



## PROGRAM RATIONALE AND RESEARCH SUMMARY

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### 1.1 BACKGROUND

While exact statistics are unavailable, there are between 70 and 120 orphanages and baby homes operating in Tanzania at the current time, with most of them focusing on children under 5 years old. These are split between locally run institutions, which are generally poorer but more integrated into the community, church owned orphanages which are marginally better funded but often still rely significantly on donations from religious tourists, and institutions run by or in partnership with international NGOs, like Nkoaranga Orphanage, which are often the best funded but run the risk of failing to prepare children for life in a community setting. For older children, there are three primary options being used by most organizations working with orphaned and vulnerable children, specifically (from most to least common), boarding schools, unsupported reintegration with any living relatives, and family-style group homes similar to Happy Family Children's Village.

### 1.2 ATTACHMENT RESEARCH

The central tenets on which we base our care philosophy revolve around the importance of family for development. Family here is being used as a broad concept, since the traditional nuclear family is generally not a viable option for the population under discussion due to HIV/AIDS, high adult mortality and short life expectancies, and severe poverty. By some estimates, less than half of youth in Tanzania live with both parents and most of those live with other adults in the household as well.<sup>1</sup> Attachment theory, originally developed in the 1950s, looks at the emotional bonds between humans, especially between young children and their caregivers, and examines how these early relationships affect later life. Lack of secure early attachment in the first two to three years of life was hypothesized to be a cause of life-long cognitive, social, and emotional difficulties, sometimes peaking in "affectionless psychopathy".<sup>2</sup> This Maternal Deprivation theory has serious implications for all of childrearing, but even more so for the care of orphaned and vulnerable children, who have by definition had disruption of the traditional maternal attachment, either due to absence of the mother, or her inability to adequately meet the child's needs.

Michael Rutter (1972) later developed a version of attachment theory which deemphasizes the importance of one single and continuous maternal attachment, lack of which would be considered deprivation, and emphasizes instead the importance of developing any attachment during the early years,

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<sup>1</sup> UNICEF Tanzania Country Report, 2012

<sup>2</sup> Bowlby, J. (1951). *Maternal Care and Mental Health*. World Health Organization Monograph.

lack of which would be considered privation, and was shown to have much more extensive negative effects and be much more difficult to combat later in life.<sup>3</sup> In other words, according to Rutter early loss of a primary attachment, as in orphaning, is difficult but not insurmountable, as long as other attachments are developed during the child's early life. Van Ijzendoorn & Tavecchio (1987) developed this theory further, and demonstrated that in some cases a stable network of caregivers can be equally or even more effective for psychological health than a single attachment.<sup>4</sup> Lack of attachment has also been shown to create physical stunting or even death, as in the hospitalism epidemics of the early 20th century.<sup>5</sup>

There have also been studies showing the effect that insecure attachment can have on OVCs in the developing world. In Zimbabwe, one study showed that orphans suffered serious psychological distress as opposed to non orphans, even when other stressors like poverty were controlled for. "Orphanhood remained associated with psychosocial distress after we controlled for differences in more-proximate determinants... [O]rphans were significantly more likely than were nonorphaned, nonvulnerable children to have engaged in sexual activity. These differences were reduced after we controlled for psychosocial distress."<sup>6</sup> In other words, that psychosocial distress is a significant driver of risky sexual activity in orphaned children. In Rwanda, a similar study showed that not only was trauma and disrupted attachment related to sexually risky behaviors, but that addressing the trauma led to significant improvements in comparison to a control group. "Increased trauma symptoms at baseline were associated with poorer coping skills and social functioning, and increased psychological distress and HIV risk-taking behavior... In this at-risk population, addressing mental health issues in the context of HIV prevention is critical."<sup>7 8</sup> In another meta-review of similar studies in South Africa, the authors found that there was a "clear impact of psychosocial effects of HIV on biomedical and developmental outcomes. Reducing sexual risk needs social protection and psychosocial support, not only behavioral interventions."<sup>9</sup>

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<sup>3</sup> Rutter, M. (1979). Maternal deprivation, 1972-1978: New findings, new concepts, new approaches. *Child development*, 283-305.

<sup>4</sup> Tavecchio, L. W., & Van Ijzendoorn, M. H. (Eds.). (1987). *Attachment in social networks: Contributions to the Bowlby-Ainsworth attachment theory*. Elsevier.

