SOCIAL WORK & CHRISTIANITY

AN INTERNATIONAL JOURNAL




ISSN 0737-5778

NACSW
NORTH AMERICAN ASSOCIATION OF CHRISTIANS IN SOCIAL WORK

SOCIAL WORK & CHRISTIANITY

AN INTERNATIONAL JOURNAL

FALL 2007
VOLUME 34, NUMBER 3
ISSN 0737-5778

CONTENTS

ARTICLES

Social Work and Christianity is published quarterly by the North American Association of Christians in Social Work, 21 Turkey Roost Rd., Sandy Hook, Connecticut 06482. Periodicals postage pending at Newtown, CT and additional mailing offices.
ISSN 0737-5778

POSTMASTER: Send address changes to NACSW, PO Box 121; Botsford, CT 06404.

Community and Family Models of Care for Orphans and Vulnerable Children in Africa

Jon E. Singletary

As North American Christians consider how to care for children deeply affected by the global AIDS pandemic, we know we must respond in ways that demonstrate God's love and appropriate care for orphans and vulnerable children. While institutional care settings (i.e., orphanages) are a common response to caring for orphans and at-risk children and youth, this paper considers practices that strengthen community and family settings as alternative models of care for offering quality support for orphans and vulnerable children, particularly in an African context. Foundational principles and examples of community and family-based models from Africa are presented.

On a vocations-related trip to Africa with social work students in May 2005, I first remember meeting two children named Peter and Paul. Having my photo taken with them felt truly apostolic, I must say. Their names had a profound impact, but the tenderness of their smiles and affection was nothing if not spirit-filled. Yet, at the same time, I saw an emptiness in these children. It may be the result of living with an HIV+ status in an impoverished country. It may be the fact that this disease had resulted in the death of at least one parent of each child. But it may also be the fact that they are surrounded daily by more than 100 children whose experiences are far too similar. Peter and Paul were orphans living in institutional care. Our trip was focused largely on institutional care settings, residential settings, children's homes; all this is to say we began by working in orphanages. I came to learn about alternative models of care for orphans and other vulnerable

Social Work & Christianity, Vol. 34, No.3 (2007), 298-316
Journal of the North American Association of Christians in Social Work

children—family and community-based models that need to be shared more widely.

Introducing the Problem

It is estimated that, by the end of 2006, there were more than 15 million children in sub-Saharan Africa who have lost one or both of their parents to HIV/AIDS, TB, and malaria—they, like Peter and Paul, will also be orphans. In Kenya alone, there is estimated to be more than 2.3 million orphans, more than 1 million of whom were orphaned due to AIDS (United Nations' Children's Fund (UNICEF), 2006). AIDS is generating orphans so quickly that families struggle to cope. The term "orphan" is commonly understood to mean a child who has lost both parents. It is important to note, however, that when child and HIV/AIDS advocates use the term "orphan," we mean a child who has lost one or both parents. Many of these children are likely living with a surviving parent, and many of the children who have lost both parents have extended family nearby. Actually, a child who is orphaned in Africa is most unlikely to be living outside of his or her extended family (Gilliam, 2002; Olson, Knight, & Foster, 2006).

Life remains very difficult for many of the vast majority of orphans who are living within a household. Many of them struggle in light of economic and health needs or with the social stigma that often follows children affected by AIDS, and some of these children are mistreated by relatives with whom they live (UNICEF, United Nations' Program on HIV/AIDS (UNAIDS), & U.S. Agency for International Development (USAID, 2004). In addition to making orphans of many children, AIDS is also increasing the vulnerability of a very large, but hard to measure, number of children. Inadequate resources must be stretched even further in situations where there are increased numbers of children with a parent ill due to HIV/AIDS and in poor households that have taken in orphans.

Children orphaned by AIDS and other children in poor households can be immensely vulnerable economically and emotionally. These children often have reduced access to basic necessities like adequate shelter, food, clothing, healthcare, and education. Besides coping with the death of family members, these children may suffer violence, exploitation, abuse, neglect, and social isolation.

Unemployment, homelessness, substance abuse, imprisonment, sexual assault victimization, and several mental health problems were among the psychosocial problems reported by orphans and vulnerable children (UNICEF, UNAIDS, & USAID, 2004; Viner & Taylor, 2005).

