

Understanding the Psychosocial Well-being of Orphans and Vulnerable Children (OVC): The Intersection of Research and Policy

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Abstract:

This paper identifies the demographic and behavioral predictors that influence the psychosocial health of orphans. A study was conducted using data from 1,851 children across six sites in Cambodia, Ethiopia, India, Kenya, and Tanzania, who are enrolled in the Positive Outcomes for Orphans Study (POFO). The quantitative analysis found that maternal orphans, double orphans, and children who engage in labor outside of the home were particularly vulnerable to psychosocial distress. In addition, the multivariate models showed that variations in site and living arrangements were significantly associated with the subjects' psychosocial outcomes. By synthesizing these findings with literature on orphans and vulnerable children (OVC), this paper recommends forging an international framework for psychosocial programming and tailoring country-level programs to address the individual, social, and cultural predictors of psychosocial distress.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	2
INTRODUCTION.....	3
BACKGROUND.....	5
LITERATURE REVIEW	
Gaps in OVC Policy.....	7
Gaps in Research on Psychosocial Predictors.....	11
Potential Predictors of the Psychosocial Health of OVC.....	12
HYPOTHESIS.....	13
METHODS.....	14
RESULTS.....	20
SENSITIVITY ANALYSIS.....	28
LIMITATIONS.....	28
DISCUSSION.....	29
POLICY RECOMMENDATIONS	
Toward an International Framework.....	32
Improving Country-Level Responses.....	36
CONCLUSION.....	40
REFERENCES.....	42
APPENDICES	
A. Number of Orphans by Region from 1990-2010.....	46
B. Total Number of Children Orphaned by AIDS and Other Causes in 2010.....	46
C. <i>Framework for the Protection, Care, and Support of OVC</i>	47
C. <i>Guidelines for the Alternative Care and Protection of Children</i>	48
E. Policies in POFO Study Countries.....	49
F. The Strengths and Difficulties Questionnaire (SDQ).....	62
G. The “Child Bereavement” Survey.....	63
H. The Life Events Checklist (LEC).....	64

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INTRODUCTION

With the rise of the HIV/AIDS in recent years, policy makers are struggling to care for the 17 million children orphaned by the pandemic (State of the World's Children, 2011). The numbers are even higher when accounting for children orphaned by all causes and those made vulnerable by the socioeconomic impact and mother-to-child transmission of HIV/AIDS. Much attention has been focused on the physical well-being of these orphans and vulnerable children (OVC); however, their psychosocial difficulties, such as depression, exposure to trauma, and difficulty coping with the loss of a parent, can no longer be ignored. As countries formulate and renew their National Plan of Action for OVC (NPA) in coming years, they need research and policy guidance to address the lack of support for the mental and emotional needs of these children.

The current shortcomings in research and policy have led to an information gap which impedes effective psychosocial programming for OVC. First, there is an inadequate understanding of the predictors of the psychosocial well-being of OVC. Previous research has produced conflicting findings on the effects of factors such as age, gender, orphan type, child labor, and school attendance (Baaroy & Webb, 2008; L. Cluver, Fincham, & Seedat, 2009; Qun Zhao, 2010). This lack of knowledge is compounded by a second barrier: psychosocial health is currently not a policy priority. There are no international frameworks or policy guidelines for psychosocial programming. Consequently, there is a dearth of comprehensive national-level efforts. Even for countries which have psychosocial programs, most take a “one-size-fits-all” approach that lacks both breadth and depth. In fact, current policies group all OVC together and fail to integrate psychosocial support into existing education and health infrastructure (Engle, 2008).

Cognizant of these barriers, this paper has three aims:

1. To explicate the dual gaps in policy and research through a review of the literature on the international and national frameworks for psychosocial programming and the predictors of psychosocial health for OVC.
2. To conduct a study assessing the significance of potential psychosocial predictors by analyzing data from the Positive Outcomes for Orphans Study (POFO), led by Duke Professor, Kathryn Whetten.
3. To bridge the chasm between research and policy by synthesizing the findings from the literature review on psychosocial programming and this study in order to inform policy recommendations for improving psychosocial support to OVC.

This paper begins with an overview of the global OVC situation and its impact on the psychosocial health of affected children. Next, it will examine the shortcomings in current research and policies through a review of the literature on global policy frameworks, national policies in the five POFO study countries: Cambodia, Ethiopia, India, Kenya, and Tanzania, and the predictors of the psychosocial health of OVC. To assess the significance of the demographic and behavioral psychosocial predictors identified in the literature, this paper studies 1,851 children enrolled in the POFO study across 6 sites in Southeast Asia and sub-Saharan Africa. The study evaluates two hypotheses regarding predictors of the psychosocial well-being of orphans by modeling data from Round 7 of the POFO study. Based on the study findings and the literature on current interventions, this study makes recommendations for an international approach and country-level responses to psychosocial programming, thereby addressing the policy deficiencies identified in the literature review.

BACKGROUND

There is no universally accepted definition of the OVC category. Although the United Nations Children's Fund (UNICEF) defines an orphan as any "child under 18 years of age who has lost one or both parents," individual countries set the definitions of "vulnerability" based on HIV-status, socioeconomic status, parental abandonment, or a combination in their national plans for action (NPA) (Smart, 2003). The *Children Affected by AIDS* report published by UNICEF captures the sharp increase in the number of orphans over the last two decades (2006)¹. According to UNICEF, Sub-Saharan Africa has the largest orphan burden with over 70 million children who have lost one or both parents (State of the World's Children, 2011). In addition, Asia-Pacific is home to the greatest number of orphaned children, 75 million (State of the World's Children, 2011). Although the HIV/AIDS epidemic is the most prevalent cause of orphan-hood, most children are orphaned by other causes such as natural disasters, conflict, and other health conditions (Gulaid, 2008)².

Statistics on the three orphan types, maternal orphans (children who have lost their mothers), paternal orphans (children who have lost their fathers), and double orphans (children who have lost both parents), are currently unavailable. Nevertheless, a review of demographic health surveys of 40 countries in sub-Saharan Africa by Monasch and Boerma (2004) provides an overview of the emerging demographic patterns in orphan-hood. Paternal orphans, which constituted 5.9% of all children surveyed, was the most prevalent orphan category followed by maternal orphans, 2%, and double orphans, 0.9%, (Monasch & Boerma, 2004). The study noted that due to the HIV/AIDS pandemic, the double orphan category is growing the fastest—a sign of the worsening OVC crisis.

¹ See Appendix A for graph on the numbers of orphans in Asia, Africa, and Latin America from 1990-2010.

² See Appendix B for the total number of children orphaned by AIDS and other causes in 2010.

Despite the current trend, the state's role in caring for OVC is minimal. Rather, extended family networks function as the social safety net. In sub-Saharan Africa, 1 in 6 households is taking care of an OVC (Abebe & Aase, 2007). Although most caretakers are blood relatives, a study of extended family networks in Ethiopia by Abebe and Asase (2007) found that close friends and "fictive kinsmen" are gradually taking on caregiving duties at the request of the child's parent, usually the mother. Nevertheless, not all extended family support structures have the capacity to adequately care for these children. Abebe and Asase (2007) note that "rupturing families "characterized by chronic poverty and "transient families," which lack of a principal breadwinner, are unable to provide for the physical, medical, and educational needs of the OVC, and often rely on the child to supplement the household income.

As a result, many OVC not only have to cope with parental death or abandonment, but also the subsequent erosion of familial support, financial burdens, and stigma (Atwine, Cantor-Graae, & Bajunirwe, 2005; L. D. Cluver, Gardner, & Operario, 2008; Killian & Durrheim, 2008; Makame, Ani, & Grantham-McGregor, 2002; G. Zhao et al., 2007). Therefore, the loss of a parent can have a grave impact on the psychosocial well-being of a child. Many OVC internalize problems, resulting in symptoms of depression, anger, hopelessness, loneliness, low self-esteem, and suicide ideation (Atwine, et al., 2005; Boris et al., 2008; G. Zhao, et al., 2007). They also externalize psychosocial distress through acts of delinquency, increased sexual activity, and more passive displays such as social withdrawal and difficulties concentrating in school (L. Cluver & Gardner, 2006; L. D. Cluver, et al., 2008; Nyamukapa et al., 2008). Without adequate intervention, such behaviors will place an entire generation of OVC at increased risk for further harm. This looming consequence necessitates a survey of present research findings and policy efforts, so that deficiencies in both can be promptly addressed.

LITERATURE REVIEW

The two streams of literature relevant to my research are current global and country-level OVC policies and studies on the predictors of the psychosocial health of OVC. I will first explore the gaps in research and policy regarding the psychosocial well-being of OVC before turning to examine potential psychosocial predictors identified in previous research studies.

Gaps in OVC Policy

Many international conventions, goals, and policies shape the global OVC policy framework; yet, none directly address psychosocial health. As a result, national responses are inconsistent, and country-level psychosocial programming lacks both breadth and depth.

International OVC Policy Frameworks

In 1990, the World Declaration on the Survival, Protection, and Development of Children urged countries to develop NPAs for children. Since then, the Millennium Development Goals in 2000 and the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 have reaffirmed international commitment (Smart, 2003). World leaders agreed to develop national policies and strategies to serve the needs of children affected by HIV/AIDS by 2003 and to implement them by 2005. At the UNGASS Review in 2006, country leaders emphasized their focus on “children orphaned and affected by AIDS” (Cardoso, 2010).

As a result, two international frameworks for OVC policy emerged. First, the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, published by UNICEF in 2004, serves as the global consensus for OVC programming³. In addition, the United Nations General Assembly adopted a resolution, *Guidelines for the Alternative Care of Children*, to guide country-level policy decisions on child

³ See Appendix C for the five principles of OVC programming.

protection and social welfare in response to emerging forms of alternative care for OVC⁴.

Although these frameworks have focused attention on the health and care arrangements of OVC, they do not address the psychosocial well-being of these children. The lack of international guidelines for psychosocial programming has subsequently led to inconsistent country-level policies.

Country-Level Policy Responses

Nearly 50 countries are developing or implementing national responses for children affected by AIDS and other vulnerable groups. Thirty-two of these countries have endorsed a NPA, and many others have integrated OVC policy into sector plans for HIV/AIDS and Poverty Reduction Strategic Plans (Engle, 2008). Nevertheless, policy responses have been inconsistent across regions. Eastern, Southern, and sub-Saharan Africa, which have the highest OVC burdens, have made the most progress (Gulaid, 2008; UNICEF, 2009). Sixteen of 22 nations in Eastern and Southern Africa have begun developing a NPA, and 14 have begun implementation (Gulaid, 2008). In sub-Saharan Africa, 29 of 35 countries have endorsed a NPA (Progress in the National Response to Orphans and other Vulnerable Children in sub-Saharan Africa: The OVC Policy and Planning Effort Index (OPPEI) 2007 Round Summary Report, 2008). On the other hand, progress on developing policy frameworks for OVC has been considerably slower in the rest of the world. So far, no nations in West Africa have implemented a NPA. Moreover in Asia and the Pacific, which has the highest number of orphans, and Latin America and the Caribbean, which has the second-highest HIV-prevalence in the world, only a few countries, such as Cambodia, China, and Guyana, have adopted comprehensive NPAs (Gulaid, 2008). Most nations in these regions have yet to formulate country-level policies to address their rising OVC burden.

⁴ See Appendix D for an overview of the guidelines for alternative care.

