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The governance of national care systems for orphans and vulnerable children in Cambodia, Uganda, Zambia and other low and formerly low-income countries: Findings and implications☆

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ABSTRACT

This article synthesizes findings from a research project on the governance of national care systems for orphans and vulnerable children (OVC) in low-income countries. The article is based on case studies of Cambodia, Uganda and Zambia, and supplementary evidence from a scoping review of peer-reviewed literature. Evidence from these studies reveals that while the countries under study have strong policies on the books, the governance of OVC care systems—including commitment, leadership, coordination, and capacity—is a different story. Few governments prioritize the care and protection of OVC, resulting in minimal public funding, weak implementation, and heavy dependence on international and non-state actors for resources and service delivery. Adverse sociopolitical and historical circumstances underpin these governance problems, including a legacy of exploitative colonial regimes, weak states that lack service delivery capacity, and kinship care that is eroding. Improving OVC care and protection requires fostering government capacity to exercise stewardship over national systems. Above all else, improved care and protection requires that actors concerned about the well-being of OVC—including involved government agencies, legislators, civil society organizations, international agencies, and the families of affected children—form political coalitions to press states to act.

1. Introduction

Most governments of low-income countries have established systems to care for and protect orphans and vulnerable children (hereafter referred to as OVC care systems). How well do these systems function in practice?

This article, the concluding paper in a series, synthesizes findings from a research project on the governance of OVC care systems in low-income countries (as well as countries that for most their history have been low-income but have recently been reclassified as lower-middle income—see Box 1). By OVC care system, we mean the set of arrangements within a country designed to ensure the care and protection of children who have lost one or both parents, or who have experienced or are at risk of some form of serious harm or neglect (see Shawar et al 2025 for elaboration of this definition). The project, funded by the GHR Foundation, involved case studies of Cambodia, Uganda and Zambia and a scoping review of peer-reviewed literature (Shiffman and Min 2025; Walakira et al 2025; Shawar and Zulu 2025; Shawar et al 2025). The project is grounded in a framework on political factors shaping OVC care systems, developed and presented in the scoping review (Box 2, Fig. 1) (Shawar et al 2025). An interdisciplinary team of social scientists based in academic institutions in Cambodia, Uganda, Zambia and the United States conducted the research.

This article draws on the three country case studies, with

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supplementary evidence from the scoping review. We ask: what are the primary political and bureaucratic factors shaping the governance and effectiveness of OVC care systems? We consider issues such as the level of priority national governments afford the issue, and the capacity of OVC care systems to deliver services. The reason for such a focus on governance and politics is that while an extensive body of scholarship exists on technical issues of OVC care such as risk prevalence and policy design, governance and politics have been much less studied. This represents a gap in knowledge, as improving care for OVC is as much a political as it is a technical concern, given potential deficiencies surrounding priority for and the governance of OVC care systems (Abebe 2009; Goldman et al., 2020; Muchabaiwa 2024). Unless political and governance challenges are transcended, OVC in low-income countries will continue to be underserved.

This paper highlights two central findings from the research results, findings that build on existing studies and advance understanding concerning political and bureaucratic issues that OVC care systems face. First, many LIC governments do not prioritize OVC care, and a major reason is that they face little political pressure to act. A critical need for advancing OVC care is the formation of national political coalitions linking OVC care proponents from various sectors—including non-governmental organizations, international agencies, concerned government agencies, and affected families—to push states to act. Second, although policy in many countries is well-developed, few LIC governments have the capacity to implement policy effectively. A pressing concern is to build state capacity to exercise stewardship over national OVC care systems, including the ability to coordinate the multiple actors involved so that they can carry out policy in a cohesive and effective way.

In the sections that follow, we describe the methods used for this article, and for the three case studies and scoping review that provide the empirical material for the article. We then present key findings, organized by the three categories of the project's framework—policymaking, governance, and context. Finally, we delineate the political challenges OVC care proponents must address to advance this agenda, and areas for future research.

2. Methods

The empirical material for this article comes from three country case studies on Cambodia, Uganda and Zambia (Shiffman and Min 2025; Walakira et al 2025; Shawar and Zulu 2025), supplemented with evidence from the scoping review (Shawar et al 2025). This article is a synthesis of evidence from these four articles, drawing out overarching implications. The three countries were purposively selected for the project for their potential to offer insights on factors driving the governance effectiveness of OVC care systems in present and former LIC. Like many present and former LIC, the governments of each of these three countries have made efforts to develop OVC care systems, but have encountered significant obstacles connected to historical and structural context. These obstacles include colonial legacies, political instability, limited public budgets, high debt repayments, donor dependence, and pandemics such as AIDS causing widespread orphanhood. Analyzing these three countries enabled us both to examine government efforts and the historical and structural factors that have impeded these efforts. Moreover, by considering in this article these three countries and then the experiences of other countries as examined in the scoping review, we are able to offer inferences on the extent to which the factors shaping the governance of OVC care in Cambodia, Uganda and Zambia are more broadly at work across LIC settings. As this article's findings below reveal, there is considerable commonality across LIC in the kinds of governance challenges faced.

The scoping review (Shawar et al 2025) began with the specification of a research question: "What are the political, economic and bureaucratic factors that influence effectiveness of national OVC care systems in low and middle- income countries?" (Full methodological details are provided in Shawar et al 2025). For that article, we used a search strategy to identify 3,113 studies of potential relevance to this question published between 2000 and 2024, of which, after an extensive screening process grounded in specific criteria for inclusion and exclusion (see Shawar et al 2025 for full delineation of these criteria), 80 were selected for in-depth analysis. Charting—a technique for synthesizing and interpreting qualitative data by sifting and sorting material according to key issues and themes—was used to delineate findings, resulting in the framework described in Box 2 and Fig. 1 above that encompasses the three categories of policymaking, governance and context.

The country case studies were qualitative, historical case studies (full details on methodology for each country study are provided in Shiffman and Min 2025, Walakira et al 2025, and Shawar and Zulu 2025). The case studies involved a total of 88 in-depth interviews with key actors in and observers of OVC care sectors, including government officials, non-governmental organizations, international donors and community activists. Interviews lasted on average one hour, and were conducted in-person and via Zoom. For each study we also reviewed more than 100 reports and research articles, including government and NGO reports, published scholarship, grey literature and media articles. We then triangulated between the information from key informant interviews and the documents to construct historical narratives on the evolution of OVC care policy and governance mechanisms, and to identify factors that facilitated and obstructed the effectiveness of OVC care systems. In conducting the analysis, we drew on the framework developed in the scoping review.