<sup>5</sup> Sullivan, Regina M., and Parker J. Holman. "Transitions in sensitive period attachment learning in infancy: the role of corticosterone." *Neuroscience & Biobehavioral Reviews* 34, no. 6 (2010): 835-844.

<sup>6</sup> Nyamukapa, Constance A., Simon Gregson, Ben Lopman, Suzue Saito, Helen J. Watts, Roeland Monasch, and Matthew CH Jukes. "HIV-associated orphanhood and children's psychosocial distress: theoretical framework tested with data from Zimbabwe." *American Journal of Public Health* 98, no. 1 (2008): 133.

<sup>7</sup> Talbot, Annie, Chaste Uwihoreye, Charles Kamen, Philip Grant, Lawrence McGlynn, Isaac Mugabe, Martin Nshimyumukiza et al. "Treating Psychological Trauma Among Rwandan Orphans Is Associated With a Reduction in HIV Risk-Taking Behaviors: A Pilot Study." *AIDS Education and Prevention* 25, no. 6 (2013): 468-479.

<sup>8</sup> Blizzard, Robert M., and AnaMaria Bulatovic. "12 Psychosocial short stature: a syndrome with many variables." *Baillière's clinical endocrinology and metabolism* 6, no. 3 (1992): 687-712.

<sup>9</sup> Cluver, Lucie, and Frances Gardner. "The mental health of children orphaned by AIDS: a review of international and southern African research." *Journal of child and adolescent Mental Health* 19, no. 1 (2007): 1-17.

### 1.3 FAMILY-SUPPORTED CARE RESEARCH

Historically, orphaned children in Tanzania were cared for by members of their extended family or community of origin.<sup>10</sup> In Tanzania, maternal aunts are traditionally not considered aunts, they are known as the *mama mkubwa* (big mother, for older sisters) or *mama mdogo* (small mother, for younger sisters), as opposed to *shangazi* (aunt in the Western sense) for paternal aunts. Similarly, paternal uncles are known as big and small fathers, not as uncles – uncle and aunt, as a role and a term, are reserved for paternal aunts and maternal uncles. The terms reflect the role that these relatives were expected to play – should something happen to either of the parents, big and small parents traditionally had the first responsibility for the children. This lent some level of predictability to the entire extended family, both in that one generally could count on their children being cared for if the worst happened, and that one could be fairly confident about needing to account for some of one’s siblings’ children, and not others.

However, due to the drastic demographic shifts caused by HIV and AIDS, in addition to the falling-but-still-high maternal mortality rates, the number of orphans has become so great that aunts and uncles no longer comprise even a simple majority of the carers, underscoring that truly traditional patterns of care are no longer an option in the post-AIDS world.<sup>11</sup> Instead, we are seeing increases in child headed households, elderly grandparents taking in young children, and children left in institutional care.

Surviving parents of single orphans are often similarly unable to provide significant support, even when they are not struggling with their own health. Widows generally lack the skills to work outside the home, and in a country almost completely without day care options outside the family, are often reduced to depending on living with relatives or employers. Fathers are generally faced with the choice to either work or to care for their child – leaving them either deeply impoverished and unable to provide for material needs, or forced to relinquish custody of the child to an orphanage. “Studies suggest that material support being provided

by relatives to orphan households is limited; in Tanzania, less than a quarter of orphans received support from the one parent who was still surviving and under 10% received support from other relatives or elsewhere.”<sup>12</sup> This is not simply a reflection of changing

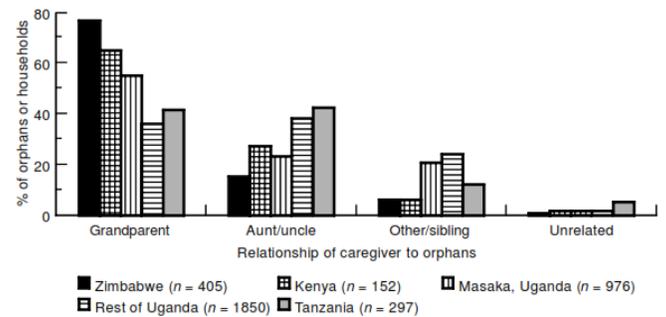


FIG. 2. Relationship of caregiver to orphans (data from Foster *et al.*, 1996; Hunter *et al.*, 1997; Ntozi, 1997b; Saoko *et al.*, 1996).