Table 1 gives an overview of OVC policies and their ramifications for psychosocial support in the five POFO study countries. These five case studies highlight two inadequacies in current country-level policies. First, there are major discrepancies between national responses. Of the five study countries, only three have NPAs which provide services for OVC. Ethiopia's guidelines merely set standards for OVC programs instead of offering any state-funded services, and India's policies focus on providing ARVs to HIV-positive parents and children instead. Moreover, in all five countries, the psychosocial components of OVC policies lack both breadth and depth. Although Cambodia and Tanzania mention "psychosocial support" in their NPAs, the programming lacks concrete targets and services (*An Update on the National Costed Plan of Action for Most Vulnerable Children*, 2010; MoSVY/NAA., 2008). Thus, the "psychosocial support" for "all OVC" takes an ill-defined, one-size-fits-all approach. Even the NPA in Kenya, which tailors psychosocial programs to a child developmental model, lacks breadth. Current state-funded programs are not integrated with existing efforts in the education and health sectors (*National Plan of Action for Orphans and Vulnerable Children Kenya*, 2008). Given these deficiencies, further research on the predictors of psychosocial health of OVC can inform policies seeking to expand the depth and breadth of country-level programming.

Table 1: Overview of National OVC Response in Selected Study Countries

Country	OVC Population	NPA for OVC?	Country- Level Policies for OVC	Psychosocial Components
Cambodia ⁵	<ul style="list-style-type: none"> ▪ 600,000 orphans ▪ 328,500 vulnerable children 	Yes	<ul style="list-style-type: none"> ▪ 2006 Policy on the Alternative Care for Children ▪ 2008-2010 National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children ▪ 2011-2015 National Strategic Plan for a Comprehensive Multi-sectoral Response to HIV/AIDS 	<ul style="list-style-type: none"> ▪ The “minimum care package” delineated by the 2008-2010 NPA includes “psychosocial support.” ▪ The 2011-2015 National Strategic Plan reaffirmed “comprehensive support packages.”
Ethiopia ⁶	<ul style="list-style-type: none"> ▪ 5.5 million orphans ▪ 855,00 AIDS-orphans 	No	Standard Service Delivery Guidelines for OVC Care and Support Programs	Psychosocial support is a core service area required by the Standard Guidelines.
India ⁷	3.1 million orphans	No	<ul style="list-style-type: none"> ▪ National Plan of Action for Children, 2005 ▪ National AIDS Control Programme (NACP III) 	N/A: Policy paradigm in India is shifting from OVC support to anti-retroviral treatments for parents and children.
Kenya ⁸	<ul style="list-style-type: none"> ▪ 2.6 million orphans ▪ 1.2 million AIDS-orphans 	Yes	2007-2010 National Plan of Action for OVC	<ul style="list-style-type: none"> ▪ Psychosocial support is a strategic target in the 2007-2010 NPA. ▪ Programming is divided into three age groups: 0-5 years, 6-13 years, and 14-18 years.
Tanzania ⁹	<ul style="list-style-type: none"> ▪ 3 million orphans ▪ 1.3 million AIDS-orphans 	Yes	2007-2010 National Costed Plan of Action for Most Vulnerable Children (NCPA)	The 136 provisions included in the NCPA include “psychosocial support” but focus primarily on food, shelter, and primary education.

⁵ MoSVY/NAA. (2008). *Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia: A Situation and Response Assessment, 2007*. Phnom Penh, Cambodia.

⁶ *Standard Service Delivery Guidelines for Orphans and Vulnerable Children Support Programs*. (2010). Addis Ababa.

⁷ *Policy Framework for Children and AIDS in India*. (2007).

⁸ *National Plan of Action for Orphans and Vulnerable Children Kenya 2007-2010*. (2008). Nairobi.

⁹ *An Update on the National Costed Plan of Action for Most Vulnerable Children, 2007-2010*. (2010): USAID.

Gaps in the Research on the Predictors of the Psychosocial Health of OVC

Past research on the psychosocial predictors of OVC is lacking in two ways. First, the results of previous studies have limited generalizability because the majority focuses on specific regions or countries in sub-Saharan Africa. Moreover, the findings across studies have been inconsistent and often contradictory.

Research on systemic predictors of the psychosocial well-being of OVC is sparse. Although previous studies suggested that cultural and social norms influence the psychosocial health of OVC, no studies have compared outcomes across countries or cultures (Wood, Chase, & Aggleton, 2006; Zhao, et al., 2007). In addition, there is a dearth of literature on the influence of care arrangements and living standards on the psychosocial outcomes of OVC. Notably, no studies have directly explored the psychosocial implications of experiential factors such as school attendance, child labor, and abuse. Further cross-regional research is hence needed to understand the impact of social and cultural contexts.

Moreover, there is no consensus on the significance of individual-level psychosocial predictors, such as orphan type and gender. While some studies indicated little difference in the psychosocial well-being between the three types of orphans (Baaroy & Webb, 2008; L. Cluver, Fincham, & Seedat, 2009; Fang et al., 2009), others reported that maternal and double orphans are more vulnerable than their paternal orphan counterparts (Baaroy & Webb, 2008; M. Kang, 2008; Qun Zhao, 2010). With regards to gender, some studies reported that girls are more susceptible to psychosocial distress (Nyamukapa, et al., 2008) whereas others found no differences between the genders (L. Cluver, et al., 2009; Onuoha & Munakata, 2010). To address these discrepancies, further analysis controlling for differences in social and cultural contexts can isolate the impact of orphan type and gender on psychosocial outcomes.

Potential Predictors of Psychosocial Distress in OVC

A review of the literature on the psychosocial health of OVC delineated four categories of potential predictors: orphan type, individual-level factors, cultural and social factors, and living arrangements and standards. Previous studies suggested that these factors may affect three outcomes of psychosocial distress: behavioral and emotional difficulties (through internalizing and externalizing problems), difficulties in coping with the loss of a parent (otherwise known as complicated bereavement), and exposure to trauma.

Previous studies identified orphan status as the most significant predictor of psychosocial health. Multiple studies revealed that orphans suffer higher levels of psychosocial distress than their non-orphans peers. In particular, maternal and double orphans are more likely to experience behavioral and emotional difficulties, suffer abuse, and report lower rates of trusting relationships with caregivers (Baaroy & Webb, 2008; M. Kang, 2008; Qun Zhao, 2010).

Besides orphan type, the literature indicated that other individual-level factors such as age, gender, school performance, self-esteem, and cognitive development are also highly correlated with psychosocial health (Li et al., 2008). Past research demonstrated that gender and age are the most strongly associated with psychosocial outcomes. In particular, girls and older OVC are especially vulnerable to psychosocial distress (Nyamukapa et al., 2008; L. Cluver et al., 2009; Onuoha & Munakata, 2010).

Studies also suggested that cultural and social norms impact the psychosocial well-being of OVC. For instance, the cultural norm to avoid the discussion of death complicates the bereavement process. The expectations to “keep silent” are not confined to African cultures (Wood, Chase, & Aggleton, 2006) but also extend to Asian norms of “controlling one’s emotions” (G. Zhao, et al., 2007). In addition, literature on OVC in both Asia and sub-Saharan

Africa demonstrated that due to social norms, orphans are often adopted into extended families that cannot support them, leading to greater risk of psychosocial harm (Killian & Durrheim, 2008; Makame, et al., 2002; Nyamukapa, et al., 2008; G. Zhao, et al., 2007).

Finally, care arrangements and living standards may influence the psychosocial health of OVC. Makame et al. (2009) reported that orphans living alone, with grandparents, or with non-relatives have significantly higher levels of internalizing problems than do orphans who reside with close kin. These findings were supported in a study by Nyamukapa et al. (2008), which also suggested that being unrelated to the caregiver is positively associated with psychosocial distress whereas residing in a household of a close relative is a protective factor. Past research identified significant disparities between the living standards of orphans and non-orphans. Multiple studies found that maternal and double orphans are especially at risk for not attending school or for delayed enrollment (Baaroy & Webb, 2008; Kagawa, 2009; Monasch & Boerma, 2004; Onuoha & Munakata, 2010). In addition, publications from the POFO team indicated that OVC are more likely to engage in child labor and experience traumatic events such as family violence and physical and sexual abuse (Whetten, Ostermann, Whetten, O'Donnell, & Thielman, 2011).

HYPOTHESIS

Based on the findings of the literature review of psychosocial predictors, this study hypothesizes that:

1. Orphans who are a part of the POFO Study will have higher levels of psychosocial distress than their non-orphans counterparts. Specifically, maternal and double orphans will exhibit higher levels of three psychosocial outcomes: behavioral and emotional difficulties, complicated bereavement, and trauma.

2. Among orphans who are enrolled in the POFO study, other predictors such as country of residence, child age, gender, relationship to the caregiver, and work outside of the home will be significantly associated with all three aforementioned psychosocial outcomes.

METHODS

Study Description

This study seeks to bridge the gap in research and policy through a quantitative analysis of data from the POFO study, based at the Duke Center for Health Policy and Inequalities Research. Unlike previous studies on OVC, which were cross-sectional and based in one country or region, POFO is a longitudinal, cross-cultural research examining characteristics of care and health outcomes of OVC across Southeast Asia and sub-Saharan Africa. POFO is unprecedented in its sample size, geographic span, and cultural inclusiveness. It employed two-stage random sampling survey methodology to select 3,320 children among six study sites across five low and middle income countries (LMIC): Cambodia, India (Hyderabad and Nagaland), Kenya, Tanzania, and Ethiopia. Study participants comprised non-orphans, institutional and community-based orphans and abandoned children, and their primary caregivers. This study examined data from 1,544 community-based orphans and abandoned children and 307 non-orphans from the most recent round of the study (Round 7), administered 36 months after the baseline assessment.

By analyzing the impact of potential psychosocial predictors identified in the literature review using data from POFO, this study strives to overcome the limited power and generalizability of past research to supplement the literature on psychosocial predictors. The quantitative models of psychosocial predictors provide a more nuanced understanding of the

psychosocial health of orphans and are integral to informing policy recommendations for future psychosocial programming.

Study Sample

The five POFO study countries were selected from a group of 13 countries in which members of the POFO research team had existing relationships with grassroots organizations. Each country is culturally, historically, ethnically, religiously, politically, and geographically unique, and the group as a whole provides a representative picture of LMIC in Southeast Asia and sub-Saharan Africa. In India, both Hyderabad and Nagaland were chosen due to their vastly different populations represented in terms of religion, geography, income levels and political histories.

POFO identified 309 clusters among the six study sites based on geographic or administrative boundaries. In each cluster, one eligible non-orphan and five orphans were selected either randomly from available lists or through a house-to-house census. If a household contained more than one eligible child, the one whose name appeared first alphabetically was chosen for the study. POFO included any child who had at least one parent who had died or had been abandoned by both parents in the “orphan” category. “Vulnerable children” were not included in the sample because the definition of “vulnerability” differs in each of the study countries. A total of 1,544 community-based orphans and 307 non-orphans ages 9 to 16 completed the Round 7 follow-up surveys and were included in this research.

Measures

Questionnaires were administered in the native language at each site by trained local researchers. Measures included potential predictors of psychosocial distress (demographic characteristics of participants, inability to attend school, and labor outside of the home), and

psychosocial outcomes (behavioral and emotional difficulties, complicated bereavement, and exposure to trauma).

Independent variables included the site-location, age, and gender of each participant. In addition, the primary caregiver of each child indicated his or her relationship to the child (i.e. biological parent, adopted parent, sibling grandparent, aunt or uncle, other relative, or non-relative) and the status of the child's biological parents (alive, dead, or missing). Each caregiver was also asked about two lifestyle predictors: whether the child attended school and how many hours of paid or unpaid labor the child conducted outside of the home per week.

Furthermore, this study assessed three psychosocial outcomes: behavioral and emotional difficulties, complicated bereavement, and exposure to trauma.

