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1 - Introduction

According to UNAIDS, by the year 2010, there will be 42 million orphans in Africa, 20 million of which will be orphaned by AIDS.[1] At the same time, the very disease exacerbating the orphan problem in Africa is crippling the ability of families, communities, and states to cope. Research shows that regardless of interventions, orphans are more likely to live in poverty and less likely to be in school. A number of non-governmental organizations ("NGOs"), both at the community and international levels, is involved in trying to provide care for the growing number of orphaned and vulnerable children on the continent. This paper will examine and evaluate the current, most widely accepted framework for non-parental care interventions (the "conventional framework") supported by governments, NGOs and inter-governmental organizations ("IGOs") . The conventional framework's approach and rationale will be scrutinized based on more dispersed and case-specific literature on orphaned and vulnerable children ("OVC") care in Africa and in general. The conclusions drawn by the conventional framework about the quality of care, based largely upon a standard estimated cost formula for all of Africa, provided to orphans by various non-parental care models are not substantiated by the more dispersed literature on the subject. I argue that the conventional framework is excessively vague and is heavily weighted toward measuring "successful" non-parental care settings in terms of estimated and ambiguous costs to the provider, rather than long-term benefits to the child and society. The conventional framework, therefore, is not a useful resource for designing programs for non-parental care of orphans and for evaluation of existing models.

This paper will begin with a brief review of the literature discussing the role of education in economic development, because the conventional framework ignores the primacy of provision of education to an orphan as a determining factor in selecting the best non-parental care setting.

[1] UNAIDS (Joint United Nations Programme on HIV/AIDS). *Children on the Brink: A Joint Report on Orphan Estimates and Program Strategies.* UNAIDS, UNICEF, USAID. Cited by Subbarao and Coury.

Then I will critically compare the dispersed literature on care for OVC in Africa and elsewhere. I will then discuss my personal experiences with OVC care in Kenya. I will conclude with a discussion of the shortcomings of the existing framework for evaluating care for OVC and some brief policy implications.

1.1 - Disambiguation of Terms

The purpose of this section is to define the working definitions of various terms that will be used extensively throughout this paper. The term orphaned and vulnerable children is perhaps best defined by Subbarao and Coury: The authors use the term "orphaned and vulnerable children" to include single and double orphans [one or both parents deceased] as well as other vulnerable children. Vulnerable children are defined broadly as "those *whose safety, well-being, and development are, for various reasons, threatened*" [italics original]. The authors continue by listing factors likely to "accentuate children's vulnerabilities". These include a dearth of: "care and affection, adequate shelter, education, nutrition, and psychological support". The loss of a parent also is a factor that has been shown to greatly accentuate vulnerability in children.[2] Recognizing that the definition of OVC offered would include a large proportion of children in Africa, they choose a working definition using a relative approach. Vulnerable children by this definition are "*those children who are most at risk of facing increased negative outcomes compared with the "average" child in their society*." The primary negative outcomes recognized are: "Severe malnutrition, above-average rates of morbidity and mortality, lower-than-average rates of school attendance and completion at the primary level, and, in all probability, a heavier work burden."[3] It should be noted that these outcomes do not include any measures of "care and affection" or "psychological support"- two factors which are of central importance to the

[2] Subbarao and Coury p1.
[3] Subbarao and Coury p2.

authors' evaluation of models of care. These definitions, while broad, are functional and largely consistent with definitions of OVC advanced or assumed in other literature.[4]

The term institutional care refers to any type of formal or informal residential care setting in which children are watched by professional or volunteer caretakers. The term orphanage technically refers to an institution that cares specifically for orphans, while the term children's home refers more generally to an institution that cares for both orphaned and vulnerable children.[5] For the most part the terms "orphanage", "children's home", and "institution" or "institutional care" are used interchangeably. The category of home-based care refers broadly to both foster care and adoption. "Foster care" and "foster home" refer to a temporary arrangement in which an orphan or vulnerable child is placed into the care of a family or single adult caretaker. Sometimes caretakers are compensated for their services. Some literature makes a clear distinction between formal and informal foster care- the only difference between them is that formal foster care involves (at least nominally) placement and monitoring by a government social worker. Adoption refers to the permanent transfer of custody for an orphan or vulnerable child to a family or caretaker.

2 - Education and Development

Perhaps the most significant breakthrough in development scholarship in the last half century has been the discovery of what has been called the "magic bullet"[6] for reducing poverty in developing countries: investment in human capital. Dr. Theodore Schultz explains in his article "Investment in Human Capital" that the clearest examples of investment in human capital are monies spent on the education and healthcare of the workforce.[7] The greatest return on

[4] Although much of the literature measures only a specific outcome or group of outcomes.
[5] Desmond and Gow use the term "children's home" differently than others. They use it to refer to a system in which a single caretaker or social worker looks after up to 14 children in her own home.
[6] I first heard this particular phrase used by economist Dr. George Ayittey in the Fall of 2006 in a lecture at American University.
[7] Schultz, Theodore. "Investment in Human Capital". *The American Economic Review*. Vol 51, No 1. March 1961, pp 1-17.

investment, he argues, comes from education. Schultz uses economic evidence from the United States between 1929 and 1956. During that period he argues between 9 and 15 percent of total economic growth in the US was due to investment in education alone- pointing out that growth far outpaced what could be explained by combining the contributions of other forms of capital, including man-hours worked.[8]

Schultz's findings directly contradicted those of the intellectual climate of the time, which had for decades been advocating investment in non-human capital in developing countries. Investment in human capital is particularly important for low income countries where income disparity is high. Schultz demonstrates that, in the United States, between 36 and 70 percent of "hitherto unexplained rise in the earnings of labor is explained by returns to the additional education of workers."[9] Not only is GDP growth closely associated with investment in education but increases in real income of workers are as well. For these reasons, Schultz advocated investment in education in low income countries as the *only* alternative to poverty for most people.[10]

The debt crisis of the late 1970's and subsequent structural adjustment policies forced many developing countries to all but abandon their investment in education. In 1997 Lin Shuanglin reaffirmed Schultz's findings in a study comparing education rates and real GDP growth in 30 Chinese provinces.[11] A correlation was found between economic growth and education level in each province that was far tighter than the correlation between GDP growth and any other factor.[12]

Shuanglin's study came following the near universal consensus by the international

[8] Schultz pp 5- 13.
[9] Schultz p 13.
[10] Schultz p 16.
[11] Shuanglin, Lin. "Education and Economic Development: Evidence from China." *Comparative Economic Studies*. Vol. 34, No. 3-4. Fall-Winter 1997. Pp 66-85.
[12] Shuanglin p 82. Also measured were kilometers of roads, presence of state enterprises, and trade among others.

community that Schultz was correct. Primary schooling has been identified as an essential aspect of human development by several influential organizations including UNICEF, the UN, USAID, and in several intergovernmental meetings in the mid 1990's.[13]

As this cursory literature review demonstrates, education enjoys a unique position among development issues because its effectiveness is all but undisputed in bringing about both overall economic development and increasing quality of life on an individual level. Oddly, this consensus has not yet found its way into the discourse surrounding non-parental methods of childcare. If education is a "silver bullet" for poverty as the research demonstrates, would it not be logical for provision of education to be considered the *central* indicator in evaluating non-parental child care?

3 - The Existing Framework: Conventional Wisdom

Perhaps the most detailed descriptive work on the current situation for OVC in Africa comes from a World Bank 2004 publication by Kalanidhi Subbarao and Diane Coury called Reaching Out to Africa's Orphans: A Framework for Public Action.[14] This book provides descriptions of both the condition of OVC in Africa as well as a detailed categorization of the various models of non-parental childcare for OVC operating in Africa. The book, which relies on the research of others, describes the strengths and weaknesses of each model and then concludes with a series of recommendations for future interventions based on these findings. Central to these recommendations is the assumption that there is uniformity in provision of care and operating cost within each model, thereby rendering some models more desirable than others.

[13] Lloyd, Cynthia, and Ann Blanc. "Children's Schooling in sub-Saharan Africa: The Role of Fathers, Mothers, and Others." *Population and Development Review*. Vol. 22, No. 2. June 1996 pp 265-298.
[14] Subbarao, Kalaidhi and Diane Coury. Reaching Out to Africa's Orphans: A Framework for Public Action. Washington, D.C.: The World Bank, 2004.

Subbarao and Coury then categorize and evaluate the various models of non-parental childcare based on the outcomes of whether each model tends to meet basic needs, economic needs, safety needs, legal needs, and psychological and social needs. Two primary categories of non-parental childcare are identified: home-based and institutional. Of these, home-based is by far the more common of the two categories.[15] This category includes the following models: surviving parent, fostering by extended family (includes child head of household arrangements), and informal and formal foster care by non-relatives. Each category has its strengths and weaknesses. In general, care by extended family is considered to be a positive situation in that it provides a "stable, secure environment" that favors psychological, intellectual and social development.[16] Weaknesses cited are a decline in social welfare, difficulty meeting the basic economic needs of the child, and an increase in child workload.[17]

The institutional category is divided into statutory residential (traditional orphanage), children's home, and children's villages.[18] The authors concede that all of these models are effective at providing for the basic material care (shelter, nutrition, healthcare) of children before offering an extensive list of shortcomings of institutional care. Criticism of statutory residential care is based primarily on a study by Chernet. The problems cited are:

- Inadequate funding
- Shortage of trained personnel
- Inadequate skills
- Lack of psychosocial services
- Lack of long-term strategic planning

[15] Subbarao and Coury p25.
[16] Subbarao and Coury p27.
[17] Subbarao and Coury p27.
[18] The former two models differ only in scale. "Statutory residential care" refers to large operations with several caretakers while "children's home" refers to an operation with a single caretaker and up to 14 children. A "children's village" is a residential setting set up by the NGO SOS Children's Village. Currently, use of this model is *extremely* limited .

