Case Study on Family-Based Care. ACE Zambia, Lusaka, Zambia

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III.1. Comparative analysis-Family Base Care vs Institutional Care for Orphans and Vulnerable Children-Lusaka, Zambia

III.2. Thesis

Family-based care should be the preferred method of care for vulnerable children versus institutional care. Drawing upon the case study of ACE Zambia this paper seeks to demonstrate the merit of this position. Here, family-based care includes family of origin, extended family, or foster and adoptive family. 'Institutional care' is defined as care for children in a facility by paid staff, where children eventually leave the facility. Institutional care includes orphanages, residential care, group homes, and short term child rescue facilities. Often children in an institutional setting are grouped by age cohort. Institutional care also includes 'family style' group homes with a 'house mother/father'. The goal of this case study is not to imply that ACE's system of family-based care in Lusaka can be exactly replicated with the same degree of success in other areas. Rather, the goal is to demonstrate a working model of family-based care which can produce a replicable framework that can be modified for other regions and circumstances. This paper does not seek to condemn institutional care but rather to shed light on positive outcomes when family-based care is prioritized. Drawing on over twenty years of experience in family-based care, Alliance for Children Everywhere seeks to share our experience in Zambia and support a transition to family-based care to other OVC organizations within Southern Africa and beyond.

III.3. Introduction

The implementation of institutional care is widespread. Orphanages and other alternative forms of institutional care have grown in response to the global HIV crisis. According to UNICEF's estimates, there are currently 140 million single parent orphans and 15.1 million double orphans worldwide, with additional children becoming orphans each day. Of these, 5.4 million reside in institutional care. In recent years, increased research has supported historical studies that analyze the short-term and long-term effects of institutionalization in both children and adults. This body of research has documented the negative effects of institutional care on children, with little room for exception. In particular, when

compared to the full continuum of family-based care it becomes clear that institutionalization should not be the first response to the global orphan crisis.

The primary goal of this paper is not to spotlight the negative effects of institutional care, but rather to demonstrate the positive results of family-based care. It is also not the position of this paper that some forms of institutional care are never appropriate but rather that those cases are not commonplace. Drawing upon the current body of literature as well as a case-study from Lusaka, Zambia, the goal of this paper is to demonstrate the need to prioritize family-based care as the best response to the needs of orphans.

III.4. Overview of Existing Research:

There is a growing body of research that objectively demonstrates the differences in outcomes between family-based care and the institutionalization of children. Drawing upon mixed sources, including academic publications, this review creates an effective analysis of family-based care versus institutional care for orphaned and vulnerable children. There are three main themes that emerge from the literature:

1. A successful family-based model of care exists that in most cases bypasses the need for institutions.

2. The family-based care continuum is operationally more effective than institutional care.

3. The family-based care continuum results in better outcomes for both children and adults, with few exceptions.

For decades, the call for deinstitutionalization has become stronger as global entities have begun defining their position. Recently the United Nations general Assembly released the following statement, *"Recognizing that the vast majority of children in orphanages have living family, all children should be reunited with or*

supported to remain with their families." Where that's not possible, the Resolution says that *"…Governments should commit to provide high-quality, family and community-based alternative care for children."* (General Assembly Resolution 74/133 on the Rights of the Child.). This statement embodies the growing global movement to transition toward family based care. The United Nations recent formal stance on family-based care is only serving to expedite this movement away from institutionalization.

Institutional care is not the only answer to the global orphan crisis. Family-based care as a full continuum of services represents a viable alternative. Family-based care means that the primary objective is to find permanence for children within some form of a familial unit. This may translate as reunification to a child's original caregivers or it may take shape as an alternative family placement such as foster care and adoption. It should be taken into consideration that a high percentage of children living in orphanages have a living parent. "Depending on the region, upwards of 50-90% of children living in orphanages have at least one living parent," (Faith to Action, 2014). This statistic speaks to the need to carefully define an "orphan" and to address the barriers to reunification given that such a high percentage of children in facilities have a living parent and an even higher percentage have a living relative that could represent a viable care giver.

