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Family Matters: Strengthening Existing Alternative Care Systems for Orphans and Vulnerable Children in Dar es Salaam, Tanzania.

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APPROVAL

This dissertation has been examined and approved as meeting the required standard of scholarship for the fulfilment of the Degree of Doctor of Philosophy in Social Work.

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DECLARATION

This is to certify that this thesis is the result of research undertaken by Mariana J. Makuu towards the award of a Doctor of Philosophy Degree in the Department of Social Work, University of Botswana. This work was conducted from January 2014 to August 2017 at the University of Botswana. References and citations of other works and authorities have been duly acknowledged and it should be placed on record that this work has not previously been submitted in any other University for the award of a degree.

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DEDICATION

This thesis is dedicated first to my daughters, Anneth and Beatrice Milley, my husband Milley Batule, and my niece Mary Vicent Munishi, for their endurance and tolerance. It is also dedicated to the memory of my son, Aggrey Milley Batule. Even though your life was short, you will forever be loved, missed, and remembered. My gratitude also goes to the many OVC in Dar es Salaam who participated in the study and whose accounts constitute in large part, the outcome of this research.

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ABSTRACT

Despite the contribution of the existing alternative care systems for orphans and vulnerable children in Tanzania, there are challenges which continue to hinder their efforts to establish adequate care for these children. The main purpose of this study was to examine the existing alternative care systems for orphans and vulnerable children in Dar es Salaam city in an effort to promote a family-based care for OVC. The researcher employed ecological systems and attachment theories to reflect on theoretical foundations of the study. Qualitative and quantitative research methods were utilized concurrently through mixed methods research. The research employed observation, semi-structured interviews, and focus group discussions in collecting qualitative data, and questionnaires in the collection of quantitative data. The site for the study was the city of Dar es Salaam in Tanzania.

The target population for the study was orphans and vulnerable children. Representatives of residential care centres, key informants, community leaders, social workers, and care givers also participated in this study. The validity and reliability of data collection methods and tools were tested through means of a pilot study. Qualitative and quantitative data were analysed separately using qualitative and quantitative data analysis methods respectively. Qualitative data were transcribed, coded and analysed using ATLAS. ti software. Quantitative data, on the other hand, were analysed through the aid of the Statistical Package for Social Sciences (SPSS) software. The qualitative and quantitative data sets were integrated during data analysis.

The results of the study show that existing alternative care systems have not adequately addressed the needs for care and protection of children without parental care. The findings indicated that social workers have played a significant role in

implementing care arrangements for such children but they face many challenges. From the findings, the situation of children in existing alternative care systems was reported to be fairly good because they had had access to fulfilment of their basic needs. The findings also identified HIV and AIDS as the main contributory factors in the problems associated with placement of children in alternative care. The findings further showed that some children without parental care in various alternative care systems were mistreated. In addition, the findings revealed that Tanzania has positively responded to the right to alternative care for children through the establishment of child related laws and policies, although implementation was reported to be poor due to inadequate government support. Furthermore, stakeholders identified promotion of the family-based care as an important measure towards addressing the need for appropriate care and protection of children without parental care in Dar es Salaam. It is recommended that the Ministry of Health, Community Development, Gender, Elderly, and Children, in collaboration with the Department of Social Welfare, and national, and international partners should adopt a holistic approach to promote alternative care for children without parental care in Dar es Salaam.

Keywords: Orphans and vulnerable children; alternative care systems; family-based care for OVC; social workers; Tanzania; HIV and AIDS.

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LIST OF ACRONYMS AND ABBREVIATIONS

ACRWC	African Charter on the Rights and Welfare of the Child
ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ACPF	African Policy Forum
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CAFO	Christian Alliance for Orphans
CBOs	Community Based Organisations
CELCIS	Centre for Excellence for Looked after Children in Scotland
CEE/CIS	Central and Eastern Europe and the Commonwealth Independent States
CRC	Convention on Rights of the Child
DSW	Department of Social Welfare (Tanzania)
FBOs	Faith Based Organisations
FGD	Focus Group Discussions
GAC	Global Action for Children
GPF	Global Partners Forum
HC	the Hague Convention
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
JLCA	Joint Learning Initiative on Children and AIDS
LGAs	Local Government Authorities
MDGs	Millennium Development Goals
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MoHSW	Ministry of Health and Social Welfare (Tanzania)
MVC	Most Vulnerable Children
NAOT	National Audit Office Tanzania

NASW	National Association of Social workers
NCPA	National Costed Plan of Action (Tanzania)
NGOs	Non-Governmental Organisations
NPA	National Plan of Actions
NSPF	National Social Protection Framework (Tanzania)
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PP	Permanency planning
PMTCT	Prevention of Mother-to-Child Transmission
RAAAP	Rapid Assessment, Analysis and Action Planning Initiative
REOSA	Regional Emergency Office for Southern Africa
REPOA	Research on Poverty Alleviation (Tanzania)
RS	Regional Secretariats
SADC	South African Development Community
SOS	Save our Souls (Children Village)
SSP	Strange Situation Procedure
TCRF	Tanzania Child Rights Forum
TDHS	Tanzania Demographic and Health Surve
TACAIDS	Tanzania Commission for HIV and AIDS
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNCRC	United Nations Convention on Rights of the Child
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children's Emergency Fund.
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organisation

CHAPTER 1-INTRODUCTION

Background to the Study

The family is a fundamental social institution in any society which shapes an individual's social, physical, psychological, and developmental traits. It normally consists of spouses and their offspring as well as the extended family members. While acknowledging that there are different types of families, in this study the focus is on nuclear and the extended families. Family offers socialization to the children in the family to ensure that they grow up respecting societal norms. It is common for families to inspire the rearing of well balanced and successful children. To fulfil this expectation families strive to provide care, love, security, and protection to their children to ensure that their basic needs are met for their spiritual, emotional, and physical development. This is why "family matters" because children who grow up in families are likely to succeed in their future life due to the positive care and support they receive.

Orphan hood is not a new phenomenon in the history of humankind. The term orphan is used to denote a situation where usually both parents or, in some cases one parent, is died. The authors in the literature have grouped an orphan as a 'single orphan' (one parent is dead); 'double orphan' (both parents are dead) (Faith to Action Initiative, 2014); and 'social orphan' (a child whose parents are living but this child is currently not under his/her parental care) (Dillon, 2008). The researcher acknowledge the fact that some countries do not regard a child whose one parent is alive as an orphan.

In human history, there have always been orphans due to various factors such as old age, disease, accidents, conflict, and famine. In the past, in many African societies, orphan hood was not regarded as a social problem for a number of reasons.

Firstly, this was due to the fact that the number of people who died at one point in time was not large. Secondly, it was not common for both parents to die at the same time while children were still very young. This meant that when one or both parents died some of the children were already able to fend for themselves and their siblings. Thirdly, the extended family and community relationships in many parts of Africa were very strong and, hence the extended family was able to provide care, support, and protection to the orphans (Abebe, 2009). It was culturally expected that every community member had a role to play in providing care and support to all children.