In the study of Cambodia, Shiffman and Min (2025) found that the country's turbulent history since independence, including decades of warfare and the tragedy of the Khmer Rouge genocide, prevented the emergence of government attention to OVC care until the restoration of political stability in the early 1990s. Since then the child protection arc has been upwards, and the government has adopted a robust set of policies on OVC care. However, implementation has been problematic, a function of insufficient public financing, the placement of the issue in a ministry with inadequate political authority to exercise stewardship over the system, and weak local government capacity. The study on Uganda (Walakira et al., 2025) showed that a variety of historical factors have resulted in an OVC care system unable to effectively address the needs of the country's many vulnerable children. These factors include a

Box 1
A note on the income status of countries studied

As noted in the scoping review article (Shawar et al 2025), most of our evidence concerns countries that according to the World Bank classification system either presently are low-income or have been so for most of their post-independence history and only in the past decade were reclassified as lower-middle income. The World Bank reclassified Cambodia as lower-middle income in 2015, and Zambia as lower-middle income in 2024 (https://blogs.worldbank.org/en/opendata/new-world-bank-group-country-classifications-income-level-fy24). In 2022, the Ugandan government announced that it had attained lower-middle income status, a reclassification the World Bank disputes (https://devinit.org/blog/data-behind-debate-over-ugandas-income-status/).

troubled political history that is a legacy of British colonialism, World Bank-led structural adjustment programs, and the HIV/AIDS pandemic which resulted in more than a million AIDS orphans in the country. The country's formal and informal care systems have strengths, including a robust set of policies on OVC protection and long-standing kinship care practices protective of children at risk. However, government priority to address OVC care is weak and, as in Cambodia, dependence on international agencies and non-state actors is extensive. The Zambia study (Shawar and Zulu, 2025) showed that government policy on OVC has alternated across time between a focus on facility-based care and family reintegration. In the past decade, policy on family integration of OVC has strengthened, culminating in the landmark passage of the 2022 Children's Code Bill. As in Uganda, the HIV/AIDS pandemic has placed a heavy burden on formal and informal OVC care systems. And as in both Cambodia and Uganda, implementation challenges are considerable, including coordination difficulties within government and between government actors and civil society organizations, workforce capacity deficiencies, minimal government funding, and heavy dependence on international actors.

To create the synthesis of evidence for this article, combining the empirical material from the three country case studies and the scoping review, we first input into a word document relevant material from the Cambodia study, then the Uganda study and finally the Zambia study, grouping evidence by the framework categories and sub-categories. We then underwent the same process for the scoping review, inputting empirical evidence into the same document. Thereafter we went through the entire evidence document to detect overarching themes, grouped according to the major framework categories of policymaking, governance and context. Finally, we drew on this evidence document to write up the findings that follow. To minimize bias, authors from Cambodia, Zambia, Uganda and the United States independently cross-checked findings.

3. Findings

3.1. Findings on policymaking: Strong policies but heavy international influence

Many low-income countries have strong OVC care policies on the books, a common theme in existing scholarship and a result confirmed by the studies in this project (Kuehr 2015; Shawar et al 2025; Shiffman and Min 2025; Walakira et al 2025; Shawar and Zulu 2025). However, there are gaps, particularly pertaining to policies addressing underlying drivers of risk such as poverty (Adebayo & Ogunbanwo, 2017; Delaunay & Germain, 2012; Munro, 2015; Shawar and Zulu 2025; Shiffman and Min 2025; Walakira et al. 2025). Moreover, shaped heavily by international actors, many policies may be skewed in directions that do not reflect national priorities—deinstitutionalization is one example (Shawar and Shiffman 2023), and lack sufficient input from grassroots actors (Jamieson, 2017; Shawar and Zulu 2025; Shiffman and Min 2025; Walakira et al 2025).

Cambodia, Uganda, Zambia, and many other countries have adopted comprehensive policies on OVC care. In 2020, the Cambodian government enacted a National Policy on Child Protection (Kingdom of Cambodia 2022), and as of 2024 was circulating a draft law on child protection, the most encompassing piece of legislation on this subject in the country's history (Shiffman and Min 2025; The Star 2024). The Ugandan government has developed policies to bring about cross-sectoral coordination on child rights and child well-being, including the National Action Plan for Child Well-Being for the Period 2016–2021, and the Uganda National Child Policy (Government of Uganda, 2016, 2020). In 2015, the Zambian government amended the National Child Policy to address alternative care for children, and in 2022 it passed the Children's Code Bill, consolidating laws on the rights and welfare of children (National Assembly of Zambia 2022). These three countries follow a general trend among low and formerly low income countries adopting policies on OVC care. For instance, in Rwanda, a UN committee of experts praised the country's "creation of an impressive architecture of laws, policies, and constitutions to protect and promote the rights of children" (Kuehr 2015). And in Vietnam, the 2016 Law on Children significantly expanded the state's responsibility to protect and assist disadvantaged children (Spence and Lan 2021).

However, these and many other low-income countries have deficiencies concerning policy design and content. For instance, studies show that laws in Madagascar, Nigeria, Ghana, and Zimbabwe, among other countries, do not adequately protect OVC (Abdullah et al 2021; Delaunay and Germain 2012; Nnama-Okechukwu et al 2020; Muchacha et al 2020).

Global agreements and international actors have played a large role in shaping OVC care policy in many low-income countries, resulting in greater priority and resources than might exist if there was no such international involvement. The 1989 UN Convention on the Rights of the

Box 2
Framework on political factors shaping OVC care systems

The framework (Shawar et al 2025) consists of three categories of factors—policymaking, governance and context—each with sub-components. Policymaking refers to the content and production of national legislation, regulations and strategies for OVC care and protection. It consists of two elements: *policy content* is the actual substance of policy; *policy process* concerns how policy is made. Governance refers to the quality of collective action on OVC care and protection. It consists of four elements. *Commitment* pertains to the extent to which government and other national actors prioritize the issue and set up strong accountability mechanisms. *Leadership* concerns whether or not strong individuals and institutions exist to guide action on the issue. *Coordination* pertains to the extent to which government, international, non-governmental and community actors work together on the issue. And *capacity* refers to the skills, resources and motivation of relevant agencies within the government bureaucracy that carry out policy. The third category—context—pertains to the socioeconomic and political environment in which OVC care systems are situated, and that shapes both the problems the systems must address, and the effectiveness of the systems themselves. It consists of two primary elements. *Social values* pertain to the beliefs families and communities hold that shape their practices with respect to care and protection of OVC, such as attitudes on kinship care. *Societal problems* pertain to large-scale political, socioeconomic and health difficulties—for instance pandemics—that shape the problems OVC care systems must address.

