervalue this caring work. Many women who do provide care, providing services such as meal preparation, comforting and cleaning, may not even see this as care because it is so much a part of their daily lives. The state plays a fundamental role in determining how political, material and symbolic resources are distributed and in mediating these resources in the markets, communities, households and individuals…the benefits and negative consequences are unevenly distributed between women and men, and among women." [172]*

## 10. CONCLUSION

Broadly speaking, current donor policies toward O/MVC reflect the trends reinforced by decades of global children's rights instruments purporting that in most cases, the family setting is the best option for providing children with the love, safety, and support they need in order to survive, if not thrive. Donors with limited funds are legitimately concerned about investing in the most cost-effective programs that will provide the

[170] Zoll, Miriam, *Expanding Access to Services and Protecting Human Rights, Integrated Health Care Delivery Systems for Families and Children Impacted by HIV/AIDS: Four Program Case Studies from Kenya and Rwanda*, Joint Learning Initiative on Children and HIV/AIDS (JLICA), Learning Group 3: February 2009.
[171] Zoll, Miriam, *The Compensation Debate,* MIT Research Fellow, Program on Human Rights and Justice, 2005.
[172] Armstrong, Pat., Armstrong, Hugh, *Thinking It Through: Women, Work and Caring in the New Millennium,"* York University and University, Nova Scotia Advisory Council on the Status of Women, March 2004.

broadest reach for their dollar—with a goal not always actualized of reaching the most vulnerable children with quality care. While much work remains to be done to assist O/MVC and their caregivers, it is important to recognize and acknowledge the progress that has been made to bring the plight of millions of at-risk children into the public and policy spotlight.

**ANNEX A:**

A number of additional child-protection measures exist in various parts of the world. They include but are not limited to the following:

**The South Asian Regional Convention on Child Welfare**:

- Reaffirms the recognition that the family is the fundamental unit of society and the ideal nurturing environment for the growth and wellbeing of children.
- Reaffirms the statement of political responsibility to ensure the fulfillment of child rights.
- Asserts the determination of States to facilitate cooperation and regional arrangements to fulfill obligations to protect child rights.
- Highlights universal access to basic services as a regional priority.

**The Hague Convention on the Protection of Children and Cooperation in Respect of Inter-country Adoption:**

- Provides, for the first time, formal international and intergovernmental approval of the process of inter-country adoption.
- Recognizes inter-country adoption as a means of offering the advantage of a permanent family to a child for whom a suitable family cannot be found in the child's country of origin.
- Establishes a minimum set of uniform standards governing international adoptions.
- Establishes a central authority in each country to discharge the duties, role and functions imposed by the Convention (certification, facilitation, information exchange, control to avoid improper gain).

**The South Asian Association for Regional Cooperation Regional Strategic Framework**

- Holds States accountable to promoting family- and community-based alternative care for children affected by HIV/AIDS
- Calls on States to ensure that institutions are not used as a substitute for family care, or used to gain access to education and other essential services.

**The Stockholm Declaration on Children and Residential Care**

- Promotes restructuring of the public care system to reduce institutionalization, prevent separation, and provide alternative care, with residential care as a last and temporary resort
- Calls for States to regulate and monitor the provision of public care according to minimum standards in line with the Convention of the Rights of the Child
- Emphasizes the development, financing, implementation, and monitoring of family-based forms of care

**Inter-Agency Guiding Principles on Unaccompanied and Separated Children**

- Provides a clear policy statement on the protection and care of children in emergencies, including armed conflicts and natural disasters
- Reaffirms the principles of family unity, family reunification/reintegration, and minimum recourse to institutionalization
- Asserts a preference for placement of children in their community of origin through alternative family-based forms of care

**ANNEX B: Care Settings for O/MVC**

*[Excerpts from the World Bank's 2004 study, Reaching Out to Africa's Orphans: A Framework for Public Action.]*

*Institutional Care/Statutory Residential Care*

Statutory residential care refers to the accommodation of orphans in institutions removed from their community (MacLeod 2001). This form of care may be appropriate for orphans with no one to take care of them and those with special needs such as orphans who are HIV-positive or who are handicapped. A growing number of facilities are looking after HIV/AIDS orphans, and some of them are providing infected children with palliative care and psychological support. The costs associated with such care often limit the number of children who can be treated.