Popular wisdom tells us that families and communities can barely fend for themselves, let alone take care of this number of orphans and vulnerable children. However, we are learning from practice wisdom, as well as from a growing body of research, that extended families and communities have more strengths than we often realize and we are discovering that institutional care is often not a good alternative because it presents great social and psychological risks for young children (United Nations' Children's Fund (UNICEF), United Nations' Program for HIV/AIDS (UNAIDS) & World Conference of Religions for Peace (WCRP), 2003; Viner & Taylor, 2005).

Among the risks associated with institutional care are the reduced ability to form lasting attachments, community stigmatization, and transitional risks related to housing, education, and employment when children leave institutional care (Dunn, Jareg, & Webb, 2003; Williamson, 2004). This review of the literature presents resources, particularly from international service organizations, that are available to strengthen the capacity of families and communities so that they may offer better care to children in need, especially in an African context.

Considering a Response

So, how are we to respond? For Christians in social work, the biblical call to care for orphans is clear. From a reference in almost a dozen of the Psalms to James' description of religion that is pure, we hear the mandate to defend, rescue, and liberate children who are parentless. Isaiah (1:17) is quite explicit in calling us to "learn to do good, seek justice, rescue the oppressed, defend the orphan, plead for the widow." And the church is learning to be faithful to this call. In new and exciting ways, Christians are saying that we cannot sit idly by as so many children struggle to make their way through life. We know we must respond; we are just not always sure how to offer the best response.

The initial response for many congregations and faith-based organizations that engage in caring for these children has been to consider providing institutional care. I spent the day with a man recently who felt the call of God to care for the orphans of our world. His family's response was to take their savings to build an orphanage in Africa. He felt a call and the response seemed natural. Now, a few years later, he's asking questions about better care for these children.

Orphanages, in whatever form, whether planned as children's homes or child villages, whether named residential setting or institutional setting, often appear at first glance to provide a promising way to care for large numbers of children in an efficient and effective manner. However, the long-term results are not so promising (Dunn, Jareg, & Webb, 2003; Viner & Taylor, 2005; Zeanah, Smyke, Koga, & Carlson, 2005). Institutional forms of care involve large numbers of children living in an artificial setting which effectively detaches them not only from their own immediate and extended family and from their community of origin, but also from meaningful interaction with the community in which the institution is located.

Recognizing the potential negative effects of institutional care and to promote better forms of family and community-based care, UNICEF, the Displaced Children and Orphans Fund (DCOF) of USAID, the Africa Bureau for Sustainable Development of USAID, and Save the Children came together to form the Better Care Network (BCN) in 2003. This decision was influenced by the Stockholm Conference on Residential Care in May of that year and a position paper presented there by Dunn, Jareg, & Webb and the Save the Children Alliance entitled, "A Last Resort: The Growing Concern About Children in Residential Care."

The BCN, and the international service organizations that comprise this network, recognize that parents, relatives, or other well-meaning adults may send a child to an institution to ensure the child's access to nutritional, medical or other assistance during desperate times. The institution may be seen as the only opportunity for education. Institutions appear to offer a safety net for families that cannot imagine or identify other options. Yet, when parents and their children most need family and community support, they turn to institutional settings that can often have a serious and negative impact on children's development and on children's rights.

Research conducted by John Bowlby in 1951 for the World Health Organization began the modern criticism of residential institutions for children. While the merit of residential or institutional care settings continues to be debated domestically (Barth, 2002), the risks that are identified here in the United States tend to be exacerbated in global contexts devastated by AIDS, poverty, and in some situations, military conflict (Dunn, Jareg, & Webb, 2003).

In the worst poverty-affected international situations, serious violations of children's rights are found in institutional care settings, including systematic sexual abuse, life-threateningly poor nutrition, unhealthy hygiene and lack of health care, educational deprivation, and regimented, harsh discipline. Here, child development outcomes have demonstrated the detrimental impacts in terms of stigma and discrimination affecting personal and social identity, self-esteem, and attachment, and in terms of stimulation affecting motor skills, intellectual capacity, and social skills, and in terms of problem-solving affecting independence and social responsibility (Tolfree, 1995,). Also, children's rights, in terms of the United Nations' Convention on the Rights of the Child, are shown to be violated in studies in diverse international institutional care settings (Dunn, Jareg, & Webb, 2003; Tolfree, 1995; Williamson, 2004).