The Strengths and Difficulties Questionnaire (SDQ) was used to measure child behaviors and emotions. The SDQ was selected because of its brevity, wide-use in resource poor countries, and age appropriateness (Goodman 1997). For the Round 7 follow-up, all children ages 11 and older were asked to complete the SDQ. For all children 10 and younger, their primary caregivers responded on their behalf. My analysis examines the Difficulties portion of the survey which encompassed 20 indicators across four categories of psychosocial health: emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship issues (see Appendix E). Each indicator was scored on a scale of 0-2, resulting in a Total Difficulties score of 0-40, with higher scores signifying more behavioral and emotional difficulties. A score of 15 is the clinical cut-off for diagnosing symptoms of PTSD in children (Goodman et al., 2004)

The "Child Bereavement" survey, based on PTSD Checklist Specific Version (PLC-S), was created to assess each child's response to parental death or abandonment (see Appendix F). For the Round 7 follow-up, orphans and abandoned children 11 and older were asked to fill out

the survey, which included 24 indicators for complicated bereavement. For orphans and abandoned children 10 and younger, their primary caregivers answered on their behalf. Each indicator was scored on a scale from 0-2, and the total “Child Bereavement” score ranged from 0-48, with a higher score signifying increased difficulty coping with parental death or abandonment.

The Life Events Checklist (LEC) from the PLC-S assessed exposure to trauma among all participants (see Appendix G). The LEC screens for potentially traumatic events in a child’s lifetime that could lead to PTSD or psychosocial distress and has been used in multiple studies of the psychosocial health of OVC (L. Cluver, et al., 2009; Killian & Durrheim, 2008; Whetten, et al., 2011). For the Round 7 follow-up, all children 11 and older filled out the checklist which consisted of 16 indicators of physical or sexual abuse, family violence, natural disasters, conflicts, and familial death over the last 12 months and over their lifetimes. For all children 10 and younger, the primary caregiver was asked to respond on behalf of the child. A Lifetime Trauma score and Incident Trauma score were calculated by assigning one point for every event that the child experienced in each respective time-frame. For the Lifetime Trauma score, only indicators in addition to the death of a parent were counted. The scores ranged from 0-16, with higher scores signifying greater exposure to traumatic events.

Analysis

The demographic characteristics of the sample (site location, age, gender, orphan status, orphan type, and relationship to caregiver) were examined using standard descriptive analysis such as calculations of count, proportions, mean, and standard deviation. In addition, the distributions of other predictor and outcome variables were examined for skew. Variables which were not normally distributed such as the Lifetime Trauma score, Incidence Trauma score, and

hours of outside labor were converted to dichotomous variables (0=no traumatic event in the stated time period, 1= at least 1 trauma in the stated time period; 0=no labor outside of the home, 1=outside labor). Whether or not a child attended school was omitted as a predictor in later stages of analysis because only 63 of 1501 respondents (4.2% of the sample) indicated that they were not attending school.

Bivariate analyses were used to test the hypothesis that orphans suffered higher levels of psychosocial distress than non-orphans; specifically, that maternal and double orphans were particularly vulnerable. Two-tailed t-tests were used to assess differences in the mean Total Difficulties Score and the “Child Bereavement” score between orphans and non-orphans. Two-tailed p-tests were used to compare the proportion of children who experienced a traumatic event in the last 12 months and in their lifetimes for orphans versus non-orphans. In addition, within the orphan category, the same analyses were repeated to examine differences between maternal versus paternal orphans and double versus paternal orphans.

Multivariate models were used to evaluate the hypothesis that other demographic and behavioral predictors were significantly associated with OVC’s psychosocial outcomes. The models encompassed all psychosocial predictors identified by the literature review that were available from the Round 7 database of POFO and analyzed six predictor variables: site location, age, gender, orphan type (maternal, paternal, or double), relationship of the caregiver to the child (biological parent, adopted parent, sibling, grandparent, aunt or uncle, other relative, or non-relative), and whether or not the child engages in labor outside of the home.

Multivariate linear regression models assessed the association between the aforementioned predictors and the two continuous psychosocial outcome variables: the SDQ Total Difficulties and “Child Bereavement” scores. Logistical regression models investigated

the association between the predictors and the two categorical outcomes: whether the participant experienced a traumatic event in the past 12 months (incident trauma) and whether the participant experienced a traumatic event over his or her lifetime (lifetime trauma). Multivariate analyses were conducted so that the effect of each predictor on the psychosocial difficulties of OVC could be examined while simultaneously adjusting for the association of the other five characteristics.

Dummy variables were created to represent the site locations, orphan type, and the caregiver's relationship to the orphan. Tanzania, paternal orphans, and children cared for by their biological parents were selected as the referents in the model. Tanzania was chosen as the referent for site location because it has the most well-established NPA and has not suffered any adverse events such as an internal conflict or a natural disaster in recent years. Paternal orphans and children cared for by their biological parents were chosen as the comparison categories for orphan type and caregiver's relationship to the child because they contained the greatest number of participants and gave the model the highest stability. Finally, each model was examined for multicollinearity and adjusted as needed to ensure that the association of each predictor and the psychosocial outcomes was not affected by any strong correlation with other independent variables.

RESULTS

Distributions of Demographic Characteristics and Psychosocial Outcomes

Table 2 shows the demographic characteristics of the 1851 children (1544 orphans and 307 non-orphans) included in Round 7 of the study. The sample was nearly evenly distributed across the six sites with Ethiopia having the greatest number of respondents (n=332) and Tanzania having the fewest (n=292). The mean age of the children was 11.8 years old, and the sample had a higher proportion of males, 61.29%. Of the three categories of orphans, paternal orphans represented the greatest number of children (n=772) and maternal orphans represented the least (n=164). Over half of the children lived with their biological parents (61.63%), and the second most prevalent living arrangement was with a grandparent (18.71%).

Table 2: Site Enrollment and Child Characteristics

	N	% or Mean (SD)
SITE		
Cambodia	310	16.75
Ethiopia	332	17.94
Hyderabad	307	16.59
Kenya	316	17.07
Nagaland	294	15.88
Tanzania	292	15.78
CHILD CHARACTERISTICS		
Age		11.81 (1.80)
Male	969	61.29
Non-Orphan	307	16.59
Orphan	1544	83.41
Maternal Orphan	164	14.04
Paternal Orphan	772	66.10
Double Orphan	232	19.86
Living with biological parent	1004	61.63
Living with adopted parent	40	2.46
Living with sibling	56	3.44
Living with grandparent	305	18.72
Living with aunt or uncle	159	9.76
Living with other relative	34	2.09
Living with non-relative	31	1.90
Hours of outside labor		5.81 (8.97)
PSYCHOSOCIAL OUTCOMES		
SDQ Total Difficulties score		8.78(5.06)
"Child Bereavement" score		9.14 (11.30)
LEC Lifetime Trauma score		1.85 (1.90)
LEC Incidence Trauma score		0.85 (1.46)

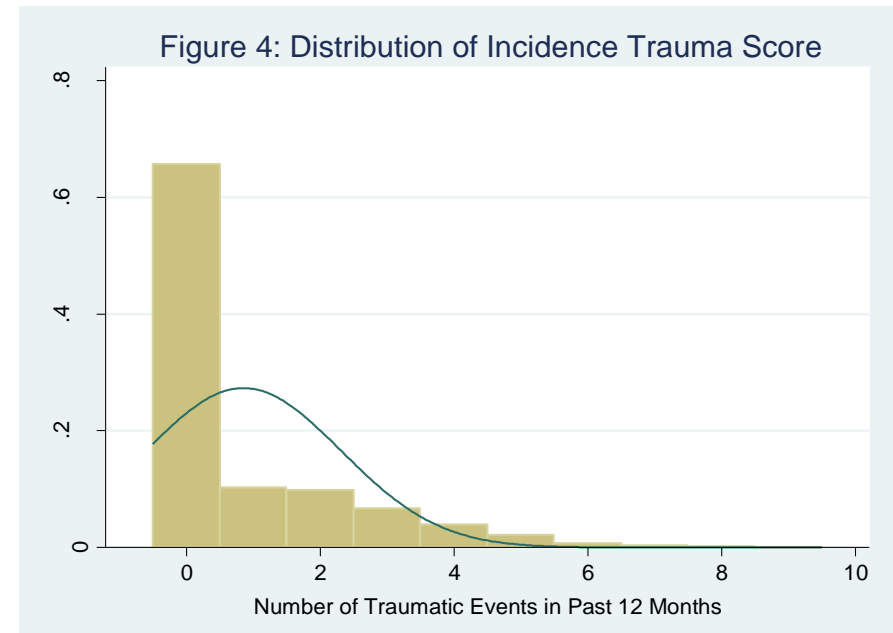
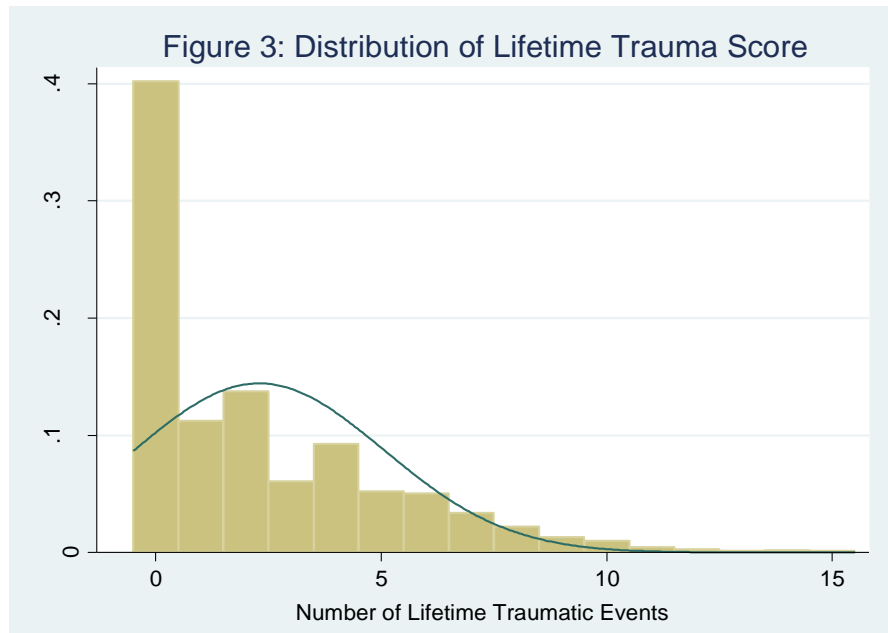
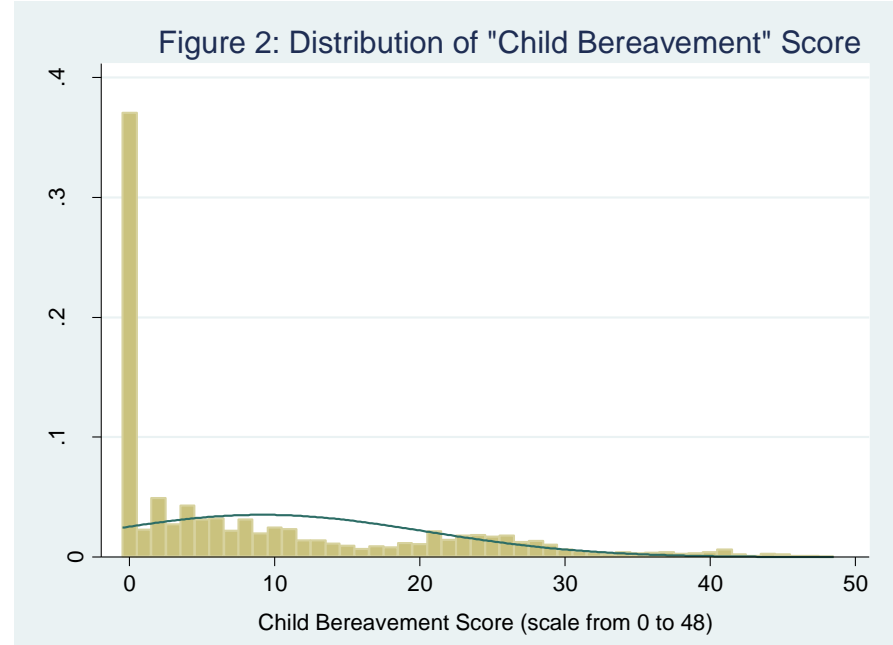
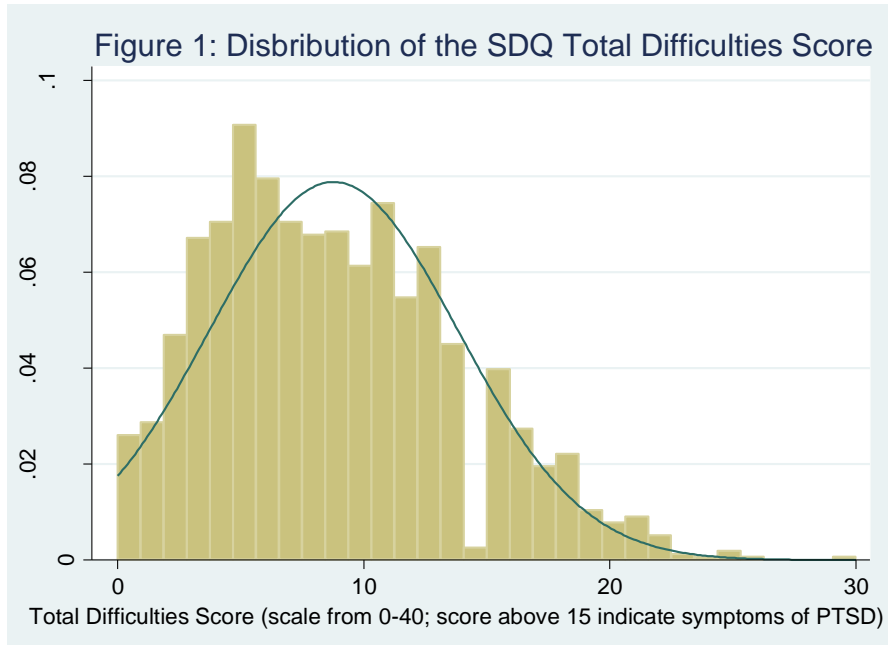
Figures 1-4 show the distributions of the four psychosocial outcomes: SDQ Total Difficulties score, "Child Bereavement" score, LEC Lifetime Trauma score, and LEC Incidence