Orphanages are by far the most formal type of institutions that care for orphans. Most orphanages are run by NGOs, religious organizations operating with grants from governments and donors, or governments. Orphanages are often believed to provide children with adequate basic care, such as shelter, food, clothing and education, although much depends on the quality of that care. Interaction between the community and the orphanage is not very common, especially when children are sent to the orphanage's school rather than to the public school.

*Family Like Settings*

In recognition of the adverse impacts of residential care on the development of children, a growing number of countries (such as Eritrea, Ethiopia, and Uganda) have begun to deinstitutionalize orphanages and rely on alternative forms of institutional arrangements that tend to recreate a family-like setting. Children's group homes and children's villages are the most popular forms developed.

Children's Homes: A children's home is an arrangement in which a paid and usually trained foster mother lives with a group of 4 to 10 O/MVC in an ordinary home, rather than an institutional building, within the community. Children's homes are usually supported by NGOs or private sponsors, and may or may not be registered with the government. When they are not registered, supervision and monitoring of the children's wellbeing is not legally required unless the children have been placed in the home by the court. These homes sometimes serve as temporary "holding places" for children who are waiting for a permanent placement within a foster family. The sustainability of this type of care depends to a large extent on the monitoring supervision and support of social workers and the level of external financing. By allowing children to evolve in their own community, well-organized children's homes may offer a viable option in communities heavily affected by the orphan crisis and where women are heavily overburdened with the care of both orphans and sick adults.

Children's Villages: The concept developed by SOS Children's Village usually consists

of a group of about 10–20 houses, which form a community and provide a family-like setting for vulnerable children. SOS-trained mothers, who takes care of on average 8–10 O/MVC, head each household. Children grow up in conditions comparable to those in "normal families" in the sense that biological siblings are not split up, children of different ages and gender become brothers and sisters, all children are enrolled in public schools, and all children are strongly encouraged to maintain contacts with the community. The village director (a male) supports the mothers and represents a father figure to the children. SOS Children's Villages are sponsored by an NGO, and as such they are not self-sustaining. These villages have often been criticized for separating children from the community and for providing a standard of material wellbeing so much higher than that of the surrounding community that it causes the children significant difficulties with social reintegration once they leave the village.

Some variations on this type of care have been developed within the framework of the deinstitutionalization of care being undertaken in some countries such as Ethiopia and Uganda. Formal orphanages are transformed into community-based resources centers where day care services for foster parents and skills training programs for older children are made available (UNAIDS 2002).

A children's village seems to meet most of orphans' basic and economic needs; uncertainties remain, however, about whether psychological and safety needs are met. Such villages can thrive only as long as (a) resources are available; (b) children are raised in an environment not too different from their original one; (c) children are part of the life of the neighborhood community; (d) trained social workers are available for monitoring and supervision; and (e) the neighborhood community shares a part of the cost of running the village. Not surprisingly, there are only very few examples of such well-functioning children's villages.

[Excerpts from Desmond, Chris, et al, *Approaches to Caring, Essential Elements for a Quality Service and Cost-Effectiveness in South Africa*, Pergamon, Evaluation and Program Planning, 25 (2002) 447–458.]

*Informal Fostering/Non-Statutory Foster Care*

Traditional Foster Care: Up to six children are placed in the home of a foster parent(s). Foster parents are not reimbursed for taking care of the children, however the child is eligible for the foster care grant, which can be used to cover expenses. Extended family members can be appointed as foster parents.

Crisis Care: Essentially, crisis care is a temporary placement for 'hard-to-place' HIV-positive babies. Some of the babies die in crisis care and others are placed in permanent care. Strictly speaking, crisis care is a place-of-safety placement rather than foster care. Crisis care mothers can receive a place-of-safety grant for the duration of the placement, which theoretically should not be longer than 12 weeks to 6 months, but can go on for over a year.

Community Family Model: Up to six children are placed with a foster mother in a home that is purchased, equipped, and owned by the organization. The foster mother is paid a small allowance in addition to receiving foster care grants for each of the children. A relief parent, who is also given a small allowance, assists this foster mother. The home is in the community and community leadership structure is involved in the process of developing and implementing the community family home. This model provides a way of keeping siblings together and keeping children integrated in their communities of origin.