- Feeling of loneliness and helplessness on the part of orphans
- Dependency
- Low self-esteem
- Lack of adult guidance
- Limited participation of children in decisions about their future[19]

Six of these ten criticisms can be categorized as relating to the psychosocial health of the child. In addition to these problems, the authors criticize institutional care for being exceptionally expensive.[20]

The accuracy and credibility of these criticisms will be discussed at length later. For now it is safe to conclude that Subbarao and Coury's central criticisms of home-based care relate to difficulty meeting material needs. Their criticisms of institutional care focus on its high cost and perceived inability to provide for children's emotional and psychological needs.[21] With very little further discussion of the merits and shortcomings of these models or any discussion of the importance of the outcomes (material needs vs. psychological needs vs. cost, for example), the authors rank the models in order of desirability. From least to most desirable they are: Orphanages/children's villages, Foster homes/children's homes, Foster care within unrelated families (adoption, formal and informal fostering), Kin-family care, and Living parent (obviously for single-parent orphans). The authors further argue that large orphanages should be diffused into smaller children's homes and should act only as temporary stages before OVC are moved into foster care arrangements.[22] While Subbarao and Coury do not prioritize the different

[19] Chernet 2001 cited by Subbarao and Coury p34.
[20] Subbarao and Coury p65,
[21] This is perhaps best indicated by table 3.4 on page 40 of the publication and proved here as Annex A. This chart also describes each model in terms of the risk of abuse and finds that risk is highest in child head of household situations, moderate in formal foster situations, kin-family situations, and institutions. Risk is lowest when child is living with a living parent or grandparents. Interestingly this chart also claims that institutions do not provide access to education, a claim not supported by cited research, or in any literature I have found.
[22] Subbarao and Coury p65.

categories of need, their rankings reflect a preference toward psychological needs and unit cost over material needs. It can be extrapolated that these variables are favored because the nature of the book is to provide a framework for interventions by governments and NGOs. That is to say, the authors assume that while home-based care models tend not to meet basic material needs of OVC, these needs can easily be met through interventions. On the other hand, it is assumed that institutions cannot, and will not under any circumstances (no matter what the intervention), be able to meet the psychological and emotional needs of children, and a foster setting is likely to. Of course, this is conjecture; Subbarao and Coury never mention the precise reason they find foster care situations more desirable than institutional care models. From the information they provide, however, a direct, positive correlation can be observed between the cost-effectiveness of each model and its desirability. No other need measured enjoys this type of correlation. This can be best observed by juxtaposing two figures included in the book:

Figure 3.1 Ranking of Living Arrangements for Orphans[23]

Most desirable living arrangement	• Living Parent

[23] Subbarao and Coury p 39.

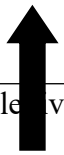 Least desirable living arrangement	• Kin-family care • Foster care within unrelated families (adoption, formal or informal fostering) • Foster homes/children's home • Orphanages/children's villages

Figure 5.1 Ranking of Living Arrangements for Orphans According to their Cost-Effectiveness[24]

Most cost-effective  Least cost-effective	• Kin-family care with community support • Foster care within alien families (adoption, formal or informal fostering) • Foster Homes • Community-based centers • Orphanages/children's villages

One can deduce from this comparison that the authors believe that cost-effectiveness is central among measures of desirability for models of care for OVC.

The World Bank is not alone in this approach to institutional care. Many large, international NGOs have expressed publicly their lack of faith in institutional care and have gone so far as to advocate against providing funds for institutional care (except in certain circumstances), favoring instead community-based foster arrangements.

For example, the Better Care Network is a coordinating organization for a number of NGOs and operates as part of the Child Rights Information Network. BCN deals with a number of OVC issues, especially interventions regarding non-parental care for orphaned and vulnerable children. Its steering committee includes CARE, the Hope for Africa's Children Initiative, UNICEF, USAID, the Displaced Children's and Orphans Fund, and Save the Children UK among others. BCN claims:

> Institutional care has been shown to cause a wide range of problems for children. Institutional care does not adequately provide the level of positive individual attention from consistent caregivers, which is essential for the successful emotional, physical,

[24] Subbarao and Coury p 81.

> mental, and social development of children. This is profoundly relevant for children under 3 years of age for whom institutional care has been shown to be especially damaging.[25]

They further claim that children in institutional care are at an increased risk for sexual and physical abuse and are less likely to attend school. Because of this, BCN advocates use of institutions as a last resort only. The organization even goes so far as to admonish governments of HIV/AIDS affected countries for "taking a backward step in resorting to the use of institutions to care for children orphaned or affected by the disease."[26] The claim that institutional care is a "backward step" as a method of care for orphans with HIV/AIDS is one that few scholars or organizations are willing to make. On the other hand, BCN has positive things to say about child-headed households if they have support, given that the intervention is provisioned in such a way as to provide for access to basic health, nutrition, shelter, and education so long as it does not undermine community support to these children.[27]

BCN has high praise for both informal and formal foster care regardless of whether it is by extended family or by unrelated persons. Foster care is always a temporary option before adoption, but sometimes, foster parents choose to adopt children in their care. According to BCN, "Foster care can provide the advantages of family-based care within a child's own community."[28] Like Subbarao and Coury, the Better Care Network advocates support of non-institutional childcare for OVC (including child headed households), but offers no such recommendation for institutional care. While Subbarao and Coury provide a more detailed discussion of care options and interventions, the Better Care Network provides an extensive database of literature alongside their policies. The vast majority of this literature, however, is of

[25] Quoted from Better Care Network Website <http://www.crin.org/bcn/topic_more.asp?topicID=1023&themeID=1003>.
[26] Better Care Network <http://www.crin.org/bcn/topic_more.asp?topicID=1023&themeID=1003>.
[27] Often the presence of NGO's is perceived in communities as indicative of a turn-around in the welfare for those benefiting from an itervention. This often means that communities will cease to support those being supported by NGO's. Better Care Network < http://www.crin.org/bcn/topic_more.asp?topicID=1015&themeID=1002>.
[28] Better Care Network. Foster Care. < http://www.crin.org/bcn/topic_more.asp?topicID=1013&themeID=1002>. (accessed ?)

a descriptive nature and deals with various interventions and government and NGO policies. Few of the literature in the BCN database are studies, surveys, or research papers dealing with the quality or cost of models of care.[29]

The Care Reform Initiative, a joint project between Orphan Aid Africa, Unicef and the Department of Social Welfare of Ghana, explains that institutional care should be used as a last resort and, when used, it should comply with the requirements of the UN Committee on the Rights of the Child (UNCRC). The document claims:

> It has furthermore been proved by extensive research on residential care setting for children that institutions should be used only as a last resort. Children need families to successfully integrate and thrive in the society, as the family is the best context for a child to successfully develop in.[30]

A series of problems associated with institutional care are then listed. The problems include (1) invasion of privacy, (2) compromising of child's right to an identity, (3) lack of stimulation, (4) high cost of "often five to ten times more than foster care,"[31] (5) inability to respond to psychological needs of children, (6)neglect of personal care, (6)frequent shift from charity to commercial status, (7) failure to prioritize schoolwork, (8) lack of opportunity for free play, (9) children growing up feeling unloved, and (10) facilitation of abuse and child labor.[32]

The authors of the document unequivocably assume the centrality of the family to child development.[33] No specific argument for foster care is made; rather foster care is implicitly understood to be most like traditional family care and therefore is deemed most preferable—this is a dangerous assumption given that many of the important aspects of child development associated by the authors are contingent on continuity of a caretaker for many years while foster care is, by definition, temporary. It should be noted also that the Care Reform Initiative does not

[29] See Better Care Network http://www.crin.org/bcn (accessed ?)
[30] Care Reform Initiative 2007-2008. p2.
[31] Care Reform Initiative 2007-2008. p2.- No source given for data
[32] Care Reform Initiative 2007-2008. p2-3.
[33] Care Reform Initiative 2007-2008. p3-4.

include any sources for its data on problems with institutional care. This fact alone makes the information in this document suspect.

The conventional view on the role of institutions in care for orphaned and vulnerable children is perhaps best summed up in the UN Guidelines for the Protection and Alternative Care of Children Without Parental Care:

> For member nation states where large child care facilities (institutions) remain, alternatives should be actively developed in the context of an overall de-institutionalisation strategy that will enable them to be phased out. No new facilities of this nature should be established under any circumstances. Children's homes should, where possible, be small structures, and children should be admitted only temporarily. If they need to stay in professional care settings, these should be with paid foster carers, in a family like structure.[34]

While the documents discussed above differ in the scope and level of their analysis, they share a number of key arguments. First, they share a wholly negative view of institutional care and advocate for a reduction in the scope of this type of intervention everywhere, *regardless of the specific circumstances in a country, city, or region*. Second, they agree that the primary shortcomings of institutional care are its high cost, lack of emotional support for children, low school attendance among children, and a higher risk for physical, emotional, and sexual abuse. The Better Care Network and the Care Reform Initiative also implicate institutional care with failing to provide for basic material needs as well. Only Subbarao and Coury list specific shortcomings of foster care, but all three agree that, in its current form, foster care is preferable to institutional care. Presumably, they believe that foster care systems are not stricken with the same shortcomings as institutional care, and the shortcomings they do have (inability to meet basic material needs, lower school attendance) are either less widespread, or just simpler to

[34] UN Guidelines for the Protection and Alternative Care of Children Without Parental Care. p5.

remedy through interventions.[35] It is difficult to discern when organizations and scholars are relying upon empirical evidence (costs) to support their arguments or theoretical assumptions (homes, regardless of their dynamics, are always better than institutions). What *is* certain is that the context that produced the orphaned and vulnerable children is ignored.

Perhaps the most important point to which these organizations accede is the assumption that the various negative outcomes cited are more closely associated with a *model* of care than any other measurable input; to say it simply: all of these organizations assume that the best indicator for quality of care for an orphaned or vulnerable child is the *model* of non-parental care, rather than individual components *within* each model. By associating model of care directly to a level of quality of care, the conventional framework grossly under-estimates the variation of inputs within each model based on variations in geographical, social and economic contexts in Africa. In some situations, for example, parents themselves have determined that institutional care of vulnerable children – specifically those institutions that provide better education, basic health care and vocational training—is better than family care, and deliver their own children to the institution's doorsteps. The point here is not that NGOs should engage in an activity (such as building more orphanages) that creates incentives that fragment families, but that NGOs need to be more sensitive to what the community believes is in the best interest of the child. In certain contexts, institutions may do a better job than a foster family at providing a child with a feeling of emotional security and foster families may do a better job at educating a child. My argument here is that the model itself should not be held as the indicator of successful non-parental care. Rather, assessments of the context; communication with community leaders, families, and the children; and the findings of literature that focus on inputs and outcomes should be our guide to caring for Africa's orphaned and vulnerable children.

[35] As the Care Initiative and Better Care Network do not cite any specific shortcomings, these examples are drawn from Subbarao and Coury p 40. It

4 - What is Known About Care for Orphans and Vulnerable Children?