Rather than each category independently shaping OVC care system effectiveness, the three categories interact to do so. For instance, policymaking and governance are intertwined. To give an example, recognizing that no government agency has the ability to bring together multiple ministries with some responsibility for OVC care—a governance difficulty—political leaders may design and promulgate policy assigning such authority to a particular government entity. Moreover, contextual influences shape both policymaking and governance. For instance, a contextual influence such as a pandemic causing widespread orphanhood may lead a government to adopt a policy allocating resources toward orphan care, and to establish a governance mechanism—a unit within a ministry or a cross-ministerial coordinating body—to ensure that these resources are used to deliver effective services for orphans.

Child (UNCRC), which brought together world leaders to address child protection and children's rights, has been especially influential. Uganda and Zambia ratified the UNCRC in 1990 and Cambodia did so in 1992. The UNCRC has influenced legislation on child well-being and protection in these three countries (Shiffman and Min 2025; Walakira et al 2025; Shawar and Zulu 2025) and many others (Shawar et al 2025), and has now been ratified by all countries except the United States (UNICEF 2024).

UNICEF has been a particularly influential international actor on child protection, pressing countries across the world to adopt child protection legislation. Its global child protection strategy, enacted in 2008, called on national governments to develop child protection systems, influencing legislation and programming in Cambodia, among other countries (ECPAT International, 2014). In 2014, UNICEF partnered with the Zambian Ministry of Community Development and Social Services to establish a Children in Families Technical Working Group to strengthen family preservation (Better Care Network 2016). The US government also played a large role in child protection: the President's Emergency Plan for AIDS Relief (PEPFAR) globally has provided care for 7 million OVC and their families (US Department of State 2024), including in Uganda and Zambia. (Research for this project was conducted prior to the ascent of the second US Trump administration and the dismantling of most US-government support to protect children in LIC).

While augmenting resources for and attention to OVC care, this heavy international influence has in some instances resulted in policies skewed toward international priorities. One example is deinstitutionalization—a reform strategy to replace institution-based with family-based care (Shawar and Shiffman 2023). Some UN agencies, the European Union, and high-income country donors including the United States Agency for International Development (USAID)[1] have pushed heavily for deinstitutionalization, influencing policy in Cambodia (Shiffman and Min 2025), Uganda (Walakira et al 2025; Olafsen et al. 2018), Zambia (Shawar and Zulu 2025), and many other countries. This push may have resulted in neglect of other dimensions of OVC care policy, including preventative measures within families and addressing underlying drivers of risk (Shawar and Shiffman 2023; Shawar et al 2025), although other studies find evidence to the contrary and that these efforts have worked in synergy (Goldman et al., 2020).

Moreover, heavy international influence commonly has resulted in little voice for grassroots actors in policymaking. For instance, in Zambia, OVC care facility officials have had little input into child protection policymaking (Shawar and Zulu 2025). In Cambodia, UNICEF, international NGOs including Save the Children, and the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) have played major roles in policymaking, but families with children at risk have had little voice in the policymaking process (Shiffman and Min 2025).

3.2. *Findings on governance: Low commitment and weak capacity*

While many low-income countries have strong policies on the books, few have governance mechanisms in place to ensure that these policies are carried out effectively. At the heart of the problem is insufficient political priority, as evidenced by the minimal funding that governments allocate toward OVC care (Canavera et al. 2016; Shawar and Zulu 2025; Shibuya and Taylor 2013; Shiffman and Min 2025; Walakira et al 2025).

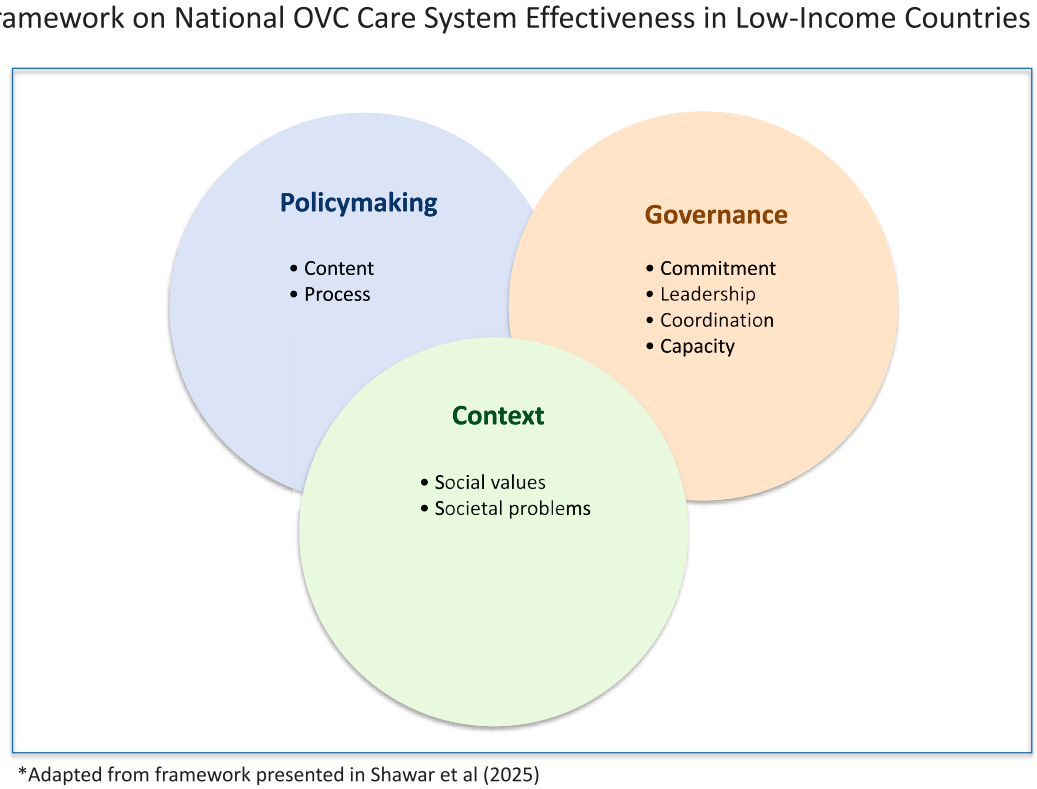

Fig. 1. Framework on national OVC care system effectiveness in low-income countries.

