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Orphaned and Vulnerable Children: A Model for Care

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Orphaned and vulnerable children

A model for care

Solveig Parsons
Messiah College
Introduction

Neatness is a teenage girl living in Zimbabwe. She told her story in a video for the nonprofit organization Forgotten Voices, in the hopes that “my story helps thousands of kids, just like me, all around me.” She lives with her immediate and extended family at the Mtshabezi Mission. Her father died when she was in sixth grade. Her grandfather, uncle, younger brother, and mother are ill, presumably suffering from AIDS. Her days are long and busy – waking up before 5 a.m. to start a fire and feed children, walking to school with cousins, cleaning her mother’s and sister’s room, doing homework, ironing her uniform. Yet, she has hope for the future: “I think God is going to bless me, and I hope I’m going to live a better life and I think I’m going to experience good times.” She has reason to be optimistic – she is eagerly pursuing her education. “Education, to me, is a key of success ….” And one of the reasons she is able to pursue that education is that, with help from forgotten voices, the church is covering her school fees. Neatness says that this has taken a lot of pressure off of her mother (Forgotten Voices, 2008).

Neatness is, as she herself recognizes, one of many children in Southern Africa who are suffering from the constraints of disease, poverty, and the loss of a parent. As an orphaned and vulnerable child (OVC), her chances of achieving her potential in life could have been drastically reduced were it not for the intervention of her local community. And that community was, in turn, supported by an organization bringing in funds from an international community. The question is: how can we ensure that more children in this situation receive the same support? What elements are needed to provide a healthy environment for child development, and who should be responsible for providing them?

The HIV/AIDS epidemic’s colossal effects on children mandate greater coordination in
the provision of care by all sectors. An examination of the havoc that the epidemic has created leads to the establishment of the Circles of Care model as a guide for conceptualizing OVC care. Interventions to improve the well-being of OVC can come from any sector, but all actions here should focus on empowering caregivers in order to preserve family units. Institutionalization should be avoided whenever possible. The advantage of this model is that it recognizes the plurality and complexity of actors, yet simultaneously provides all of them with a coordinated goal towards which to aim their efforts. In order to provide an example of how the Circles of Care can be utilized in a real life scenario, Forgotten Voices will be introduced as a case study. This nonprofit – which is involved in supporting Neatness and many children like her in Zambia and Zimbabwe – provides an example of how an intervention can operate on the principles of the Circles of Care while also conforming to best practices in community development leadership. This case study is significant in that expansion of operation models similar to that of Forgotten Voices could allow many more OVC and their caregivers to gain access to necessary services.

The HIV/AIDS Epidemic and Its Impact on Children

Like many of the historic epidemics of history, HIV/AIDS is currently affecting entire nations. Its widespread impact has left children in a particularly vulnerable position. In order to understand the extent of the need, it is necessary to first look at a basic history of the epidemic and then to systematically examine its effects.

The Spread of the Disease

Originally the human immunodeficiency virus (HIV) was carried by primates. However, it migrated to humans (as have other viruses such as those causing severe acute respiratory syndrome [SARS] and Ebola), and – while the exact start date is uncertain – it is believed to have begun slowly spreading in the 1930s. Then in the 1970s it really took off. An unexplained
rise of otherwise unusual diseases among homosexual men in the United States led to the
discovery of acquired immunodeficiency syndrome (AIDS) – and its existence was announced
by Atlanta’s Centers for Disease Control in 1981. It was not until 1983 that the actual virus was
discovered, however, and the creation of antiretroviral therapies (ART) was only achieved in
1996 (Whiteside, 2008). At first the groups affected were marginal, since HIV was mainly being
transmitted through homosexual sex, intravenous drug use, and blood transfusions. However, as
the epidemic developed globally it began to look different. To this day, HIV/AIDS in the
developed world is still confined to narrow demographics, and ART is readily available¹. In the
developing world, on the other hand, the method of transmission and the extent of the impact
have varied widely from region to region (Whiteside, 2008). This global inequality is a notable
feature of the epidemic.

Historically, Africa has borne the brunt of the epidemic. “Sub-Saharan Africa has the
largest number of people living with HIV: two-thirds (64%) of infected people and three-quarters
of all infected women live [there]” (Whiteside, 2008, p. 6). Within Sub-Saharan Africa,
“Southern Africa has the worst epidemic” (p. 6). In fact, “by 2004 the region had 2 per cent of
the world’s population and nearly 30 per cent of its HIV cases” in 2004” (Iliffe, 2006, p. 33).
Globally speaking, then, Southern Africa has been one of the regions most affected by
HIV/AIDS.

In Southern Africa, transmission has occurred primarily through heterosexual sex
(Whiteside, 2008, p. 6). Its long incubation time and gradual development of symptoms allowed
it to spread quickly without anyone’s knowledge (Iliffe, 2006, p. 33). Beyond this
epidemiological reality, though, other cultural and social factors may have further exacerbated

¹ That being said, HIV is increasingly affecting the African American community in the US. And in Europe,
immigration of infected persons is also becoming an issue.
the spread of the virus. A secondary role may have been played by “the region’s history of white
domination and the dramatic economic change and social inequality it wrought” (p. 33). In “A
Question of Power,” Amy Patterson (2009) also identifies women, youth, and migrants as being
at special risk for infection. Gender is a vital component in determining who is most affected by
the disease. “Biology contributes to women’s vulnerability …. Women are seven times more
likely than men to become infected during sexual intercourse with an infected partner” (p. 234).
Furthermore, “women’s lower economic and social status increases their risk of HIV infection”
(p. 234). Youth are at risk due to the danger of being infected by their mothers (which will be
discussed in detail later), the destabilization of their social supports as adults are infected, and the
risk of being infected during their early sexual life (15-24 age group account for 50% of new
infections). Migrants often are in very difficult economic situations, and many of them engage in
unsafe sexual behaviors (a partner at home and a partner near the work site) which put them at
increased risk (Patterson, 2009). Thus, the factors that make people generally vulnerable in
society also make them especially at risk for infection.