However in recent times, the orphan status has turned into a crisis due to unprecedented numbers of orphans as a result of AIDS (UNAIDS, 2010; UNICEF, 2016). According to statistics generated by Global Action for Children (GAC) (2010), about 25 million children were orphaned due to HIV and AIDS in 2010 in the developing world. Furthermore, one billion children in developing countries were living in poverty, with 10 million of them dying annually of preventable diseases and malnutrition. Seventy seven (77) percent of these children were out of school, 44 percent of them being girls (UNAIDS, WHO, & UNICEF, 2007). In addition, poverty related factors have exacerbated the intensity of vulnerability of orphans in terms of care, security, and protection. The devastating impact of HIV and AIDS has raised genuine cause for concern for child welfare in many countries including Tanzania. This is due to the large number of orphans and vulnerable children (OVC) placed in residential care centres (UNICEF, 2012). While in the past no orphan was left without care, today the situation is different due to the orphan crisis and social change, which have rendered the extended family system unable to play its role like before. As a response to the plight of orphans and other vulnerable children new alternative care systems such as community based care, institutional/residential care, supervised child-

headed households, and group homes, have been established to provide care and support to OVC.

Therefore term alternative care systems refers to informal or formal residential care arrangements outside the family of origin made to accommodate children deprived of parental care due to AIDS and other factors causing vulnerability (USAID, 2010). The informal care system refers to any private care arrangements offered in a family environment, where a child is given care by relatives or friends. Sometimes an individual is chosen by the extended family to foster the child (SOS, 2013). This means that the child is integrated into the family of the nominated caregiver and is cared for like a child in the family of origin. The arrangements under the informal care system are not ordered or regulated by the government (UNICEF, 2011). For example, members of the extended family will privately discuss and agree upon who will provide care and support to a child after the death of her/his parents. Community based care and child-headed households are also regarded as informal alternative care systems (SOS, 2014)

By contrast, the formal care system refers to care provided in a family environment sanctioned and regulated by government or any administrative body or judiciary such as adoption and statutory foster care. Formal care is also offered under the conceptualization of a residential/institutional environment or group homes. Seemingly, the increase in the number of OVC as a result of HIV and AIDS, poverty, urbanisation, and unemployment has undermined the existing alternative care systems making it difficult for them to enhance family-based care for OVC access across the world. This equally true of Dar es Salaam in Tanzania. Consequently, OVC have been pushed into critical vulnerability in terms of care, support, security, and protection

due to discrimination, stigmatisation, exploitation, abuse, and general neglect (Delap, 2010).

There is consensus in the OVC literature globally that the 'family -based care model' for OVC is the best alternative care system (UN, 2009; Family Health International (FHI), 2013). First, the family-based care encourages the likelihood that children without parental care remain in their communities or with their extended family whenever possible and advocates for social protection to empower child-headed families and develop community based care programmes. Second, the family-based care promotes the likelihood of other alternative care systems for a child if requested for short or long term purposes depending on identified needs. Such placements should act as an emergency facility and should ensure adequate care and support of OVC pending setting up of care under the family environment. Third, perhaps most importantly, the family-based care for OVC promotes the likelihood of child placement that would lead to family reunification, adoption, and/or legal custody. This implies that professionals like social workers should cooperate with all care systems in order to secure permanent care for the OVC. This is to ensure that children without parental care get access to adequate care and protection.

Globally, a considerable number of children have become vulnerable due to various factors such as disease, poverty, child abuse, oppression, stigmatisation, and exploitation (Save the Children, 2013). Previous studies estimated that 17 million children worldwide had lost both parents due to AIDS (USAID, 2014; UNAIDS, 2016). It is estimated that 153 million children worldwide have lost *either* one parent (single orphan) or both parents (double orphans) (UNAIDS, 2010; (US President Emergency Plan for AIDS Relief) PEPFAR, 2013). Unfortunately these figures are not a complete reflection of the situation of OVC. In fact according to the Christian

Alliance for Orphans (CAFO) (2012), the global orphan estimate has been criticized due to its limitation in excluding an estimated 2 to 8+ million children taken care of by institutions. In addition, the global estimates also exclude the number of children living on the streets. The implication, as noted by CAFO (2012), is that a large number of Orphans and Vulnerable Children (OVC) worldwide is not indicated in the global estimates of OVC which results in failure to meaningfully respond to their pressing needs.

The most affected region in terms of OVC as a result of HIV is sub-Saharan Africa, which accounts for about 71% of all people infected with AIDS (UNAIDS, 2014; Averting HIV and AIDS, 2016). In addition, more than 3 million young people (aged 15-24) are living with HIV in sub Saharan Africa. It is estimated that sub-Saharan Africa has about 45 million orphans and 11.4 million of these children are orphaned due to AIDS (Campbell-Hinda, Maroni, Odongo, & Palermo, 2010; UNICEF, 2016). Based on HIV and AIDS statistics in sub-Saharan Africa, it is estimated that a child somewhere in Africa loses a parent to AIDS every 15 seconds (Epoch Times, 2013).

According to MoHSW (2014), Tanzania had about 1.4 million adult Tanzanians who were living with HIV and AIDS, equivalent to an estimated HIV prevalence of around 5%. It is estimated that 2% of 15-24 years olds are living with HIV in Tanzania making a total of 11% of all Tanzanians living with HIV (Averting HIV and AIDS, 2016). This has had a considerable impact on child welfare in terms of nutrition, health, and education because AIDS has made the parents physically, socially, psychologically, and financially vulnerable. A majority of those who are affected by HIV and AIDS are within the most productive age category of 15-49 years working in the public and private sectors. They are the ones providing the necessary

parental support and care to school going children to see them through their education. For example, of the total 1,728534 student enrolment in secondary school in 2013, 236,414 were orphans, of which 116,555 were female and 119,859 were male. In 2013, of the total enrolment number of 8,231,913 in primary schools, 202,971 were orphans; 103,091 female and 99,880 male (Tanzania Prime Minister's Office, 2013). Given their situation, children (like women) are more adversely affected than men by HIV and AIDS. Their situation is exacerbated by poverty since parents or caretakers do not generate adequate income for survival. In Tanzania, it is estimated that 6 million children under the age of 14 years live below the basic needs poverty line (UNICEF, 2009b).

According to the 2012 national census, Tanzania has a population of about 45 million (National Population Bureau of Statistics, 2012), and, of these, 44 percent are children below 15 years of age. It is estimated that 3 million Tanzanian children are orphaned due to HIV and AIDS (SOS, 2013; PEPFAR, 2015). According to the 2012 national census the city of Dar es Salaam, one of the 30 regions of Tanzania, has a population of 4.5 million. The number of children living in the streets of Dar es Salaam is estimated to range from 3 to 5 thousands (UNICEF, 2012; Kind Heart Africa, 2013). A study by Research on Poverty Alleviation, (REPOA, 2007) indicated that at an individual level analysis based on poverty mapping techniques, orphaned children are poorer as compared to children who are not orphaned. This study further indicated that, the difference between the two groups is larger in Dar es Salaam than in other Tanzanian cities. The difference might be explained by the fact that many orphaned children have moved to Dar es Salaam because they believe they will easily get support from Samaritans. Thus, orphans will be exposed to child labour as they attempt to raise money to meet their basic needs, whereas children in families will

rely on parents for support. The country profile paper by the Ministry of Foreign Affairs (2013) has noted that the Tanzanian population living below the international poverty line spends about $ 1.25 per day, and an estimate of 90 percent of the total population lives below $ 2 per day. This implies that many families are poor and the most affected group is the OVC due to a lack of necessary resources to ensure their sustainable well-being.