[1] The research for this article was conducted prior to the dismantling by the Trump administration of USAID, historically a major source of support for OVC care in low and formerly low-income countries.

This low priority perpetuates other governance problems, including weak individual and institutional leadership, fragmentation among government and civil society actors working on child protection, and weak government and social service workforce capacity (Canavera et al. 2016; Delaunay and Germain 2012; Hamilton et al 2018; Nhep and Fronek 2021; Shawar and Zulu 2025; Shibuya and Taylor 2013; Shiffman and Min 2025; Walakira et al 2025; Wessells et al. 2012). Low capacity and limited funding in turn result in many OVC care systems heavily dependent on donors and NGOs for resources and service delivery (Kuehr 2015; Hailu 2017; Nhep and Fronek 2021; Shawar and Zulu 2025; Shiffman and Min 2025; Walakira et al 2025).

Few governments allocate more than minimal resources for OVC care. MoSVY—the Cambodian ministry responsible for this issue—was allocated only US$34 million in 2023, less than 0.5 percent of the national budget, of which only US$270,000 went to child protection specifically (Royal Government of Cambodia, 2023). In Zambia, core interventions for child protection programs accounted for only 0.6 percent of the 2023 national budget (UNICEF, 2023b; UNICEF, 2023a). As a percentage of GDP, Uganda spent only 0.17 % on social protection in 2023/24, of which child protection is one component (UNICEF 2023b). Other studies report similar findings on low public financing for the care of OVCs in low income countries (Abdullah et al. 2021; Abdullah et al. 2018; Canavera et al. 2016; Frimpong-Manso 2021; Mogotlane et al. 2010; Shibuya and Taylor 2013; Van Niekerk and Matthias 2019).

This weak commitment is exemplified by a lack of strong individual champions and institutional leadership for OVC care within governments. Cambodia's MoSVY and Uganda's Ministry of Gender, Labour, and Social Development (MoGLSD)—the government bodies with OVC care mandates—lack sufficient authority and capacity to effectively bring together other ministries such as health, education and justice that are critical to addressing the needs of OVC (Shiffman and Min 2025). Similarly, in Zimbabwe, the care of OVCs is placed in government agencies that lack such authority and coordination capacity (Muchacha et al. 2020).

With respect to coordination within government, and between government and non-state actors, there are some strong examples, facilitated by domestic and international leadership and donor resources. In Cambodia two child protection networks (named 3PC and FCF|REACT) effectively have linked NGOs, international agencies and government (Shiffman and Min 2025). In Zambia, the Children in Families Technical Working Group, noted above, brings together the Ministry of Community Development and Social Services (MCDSS), UNICEF, Catholic Relief Services, Save the Children and other agencies working on child protection (Better Care Network 2016). Also in Zambia, MCDSS' Department of Social Welfare developed structures from the national level down to the community level to support management and coordination of OVC care services (Shawar and Zulu 2025).

However, coordination remains a problem for OVC care. In Uganda the state, due to minimal allocation of resources for child protection, lacks capacity to coordinate work with and between civil society organizations delivering OVC care services, who themselves are ill-equipped to play coordination roles. The result is siloed work on child protection (Walakira et al 2025). In Cambodia, numerous ministries and government agencies have child protection roles, as do several national committees and provincial, district and commune-level bodies (Hamilton et al 2018; Nhep and Fronek 2021). As MoSVY lacks the power to bring them together, the system is fragmented. In Zambia, MCDSS struggles to bring together the Ministry of Youth, Sport and Arts, the Ministry of Justice, the Ministry of Health and other ministries charged with OVC care. And even inside MCDSS there is fragmentation, as both the Departments of Social Welfare and of Child Development deliver child protection services (Shawar and Zulu 2025; UNICEF Zambia 2023). Studies of Zimbabwe, South Sudan, Madagascar and Sierra Leone also report weak coordination among government agencies and between government agencies and civil society organizations working on OVC care (Munro 2015; Canavera et al. 2016; Delaunay and Germain 2012; Wessells et al 2012).

Problems with commitment, leadership and coordination contribute to limited capacity of government bureaucracies to deliver OVC care services. Capacity difficulties include low staffing levels—particularly of social workers, stretched responsibilities, inadequate training, poor monitoring, and corruption. For instance, a 2014 study found that Cambodia's MoSVY had only 1017 sub-national personnel to cover 1633 communes (the lowest administrative unit of the Cambodian state) (Harachi 2014 cited in Jordanwood 2016). And a 2019 UNICEF study on the social service workforce in East Asia reported only 3,764 social work positions in the Cambodian government, or a ratio of 64.4 social service workers per 100,000 children, compared to 80.0 in Indonesia and 280.8 in Mongolia, although Cambodia's figure exceeded Vietnam's (62.4), Thailand's (20.1) and the Philippines' (13.8) (UNICEF East Asia 2019). Some districts had no social workers at all (UNICEF 2016). Also in Cambodia, documentation of OVC historically has been inadequate despite onerous reporting requirements. For example, during reintegration processes, children were not always tracked and the whereabouts of some children was unknown (Fronek et al. 2019). In Uganda, community development officers at the local council level have to oversee all aspects of development, and have little time to address child protection; nor do they have sufficient budgets to respond to the care concerns of OVC (Mubangizi 2021; Bulwani and Twikirize 2019). In Zambia, a study found only 244 government social service workers—only one for every 59,584 people (Global Social Service Worldwide Workforce Global Alliance and UNICEF 2019). Problems with capacity have also been documented in Mozambique, Sierra Leone and Zimbabwe (Shibuya and Taylor 2013; Wessells et al. 2012; Muchacha et al. 2020). And in Uganda, police and health workers have demanded payment in exchange for services, resulting in infrequent reporting of violence (Sharpe 2018), and there have been reports of politicians and police officials preventing cases of abuse from progressing in exchange for votes or bribes, and of paraprofessionals being threatened by the police (Driscoll 2020).