The Impact

All these factors contribute to endangering the welfare of millions of children in the
region. First, failure to obtain adequate education, preventative medication, and social support
has led to many infants being exposed to the virus by their mothers (Fonseca, et al, 2008). Thus,
many children born to HIV positive parents already have their life expectancy rudely curtailed.
“With no intervention, the majority of African children infected from their mothers develop
HIV-related causes by 6 months of age, and fully half die of AIDS-related causes by age 2”
(Fonseca et al, 2008). Indeed, while as of 2002 “HIV/AIDS caused roughly 3.6 percent of
childhood deaths globally,… in southern Africa that figure was nearly 8 percent” (p. 95). Indeed,
the percentage was over half in certain of these countries (Fonseca et al, 2008). Thus, in a very direct sense, maternal infection during pregnancy directly reduces the probability of a healthy life for children.

Even where children are not infected, though, the progression of the disease depletes resources in families, causing many children to become vulnerable. A good general definition for vulnerability is provided in a World Bank study (Subbarao and Coury, 2004), in which “vulnerable children are defined as those whose safety, well-being, and development are, for various reasons, threatened” (p. 1). Chief among the “the many factors that accentuate children’s vulnerabilities … are lack of care and affection, adequate shelter, education, nutrition, and psychological support” (p. 1). Yet, sometimes more discriminatory definitions must also be used, the researchers note, since it is not possible to reach all vulnerable children with assistance. Thus, the study simultaneously suggests that a working definition might be “those children who are most at risk of facing increased negative outcomes compared with the ‘average’ child in their society” (p. 2).

Whole communities are made vulnerable by AIDS’ impact. Yet, even on a relative scale, in southern Africa “orphans, children whose parents are chronically ill (and who are likely to be HIV-positive), children infected with HIV/AIDS, and children living in households that have taken orphans are particularly vulnerable” (Subbarao and Courty, 2004, p. 4). The following chart provides a good summary of the impacts – both individual and communal – that the disease causes:

<table>
<thead>
<tr>
<th>Potential Impact on Children</th>
<th>Potential impact on families and households</th>
<th>Potential impact on communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Loss of family and identity</td>
<td>• Loss of members, grief</td>
<td>• Reduced labour</td>
</tr>
<tr>
<td>• Depression</td>
<td>• Impoverishment</td>
<td>• Increased poverty</td>
</tr>
<tr>
<td>• Increased malnutrition, starvation</td>
<td>• Changes in family composition, and family and child roles</td>
<td>• Inability to maintain infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Loss of skilled labour,</td>
</tr>
</tbody>
</table>
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| Failure to immunize or provide health care | Forced migration |
| Loss of health status | Dissolution |
| Increased demand in labour | Stress |
| Loss of educational opportunities | Inability to provide parental care for children |
| Loss of inheritance | Lack of income for health care and education |
| Forced migration | Demoralization |
| Homelessness, vagrancy, crime | Long-term pathologies |
| Increased street living | Decrease in middle generation in households, leaving the old and young |
| Exposure to HIV infection | including health workers and teachers |
| | Reduced access to health care |
| | Elevated mortality and morbidity |
| | Psychological stress and breakdown |
| | Inability to marshal resources for community-wide initiatives |


Indeed, it is important to emphasize that for children in families affected by HIV/AIDS, great vulnerability often precedes parental death.

The vulnerability of children orphaned by AIDS begins well before the death of their parent (or parents). The effects often commence with the onset of a parent’s illness and may include impoverishment; the emotional suffering, neglect and increased burden of responsibility associated with a parent’s illness; and the stigma and discrimination associated with HIV that can isolate and demean a child. (*Africa’s..., 2006*, p. 18)

The pressures of sickness in the household may also prevent school attendance, particularly for girls, due to the need for another pair of hands (Fonseca et al, 2008). Children are therefore often put in a precarious position.

Finally, the epidemic has stolen away countless parents. Orphans make up a substantial portion of the population: in 7 southern African countries, orphans account for at least 15 per cent of all children. And AIDS is a grossly exacerbating factor. In fact, “in 7 of the 10 countries in southern Africa with data, more than 50 per cent of orphaning is due to AIDS” (*Africa’s..., 2006*, p. 4). This loss tends to vastly reduce the resources available to care for children,
especially in the case of paternal death, and “orphans’ care tends to fall more and more on the poorer homes” (Subbarao and Coury, 2004, p. 14).

Being orphaned decreases the likelihood that children will receive adequate provision of nourishment, health care, and education (*Africa’s...,* 2006). How orphaned children compare to non-orphaned children in terms of school attendance differs between countries. Overall household resources seem to play the major role (double check interpretation here), but in some countries there is a disparity solely explained by orphaned status. And, in certain places, gender plays a compounding factor (Subbarao and Coury, 2004). Again, health care and nutrition disparities differed based on region, but in some areas there were indeed both orphan-based and gender-based inequities. There is also a risk that children will be abused, have property taken from them forcibly, or be over-worked. Finally, orphaned children may experience additional “stigma and discrimination” (Subbarao and Coury, 2004, p. 21; Fonseca et al, 2008, p. 95). For all these reasons, more support for orphaned children is absolutely imperative if optimal development is to be achieved.

**Circles of Care**

Therefore, in evaluating the issue of caring for orphaned and vulnerable children (OVC) in the wake of the HIV/AIDS epidemic, I am settling on a model of care proposed by Linda Richter, Geoff Foster, and Lorraine Sherr (2006, p. 27, see Table 1). This model consists of a set of four concentric circles. The innermost circle represents the child’s direct caregivers, the immediately surrounding circle represents the surrounding family and community, and the outer two represent NGOs and the state respectively. Since children have been shown to develop best in the context of a stable family environment, the driving force in this model is inward: i.e. that all efforts on behalf of OVC should focus on supporting their immediate surrounding care
structure. I chose this model because it encompasses all that is good from the development theories described above. The state’s crucial supportive role is recognized, yet the focus is always on how individual families and communities can be empowered with the substantive ability to care for the children in their midst.