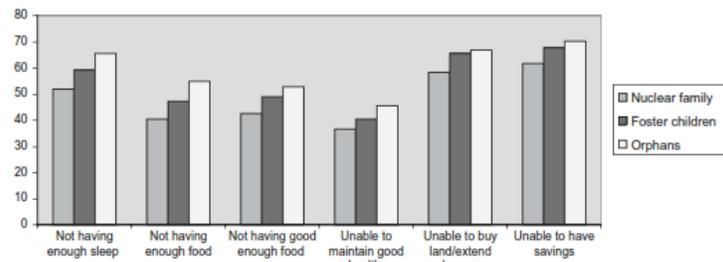


Figure 2. Problems caused by children in household, by type of household.

<sup>10</sup> Ksoll, C. (2007). Family Networks and orphan caretaking in Tanzania.

<sup>11</sup> Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. *Psychology, Health & Medicine*, 5(1), 55-62.

<sup>12</sup> Foster (2000)

attitudes, as families caring for orphaned as well as biological children face significantly more difficulties, shown in Figure 2.<sup>13</sup> Another study showed over 40% of households with orphans in Tanzania unable to meet even their basic needs, with the breakdown of which needs they struggled with shown in Figure 4.<sup>14</sup> Clearly this traditional model of the extended family has been strained beyond its capacity to handle the unprecedented scale of the crisis.

Successful family preservation models have included access to microfinance, parenting classes, formula and food support, direct cash transfers, day care, and business creation<sup>15</sup>, in order to ensure that willing family members are able to care for orphaned relatives without endangering their own biological children. For NGOs, these efforts make sense from a purely practical perspective, as the UN has estimated it is, on average, six times more expensive to house a child residentially than to provide family preservation services. TST's own efforts bear this out, with residential care approximately 4x the cost of family preservation care. The discrepancy between this and the average is likely due to the quality of residential care we provide (including high caretaker ratios, excellent education, and regular enrichment), in comparison to many of the organizations surveyed by the UN.

## 1.4 FAMILY PRESERVATION PROGRAM

While poverty should never be a barrier to a loving home, sadly in Tanzania, it is currently much easier to give up a child to an orphanage than it is to get help to keep them at home. Barring circumstances of abuse or neglect, TST offers family preservation services prior to and after accepting children for at Nkoaranga Orphanage or Happy Family Children's Village. Whenever a child is referred to our care, our first priority is determining whether there is any way to keep the child living at home. If it is determined that residential care is the best option, we develop a reunification plan with the family. Through basic business classes, hands-on skills training, and small start-up grants, TST's Family Preservation Program helps impoverished families to develop a steady source of income, empowering them to give their children the care they deserve and keep them out of residential care. Our clients have created successful businesses based on clothing and shoe resale, crafts, cooking, chickens, goats, and many other agricultural projects. In our community center, we offer preschool, adult education classes, and a lending library to the community. We are tackling the problems that these communities face from all angles, in respectful partnership. Our holistic model is also responsive to the social needs of the children we work with, encouraging connection to living family members to the greatest degree possible, even if they will not be able to return to live with them, and keeping all children deeply engaged in their own communities, so that they will be prepared to create their own healthy, happy families when they grow up.

## 1.5 INSTITUTIONAL CARE RESEARCH

Traditional orphanages and baby homes have many well documented risks for healthy child development. The serious issues that are engendered by institutional deprivation first generated

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<sup>13</sup> Baaroy and Webb (2008)

<sup>14</sup> UNICEF, U. (2003). Africa's orphaned generations.

<sup>15</sup> Wolff, Peter H., and Gebremeskel Fesseha. "The orphans of Eritrea: what are the choices?." *American Journal of Orthopsychiatry* 75, no. 4 (2005): 475-484.

significant interest upon the dissolution of the Ceausescu regime, which had outlawed contraception leading to the filling of thousands of orphanages. Children coming out of these institutions had experienced a disruption or total lack of primary attachment depending on when they entered the institution, frequent turnover of caregivers, and little or no access to their communities of origin. Up to 90% were underweight, and they appeared to fall behind approximately one month, in terms of physical and mental development, for each five months spent in institutional care.<sup>16</sup> In one study in Russia, “when asked on a questionnaire why there was generally a lack of interaction with the children, 57% of a sample of 63 caregivers in a single Baby Home said that the law on Baby Homes dictated that their main work was medical care and education, and 37% said they were unwilling to form attachment relationships with the children.”<sup>17</sup> This type of attitude is common in institutions, especially those based on the Eastern European model.