Throughout the history of Tanzania, the extended family is known for its contribution towards the care and support of OVC. Today, the ability of the extended family to offer care and support to OVC has been greatly reduced by HIV and AIDS affecting life expectancy and thereby creating a burden of care for the older people and children themselves (Abebe & Aase, 2007; TACAIDS, 2013). This is partly because there is no specific safety net dealing with the livelihoods of OVC in Tanzania. There is, also a lack of proper structures and facilities and a social welfare system which is under performing due to financial, material, and human resource constraints. Consequently, many OVC are not accommodated in the existing alternative care systems such as foster care, adoption, supervised child-headed households, and community based care. Moreover, the coordination of the multiple stakeholders providing care and support to OVC seems not effective especially where some residential care centres offer services without state registration (SOS, 2013).

The Department of Social Welfare under the Ministry of Health and Social Welfare (MoHSW), which is responsible for the well-being of the OVC in Tanzania, indicates that the orphanages in Tanzania are mostly owned by faith-based and non-governmental organisations (MoHSW, 2013). This might be the reason a considerable number of OVC in Tanzania are placed in institutional/residential care. However, the information available does not specify the scope of alternative care systems for OVC

in Tanzania, and Dar es Salaam in particular. This makes it difficult to understand the type of care provided and the number of OVC receiving care from existing alternative care systems and children's homes in Dar es Salaam. This might have been due to lack of appropriate measures and adequate resources by the government to monitor and evaluate existing systems of care and number of OVC receiving care (Williamson & Greenberg, 2010). Before putting into operation a residential care facility for OVC, the responsible institution has to follow proper procedures related to government regulations and policies. Unfortunately, private organisations dealing with OVC have been allowed to offer services without following proper procedures, and this has resulted in many local and international organisations operating with little or no government oversight. The information consistently emphasises that formal care which is mostly provided by private organisations and NGOs is poorly coordinated and lacks adequate inspection, monitoring or regulation by the government (SOS, 2013).

Furthermore, the information gap in existing alternative care systems of OVC in Tanzania, and Dar es Salaam in particular, might hinder development of effective programmes for the well-being of the OVC. As noted by USAID (2010, p. 1) "the scale, scope, and the impact of the alternative care towards OVC have not been well summarized". In addition, it is not clear whether the implemented alternative care programmes are suitable, given the status and nature of OVC in Dar es Salaam. The information gap regarding the scope of OVC problems in different existing alternative care systems raises concern over the comprehensiveness and responsiveness to the pressing needs of the children. In Tanzania the situation is worse especially in big cities like Dar es Salaam, Mwanza, and Arusha where many OVC live on the streets. According to research conducted by UNICEF in collaboration with the MoHSW

(2012), Dar es Salaam had about 5580 children living and working on the streets. The figures indicate that 4,520 (80%) of the total number of street children were boys and 1,060 (20%) were girls. These figures show the seriousness of the situation and the need for an appropriate strategy to address the poor living conditions of the children. Due to challenges facing the existing alternative care systems in establishing a family-based care for OVC, there is need to revisit the care systems in order to strengthen them. The current study seek to examine the existing alternative care systems may promote family-based care for OVC in Dar es Salaam.

Based on global debates on alternative care for OVC (UN, 2010; USAID, 2010; SOS, 2013) it is clear that the major challenge facing vulnerable children globally is the limited implementation of the family-based care (for OVC) to ensure effective support, security, care, and protection and Tanzania is not an exception. It is estimated in the study by the US Government, (USG) and Partners (2009) that globally, 428 million children under 17 years of age experience extreme poverty; 150 million girls have been sexually abused; 2 million children are in residential care; and about 218 million children have been exploited through child labour. The situation of OVC is exacerbated by extreme poverty, poor access to social services, and increased vulnerability to diseases like HIV as well as material and non-material deprivation (Richter, Manegold, & Pather, 2004). According to PEPFAR (2006) children who are deprived or likely to be deprived of parental care or harmed as a result of their environment, require external support because their current care and support system can no longer expand appropriately to meet their needs.

To address the negative impact related to lack of parental care, short and long-term strategies to support families in providing adequate care to OVC through providing cash and material transfer, have to be implemented. Consideration should

be given to the establishment of appropriate emergency services for children not placed under family care especially those OVC with a history of abuse or mental illness (USAID, 2010). As noted by Tolfree (2007) alternative care systems should ensure adequate care whereby basic needs-inter alia, emotional, physical, and academic, are met by their providers to allow for children's sustainable development. This will also imply protection of OVC from abuse, neglect, exploitation or violence, and the use of available resources to ensure their well-being.

To respond to the need for effective care and support of OVC, Tanzania utilises several approaches (UNICEF, 2009b), and those are reflected in instruments such as the Child Development Policy (1996); Community Development Policy (1997); the National Vulnerable Children Identification Guide (2000); National Guidelines for Community- Based Care, Support and Protection of Orphaned and Vulnerable Child (2003); National HIV and AIDS Policy (2001); National Costed Plan of Action for the Most Vulnerable Children (NCPA) (2007); National Social Protection Framework (NSPF) (2008); and National Guidelines for Improving Quality of Care, Support and Protection for Most Vulnerable Children (2009). However, the established policies and approaches have not addressed the problem hindering OVC access into permanent care within a family environment. This has resulted in OVC discrimination, stigma, abuse, and exploitation (as mentioned earlier). As noted by SADC (2010) the major obstacle to realising effective responses to OVC needs lies in the existing gap between policies, guidelines, principles, and frameworks on the one hand; and practice and action on the other. Due to the highlighted gaps, research is needed which can evaluate the existing policies and guidelines and recommend effective approaches for strengthening alternative care systems for OVC.

Research Problem

Dar es Salaam, the biggest city in Tanzania has one of the largest numbers of OVC mainly due to HIV and AIDS (TACAIDS, 2012). It has a prevalence of 6.9%, compared to the overall national average of 5.1% among the year 15-49 age groups (TACAIDS, 2012). A study by SOS (2012) on the theme rights- based situational analysis of children without parental care and at risk of losing parental care in Tanzania, revealed that 11,565 children were placed in residential care; 80 children were in retention (a detention facility for children who have violated the law which was established under the Law of the Child (Retention Homes) 2009, and 80 in approved schools. The study further noted that 453 children were in prison whereas 578 children were in detention in different cities of Tanzania and Dar es Salaam city is not exceptional. A study conducted by the Department of Social Welfare (2011) on assessment of the situation of children in institutional care in Tanzania indicated that there are more than 40 residential care centres providing support to almost 2000 OVC in Dar es Salaam. Anecdotal evidence shows that Dar es Salaam also has many street children who can be seen wandering about. This indicates that alternative care systems such as kinship/extended family care, statutory foster care, supervised child-headed households, group homes, and community based care systems are not fully addressing OVC care and protection needs.