Cluster Foster Care: Volunteer women and couples are recruited and trained in the basics of childcare. Up to six children are placed with each volunteer who receives foster care grants and material support. Community workers link these volunteers to other resources such as day care centers that relieve foster parents of childcare duties in order to undertake income-generating activities.

Collective Foster Care: Instead of being placed with a volunteer, woman, or couple, children are placed in the collective care of a social, religious, or work-related body whose members undertake to collectively act as surrogate caregivers for the children. Children remain in the homes of their parents. This approach is commonly used to support child-headed households (McKerrow, 1996:14).

Community-based Support: Community organizations in this model category offer support to indigenous, informal caregivers. Their focus varies between emotional support, information provision, advice, advocacy, donations, and income generation programs. Generally, OVC stay in their communities of origin and are cared for by family and members of the same community. Within this approach a variety of organizational structures exist. Some organizations have a constitution, a board of management, staff structure, and government registration. Others are completely voluntary, often associated with religious groups, and tend to be more charity oriented and unlikely to be registered in any way.

Home-based Care and Support: Home-based care initiatives (HBCIs) provide services to households of people living with AIDS, TB, disabilities and injuries or other chronic illnesses. Community home-based care models recruit community members to visit and care for needy people in their homes. These HBCI models can either have a community base or an institutional base. All the sites that were visited by the research team provided home care services to anyone in need of care, however the bulk of their patients were living with AIDS. There are no minimum standards of training for workers or quality of service for home-based care programs in South Africa. Most HBCIs are independent organizations registered as NGOs and are therefore guided by a constitution and board of management. Many have access to donor funding.

Unregistered Residential Care: Non-statutory residential care provides housing that is often outside the child's community of origin. As with statutory residential care, these homes care for children who are abandoned, abused, or have no family who can care for them. In some cases the children are even placed in these homes by court order. However, unlike statutory residential care, these homes are not registered and are

therefore not under the supervision of the Department of Social Development (DoSD).

This approach clearly fills a gap in the need for substitute care and is used as a resource by social workers even though these homes often do not meet prescribed regulations for providing care. Even at one third of the cost of statutory residential care this is still a relatively costly approach. As the legal status of these homes is unclear, oversight and monitoring of care in the homes is not legally required unless a child has been placed there by a court order. The care offered by unregistered homes was, in many respects, seen to be preferable to statutory residential care settings. This was due to the fact that the homes had one constant primary caregiver, were smaller and offered a more 'normal' family-type experience for children.

Statutory Adoption and Foster Care: Fostering requires a person appointed by the court to perform the role of a surrogate parent and to take full custody of the child. The place of abode is almost always the home of the foster parent. Child Welfare Societies are the state-appointed authorities managing adoption and foster placements. This includes recruiting and screening the parents as well as matching and placing the children. Statutory adoption and foster care address the shortcomings of informal fostering and home-based care models in terms of providing a long-term legal framework for the OVC. However, a continuum of foster care approaches, with accompanying training and financial support, needs to be developed. This continuum could include traditional foster care and specialized foster care (i.e. for children who are HIV positive or those who have been sexually or physically abused). Specialized foster parents require additional training and additional financial support.

Statutory Residential Care: Traditional children's homes, reform schools, and places-of-safety all fit into the model of statutory residential care. These are legal, formal institutions that function with government support and supervision. Residential care facilities tend to be large and staffed by many different caregivers. Given the new challenges of children living with HIV/AIDS, these facilities will need to re-think how they provide and finance the care that is given. These facilities often face the difficulty of being constitutionally obliged to accept HIV-positive children without being able to know their HIV status, or provide the complex and costly care that is required (Table 1).

Infant Centers: Many of these centers assist infants who have been orphaned or abandoned, or whose parents are in crisis. The care is intended to be temporary and short-term until relatives can resume care. This model is expensive and often includes medical and intensive nutritional care in the beginning when the infants first arrive. The crisis nursery in Lilongwe, Malawi, costs around $5 per child per day. The ratio of trained staff to children is high.[173]

[173] Dimmock, Frank, *Africa's Children: A Church Response to Children's Issues in Sub-Saharan Africa,* Presbyterian Church (USA), 2007.