Research has shown that orphaned children in traditional institutional care in modern Africa are likely to finish fewer years of school and deal with psychosocial difficulties as adults<sup>18</sup>. Institutionalized children also face the risk of aging out of care without having learned to live in a community, leading to serious social difficulties later in life. One meta-analysis showed that institutional care is systematically associated with lower IQs<sup>19</sup> (although it is possible to modify institutions to prevent these effects, as discussed later in the paper). These effects all seem to be compounded the earlier children enter institutional care. As Varnis notes in his work on adoption, it is crucial that “care for orphans should be oriented toward providing what orphans have lost: parents.”<sup>20</sup> All available studies seem to point to the same conclusion, namely that “the consequence of increasing numbers of orphans and weakening of the extended family safety net is that increasing numbers of orphans are now living in especially difficult circumstances leading to physical, social, economic and psychological morbidity and increased vulnerability to HIV infection.”<sup>21</sup> These effects are shown to be strongly persistent into adulthood<sup>22</sup> and lead to the inevitable conclusion that traditional orphanage care models simply don’t work.

Some organizations working in Tanzania and elsewhere have adopted a boarding school model for children as young as 4, with the goal of combining education and care. However, attending boarding school from a young age has been shown to be seriously detrimental to attachment and development, even for children with families. “Children sent away to school at an early age suffer the sudden and often

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<sup>16</sup> Albers, Lisa H., Dana E. Johnson, Margaret K. Hostetter, Sandra Iverson, and Laurie C. Miller. "Health of children adopted from the former Soviet Union and Eastern Europe: comparison with preadoptive medical records." *Jama* 278, no. 11 (1997): 922-924.

<sup>17</sup> Groark, C. J., R. B. McCall, R. Muhamedrinov, N. Nikofova, and O. Palmov. "Characteristics of children, caregivers, and orphanages for young children in St. Petersburg, Russian Federation." *Journal of Applied Developmental Psychology* 26, no. 5 (2005): 477-506.

<sup>18</sup> UNICEF Tanzania Country Report, 2012

<sup>19</sup> Whetten, Kathryn, Jan Ostermann, Rachel A. Whetten, Brian W. Pence, Karen O'Donnell, Lynne C. Messer, Nathan M. Thielman, and Positive Outcomes for Orphans (POFO) Research Team. "A comparison of the wellbeing of orphans and abandoned children ages 6–12 in institutional and community-based care settings in 5 less wealthy nations." *PLoS One* 4, no. 12 (2009): e8169.

<sup>20</sup> Varnis (2001)

<sup>21</sup> Varnis (2001)

<sup>22</sup> Beegle, K., De Weerd, J., & Dercon, S. (2010). Orphanhood and human capital destruction: Is there persistence into adulthood?. *Demography*, 47(1), 163-180.

irrevocable loss of their primary attachments; for many this constitutes a significant trauma.”<sup>23</sup> There are also high rates of bullying and sexual abuse in boarding schools, due to the low levels of oversight. While one study<sup>24</sup> showed boarding school has been shown to have positive effects on children 13-19 in Uganda, in fact producing better results than extended family care for orphaned children, there is a huge difference between a securely attached and psychologically healthy teenager and a young child in a critical window for attachment. It is difficult to see how a boarding facility, which as a primarily educational facility by definition places less emphasis on children’s psychological health than intellectual development, could be a preferable solution to a residential institution. It seems to face all the existing problems of residential institutions, without the option of family-style restructuring.

## 1.6 FAMILY-STYLE RESIDENTIAL CARE RESEARCH

Research has shown that institutions are not inherently damaging to children – rather, the problems stem from the way that institutions have generally been conceptualized and run. If they are reorganized on principles that foster healthy attachment, in other words if they mimic a family to the greatest degree possible, they have been shown to be a good alternative to other forms of care. Indeed, some studies have indicated that it may in fact be preferable to community care in many cases.