The literature discussed above revealed a wide array of indicators used to evaluate various aspects of quality of care for OVC. Some were more measurable than others. The literature discussed below offer a similarly overwhelming variety of indicators. In order to simplify our analysis, we will categorize these indicators into the categories: Cost, Child Development, Basic Education, and Health. Child Development refers specifically to emotional and psychosocial development. The term health is meant broadly to include all basic material needs in addition to medical services, especially clothing and nutrition.

4.1 - Basic Education and Health

The following is a literature review comparing and synthesizing the results of a number of studies evaluating basic education and health of children in foster and institutional care situations.

As Zimmerman recognizes in her examination of the literature on this topic, much of the literature evaluating the quality of care by orphanages has been negative.[36] One such negative assessment comes from a descriptive study of the problems facing orphanages in Ethiopia by Tsegaye Chernet.[37] Chernet attributes the growth of orphanages to extensive NGO interventions to accommodate the growing number of orphans due primarily to family separation (from migration) during and following the famine in the mid 1980's. [38] According to Chernet, in the years that followed, orphanages faced inadequate funding, which resulted in a shortage of trained personnel and inadequate skills training for children. Chernet implies shortfalls in material care for children and claims generally that many children were not in school, or receiving adequate

[36] Zimmerman, Brigitte. "Orphan Living Situations in Malawi: A Comparison of Orphanages and Foster Homes." *Review of Policy Research*. Vol. 22, No 6. 2005 p. 887.
[37] Chernet, Tsegaye. "Overview of Services for Orphans and Vulnerable Children in Ethiopia". 26 April 2001.
[38] Chernet p. 4.

vocational training.[39] Chernet then goes on to discuss a successful reunification program to return children to their separated families.[40]

Chernet's paper is derived from a presentation he gave at a conference dealing with OVC issues. As a result, his data-finding methods are not discussed and the documented sources of his data are very limited. It is clear that demographic data came from the CIA World Fact Book and a substantial amount of his specific information about problems confronting orphanages and reunification came from the experience of the Jerusalem Association Children's Homes.[41] Chernet's observations of the various problems facing orphanages in Ethiopia are highly suspect do to the anecdotal nature of the evidence. The difficulties facing the orphanages discussed in this study were no doubt exacerbated by the fact that they occurred in the context of a complex emergency in which some orphanages cared for as many as 4000 children.[42] Nonetheless, his paper provides most of the substance for Subbarao and Coury's claims about the weaknesses of institutional care, especially in regard to emotional and psychological development, and their claim that reunification programs are practical.[43]

Chernet's results contrast sharply with those of Zimmerman's study on orphan living situations in Malawi. Zimmerman compares orphanages and foster homes based on how they meet material and psychological needs. In his qualitative study, fifty orphans and nine orphanage and foster administrators were interviewed. In addition five foster and group home caregivers, five health workers, and five community members were interviewed. All were asked about children's routines, educational experience, responsibilities, free time, residence characteristics, future prospects, and healthcare. Sites were also visited and facilities observed.[44]

[39] Chernet p. 5.
[40] Chernet p 10.
[41] "The Experiene of Jerusalem Association Children's Homes (JAHC) on Reunification and Reintegration (De-institutionalization of Children).
[42] Chernet p. 4.
[43] Subbarao and Coury p. 34.
[44] Zimmerman p. 889.

The individuals interviewed were of an evenly distributed age and gender make-up and came from three different children's homes and two different foster care systems with very few exceptions.[45]

Zimmerman's findings contrast Chernet's sharply. She found that children in orphanage settings were far more likely to have their own sleeping place with blankets, while by contrast 25% of children in the foster care setting shared their sleeping space with livestock.[46] All orphanage children reported having nearby access to clean water, while only 20% of fostered children did. Ninety percent of children in orphanages reported regularly eating three meals a day while only ten percent of foster children reported eating that many meals per day. Fifty percent of foster children reported eating only one meal a day. Children residing in orphanages also enjoyed greater food variety on a regular basis.[47] Health care protocol is more clearly defined and followed in institutional care. Among those in foster care, only 70% of children reported their illnesses to their caregiver and of those 60% of children who reported an illness to their caregiver received treatment in a clinical setting. Institutions also administer antiretroviral therapy to children who are HIV positive.[48] All children surveyed in institutional care were enrolled in school compared with only 65% in foster care. Graduation rates are also higher among children from orphanages.[49]

Zimmerman concludes that institutional care settings provide a superior level of material care to children and provide for basic needs better than foster homes even when these homes are monitored.[50] While Zimmerman's data appear very convincing, it should be kept in mind that her sample size was small and she did not cross-check her sources. While these limitations are

[45] Zimmerman p. 890.
[46] Zimmerman p. 893.
[47] Zimmerman p. 897.
[48] Zimmerman p. 903.
[49] Zimmerman p. 899.
[50] Zimmerman p. 907.

not as excessive as those in the Chernet study, they still, if only slightly, reduce the credibility of these results.

Observations recorded by Desmond and Gow in their analysis of cost-effectiveness of various models of OVC care indicate similar findings to Zimmerman's. Desmond and Gow point out the capacity of formal statutory and unregistered institutional care to provide for material needs well beyond the minimum and provide medical care and ARV therapy for HIV positive children.[51] This is juxtaposed with informal foster care and community interventions that are unable to provide for even the most basic material needs.[52] While some home-based care models did meet the minimum standard, it was recognized that the quality of care associated with the institutions was higher.

In addition to painting a rosier portrait of institutional care than has heretofore been presented; Zimmerman also highlights a number of key problems with the foster care system in Malawi. Desmond and Gow also recognize the superior capacity of institutions to provide basic care and education, especially to children with special needs, though they criticize it for its high unity cost.

The work of Case, Paxson, and Ableidinger takes a different approach from Zimmerman, Desmond and Gow by first assuming that educating orphans is a priority in the development of both the child and the community and then researches the relationship between orphanhood and education.[53] Based on demographic health surveys in ten African countries.the authors found that (1) orphans are significantly less likely than non-orphans to be enrolled in school,[54] (2) there

[51] Desmond, Chris and Gow, Jeff. "The Cost Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa". *Health Economics and HIV/AIDS Research Division, University of Natal.* Prepared for UNICEF. Feb. 2001. p. 24-28.
[52] Desmond and Gow p.31-34.
[53] Note- this did not include children in institutional care.
Case, Anne; Paxson, Christina; and Ableidinger, Joseph. "Orphans in Africa: Parental Death, Poverty, and School Enrollment". *Demography*. Vol. 41, No. 3. August 2004. P 485.
[54] Case et al. p. 484.

is a positive relationship between degree of relatedness of orphan and caretaker and outcomes,[55] and (3) there is significant intrahousehold discrimination against orphans in provision of education.[56]

Substantial disagreement among the literature about the strengths and weaknesses of institutional care suggests that there is a great deal of variation in provision of basic education and health between orphanages. The literature reviewed agrees that there are significant problems associated with foster care and education. Zimmerman's study, along with the observations of Desmond and Gow, indicate that the claims made by Subbarao and Coury, BCN, and the Care reform initiative regarding the tendency of institutional care to neglect education, health, and other basic needs are not wholly accurate. Quite to the contrary, in fact, the literature reviewed suggest just the opposite: that as is, institutions are providing higher quality material care and more access to education than foster arrangements do, especially when these foster arrangements are not monitored and with non-relatives.

4.2 - Child Development

Perhaps the most pointed criticisms of institutional care leveled by the organizations reviewed relate to the inability of institutions to provide adequate emotional support for the psychological development of children. Indeed, preliminary literature reviewed by Zimmerman revealed that orphans in institutional care displayed delayed cognitive development when compared to non-orphans[57]. It is unclear whether these results are symptomatic of institutional care or the children's orphaned status. This section seeks to illuminate the source of these perceptions of institutional care and then evaluate them using the contemporary literature. Then I provide a comparison to the alternative models of care evaluated in the literature.

[55] Case et al p. 506.
[56] Case et al p. 507.
[57] Drew, Makufa, and Foster 1998 cited in Zimmerman p. 887.

Of all of the negative outcomes attributed to institutional care by Subbarao and Coury, the evidence for negative emotional and psychological outcomes was the most poorly documented. These negative outcomes more than any others are grounded in conventional wisdom. In my online interviews with Mr. Desmond, the economist whose work was relied upon by the World Bank for its conclusions on orphan care, the distinction between findings based on empirical evidence and those based on theoretical assumptions became clear. Mr. Desmond, in an October 2007 email to me, highlights this point:

> Generally we know that institutions are bad for children. We have learnt from experiences around the world that no matter how well resources or how low the staff to child ratio the outcomes for the child are problematic. This is because it is very important for children to form a bond with at least one adult. This provides them with a sense of security that allows them to learn and develop. Traditional institutions by their nature involve staff working there and then going home. This is where the attachment is lost and typically children are not allocated to a particular staff member so they do not form bonds.[58]

When challenged to explain exactly how this was known, Mr. Desmond said he was an economist and left that up to the psychologists, but cited the experience of post-war Eastern Europe and maintained that this was a consensus in the child welfare community.[59]

At this point I was accustomed to being told that it was a fact that children do not develop well in institutional settings. The evidence was everywhere. After all, we have all but stopped using institutional care for orphaned children in the US; there had to be a good reason. To find out I consulted the available psychology literature on the subject. I feel it is practical to assume that the psychological and emotional effects of institutional care would be comparable on an orphan or vulnerable child whether he/she lives in Africa, the United States, Europe or anywhere else for that matter. After all, the criticisms aimed at institutional care in Africa seemed all but identical to those directed at institutional care in the US. Richard McKenzie describes the nature

[58] Desmond, Chris. "Re: The Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children." 17 October 2007.
[59] Desmond, Chris 18 October 2007

of criticism of institutional care in the US explaining that child welfare professionals in the US "dismiss orphanages…for damaging children in almost all regards—intellectually, emotionally, and economically."[60]

The best critical examination of the source of the conventional wisdom comes from a literature review by McCall. McCall reviewed the most frequently cited studies in child welfare journals used to criticize various aspects of institutional care. This is the first work of its kind in a half-century. McCall analyses the literature by addressing the following basic questions for each: "Were appropriate research questions asked? Were the research methods suited to the questions asked? Do the conclusions correctly follow the methods used and the data collected? How widely may we generalize the findings?" While these should be basic considerations for any scholar seeking to conduct a study and publish a paper, McCall found that almost all of the literature examined failed in one or more of these areas.[61] McCall sums up his criticisms very concisely:

1. Theories about the detrimental effects of maternal deprivation receive highly tenuous, indirect support at best from orphanage research. Where psychological deterioration in infants was found, it is not clear whether the mother's absence or simple physical and social neglect was the essential cause. Neither was there any evidence that such neglect was widespread practice.
2. Some teenagers and young adults with orphanage experience show deficits in language development, intellect, personality, or social skills. It is far from clear, however, that these were caused by their orphanage care. Orphanage care, per se, was almost never directly observed or explicitly manipulated in this research.
3. Most of the research suffers from the overuse of small, opportunistic samples, and there is a general failure to describe population sources and methods of selection. These limitations make it impossible to generalize findings based on isolated samples to all orphans or orphanages.
4. Most orphanage research is limited to a narrowly focused, clinical search for psychological damage. Very little of it deals with the effects of age at placement. None of it deals with the role of sibling support, the effects of age or gender groupings, the role of work, moral training, and a host of other practical issues in orphanage care.