Trauma Score. The LEC Lifetime and Incidence Trauma scores were significantly skewed to the right and were therefore converted to dichotomous variables (0=did not experience traumatic event, 1=experienced traumatic event). Close to three-quarters of the children (n=1249) had experienced at least one traumatic even in their lifetimes, other than the death of their parent, whereas only 34.25% (n=634) experienced a traumatic incident in the 12 months prior to the survey.

Comparison of the Psychosocial Outcomes between Orphans Types

Table 3 compares the mean scores of orphans and non-orphans on the SDQ Total Difficulties and “Child Bereavement” surveys and the proportions of children in each category who experienced a traumatic event in their lifetimes or in the past 12 months. The differences in all four outcomes were significant. Orphans had significantly higher mean scores on the SDQ ($p<0.001$). In addition, a higher proportion of orphans experienced incidences of trauma, in addition to the death of a parent, over their lifetimes ($p<0.001$) and in the last 12 months ($p<0.01$).

Table 3 also compares the mean scores of the three orphan types: maternal orphans versus paternal orphans and double orphans versus paternal orphans on all four psychosocial measures. Only the difference in the “Child Bereavement” score between double orphans and paternal orphans was significant ($p<0.01$). The mean of the “Child Bereavement” scores of double orphans was significantly higher than that of paternal orphans. Maternal and double orphans did not differ significantly from paternal orphans on measures of behavioral and emotional difficulties (SDQ Total Difficulties score) or exposure to trauma (whether they experienced an indicator on the LEC in their lifetimes and the in the past 12 months).



Note: The Lifetime Trauma score reflects the number traumatic events experienced in addition to the death of a parent.

Table 3: Psychosocial Outcomes by Orphan Status

	Orphans		vs.	Non-Orphans		
	Mean/ Proportion	SE		Mean/ Proportion	SE	t-statistic/ z-score
SDQ Total Difficulties	9.08	0.15		7.74	0.27	-3.98 ***
Suffered traumatic event in lifetime	0.82	0.01		0.42	0.03	-12.07 ***
Suffered traumatic event in last 12 months	0.4	0.01		0.31	0.03	-2.75 **
	Maternal Orphans		vs.	Paternal Orphans		
	Mean/ Proportion	SE		Mean/ Proportion	SE	t-statistic/ z-score
SDQ Total Difficulties	9.23	4.51		9.01	5.10	0.50
"Child Bereavement" score	12.91	0.94		11.91	0.42	0.97
Suffered traumatic event in lifetime	0.83	0.03		0.82	0.01	0.23
Suffered traumatic event in last 12 months	0.45	0.04		0.41	0.02	0.95
	Double Orphans		vs.	Paternal Orphans		
	Mean/ Proportion	SE		Mean/ Proportion	SE	t-statistic/ z-score
SDQ Total Difficulties	9.19	0.38		9.02	0.19	0.44
"Child Bereavement" score	14.77	0.76		11.91	0.43	3.25 **
Suffered traumatic event in lifetime	0.83	0.03		0.82	0.01	0.14
Suffered traumatic event in last 12 months	0.34	0.03		0.41	0.02	1.76

p<0.05 = * p<0.01 = ** p<0.001 = ***

All p-values reflect a two-tailed test

The "Child Bereavement" score was omitted from the analysis of orphans vs. non-orphans because the "Child Bereavement" Survey is intended for orphans and abandoned children only.

Significant Predictors of Psychosocial Outcomes

No multicollinearity was found between the independent variables selected for the multivariable linear regression analysis of the SDQ Total Difficulties score or the “Child Bereavement” score. Table 4 lists the correlation coefficients of each predictor and the two aforementioned outcomes.

The site location, age, and gender were significantly associated with the SDQ Total Difficulties score when all of the independent variables were simultaneously adjusted for one another. Children from Cambodia and Kenya were more likely to have a higher Total Difficulties score, and children from Ethiopia, Hyderabad, and Nagaland were more likely to have a lower score compared to children from Tanzania. In addition, being younger ($p < 0.05$) and being male ($p < 0.05$) was significantly correlated with a higher Total Difficulties score.

With regards to the “Child Bereavement” score, the site location, double orphan status, and being taken care of by a non-immediate family member were significantly associated with this outcome. Children from Kenya were more likely to have a higher “Child Bereavement” score, and children from Cambodia, Ethiopia, Hyderabad, and Nagaland were more likely to have a lower score as compared to children from Tanzania. In addition, being a double orphan (vs. paternal orphan) was correlated with a higher “Child Bereavement” score ($p < 0.01$), whereas being taken care of by a non-immediate family member (vs. being taken care of by a biological parent) was correlated with a lower “Child Bereavement” score ($p < 0.05$).

Table 4: Multivariate regression models for orphans' mean scores on SDQ and "Child Bereavement" indices

Explanatory variables	Dependent variable: mean SDQ Total Difficulties Score			Dependent variable: mean "Child Bereavement" scores		
	Coefficient	SE		Coefficient	SE	
Site						
Cambodia	2.90 ***	0.46		-8.67 ***	0.81	
Ethiopia	-5.12 ***	0.49		-16.20 ***	0.87	
Hyderabad	-1.96 ***	0.49		-16.60 ***	0.87	
Kenya	2.30 ****	0.45		1.63 *	0.80	
Nagaland	-3.48 ****	0.50		-21.77 ***	0.88	
Child Age	-0.16 *	0.07		0.22	0.13	
Gender (0 = male, 1 = female)	-0.59 *	0.27		0.69	0.47	
Orphan Type						
Maternal orphan (0 = no, 1 = yes)	0.24	0.41		1.18	0.72	
Double orphan (0 = no, 1 = yes)	0.21	0.44		2.27 **	0.78	
Caregiver relationship to child						
Adopted parent (0 = no, 1 = yes)	0.92	0.84		-1.14	1.50	
Sibling (0 = no, 1 = yes)	0.97	0.70		0.70	1.24	
Grandparent (0 = no, 1 = yes)	0.08	0.39		-0.77	0.71	
Aunt or uncle (0 = no, 1 = yes)	-0.34	0.50		-0.96	0.85	
Other relative (0 = no, 1 = yes)	-1.29	0.88		-3.57 *	1.57	
Non-relative (0 = no, 1 = yes)	0.82	1.06		3.09	1.89	
Work outside of the home (0 = no, 1 = yes)	-0.40	0.36		0.07	0.64	

p<0.05 = * p<0.01 = ** p<0.001 = ***

A strong correlation was found between the child characteristic, “double orphan,” and the caregiver characteristic, “relationship to child” (i.e. grandparent, sibling, aunt or uncle, etc.), in the lifetime trauma model. Combining the “Double orphan” and “Paternal orphan” categories as the referent in the analysis corrected this multicollinearity. As a result of this adjustment, the model for incident trauma compares all three orphan types whereas the model for lifetime trauma compares maternal orphans to other orphans (paternal and double). Nevertheless, the significance or interpretations of the findings remained unchanged.

Table 5 lists the odds ratio (OR) of both the lifetime and incidence trauma indicators. When all of the predictors were simultaneously adjusted for one another, two characteristics were independently associated with a higher likelihood of having experienced a traumatic event at any point in life in comparison to the referent categories: being from Ethiopia ($p < 0.001$), Hyderabad ($p < 0.05$), or Kenya ($p < 0.05$), and engaging in labor outside of the home ($p < 0.01$). In addition, two characteristics were independently associated with a lower likelihood of having experienced lifetime trauma: being from Cambodia ($p < 0.001$) or Nagaland ($p < 0.001$), and living with a grandparent ($p < 0.05$), an aunt or uncle ($p < 0.001$), or a non-relative ($p < 0.05$).

With regards to incident trauma, three characteristics were independently associated with a higher likelihood of having experienced a traumatic event in the past 12 months in comparison to the referent categories: being from Cambodia ($p < 0.001$) or Kenya ($p < 0.001$), being a maternal orphan ($p < 0.05$), and engaging in labor outside of the home ($p < 0.01$). In addition, only one predictor was significantly associated with a lower likelihood of having experienced incidence trauma: being from Ethiopia ($p < 0.001$) or Nagaland ($p < 0.001$).