Perhaps the most famous study demonstrating the positive effects of attachment-oriented intervention in standard institutions is the study performed by the St. Petersburg-USA Research

| Variable Mean (SD)       | Overall     | Group Home  | Orphanage   | Kinship                  | Post Hoc Pairwise Comparison*                                 |
|--------------------------|-------------|-------------|-------------|--------------------------|---|
| <b>Life improvement</b>  |             |             |             |                          |   |
| Living condition         | 3.30 (1.32) | 4.35 (1.09) | 3.61 (1.15) | 2.38 (1.16) <sup>b</sup> | (GH, O) <sup>c</sup> (O, K) <sup>b</sup> (GH, K) <sup>b</sup> |
| Schooling                | 3.39 (1.34) | 3.75 (1.48) | 3.57 (1.28) | 2.94 (1.32) <sup>d</sup> | (GH, O) (O, K) <sup>d</sup> (GH, K) <sup>d</sup>              |
| Mood                     | 2.86 (1.37) | 3.93 (1.11) | 3.10 (1.30) | 2.07 (1.17) <sup>b</sup> | (GH, O) <sup>d</sup> (O, K) <sup>b</sup> (GH, K) <sup>b</sup> |
| Peer relationships       | 3.32 (1.21) | 4.18 (.95)  | 3.36 (1.21) | 2.96 (1.13) <sup>b</sup> | (GH, O) <sup>d</sup> (O, K) (GH, K) <sup>b</sup>              |
| <b>Life satisfaction</b> |             |             |             |                          |   |
| Overall quality          | 3.69 (1.22) | 4.31 (.85)  | 4.12 (.95)  | 2.64 (1.13) <sup>b</sup> | (GH, O) (O, K) <sup>b</sup> (GH, K) <sup>b</sup>              |
| Satisfaction             | 3.69 (1.19) | 4.34 (.72)  | 4.06 (.98)  | 2.76 (1.14) <sup>b</sup> | (GH, O) (O, K) <sup>b</sup> (GH, K) <sup>b</sup>              |

NOTE: GH = group home, K = kinship, O = orphanage.

Team in 2005. They studied three baby homes with the usual drawbacks of institutional care, discussed extensively above. Then one baby home had training and structural changes implemented, a second had training only, and a third had no intervention. Training aimed to transform interactions between carers and children, and increase warmth, sensitivity, responsiveness, and child-directed interactions, while the structural changes included reduction of group sizes, assigned primary and secondary caregivers, reduce of segregation of children by age and disability, and reduced the number of caregivers per child while increasing consistency. They also established ‘‘family hours,’’ during which children and caregiver spent at least 2 hours daily of uninterrupted time interacting.<sup>25</sup> Training alone had very little effect, but the structural reorganization, which mimics other family-style models in use in other institutions, was effective at improving children’s physical, cognitive, and social-emotional development, based on the

<sup>23</sup> Schaverien, Joy. "Boarding school syndrome: broken attachments a hidden trauma." *British Journal of Psychotherapy* 27, no. 2 (2011): 138-155.

<sup>24</sup> Catrine Christiansen (2005) Positioning children and institutions of childcare in contemporary Uganda, *African Journal of AIDS Research*, 4:3, 173-182

<sup>25</sup> Crockenberg, Susan C. "How valid are the results of the st. Petersburg–usa orphanage intervention study and what do they mean for the world's children?." *Monographs of the society for research in Child Development* 73, no. 3 (2008): 263-270.

Home Observation for the Measurement of the Environment (HOME) Inventory and the Battelle Development Inventory. These effects persisted for six years following the initial intervention.<sup>26</sup>

Similar results were found in China, where family-style group homes outperformed both traditional orphanages and kinship care, as seen in Figure 5. Results even “indicate that children living in group homes and orphanages felt better about their current living situation than children living in kinship households. This result may be because of a larger degree of unmet basic needs in kinship households,”<sup>27</sup> an effect we have seen in action in community care in Sub-Saharan Africa as well. Chinese orphans living in family-style group homes also were more integrated into their communities and suffered less stigma than those in orphanages, and

*Figure 1: Group Differences in Perceived Life Satisfaction*

had better mental health when it comes to mood and peer relationships.