Figure 1: “Circles of Care”

Source: Richter, Foster, Sherr (adapted from Bronfenbrenner 1979)

The Circles of Care paradigm stands out as the preferable model in terms of promoting children’s psychosocial health, coordinating all sectors of society towards a focused goal, and maintaining cost-effectiveness. Children are best supported in family or family-like environments where they can receive personalized care, attention, and stability. The importance of prioritizing home care arrangements has been affirmed by many researchers. Richter, Foster, and Sherr (2006) argue the following:

The vast majority of vulnerable children are being cared for in family environments, and family care is especially important for the most vulnerable children. Children placed in institutions have increased risk of death, illness, language delay, socio-emotional
disorders and personality dysfunctions. There is also a greater likelihood that
institutionalised children grow up disconnected from their culture, extended families, and
communities. (p. 27)

In their assessment of the impact of HIV/AIDS on Early Childhood Development, Engle,
Dunkleberg, and Issa (2008) also affirm that “everyday systems of care” (p. 300) should be made
a focus of intervention efforts, at least for young children. “The most appropriate and sustainable
sources of psychosocial well-being for young children come from caring relationships in the
home, school, and community… Children under stress are calmed and reassured when their
familiar surroundings and everyday activities are restored” (p. 300). Comparing different types
of childcare, Subbarao and Coury (2004) note that “each arrangement has its pros and cons”
(39). However, that being said, they state that “there is a common acknowledgment that,
whenever possible, orphaned siblings should remain together and with their kin and their
community of origin” (39). Of course, a family placement for OVC is not always possible. Other
care placements – adoption, fostering, and various types of institutional arrangements – must be
used at times. But the most personal and individualized approaches should be the first choice,
while institutional arrangements “should always be considered a last resort” (p. 39).

A tendency exists, particularly in the United States, to take a very individualistic
approach to crafting policy. However, what this approach misses is that each individual is
located within a social situation that impacts identity and action. For many people the most
important connections and influences they have come from their families. Thus, for instance,
when health professionals focus only on their patients, they miss the fact that the well-being of
the family will impact their patients’ health. The family will also play a role in whether or not
patients take their medication and are supported in their treatment plans. Thus, failing to train
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and support patients and their families collectively can have negative impacts on health. Health is only one among many spheres that family relationships affect (Bogenschneider, 2006). The takeaway is that failing to account for the collective generally risks also disadvantaging the individual.

This principle applies to OVC care as well. Children’s needs may be the priority of an initiative, but it is vital to remember that children’s families play a pivotal role in providing them with the love and security they need to thrive. Indeed, this understanding is already embedded in African cultures, where – as aforementioned – extended families are the primary caregivers for children in need. Thus, there is a need for outside organizations to adopt a holistic perspective that recognizes that supporting the family unit is a key component of any plan to support OVC.

In a situation of nearly infinite need and limited resources, cost-effectiveness is a factor that must also be considered. Here, too, care in the home emerges as the best option. Interestingly enough, the ordering of care situations from best to worst for psychosocial support seems to align with an ordering based on cost assessment. Subbarao and Coury (2004) gauge various interventions along the spectrum of cost, with “Kin-Family care with community support” being the least expensive option and “Orphanages/children’s villages” the most expensive (Figure 5.1, p. 81). They contend that “keeping a child in an institutionalized environment is financially unsustainable because of the long-term heavy burden it places on the organizations running them” (p. 77). The Circles of Care approach thus takes a wise focus financially as far as enabling this type of home-based care.

Finally, it is worth noting that the Circles of Care model is consistent with many of the principles that have been affirmed by other practitioners of orphan care. Indeed, enabling caregivers and communities to care for children while involving government to provide access to
vital services is the nearly unanimous approach in the literature on OVC care. Furthermore, in 2001 the UNAIDS Committee of Co-sponsoring Organizations affirmed the importance of a combination approach addressing OVC, families, communities, government, and society at large (Richter, Manegold, and Pather, 2004). The Circles of Care model is an exceptional tool in that it takes this widespread general desire for a multi-sectorial approach and gives it focus. Actually, a nearly identical model (Circles of Support) has been used in South Africa’s Moving the Nation to Act Campaign, an educational anti-discrimination project. That model uses three concentric circles, representing a) “family, neighbors and friends”; “the community”; and “the wider society” (Smart, 2003, p. 43). Thus, there is good precedent for the use of this model.

**Evaluation of Existing Efforts to Reach OVC**

The plight of OVC has increasingly become a point of attention both on the national and global scenes. Individuals and organizations at all levels have been mounting responses, some more comprehensive than others. By evaluating responses along the lines of each level of the Circles of Care reveals that the existing efforts, while good first steps, need to network with each other and focus their efforts more selectively.

On the policy level – the outer encompassing Circle – legislation and programs aimed at OVC care has been a major gap in the response to HIV/AIDS. At first, many African state leaders simply did not want to acknowledge the presence of the disease. This presented a major obstacle to mounting any meaningful response. Senegal was an exception to this rule, recognizing the danger imposed by the epidemic and mounting a series of comprehensive national policies to combat it (Iliffe, 2006). In the past several years, however, many governments in the region have created national plans to address the wave of OVC created by the spread of HIV/AIDS. Still, in general, service provision tends to be minimal in the countries
most affected by the epidemic. Furthermore, “strategies that improve access for all children may benefit orphans and vulnerable children in particular” (*Africa’s…*, 2006, p. 31). For instance, making education more accessible is one area where governments can play a role. There are many ways to make education more accessible to children from families of limited means, one of the most basic being making school free. “By eliminating school fees, such countries as Kenya and Uganda … have increased school enrolment in general and decreased disparities between orphans and non-orphans” (*Africa’s…*, 2006, p. 30). Subbarao and Coury (2004) echo this, nothing that “[t]he orphan disadvantage in school enrollment—to the extent it stems from financial hardship—could be greatly reduced, if not eliminated, if sectoral policies bearing on education were less restrictive (with no fees or uniforms) and more inclusive” (p. 16). It has also been argued the government should fund health care interventions for OVC and their caregivers (Subbarao and Coury, 2004; Engle, Dunkelberg, and Issa, 2008). Overall, we still have a long way to go in terms of seeing “equitable access to education and health, birth registration, birth registration, foster care and inheritance legislation” (*Africa’s…*, 2006, p. 31).