In most cases, family-based care produces better long-term outcomes in both children and adults versus institutional care. The health and development of children is core to this issue. "In seminal studies, children raised in biological, foster, and adoptive families demonstrate better physical, intellectual, and developmental outcomes as compared to children living in institutional care," (Faith to Action, 2014). These findings are only reinforced by other similar studies in recent years. It is also important to note that these results are not limited to a specific time or geographical location. They are also not limited to biological reunification but also are applicable to alternative forms of family-based care as well. "A meta-analysis of 75 studies (more than 3,800 children in 19 countries) found that children reared in

orphanages had, on average, an IQ 20 points lower than their peers in foster care" (Williamson, Greenburg 2010). The 'Behavioral' approaches which are largely guided by social learning theory will help understand what goes on in the development of children in institutions. Social learning theory postulates that a greater part of social behavior is learnt and has a consequence, children's behavior is shaped by the type of interactions and context in which they live. From the foregoing it should be clear that children brought up in an institution would not be the same as those brought up in a natural family setup. Children in an institution get exposed to a lot of different behaviors from different actors including fellow friends, caregivers, management of the institution, visitors. Clearly, children in an institution would be exposed to a lot of different behaviors in any given day and as such it must be very difficult for the children to have an attachment and to pick up on which behaviors to learn and which ones not to. Further, any change in caregivers would disrupt the children's role model and source and type of discipline which they may have gotten accustomed to over time.

It is important to note that not all relevant research supports the notion that family-based care *universally* produces better results in children and adults than some institutional care settings such as group homes. One study from 2014 produced results that challenge this notion. "These findings contradict the hypothesis that group home placement universally adversely affects child wellbeing. Without substantial improvements in and support for family settings, the removal of institutions [group homes], broadly defined, would not significantly improve child wellbeing and could worsen outcomes of children who are moved from a setting where they are doing relatively well to a more deprived setting," (Whetten, et al. 2014). This particular study reported on results from five countries tracing outcomes from thousands of children.

These findings add nuance to the position of this paper. Decisions regarding a child's care should be based on their unique circumstance and their individual best interest. ACE does not hold the position that some forms of residential care, such as group homes, are never contextually appropriate. The 'best' group home for children may lead to better outcomes than the 'worst' family living situation. However, we believe that as a policy, family-based care should be the preferred method of care and the default response, because it is far more likely to lead to positive cognitive, emotional, behavioral, and socially successful outcomes for children. The referenced study itself makes a similar stance, "These studies and ours should not be interpreted to mean that institutions are the preferred living environment for children, but rather that a family-based setting is not guaranteed to be a better place to live," (Whetten, et al. 2014). Critics of the study point out that this only pertains to conditions at the moment of care, and does not account for post-care impacts on the child, where cognitive. Emotional, and behavioral issues are more likely to surface. It is also worth noting that of the core responsibilities of family-based care is to ensure that a family placement is a healthy environment and in the best interests of the child.

There are other considerations beyond development outcomes that must also be taken into account when comparing these two frameworks of care. The possibilities of abuse and neglect should also be on the forefront of our minds. "Children who live in orphanages were also found to be at increased risk of violence, abuse and neglect. A study conducted in five countries showed that 50.3% of children in orphanages had experienced physical or sexual abuse. Another study found that 36% of children were emotionally abused and 57% emotionally neglected," (Rethink Orphanages, 2019). These statistics are startlingly high and indicate that living in an institutional setting exposes children to potential abuse at a high degree. Evidence shows that institutions are not a safe location for children. Institutions are high-risk environments for vulnerable children.

These elements of abuse directly result in long term negative outcomes. In particular, children that "age-out" of institutions typically have few options and are grappling with trauma from their years of institutionalization. "Impacts of growing up in orphanages can continue to affect young people well into adulthood. They are more likely to experience mental health problems, struggle to form healthy relationships and adapt to the demands of independent living.· A study which looked at outcomes for care leavers from Russian orphanages found that 20% had criminal records, 14% were in prostitution

and 10%had committed suicide . Another study found that young people who left orphanages in Moldova were 10 times more likely to be trafficked," (Rethink Orphanages, 2019). Compared to general population averages, these are not only statistically significant differences but exponentially higher.

The literature review is not meant to be skewed in favor of family-based care in a biased manner, it simply represents the latest data which consistently points to the need to prioritize families over institutions. This literature refers to the growing movement for transition away from orphanages to family. ACE seeks to act on the forefront of this movement not only as an implementer, but as a capacity builder as well. The central gap that presents itself in the review is not the need for transition but rather the methodology to effectively implement family-based care. ACE's goal is to fill this gap by fulfilling the role of consultant to transitioning organizations in Southern Africa within the scope of our capacity.