Gudbrandson (2004) and Tobis (2000) report delayed physical, mental and social development in institutional care settings in Central and Eastern Europe that are related to anxiety and personal uncertainty, passivity, aggressiveness, and antisocial behavior. In the same reports, statistics from Russia and other former Soviet Republics show one in five children leaving institutional care end up with a criminal record, one in seven becoming victim to sexual trafficking and prostitution, and one in ten committing suicide. Bulkenya (1999) identifies several problems associated with residential care in Uganda. In particular, staff turnover add to the costs and the attachment problems of children; and, without mandatory health screening for staff, children are infected with diseases such as tuberculosis. A study in East Africa (Chernet, 2001) identified children in institutional care experiencing depressive symptoms, developing a dependency on staff and little sense of responsibility, feeling inferior to local children and having low self-esteem, and having little adult guidance and little individual attention from caregivers. Family reunification was

seldom offered even if family members were identified, and when offered, resistance by children and staff made it difficult. Finally, the children were seldom offered skills training or preparation for adult life outside the orphanage. UNICEF (2003) offers longitudinal research and historical documents compares several industrialized nations over the past half century as they have transitioned care away from institutions because of records demonstrating psychosocial developmental risks and human rights violations.

In general, difficulties children face include the inability to bond with a primary caregiver, the lack of individualized attention, the regimentation of daily activities, the isolation from normal life, and the stigma of living in a facility for marginalized individuals. As a result, institutional care has been found to limit children's ability to bond and form lasting relationships, to delay or stunt their cognitive development, and to prepare them inadequately to live in the broader society (Tolfree, 1995). A growing consensus in research considering the effects of institutions on children in poor nations indicates that the longer children stay in an institution, the greater is the likelihood of emotional or behavioral disturbance and cognitive impairment (Tolfree, 2003a). The Stockholm declaration of the Second International Conference on Children and Residential Care demonstrates "indisputable evidence that institutional care has negative consequence for both individual children and society at large" (McCreery, 2003).

Given the negative impact of international institutional care settings, advocates in the BCN suggest that one of the fundamental strategies to improve the safety and well-being of orphans and vulnerable children, and to protect their rights, is to strengthen the capacities of their families and communities to protect them and provide for their needs (personal communication, John Williamson, 2005). Moving beyond the criticism of institutional care found in "A Last Resort" (Dunn, Jareg, & Webb, 2003), a "First Resort" series was launched by Save the Children Fund (UK). The first of these reports was written by David Tolfree (2005) and offered ways to support children to live with their families in their communities. There are multiple family and community-based based models of care that are seeking to do just this.

Foundations for Family and Community-Based Models of Care

A review of the literature and the collective experience of numerous organizational leaders organized by social worker Jan Williamson (2004) demonstrated that family and community-based models of care best serve to meet the needs of children affected by HIV/AIDS and extreme poverty in Africa and other international contexts. Such approaches rely upon keeping children within a family setting rather than in children's homes, orphanages, and large institutions and providing economic, educational, health care, and upon social support services for their communities. Provision of care that is in the best interest of a child most often occurs when children remain in the care of their immediate or extended families (recognized as their key safety net), for the sake of continuity of care and when community capacity is strengthened in order to provide the highest level of care for children orphaned by AIDS.

The goal of family and community-based models of care is for orphans and vulnerable children to be supported by familiar adults (as far as possible) and to remain within their own communities. First, programs of this type seek to strengthen the familial households where these children live so that they may provide adequately for their care and protection. Alternative care is the second option being encouraged by agencies and advocates alike and this includes local foster care, kinship care, or adoption. Long-term institutional care is seen only as a last resort for these children, particularly the most vulnerable, yet even then it is suggested that residential care be provided on a short-term basis (Dunn, Jareg, Webb, 2003; Tolfree, 2003a; 2003b; 2005; UNICEF, UNAIDS, & USAID, 2004; Williamson, 2004).

Family-based care in a community is not only more likely to meet the developmental needs of children, but also more likely to equip them with the knowledge and skills required for independent life in their communities. By remaining within their own communities these children retain a sense of belonging and identity and also benefit from the continuing support of networks within the community (Tolfree, 1995).