Capacity and financial difficulties in turn lead to heavy dependence on international actors and NGOs for resources and service delivery. For instance, MoSVY's budget in 2018 for child welfare and youth rehabilitation was $1.65 million (UNICEF 2018); by contrast, in 2017 funds for UNICEF's Cambodia child protection program, one development program among several in the country, amounted to twice that amount–$3.35 million (Hamilton et al 2018). Also in Cambodia, NGOs fill in service provision gaps given limited government sub-national capacity (Shiffman and Min 2025; Nhep and Fronek 2021). In Uganda, several USAID and PEPFAR-funded child protection projects were funded at the level of tens of millions of dollars, a marked contrast to the Uganda government's allocation of just $950,000 for child protection in 2020 (Mubangizi 2021). In Uganda, non-state actors are heavily involved in running alternative care facilities (Walakira et al 2025; Milligan 2016; Faith to Action Initiative 2014). In Zambia, a Nationwide Assessment of Child Care Facilities conducted in 2017 found that most funding for OVC care facilities came from external, non-state donors (MCDSS 2017). Similar dependence on donors and NGOs has been reported in Rwanda, Zimbabwe, Ethiopia, Vietnam, and Ghana (Kuehr 2015; Muchacha et al. 2020; Hailu 2017; Spence and Lan 2021; Frimpong-Manso 2021).

Despite these challenges, some national experiences are instructive. In Zambia, the government-led Children in Families (CIF) Initiative and its Technical Working Group, mentioned above, developed with international NGO and donor partners, strengthened family preservation and family-based alternative care (Shawar and Zulu 2025). In Türkiye, the Ministry of Family's "Ambassadors of Hearts" media campaign on foster care generated 1,850 meetings in all 81 provinces (Ellis 2021). And in Georgia, the Prime Minister's 2005 Government Commission on Child Protection and Deinstitutionalisation drove reforms of the OVC care system (Greenberg and Partskhaladze, 2014).

3.3. Findings on context: Eroding kinship ties and problematic political legacies

OVC care systems, and the problems these systems must address, are products of historical, political and socioeconomic context. Most contextual influences—including eroding kinship ties, colonial legacies, political instability, and persistent poverty—have had adverse effects on these systems (Kuehr 2015; Canavera et al 2016; Delaunay and Germain 2012; Littrell et al. 2012; Adamek, Chane and Kotecho 2020; Mathambo and Gibbs 2009; Foster 2002; Shawar and Zulu 2025; Shiffman and Min 2025; Van Schaack et al 2011; Walakira et al 2025). In addition, shifting social norms around gender roles (e.g., higher female labor force participation and migration for work) and family (e.g., non-marital births, separation, and weaker obligations within extended families) have weakened family cohesion and increased child vulnerability, as seen in rising births outside marriage, fathers' abandonment of families, and increasing parent–child conflict (Shawar et al 2025). Some contextual influences, however, have had positive effects: for instance in some countries the HIV/AIDS pandemic spurred the adoption of professional care practices for orphans (Augustinavicius et al 2019; Luyirika et al 2013; Bikaako-Kajura et al 2006; Walakira et al. 2025).

Traditionally a foundation for the care of OVC, especially in Sub-Saharan Africa, kinship and extended family ties have been eroding in many countries. In the colonial era in Zambia, industrialization and migration upset traditional kinship care, and in the 1980s and 1990s the HIV/AIDS pandemic, urbanization and economic liberalization placed additional stress on these practices (Shawar and Zulu 2025; Foster 2002). In Uganda, the HIV/AIDS pandemic, poverty, urbanization and civil conflict have led to a decline in kinship care (Adamek, Chane and Kotecho 2020; Mathambo and Gibbs 2009). In Cambodia, the Khmer Rouge, who held power between 1975 and 1979, promoted a radical egalitarian vision that devalued family ties and shattered kinship relationships (Brickell 2011), a legacy of trauma that persists (Van Schaack et al 2011). A decline in extended family systems with consequent effects on OVC care has also been documented in, among other countries, Malawi, Ghana, Vietnam, and Madagascar (Abdullah et al. 2018; Delaunay and Germain 2012; Frimpong-Manso 2014; Littrell et al. 2012; Spence and Lan 2021). Nonetheless, some recent government policies do support kinship-based care. In Zambia, the social cash transfer program, 2017 Alternative Care and Reintegration Guidelines, and initiatives such as the 2019 Children in Families Plus initiative have supported immediate and extended family care for vulnerable children (Shawar and Zulu 2025).

Developments concerning political history—including colonial legacies, civil strife, regime instability and political oppression—have been another set of negative contextual influences on OVC care systems and on the problems these systems have had to address. The British colonial regime exploited Uganda's ethnolinguistic diversity to maintain political control and secure financial gain, resulting in post-independence political instability and state capacity deficiencies that made it difficult to enact and carry out social welfare programs (East Africa Living Encyclopedia 2024). The formation of a post-colonial state, which depended heavily on promoting social programs, institutionalized reliance on external actors to support social welfare programs such as OVC care systems (Glasman and Schlichte 2023). As noted above, British industrial policies in the colonial era in Zambia led to migration that disrupted traditional kinship care. Zambia has since experienced ongoing fluctuation in OVC care strategies corresponding to shifts in regimes, wavering between pro-family and pro-institutionalization oriented policy (Shawar and Zulu 2025). Due to sustained political turmoil, until the Cambodian Paris Peace Accords were signed in 1991, there was no hope in the country's first four decades of independence for meaningful government attention to OVC care (Shiffman and Min 2025). Particularly traumatic was the Khmer Rouge genocide, which led to the deaths of approximately 1.7 million people and produced thousands of orphans (Kiernan 2008). Political turmoil has also harmed OVC in other countries, including Rwanda, where one in ten children lost one or both parents during the 1994 genocide (Kuehr 2015), and South Sudan, where armed conflict, a weak state and refugee problems have crippled the social welfare system (Canavera et al 2016).