Table 5: Multivariable-adjusted OR for Lifetime and Incidence Trauma outcomes of orphans

Predictor	Experienced trauma in lifetime (yes/no)			Experienced trauma is last 12 months (yes/no)		
	OR		95% CI	OR		95% CI
Site						
Cambodia	0.31	***	[0.52, 1.24]	2.19	***	[1.40, 3.43]
Ethiopia	7.60	***	[2.23, 25.90]	0.19	***	[0.10, 0.36]
Hyderabad	5.01	*	[1.34, 18.72]	0.71		[0.43, 1.17]
Kenya	6.00	*	[1.30, 27.72]	47.16	***	[19.4, 114.45]
Nagaland	0.06	***	[0.03, 0.13]	0.24	***	[0.13,0.44]
Child Age	1.12		[1.00, 1.26]	0.98		[0.90,1.08]
Gender (0 = male, 1 = female)	0.81		[0.52, 1.24]	0.73		[0.53,1.02]
Orphan Type						
Maternal orphan (0 = no, 1 = yes)	1.46		[0.80, 2.65]	1.80	*	[1.10, 2.96]
Double orphan (0 = no, 1 = yes)				1.36		[0.79, 2.35]
Caregiver relationship to child						
Adopted parent (0 = no, 1 = yes)	0.55		[0.15, 2.08]	0.57		[0.13,2.45]
Sibling (0 = no, 1 = yes)	0.37		[0.12, 1.16]	0.48		[0.19, 1.24]
Grandparent (0 = no, 1 = yes)	0.50	*	[0.28, 0.89]	0.81		[0.30, 2.17]
Aunt or uncle (0 = no, 1 = yes)	0.29	***	[0.15, 0.55]	0.58		[0.33, 2.61]
Other relative (0 = no, 1 = yes)	0.32		[0.07, 1.40]	0.62		[0.62, 1.68]
Non-relative (0 = no, 1 = yes)	0.14	*	[0.03, 0.74]	0.51		[0.12, 2.11]
Work outside of the home (0 = no, 1= yes)	2.23	**	[1.33, 3.75]	2.00	**	[1.26, 3.14]

p<0.05 = * p<0.01 = ** p<0.001 = ***

The 'Double orphan' category was combined with the 'Paternal orphan' category as the referent in the analysis of lifetime trauma to remove multicollinearity

SENSITIVITY ANALYSIS

The mean SDQ Total Difficulties and “Child Bereavement” scores and the proportions of children who experienced lifetime and incident trauma differed significantly between children abandoned by both parents and those who were orphaned. Nevertheless, in the sensitivity analysis, no differences in significance were observed in the bivariate analysis between the samples including the 23 abandoned children in the orphan sample and those that excluded them. Thus, the abandoned children were included in the bivariate analysis in the orphan category, but omitted from the multivariate modeling because there were not enough subjects to maintain a stable model if they constituted their own “orphan type” category.

LIMITATIONS

There were three main limitations to this research design. First, predictors such as school attendance, socioeconomic status, and the level of trust between the child and caregiver were not included in the multivariate analysis because data was unavailable. These factors have been shown to be significantly associated with the psychosocial health of OVC in previous studies (Nyamukapa, et al., 2008; Ruiz-Casares, Thombs, & Rousseau, 2009; Wood, et al., 2006; G. X. Zhao et al., 2009). Thus, some variables significant in the multivariate models could have been otherwise were they adjusted for these predictors. Moreover, the outcome measures such as the SDQ, “Child Bereavement” Survey, and LEC, may lack criterion validity. Using the same standardized scales and constructs across the six sites may constitute a “category fallacy” –the false idea that symptoms described in different cultural contexts share the same meaning (Dawes, 2006). As a result, the differences in scores on the SDQ and “Child Bereavement” surveys across sites may reflect social and cultural differences instead of varying levels of psychosocial distress. Finally, the study sample only included orphans and children abandoned by both parents. Thus, the results may not generalizable to all OVC.

DISCUSSION

This study confirms findings from previous research which concluded that orphans have higher levels of psychosocial distress than non-orphans (Atwine, et al., 2005; L. D. Cluver, et al., 2008; Killian & Durrheim, 2008; Makame, et al., 2002; G. Zhao, et al., 2007). This study is also in line with previous research demonstrating that maternal orphans and double orphans have higher levels of psychosocial distress than their paternal orphan counterparts (Ruiz-Casares, et al., 2009; Wood, et al., 2006; Yucelen, 2007). Bivariate testing reveals that double orphans are more likely to have complicated bereavement. In addition, the multivariate logistic model for incidence trauma shows that controlling for other demographic factors such as site location, age, gender, and living arrangements, maternal orphans are 1.80 times more likely than paternal orphans to have experienced a traumatic event in the past 12 months. Moreover, this study supplements previous studies which indicated that age and gender are significantly associated with psychosocial health (Nyamukapa, et al., 2008; Wood, et al., 2006). However, unlike previous research, the analysis finds that controlling for other demographic factors such as orphan type and living arrangements, younger children and boys are more likely to exhibit behavioral and emotional difficulties.

This study also challenges the findings of previous studies on the impact of living arrangements on the psychosocial health of OVC. Unlike Makame et al. (2009) who found that residing with a grandparent is associated with higher levels of internalizing problems and Nyamukapa et al. (2008) who suggested that living with a biological caregiver is associated with lower levels psychosocial distress for OVC, this study reveals that living with a grandparent, an aunt or uncle, or a non-immediate family member is a protective factor. Specifically, this study shows that living with a non-immediate family member (ie: not a grandparent, sibling, aunt or

uncle) is negatively associated with complicated bereavement. Moreover, orphans who are living with a grandparent, aunt or uncle, or non-relative are more than two times less likely than children living with their biological parents to have experienced a traumatic event in their lifetimes. Although these findings by no means suggest that living with a grandparent, aunt or uncle, or distant relative is the ideal care arrangement for OVC, they reflect the possibility that these categories of caregivers may be more likely than biological parents to have the financial, emotional, and physical means to provide stable care. It is possible that after the death of a spouse, the remaining parent is ill or in poor emotional health. In addition, it is common for the death of a parent, especially the father, to lead to land-dispossession and chronic poverty. Thus, further research is needed to isolate the effect of living with a non-biological caregiver, controlling for these socioeconomic factors.

Finally, this study highlights two additional predictors of psychosocial health: site location and engaging in labor outside of the home. Across the four psychosocial outcomes, orphans from Kenya tend to experience higher levels of psychosocial distress than the referent group in Tanzania whereas orphans from Nagaland tend to do better. The poorer outcomes in Kenya may reflect the recent violence in the region while the more positive outcomes in Nagaland suggest that the culture of strong extended family networks in the region could be a protective factor in mitigating psychosocial harms. This study is the first to compare psychosocial outcomes of orphans across sites in Southeast Asia and sub-Saharan Africa, and the results indicate that the cultural, historical, and current sociopolitical context of each country significantly impacts the psychosocial well-being of orphans. In light of these results, policies related to the psychological wellbeing of orphans should be sufficiently nuanced to take into account local differences.

Moreover, labor outside of the home is a significant predictor of both lifetime and incidence trauma. Children who engaged in labor outside of the home are approximately two times more likely to have experienced a traumatic event in their lifetimes and in the last 12 months than those who did not. These findings suggest that psychosocial programming needs to include a component to curb child labor and further protective services for orphans. Because other studies have found that the predictor of child labor is the financial wellbeing of the household, protecting children from child labor may necessitate ensuring that families caring for orphans are economically stable.

In summary, this study reveals that many cultural, demographic, and standard of living factors have a bearing on the psychosocial health of orphans. In particular, greater attention needs to be focused on especially vulnerable categories of orphans: maternal orphans, double orphans, and orphans who engage in labor outside of the home. Moreover, with regards to living arrangements of orphans, government policies should encourage placement with caregivers who can best provide stable care, instead of giving preference to those who are closer in kinship. Given the diverse predictors of psychosocial health, especially the differences in well-being between orphans across the six sites, psychosocial programming should not be a one-size-fits-all approach. Instead, this study suggests that effective programming must address an array of predictors such as cultural and sociopolitical context, orphan type, and labor outside of the home.

POLICY RECOMMENDATIONS

Toward an International Response

Given that the study findings indicate that cultural and sociopolitical contexts significantly impact the psychosocial well-being of OVC, developing one set of international standards for programming would be counterproductive to encouraging country-level policies which are specific and culturally-relevant. Nevertheless, the policy literature review has shown that leaving countries without an international framework for psychosocial support has led to inconsistent and ineffective policies across the board. Thus, a balance between international support and country-ownership must be found. The international community can help achieve this balance in three main ways:

1. Emphasize Psychosocial Health in Existing Frameworks

Although the 2001 UNGASS Declaration of Commitment on HIV/AIDS specifically mentions providing “a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counseling and psychosocial support,” the psychosocial needs of OVC has received less attention than the OVC’s physical well-being and living standards (Dawes, 2006). International bodies such as UNAIDS, UNICEF, and USAID can elevate the importance of psychosocial programming on county-level policy agendas by integrating psychosocial support into the two existing international frameworks: *Framework for the Protection, Care, and Support of OVC* and the *Guidelines for the Alternative Care of Children*.

Psychosocial programming and policies can be emphasized in the five principles of OVC care delineated by the *Framework* (see Appendix C). For example, the third principle states that existing OVC programs should “ensure access to essential services such as birth registration,

schooling, health and nutrition services, and basic water and sanitation” (The Framework: For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, 2004). Given the findings that orphans had significantly higher levels of psychosocial distress than non-orphans (see Table 2), UNICEF should call attention to the need for psychosocial programming by inserting “psychosocial support” in the list of “essential services” mandated by the document.

Similarly, the UN can integrate measures to address the significant predictors of psychosocial distress into the *Guidelines for the Alternative Care of Children* (see Appendix D). The UN should address the psychosocial difficulties manifested in this study’s findings by including psychosocial counseling and support in the list of services residential facilities are required to provide for OVC. In addition, given that child labor is a significant predictor of psychosocial distress (see Table 5), the guidelines should also set standards (in addition to those mandating basic healthcare, nutrition, and schooling) to protect children from exploitative labor practices in alternative care settings. Finally, the document should critically re-examine its priorities in the placement of children. This study found that living with a grandparent, aunt or uncle, or non-relative may be a protective factor against psychosocial distress (see Table 5). Thus, instead of prioritizing the degree of “kinship,” the guidelines should develop a metric for selecting the most stable caregiver.

2. Draft Guidelines for Psychosocial Support

Despite the fact that “best practices” in implementing psychosocial policies differ based on cultural and sociopolitical conditions, there are many universal principles in providing effective programming. UNICEF should publish these guiding principles, similar to the strategies enumerated in the *Framework for the Protection, care, and Support of OVC*. A synthesis of the

literature review of previous psychosocial interventions and the findings of this study suggest three overarching “best practices”:

- A. ***Take a developmental approach to psychosocial programming:*** Given that age and gender were found to be significantly associated with levels of psychosocial distress among OVC (see Table 3), policies should tailor interventions to boys and girls of distinct age groups. For example, this study found that younger children and boys were at greater risk for behavioral and emotional difficulties. This suggests that interventions for pre-adolescents (ages 6-13) and boys should focus on breaking the cycles of internalizing and externalizing psychosocial distress. Past research also supports this developmental approach. A proposal for reforming the UN Psychosocial Indicators suggests that instead of framing targets and interventions around reducing psychosocial distress, the international guidelines could do so in terms of fostering indicators of resiliency: “competence, connection, character, confidence, and compassion” (Dawes, 2006).
- B. ***Give special attention to vulnerable OVC groups:*** Current psychosocial programming is too blunt in its approach. Although all OVC are vulnerable to psychosocial distress, they should not receive the same “counseling” or “minimum care packages” for psychosocial support. This study delineates three groups which are particularly vulnerable: maternal orphans, double orphans, and children who engage in labor outside of the home.
- C. ***Encourage multi-sectoral and community-based interventions:*** Psychosocial well-being is not solely a function of a child’s personal difficulties. This study suggest that the caregiver’s capacity to care for the orphan, their relationship, and the family’s

socioeconomic status, which often dictates whether the child works outside of the home, all significantly impact his psychosocial well-being. Thus, programming should not be limited to formal counseling sessions; rather, psychosocial measures can be integrated into existing initiatives in other sectors. Psychosocial counseling to at-risk-children can be coupled with material support for their caregivers to build the capacity of household to care for the child. By training local teachers to be school counselors and organizing OVC youth groups, the government can buttress the social support orphans receive from the relationship with a stable. Multiple intervention studies have confirmed that these types of community-based approaches are not only the most cost-effective ones (Desmond, 2001) but also the best option for developing community ownership and sustainability (Schenk, 2009).