These approaches benefit from being potentially far less expensive than residential and institutional care and hence more sustainable (Tolfree, 1995, 2005). But, as I was asked by the organizers of

a large institutional care setting, "Are these family and community models just pipedreams?" Consider an example from Kenya (Donahue, Hunter, Sussman, & Williamson, 1999). A program in the slums of Nairobi found that when 200 single, HIV+ mothers were asked who could care for their children if they became too ill to do so, half denied having extended family members who could provide care. After the social worker that interviewed the women developed a relationship with them, she discovered that most of the women had relatives from whom they had been estranged. The social worker was able to identify, in most cases, a grandmother, or other extended family members prepared to provide ongoing care for the children. The provision of care was not contingent on the provision of cash or material support.

Community responses vary in the scope and scale of their services. The services are offered by community-based organizations with voluntary membership, local non-governmental organizations employing paid staff, and religious groups and networks. They include clinics and nutrition programs, child care and educational programs, income generating activities, extended family supports, orphan care committees, and respite-care programs for caregiving adults (Williamson, 2004).

"Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS," a paper developed by UNICEF, UNAIDS, and USAID (2001), provides a central overview of principles to be considered in planning a response and in offering community and family-based models that provide care for orphans and other vulnerable children. The paper offers a comprehensive view of significant issues and seeks to help communities and families by offering the following principles to leaders:

1. Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities.
2. Strengthen the economic coping capacities of families and communities.
3. Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers.

4. Link HIV/AIDS-prevention activities, care, and support for people living with HIV/AIDS, and efforts to support orphans and other vulnerable children.
5. Focus on the most vulnerable children and communities, not only those orphaned by AIDS.
6. Give particular attention to the roles of boys and girls and men and women, and address gender discrimination.
7. Ensure the full involvement of young people as part of the solution.
8. Strengthen schools and ensure access to education.
9. Reduce stigma and discrimination.
10. Accelerate learning and information exchange.
11. Strengthen partners and partnerships at all levels and build coalitions among key stakeholders.
12. Ensure that external support strengthens and does not undermine community initiative and motivation.

Focusing these issues further, UNICEF (2004) published *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*. This document describes the impact of HIV/AIDS on children, including psychosocial stress, economic problems, and risk of HIV infection. It incorporates the above principles and presents five key strategies for addressing the needs of orphans and other children made vulnerable by AIDS. These strategies include building the capacity of families, supporting community-based responses, ensuring essential services to children (e.g. education, healthcare), improving policy responses, and fostering supportive environments for children. These have been recognized as fundamentally important in writings such as *A Generation at Risk* (Foster, Levine, & Williamson, 2005) and the U.S. Government's *Children on the Brink* (UNICEF, UNAIDS, & USAID, 2004) series and in funding from the United States and other G-8 nations to support services for orphans and vulnerable children.

President Bush demonstrated his commitment to community and family-based programs when the Office of the United States Global AIDS Coordinator (USAID, 2006) called for a rapid scale-up of services and support systems for orphans and other vulnerable children. This scale-up relies on improving the quality and expanding

the reach of existing responses, as well as supporting new programs. Program improvements would ideally be guided by operational strategies such as strengthening the capacity of families to cope with their problems, mobilizing and strengthening community-based responses, increasing the capacity of children to become proactive in meeting their own needs, and integrating care services with existing prevention and care programs. The foundation for this effort is the President's pledge of $15 billion over five years to fund the Emergency Plan for AIDS Relief (Office of the United States Global AIDS Coordinator, 2004; USAID, 2006).

Exemplary Models of Family and Community-Based Programs

The overwhelming majority of orphans in Africa are living in households which often cannot provide fully for their needs, yet social workers and leaders in faith-based and other organizations, including congregations, can play a vital role in strengthening these families and communities as they protect children and provide for their needs. Once just a hypothesis, organizations throughout Africa, with the support of international governmental and nongovernmental support, are making this vision of care a reality. WorldVision, Care, Save the Children, USAID, UNICEF, Hope for Africa Children Initiative, Firelight Foundation, and the International HIV/AIDS Alliance are among the leading organizations implementing family and community-based models of care as alternatives to institutional care settings. Let's consider several examples of models strengthening families and communities in this way.