International organizations, particularly the UN and the World Bank, have begun to turn their attention towards the OVC crisis. It was largely the UN’s advocacy and goal-setting that motivated many countries to set up plans for OVC service provision (*Africa’s…*, 2006). In going forward, these organizations could make a major contribution to the field through using their research capabilities to synthesize reports on the progress in individual countries. As I explain in more detail in my final recommendations, this is an area that needs to be further developed. Furthermore, they can continue pursuing the Millennium Development Goals. Indeed, fully 6 of the 8 could have direct impacts on benefiting OVC: those that aim to “eradicate extreme poverty and hunger, … achieve universal primary-school enrollment, … promote gender equality and
empower women, … [and] combat HIV/AIDS, malaria, and other diseases” (Easterly, 2006, p. 9). That being said, “[u]nderstanding the risks of orphans and vulnerable children is critical to attaining the … MDGs” (Subbarao and Coury, 2004, p. 5). So there is an interaction here.

International organizations have a unique position to advance the goals of OVC, and with wise planning they may be able to do just that.

Many of the initiatives taking place on the community level are led by Faith-Based Organizations (FBOs). To give an idea of the scale of impact, consider the following study: Geoff Foster (2003) researched 322 FBOs in six Sub-Saharan African countries. They were providing some form of care to 139,409 OVC. This widespread involvement represents a great opportunity. Religious Coordinating Boards (RCBs) could play a role in connecting Faith-Based Organizations, and could be good connection points for NGOs. “Most NGO probably have no more than a dozen or so active partnerships with community groups for project delivery. Yet most RCBs have at least a hundred congregations in their network and some of the largest bodies reach thousands of individual congregations. RCBs occupy a strategic position in relation to scaling up OVC responses” (Foster, 2003, p. 17). In funding, too, there is a shared role to be played:

Development organizations should partner with inter-religious groups to carry out efficient mapping of these religious networks … Congregations have the capacity to implement OVC support activities and receive funds but most receive no external support. Funding should therefore be provided through small grants funds operated by RCBs to support activities initiated by congregations. Donors should ensure that a majority of RCB funding is spent at community level. (p. 18)

Greater coordination has the potential to makes sure gifts are delivered in the most efficient
manner possible.

Families are currently providing the vast majority of support for orphaned children. For instance, in a study looking at orphan care in Uganda, Zambia, and Tanzania, the extended family safety net accounts was found to account for 95% of orphaned children in the Tanzanian countryside, with comparable numbers in the other countries (Subbarao and Coury, 2004). Even if a parent is still alive, the child may still be moved, especially in the case of maternal death. And, sometimes an older orphan steps up to head the family – which tends to put all the children in a precarious position. There are instances where other care arrangements (foster care, adoption, institutional care) are resorted to, but overall, the extended family system is the primary means of emergency child care in Africa, so this response to the HIV/AIDS crisis is no surprise (Fonseca et al, 2008; Subbarao and Coury, 2004). However, as noted earlier, the epidemic has reached such a scale in conjunction with widespread poverty that families are often hard-pressed to obtain sufficient resources to give the children in their charge an optimal environment. This is where support from all the preceding spheres should be focused.

The key takeaway from the Circles of Care model is that individuals and organizations from any sector can usefully intervene to help OVC, yet not all interventions are equal. The best practice approaches favor family unit preservation and focus on the empowerment of caregivers. International organizations, NGOs, governments, communities, and individuals all have different resources to offer. However, these will be most effective when honed in on a common goal of supporting caregivers and the children in their care.

**Case Study of Forgotten Voices**

The Circles of Care serves an important role in emphasizing that interventions should be geared towards fulfilling the psychosocial needs of children. However, in creating initiatives
there is another aspect that must also be considered – best practices in community development (CD). Years of experience and research have demonstrated that certain ways of operating are better than others in effecting positive lasting change in communities. The question arises: Can operating along the Circles of Care align with also following CD best practices?

Forgotten Voices (FV) serves as a case study that demonstrates not only that a caregiver-centered approach is compatible with CD, but also that best practices in development actually point to the need for models like the Circles of Care that emphasize empowerment at the community level. FV is a small nonprofit based in Dillsburg, Pennsylvania. Their eleven member board is composed of Americans, and six of the nine members on their leadership team are American (with the president and CEO, Ryan Keith serving on both). Various additional volunteers also assist on the American end. However, most of the personnel are the local national partnering pastors in Zimbabwe and Zambia who are driving the day-to-day provision of to OVC in their communities (Forgotten Voices, 2008). Located in Southern Africa, these countries are part of the region of the world most affected by the HIV/AIDS epidemic (see Figure 2). This aspect is beneficial for the case study, because it demonstrates that FV’s model is affected even in an area that is severely affected and has limited resources. It is also significant in that it affirms that, even in developing areas facing huge challenges, depending on local voices is still a highly feasible method for formulating solutions.
Zambia and Zimbabwe both exhibit a certain degree of coordination in regards to OVC care, but Zambia especially still has a lot of gaps. First, as mentioned earlier, rates of orphaning are drastically high. Twenty percent of Zambia’s children have lost at least one parent, with fifty-seven percent of these cases attributable to AIDS, while in Zimbabwe those figures are 21 percent and 77 percent respectively (*Africa’s…*, 2006, p. 36). In a ranking of national plans for OVC care in Africa, Zambia received an overall score of 29 – the lowest among all the Southern African nations for which there was data. Zimbabwe did better with a score of 63 (p. 39). Thus, while there are aspects of policy and support in place, comprehensiveness is still lacking. As mentioned earlier, birth registration rates are another indicator of a state’s ability to account for and provide services to its children. In Zambia only 10% of children are registered in the country as a whole, while again Zimbabwe fairs somewhat better at 42%. In terms of schooling, both countries boast small gaps in attendance between non-orphans (which in this case are defined as “children living with at least one parent”) and double orphans. However, in Zimbabwe there are 92% of non-orphans and 90% double orphans enrolled, versus 78 and 73 percent in Zambia (p.
Clearly there are still needs in both countries, especially in Zambia. Given the high prevalence of HIV and these outstanding needs, FV is working in a demanding environment.