3. Revise the UNICEF Psychological Indicator for National-Level Monitoring

A review of current international monitoring mechanisms for the psychosocial well-being of OVC reveals that they are inadequate for encouraging country-level accountability. Of the ten indicators which constitute the UNICEF *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS*, only two sub-indicators address psychosocial health. Moreover, most countries use “the percentage of orphans participating at least monthly in organized group activities which address ‘appropriate psychosocial support’” as the benchmark for assessing psychosocial programming (Dawes, 2006). This study reveals that such benchmarks are insufficient for assessing the psychosocial well-being of OVC. The findings show that despite meeting this benchmark, Kenya’s OVC have considerably higher levels of psychosocial distress than their counterparts in Tanzania, who do not have mandated counseling services (see Table 4 and Table 5). Thus, only by establishing

concrete assessment tools (such as the SDQ, PCL-S, and LEC) can UNICEF help countries determine the scope of psychosocial distress among their OVC population and determine the effectiveness of programming efforts.

Improving Country-Level Responses

Individual nations can bolster effective psychosocial programming through five steps:

1. Conduct an OVC Situation Analysis

The first step to designing effective psychosocial programming is to identify the unique risk factors facing OVC in each region and the country as a whole. Given that the study finds that sociopolitical and cultural factors have a large impact on the psychosocial health of orphans, the only way to formulate relevant policies is to assess which predictors studied in this paper are most relevant to population. Although UNAIDS, UNICEF, and USAID carry out Rapid Assessment, Analysis and Action Planning on Children Orphaned and Made Vulnerable by HIV/AIDS (known as the OVC RAAAP exercise), countries should carry out their own situation analysis annually or bi-annually (Dawes, 2006). National contexts, such as the 2009 post-election violence in Kenya, have to be monitored in relation to their impact on the psychosocial health of OVC. Moreover, with the absence of a universal definition of “vulnerability,” each country’s OVC situation analysis should come up with a working definition tailored to its cultural and sociopolitical context.

2. Develop a NPA Specific to OVC

The study shows that being an orphan is associated with higher levels of behavioral and emotional difficulties. Thus, the only effective way to promote psychosocial support for all OVC is through a NPA specific to OVC. Although many countries address the psychosocial

well-being of orphans through policies targeting all children or those affected by HIV/AIDS, this study suggests that OVC should be addressed separately due to their increased likelihood of experiencing psychosocial difficulties. A review of the policy literature also supports the establishment of NPAs for OVC. The NPA acts as “political glue” which will help coordinate programming at the village, district, and national levels. For example, Tanzania, which has implemented a NPA since 2007, has more coordinated programming than Ethiopia, which relies on a loose set of national guidelines (*Standard Service Delivery Guidelines for Orphans and Vulnerable Children Support Programs*, 2010).

Integrate Psychosocial Programming across Sectors

The findings suggest that the relationship between the caregiver and the orphan, the caregiver’s capacity to care for the orphan, and the household’s socioeconomic status, which often determines whether the child works outside of the home, all significantly impact his or her psychosocial well-being. To achieve the “breadth” in programming that addresses these predictors, countries should coordinate psychosocial support from all sectors. In particular, psychosocial measures can be integrated into the five main categories of existing OVC interventions identified through a review of the literature:

1. **Advocacy:** These interventions provide OVC with legal representation and tackle stigmas against them (Christian Aid, 2006; CRS, 2008; *The Framework: For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, 2004). Given the findings that child labor is a significant predictor of psychosocial distress, national governments should also focus on tackling exploitative child labor practices.

2. ***Strengthening families and communities:*** These interventions aim to prevent the breakdown of nuclear families (CRS, 2008; The Framework: For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, 2004). Given the findings that living with a grandparent or aunt or uncle are protective factors against psychosocial harm, these interventions can be expanded to empower extended families as a social support network.
3. ***Material and Service Support:*** These interventions provide income generating activities for families and communities, provision of food and material aid, provision of subsidies and vouchers, and enhancing access to social services and medical care (Better Care Network, 2009; CRS, 2008; Klaus Denninger, 2003). Given that the caregiver's capacity to care for the orphan plays a large role in his or her psychosocial well-being, this study suggests that governments should expand these services and couple food and material aid with psychosocial support for both the caregiver and orphan.
4. ***Emotional and Spiritual Support:*** These interventions already address psychosocial support (Christian Aid, 2006; CRS, 2008; The Framework: For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, 2004). Governments should supplement these existing programs.
5. ***Educational Support:*** These interventions include provision of school-fees, uniforms, and scholastic material, incentivizing attendance by providing meals, vocational training and life skills programs (Christian Aid, 2006; CRS, 2008; The Framework: For the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, 2004). Given that this study shows that orphans have higher levels of behavioral and emotional difficulties (see Table 3), governments should mandate

curriculum in reproductive health, emotional health, youth-empowerment to build the resilience of OVC through education.

3. Connect Existing Actors and Interventions

The significant predictors of psychosocial outcomes in OVC shown in Table 4 and Table 5 (i.e. caregiver's relationship to the orphan, cultural and sociopolitical conditions, work outside of the home, etc.) suggest that collaboration between multiple sectors and actors is needed to address the full scope of the problem. Governments should act as the “umbrella organization” for connecting these diverse partners. A literature review of psychosocial interventions identifies four main groups of implementers: governments, international NGOs, local NGOs and faith-based organizations (Christian Aid, 2006; CRS, 2008; Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa, 2006; MoSVY/NAA, 2008; Schenk, 2009). Governments are currently the least involved actors while international NGOs are overwhelmingly in charge (Schenk, 2009). Recently, faith-based organizations (FBO) have been playing a more prominent role as well. FBOs are well-equipped with volunteers and currently offer a number of services including household visits, counseling, and youth camps (Christian Aid, 2006; Faith Untapped: Why Churches Can Play a Crucial Role in Tackling HIV and AIDS in Africa, 2006). Thus, while it is crucial for countries to take ownership of psychosocial programming and to formulate their own NPAs, the findings suggest that it may be useful for them to engage existing actors in doing the work, given their resource and budgetary constraints.

4. Define Concrete Targets and Monitor Outcomes

Finally, the success of psychosocial programming is dependent on effective goal-setting and monitoring. The gravity of the psychosocial difficulties elucidated by the study suggest that

current “minimum packages” of support like bi-annual counseling sessions are too “low-dose” to be effective. Targets should instead be linked to reducing the psychosocial difficulties manifested in the study such as behavioral and emotional difficulties, bereavement, and trauma. For example, countries could pledge to reduce the incidence of PTSD among OVC or the prevalence of risky sexual behaviors among adolescent OVC due to externalization of psychosocial distress. These targets should be concrete numbers and have a fixed time frame. Although these benchmarks require rigorous monitoring, national governments can seek the help of UNICEF, UNAIDS, and USAID to conduct annual or bi-annual assessments that resemble the OVC RAAAP. This final step also enhances the collaboration between national and international efforts to promote psychosocial support.

CONCLUSION

As an entire generation of 170 million orphans approach adulthood, the consequences of their psychosocial difficulties can no longer be overlooked (State of the World's Children, 2011). Despite the rising need for psychosocial support, little research has been conducted on the predictors of psychosocial health across cultures and how to address them. Coupled with the lack of international frameworks to provide guidance for country-level programming, this information chasm has led to inconsistent and ineffective national policies for psychosocial programming.

This paper addresses the dual shortcomings in research and policy. To contribute to the literature on psychosocial predictors, the study of 1,851 children enrolled in POFO across 6 sites in sub-Saharan Africa and Southeast Asia identifies differences in psychosocial health between maternal, paternal, and double orphans, and the impact of various demographic and standard of living predictors. After finding that maternal orphans, double orphans, and children who

engaged in labor outside of the home are particularly vulnerable and that sociopolitical and cultural factors had a large impact on the psychosocial well-being of OVC, this paper has made recommendations for addressing the gaps in the international and country-level approaches to psychosocial programming. These policy recommendations stem from the synthesis of quantitative research and policy analysis, thereby bridging the gap between the two disciplines.

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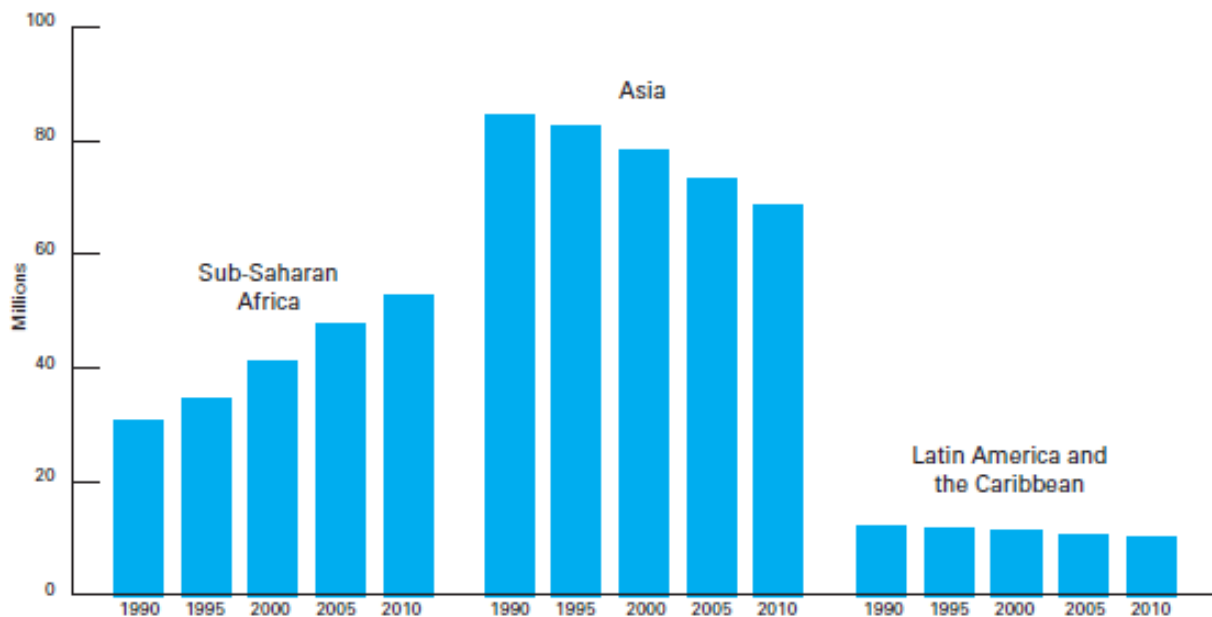
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APPENDIX A: NUMBER OF ORPHANS BY REGION FROM 1990-2010

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



Source: UNAIDS and UNICEF estimates, 2006.

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

APPENDIX B: NUMBER OF CHILDREN ORPHANED BY AIDS AND OTHER CAUSES WORLDWIDE, 2010

Region	Orphans, Children (aged 0-17) orphaned by AIDS, 2009, estimate (thousands)	Orphans, Children (aged 0-17) orphaned due to all causes, 2009, estimate (thousands)
East Asia and Pacific	540	30600
Eastern and Southern Africa	10100	26600
Latin America and Caribbean	730	9800
Middle East and North Africa	200	5700
South Asia	580	43000
Sub-Saharan Africa	15000	55100
Western and Central Africa	4700	26400
World	17100	153000

Source: UNICEF, State of the World's Children Database, 2011

APPENDIX C: OVERVIEW OF THE FRAMEWORK FOR THE PROTECTION, CARE, AND SUPPORT OF OVC

The framework delineates five principles for OVC programming:

1. The Framework emphasizes the need for programs to strengthen the capacity of families. This not only includes improving the economic capacity of households, but also prolonging the lives of parents, and providing psychosocial support for parents and children.
2. The Framework encourages the mobilization of community-based responses. In particular, it recommends that OVC programs engage local communities and local leaders in open dialogue about issues such as HIV/AIDS. Moreover, it advocates supporting community care for children and sustainable community level programs.
3. The Framework suggests that existing OVC programs such ensure access to essential services such as birth registration, schooling, health and nutrition services, and basic water and sanitation. In addition, it recommends engaging with the judicial system and placement services for children to ensure that children are fully protected from discrimination and abuse.
4. The Framework asks governments to take action to address the needs of OVC and encourages other actors to enhance the government's capacity to do so. The biggest emphasis is for governments to adopt their own national policies, strategies, and action plans for OVC.
5. The Framework seeks to create a supportive environment for OVC and for programs assisting OVC. It seeks the collaboration of multi-sectoral actors to support social mobilization actives at the community level.