[60] McKenzie, Richard. "Rethinking Orphanages: An Introduction". Rethinking Orphanages for the 21st Century. Thousand Oaks: SAGE Publications, 1999. P. 4.
[61] McCall, John. "Research on the Psychological Effects of Orphanage Care: A Critical Review". Ed. McKenzie, Richard. Rethinking Orphanages for the 21st Century. Thousand Oaks: SAGE Publications, 1999. P. 127.

5. Critics of orphanage care seem overzealous to produce negative evidence and then generalize their findings to all orphans or orphanages. More consideration should be given to positive orphanage experiences and ways of assessing their effects. Besides the controlled experiments with infants using social stimulation, there was only one developmental study that directly measured change. More developmental research is needed.[62]

Among the most startling observations made by McCall was the frequency with which results were tampered with or discarded because they did not support the researcher's hypothesis.[63]

While this literature review is not absolutely comprehensive, the conclusions bring into question our most basic assumptions about orphanage care, as well as the "established" claims by Coury and Subbarao, BCN, and others about the negative outcomes associated with institutional care.

Marvin Olasky conducted an historical analysis of orphanages in the US by examining various texts and primary sources. He ultimately concludes that orphanages fell out of favor politically before they did so in psychological and academic circles.[64] While he is unable to firmly establish a causal relationship between the events, his findings speak directly to the rationale behind policy shifts, whether it is domestic or through international organizations: political will causes shifts in policy. Shifts in political will do not always follow research.

A study carried out by Richard McKenzie serves to further debunk the myth of a consensus on the quality of care afforded by institutions. McKenzie, himself an orphanage alumnus, sent a survey to 4,500 orphanage alumni from nine different homes.[65] Of those, fewer than 4000 were actual living alumni. The survey asked a variety of questions evaluating orphanage experience and quality of life after leaving the orphanage. Among the areas surveyed were questions about abuse encountered before and during the time spent in institutional care,

[62] McCall p147.
[63] As was the case with in Bowlby 1951 cited in McCall p. 145.
[64] Olasky, Marvin. "The Rise and Fall of American Orphanages" Rethinking Orphanages for the 21st Century. Thousand Oaks: SAGE Publications, 1999. P. 74.
[65] McKenzie, Richard. "Orphanage Alumni: How They Have Done and How They Evaluate Their Experience". Rethinking Orphanages for the 21st Century. Thousand Oaks: SAGE Publications, 1999. P. 108

and free response questions evaluating the overall orphanage experience, including shortcomings. Questions also addressed post-orphanage educational attainment, income, divorce rates, and a number of indicators of psychological health. Whenever possible, questions were borrowed directly from the US census so that outcomes of those who had orphanage experience could be compared to outcomes of the general corresponding demographic group.[66] This appears to be a sound methodology given the goal of associating orphanage care directly with a large number of outcomes- outcomes that the conventional wisdom says should be correlated negatively with orphanage care.

One thousand eight hundred surveys were completed and returned, an estimated response rate of just over 50%. Recognizing that this research model is subject to free response bias, an attempt was made to test for this bias by calling one hundred alumni from the list of one orphanage. Respondents were asked first whether they had returned a completed survey, and second a series of the questions evaluating the orphanage experience. There was no correlation between non-response and negative responses regarding orphanage care (in fact, non-respondents had slightly more favorable opinions of their orphanage experience). It was thus concluded that while free response bias may still affect the results, there is no indication that this is the case.[67]

Across the board, the results of this study revealed higher levels of achievement for orphanage alumni. They showed higher levels of educational achievement and higher median incomes, as well as lower rates of poverty and incarceration than the overall white population of

[66] McKenzie p. 109.
[67] McKenzie p 108- A possible negative bias is also identified. Many orphanage alumni were admitted because of abusive home situations- negative psychological outcomes could be attributed to this abuse rather than orphanage experience. The key bias- the fact that the population sampled was slightly opportunistic will be addressed.

the US.[68] Significantly, more orphanage alumni consider themselves happy or very happy than in the whole white population of the US. A lower percentage sought psychiatric services as well.[69]

Overall, orphanage alumni had a very positive assessment of their orphanage experience. Seventy-six percent of respondents rated their overall orphanage experience as "very favorable" compared to just over two percent of respondents combined in the categories "somewhat" and "very" unfavorable. Only three percent of respondents indicated that they ever wanted to be adopted.[70] The most common positive attributes associated with orphanage upbringing were "[p]ersonal values and direction fostered, sense of self-worth fostered, excellent basic amenities, education and skills development, and friendship and close sibling ties." The most commonly cited negative attributes were "separation from immediate families and siblings, and lack of love and emotional support from institution staff. A full 20% explicitly claimed that there were no problems with their upbringing.[71]

On the surface, this study appears to directly refute every claim attributed with the institutional model of care. The impacts of its findings are limited, however, by the fact that the sample selection was opportunistic. The mailing lists used for the survey were from orphanage alumni associations. In order to be on the list of potential recipients of the survey, one would have to request to be part of the alumni association. This has the potential to skew the results of the study in a positive direction, as an alumnus who had a negative orphanage experience is probably less likely to request membership in an alumni association.[72]

McKenzie's concluding remarks warn against the expansion of a foster care system from which only six percent of children are adopted each year.[73] Even in the US, the number of

[68] McKenzie p110-113. All respondants to the survey were white, so they were compared to census results for whites in the US.
[69] McKenzie p 112.
[70] McKenzie p. 117
[71] Mc Kenzie p 117
[72] McKenzie p. 108.
[73] McKenzie, Richard. "Rethinking Orphanages for the 21st Century: A Search for Reform of the Nation's Child Welfare System." P. 289

children entering the foster system is expanding as the number of available foster parents contracts. This has resulted in 23% of foster care children having two foster placements. An additional 20% experience between three and five placements, and seven percent more will have over seven placements. A quarter of children entering the foster care system in the US can expect to be placed three or more times.[74] Forty percent of foster children leave the system and enter the welfare system. The already strained foster system in the US has few available placements for children facing abuse at home. Many children are returned to abusive situations several times by courts with few or no placement alternatives.[75] While these findings are specific to the US, it would be naïve to deny the potential for such problems to emerge on a continent where government monitoring structures are even more poorly funded and coping mechanisms (that is traditional mechanisms for fostering and adoption) are being besieged by HIV/AIDS.

The results of these studies concur perfectly with the findings by Zimmerman regarding the strengths and weaknesses of institutional care and foster care. It was found that orphans in orphanages have a "broader concept of what they can do as adults, and are less restricted by the typical path of adults in their society." All of the orphanage alumni interviewed were self-sufficient.[76] A slightly higher percentage of orphanage residents reported that they felt their caretakers loved and cared for them than foster care children.[77]

If these results are truly valid, then the conventional claims of negative outcomes associated with institutional care are completely invalidated. The literature reviewed certainly has its limitations. What can be concluded from this literature review is that there is neither a preponderance of evidence nor a consensus among childcare experts to support the claims made by the NGO community operating in Africa.

[74] McKenzie p 290.
[75] McKenzie p. 290.
[76] Zimmerman p. 906.
[77] Zimmerman p. 906.

4.3 - Cost and Cost-Effectiveness

The literature on cost and cost-effectiveness of various models of care present a wide variety of figures for the cost of various institutional and foster arrangements. The literature reviewed all agree that foster care arrangements cost less than institutional care. However, as Brigitte Zimmerman aptly points out, many authors make the mistake of comparing costs of "two things that are not comparable."[78] She reviews two studies comparing the cost of various models of non-parental care. The first study was conducted in Lilongwe, Malawi and found that while it would cost $64 to care for one child over age five in a children's home, it would cost only $53 in a foster home.[79] The second study, conducted in Tanzania, claims that it costs six times as much to care for a child in an institutional setting compared to a foster arrangement.[80] Zimmerman points out that these studies do not take into account the quality of care being delivered by the arrangements compared and that comparing costs of completely different standards of care does not reveal anything about cost-effectiveness.[81] Subbarao and Coury cite a number of such studies in their book.[82]

Desmond and Gow attempted to overcome this obstacle in their study "The Cost Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa."[83] This is the first study that attempts to measure the cost-effectiveness of various models of care for orphan and vulnerable children. This paper is the most frequently cited as justification for the claim that institutional care is not cost effective. It provides such justification for the conventional framework penned by Subbarao and Coury, among others.

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[78] Zimmerman p 907.
[79] Bhargava & Bigombe, 2003 cited in Zimmerman p 887.
[80] Global Partners Forum, 2003 cited in Zimmerman p 887.
[81] Zimmerman 907.
[82] Subbarao and Coury p 77-79.
[83] Desmond, Chris and Gow, Jeff. "The Cost Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa". *Health Economics and HIV/AIDS Research Division, University of Natal.* Prepared for UNICEF. Feb. 2001.