III.5. Case Study theoretical framework

The following case study draws upon the experiences and outcomes of Alliance for Children Everywhere work on the ground in Lusaka, Zambia and the surrounding region. This case study uses both qualitative and quantitative methodology to demonstrate the successful implementation of family-based care within Lusaka over the last twenty years. ACE institutional care exceeds the minimum standards of care as prescribed by the government of Zambia. It should be noted that there are challenges to the implementation of family-based care that will be presented. Also, within the framework of family-based care there is the need for risk assessments and due diligence to ensure the welfare of children within the system. In fact, only through comprehensive systems and operations can family-based care be successfully implemented through its full spectrum of services.

The catchment area for this study is Lusaka. Lusaka is an urban community that hosts over 10% of the Zambian population. The city has an estimated population of approximately 1.7 million people made up of mostly young people below the age of 35 (over 66 percent of the population). Unemployment and consequently poverty rates are high. As such most people, especially women are in informal employment and child labour is rampant.

Due to the aftershocks of the HIV and Aids epidemic the number of orphans and vulnerable children in the country is high and the city has the highest number of childcare institutions in the country. Lusaka is the center for both commerce and government in Zambia and connects to the country's four main highways heading to north south east and west. This is where many institutions headquarters are located, and it is full of economic activities.

There are of course limitations to this case study, the most notable being that it is specific to a time and region. The goal of this case study is not to imply that ACE's system in Lusaka can be exactly replicated with the same degree of success in other areas. Rather, the goal is to demonstrate a working model of family-based care which can produce a replicable framework that can be modified for other regions and circumstances. The preceding literature review spoke to the need for family-based care on a global level, and the following case study will give a tangible example of how that form of care can be implemented.

III.6. Case Study: Lusaka, Zambia (ACE Zambia)

ACE has successfully transitioned to a family based model of care in our Zambia operations, with the goal of finding permanent families for each child that is in our care, as well as for children in orphanages within our network. However, our emergency nurseries still have children who are referred for immediate care from government organizations, such as hospitals or police stations. Some of these children are not able to be released, as they are not a match for foster or adoptive parents, or more commonly, family members will not take the child back nor permit them to be released for adoption.

As a result of these circumstances, ACE Zambia has a natural experiment in outcomes for children who are placed in a permanent family (either through family reunification, foster care, or adoption) and those

children who are retained in our institutional care facility.

These two pathways for children allow us to conduct a case study comparing the effects of institutional care with family based care for children whom we have received. One potential bias in the data is that children selected for foster care or adoption by non-biological parents may be those children that are already more emotionally and cognitively developed. However, that does not account for the higher benchmark scores for children who enter our institutional care at a later age vs. those who enter institutional care at birth.

1. Program Summary: ACE Zambia

   ACE Zambia primarily mitigates and intervenes in the pressing needs of orphans and vulnerable children. Under its continuum of care, ACE Zambia has two pillars. Embrace Zambia Project, Child Rescue and Care, Reintegration and Foster to Adopt are under the response pillar; and Family Preservation & Empowerment Programs and Educations falls under the prevention pillar. The organization runs two crisis homes under the first pillar which are literally the difference between life and death for fragile children, such as those abandoned at birth or those who are rejected by their families. The House of Moses (HOM), houses children from zero to two years and Bill and Bette Crisis Nurseries (BBCN), houses children between two and 6 years old. In collaboration with the Department of Social Welfare (DSW) under the Ministry of Community Development and Social Services (MCDSS), ACE Zambia helps reintegrate children with their families or seek foster or adoptive homes in cases where no biological family or any other relative is traced.

   Christian Alliance for Children in Zambia also tries to address the root cause of child abandonment by supplying vital milk and food supplements so that children are fed and remain with their family through the Family Preservation & Empowerment Program. This is done because participant interviews reveal that parents severe poverty and diseases such as HIV cause infants to be abandoned in desperate acts with the hope that someone will feed them. The organization also partners with neighborhood churches in the Faith Works schools to offer primary education for grades 1-7 and operate the Helen DeVos Christian Secondary School in Kanyama compound providing orphans and vulnerable children with a high quality secondary education in grades 8- 12 through School Feeding programs. - Summary by Ackim Chimbalanga, M&E Officer ACE Zambia