Hope for African Children Initiative

Several alternative models of care can be found in the work of the Hope for African Children Initiative (HACI), organized throughout Africa by seven leading international NGOs—CARE, Plan, Save the Children, the Society of Women Against AIDS in Africa, the World Conference on Religions for Peace and World Vision International. These are among the world's largest service delivery organizations operating community programs throughout Africa. While continuing their individual projects, the entities combined their experience and resources to offer a unified response to the needs of children and families impacted by HIV/AIDS.

The Hope for African Children Initiative is an inclusive, collaborative effort that adds value to all organizations addressing the AIDS pandemic. This partnership harnesses the experience, networks, and contacts of like-minded organizations to serve more children at the community level. Its work is based on a conceptual model entitled the "Circle of Hope" which focuses on approaches that are culturally and socially appropriate and that can be applied on a much larger scale than currently exist. The model and the Initiative are based on three fundamental principles which are child-focused, community-focused, and integrated. The Initiative is designed to attract more partners, to engage more communities and to leverage more funding for holistic orphan programming that is family and community focused.

As one example, HACI is sponsoring a program in Busia, Uganda, where 30 families are trained and supplied with seeds and goats. Vulnerable children in each of these families congregate biweekly for a day of activities, skills workshops, counseling, and health care; and forty orphans are paired with local artisans and are trained in marketable skills (HACI, 2007).

In Ghana, HACI established a presence in 2003 and within one year directly reached 5,126 male and 6,112 female children. They provided medical support to children and their families and facilitated enhanced access to HIV information and services. They provided school uniforms as well as school furniture, educational materials, and also paid school fees. In addition, HACI has facilitated training and skills development for unemployed women living with AIDS and established three youth centers with resources on HIV/AIDS. Furthermore, HACI Ghana has also established farms and facilitated succession planning for the future care of children and organized training for school food vendors. The Ghana AIDS Commission (GAC) is supportive of HACI's work, helping secure public funding from Ghana as well as from the Global Fund, UNICEF, and the Bill and Melinda Gates Foundation (Zaney, 2004).

Kayoyo Skills Center

Another alternative to institutional care is the grassroots model begun by the Community Orphan Care Committee in the rural village of Nthondo, Malawi. In partnership with World Vision and the

Ntchisi District AIDS Coordinating Committee, the Kayoyo Skills Center provides job skills and income generating opportunities for orphans and vulnerable children as well as basic childcare, recreation facilities, and an HIV/AIDS resource center. The Academy for Educational Development (AED 2003), co-sponsored by UNAIDS and private voluntary organizations, describes the work of Kayoyo as an emerging 'promising practice.'

When the AIDS-related death tolls made it difficult for extended family members to care for children and child-headed households began to emerge, community leaders noticed school dropouts and economic hardships increasing. Therefore, faith and other community-based organizations began to address some specific needs of children, such as providing social and economic skills and physical and mental health services. World Vision initially facilitated these services while local leadership began to organize the Nthondo Orphan and Vulnerable Children Projects (World Vision, 2005).

One of these Nthondo Projects, the Kayoyo Skills Center, began with a few children and a $5,000 grant in 2001; it served 32 children in 2003. The project monitors several community indicators tied to specific outcomes objectives. They report an annual increase in the number of children served, increased demand for the services, and fiscal responsibility in managing equipment and other resources. Despite the fluctuating economy and its hardships, Kayoyo is collecting data on several indicators, but records positive impact for three outcomes in particular: participants express happiness in being able to earn a living, community recognition and participation in programming, and community pride for the project (AED, 2003).

KICOSHEP

Another locally developed model is found in the slums of Nairobi and is now more than a decade old. The Kibera Integrated Community Self-Help Programme (KICOSHEP), featured in the film, *The Constant Gardener*, was founded in a begrimed clinic at the slum settlement of Kibera in Nairobi, Kenya, in 1991. The majority of patients were diagnosed with HIV/AIDS, revealing the impact and spread of HIV/AIDS within the community. KICOSHEP has become an award-winning "community home-based care" model utilizing nurses, social workers, community volunteers, and religious lead-

ers who are well trained to offer a range of services for orphans and vulnerable children that includes treatment, cleaning, washing, bathing, cooking, and shopping.