As the title suggests, Desmond and Gow conducted a quantitative study of six models of care for OVC. They selected one example for each of the following models (listed from most to least formal): statutory residential care (orphanage), statutory adoption and foster care (formal fostering and adoption), unregistered residential care (orphanage), home-based care and support, community-based support structures, and informal fostering/non-statutory foster care. Desmond and Gow reject the raw unit of cost per childcare month, as it does not account for variation in quality of care, and would thus only be measuring cost, not cost-effectiveness. The study establishes a "minimum standard of care":

> Derived from the essential elements of care…[these elements] comprise five categories: survival, security, socialization, self-actualization, and palliative care. All essential elements require the child to have a care giver, there after the resource constraints are concentrated on the realization of the survival elements: food, clothing, home environment, education, hygiene, and health care.[84]

Real costs, determined by examining the financial statements of each organization and interviewing staff, are adjusted to what they would be only to provide the minimum standard. Costs are further adjusted to include the cost of salaries for social workers and caretakers who work as volunteers in institutional settings. The authors argue that because the intention of the article is to compare the cost-effectiveness of models of care, volunteer labor cannot be assumed, and thus for the purpose of replicability, the cost figures should reflect compensation of volunteers.[85] However, additional cost is not added as salary for caretakers in home-based situations- grants received (if applicable) are considered sufficient to cover this.

The results of the study suggest that institutional options (statutory and unregistered residential care) are the least cost effective by a substantial margin.[86] It is concluded that institutional care is not nearly as cost effective as home-based support for foster care. Desmond

[84] Desmond and Gow p 16.
[85] Desmond and Gow p 15.
[86] Desmond and Gow p 37.

and Gow also observed that the quality of material care provided in the institutional arrangements was considerably higher than in foster arrangements.[87] It is also recognized that the institutions, both Jardim house and Nazareth House, were caring for a considerably higher proportion of children who were HIV positive or required specialized care- this obviously caused an increase in the cost of care.[88] Interestingly, informal foster care and community initiatives failed to provide the minimum standard of care to the children. An estimate was still made for what it would cost for these models to reach the minimum standard, but the authors concluded that it would be unwise to advocate the use of any model that has failed in practice to provide even the most basic quality of material care.[89]

While this study is certainly a good attempt to overcome the problems associated with previous cost analysis, there are crucial flaws in the methods. The first issue is a small sample size. While the purpose of the study was to compare six models of OVC care, the study really only succeeded in comparing six *examples* of OVC care. While the authors attempt to select examples that are characteristic of the models they are comparing, this could be better achieved through a larger pool of examples.[90] One example of one model cannot be used to infer about the attributes of a larger population.

The most important problems with the methods of this study are in the adjustments made to cost. First among these is the key variable- the "minimum standard of care". While it was clear that this was an attempt to correct for variation in quality of care between models, it is unclear precisely how actual costs were adjusted to be cost for "minimum standard of care".

[87] Desmond and Gow p 24.
[88] Desmond and Gow pgs 21 and 27.
[89] Desmond and Gow p 38
[90] Desmond and Gow p 9. The authors explain that they attempt to select organizations that represented an even urban-rural spread and had been in opertation for at least one year among other factors.

Only a very brief explanation is offered in the appendices.[91] Another brief explanation was offered to me in another communication from Mr. Desmond. He explained:

> What I think we did was remove all the material costs such as food and clothing and replace these with the minimum. Then remove any delivery or infrastructure costs that would no longer be necessary with this level of material provision. That is if they had staff of other costs that would not be necessary if they offered a minimum standard then these were removed. It was really an effort to get down to the costs of delivery that were fixed and did not vary with the level of material inputs.[92]

While this was more complete than the explanation offered in the document itself, it still did not adequately explain exactly how the final figures were reached.

Other adjustments were clearly stated, but skew the results in favor of home-based care options. The first is the salary adjustment to volunteer labor. Desmond and Gow argue that this is necessary to measure the cost of replicating the model, which is the point of the study. Including these salary costs effectively negates a clear advantage institutions have in reducing their operating costs: their ability to mobilize volunteer labor and donations on a scale inconceivable to home-based models. This point will be highlighted later in my recounting of my personal experience working for an orphanage in Kenya.

Because the constitution guarantees education and healthcare to children in South Africa, Desmond and Gow chose not to include the cost of education or healthcare in their minimum standard. This limits the scale to which this study's results can be applied, for a number of reasons. First, few countries in Africa have a functional free education or healthcare systems for children (including South Africa). Secondly, it eliminates the impact of a second advantage that institutional care is recognized to have over foster and home-based care- the widespread provision of education and healthcare to children in their care.[93]

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[91] Desmond and Gow see appendix 2

[92] Desmond, Chris. "Re: Successful Models For Non-parental child care in Africa" 25 October 2007. See appendix A for a complete record of the correspondence between Mr. Desmond, Dr. Collins, and myself.

[93] See discussion in section 3-1.

This illuminates perhaps the most important criticism of the Desmond and Gow study. While the minimum standard of care is useful for the purpose of cost-comparison, the authors do not adequately explain precisely what quantities are required for a model to have met the "minimum standard" per child (for example, what are the nutritional requirements? are they simply caloric?).[94]

The authors themselves cite an important limitation of these results: costs are higher when providing care for HIV positive children -- this translates into a much higher cost for the provision of the minimum standard of care, especially if ARV therapy is included in the minimum standard of care (as it should be).[95] This example brings to light a major shortcoming in the conclusions of this study: different children have different needs. Those needs have (or should have) a major effect on the nature of the "minimum standard of care" and thus the cost of providing it. The Nazareth House provides an excellent example of a characteristic of institutional care recognized by Desmond and Gow, as well as many others:[96] Institutional settings care for the most needy, especially the very ill. Desmond and Gow sum it up best:

> At both Nazareth House and Jardim House it was made clear that children were placed there because there was nowhere else to go. The local children's societies try first to place children in one of the less formal arrangements, but when they fail they are placed at homes like the ones mentioned. The costs, therefore, although high, may in some circumstances be the only option to abandonment and life on the street for the children.[97]

Ultimately, this study prioritizes analysis of cost over quality. Because the specifics of the "minimum standard" of care are unclear, we are unable to evaluate whether or not they are adequate. It is important to recognize though that thoughtful analysis of a "standard of care" is

[94] It should be noted that a published version of this paper exists and I am told it includes a more detailed discussion of the determination of the "minimum standard". It is important to examine this version of the paper though, because this is the version cited most frequently. It is also the version upon which Subbarao and Coury base their analysis of cost effectiveness.
[95] Desmond and Gow p. 41.
[96] See Meintjes, Helen; Moses Sue; Berry, Lizette; and Mampane, Runth. "Home Truths: The Phenominon of Residential Care for Children in a time of AIDS". *Children's Institute, Center For the Study of AIDS*. University of Pretoria, June 2007.
[97] Desmond and Gow p. 39.

more sophisticated than a simple distinction between adequate and inadequate. Children with different needs require a different standard of care, which is associated with variation in cost.

While I am aware that the Desmond and Gow study is descriptive in nature, the omission of any meaningful discussion of the possible causes of the gap in efficiency described is very noticeable. As Zimmerman notes, it is counter-intuitive that these organizations be less cost-effective given the impact of economies of scale. When Zimmerman asked orphanage management about cost, they all speculated that because institutions are able to purchase in bulk and enjoy regular donations, they thought it would be much more expensive to care for the children individually.[98]

It would be misleading to claim that these criticisms invalidate the findings of Desmond and Gow; they do, however, bring into perspective their limitations. It can be safely concluded that institutional care is more expensive than home-based care. The study leaves in question to what extent home-based models are more "cost-effective" and whether the most "cost-effective" models are capable of providing a high quality of care for OVC. Given the shortcomings of this study, it would certainly be a mistake to conclude that institutional care per se is too inefficient to be useful. The variation in "cost-effectiveness" can be largely attributed to variation in the cost of the "minimum standard" based on the needs of the children in care at institutional settings and the relationship between institutional care and children with special needs, often attributed to their HIV positive status.

5 - Testing the Conventional Framework: The Stories of Three Orphans

As fully set out in the preceding sections, I argue that the conventional framework for determining "best practices" for selecting non-parental childcare is built upon methodological errors and outdated theoretical assumptions. I built my initial argument around multi-

[98] Zimmerman p908.

disciplinary scholarly literature and my online interviews with the key economist whose data collection and analysis was the foundation upon which the conventional framework was built. Using an ethnographic approach, I further tested the generalities posed by the conventional framework through my direct observations of three care institutions for OVC in Nairobi, Kenya, from January through March of 2007. Provided below is a summary of my direct observations and inquiries into the lives of four orphans that I encountered. Aisha's story is from a formal interview which took place in February 2007. In addition, I will present a brief description of two institutional care facilities and the stories of two children who live at one of them, as well as the story of one child I knew in foster care.

The Mama Fatuma Goodwill Children's Home

The institution that would become the Mama Fatuma Goodwill Children's Home was founded in 1966 by the Kenyan Woman's Organization as an education and training facility for the physically handicapped in Eastleigh, Nairobi. Shortly after the launch of the program, Mama Fatuma Gullam converted the home into a facility to care for Nairobi's growing population of orphans and vulnerable children. The home sought to care specifically for minority Muslim children who would likely be converted if raised in a Christian children's home. While the home was established to care for Muslim children, it also takes in non-Muslim children (they are not asked to practice Islam). After the death of Mama Fatuma in 1997, her son became manager, and the home fell into neglect. Upon learning of the deteriorating conditions at Mama Fatuma's, the Kenyan Government appointed the Supreme Council of Kenyan Muslims (SUPKEM) to manage the home and its children. SUPKEM appointed a board of directors and Mohamed Hiribae as the homes manager. Presently the home has 65 children in residential care and provides support to an additional 20 children in its outreach program.

On my first day working at Mama Fatuma's, I sat down with Mohamed to discuss my role in the organization. Mohamed stressed that the priorities of the home were "food and respectable clothing, education, and medical care in that order." He indicated that my priority would be finding money in the form of recurring donations for school fees and medical care. "We are able to feed each child for only about one dollar each day, but their school fees and supplies cost far more than that, and it is meeting this need that is most difficult for us, but also most important for the children."

I soon learned that indeed the children were able to eat substantial portions of nutritious meals for minimal expense. This was largely because the home was able to secure donated food to supplement its purchases. I rode in the bed of a pick-up truck with several of the homes oldest boys to pick up huge shipments of donated vegetables from the airport (where they would have otherwise been exported). The home also enjoyed regular donations of milk and live goats. The children in the home's care enjoyed a much larger micronutrient variety than was typical in the surrounding community.