APPENDIX D: OVERVIEW OF THE GUIDELINES FOR THE ALTERNATIVE CARE OF CHILDREN

The guidelines contain two major themes:

First, they heavily emphasize supporting families. In particular, an entire section is devoted to reducing the need for alternative care. The document encourages promoting parental care, preventing family separation, and in dire cases mandating separation, keeping children as close to home as possible. Given these dire cases, the guidelines state that decision-making on alternative care should take place through judicial, administrative or other adequate and recognized procedures (Guidelines for the Alternative Care of Children, 2010).

In addition, the guidelines classify alternative care into categories and enumerate standards that caregivers and formal care facilities must meet. These standards cover a range of conditions such as the quality of food, the right to privacy, and access to health care (Guidelines for the Alternative Care of Children, 2010). These currently serve as the model for many national alternative care policies.

APPENDIX E: POLICIES IN STUDY COUNTRIES

Cambodia

Development of National OVC policy

Currently, over 600,000 children below the age of 18 in Cambodia are orphans (MoSVY, 2007). In addition, 24,700 children are roaming the streets (MoSVY/NAA, 2008) and 3,800 are living with HIV (MoSVY, 2007). When widening the scope to include vulnerable children, the situation is even more acute. Due to three decades of social and economic devastation from civil war and invasion, 300,000 children live in extreme poverty (MoSVY/NAA, 2008). Moreover, a growing proportion of children are living in grandparent-headed households, engaging in child labor, and taking care of sickly parents (MoSVY, 2007).

Three national policies address the OVC crisis. The 2006 Policy on the Alternative Care for Children led by the Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) outlined the hierarchy of preferences for placement options of OVC and mandates minimum standards for each type (Jerker Edström, 2008). In addition, the 2008-2010 National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children developed a comprehensive strategy for integrating OVC responses across all sectors. Finally, the 2011-2015 National Strategic Plan for a Comprehensive Multi-sectoral Response to HIV/AIDS, led by MoSVY and the National AIDS Authority (NAA), also contains a special focus on OVC (Jerker Edström, 2008).

2006 Policy on the Alternative Care for Children

The national Policy on the Alternative Care of Children outlines eight models of non-residential and residential care:

Non-residential care

1. Foster care: OVC are temporarily placed in an unrelated family. This practice is deeply rooted in Cambodian society and generally does not involve any legal agreement.
2. Kinship care: Extended family members take in orphaned or other children.
3. Adoption: Children are legally placed with another family. The rights and responsibilities of the child's biological parents are transferred to the adoptive parents.
4. Pagoda and other-faith based care: Buddhist monks, nuns, and lay clergy provide children with food, shelter, education, and health care.
5. Children headed households: Groups of sibling orphans live under the responsibility and care of older children.
6. Group-home based care: A small number children are housed in a family environment under the supervision of a small group of caregivers unrelated to the children. Group homes are integrated into a community, but not run by it.

Residential care

1. Recovery and Child protection centers: These facilities provide basic development needs in addition to counseling, education, and vocation training.
2. Orphanages: Long-term residential centers that provide basic developmental needs for children.

The policy emphasized the benefits of family and community-based solutions. In particular, it stated that kinship is the most desirable option for OVC. In the event that family is not able to take care of the child, the policy prioritizes adoption over institutional care and non-permanent solutions such as foster care.

2008-2010 National Plan of Action

The 2008-2010 National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia contains the following 5 strategies which mirror the UNICEF 2004 framework for OVC care:

1. Strengthen family capacity
2. Mobilize community-based responses
3. Ensure access to essential services
4. Promote legal and policy protection for OVC
5. Support and coordinate response efforts

In addition, the plan outlined two main goals. First, it set out to ensure that ensure 30% of OVC households receive minimum package of care by 2008, and 50% by 2010. The minimum package includes food provision, psychosocial support, educational support, vocational training, life-skills programs, and access to healthcare and routine checkups. In addition, the plan wanted to ensure that 50% of communes had at least one organization providing care and support to households with OVC in 2008, with 100% of communes being served by 2010 (MoSVY, 2007).

National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV and AIDS

Although the 2011-2015 plan addressed the HIV/AIDS epidemic in Cambodia as a whole, it prioritized the needs of OVC. In particular, it reaffirmed the need for the provision of a comprehensive package of services, as described by the National Plan of Action to all OVC and their households. In addition, it addressed the reproductive health needs of older OVC, especially girls who maybe at increased risk for early marriage, sexual violence, trafficking and sexual exploitation. Finally, the plan encouraged collaboration between government agencies, NGOs, and CBOs to strengthen the response to OVC.

Ethiopia

Development of National OVC policy

According to the most recent estimates by the Ethiopian Ministry of Health (MOH), there are over 5.5 million orphans in the country, 855,000 of whom lost their parents to the HIV/AIDS pandemic. (*Standard Service Delivery Guidelines for Orphans and Vulnerable Children Support Programs*, 2010). Despite having one of the largest OVC populations in Africa, Ethiopia lacks a comprehensive national plan of action to address the needs of these children. Nevertheless, as a signatory of the UN Child Rights Convention and the African Charter on Rights and Welfare of Children, Ethiopia is beginning to consolidate and to prioritize the development of national OVC policies.

Prior to 2010, OVC programming was managed through the Network of Organizations working in Support of Orphans and Vulnerable Children. This loose coalition of government, non-governmental, and community-based organizations was created in 1998 to coordinate cross-sector efforts to benefit OVC (Chernet, 2001). Nevertheless, the services offered by network members were not standardized or made uniform in terms of quality and size. To address this issue, the Ministry of Women's Affairs (MoWA) and the Federal HIV/AIDS Prevention and Control Office (FHAPCO) developed the *Standard Service Delivery Guidelines for OVC Care and Support Programs* (2010). This document is thus far the most comprehensive national framework on OVC.

The *Standard Service Delivery Guidelines* document contains seven core service areas which are considered critical components of programming targeting OVC: shelter and care, economic strengthening of families, health care, psychosocial support, education, and food and nutrition. In addition, the guidelines specify “critical minimum activities” which are supposedly

“doable by all service partners irrespective of financial and human resources” (2010, p.34). For example, under psychosocial services, all providers are required to train volunteers to provide counseling, establish support groups, provide life-skills training, and follow up regularly (2010, p. 36). Finally, the document delineates the application of each core service at the child-level, community-level, and policy-level. Continuing with the psychosocial services example, the guidelines require providers to assess the psychosocial well-being of individual children, provide caregivers with guidance on how to counsel children, establish community support groups, and use the local education system to identify and counsel OVC (2010, p. 39).

Political Structure of Implementation

The application of the Standard Service Delivery Guidelines requires concerted efforts by all stakeholders at the federal, regional and local levels. In addition to establishing the framework for OVC service provision, the guidelines also provide monitoring checklists for implementing partners. The success of the framework depends on the dissemination of the document and implementation of the monitoring checklists.

At the federal level, the MoWA and the FHAPCO are in charge of resource mobilization and allocation to support programs which follow the Standard Service Delivery Guidelines. Nevertheless, other ministries such as the MOH and the Ministry of Finance (MOF) are also involved in the planning process. Most importantly, the Standard Service Delivery Guidelines document states that the federal government is responsible strengthening the legal framework and enforcement mechanisms for OVC support (2010, p. 10).

At the regional level, the Standard Service Delivery Guidelines expects institutions to build partnerships with all actors and coordinate OVC programs. In particular, regional governments are the principle actors responsible for actively monitoring and evaluating program

implementation, and for documenting and disseminating promising practices (2010, p.11). Regional actors are supposed to work closely with the federal government in ensuring that programs adhere to the guidelines.

Finally, the local level is sub-divided into *woreda*, wards, and *kebele*, neighborhoods within wards. *Woreda* governments are principally in charge of mobilizing community and resources to support OVC activities and providing capacity building programs to implementing partners (2010, p.12). They are the principal actors for organizing NGOs and CBOs. The work of *kebele* is even more focused on program implementation. *Kebele* leaders are in charge of spearheading community initiatives to identify OVC and to organize a database which includes the demographic information of these children. On a policy level, *Kebele* leaders are responsible for integrating the OVC guidelines into neighborhood policies and programs (2010, p.12).

India

Development of National OVC policy

According to 2009 UNICEF estimates, there are over 3.1 million orphans in India. Nevertheless, the policy paradigm in India is shifting from OVC support to anti-retroviral treatments (ART) for parents and children. Whereas OVC programs in the 1990s were based on the premise that parents would die from HIV/AIDS, the roll-out of ART has shifted the emphasis to treatment and the prevention of HIV transmission from mother to child and between couples (*Policy Framework for Children and AIDS in India*, 2007)

The policy environment has not been focused on OVC, but rather, the rights of children in general. India signed the International Child Rights Convention in 1992, and has since been very proactive in promoting the education, gender equity, and legal protection of children. The National Plan of Action for Children, 2005, the Education Policy and Right to Education Bill,

and HIV/AIDS bill all emphasize “the survival, development, protection, and participation of children” (*Policy Framework for Children and AIDS in India*, 2007). Although OVC are not explicitly mentioned in these policies, they benefit from the primary education, ART, and foster care systems established by these laws.

Policy Framework for Children and AIDS

Although India is currently on its third National Aids Control Programme (NACP III), the Policy Framework for Children and AIDS is the first document which specifically addresses the well-being of children made vulnerable by HIV/AIDS from a rights-based angle. The framework focuses on adolescents vulnerable to HIV infection, children who are HIV-positive, children who have lost one or both parents to AIDS, and children whose parents are infected. In particular, it delineates five goals: prevention of HIV-transmission among adolescents, prevention of parent to child transmission, universal ART for children, protection and care of children affected by HIV/AIDS, and reduction of stigma and discrimination against children affected by HIV/AIDS.

Four key ministries are in charge of leading the integrated, universal response to children and HIV/AIDS: the Ministry of Health and Family Welfare, through the National AIDS Control Organization, the Ministry of Women and Child Development, the Ministry of Human Resource Development, and the Ministry of Social Justice and Empowerment (*Policy Framework for Children and AIDS in India*, 2007). Thus far, the Ministry of Women Child Development has taken the lead in establishing the Integrated Child Development Service (ICDS) and the Integrated Child Protection Scheme (ICPS) to address the needs of children. ICDS trains community-based workers to provide a package of services which includes supplementary nutrition, non-formal pre-school education, immunization, and health education to local children.