From their youth center's income-generating programs to the low-cost pharmacy associated with their hospice program, KICOSHEP provides a wide range of internationally funded services to children and their families in the Kibera community. The founder of these services, Rev. Anne Owiti, continues to develop the programs for Kibera while also presenting papers on the model in international settings each year.

A Ford Foundation report (Epstein, 2002) describes Owiti's achievements, which include convincing congregational leaders to conduct sex education and garnering her nation's leaders' support for the provision of education and healthcare in Kibera. As a result of her advocacy, the KICOSHEP clinic has doctors' offering office hours in the community, as opposed to similar settings in which children and their families have to walk great distances and spend hours waiting for medical care.

Next Steps for Children and their Families

A recent report from the Firelight Foundation entitled "From Faith to Action" states, "The first line of support for children orphaned and made vulnerable by HIV/AIDS is family and community. With great creativity and resilience, growing numbers of organizations are working to strengthen and revitalize the local safety nets that have been unraveling as the [AIDS] pandemic spreads. All children need the nurturing support of family and the experience of community in order to thrive" (Olson, Knight, & Foster, 2006). UNICEF and WCRP (2003), in a joint publication, call religious leaders to strengthen social values and policies, including acts such as protecting the property rights of orphans and widows; ensuring that orphans and other vulnerable children have the same access to shelter, school, houses of worship, counseling and social services as other children; protecting orphans and other vulnerable children from all forms of abuse, violence and exploitation; and promoting and strengthening family and community-based care.

More and more religious organizations are recognizing these perspectives and the value of family and community as alternatives

to orphanages for providing quality care for orphans and vulnerable children, yet most of the residential care settings built in the past decade have been funded by Christian groups. In fact, a forthcoming study from Zimbabwe suggests that orphanages have increased by 100% over the past decade and a large majority of their funding is from evangelical Christian organizations (Aaron Greenberg, Better Care Network, personal communication, 2006). While six to ten times less expensive than institutional care (Barth, 2002; Desmond & Gow, 2001; Swales, 2006; World Bank, 1997), a major challenge facing organizations offering family and community-based models continues to be related to the need for funding support from private individuals, foundations, corporations, congregations and public entities.

Research from Zambia revealed a four-tier response for developing programs that must be taken into consideration when caring for orphans and vulnerable children (McKerrow, 1996). The first level of response for children is the *family* who must identify and provide the basic day-to-day needs of the children as well as their emotional support. Second, the *community* must support both the children and their caretakers, as well as act as a forum for encouraging others to assist in providing an effective response to their needs and rights. The third level involves *churches and organizations* which coordinate and provide services. The *state, or public, governmental entities,* which form the fourth tier, must "develop local infrastructure, empower state personnel, create an enabling environment at all levels, modify state services and facilitate funding for grassroots responses" (McKerrow, 1996, p. 3). While seemingly straightforward, this can be useful in providing social workers a framework for understanding what promotes and prevents family and community-based model development in other situations.

McKerrow's levels of response offer a helpful reminder to social workers and religious leaders that while family and community are vital primary systems of response, they often depend on private and public organizations to provide capacity-building in situations of poverty. Furthermore, the model suggests that churches and other community-based organizations depend on public resources for their support. Showing that this is not a hierarchy of needs, it is equally true in most African nations that government entities also depend on community-based organizations, congregations and religiously-af-

filiated organizations, and that all of these groups depend on strong families and communities in the care of children. This framework is a dynamic response model showing that individuals and organizations at multiple levels of society are vital in providing for the care of orphans and vulnerable children. Furthermore, the application of *international efforts*, whether in the form of short-term volunteers and missionaries, professional social workers and other helping professionals, or funding through United States poverty-focused development assistance, individual and corporate donations, and foundation support, suggests a fifth level of response for us to consider.

As North American Christians hear the call of God to care for children deeply affected by the global AIDS pandemic, we know we must respond in ways that demonstrate God's love and appropriate care for these children. People of faith can respond by acting at public and private levels, through governmental agencies and NGOs, churches and religious affiliates, and other community agencies. At whatever level Christians in social work offer a response in Africa and other international settings affected by poverty, we can offer the highest quality support by engaging in family- and community-based models rather than simply supporting long-term institutional care settings. Residential settings are open to visitors and volunteers, and provide interesting missional opportunities for engaging children and caregivers, but there are other ways that are gaining recognition for the high quality levels of care they offer and for their sensitivity to the multiple and long-term needs of children, families, and communities. Those who seek to address the needs of the large and growing number of children orphaned by AIDS may not realize that approximately 90% or more of these children are still living within a household. Strengthening the capacity of those households to provide better care and support must be the first priority of Christians serving orphans and vulnerable children. From financial support to short-term volunteer missions, and from donated goods to research, there are many opportunities for us to participate with and to learn from the care offered by family and community-based models and the principles that guide their work.