Education was in fact the most substantial expense per child. While the home's senior house mothers were paid, a significant portion of the home's staff was volunteer. Children were also attended to by doctors on a volunteer basis and were even able to receive hospital care at minimal or no cost when they were accompanied by a note from the home explaining their situation. While the Kenyan government enjoys support for having established a nominally universal primary education system, it has not created a comprehensive public school system. As a result, in order to attend even primary school, fees must be paid every term and books purchased by each student. The home paid most school fees through irregular donations from various businesses and individuals solicited by Mr. Hiribae, although some children were

sponsored individually or in groups. Through the diligent efforts of the home's management, all of the children attend school. The home guarantees education through the secondary level but will not discharge a child until he/she has a job and a place to live. This often means the home tries to assist in paying for vocational training or even university education when children are eligible. This is especially true for girls, who have difficulty finding jobs with only secondary education.

Aisha Mohamed

Aisha Mohamed[99] was born in 1985. The whereabouts of her parents unknown, she was abandoned in Eastleigh, Nairobi and found crying in an alley way by police officers. That evening the police brought her to Mama Fatuma's. Though she was dehydrated when she was brought in, the house mothers took care of her and she grew into a healthy child.

Aisha claimed to be very nervous when she began primary school, but found that she fit in very well at school even though she was very shy. She enjoyed her time at the New Eastleigh Primary School- a formal, coeducational day school near the home but had to leave school for three years while being treated for a chronic stomach condition. Aisha spent three years seeing various doctors before her condition was successfully treated.

By that time the home's management had enough money to send Aisha to a better performing school. Entering standard five, Aisha adjusted well to her new school setting and earned good grades. She had made several good friends and recalls fondly the time she spent playing and reading at the library with her friends. Because Aisha was always very well behaved, when it came time for her to apply to high school the management at Mama Fatuma's allowed her to apply to a Christian school where she believed she would have more freedom. She had hoped her best friend Zakia would be able to join her at high school, but Zakia was

[99] The names of all children discussed have been changed for confidentiality.

forced into marriage by her father, a practice that is not uncommon for girls in the Eastleigh community.

While Aisha earned good marks at Navigators high school in nearby Nakuru, she was disappointed by her score on the Kenya Certificate of Secondary Education.[100] I knew Aisha during this time, for weeks she was depressed because she knew that she would not be able to get into a university and become a lawyer as she had always dreamed. I had discussed with her the option of retaking the KCSE, but she refused, saying that she did not think her secondary school had prepared her well enough to score higher on the exam. She spent a lot of time with Mohamed Hiribae discussing other career options, and finally decided to enroll in a two-year program for business administration. Aisha has been in the program for almost a year now and has been doing very well.

Elizabeth Fatuma

Like over 20,000 other children in Nairobi, Elizabeth grew up on the street. While the details of the first four years of her life are unknown, by the time she was brought to Mama Fatuma's by the police, she was malnourished and addicted to glue. Elizabeth's case history indicates that when she first arrived she had very limited language skills- only able to speak and understand *Sheng*- a type of Nairobi slang with elements of English, Kiswahili, and a number of other Bantu languages. She also had physical and emotional signs of a child who had been abused regularly as a child.

Elizabeth had a difficult time overcoming her substance addiction and there was evidence that she was suffering physical and emotional withdraw symptoms. On several occasions,

[100] A standardized test all children take upon completion of secondary school- determines ability to gain entry to University or vocational training.

Elizabeth tried to run away. When she was asked why, she said her head was ringing and hurting her and the only way she believed she could make it stop was to find glue to sniff.

While her early months at Mama Fatuma's were difficult, she eventually overcame many of the problems she was having when she first arrived. By the time I had the pleasure of meeting Elizabeth, she was enrolled at the New Eastleigh Primary School and told me that of all the things she does, she loves going to school the most. She said she appreciated very much her "family"[101] at Mama Fatuma's because there were always people to talk to when she was upset, and always older children to stand up for her when she needed it.

I do not wish to imply that all of the children at Mama Fatuma's got along with one another all the time. There were instances of conflict between children. Nor am I claiming that all of the children at the home were happy- at times it was obvious that children were very unhappy- but unhappiness was usually a result of outside circumstances that had little to do with the home. On the whole, there are several important things to recognize about Mama Fatuma's. First, all of the children are in school- primary, secondary, and vocational. The availability of vocational training (and even university for those children who are admitted) makes children feel that they are in control of their own future. Second, Mama Fatuma's does not receive regular financial support from NGO's or governments- almost all of its funding is procured locally. Third, children have a strong feeling of community, but also an individual sense of self. Mama Fatuma's management has gone to great lengths for all children to have their own locked closet in which they can secure their own private property- children do not share clothing, shoes etc. Fourth, children are never encouraged to work inside or out of the home- except to clean up their own messes. Finally, girls at Mama Fatuma's are always sent to school and encouraged to start

[101] She used the Swahili word Jamaa- which is often translated as "family". Indeed "jamaa" is often used to refer to the nuclear family, but it can also be used to refer to any close-nit group of relatives or community.

careers. The home's management believes strongly that women should have careers. It is believed that women who are self-reliant will enter marriage out of love rather than necessity and under these circumstances they are less likely to enter or remain in abusive marriages.

Obviously all children's homes in Kenya are not as well managed as Mama Fatuma's. Another orphanage, Mama Ngina's, sits on the other side of town and has a very different reputation.

Mama Ngina's

My first impression of Mama Ngina's was how well funded it appeared. The home had well manicured gardens surrounding a new white-tile facility all in a large grassy field. In my mind it stood in stark contrast to the concrete courtyard and older building at Mama Fatuma's. This first impression would prove to be deceiving though as the reality of the operation of Mama Ngina's became clear. Colleagues of mine who worked in the home complained of terrible conditions for the children and corruption in the management- several examples of each I observed myself.

During my four months there it became clear that the children were made to take care of themselves. The staff of house-mothers was about half the size of that at Mama Fatuma's and were expected to take care of nearly twice as many children. The home was cleaned by the children, and the older kids purchased groceries and did a substantial amount of the cooking for all of the children. Children were often fed spoiled food and milk.

Neglect and lack of supervision resulted in poor health among the children, especially the youngest ones. Children suffered from chronic sinus infections and were never brought to see doctors or to health clinics. The very young children in the baby ward suffered worst from this

neglect. Babies were rarely taken out of their cribs and their diapers were changed only about once every few days. As a result babies often had skin conditions and infections.

Several of the home's children also suffered from mental and physical disabilities. One baby was discovered to have pneumonia and turned out to be deaf. Diagnosis only occurred after ex-patriot volunteers took the child to a doctor.

All medical treatment offered to the children was resisted by the management. Allegations of corruption among the management were widespread. While volunteers were not granted access to the home's financial records, it was known that the home received government support and had several regular corporate sponsors and sources of income from Europe and the United States. All donations in kind were sold by the management as were any valuable items found in possession of the children.

Sanitary conditions in the home were also poor. At one point a group of volunteers (myself included) inspected and cleaned up the children's indoor and outdoor play areas. We found that the home itself was infested with pests and rats. Barefoot children played unsupervised outdoors in a field covered in broken glass and garbage. All garbage from the home was dumped in the field where children played, and no attempt was made to keep children from playing in garbage piles and forage through them for food.

While I was not permitted to see the children during meals, because children were often found foraging for food in garbage piles, I speculate that children were not fed well.

Several children were sent to school, but many did not regularly attend. A major donor had constructed a state of the art school facility and playground on the Mama Ngina's grounds, but within a year of the schools completion, the home's management had sold the property and

fenced it off. The school became a private primary school- too expensive for children from Mama Ngina's to attend.

Wafula's Experience with informal foster care:

Wafula was born in 1999 in the far west of Kenya, north of Lake Victoria. His mother, Nabila, was between fourteen and sixteen years of age and unmarried. While much of Wafula's early life is unknown, we do know that his mother married shortly after he was born and had two more children. The whole family moved to the Kawangware slum outside of Nairobi. While the Kenyan Children's Act stipulated that in agreeing to marry Nabila, her husband became Wafula's father, he did not treat Wafula like the rest of his children. Wafula has revealed that his stepfather used to beat him mercilessly during his childhood, justifying the abuse by claiming that Wafula was not his son.

Wafula was never enrolled in a formal school, but regularly attended the Ray of Hope Community Learning Centre, an NGO-operated informal school in Kawangware that teaches children how to read and write basic English.

Wafula's mother became very ill. It is unclear whether she has HIV, but her husband sent her "upcountry" to stay with his parents.[102]After Nabila left, the beatings increased in frequency and severity. One day, Wafula was told that he was no longer welcomed in his stepfather's house and not to bother returning after school that day. Sure enough, one day Wafula found his home empty and locked. Wafula's stepfather had taken his brother and sister and left Nairobi, he was eight years old. At school Wafula became very ill. He revealed to his

[102] "upcountry is a term commonly used in Kenya to refer to the rural area from which an urban dwelling Kenyan moved or the area in which one's relatives live. Often people who are very ill go upcountry to get better, or more likely pass away. We assumed that the latter was the case for Nabila, but later found that she is still alive.

teacher and an American volunteer that his stepfather had abandoned him and that he had been sleeping on a neighbor's floor for the past week.

The volunteer called me at Mama Fatuma's to see if there was a temporary place for Wafula at the home. Mohamed informed us that Mama Fatuma's can only take children referred there by the Children's Department, but was adamant that Wafula's stepfather be prosecuted for abandoning his legal son. After discussing the matter at length with Mohamed, he admitted that it was very unlikely that the police would be able to track down Wafula's stepfather.

In the mean time, Wafula was sent to stay with his cousin Evan, who also attended the school.[103] Evan's family, like most in Kawangware, lived in a small, single room shack with one bed and two small benches. Evan's parents were both unemployed, and accommodated another relative as a permanent guest. The parents slept on the bed, the guest on one bench, and the two boys on another, though we suspect that Wafula at least occasionally slept on the floor. Wafula revealed to his teacher that his cousin Evan had been mistreating him regularly, and that he did not like staying with his aunt and uncle. It became clear that Evan's parents were not taking good care of either of the children, and that Wafula was being neglected more than Evan.

Wafula's teacher agreed to take care of him, and has been receiving support from outside donors. Wafula has now been with his teacher for seven months and is happier than he has ever been. The teacher had to keep the fact that she was receiving outside support from the rest of the Ray of Hope staff. Such support has been known to create jealousy in that community, and the teacher feared that she might lose her job. Eventually, Wafula's mother was found and signed over custody of the boy to his teacher. At this point it seems that the teacher is taking very good care of Wafula, and the donors have ensured that there is enough money for him to be well fed, clothed, attend formal school, and receive medical care when he needs it.