2. Monitoring & Evaluation Records: ACE Zambia Program

   Numbers TABLE 1: Direct OVC Programming

Program	2017	2018	2019
Nutrition Children	407	356	365
House of Moses	28	18	18
Bill and Bette	15	9	25

Program	2017	2018	2019
Foster/Adoption	18	9	16
Reunification	15	14	14

TABLE 2: Indirect Programs

Program	2017	2018	2019
FPEP Families	330	297	297
FPEP Life Skills	53	84	84
FPEP S&L	8	8	8
FaithWorks	1996	1046	1904
Helen DeVos	350	350	332
College	23	9	11

TABLE 3: 2019 cost of care per beneficiary by program, including CACZ Admin (17%). For comparison, average annual per capita income in Zambia is $1,505 USD.

Program	Direct Beneficiary #	Cost per program	Annual Cost per beneficiary	Years	Annual cost over lifetime years
Nutrition / Prevention	264	$117,260	$444	2	$444

Program	Direct Beneficiary #	Cost per program	Annual Cost per beneficiary	Years	Annual cost over lifetime years
Reunification	14	$57,759	$4,125	13	$317
Foster Parents and Adoption	16	$66,000	$4,125	13	$317

TABLE 4: 2019 cost of care per beneficiary by location, including CACZ Admin (17%). For comparison, average annual per capita income in Zambia is $1,505 USD.

Location	# Children	Annual cost	Cost per child	Years in care	Lifetime cost per beneficiary
House of Moses	19	$182,574	$9,609	2	$19,218
B&B Home	28	$97,572	$3,484	3	$10,452
FaithWorks Primary	1904	$46,116	$24	7	$168
HDCS Secondary	332	$207,280	$624	5	$3,120

3. M&E program beneficiary costs and discussion

   Here we look at direct vs. indirect programming, and compare the cumulative cost or 'lifetime' cost of a specific program; or the cost of the program spread out over the years of impact (0-18 for a child). As a baseline of comparison to ground truth to relative cost, we can look at per/capita income for Zambia, $1,503

4. General notes

   Direct beneficiaries are when program recipients are OVC. Indirect beneficiaries indicates that the person receiving benefits is not an OVC, or that the benefits do not impact their OVC status.

5. General comments on cost

On an annualized per/beneficiary cost, family based care costs about 40% of a single year at House of Moses. A placement costs about 120% of a single year of care at Bill and Bette. However, this results in 13 additional years of family care at zero cost, so the annualized cost of care for the child drops to $317. Even if only compared to 5 years of institutional care from CACZ, the cost becomes $825 annually, or $4125 for five years of FTA care vs. $29,670 for five years of CACZ care at Bill and Bette or House of Moses. By this comparison, A placement in year 1 of a new infant will save ACE $25,545

The cost of care at House of Moses, where infants predominate, is higher due to the higher ration of care giving staff needed for children under two years of age.

A savings of $25,545 would support 28 children for two full years of nutrition services and prevention of child abandonment. So for every child we can reunify with a family member we can support 28 children in our prevention program (assuming costs are realized operationally).

Reunifying a majority of children in our emergency nursery and temporary home could save significant funding over the next five years, funds that can be spent on prevention and transforming systems of care.

6. Methodology, M&E Data on quality of care and child wellness outcomes

The data set we are using are a selection of Childhood Assessments conducted for children within institutional care and those that were placed within families. This is a preliminary study of child wellness impacts. We chose our most complete child records for developmental milestones, some previous children were placed prior to adoption of our current child welfare monitoring tools. We hope to expand the study to include more children in the future/

There is additional data that has not yet been reviewed for this document due to time and resources constraints. This includes nutritional data, height/weight data, additional quantitative information in medical records, and a breakdown of staff to child ratios.

However, the preliminary records show both quantitative and qualitative developmental gaps in institutional care, as well as notable improvements within a family setting.

Some data could not be used, either because it was incomplete, was incorrectly assessed, or had anomalies that made it not applicable to the study.

The M&E data on quality of care indicate that institutional care leads to significant missed milestones in social, emotional, linguistic, and motor skills; and that improvement in these milestones of human development occur once a child is placed in an appropriate home.

It is recommended to further this study by pulling a larger set of Child Assessments and health records from the pool of cases present in CACZ historical records. It is recommended to collect additional developmental milestones data from a larger pool of children in family based care at the 12 month and 24 month post-care intervals.