To this end, the research and literature on family and community-based models clearly point to the care of children in families rather than in institutions. Vulnerable children can be strengthened

economically and supported in many ways by strengthening their families and communities. There is no lack of enthusiasm for the value of alternative care; however, there is a need for dedication and skill development among caregivers, volunteers, and helping professionals across the disciplines to bring about a transition to family and community-based models of care where the work of orphanages abounds. It is the hope of the Better Care Network, the organizations studied and cited here, other organizations partnering together in new ways, and the community leaders who are guiding them that models such as these will provide important lessons for strengthening families and communities. It is their hope that our faithful response will provide better care for children who are orphaned and vulnerable, yet who are also full of grace and beauty. ❖

References

Academy for Educational Development (2003). *Multisectoral responses to HIV/AIDS: A compendium of promising practices from Africa. USAID-Private Voluntary Organization Steering Committee on Multisectoral Approaches to AIDS & The Mitchell Group.*

Barth, R.P. (2002). *Institutions vs. foster homes: The empirical base for the second century of debate*. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Bowlby, J. (1951). *Maternal care and mental health*. World Health Organization Monograph No. 2. Geneva: WHO.

Bulkenya, S. (1999). *Children in residential care: Prevention—social policy strategy: The Ugandan experience. Kampala, Uganda*, Inspector of Children and Babies Homes, Department of Child Care and Protection, Ministry of Gender, Labour and Social Development.

Chernet, T. (2001). *Overview of services for orphans and vulnerable children in Ethiopia.* Paper presented for the Ministry of Local Government and Social Affairs of the Republic of Rwanda.

Desmond, C. & Gow, J. (2001). *The cost effectiveness of six models of care for orphans and vulnerable children in South Africa*, Durban, South Africa, UNICEF.

Donahue, J., Hunter, S., Sussman, L., & Williamson, J. (1999). *Children Affected by HIV/AIDS in Kenya: An overview of issues and action to strengthen community care and support*. Washington, DC: Displaced Children and Orphans Fund/USAID & UNICEF.

Dunn, A., Jareg, A. & Webb, D. (2003). *A last resort: The growing concern about children in residential care: Save the Children's position on residential care*. Washington, DC: International Save the Children Alliance.

Epstein, A. (2002). *Family crisis, community response*. Ford Foundation Report. Available online at: http://www.fordfound.org/pub-lications/ff_report/view_ff_report_detail.cfm?report_index=351.

Foster, G. Levine, C. & Williamson, J. (2005). *A generation at risk. The global impact of HIV/AIDS on orphans and vulnerable children*. New York: Cambridge University Press.

Gilliam, M. (2002). *Family matters: The care and protection of children affected by HIV/AIDS in Malawi*. New York: International Save the Children Alliance.

Gudbrandson, B. (2004). *Children in institutions: Prevention and alternative care*. Council of Europe: Focus on Children and Families' Working Group on Children at Risk and in Care.

Hope for African Children Initiative. (2007). Features: Bridging the information gap. Available online at: http://www.hopeforafricanchildren.org/field.htm.

McKerrow, N. (1996). *Responses to orphaned children*. Lusaka: UNICEF.

McCreery, R. (2003). *Statement for Stockholm Conference on Residential Care*. Stockholm, Sweden: UNICEF.

Office of the United States Global AIDS Coordinator. (2004). *The President's emergency plan for AIDS relief: U.S. Five-Year Global HIVAIDS Strategy*. Washington, D.C.: White House.

Olson, K., Knight, Z. S., & Foster, G. (2006). *From faith to action: Strengthening family and community care for orphans and vulnerable children in Sub-Saharan Africa: A resource for faith-based groups and donors seeking to help children and families affected by HIV/AIDS*. Santa Cruz, CA: Firelight Foundation.