[103] We do not know the precise relationship between Wafula and Evan Kenyan's often do not differentiate between relatives.

My brief, yet highly informative exposure to Kenya's orphans demonstrates that all models of care have the potential to be successful, and also have the potential to fail at providing OVC with even the most basic care, especially education. The quality of care in these cases was dictated more by the competence and character of care-givers, the presence of oversight, and to a lesser extent, the availability of resources.

6 -Towards a More Comprehensive Framework for Analysis

The results and conclusions of the literature reviewed, my online interviews, and my observations in Kenya, taken at face value, would completely undermine the conclusions of the World Bank, the Better Care Network, Orphan Aid Africa, and the majority of NGOs and IGOs that deal with OVC issues. However, it would be presumptuous to conclude that we have demonstrated the superiority of institutional care in its ability to provide for child development, basic education, and health. To do so would be to both ignore the limitations of the literature and declare that the literature reviewed is comprehensive enough to represent the entire body of work done in the field of care for orphan and vulnerable children. This conclusion is also undermined by my personal experiences in Nairobi. Fortunately that is not the intention of this paper.

The literature that was examined revealed that foster care is not per se more desirable than institutional care by any measure. There is substantial evidence that institutional care is capable of providing for child development and health as well as, if not better than, foster care. It is nearly universally accepted that institutional care provides for greater educational opportunities. No evidence has been found that indicates child-headed households are capable of providing for any of these needs. The data on cost effectiveness indicates that institutional care is slightly more expensive, but this is explained as much by the high level of care provided to meet children's needs as it is by efficiency. Furthermore, the literature upon which the

conventional frameworks established by the World Bank, BCN, and Orphan Aid Africa is too limited in its scope and quality to draw the conclusions about the quality of *models* of care just as the more dispersed literature reviewed in this paper is too limited to definitively overturn the evaluations by these organizations.

What is very clear is that the body of literature on OVC care is exceptionally limited in its scope and varied in its conclusions. The literature have revealed at least as much variation in quality and cost of care within each model as there is between models. Furthermore, most of the literature has indicated that different models of care tend to serve children with different types and degrees of vulnerability, and also that certain interventions are more or less successful depending on specific environmental circumstances.

Indeed, the largest mistake made by the World Bank and a number of NGOs in their attempts to describe the current situation in OVC care and provide a useful framework for future interventions lies in their assumption that the model of non-parental care best explains the quality of care. If this research and my anecdotal experience have demonstrated anything, they have shown that various models of care have been successful in provision of all of these standards of care, just as all have demonstrated a capacity to fail. Recommendations based on examination of models of care alone are not specific enough to be useful.

As Meintjes et al. reveal, most practical models of childcare in use demonstrate some form of blurring between family-based, community-based, and residential care.[104] That said, it is completely counterintuitive to advocate only family and community-based interventions while these social structures are being broken down by HIV/AIDS- the very cause of the increasing number of OVC. Furthermore, while the nuclear family may be the central institution of child development in the west, this is not necessarily the case in tropical Africa. In Africa the family

[104] Mientjes, et al. pg 91.

is important, but community is equally as central. An analysis of Bantu languages would illustrate that often little distinction is made between family and community. In Africa there is little pretext to assume the central nature of the family in childhood development.

In order to quickly, successfully, and adequately care for the growing number of orphan and vulnerable children in Africa, the existing structures for OVC care will have to be bolstered. Interventions should be based on specific environmental, demographic, and cultural factors. It is useless to attempt to implement an extensive foster-care network unless there are enough people willing to foster and especially adopt children. As Subarrao and Coury indicate, factors like HIV prevalence, infrastructure and employment will affect the capacity of households to care for additional children. Where factors like these limit the capacity of households to foster or adopt additional children or institutions are already present, institutional care may be a useful option. In circumstances in which capital is scarce and NGO's are not present- community and household type care are the only options, and institutions can operate outreach systems to support other models of care..

In order to successfully intervene to improve the quantity and quality of care for OVC, NGOs and governments must understand that the following elements are crucial. First, there needs to be adequate political will worldwide to mobilize the necessary resources. Second, the capacity of existing care mechanisms must be expanded and monitored. It may be worthwhile for NGO's and governments to make funding and grants contingent on transparency and improved monitoring. Any model of care can have success if it is operated responsibly and professionally. NGO's and governments must be careful to evaluate exactly what types of interventions are successful in which circumstances, and then scale up operations that work in appropriate circumstances.

That said, the first priority for both governments and NGO's should be getting OVC off of the streets and into schools- this simple equation is the most likely to yield a long-term, higher quality of life for OVC and economic growth for affected countries in sub-Saharan Africa. In cities like Nairobi there are over twenty thousand children of diverse backgrounds living on the streets at any given time, all subject to widespread violence and sexual abuse.[105] Both critics and supporters of institutional care concede that it has the advantage of being replicable, can handle children with diverse, specialized needs, and tends to provide children the highest likelihood of attending formal educational institutions. Therefore, the most practical short-term solution to reach our simple goal is almost certainly closely monitored institutional care. Ultimately care for OVC can be decentralized in appropriate circumstances. Regardless of the model of care used, education must be a top priority because it is most closely related to increased adult income and development of states as a whole. Only well-managed economic development will ultimately give Africa sustainable means to support care for orphans and vulnerable children.

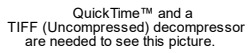
[105] "Police Abuse and Detention of Street Children in Kenya." Human Rights Watch. June 1997. <http://www.hrw.org/reports/1997/Kenya>. Accessed 15 October 2007.

Annex A: Table 3.4

Table 3.4 Propensity of Caregivers to Meet Orphans' Needs

Needs / Caregivers	Living parents	Grand-parents	Other relatives	Child household head	Foster family		Adoption	Foster Home	Children's village	Orphanage
					Formal	Informal				
Basic needs										
– Shelter	High	High	High	Low	High	High	High	High	High	High
– Food	Low	Low	Low	Low	High	Low	High	High	High	High
– Access to health care	Low	Low	Low	Low	High	Low	High	High	High	High
– Clothing	Low	Low	Low	Low	High	Low	High	High	High	High
– Education	Low	Low	Low	Low	High	Low	High	High	High	High
Economic needs										
– Productive skills (training, vocational education)	Low	Low	Low	Low	High	Low	High	High	High	Low
– Income-generating activities	n.a.	n.a.	n.a.	Low	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
– Farm/productive inputs	n.a.	n.a.	n.a.	Low	n.a	n.a.	n.a.	n.a.	n.a.	n.a.
Safety needs										
– Protection from										
– verbal abuse	High	High	Risk	Low	High	Risk	High	High	Risk	Risk
– physical abuse	High	High	Risk	Low	High	Risk	High	High	Risk	Risk
– sexual abuse	High	High	Risk	Low	High	Risk	High	High	Risk	Risk
– work exploitation	Low	Low	Low	Low	High	Low	High	High	High	High

(Continued)



Appendix B: Correspondence with Chris Desmond

From: tyler.alvare@gmail.com
Subject: **The Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa**
Date: October 15, 2007 4:02:01 PM EDT
To: cdesmond@hsrc.ac.za

Sir,
I first would like to thank you for contributing your article "The Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa". While much work has been done evaluating the cost of various models of OVC care, this is the first which attempts to take into account the effectiveness of each model. Central to this evaluation though, is your notion of the "Minimum Standard of Care". I was unable to locate a copy of part one of this study in which you define this term. I would appreciate it if you could send me a copy of this.

I am also writing in the hopes that you will be able to clarify for me the specifics of your calculation of the "Minimum Standard of Care" i. While appendix 2 of the study explains the source of the data for prices of products required for subsistence (Food, Clothing, and sometimes fuel), earlier in the study you explain that the minimum standard also includes the costs of education and medical care.

Were these costs also included in the cost of minimum standard for each model? If so, were they adjusted or were the prices recorded by each organization used?

More theoretically, I would like to know exactly how the variation in cost of the minimum standard of care among the models analyzed reflects on the cost-effectiveness of each model. If adjustment in cost to find the cost of minimum standard relies exclusively on variation in the prices of each good (based on its proximity to the relevant urban area in the Potgieter study), then how can the results be used to evaluate the cost-effectiveness of a model? Is the cost of the "minimum standard" simply all of the administrative costs etc. added to the adjusted costs of food, and clothing?

Another matter is exactly how you calculated the cost of time for foster caregivers and orphanage volunteers. Did you adjust the costs of foster care to include the cost of hiring the foster parent as a full-time caregiver at appropriate wages as you did for full-time staff at institutional settings? I feel that to adjust orphanage costs to include the value of volunteer employees, while practical for raw replicability, ignores the capacity of orphanages to mobilize volunteer labor at a local level where labor may be prevalent and capital scarce.

Central to all of this is how exactly you explain this variation in costs of various models of OVC care in Africa. While this paper does a very good job describing variation in cost-effectiveness, I would like to know exactly why you think that institutional settings are less cost-effective. Where does the money go, and is any of it *wasted* in the traditional sense?

Finally, I was relieved to read that you prescribe a "continuum" of models to care for the various specialized needs of OVC throughout such a diverse continent. Have you read the Subbrao and Coury Book Reaching Out to Africa's Orphans: A Framework For Public Action? This book relies heavily on the findings of your cost-effectiveness study. I found though that the book does not seem to adequately address your call for the necessity of a "continuum" of care ranging from institutional to informal foster. The book seems to focus more on the "desirability" of each model, relegating a "temporary stay only" role to the traditional orphanage. I was struck by this implication. I am under the impression that the diverse economic, political, demographic (environmental) and cultural situations will each require a specialized model of care. In some situations, especially urban with high HIV infection rates where traditional coping mechanisms for dealing with OVC are saturated, disrupted, or nonexistent, a formal orphanage (under adequate oversight) is the best model- as the alternative is neglect and a growing number of street children. Formal orphanages are easy to replace, mobilize volunteer labor and donations from the community, and under good management provide excellent care for OVC. They can also act as an administrative framework through which fostering and corresponding support programs can be established. On the other hand, there are many circumstances in which foster care is far more appropriate, and effective in providing for the needs of each child. My point is that shouldn't the specific environmental factors of each community dictate the appropriate model of OVC care?

I very much appreciate your attention to this matter.