One reason FV stands out as an appropriate case study is the success it has had in a short amount of time within this context. Founded in 2005, it is less than ten years old (Forgotten Voices, 2013). It is dealing with countries that have been heavily affected by the epidemic but have limited resources available to combat the damage. Within this context, however, FV’s funding has already met key needs for a significant number of children, families, and communities. They are currently supporting six projects in Zimbabwe and thirteen in Zambia. In terms of impact, FV’s 2011 annual report (the most recent available on their website) indicated that their partnering churches in Zimbabwe paid school fees for 418 children, skills training for 188 individuals, home-based care for 160 households, IGA assistance for 77 individuals, and psychosocial support for 625 individuals (both children and caregivers). In Zambia, the figures were comparable: 606 children sent to school, 340 receiving skills training, home-based care for 481 households, 71 receiving IGA assistance, and 611 benefiting from psychosocial support (Forgotten Voices International, 2011). Thus, FV provides a relevant opportunity to see how an intervention along the lines of the Circles of Care can play out in a real context and to evaluate its effectiveness. (Insert Zimbabwe stats)

Another notable aspect of FV is that the projects it funds through its partner churches typically support children and their families, the type of interventions supported by the Circles of Care (see figure 4). Empowering people to become self-sufficient is one priority in these projects. Sometimes this might come in the form of a small loan – such as a $100 loan to widow named Cecilia to start up a business selling fish in order to support her three children (Forgotten Voices, 2012). Interventions like this that empower caregivers by helping households gain
financial independence play a crucial role in ensuring children’s long-term well-being.

FV is not dogmatic about providing aid that goes directly to families – flexibility is a core component of their partnerships, and local realities may mandate other types of interventions. At times this flexibility may mean supporting an institutional approach. Thus, for instance, they fund one church’s program to take in abandoned children and help them find either relatives or connect them to the equivalent of foster families (Forgotten Voices, 2008). While the Circles of Care is generally a reliable guide, the reality is that there are extenuating circumstances where an institution may be needed to provide interim support, which FV clearly recognizes.

At times FV also participates in indirect support to caregivers by providing funds to seminaries that are working on related issues. They have given grants that help seminaries put together an alumni network that FV can then utilize to find partners. They also currently fund a project in a Zimbabwean seminary that focuses on preparing pastors to deal with the HIV/AIDS issue (Forgotten Voices, 2008). In the Circles of Care, this could be visualized as the outer layer supporting the community layer, which in turn supports the family and caregiver layers. This
flexibility is exactly what makes FV credible, as it demonstrates that they are able to follow the principles of a model without becoming dogmatic.

Throughout its operations, FV demonstrates that caring for children along the lines of the Circles of Care is compatible with community development best practices. Their close working partnerships with community organizations facilitates the provision of services to children within their existing communal and cultural context, rather than importing new institutions or cultural practices. Through its emphasis on long-term project sustainability and empowerment of families to provide for themselves, FV also ensures that the recipients of aid are gaining voice and ability to self-determine. The fact that harmonization of children’s best interests and CD practicability is possible bodes well for the future of OVC care.

*Evaluative framework*

A framework for evaluation will be drawn from community development (CD) literature, since FV’s specific mission falls under the larger umbrella of CD. At its root, CD is simply a group of residents in a locality joining together to effect changes in their community. While FV is based in and draws funding from the United States, the formation and direction of projects takes place on the ground under the guidance of partnering pastors. Their basic formula is to first help their partners inventory the resources already available in the community, set project goals, and set up income-generating activities to eventually make those projects self-sustaining. FV only funds in the interim until this sustainability goal is reached (Ryan Keith, personal communication, 23 October 2012). Throughout this process, FV serves as to guide and provide accountability, but the whole process functions much like a grant system, where recipients of funds are setting their own direction. Thus, a CD framework is appropriate for the evaluation of FV’s operations.
Specifically, this framework will be adopted from Barker, Johnson, and Lavalette (2001), who examine leadership in terms of its personal, structural, and governance requirements. While CD is by definition a collective venture, the impact of individual leaders can play a vital role. Movements are made up of diverse people and thus “[l]eadership in movements consists in proposing to these differentiated entities how they should and can identify themselves and act together. Without such proposals, and any assent they receive, movements do not exist, collective identity is not formed, collective action does not occur” (p. 5). Leadership within a movement may be diffused and informal (p. 9). Still, formalized leadership positions have retained a significant role in CD movements. Formal leaders in a study of Social Change Organizations (involved in CD), for instance, were usually responsible to set vision and direct operations accordingly, a position to which they were assigned since “the formal position they occupy is often the only one with a perspective that is holistic, outward-looking, and future-oriented” (Chetkovich & Kunreuther, 2006, p. 53). Not only that, but leaders were often asked to interface between their organizations and the outside world, managing the “the strategic interactions—generating support, ensuring relevance, and scanning for threats and opportunities” (p. 58). The three-part framework exploring personal, structural, and governance aspects of leadership implies the recognition that many factors play into leaders’ ability to successfully negotiate these tasks.

In the case of FV, this three-part leadership structure will be applied to the organization as a whole, since the entire structure revolves around partnering with and empowering local leaders. I will ask the following questions: Is FV partnering with local leaders who have sufficient personal resources to engage in effective CD? Do FV and its partners have appropriate strategies in place to operate within the existing structural challenges in Zambia? Are the
governance patterns within the organization conducive to the inclusion of diverse perspectives and community input?