Various measures to curb the problem of OVC in Tanzania in general and Dar es Salaam in particular have been instituted by internal and external organisations including Tanzania Ministry of Health and Social Welfare, Tanzania Ministry of Constitutional and Legal Affairs, Tanzania Ministry of Education and Vocational Training, UNAIDS, TACAIDS, UNICEF, SOS, SADC, ACERWC, PEPFAR, USAID, WHO, and Save the Children. These measures are meant to enhance

accessibility to education, health services, nutrition, shelter, and clothing as well as security and protection. For example, TACAIDS (2013) noted that there have been progressive initiatives to offer care and support to OVC in Tanzania, and about 127,385 OVC were receiving support ranging from health care through psychosocial, food, and nutrition, to educational materials in 2012.

Nevertheless, there is increasing concern that the above interventions have not achieved their set objectives, the reasons being that a large number of OVC is still placed in residential/institutional care, and many children are living and spending their lives on the streets (Kind Heart Africa, 2013). As such a considerable number of OVC in Tanzania, and particularly in Dar es Salaam, do not have access to education, health care, and nutrition which indicates insufficient care and protection.

While alternative care initiatives for OVC are in existence in Dar es Salaam, their effectiveness in establishing the family-based care for the children in Dar es Salaam has not been empirically tested. Existing alternative care systems such as the extended family/kinship care, statutory foster care, adoption, community based, and residential/institutional care have faced challenges which have hindered their effectiveness (Roelen & Delap, 2010). In studies regarding children's rights, child care, and child protection (Everychild, 2011a; Save the children, 2012; SOS, 2013); 'family', as an institution, has been considered the best place for care and protection of children. This supports the slogan used by several agencies dealing with children that; "every child needs a family". This is because most OVC who have been raised in a family-based care have been successful (independent social and economic positions) in their lives (UNCRC, 2009; Save the Children, 2012). It is believed that a family environment has provided them with social orientation, self-discipline at school, and participation in home chores. This is in line with the result of a study by Olson,

Messinger, Sutherland, and Astone (2005) which showed that OVC who grew up with families are likely to be more successful in life than those growing up in residential/institutional care. Therefore, there is a need to establish effective initiatives to promote the family-based care for OVC.

However, in Tanzania apparently no recent nationwide comprehensive situational analysis has been conducted of OVC in various alternative care systems, other than a baseline survey on a situational analysis of OVC in residential care centres conducted by the Department of Social Welfare and non- government organisations. This limits the understanding of the number of OVC under the support of different alternative care systems, the nature of services provided, and challenges experienced. The baseline report on alternative care systems in Tanzania (SOS, 2014) indicated that traditional practices of providing care and support to OVC have been weakened by the increased number of OVC due to HIV and AIDS. As a result many OVC have been affected by abuse, exploitation, discrimination, stigmatisation, killings, and torture because they have no access to care under the family environment and no effective support from the stakeholders. Furthermore a study on the nature of alternative care systems for OVC, the situation of OVC in various alternative care systems, and the contribution of the existing legislation towards the enhancement of alternative care for OVC, is very limited, to the researcher's knowledge. In addition, research on how alternative care systems for OVC can be strengthened to promote family-based care appear to be quite limited on research. This study, therefore, seeks to examine existing alternative care systems for OVC in Dar es Salaam, with a view to exploring strategies for these in an effort to promote family-based care in Tanzania.

Aim of Study

The overall aim of this study is to examine the nature of the existing alternative care systems for OVC in Dar es Salaam Tanzania, in an effort to explore ways to strengthen them in order to promote the family-based care for OVC

Specific Objectives

a. To describe the nature of the alternative care systems for OVC in Dar es Salaam.
b. To examine the situation of OVC in existing alternative care systems in Dar es Salaam.
c. To examine the potential contribution of the existing child related laws and policies towards the enhancement of alternative care for OVC in Dar es Salaam.
d. To explore stakeholders' perceptions on promotion of the family-based care for OVC in Dar es Salaam.
e. To provide appropriate recommendations to promote the family-based care for OVC in Tanzania.

Research Questions

a. What is the nature of the alternative care systems for OVC in Dar es Salaam?
b. How is the situation of OVC in various alternative care systems in Dar es Salaam?
c. How child related laws and policies can help in the enhancement of alternative care for OVC in Dar es Salaam?
d. What are the perceptions of various stakeholders regarding promotion of the family-based care for OVC in Dar es Salaam?

Significance of the Study

A number of studies on alternative care and the living conditions of OVC in Tanzania have been conducted over the years. However, these studies have not examined how the existing alternative care systems can be strengthened to realise the

family-based care for children who have been deprived of parental care. This study intends to direct attention towards examining the existing alternative care systems for OVC in Dar es Salaam with a view to exploring strategies for strengthening the family -based care model. The study is significant because it seeks to contribute to policy, practice, and research.

Contribution to Policy

It is anticipated that the outcome, of the study will contribute to the development of new policies, programmes, and projects related to care and support of OVC by reflecting on ways of strengthening the existing alternative care systems. There exist some policies related to child care and protection in Tanzania. However, the policies have not been very effective in promoting practice in the care for OVC. For example the adoption policy has been implemented for many years but very few children have benefited from positive domestic and international adoption programmes. The results of this study therefore are expected to provide evidence on how to strengthen the existing alternative care systems for realisation of the family-based care for OVC. The results might also lead to reflection on policies that will trigger interest and debate among the stakeholders including political leaders, educationists, physicians, legal officers, and social workers in developing a tool for advocacy for use by social workers, and caregivers. NGOs, CBOs, FBOs, caregivers, social workers, and community leaders will also gain knowledge which will help to promote their efforts towards effective care and support for OVC.

Contribution to Practice

Provision of care and support to OVC is not a new phenomenon. Families and communities are recognised for their efforts in taking care of children who have been deprived of parental care. Due to challenges related to the impact of HIV and AIDS

and poverty related factors, the efforts of the existing alternative care systems to continue supporting OVC have been undermined. This has led to inadequate care and support for OVC which has left them vulnerable to abuse, discrimination, and exploitation. The social work profession under the Department of Social Welfare in Tanzania is responsible for implementation of alternative care arrangements such as statutory foster care and adoption. The Department is implementing the National Costed Plan of Action for the most vulnerable children (2012-2017). The plan is responsible for strengthening the capacity of the extended family and communities to protect, care, and support OVC. Unfortunately Social work practice has not been effective in ensuring that OVC are able to access a positive family care environment. This study is expected to constructively contribute to social work practice in the sphere of the family-based care for OVC. The study is expected to shed light on the potential effectiveness of the family-based care for OVC in promoting welfare of the OVC. It is expected that the findings might be used to reveal the importance of this form of care, providing understanding of practice, and advocate for its enhancement in communities. This might help to attract further support from the government and other stakeholders to create opportunities for more families to offer care and support to OVC.