7. Quality of care data

TABLE 5: Those raised in an institution starting near birth and for longer than 18 months: % attainment toward standard developmental milestones

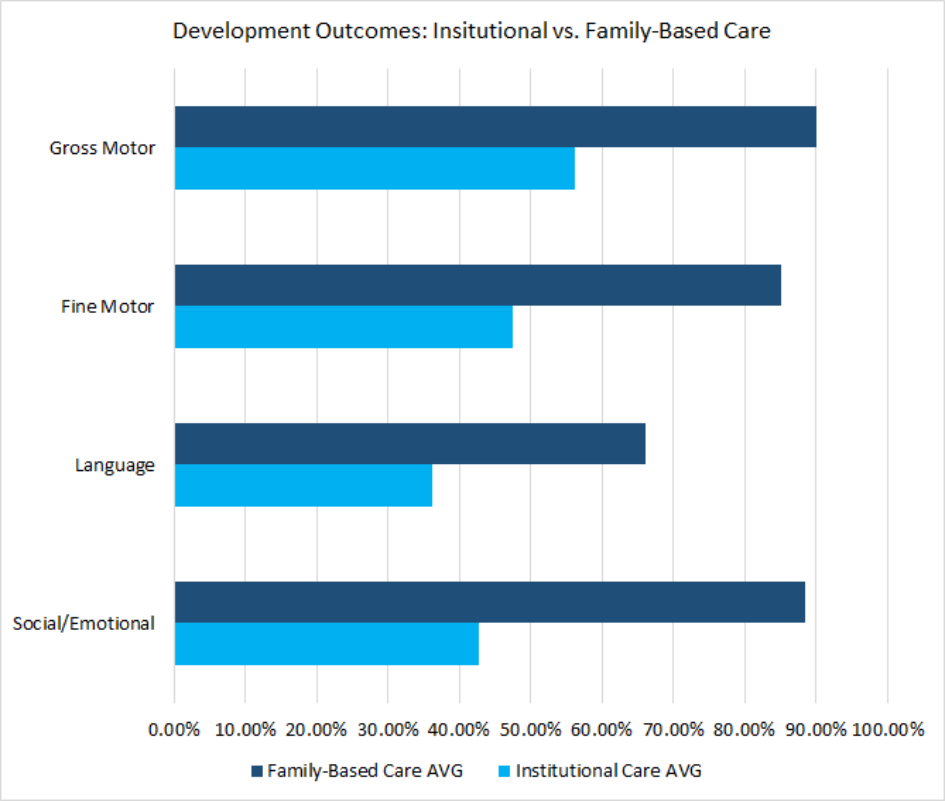
Name	Social/Emotional	Language	Fine motor	Gross Motor

Baby B___	53%	50%	61%	57%
Baby C____	28%	9%	38%	50%
Baby E____	55%	77%	50%	60%
Baby J_____	35%	9%	41%	58%
AVG	42.75%	36.25%	47.5%	56.25%

TABLE 6: Those who were raised outside of an institution until at least age 30 months, and then experienced institutional care for at least 18 months: % attainment toward standard developmental milestones.

Name	Social/Emotional	Language	Fine Motor	Gross Motor
Baby F___	77%	66%	90%	80%
Baby L___	100%	66%	80%	100%
AVG	88.5%	66%	85%	90%

FIGURE 2: Development Outcomes: Institutional vs. Family-Based Care



8. Comments

   Children in institutional care were not able to reach 50% on three out of 4 developmental milestones. In contrast, children raised for their first 18 months outside of an institution were able to realize 85% or above on 3 of four milestones, and above 65% on all milestones.

   In addition, no child within the institutional setting was able to reach a median weight-for-age based on a monthly cumulative weight according to WHO standards. Also, several children were observed to have declining weights, a sign of lack of proper nutrition within the institutional setting.

   In addition, while two placements of children into foster care had to be reversed due to poor family settings, in the institutional environment two children died. In the month of December 2019 over 50% of children needed aggressive medical interventions in the form of prescription medicine, and 25% of children needed to be hospitalized. This contrasts with a pattern of reduced hospital and medical visits after children are placed in family based care.

   We recommend conducting further analysis from a larger pool of institutional child records, including health and medical records. We also recommend follow up child visits at 1 year with a survey identical to those carried out in the institutional setting so that we can compare the exact metrics of social, emotional, cognitive, linguistic, and fine and gross motor skills milestone attainment.