Personal requirements

Leaders need to bring certain personal resources into their positions in order to be effective. While material assets could potentially fall into this category, the emphasis here is on intangible assets such as education and pertinent past experiences that prepare leaders to fulfill their roles. Indeed, cultural competency can be a crucial personal requirement and one that is certainly relevant for FV’s work in Zambia (Barker, Johnson, & Lavalette, 2001, pp. 11-12). FV has an advantage here in that it partners with pastors who are already embedded in the target communities, which means that they have an intimate understanding of the local context.

Within the context of the role that FV’s partners are asked to fill, two other essential categories of personal resources are a relevant seminary education and high self-efficacy. First, an effective education would equip them with relevant knowledge and skills transferrable to the CD work in which they are now engaged as pastors. While seminaries in an American context might not find CD to be a necessary area of focus, for institutions situated within developing countries where HIV/AIDS is an omnipresent reality, providing future pastors with a basis in development is a highly relevant endeavor.

Second, a high self-efficacy enables leaders to use their knowledge and skills to their fullest potential. Bandura (1997), one of the foremost scholars on self-efficacy, defines it as a person’s belief in his or her capacity to accomplish certain tasks. Self-efficacy must be distinguished from self-esteem as regarding “judgments of personal capability” rather than “judgments of self-worth” (p. 11). This particular personal resource becomes crucial as it bridges into the second framework aspect of structure. There are structural constraints on any given
project. What sets efficacious individuals apart is that they understand how to work to accomplish their goals within existing realities. They can “take advantage of opportunity structures and … circumvent institutional constraints or change them by collective action” (p. 6). This ability is absolutely crucial for FV partners, who must leverage their personal resources within a context that is highly constrained with limited infrastructure, low resources, and high rates of death within their communities. While bringing in a strong education and sense of self-efficacy may be crucial for any leader, it is perhaps especially vital in this case.

As an organization, FV is indeed making strategic decisions to partner with capable local leaders with well-developed personal resources. All of their partnering pastors have graduated from accredited seminaries, an indication that they come into FV with at least a minimal level of education and experience. In Zambia, the main seminary with which FV networks to identify potential partners is TICA, the Theological Institute of Central Africa. TICA has a foundation in place to effectively prepare its students both with pertinent information and with formative experiences that have the potential to build self-efficacy. This particular seminary is notable in that it offers a course on development that also equips students with basic research skills such as administering interviews. This means that, at least for those who choose to take that course, graduating pastors can approach ministry with at least a rudimentary introduction to the issues they will face and the tools they will need to meet those challenges. It also has the potential to make them more effective partners, in terms of understanding how to gather and present information from the field.

Not only does TICA provide this specific course, but it also requires all seminary students to complete a three month internship. One avenue for building self-efficacy is to engage in mastery experiences – i.e. opportunities to practice a skill or effect a change. Mastery
experiences allow individuals to grow in a realistic assessment of their own influence and capability. In pastoral internships through TICA, students are more likely to be involved in the teaching aspect, but there may be opportunity to be exposed to community development work depending on the church (Kathy Stuebing, personal communication, 20 Nov. 2012). Clearly specific development mastery experiences would be ideal for future FV partners; however, the building of leadership efficacy through pastoral internships may have overflow benefits that positively impact their leadership role in CD.

**Structural requirements**

Regardless of leaders’ qualifications and personal resources, they also have to be able to adapt to the specifics of the context in which they work. Barker, Johnson, and Lavalette (2001) focus on the aspect of communication and persuasiveness, i.e. what leaders have to do to get their ideas across. However, I propose that structures can also be composed of policies, available funds, community demographics, and more. A leader with high-self efficacy will be able to work within existing constraints to work towards achieving goals. Furthermore, structures are not necessarily static and thus well-prepared individuals with high self-efficacy (i.e. leaders with strong personal resources) can contribute to changing the structures that confine them (Bandura, 1997). In the context of CD in a developing nation, the ability to navigate complicated or limiting structures is all the more crucial.

Through its assessment and funding structure, FV is intentional about taking existing structures into account while also working to transform them. Their basic structure is to help their partners assess and plan, fund those plans, and remain flexible throughout the process (see Figure 3). In the preliminary stage of assessment, FV asks its partners to take account of the

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2 In order for these experiences to be effective, the individual’s interpretation is also important. A person who attributes a success simply to luck rather than his or her own competence, for instance, is not improving in self-efficacy.
resources already available in their church and in their community. This ensures that FV does not fund replication of resources that could already be accessed within the community. Furthermore, FV guides the process of project creation such that they only fund to the amount that could eventually be self-sustained by the community. In order to work towards this goal of sustainability, they also aid in the creation of income-generating activities (Ryan Keith, personal communication, 23 October 2012).

Figure 3: FV’s model (Forgotten Voices, 2008)

When locally generated revenue replaces FV’s funding of projects, FV is leaving its partners an expanded infrastructure and access to resources that were not part of the structural reality initially. Thus, each of these steps in the process demonstrates not only an awareness of local constraints, but a commitment to changing structures in a positive way.

Governance requirements

Personal resources are important, as is the ability to work within structural realities, but just as vital for leadership is how a leader relates with his or her followers, a factor that I am terming governance. Barker, Johnson, & Lavalette (2001) suggest that various models of leadership are possible, including but not limited to democratic forms. It is important to remember, however, that being a leader is far from an individual endeavor – leadership in CD
requires bringing guidance to a collective movement. Which voices are included in this process can have an impact on results. Thus, I argue that inclusivity should be a priority.

The preference for this type of governance can be understood from the perspective of standpoint theory. Standpoint theory posits that people’s perception of situations tends to be affected by their context. For those groups that experience discrimination or a lack of privilege in society, their experience allows them a view of reality that those in power will not necessarily understand. Thus, in order to get a holistic understanding of any social issue, it is necessary to incorporate the views of individuals and groups that represent different demographies and can bring their unique experiences to the table (Wylie, 2003). Standpoint theory specifically critiques uses of the concepts of “objectivity” and “neutrality” when such labels are used to cut off discussion. In other words, people in power sometimes protect their ideas or scientific processes of which they approve from critique by claiming that they are objective and therefore not up for debate (Harding, 1995). Certain voices get privileged and others excluded in such situations.