Contribution to Research/ Generating Theoretical Knowledge Base

Literature on alternative care for OVC in Tanzania exists but it does not capture the scope of the alternative care systems and various challenges faced in implementation of same. The findings of this study are expected to extend the literature on nature of alternative care for OVC and the situation of OVC in various alternative care systems. The findings will also add new information with respect to the potential contribution of child related laws and policies in the enhancement of

alternative care for OVC as well as best practices for enhancing the family-based care for OVC in a Tanzanian context. Available evidence suggests that family based care is the best system for ensuring sustainable wellbeing of OVC. In addition, the study is also expected to provide evidence to support the need for further investigation into issues related to strengthening alternative care for OVC.

Furthermore, the findings are expected to provide evidence-based information on attachment and ecological systems theories, related to addressing challenges facing existing alternative care systems for OVC. This will contribute to the understanding of the relationship and interaction between OVC, caregivers, teachers, social workers, parents, and communities as important aspects of care systems. The study is expected to contribute to knowledge and relevant literature which will guide new studies.

Definition of Terms

Adoption of a child: The encyclopedia of human relationship defines adoption as "a legal transfer of the parental rights and responsibilities from the biological parent/parents to another adult who rear the child." (Harry&Sprecher, 2009). In this study adoption of a child is referred to as a procedure carried out by the appointed social welfare officers based on the Law of Child Act, 2009; to grant permanent family care to children who have no acceptable alternative permanent family care. Tanzania Law of the Child Act (2009 CAP 13, defines adoption a measure taken to provide a child who is deprived of his/her parental care a permanent placement under the best interests of the child. The implication is that after a child is adopted the rights and obligation of biological parents as well as extended family are terminated to allow formation of a new bond between the child and the adoptive family (Tanzania Law of the Child Act, 2009).

Alternative care: Alternative care in this study is regarded as the support mechanism offered to children without parental care outside the family of origin. As noted by the USAID (2010) such alternatives include: the extended family, foster families, adoption, group homes, residential care centres, supported child-headed households, and community-based care. This definition is appropriate for this study because identified care systems can be strengthened to promote the family-based care for OVC that is expected to offer permanent care for OVC in Tanzania.

Child-headed household: In this study this will refer to an alternative care arrangement where children live on their own together in their family home after death of their parents. This might happen as a result of decision made by children themselves or might happen as a result of lack of relatives to offer care to children deprived of parental care. The head of the family under this care system is an elder child who takes the responsibility of supporting the siblings in terms of the basic needs. According to UN (2009) guidelines, a child-headed household is a care system where siblings stay together in their households after death of their parents.

Community-based care: Community-based care in this study is defined as different initiatives developed in the communities for supporting children without parental care, vulnerable groups, and poor families to realise social, psychological, physical, and economic development. According to USAID (2010) community led interventions include family-strengthening, psychosocial support, empowerment, economic development, and cash assistance; all provided within the OVC's own community and within a family or family-like setting. USAID (2010) has identified five relevant elements of effective community based care such as: community mobilisation, community structure, community capacity, resource mobilization, and linkages.

Extended family/kinship care: In this study kinship care is referred to as care under the family environment which involves care by kinship members such as grandparents, uncles, aunts, nephews, cousins, and older siblings. This definition is supported by Save the Children (2007) which defines kinship care as a type of alternative care that is family based, within the child's kinship system or with close friends of the family known to the child.

Family-based care for OVC: For purpose of this study, the family-based care for OVC is a system of care whereby a child deprived of parental care is placed in a family environment for securing a permanent home. This can be care and support provided to OVC through kinship/extended family, statutory foster care, supported child-headed households, group homes, and community-based care (UNICEF, 2011). The purpose is to ensure that OVC are able to access a secure environment for their social, mental, physical, psychological, and economic development.

Foster care: In this study, it refers to the care provided to OVC by families, which are not part of the extended family. These families can be friends, neighbours or other people from the community who are not related to the child. Formal/statutory foster care is defined as "Situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family that has been selected, qualified, approved and supervised for providing such care" (UN, 2009, p. 9). In this study the term formal foster care will be used interchangeably with statutory foster care.

Institutional care: This refers to care provided to OVC by a registered residential care centre. According to World Vision (2009), the terms institutional care and residential care are often used interchangeably to cover a wide range of care systems. Residential care is mostly preferred because institutional care often carries a

negative connotation which makes practitioners avoid the term. The Guidelines for Alternative Care for Children defines it as "Care provided in any non-family based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities, including group homes" (UN, 2009 Art 28, p. 6). Institutional care, in this study, will be used interchangeably with residential care. The latter definition will suffice for purposes of this study.

Orphan: An orphan is a term that had been defined differently in the literature. Richter (2004) defines an orphan as a child whose one parent is dead (single orphan) which can either be maternal (mother is dead) or paternal (father is dead); and a child whose both parents are dead (double orphans). Dillicon (2008) identified a social orphan as a term used to refer to a child who's both parents are living, but not currently providing care to their child due to various reasons. The researcher acknowledge that in some societies a child with one living parent is not regarded as an orphans. According to Skinner et al., (2004), the term orphan and vulnerable children (OVC) was introduced due to limited usefulness of the constructs of orphanhood and vulnerability in the context of HIV and AIDS. Due to some difficulties with these terms and lack of clear meaning or criteria of inclusion and exclusion, they are best applied as theoretical designs. An orphan in this study is regarded as a child less than 18 years of age whose parents (one or both) have died. This is in line with the definition of orphan used by the Government of Tanzania. This definition is different from the one provided by UNAIDS (2011) which uses the term 'orphan' to describe a child who has lost either one or both parents to AIDS, without indicating other related death factors. The death of a parent in this study can be due to factors other than AIDS, although the author agrees that the AIDS pandemic has

indeed helped significantly increase the number of orphans, creating global crisis in the process.

Social work: Social work in this study is referred to as a profession, which strives to help and empower vulnerable groups in society such as people affected by HIV and AIDS, children, women, the older people, as well as people living with disability. The International Federation of Social workers and the International Association of Schools of Social Work defines social work as:

"A profession that promotes social change, problem solving in human relationships, and empowerment and liberation of people to enhance wellbeing. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environment. Principles of human rights and social justice are fundamental to social work" (International Federation of Social Workers, 2009, p.409). Social workers in Tanzania work under the Department of Social Welfare in the MoHSW and they are employed as social welfare officers.

Vulnerable children: In this study this term refers to children who have no parental care such as orphans, street children, neglected children, children living with disabilities, very sick children, homeless children and children living with very sick or very poor parents. SADC (2011, p.7) has defined vulnerable children as "children who are unable or who have diminished capacity to access their basic needs, as well as rights, to survival, development, protection, and participation as a result of their physical condition or social, cultural, economic or political circumstances, and environment". This definition is consistent with the definition of the term 'most vulnerable children' (MVC) which refers to as children who are living in extreme poverty, affected by illness and lack care and support, living with chronically ill parents, living in institutional care, living on the streets, marginalized, stigmatized or

have disabilities, and do not have access to adequate support (USAID, 2008). The next chapter focuses on reviewing literature and theoretical framework that support this study.