Another set of contextual influences on OVC care systems are economic in nature. In Uganda, World Bank-initiated and Western government-supported structural adjustment policies forced the government to drastically cut back on resources for social protection (Nystrand and Tamm 2018; Ssali 2018; Walakira et al 2014). In Zambia, the economy began to deteriorate in 1974 when the price of copper, the country's major expert, fell sharply on the world market, ultimately leading to structural adjustment policies with greatly reduced spending on social services (Wolkenhauer 2022). In Zimbabwe, government fiscal deficits over 30 consecutive years hampered its ability to deliver services for children (Munro 2015). Conversely, in Cambodia growing prosperity has reduced the number of vulnerable children: from 2000 to 2015, GDP grew at an average of 7.8 % per annum, one of the fastest rates in the world, propelling the country into lower middle-income status, and during the same period, resulting in a reduction in poverty rates from over 60% to 13.5% (OECD 2017).

Pandemics have also shaped OVC care systems and the problems these systems have had to address. A 2001 Demographic and Health Survey identified 1.6 million orphans in Uganda, half due to HIV/AIDS (Uganda Ministry of Health 2001), overwhelming a weak OVC care system. The pandemic spurred a proliferation of residential care facilities in the country—from 30 to about 800 between 1992 and 2013 (Faith to Action Initiative 2014). In Zambia, 33% of all orphans in 2001–2002 lived in households headed by a grandparent due to death of parents. The number of child-headed households rose significantly around this time (Chama, Falle and Koffler 2012). In the late 1980s and early 1990s a drastic rise in AIDS orphans was reported in Zimbabwe (Muchacha et al. 2020; Munro 2015), Mozambique (Shibuya and Taylor 2013), Ghana (Yarney et al. 2015), Nigeria (Adebayo and Ogunbanwo 2017), Kenya (Stuckenbruck and Roby 2017), Malawi (Littrell et al. 2012), and India (Kumar 2012). Another pandemic—Covid-19—contributed to a rise in child labor in Zambia, with children forced to sell products to contribute to household income; growing domestic violence, with the closing of schools resulting in children being confined in the home; and an increase in transactional sex and early pregnancies (Mathew et al. 2020; Chavula et al. 2023; Shepherd et al. 2022). In Uganda, Covid-19 put girls at greater risk for violence (Bukuluki et al. 2023).

Yet these pandemics did have some positive effects. In Uganda, the HIV/AIDS pandemic spurred practices including the holistic delivery of care encompassing both medical and non-medical services, such as psychosocial care, nutrition and support for affected families (Augustinavicius et al 2019; Luyirika et al 2013; Bikaako-Kajura et al 2006). And in Cambodia, in response to the Covid-19 pandemic, the government allocated US$ 932 million for cash transfers to approximately 700,000 impoverished households, benefiting around 2.7 million citizens (NSPC 2023). In a number of countries, Covid-19 had the effect of bringing political attention to the plight of OVCs, who were among the most severely affected by the pandemic of all population groups (Manoj et al 2023).

These contextual influences concerning kinship ties, colonial legacies, political stability and instability, poverty and economic development, and pandemics—shape present-day effects on OVC care and policy responses. One example is that just mentioned—the HIV/AIDS and Covid-19 pandemics spurring government support for OVC care. Another example is the influence of the long-standing Zambian ideology of Humanism, with its emphasis on kinship ties and family-centeredness, on present family-centered OVC care policy as exemplified in the 2022 Children's Code Bill (Shawar and Zulu 2025). A third example is the restoration of political stability in Cambodia via the 1991 Paris Peace Accords, a condition that was necessary to initiate the evolution of an OVC care system in the country over the past three decades (Shiffman

and Min 2025).

3.4. Synthesis of findings

Many low-income countries have strong OVC care policies on the books. There are policy gaps, especially with addressing underlying drivers of risk for children such as poverty and drug and alcohol abuse in the family. Moreover, the policy-making process in many countries is dominated by international actors, resulting in policies insufficiently tailored to national context. Nevertheless, many countries have promulgated a robust set of policies surrounding OVC care.

The governance of OVC care systems is a different story. A major deficiency is that few governments of low-income countries prioritize the care of OVC, as indicated especially by minimal public budgets allocated to this issue. Weak priority leads to deficiencies in implementation. Few countries have effective individual champions for the issue, or lead agencies with sufficient power to orchestrate the multiple actors inside and outside government with a mandate for OVC care. Coordination therefore tends to be poor—between responsible government agencies; across government levels from national to sub-national to local; and among state, non-state and international actors. Also, the capacity of government bureaucracies is commonly circumscribed: there are insufficient numbers of individuals charged with OVC care, and they are often overburdened, underpaid, and lacking requisite skills. Weak implementation capacity both shapes and is shaped by heavy dependence on international and non-state actors for resources and service delivery. The consequence of these governance problems is millions of children falling through the cracks.

These problems of policymaking and governance cannot be understood without reference to historical, political and socioeconomic context. The present functioning of OVC care systems is shaped by a number of contextual factors, including exploitative colonial regimes resulting in post-independence governments that are weak and autocratic and lack capacity to deliver social services; social problems—including poverty, inequality and pandemics—that these governments struggle to address; structural adjustment policies and debt repayment obligations that have circumscribed government fiscal space and limited social protection allocations; and eroding informal care, particularly kinship care, placing ever greater demand on ill-equipped public systems.

These difficulties pertaining to policymaking, governance and context notwithstanding, there are a number of positive developments with respect to national OVC care systems. Global norms pertaining to the right of children to protection—as exemplified especially in the 1989 adoption of the UN Convention on the Right of the Child—are enshrined in many constitutions and national policies; few governments deny that, at least in principle, they have a responsibility to care for and protect OVC. The number of trained social workers in many low-income countries is growing, and consequently the capacity of state and social systems to deliver appropriate services to OVC. Several countries have strong coordination networks focused on child protection that link NGOs, governments and international agencies. And in some countries, the OVC care arc is upwards: government budgetary allocations are rising, and government capacity to serve OVC growing.

As noted in the scoping review (Shawar et al. 2025), the focus on the literature covered in that review and on Cambodia, Uganda and Zambia limits the generalizability of and potentially introduces a measure of bias into these conclusions. The scoping review notes that literature relevant to the politics of OVC care systems in LICs is limited, that this literature has a focus on negative findings, and the literature that does exist concentrates heavily on Africa. Also, Cambodia and Uganda in particular have had turbulent political histories, more so than many past and present LIC. And the impact of colonialism, among other influences, on post-independence state engagement with OVC care varies considerably by country. Therefore, these conclusions must be considered tentative, and additional research on the governance of OVC care systems in LICs is critical. In the discussion we suggest areas for future research.