In the context of working in communities affected by HIV/AIDS, development practitioners need to be mindful that they are often dealing with vulnerable populations. As mentioned earlier, Patterson’s (2009) research shows that women, youth, and migrants – groups that may be socially disadvantaged – are also those particularly affected by the disease. In order to shape responses that will truly meet the needs of these populations, it is necessary for decision-makers and researchers to be open to marginal views and in fact to make understanding them a priority. Standpoint theory holds that people’s social situation affects even their thought lives and how they perceive their own situations. Thus, listening to marginalized people is just one part of the puzzle (Harding, 1995). However, arguably this piece cannot be excluded. CD leaders must be mindful to welcome input from those they serve and to constantly be trying to
put themselves in their clients’ shoes, so to speak. Otherwise they risk translating a skewed perspective into skewed interventions.

The inclusion of diverse voices becomes all the more salient when CD involves outside technical assistance. In situations where outside sources are being utilized to fund CD, it is especially important that development leaders are listening to the people their interventions affect (Robinson & Fear, 2011). In international CD particularly, foreign NGOs and development agencies often fail to form partnerships with local leaders and focus on reaching their own goals (Foster, 2003). Part of the reason for this autonomy is that these entities must meet the expectations of their donors (Kathy Stuebing, personal communication, 20 Nov. 2012). However, relying solely on the perceptions of donors and excluding the voices of community members risks making decisions on limited information and thus potentially setting up policies that are unsustainable in the long run. This lack of connection between outside organizations and community organizations ends up disadvantaging both parties – development entities miss out on crucial information while local leaders miss out on recognition for their work and the resources needed to scale up their interventions.

In terms of their overall organization, this is clearly aspect of CD in which FV excels. As already detailed, the entire process of FV partnerships depends heavily on the direction of local churches in terms of creating goals and programs. Another notable feature of these partnerships is their flexibility. For instance, a church may request assistance in setting up IGA but decline the offer of intermittent funding (Ryan Keith, personal communication, 23 October 2012). In this sense, FV’s priority is allowing local leaders to define what type of assistance they want rather than imposing a one-size-fits-all programming approach. Not only does FV rely on its community partners to set goals and run projects, but it also seeks to encourage local leaders to
include the diversity of voices within their own communities. The initial phase of pre-partnership preparation requires pastors to fill out paperwork, a process that pushes pastors to seek information from many sources within their communities. FV may send back the forms several times asking for more information. The end result is that many viewpoints are incorporated, although FV uses a methodology that emphasizes the need for a robust information base rather than the need for inclusivity per se. FV does not explicitly tell their potential partners that they need to seek out more perspectives from women, for example. However, the search for particular types of information demonstrates that no one party has the full picture of the community situation and thus that speaking to a diversity of sources is necessary (Ryan Keith, personal communication, 26 February 2013). Thus, both the overall mechanism of community partnership and the process for including diverse voices within those partnerships demonstrate that FV has an understanding of the need for inclusive decision-making.

**Recommendations for Forgotten Voices**

This brief overview of FV’s operations in light of CD best practices opens many potential avenues for commentary and further research. On the topic of personal resources, it is clear that overall FV is investing in partnerships with well-qualified local leaders. However, further attention into the degree to which seminaries promote relevant courses and internships that include a development component could be a fruitful avenue of inquiry. Do all students receive at least a basic education on HIV/AIDS and learn how to confront the various related issues – such as stigma, testing, etc. – in their future congregations and communities? What percentage of students is being exposed to development work in their internships? Questions such as these would equip FV with a platform from which to advocate for relevant innovations in seminary education. Such advocacy might have direct benefits for FV in terms of the effectiveness of their
partners. However, it could also have more generalized social benefit by preparing pastors who – even if they do not partner in the future with FV – would be more effective in their own ministries and would be better prepared to potentially partner with other organizations.

In terms of dealing with structures, FV has a strong overarching organizational plan that acknowledges limitations yet seeks to equip communities with expanded resources and infrastructure. An avenue of further research here might be whether there are ways for FV partners to connect OVC in their communities with other services. For instance, one pastor indicated that his children had never received any governmental services until this year, when the church partnered with the state to get children immunized (personal communication, April 2013). Given that FV is working in areas where the national governments have only low to moderate involvement in OVC care, this might be difficult. Nonetheless, where such services can be harnessed and maximized, children in the community could benefit at no additional cost to FV or the churches involved.

Finally, FV follows best practices for governance by intentionally includes many voices in the planning and execution of projects. Further potential for research might be found in enquiring into the decision-making processes used by local leaders. The pre-partnership process undergone by all partnering pastors sets a high standard for inclusivity. Does this mindset continue on beyond those initial steps? While FV provides periodic oversight, pastors are generally responsible for their own projects, indicating the possibility of variance among pastors in how they handle local governance issues. Do they exhibit decision-making behavior that reflects best practices? Investigating these aspects would allow FV to see if its training in the early stages is paying off long-term, or whether there might need to be additional measures in order to maximize performance in this area.
I recommend that FV prioritize the issue of seminary preparation on their future research and development agenda for several reasons. First, this is an area where FV has a good likelihood of high returns on the effort and resources they invest. FV is likely to have credibility with seminary leadership, given their track record of partnerships with local pastors. Offering services as a consultant would position FV such that they would dialogue with seminaries that were expressing the desire for consultative services. This process would likely involve much less hassle than trying, for instance, to improve state service provision. Likewise, attempting to harmonize all pastors in the same leadership style would not only be difficult, but might also undercut the principle of local control on which FV largely operates. Consulting would mean giving help where help was wanted; it would mean dialoguing with like-minded organizations; and it would have the potential to directly impact the quality of future FV partners.