CHAPTER 2-LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Introduction

This section presents a literature review from national, regional, and international studies about alternative care systems focusing on care, support, security, and protection of the OVC. In the concept of the review the researcher synthesized, commented, and critiqued the literature in order to establish the present gaps related to the suggested theme. The chapter is divided into two main sections. Section one reflects on the specific objectives of the study which are: to describe the nature of the alternative care systems for OVC in Dar es Salaam; to examine the situation of OVC in various alternative care systems; to examine the potential contribution of the existing child related laws and policies towards the enhancement of alternative care for OVC; and lastly to explore stakeholders' perceptions with regard to promotion of the family-based care for OVC in Dar es Salaam. The second section covers the theoretical framework where two theories which are employed for purpose of this study are described (i.e. attachment theory and ecological systems theory).

The Nature of the Alternative care systems for OVC

The definition of alternative care by different scholars appears to have some similar features which include care outside the family of origin or parental care such as kinship/extended family care, statutory, and informal foster care, adoption, community-based care, institutional/residential care, orphan village/group homes, and supervised child-headed households (UN, 2009, SADC, 2010; EveryChild, 2012a). Similarly, the UN (2009) suggests different forms of alternative care such as informal care. This is where care is provided in a family (or family type environment) on a

long-term/permanent basis by relatives (extended family/kinship care) or friends. Another form of alternative care is formal care which includes all care provided in a family environment which has been formalized legally through adoption, residential care or statutory foster care. The purpose of alternative care as provided by the UN (2009) is to ensure that children who are deprived of parental care are highly protected by observing implementation of the Convention on the Rights of the Child. The study by EveryChild (2009a) titled 'Every child deserves *a family*'; and Roelen and Delap (2012) on '*Researching* the links between social protection and children's care in Sub Saharan Africa' claimed that, almost 24 million children across the world are deprived of parental care.

Research by Dunn and Webb (2003); World Vision, (2005); NCPA (2007-2010); and EveryChild (2012a,) has found out that the family is the ideal institution for providing care and support to OVC. World Vision (2005) established that globally it is believed that even if the family is impoverished, it can still offer care and support to a child with assistance from the government. However, studies by UNICEF (2010); USAID (2010) and EveryChild (2012a) established that poverty is the main contributory factor to the loss of parental care and institutionalization of children. Some OVC have run away from their family homes due to poor living conditions as a result of extreme poverty (Roelen & Delap, 2012).

Research by World Vision (2009b); USAID (2010), and Roelen and Delap (2012) proposed alleviating the effects of poverty by supporting families financially so that they can manage to provide basic necessities to OVC as well as to their own families to ensure sustainable development of OVC. The UN (2009) has recommended on proper arrangements to facilitate informal foster care while ensuring that formal arrangements are realised for statutory foster care in order to enhance the

child's best interests. Studies have been conducted worldwide about child adoption policy and its challenges regarding OVC safety and protection, but in Africa (and in Tanzania specifically) the studies in this area are limited. As noted in the literature, there is need to change the adoption tradition which mostly emphasised providing homes to vulnerable children, and maintain the 21st century notion of adoption which is more concerned with providing secure, permanent relationships for OVC (PEPFAR, 2012). Save the Children (2007) contends that, the most appropriate way to address problems faced by OVC is to facilitate establishment of cost effective programmes to promote family-based care for OVC which will improve living conditions of OVC.

Scope of the Alternative care systems for OVC

Alternative care as noted earlier is defined differently by different scholars. The scope of alternative care for OVC is also considered to be very wide and it has been defined differently by various authors under different contexts (USAID, 2010). However, arrangements involved in alternative care for OVC include kinship/extended family care, statutory foster care, adoption of a child, child-headed households, group homes, community-based, and institutional/residential based care. These are elaborated on in the next few paragraphs.

Extended Family/Kinship Care

Kinship care is regarded to be the most common system of alternative care around the world with grandparents' care constituting the most common form of care (EveryChild, 2012a; Better Care Network & UNICEF, 2015). As noted by the Department for Education (2010) and Every Child (2012a) in the UK, kinship carers are referred to as 'family and friends' carers. In extended/kinship care, children can be cared for by kin within the country of residence or sent to relatives across borders

(EveryChild, 2012a). Cross border kinship care often involves sending a child from a poor county with more limited resources to relatives in a wealthier environment, possibly in another country (UNICEF, 2004). It is believed that kinship care is one of the most common alternative care systems which are mostly practiced in Sub-Saharan African countries (Better Care Network, 2009; USAID, 2010; SOS Tanzania, 2013). The study by Tshitswana (2003) in Botswana indicates that the extended family is the best response to the orphan crisis and it requires support and advocacy for its sustainability. A study by Miller, Gruskin, Subramanian, Rajaraman, and Heymann, (2006) on orphan care in Botswana's working households revealed that, the extended family supported over 90% of OVC, which scenario calls for comprehensive social, psychological, and financial support from national governments and international agencies. It is believed that kinship care, if well managed, can effectively promote the family-based care for OVC and sustainable care for OVC (EveryChild, 2012a).

Nevertheless, extended family/kinship care faces challenges such as critical poverty (Roelen & Delap, 2010) and changes of family structure where some families are adjusting to the nuclear families mode which concentrates much on providing support to the families members (Maundeni, 2009). Malinga and Ntshwarang (2011) in their study on alternative care for children in Botswana found that, OVC are sometimes abused by their extended family through child labour, violence, discrimination, and stigmatization. A study on orphan-hood and the care dilemma on global orphans by Abebe (2009) proposed that a critical assessment should be carried out regarding constraints facing the extended family unit. This should take place before placing OVC in inappropriate families to avoid compromising the OVC's physical and psychological well-being. In order to ensure that these children are

effectively supported and protected, a critical assessment and evaluation of OVC placements has to be implemented within the framework of every system of care.

A snap-short study on alternative care in Tanzania by SOS (2013) revealed that, alternative care arrangements for OVC in Dar es Salaam are based on formal and informal care arrangements. The informal care arrangement dominates and covers the extended family providing care and support to OVC without having been ordered by an administrative or judicial authority (UN, 2010). Kinship care enables many OVC to be taken care of within the family environment which helps to preserve kinship and community (SOS, 2013). When compared to other forms of alternative care, care in a family environment is considered the best in promoting a long lasting secure base of attachment which helps the OVC to develop mentally and physically hence realise a successful future (EveryChild and HelpAge International (2012). In Tanzania (UNICEF, 2009a) grandmothers were caring for, almost 50 per cent of orphaned children.

However, limited research exist concerning many challenges confronting the extended family in Dar es Salaam as in many other African communities (as noted earlier) and these include financial constraints which has make it difficult for units to support the large number of children in need of care. This is due to the fact that the kinship care system is not adequately supported by governments in many developing countries such as Tanzania (Joint Learning Initiative on Children and AIDS (JLCA, 2009). As a result some OVC have been denied their right to parental care, education, health services, food, and shelter. This has resulted in phenomena such as street children, child labour, and child trafficking as children struggle to meet their basic needs (SOS, 2013).