4. Discussion

These overarching findings of the project point to two linked political challenges proponents must address to enhance the effectiveness of OVC care systems. These are augmenting national priority for OVC care and enhancing government capacity to exercise national stewardship for OVC care.

4.1. Augmenting priority

Most governments do not feel pressed to prioritize the care of OVC. They will do so only if they are compelled by circumstance or champions. The project's findings, and a recent analysis of underfunding of child protection in Africa (Muchabaiwa 2024), point to several factors that may explain why priority for OVC care is low in most low-income countries.

First, societies minimize or hide the problems, and governments therefore face little pressure to act. In many societies, certain practices, such as child marriage and corporal punishment, are commonly not even considered to be abuse (Muchabaiwa 2024). Moreover, abuse and neglect within families are often considered private affairs, and government involvement understood to be inappropriate. In addition, OVC are often stigmatized, marginalized or ignored (Shawar et al 2025). The problem of invisibility is exacerbated by the fact that data on the number of OVC are lacking in many countries, a product of poor national information systems.

Second, even when OVC care problems are recognized, they must compete against other priorities for scarce public resources, and they do so from a weak position. Most governments prioritize, above all else, security and the economy, directing spending to concerns such as military and infrastructure. These kinds of investments offer political capital to national leaders by presenting visible benefits such as crime prevention and roads. Supporting OVC care, by contrast, rarely offers such tangible political benefits to political leaders (Muchabaiwa 2024): the effects of investment in these issues—the protection of children from abuse and neglect, and ensuring their long-term contributions to society—are not easily or immediately detectable, nor always appreciated or valued by political leaders and citizens. Spending for OVC care fares poorly even compared to other social policy concerns such as health and education. One reason may be that most citizens require such services for themselves or their families; by contrast OVC care is a need primarily of disadvantaged, politically weak and marginalized population groups.

Third, in most societies the case for allocating resources toward OVC care is not framed as effectively as it could be. While appropriately arguing that, fundamentally, OVC care is a moral imperative and a rights issue, proponents commonly overlook additional framings of the issue that are more likely to appeal to politically powerful actors and therefore to attract their support (Muchabaiwa 2024). For instance, protecting children from abuse and neglect and caring for those who have suffered harm helps to ensure these children do not become drains on resources for their families and communities, and that they can make long-term contributions to society and the economy. In other words, OVC care can be viewed as an investment in human capital, with benefits for economic growth and social stability (Muchabaiwa 2024).

Finally, the actors within countries that are concerned about OVC care for the most part are politically weak, and do not coordinate well to advance the agenda (Shawar et al 2025; Muchabaiwa 2024). Ministries with OVC care mandates—typically those charged with social development—are commonly among the weakest and most poorly funded in government bureaucracies. Legislators who speak out against child abuse and neglect typically gain little political capital by doing so, and at times risk their own political careers if they call out powerful institutions such as the Catholic Church. NGOs involved in OVC care tend to be

poorly funded and with little access to the political system. Social workers as a professional group tend not to be well-organized or politically well-connected, unlike other professional groups such as physicians and teachers. Most families of affected children are among society's most impoverished and politically marginalized. One exception to lack of political power among OVC care proponents are international agencies, and UNICEF in particular, an organization that commands respect globally, is commonly able to access top government officials, and plays a global leadership role in advocating for child protection.

To advance priority, national actors, rather than working disjointedly, must come together in political coalitions. They need to set up venues to develop shared strategy on such matters as building effective leadership for the sector; securing more public funding; inserting the issue early into public budgeting cycles; recruiting new allies such as ministers of finance who control resources; targeting national political leaders including parliamentarians and heads of state; and leveraging international resources and pressure. In doing so, OVC care proponents might look to the health sector for strategy, where several examples of effective local, national and global coalition-building exist that have led to political priority, including HIV/AIDS (Harris and Siplon 2007), polio eradication (Shiffman, Beer and Wu 2002) and child survival (Henderson 1990). Another valuable move would be the development of a common set of indicators of governance effort and effectiveness for OVC care—especially comparable data across countries on the amount of public budgets devoted to OVC care. With such data, country progress could be monitored, and governments more easily be held to account.

Optimal political strategy will differ by context: pressuring the state may work well in democratic political systems, for instance, but may backfire in authoritarian settings where political space is constricted—in such contexts subtle lobbying strategies may be more efficacious. Whatever the setting, OVC care champions need to work in tandem politically, and to develop explicit political strategies; in most low-income countries coalitions are weak or non-existent, and political strategies—in contrast to technical strategies—underdeveloped or overlooked entirely.

Related to the coalition-building challenge is the need to reframe the issue in ways that resonate with the actors whose resources are needed to advance OVC care. Many OVC care proponents see the issue only in moral terms: an ethical requirement that places an obligation on the state and social institutions to ensure the most vulnerable citizens are protected and can thrive. Political officials outside the child protection sector who control needed resources may not see the issue in this way. For instance, ethical arguments may not resonate for ministers of finance as much as, say, arguments for investment in human capital to promote economic growth and avert social instability. These ministers are, after all, bombarded by a plethora of advocacy groups pushing a variety of social causes, each of whom sees their issue as a pressing moral concern. Similarly, ministers of education and health may be less concerned with protection than with advancing their sectoral mandates, respectively, on learning and averting illness and death. And national political leaders are concerned with preserving power, and need to be convinced that investing in OVC will help them gain political support. The point is not that OVC care proponents should abandon ethical arguments; rather, they need to supplement these arguments with framings of the issue that appeal to the goals of political leaders outside the child protection sector whose resources and support are needed.

4.2. Enhancing capacity

In addition to augmenting priority, OVC care proponents face the challenge of enhancing government capacity to deliver services. The two challenges are linked. The primary reason many governments of low-income countries lack such capacity is that they consider the issue unimportant, resulting in lack of attention by national political leaders, insufficient public financing, placement of responsibility for the issue within weak government agencies, weak coordination among organizations involved with OVC care, and minimal investment in the social service workforce.