These effects extend to Sub-Saharan Africa as well, as shown in Duke University’s Positive Outcomes for Orphans (POFO) study comparing the wellbeing of orphaned and abandoned children between the ages of 6 and 12 in institutional and community care<sup>28</sup>. This study used data from Tanzania, Kenya, Cambodia, Ethiopia, and India to determine whether it is truly the question of family vs. institutional care that affects outcomes, or whether the differences between institutions outweighs binary classifications. An earlier meta-analysis had demonstrated that IQ is negatively impacted by institutionalization, but that the effects can be mitigated by low caretaker ratios, participatory decision making, and other family-style characteristics. They found that than institution-based children “scored higher on intellectual functioning and memory and had fewer social and emotional difficulties. The differences were more pronounced when comparing these children only to unsupported community-based children not cared for by a biological parent” – in other words, institutions outperformed kinship care, especially for orphans living with neither parent. There was “significant variation in average child wellbeing across institutions and across community settings, explaining more of the variation in child outcomes than differences between institution- and community based care settings,”<sup>29</sup> and again this difference was largely ascribed to structural and attitude differences between carers. They authors also hypothesize that in poor countries, “positive institutions may provide a place where children can focus on education and their own needs rather than supporting their families... Finally, cultures may differ so that institutional caregivers provide more parent-like support; and children living in the institutions may be

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<sup>26</sup> McCall, Robert B., Christina J. Groark, Larry Fish, Rifkat J. Muhamedrahimov, Oleg I. Palmov, and Natalia V. Nikiforova. "Maintaining a Social-Emotional Intervention and Its Benefits for Institutionalized Children." *Child development* 84, no. 5 (2013): 1734-1749.

<sup>27</sup> Zhao, Qun, Xiaoming Li, Xiaoyi Fang, Bonita Stanton, Guoxiang Zhao, Junfeng Zhao, and Liying Zhang. "Life improvement, life satisfaction, and care arrangement among AIDS orphans in rural Henan, China." *Journal of the Association of Nurses in AIDS Care* 20, no. 2 (2009): 122-132.

<sup>28</sup> Whetten, Kathryn, Jan Ostermann, Rachel A. Whetten, Brian W. Pence, Karen O'Donnell, Lynne C. Messer, Nathan M. Thielman, and Positive Outcomes for Orphans (POFO) Research Team. "A comparison of the wellbeing of orphans and abandoned children ages 6–12 in institutional and community-based care settings in 5 less wealthy nations." *PLoS One* 4, no. 12 (2009): e8169.

<sup>29</sup> Whetten, Kathryn, Jan Ostermann, Rachel A. Whetten, Brian W. Pence, Karen O'Donnell, Lynne C. Messer, Nathan M. Thielman, and Positive Outcomes for Orphans (POFO) Research Team. "A comparison of the wellbeing of orphans and abandoned children ages 6–12 in institutional and community-based care settings in 5 less wealthy nations." *PLoS One* 4, no. 12 (2009): e8169.

more incorporated into the surrounding community,”<sup>30</sup> both indications that caring institutions are preferable to unsupported, and especially unwilling, kinship care.

## **1.7 NKOARANGA ORPHANAGE AND HAPPY FAMILY CHILDREN’S VILLAGE**

At Nkoaranga Orphanage and Happy Family Children’s Village, attachment is at the heart of everything we do. Ideally, The Small Things’ prevent children from entering residential care at the orphanage or children’s village in the first place – however, in many cases, especially with fragile newborns, that can be a necessary interim step. In these cases, we encourage and facilitate ongoing visits and relationships between the children and their relatives, as a precursor to reunification. We do not judge or push away families who, for whatever reason, are not in a position to offer permanent care, as we feel strongly that families generally know best what they need and are able to provide. For these children, we ensure they have close and loving relationships with caretakers, as well as with any living relatives, whether or not those relatives can take them home permanently.

With a focus on attachment, extensive training, participatory decision making, contact with relatives, and high caretaker ratios, we have been able to turn Nkoaranga Orphanage and Happy Family Children’s Village into well-supported, loving homes for the children in our care. Health and development outcomes are also excellent, with regular development assessments and interventions when necessary, regular preventative and acute medical care, high quality preschool and education, afterschool tutoring, and a general ethos of approaching each child as an individual with their own specific personalities and needs. We also facilitate weekend and holiday visits with living family members and run a community integration program to ensure the kids will be able to successfully transition to Tanzanian adult life. While we are very proud of our reunification rates of over 50%, we work hard to ensure that the children remaining in these two facilities are equally loved, cared for, and have bright futures ahead of them.

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<sup>30</sup> *ibid*