Statutory Foster Care for OVC

The term ‘foster care’ or ‘fostering’ as noted by Williamson and Greenberg (2010) is used to refer to various approaches to child care. These authors provided an example of the USA and Europe, where foster care is regarded as a form of care for children without parental care in which the state is responsible for supervision, provision of material, and financial resources. Foster care according to Cohen and Garret (2006) refers to different services which are offered to children who have experienced abuse or neglect, death of their birthparents, and defective families. The study by Pitso, Maxhela, Xhongo, and Vazi (2014) on behavioural impact of foster care (Alice township-South Africa), established different forms of foster care for children deprived of parental care such as care provided by unrelated foster parents, relatives, or in group homes or residential treatment centres.

Foster care is generally not considered as permanent (though it may be long-term in specific legal cases (EveryChild, 2011a). The use of foster care varies greatly around the world (Mkombozi, 2005; EveryChild, 2011a). In Northern America, Australia, and Western Europe, foster care generally refers to as a placement choice for children requiring alternative care, with small group residential care centres, but used only when kinship care is not available or suitable for a child’s needs. The South African Children’s Act 38 of 2005 states that foster care is generally applicable to children who are not willing or able to remain with their own families due to abuse, neglect or abandonment; but for whom adoption is not feasible or recommended. In Central and Eastern Europe and the Commonwealth Independent States (CEE/CIS) (i.e.Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Uzbekistan and Ukraine); as well as some parts of Latin America, more organized foster care initiatives have been created but it is only

extended to a small proportion of children in alternative care (EveryChild, 2011b). The term ‘foster care’ or ‘fostering’ is also used to denote informal/traditional care arrangements which are widely used in some regions such as West Africa (Williamson & Greenberg, 2010).

Foster care according to EveryChild (2011b) is a key mechanism for creating a family like environment recognized for its effective role in providing care and support to OVC in terms of short and long-term change, growth, and development. OVC continue to receive close parenting supported by emotional, social, and physical nurturing which facilitates a sense of identity and belongingness. In addition, OVC develop confidence and maturity that serve to enhance adult life (EveryChild, 2011b). However, the challenge that remains in many parts of the world that foster care, which would be an essential system in promoting the family-based care for OVC, is not well developed and is frequently underutilised (EveryChild, 2011b). EveryChild (2011b) notes that, if foster care is developed to its maximum level it can be an effective mechanism for ensuring wellbeing of OVC especially in situational emergency. Furthermore, it can serve as a long-term response for children for whom adoption is not an option or those who cannot be returned to their families due to unresolved issues (like abusive, alcoholic or drug addicted parents) (EveryChild, 2011b).

It is evident that, in sub Saharan-Africa, a large number of OVC outside parental care are supported by the extended family network which have been overwhelmed by the burden caused by the AIDS crisis (JLICA, 2009; EveryChild, 2010). However, the growing number of residential care centres in many countries may lead to more children moving out of kinship care, especially if there are no effective plans to support the families, or programmes of statutory (non-related care). Effectiveness of foster care in sub-Saharan Africa according to EveryChild (2011b)

has not been fully realized and the approach tends to be used in a piecemeal manner. For example, a review of alternative care systems in southern Africa, established that the number of OVC in institutional care was higher than those in foster care (Parry-Williams & Dunn, 2009). EveryChild, (2011b) noted that formal non-relative foster care programmmes in South Africa for instance are affected by limited use of formal foster care. For example, about 50,000 children are in formal non-relative foster care which is far beyond the expected 16,500 children. Furthermore, many OVC in Namibia are placed in formalised foster care programmes (Parry-Williams & Dunn, 2009).

In Tanzania, informal foster care is well recognized and widely used as compared to formal foster care (Mkombozi, 2005). It is common to find people who have been raised by relatives even when they had biological parents to care for them. To date, there is no specific initiative to ensure that formal foster care is established across the country to address the OVC crisis, although it is indicted in the literature that it is less expensive than institutional care (Williamson & Greenberg, 2010, p. 7). World Bank (1997) noted that the annual cost for one child in residential care centre in Tanzania was approximately $1,000; more than six times what it costs in foster care; and in South Africa institutional care was four times more expensive than statutory foster care.

Research has identified some limitations of foster care which implies that some measures are needed to ensure effective care, support, and protection of children. The limitations include the increasing number of children in need of alternative care, using foster care as a placement option instead of developing the family-based care for OVC, and challenges associated with fostering (Hudson & Levasseur, 2002). A study by Pittracher, Rudisch-Pfurtscheller, and Westreicher

(2004) that based on both informal and statutory foster care in Botswana revealed some challenges faced by working families that took care of orphans compared to families not caring for orphans. They found out that these families were likely to face difficulties in meeting the needs of their own families in addition to those of OVC, limited time to take care of their own families, difficulty in coping with overall responsibilities at home, and inability to find reliable child care assistance because of financial constraints. The implication is that, the quantity and quality of services provided to OVC might be insufficient which will affect their living conditions.

Community Based Care for OVC

Community based care can be an effective approach for the sustainable development of OVC due to a variety of community initiated and/or community led interventions (USAID, 2010). This type of system includes providing care and support to OVC within their communities and in family-like settings. Effective community based care encompasses five main approaches: community mobilization, community structure, community capacity, resource mobilization, and linkages (USAID, 2010). It is believed that community-led child care programmes that are well networked and established through a strong community mobilization process can be a sustainable mechanism for enhanced child well-being at the community level.

Community initiatives have been implemented to address the OVC crisis in various parts of Africa such as Kenya, Botswana, Malawi, Uganda, Zambia, Ethiopia, Tanzania, Rwanda, and Ghana. Unfortunately research on community-based initiatives in Africa is very limited which makes it difficult to evaluate the scope of services related to OVC and related challenges (Abebe & Aase, 2007). The initiatives are based on voluntary, consultative decision making processes, utilization of

available resources in the community, and community leadership. Sometimes the initiatives offer intangible resources/services like food, washing products and clothes to caregivers, companionship, acceptance, and encouragement through prayers (Mathombo & Richter, 2007). Educational messages can be important through traditional music, dance, and drama plays (Hyun, 2007). Examples of community initiatives may include savings associations and community based organisations that can use volunteers and that receive minimal external support. These may include: labour sharing schemes, agricultural cooperatives, revolving savings and credit associations, burial societies, and mutual assistance groups (Foster, 2005b).

A community initiative may also include care for orphans by the extended family, a selected guardian or a responsible adult. In extreme cases it includes care by older children, or female /grandparent headed households (Chama, 2008). The positive responses of communities to the provision of care and support to OVC through various initiatives, are often confronted by a number of limitations, which include inadequate appreciation of community initiatives and coping mechanisms by external agencies (Foster, 2005a); lack of access to financial and material resources, impact of HIV and AIDS on communities, limited technical capacity (Mathambo & Richter, 2007); and a strong reliance upon women volunteers (UNAIDS, 2000).