Historical and structural factors—ones largely beyond the control of government—contribute to capacity problems. For instance, as noted above, the exploitative legacy of colonialism left newly independent countries with weak states facing enormous social problems, including ethnic conflict and economic dislocation. Yet these structural factors are not determinative. Many governments of low-income countries have managed to build capacity in other sectors, including social sectors. For instance, after independence governments of low-income countries set up ministries of health to build and oversee national health systems, resulting in substantial progress in many countries in addressing infectious disease, maternal and child health, and malnutrition (Balabanova et al. 2013). Governments also have put in place national education systems, increasing access to primary and secondary education (UNESCO 2014).

The capacity-building needs follow from the problems identified in the project's studies. The primary need is to equip governments with the authority and power to exercise effective stewardship of national OVC care systems—the ability to bring together the many state, civil society, and international actors working on OVC care to ensure coordination from national to local levels. Presently, many OVC care systems are fragmented, and few governments act as effective stewards. Building such stewardship requires leadership from national political officials, rather than outsourcing responsibility to weak social development ministries, which typically lack the authority to move other ministries to action. Social development ministries must play a role in OVC care, but less as political mobilizers than as coordinators for implementation—a task made easier when national political leaders signal that OVC care is a priority and allocate sufficient funds.

Another set of capacity needs concerns human resources. One issue is the development of the social service workforce—social workers in particular—the professionals that can support families in averting problems, and help children when difficulties arise. Unlike health professionals and teachers, few low-income countries have adequate numbers of social workers employed in the public sector. In addition, staffing for those charged with OVC care at national, sub-national and local levels needs to be enhanced. The findings reveal that government administrators responsible for OVC care commonly are burdened with numerous responsibilities beyond child protection, making it difficult for them to devote more than minimal attention to these issues. Building social service workforce capacity is all the more critical given the frequent maltreatment, stigmatization and in some instances even contempt for children living without adequate adult care.

Building capacity raises tricky questions concerning international donor involvement in the sector. On the one hand, given insufficient government attention to OVC care in many low-income countries, donor involvement is critical to ensure that OVC do not fall through the cracks. On the other hand, heavy donor presence can disincentivize state action—governments can pass the buck knowing that international agencies will pick up the slack. Also donors sometimes skew policy in directions that accord with international but not national priorities and needs. Donors need to think through how to calibrate support in ways that address the national needs for OVC care but do not deter government initiative.

4.3. Future research

Additional research on the governance of OVC care systems in low-income countries will help in identifying political factors facilitating and hindering system effectiveness, and devising strategies to augment priority and build national capacity. We suggest four research areas, each inspired by scholarship on welfare state development and social protection policy in Western Europe and low and middle-income countries (Bambra 2007; Biswas, Sambo and Pellissery 2024; Dorlach

2020; Esping-Andersen 1990; Gough 2008; Lavers and Hickey 2016; Leisering 2021).

First is to explore the effects of longer-term economic and political changes on the expansion of OVC care systems. For instance, will economic growth and consequent expanding state fiscal capacity result in governments spending more on OVC care? Will democratization push governments to pay greater attention to social demands, including for OVC care? Will globalization result in the cross-national spread of norms surrounding social protection, placing pressure on governments to address the needs of their most vulnerable citizens? Alongside intentional political action by proponents, these kinds of structural shifts may induce states and societies to provide more resources for OVC care.

Second, and related to the first set of questions, is to examine the role of interests vis-à-vis norms in spurring countries to prioritize and neglect OVC care. Interests concern political agendas, such as the desire for politicians to maintain power; norms concern commonly held standards about appropriate behavior, such as the belief that states have an ethical obligation to take care of their most vulnerable citizens. Both kinds of factors may work for, and against, OVC care. For instance, with respect to interests, politicians may find that in some instances promoting the well-being of OVC elicits public sympathy, and therefore votes. Conversely, the political weakness of constituencies concerned with OVC care may mean that this issue loses out in the competition among interest groups for scarce public resources. With respect to norms, international organizations such as UNICEF have placed pressure on governments to fund social protection, helping to create a global expectation that states act on OVC care. National political coalitions that link civil society organizations with governmental and international actors may have similar effects on state priority. Conversely, members of society may stigmatize certain categories of OVC, including street children, viewing them as responsible for their fate and not deserving of public support.

Third is to delineate the various pathways that countries follow as they build OVC care systems, and to consider how roles for state, social and private sector actors should vary by context. For instance, in some countries the state may play the central role, not just in stewardship, but also in public funding and service provision. In other countries the state may take on only a limited role, as social institutions—including NGOs, religious institutions and families—as well as the private sector, adopt stewardship, funding and service provision functions. In still other countries, state, social and private sector institutions may share responsibilities relatively equally. A related question is how the roles of state, social, and private actors differ, and should differ, by type of vulnerable child: children grow up in different kinds of care arrangements; moreover the needs of child survivors of sexual violence, for example, are different from those of children living on the street or other categories of vulnerable children.

Fourth, the utility and limitations of the framework need to be explored. The framework's eight sub-categories (policy content, policy process, commitment, leadership, coordination, capacity, social values, and societal problems) can be used to identify additional research questions. For instance, with respect to leadership, is OVC care best guided by stand-alone institutions, or integrated into broader social protection systems? And concerning policy process, as noted above, how can international involvement be tailored in ways that support domestic priorities but avoid disincentivizing state action? Researchers should also consider whether there are additional critical dimensions of the governance of OVC care systems not captured by the eight sub-categories. In addition, investigators may want to explore whether policymaking, governance and context is the most useful way to categorize factors shaping priority for OVC care; there may be better ways to do so—for instance the broad categories of interest and norm-oriented factors noted above.

4.4. Concluding comment

OVC are poorly served by most governments of low-income countries. Few countries prioritize their well-being or have systems in place to protect them from harm and neglect. While strong policies are on the books in many countries, implementation is weak. Transcending neglect of the issue is more than a technical matter; it is a political challenge. Proponents need to form coalitions to press governments to act, generate framings of the issue that appeal to the interests of national leaders, and foster the ability of governments to exercise effective stewardship over national OVC care systems.

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Author contributions

All authors contributed to conceptualizing the research. JS wrote the first draft of the article. All authors contributed to manuscript revisions.

Data availability

To protect the confidentiality and anonymity of key informants, the interview transcripts that have been used are confidential.

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