Furthermore, upper leadership at FV headquarters has already expressed an interest in pursuing more involvement with seminaries. Recognizing that FV’s current model could continue to be replicated, they also are considering diversifying the services that they offer. Specifically this could manifest in serving as a consultant for seminaries. FV realizes that, at least at present, they cannot provide support to all the pastors who graduate from their partnering seminaries. However, they could potentially provide guidance to seminaries that are interested in pioneering similar models of development partnerships, as well as helping them prepare their graduates for the development challenges that will face them on the field. So, FV has already demonstrated momentum on this issue by beginning to explore the possibility of consultation.

Finally, compiling the high quality information necessary for high quality consultation would be a highly feasible research project. Naturally, FV already has a lot of information and experience related to the implementation of its model. When it comes to the issue of preparing
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Seminary students to be future CD leaders, FV may have to gather more information in order to provide feedback. However, they have an entire pool of subjects already at their disposal in the person of their pastoral partners. FV could begin collecting relevant information on their pastors’ seminary education and how it prepared (or failed to prepare) them for ministry. A sample survey is provided in the Appendix to indicate the types of questions that could be asked in an initial explorative survey. Objective questions related to pastors’ seminary experiences would capture the nature of the courses and internships to which they were exposed, and subjective questions would allow them to share their own perceptions of whether they could have been better prepared. Such a survey would also attempt to create a holistic view of their CD leadership – accounting for additional personal resources, structural constraints, and governance methods to serve as controls. In this way, it would be possible to attempt to isolate the impact of seminary experiences on their work. It would also be possible to examine the other research items mentioned above if this eventually became of interest to FV. Such a survey, though explorative in nature, would allow FV to begin painting a picture of how seminary fits into the bigger scope of ministry and CD.

Conclusion

 Forgotten Voices is just one among many faith-based organizations that is trying to provide care for the vulnerable in an area of the world where resources are scarce. The global church, however, has not been very coordinated. Within African countries, religious coordinating boards (RCBs) have not stepped up to the role they could play in connecting local churches and providing them with funding. This lack of coordination has played all the way up the chain, with NGOs also often missing the boat in terms of encouraging the preexisting efforts of those already on the ground (which could potentially be done through the RCBs). (Foster, 2003) There is a real
need to recognize that there are people at all levels trying to help, and working together would produce the best results.

FV puts the dilemma this way on its website: “[T]he African church has changed, but the way the American church partners with the African church has not.” (Forgotten Voices, 2008) When faced with the alarming statistics of the HIV/AIDS epidemic, it is appropriate to want to respond with care for the children who have been affected. However, it is important to consider the factor of children’s long-term well-being. Building orphanages, for example, may be necessary at times. Yet often a little extra support is all that is needed for a child’s family or extended family to provide them with not only the material but also the psychosocial support they need to grow up healthily. Also, churches should recognize that their efforts fall under the greater umbrella of CD and do the research necessary to understand how to practice CD sustainably. There is a growing need for closer partnerships between churches on different sides of the globe, with donor churches recognizing that the recipients of their gifts are best positioned with their proximity and cultural wherewithal to design interventions.

Strengthening ties between churches and FBOs is all the more important as other entities start recognizing the salience of local connections. Kathy Stuebing, a former professor at TICA in Zambia, mentioned that there was growing interest in the World Bank to partner with pastors. A realization was growing among actors at this level that partnering with individuals who had already had a stake in providing for those in need could be an effective way of channeling aid (personal communication, 20 November 2012). With the international community potentially awakening to this possibility, it is all the more crucial for organizations like seminaries and FBOs to prepare their members to be well-educated and efficacious partners who know how to operate within existing structures and include many voices in their leadership.
For organizations that are interested in pursuing this goal, the case study of FV can be used to jumpstart brainstorming. Of course, FV represents just one permutation of the many organizational configurations that are possible within the Circles of Care. However, their model of focusing on partnering with qualified local leaders, operating with savvy amidst restrictions, and promoting inclusivity in decision-making promotes principles that could be transferable to many different contexts.

Disease, like time, waits for no one. There are millions of children like Neatness who are still lacking the support and stability they need to thrive. Actors in this field of development need to begin to reassess whether their current models are truly meeting these needs effectively. Using the Circles of Care and basic CD principles, it is time to begin reformulating plans and forging partnerships to make a network that spans continents, connecting both the local and global, to provide empowering care to orphaned and vulnerable children and the caregivers that provide for them.
Appendix

Sample Survey

Questions related to programming:
- Please describe the work you are doing with Forgotten Voices in your community.
- How many children does your program serve? What services do you provide your clients?
- You already have a partnership with Forgotten Voices. Are there other groups or individuals with whom you partner or cooperate in order to care for the children in your area? How are decisions made about how to allocate funds or run the project – do you work with a group to make these decisions or is that your responsibility? If in a group: what is the procedure for making a decision? If there is a disagreement, who gets the final word on the decision?
- Do the children under your care also benefit from any government services – schools, health care, or other supports?
- How did you get involved in this work with orphaned and vulnerable children? Did you initiate these projects or did you take over leadership from (a) predecessor(s)?

Seminary education:
- What experiences in seminary (if any) best prepared you for the work you do now?
- Did you take a class pertaining to community development in seminary?
- In retrospect, do you wish there had been any additional resources or support on certain subjects?
- Where did you complete your internship? What did you do? What skills do you think you gained? During your internship, did you participate in any activities related to development? Did you interact with any children affected by HIV/AIDS during that time?
- Did you make any connections with other pastors, teachers, or other individuals that you still maintain? Does this network help in the work you are doing?

Control factors:
- Were there experiences outside of seminary that equipped you for the work you do now? For instance - volunteering, organizing or leading a project, or other experiences.
- Let’s talk about some of the challenges of the work you’re doing.
  - Have you faced interpersonal challenges - in terms of teamwork or with the community?
  - Have you faced material challenges – in terms of finances or lack of infrastructure?
  - Have you faced workload challenges – in terms of fatigue or other emotional burdens associated with the work?
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