9. Examples of care differential between institutional care and family-based care

   The following specific examples highlight some of the contrasts in institutional and family based care.

   a. Baby x

      Baby x was brought to the institution at just a few weeks old. After 4 months in the

institution the following objective data were collected: Baby x missed 5/13 fine motor skill development milestones, missed 5/10 language communication milestones, and missed 6/11 social, emotional, and cognitive milestones.

After adoption into a family setting following 6 months of institutional care, the following objective and qualitative information was gathered after 3 months of family based care:

"Furthermore, Baby x communication skills have improved. He engages well in interaction and is able to understand facial expressions. He is able to combine syllables, he Jabbers and babbles. He has started saying "Mama" and "Tata" and is able to respond to simple instructions such as come and he is able to crawl towards the person. His behavior is clearly stimulated by Mr. and Mrs. X.

"Since placement, Baby x has developed positively with his gross motor skills and fine motor skills. He is able to sit unsupported, stand with support for a little while and he is able to crawl. He is also able to walk for a very short distance while holding onto the hand of a caregiver. With regards to the fine motor skills, he is able to pass a cube to the other hand and bang two objects held in the hands. Brian is now apprehensive about strangers and tends to cling to familiar adults. He is very cooperative with dressing and demonstrates affection."

b. Baby y

"Baby y's' gross and fine motor skills are excellent. She is an active little girl, able to run around, and keep up well. Chipego has improved in her communication since the last visit and she is able to say words like ''hi, fine, no''. English is the main language primarily spoken in the home. She is able to understand instructions given to her in English as she was seen responding using both verbal and Non-verbal language and actions."

"Baby y has not had any serious illnesses since being placed in the home. She has been taken to the clinic for her under five and she is growing as a normal child."

10. Testimonials of staff and recipients
    a. "With decades of research, it is well known that separation from families is traumatic for children, and can lead to serious long-term psychological and physical damage. Family-based care provides the best outcomes for children, and so I wish to see a Zambia where all children thrive in families, be it biological or alternative." - Simon Kanyembo, Director of Social Services, CACZ
    b. "My work is mainly based around rescue, rehabilitation, and reintegration of children in our care. We rescue orphaned and abandoned children by admitting them to one of our crisis nurseries while ensuring their needs are met. We rehabilitate children who experience traumas such as family separation. And whenever it is safe and possible, we reintegrate children with their families." - Jackie Namagembe, Child Development Specialist, CACZ
    c. On his adoption of his two daughters: "We have bonded and we are bound by the cords of God's love which cannot be broken." - Bishop Mwiinga, adoptive parent

11. Significance and conclusion

The initial examination of child level data on attainment of developmental milestones within an institutional setting indicates that there is not satisfactory progress towards social, emotional, cognitive, language, or fine motor skill development. This comes despite appropriate availability of nutrition, a more-than-adequate child-to-adult ratio, trained and qualified personnel,

dedicated nurse and dedicated teachers, qualified and engaged social work professionals, and significant financial resources invested in the institutional care facility.

In addition, a financial analysis indicates that family placement, when examined on a cost-per-year-of-care, is significantly less expensive. In addition, preventive services are even less expensive, at over 28 times less expensive if the 'lifetime care' costs of the child are calculated (two years of prevention vs 5 years of facility based care).

Our conclusion is that even with significant investment of resources and personnel, institutional care cannot provide the positive benefits of family based care. We recommend that a policy of rapid family based care, emergency foster care, and a goal of deinstitutionalization be formally adopted at a governance and executive level, and annual work plans be built to achieve this goal.

An important point to consider is additional support for families of institutionalized children who are unwilling to release children to foster care and also unwilling to receive them back into the home. Over 90% of CACZ institutionalized children fall into this category. Our belief is that the material support and nutrition support provided in institutional care, plus the fear of taking on a child as an economic burden, lead these families to believe that institutional care is a better outcome for their child. We recommend a targeted program of education for families to understand the negative outcomes from institutional care. Wrap around programming and links to other CSO and government agencies for nutrition, livlihoods,micro-savings and micro-finance, can also address issues of family resilience. In some rare circumstances consideration of temporary direct family support for 6-18 months may be appropriate.

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Photography of reunified families through direct programming