These services are delivered through public health infrastructure such as health centers and community centers. ICPS is in the process of establishing a nationwide child protection mechanism by creating Child Protection Unites at state and district levels. These bodies will be equipped to deal with cases of discrimination or abuse arising from HIV/AIDS. In addition, these unites will monitor “out-of-family care” of children such as foster care and other living arrangements where the child is not residing with his biological parents (*Policy Framework for Children and AIDS in India, 2007*)

Kenya

Development of National OVC Policy

According to the latest estimates by UNICEF, there are 1.2 million children orphaned by AIDS in Kenya and 2.6 million orphans overall (2009). Kenya has been steadily working toward a national plan of action for OVC since the early 2000s. In 2001, Kenya committed to the UNGASS (special convention of UN general assembly on HIV/AIDS) goal of coming up with a national plan by 2003. The government conducted the Rapid Assessment, Analysis and Action Planning Process (RAAAPP) in July 2004 to establish the nature and scope of existing responses and a National Plan of Action was conceptualized in late 2005. Nevertheless, the National Plan of Action for OVC was not enacted until 2007 (*National Plan of Action for Orphans and Vulnerable Children Kenya 2007-2010, 2008*). The impetus for implementation of the plan was a 2006 study by the Kenyan Ministry of Health (MOH) which found that the deteriorating circumstances due to the impact of poverty and HIV/AIDS was leading many children to crime and abuse. In particular, the study pointed out that 30% of 12-18 year-old girls in coastal region were involved in casual sex work to support their family.

The 2007-2010 National Plan of Action for OVC emphasized seven strategic targets:

1. Strengthen the capacity of families to protect and care for OVC.
2. Mobilize and support community-based response to OVC needs.
3. Ensure OVC access to essential service such as health care, education, birth registration, psychosocial support, and legal protection.
4. Ensure that improved policy and legislation are put in place to protect the most vulnerable children.
5. Create a supportive environment for children and families affected by HIV/AIDS.
6. Strengthen and support national coordination and institutional structures.
7. Strengthen national capacity to monitor and evaluate program effectiveness and quality.

In accordance with the seven targets, the 2007-2010 National Plan of Action for OVC proposed minimum packages of care for three age groups: 0-5 years, 6-13 years, and 14-18 years. Unlike other national plans, Kenya's policy program is unique because it takes a developmental approach to meeting the needs of OVC. Each minimum package is tailored to the needs of the particular age group. For example, the infancy and early childhood (0-5 years) package emphasizes the provision of nutritional supplements while the middle childhood (6-13 years) one focuses on life-skills and psychosocial support and the adolescence package (14-18 years) focuses on vocational training and income generation.

Moreover, another unique characteristic of the Kenyan plan is the delineation of specific principles for prioritizing resource allocation. According to the 2007-2010 plan, areas with the highest HIV prevalence were given first consideration. Next, regions were sorted by poverty index. Finally, areas with high prevalence of drug abuse, urban slums, and arid and semi-arid lands were given preference.

Implementation Mechanism

According to the structure established by the 2007-2010 national plan, the primary actor responsible for overseeing and coordinating OVC activities was the Ministry of Gender, Children, and Social Development, through the Department of Child Services (DCS). Within the DCS, the national plan established a National OVC Secretariat to coordinate OVC interventions while a National Steering Committee for OVC was also created to provide leadership and guidance. Moreover, the National Council for Children Services (NCCS) was in charge of overseeing the national plan in all of the districts. Finally, many other government agencies such as the Ministry of Finance, the Ministry of Planning and National Development, the Ministry of Education, the Ministry of Health, and the National AIDS Control Council were also represented on the NCCS and the National Steering Committee on OVC (*National Plan of Action for Orphans and Vulnerable Children Kenya 2007-2010*, 2008).

At the regional and local levels, Area Advisory Councils (AAC) ensured that all OVC programs implemented the minimum package. The work of the AAC was complemented by the existence of a network of community volunteers known as volunteer children officers and home visitors. In addition, civil society organizations such as NGOs, CBOs, and faith-based organizations, private sector businesses and development partners also played a large role in working with the AAC to provide services for OVC (*National Plan of Action for Orphans and Vulnerable Children Kenya 2007-2010*, 2008).

Finally, the 2007-2010 national plan proposed a pooled funding mechanism where willing actors were encouraged to put their contributions into a common account that facilitated a joint country response to OVC problems. In particular, the plan targeted government funding sources, bilateral funding from development partners, faith-based giving, individual donors,

charitable foundations, corporate giving, and professional associations. Although the funding mechanism was successful in drawing diverse actors together, it nevertheless could not meet the funding demands of OVC programs. Thus, it is currently undergoing revisions in the 2012-2015 updated plan.

Tanzania

There are currently 3 million orphans in Tanzania, 1.3 million of whom were left parentless by HIV/AIDS (UNICEF, 2009). However, until recently, there was no structured approach to addressing the needs of OVC. In 2006, the Tanzanian government began formulating The National Costed Plan of Action for Most Vulnerable Children. The policy was implemented in 2007, and it is currently undergoing revision for 2012-2015. NCPA defines most vulnerable children (MVC) as any child who is orphaned, abandoned, or neglected due to economic circumstances or parental death (Lucia Correll, 2006). The plan includes 136 provisions, all of which center on providing MVC with food, shelter, and a primary education as well assisting the families and institutions which support them through subsidies (Lucia Correll, 2006).

The political structure of the Tanzanian government is similar to a parliamentary democracy. The president appoints a prime minister to head the cabinet, which contains 23 ministries. The country is divided into 26 regions which contain a total of 126 districts. Each district is then further divided into wards, sub-wards, and, finally, villages. Implementation of NCPA has been divided between three levels of government: village, district, and national (Lucia Correll, 2006).

At the local village level, NCPA calls for the formation of Most Vulnerable Children Committees (MVCCs). Each village MVCC is comprised of elected community members

whose sole job is to identify children who fit the “most vulnerable children” definition (Lucia Correll, 2006). MVCC members periodically follow up with these children and refer them to social services offered under the NCPA. MVCCs have not only been instrumental in the grassroots mobilization of community members to address the needs of OVC, but have also been integral to the national effort to formally identify and document OVC (Lucia Correll, 2006).

The districts are in charge of coordinating the MVCCs in the villages that they oversee. Each district is led by a District Executive Officer. The district councils not only manage OVC records, but also coordinate meetings of MVCCs and facilitate communication between districts. Most importantly, each district is responsible for financing interventions including social services for OVC, medical care, and subsidies to families. Although NCPA is a national policy, its budget is funded entirely at the district level (Lucia Correll, 2006).

At the national level, oversight of NCPA is the responsibility of the Department of Health and Social Welfare, under the Ministry of Health and Welfare Services. In addition, once a year the National Steering Committee for MVCC, which includes all ministries related to health and social services, meets to assess the progress of NCPA. Finally, the National Technical Committee comprised of policy analysts and other experts assesses the reports from MVCCs and recommends interventions for each district (Lucia Correll, 2006).

Initial results

Since its initial pilot test in 2007, NCPA has gained great momentum. During the rollout phase of the plan from 2008-2009, the Tanzanian government spent nearly 500 million TZ shillings establishing the infrastructure of MVCCs, implementing a national electronic databank, and bolstering the training of social service workers (An Update on the National Costed Plan of Action for Most Vulnerable Children, 2007-2010, 2010). As a result, the rollout phase covered

1,049 wards and 5,346 villages. In each of the villages, a MVCC was formed and committee members were trained to identify OVC and other vulnerable children. As of 2007, these committees have identified and reported 611,150 OVC and vulnerable children--- 317,798 males and 293,352 females--- to the Department of Health and Social Welfare. In addition, the social worker training programs have been successful (An Update on the National Costed Plan of Action for Most Vulnerable Children, 2007-2010, 2010). More than 25,000 community-justice facilitators have been trained to provide paralegal support for vulnerable children and their households (An Update on the National Costed Plan of Action for Most Vulnerable Children, 2007-2010, 2010)

APPENDIX F: THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)

I. How I think about myself	Usually true of me	Sometimes true	Never true of me
1. I try to be nice to other people. I care about their feelings.			
2. I am restless. I cannot stay still for long			
3. I get headaches, stomachaches, or sickness.			
4. I share with others, for example toys and food.			
5. I get very angry and lose my temper.			
6. I would rather be alone than with others my age.			
7. I do what adults tell me to do.			
8. I worry a lot.			
9. I am helpful if someone is hurt, upset, or feeling ill.			
10. I am constantly moving around, squirming, feel restless.			
11. I have one good friend or more.			
12. I fight a lot			
13. I am unhappy, depressed, tearful.			
14. Other people my age like me.			
15. I am easily distracted. I find it difficult to concentrate.			
16. I am nervous in new situations. I easily lose confidence.			
17. I am kind to younger children.			
18. I am have been accused of lying or cheating.			
19. Other children or young people pick on me or bully me.			
20. I offer to help others (adults, other children.)			
21. I think before doing things.			
22. I take things that are not mine from school, home, or elsewhere.			
23. I get along better with adults than with people my own age.			
24. I am afraid of many things. I am easily scared.			
25. I finish the work I am doing. My attention is good.			

Note: This is the self-report version of the SDQ. Caregivers of children 11 and younger were asked to fill out the SDQ adapted for caregivers.

APPENDIX G: THE “CHILD BEREAVEMENT” SURVEY

III. Things I do and think after my parent(s) died or left	Usually true of me	Sometimes true	Never true of me
47. I watch out for danger or things I am afraid of			
48. If I am reminded about losing my parent(s), I get very upset, sad, or scared.			
49. When upset, I think about (in thoughts, pictures, or sounds) what happened to my parent(s) even if I don't want to.			
50. I feel grouchy, angry, or mad			
51. I have bad dreams or dreams about what happened to my parent.			
52. I can't stop thinking about my parent.			
53. I often stay alone and do not spend time with friends.			
54. I feel alone inside.			
55. I try to avoid thinking or talking about my parent(s).			
56. I have trouble feeling happy or love.			
57. I have trouble feeling sadness or anger.			
58. I feel very jumpy, nervous, or agitated.			
59. I have trouble going to sleep at night.			
60. I have trouble staying asleep at night.			
61. I have trouble remembering about what happened to my parent.			
62. I have trouble paying attention or thinking clearly.			
63. I try to stay away from people or places that remind me about my parent.			
64. Thinking about my parent makes me have sick feelings in my body (head aches, stomach aches, fast heart beat)			
65. I am afraid that the bad thing will happen again.			
66. I miss my parent.			
67. I do not want to do things I should do because they make me think about my parent.			
68. I feel sad about my parent.			
69. I cannot stop thinking about my parent even when I want to stop.			
70. I still cannot believe my parent is really gone.			
71. I do not have good memories about my parent.			
72. I feel that my parent is still an important part of my life although they are gone			
73. I can see or hear my parent or sometimes feel her nearby even though she is not.			
74. I have good memories of my parent.			
75. I do not talk about my parent because it is too painful.			

Note: This is the self-report version of the SDQ. Caregivers of children 11 and younger were asked to fill out the SDQ adapted for caregivers.

APPENDIX H: THE LIFE EVENTS CHECKLIST (LEC)

II. Things I have seen and heard	Yes, one time	More than one time	Not happened
26. Been in a big earthquake that damaged the building I was in			
27. Been in another disaster, like a fire, tornado, flood, hurricane, tsunami, big storm			
28. Been in a bad accident, like a car accident			
29. Been in a place where war, conflict, fighting, or riots were going on			
30. Been hit, kicked, or beaten at home.			
31. Been hit, kicked, or beaten by other children.			
32. Saw a family member hit, kicked, or beaten.			
33. Saw a family member shot at or killed.			
34. Saw someone in the town shot at or killed.			
35. Someone touched my private sexual parts when I did not want them to.			
36. I was raped or sexually molested.			
37. I saw a family member raped or sexually molested.			
38. Saw a family member die a violent death or be seriously injured.			
39. Heard about a family member who died.			
40. Seen a family member die from illness.			
41. Have a brother or sister who has died.			
42. Seen a dead body in my town			
43. Had a painful or scary medical treatment when sick or hurt			
44. Seen someone hurt or killed during a war			
45. Was forced to move or run from home due to a war, conflict, fighting.			
46. Was forced to move from home because there was no one (adult) there to stay with			

Note: This is the self-report version of the SDQ. Caregivers of children 11 and younger were asked to fill out the SDQ adapted for caregivers.