Swales, D. M. (2006). *Applying the standards: Improving quality childcare provision in East and Central Africa*. London: Save the Children (UK).

Tobis, D. (2000). *Moving from residential institutions to community-based social services in Central and Eastern Europe and the former Soviet Union*. Washington, DC: World Bank.

Tolfree, D. (1995). *Roofs and roots: The care of separated children in the developing world*. Aldershot Hampshire, United Kingdom: Arena Ashgate Publishing for Save the Children.

Tolfree, D. (2003a). *Whose children? Separated children's protection and participation in emergencies*. Sweden: Save the Children.

Tolfree, D. (2003b). *Community based care for separated children*. Sweden: Save the Children.

Tolfree, D. (2005). *Facing the crisis: Supporting children through positive care options*. London, United Kingdom: Save the Children.

United Nations' Children's Fund (UNICEF), World Conference of Religions for Peace (WCRP), & United Nations' Program on HIV/AIDS (UNAIDS). (2003). *What religious leaders can do about HIV/AIDS: Action for children and young people*. New York: UNICEF.

UNICEF (2003). *Children in institutions: The beginning of the end: The cases of Italy, Spain, Argentina, Chile, and Uruguay*. Florence, Italy: UNICEF Innocenti Research Centre.

UNICEF. (2004). *The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS*. Washington, DC: UNICEF.

UNICEF. (2006). *Africa's orphaned and vulnerable generations: Children affected by AIDS*. New York: UNICEF with UNAIDS and U.S. President's Emergency Plan for AIDS Relief.

UNICEF, UNAIDS, & U.S. Agency for International Development (USAID). (2001). *Principles to guide programming for orphans and other vulnerable children*. (Draft 3, January 2001). New York: UNICEF.

UNICEF, UNAIDS, & USAID. (2004). *Children on the brink 2004: A joint report on orphan estimates and program strategies*. Washington, D.C.: The Synergy Project.

Viner, R. M., & Taylor, B. (2005). Adult health and social outcomes of children who have been in public care: Population-based study. *Pediatrics 115*(4), 894-899.

Wallace, L. & Dilday, R. (2005). *CBF, Buckner debut holistic ministry to African AIDS orphans*. Dallas, TX: Buckner Baptist Benevolences. Available online at http://www.buckner.org.

World Bank (1997). *Confronting AIDS: Public priorities in a global epidemic*, Oxford: Oxford University Press.

WCRP & UNICEF (2004). *Study of the response by faith-based organizations to orphans and vulnerable children* (G. Foster, Ed.). New York: UNICEF.

Williamson, Jan. (2004). *A family is for a lifetime*. USAID Office of HIV/AIDS. Washington, D.C. The Synergy Project.

Williamson, John. (2000). *What can we do to make a difference? Situation analysis concerning children and families affected by AIDS*. Washington, D.C.: Displaced Children and Orphans Fund.

Williamson, John. (2005b) Finding a way forward: Principles and strategies to reduce the impacts of AIDS on children and families. In *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children* (G. Foster, C. Levine, & J. Williamson, Eds.). New York: Cambridge University Press.

World Vision. (2005). *Hope in action; Summaries of World Vision's strategies for HIV/AIDS responses*. Available online at: http:// https://www.worldvision.org.uk/upload/doc/Hope_in_Action_-_07-05.doc

Zaney, G. D. (2004). *AIDS Orphaned and vulnerable children: HACI offers hope*. Ghana governmental report. Available online at: http://www.ghana.gov.gh/dexadd/feature/aoav.pdf

Zeanah, C. H., Smyke, A. T., Koga, S. F., & Carlson, E. (2005). Attachment in institutionalized and community children in Romania. *Child Development, 76*(5), 10-15.

Jon E. Singletary, Ph. D., M.S.W., M.Div, Assistant Professor, School of Social Work, Baylor University, One Bear Place # 97320, Waco, TX 76798-7320. Email: Jon_Singletary@baylor.edu. Phone: (254) 710-4819.

Key Words: Orphans, Vulnerable Children, Institutional Care, Residential Care, Family Care

Acknowledgement: The author would like to acknowledge the work of Aaron Greenberg and John Williamson of the Better Care Network for their research, support, and insight in the development of this manuscript.