Tyler J Alvare
American University
4400 Massachusetts Ave, NW
Washington, DC 20016
United States
+1 215 205 5445

From: CDesmond@HSRC.ac.za
Subject: **Re: The Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa**
Date: October 17, 2007 10:30:19 AM EDT
To: tyler.alvare@gmail.com

Dear Tyler
My paper outlined that there was a continuum of care. It was intended as a description more than a recommendation. There are indeed places for different types of care and you should perhaps see the document by Save the Children on Institutions as last resort.

Generally we know that institutions are bad for children. We have learnt from experiences around the world that no matter how well resources or how low the staff to child ratio the outcomes for the child are problematic. This is because it is very important for children to form a bond with at least one adult. This provides them with a sense of security that allows them to learn and develop. Traditional institutions by their nature involve staff working there and then going home. This is where the attachment is lost and typically children are not allocated to a particular staff member so they do not form bonds. There have been alternative models suggested which link a small number of children to a particular care giver and they act in a similar manner to a parent. This caregiver may have other roles in the organization but each child knows that they belong to a particular person.

Even in urban areas there are plenty of family type settings, either in actual families of in organizations which replicate them, and resources should be directed towards these if we are to get the best outcomes.

Attached please find a document with a more recent discussion of some of the methodological issues you raised, it is intended as a methods paper so please do not cite the results anywhere as the sample was just to test the methods and is too small to report on. Otherwise I also suggest that you access the article version of the paper you mention as it combines both parts of the report. If you still have questions feel free to come back to me.

Regards
Chris

Desmond C., Gow, J., Loening-Voysey, H., Wilson, T and B Stirling. 2002. Approaches to caring, essential elements for a quality service and cost-effectiveness in South Africa. Evaluation and Program Planning, 25, pp 447-458.

From: collins@american.edu
Subject: **Successful Models for Non-Parental Child Care in Africa**

Date: October 17, 2007 12:51:46 PM EDT
To: CDesmond@HSRC.ac.za
Cc: tyler.alvare@gmail.com

Hello Chris. I am a professor at American University working with Tyler Alvare on a comparison of models for non-parental child care for Africa's orphans. Tyler forwarded your email response to him. I would be most appreciative if you would also clarify some of your points for me. At the risk of broad generalization (and without first looking at your methodology and data sources), is this a correct interpretation of what you said in your email:

The primary measurement of success in non-parental child rearing of Africa's orphans is their (self-assessed?) level of personal security, which is, in turn, measured by the degree of bonding between one child and one adult?

Does your data measure positive outcomes of institutional non-parental childrearing beyond simply bonding? And was the level of personal security measured qualitatively? Did it make a difference if the staff were indigenous or a foreign NGO in terms of bonding? Did you begin with the assumption that institutional care had less positive outcomes based solely on the bonding issue? Or was basic health and education also measured in a comparative way between fostering and institutional care?

We greatly appreciate your taking the time to respond to our queries. Most respectfully, Cindy Collins

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From: CDesmond@HSRC.ac.za
Subject: **Re: Successful Models for Non-Parental Child Care in Africa**
Date: October 18, 2007 2:46:44 AM EDT
To: collins@american.edu
Cc: tyler.alvare@gmail.com

Dear Cindy
I should note first of all that I am an economist and typically defer these issues to the psychologists I work with. My interest has been in measuring the cost effectiveness of care. To do this requires an understanding and measuring of the outcomes which is when I bring in the psychologists. That aside I think that I can still clarify some points.

What I was saying to Tyler was that the literature in general, rather than any of our work, shows that formal institutions tend to result in poor outcomes and that much of this has to do with attachment and insecurity issues relating to the nature of the care. Experience from post world war orphanages and orphanages in eastern Europe have repeatedly shown this. This is particularly the case when young children are cared for in these settings. If it would help I would happily forward you some references.

The point of the first study we did on this, which Tyler ask about, really looked at costs and a material minimum standard of care. So in that study we did not examine psychological outcomes. The study showed that formal institutions are very expensive relative to family care or smaller scale semiformal organizations.

The paper which I sent through last time is about a method and a pilot study to examine its use. In this we examined a range of outcome measures relating to educational outcomes, behaviour

and health. In the pilot we did examine a model of non family based care but it could not really be considered an institution in the traditional sense. In this model each employee was linked with up to six children and acted as their parent. They all lived in the same location but each child was clear who their primary care giver was and the caregivers lived on site.

I do not suggest that there is not a place for orphanages but beyond short term emergency care I do not see a place for them. There may be some exceptions relating to older children but for younger children they really are not good places. The response is often that they are necessary because family systems break down. My response is that we should then find innovative ways of supporting families so that they don't break down. This is an area we are working on at the moment. We have a joint project with a number of other groups called the Joint Learning Initative on Children and AIDS (JLICA) www.jlica.org. I should also note that many children in the African and particularly Southern African context do not live with their parents even if they are alive. The migrant labour system, poverty and other socio economic factors have done a great deal to break down the family. Responding to orphans in this context is important but also complicated as many, although not all, of the challenges they are their carers face relate as much to poverty as to orphaning.

If there is anything further that you would like to discuss please feel free to contact me.
All the best
Chris

From: tyler.alvare@gmail.com
Subject: **Re: Successful Models for Non-Parental Child Care in Africa**
Date: October 22, 2007 2:55:11 PM EDT
To: CDesmond@HSRC.ac.za

Chris,

Thank you for the additional resources provided to supplement your study. While I believe that the psychiatric community is not necessarily in consensus regarding the issue of institutional child care, I understand that that was not the question addressed in your study. There are still some questions which escape me regarding how you measured the inputs (costs) of each model. Forgive me for quoting a previous email to reiterate these questions:

While appendix 2 of the study explains the source of the data for prices of products required for subsistence (Food, Clothing, and sometimes fuel), earlier in the study you explain that the minimum standard also includes the costs of education and medical care.

Were these costs also included in the cost of minimum standard for each model? If so, were they adjusted or were the prices recorded by each organization used?

More theoretically, I would like to know exactly how the variation in cost of the minimum standard of care among the models analyzed reflects on the cost-effectiveness of each model. If adjustment in cost to find the cost of minimum standard relies exclusively on variation in the prices of each good (based on its proximity to the relevant urban area in

the Potgieter study), then how can the results be used to evaluate the cost-effectiveness of a model? Is the cost of the "minimum standard" simply all of the administrative costs etc. added to the adjusted costs of food, and clothing?

Thank you,
Tyler

From: CDesmond@HSRC.ac.za
Subject: **Re: Successful Models for Non-Parental Child Care in Africa**
Date: October 24, 2007 10:16:06 AM EDT
To: tyler.alvare@gmail.com

Dear Tyler
I think we shall have to agree to disagree on the consensus issue. Although even if formal institutions were not so bad for children they cost so much that they are highly inefficient models of care and far more children could be provided for through other models of family or semi-formal care. The family strain which occurs is not simply a result of orphaning but more because of the context of poverty in which it occurs. Countries in highly affected regions have unemployment rates well over 30% and at times much higher. There is no shortage of human resources. So if the shortage is of financial resources than the family will always be a more efficient use of resources than formal institutions.
In truth the paper you ask about was a long time ago and I don't have a copy to hand. The one I sent you last time is more recent. I will, however, try and answer as best I can recall.
The provider cost of education and medical care was not included - as in the cost to the state of providing schools and clinics. This is because the cost is independent of the model of care and is therefore not relevant to the comparison. You could argue that certain models access better schools or better health care, but that would only be because they pay more for it and then the analysis would become about the CEA of health care or education.
The cost included then in regards health and education is the cost to the care provider of accessing the service or rather the cost in supporting the child to access the service. So in terms of health care this would include the time and costs of getting the child to the health care facility. This links to your second point. This particular paper - which as I note above is an older version and does not consider outcomes - was aimed at trying to examine the relative efficiency of different models in delivering a set material minimum standard of care. Obviously then the material minimum remains constant, as that is the point. The variation in what you refer to as administrative costs is the variation in the costs of delivering the material minimum. It was the efficiency of the model we were interested in. If we allowed the input costs to vary it would conflate the model efficiency with differential inputs and make the model comparison impossible without another outcome measure.
Regards
Chris

From: tyler.alvare@gmail.com
Subject: **Re: Successful Models for Non-Parental Child Care in Africa**
Date: October 24, 2007 11:54:00 AM EDT
To: CDesmond@HSRC.ac.za
Cc: collins@american.edu

Dear Chris
Thank you for your help. I have one further issue in need of clarification, and it is what I have been grappling with since I first read the paper. If the material cost of providing the minimum standard of care is constant (as I believe you are saying), how exactly is the cost of delivering the material minimum standard determined for each model? My impression was that it was extrapolated from the costs for each model to provide the

level of care it did in fact provide...but I would like to know exactly cost of minium care (b) was determined from actual expenditure per child (a)-- did you simply subtract the expenditure of material items/ services which were not included in the minimum standard?

Secondly, do you think that leaving out the cost of medical care and school fees in the minimum standard limits the replicability of the standards advocated in this model outside south africa?

Regards,
Tyler

From: CDesmond@HSRC.ac.za
Subject: **Re: Successful Models for Non-Parental Child Care in Africa**
Date: October 25, 2007 3:33:53 AM EDT
To: tyler.alvare@gmail.com

Dear Tyler
If I recall correctly we first reported the costs as they were. That is including all input costs. Now if we had some measure of 'care' then we could simply compare all of these costs to that outcome. This is to some extent what we tried in later work. In the case of the project on which this paper is concerned we did not have this outcome measure so we elected to compare the models in terms of their efficiency in delivering the material aspects of care. If, however, one does this it is necessary to standardise what is delivered so as to examine the relative efficiencies. The choice of a minimum standard was made but this could have been another standard, maybe a target standard which is over the minimum. The important thing is that its the same for each model. This links in with your question about leaving out medical care and schools. You could add this in, its no problem, the important thing is that you do it for each model. If however the figure added is standard then it will not change the ranking of the models as the cost of accessing (in terms of staff time etc) these services was already included.

To estimate the costs of delivery I am trying to remember what we did. What I think we did was remove all the material costs such as food and clothing and replace these with the minimum. Then remove any delivery or infrastructure costs which would no longer be necessary with this level of material provision. That is if they had staff of other costs which would not be necessary if they offered a minimum standard then these were removed. It was really an effort to get down to the costs of delivery which were fixed and did not vary with the level of material inputs.

I hope this helps. If you still have questions I think that it would be best if you gave me a call and we talked them through.

Regards
Chris
+27 31 242 5624 (GMT+2)