Institutional/Residential Based Care for OVC

Alternative care in the form of residential/ institutional facilities has been discouraged and is usually considered ‘a last resort’ (UN, 2009; SADC, 2010). Research by Dann and Webb (2003) notes that the extensive use of residential care in sub-Saharan Africa has been fanned by the death of parents due to AIDS. Residential care involves providing basic, social, and psychological needs to children deprived of parental care. For example it offers shelter, food, clothes, beddings, education,

medical care, and counselling services to those children. Residential care as a long-term care mechanism has been associated with developmental problems and psychological problems, abuse, and exploitation (Dunn & Webb, 2003; World Vision, 2005; Save the Children, 2009b; Save the children, 2012). Over fifty years of research has found that residential care for children generally does not adequately meet their social and emotional needs (World Vision, 2005; Save the Children, 2009a). Save the Children (2012a, p.3) states that "residential care is a rights issue," and that children in such care arrangements are more exposed to risks while their rights are ignored or abused. Other problems associated with institutional care include reduced ability to form lasting attachments; community stigmatization; and transitional risks related to housing, education, and employment when children leave institutional care (Dunn, Jareg, & Webb, 2003; Williamson, 2004).

The existing literature indicates that the cost of maintaining OVC in institutional centres was higher than that of maintaining OVC in family settings and community based care. As noted by Save the Children (2009b), in Central and Eastern Europe and the Former Soviet Union residential care was twice as expensive as the most expensive alternative (small group homes); three – five times more expensive than foster care; and approximately eight times more costly than the provision of family and community support services for vulnerable families (Carter, 2005).

However, data on OVC in institutional-based care are limited and poorly documented (Better Care Network, 2009). SADC (2010) stated that many residential care facilities in the region were unregistered, and thus they are neither monitored nor supported by national social welfare departments. This suggest that the numbers of OVC placed in residential care was not to be known. There is also a possibility that the nature and quality of care and support provided to OVC in such care facility is

unknown which makes it difficult to evaluate the effectiveness of this strategy. Despite a substantial body of research highlighting the harm that may be caused by institutional care, there is growing evidence that an increasing number of institutional care facilities are being established worldwide (EveryChild, 2011a). The expansion of this form of care as noted by EveryChild (2011a) does not conform to the global guidance (UN, 2009) and the stated policies of many governments. Furthermore, the expansion of institutional care is not always fully monitored by government policies and does not adhere to child welfare regulations (Williamson & Greenberg, 2010). As noted by Williamson & Greenberg (2010) institutional care in some countries and in some special cases is inevitable. The authors cite the removal of adolescents living on the streets and being reallocated to institutions as a first step in their rehabilitation (Williamson & Greenberg, 2010).

It has been recommended by the UN (2009) that alternative care for OVC has to support efforts to keep children in, or return them to the care of their families or, failing this, to find other appropriate and permanent solutions, including adoption and *kafalah (*in the case of Islamic law). Kafala is defined as "the commitment to voluntarily take care of the maintenance, of the education and of the protection of a minor, in the same way a parent would do for a child" (ISS, 2007).

Child-headed Households

Child-headed household as stated in the previous chapters is an alternative care arrangement where children live on their own together in their family home after death of their parents. Emergence of child-headed households has been contributed mostly by lack of the parental care due to death of parents as a result of HIV and AIDS, accidents, non communicable diseases, and other related causes. Other contributing factors include armed conflicts, family breakdown, and natural disasters

(UNICEF, 2009a; UNAIDS, 2010; Phillips, 2011). The findings by Evans (2010) and Kijo-Bisimba (2011) revealed that some children might have decided to remain together in their family home after the death of their parents to prevent the possibility of being separated from their siblings, and to ptotect the family's property from being grabbed by relatives. For example separation may occur when children who are already attending school are placed with relatives in town and their young siblings sent to the villages to live with grandparents. Some children living on the streets might also decide to join friends in child-headed households. The main reason behind the formation of child-headed households is the lack of adequate alternative care in a family environment for children deprived of their parental care in many African coutries is limited (Phillips, 2011).

Apart from the fact that child-headed households offer care under the family environment it is regarded as one of the alternative care systems which is vulnerable due to inadequate supervision and protection (UNICEF, 2007; Kijo-Simba, 2011; SOS, 2014; Faith to Action Initiative, 2015). This is because after the death of the parents the elder child has to play the roles of parenthood to ensure that the siblings get the basic needs such as food, water and medication. MoHSW (2011) and SOS (2012) noted that many children living in child-headed households are not only deprived of their parental care, but also their right to education and health sevices. According to Phillips (2011), some child-headed households might be providing care to their very old grandparents, very sick parents or relatives living with disabilities who are unable to fend for themselves. Furthermore, children living in child-headed households are confronted with inadequate material and financial resources to fulfil their basic needs, failure to attend school, abuse, stigmatisation, and exploitation (UNAIDS, 2010). This is against the provisions of the UNCRC Committee (2003)

which requires all governments to ensure that children living in child-headed households have access to food, clothing and shelter, health and education services, as well as the right to inheritance.

Previous studies have indicated that the number of children living in child-headed households was increasing (UNICEF, 2010; Phillips, 2011; SOS, 2012). Unfortunately, research on the situation of children living in child-headed households and immediate measures that would ensure their support and protection is limited. For example there should be adequate supervision from the communities as well as social, psychological, and financial support from various stakeholders for their wellbeing. It has been reported that children living in child-headed households have been affected by the caring responsibilies due to the many challenges they encounter in their daily lives (Foster, 2004; Evancy, 2010). For example, child-headed households stuggle to adjust to the care roles sometimes from the time when their parents were very sick. These children had to make decisions related to finance, care taking, and home keeping (Evans, 2010; Phillips, 2011). Consequently some such children had failed to continue with their schooling because of being overwhelmed by the care role responsibilities. Evans (2010) noted that many child-headed households had not sufficient support for their young siblings' education. This means that many children living in child-headed households would end up wallowing in illeteracy in their adulthood and they would find it difficult to secure employment, which would accelerate the viscious circle of povery. This calls for effective programmes to ensure that children living in child headed households are able to receive appropriate education.

The Situation of OVC in Various Alternative care systems

Many children globally are growing without one or both parents due to HIV and AIDS, poverty, child negligence, disability, violence, discrimination, stigmatisation, abuse, and exploitation (Dunn & Parry-Williams, 2008; Save the Children, 2009; UNICEF, 2009a). With an overall population of 45 million, Tanzania has an estimated 3 million OVC mainly as a result of devastating impact of HIV and AIDS (National Population Bureau of Statistics, 2012; UNAIDS, 2012). A report by the TACAIDS (2013) revealed that 44% of the Tanzanian population are children below 15 years of age. According to SOS (2014) Tanzania has 230,256 children who are double orphans, 462,688 maternal orphans, and 1,283,067 paternal orphans. Previous studies acknowledged that children in various alternative care systems such as kinship, foster, community-based, adoption, group homes care, and supervised child-headed households, have an opportunity to access food, shelter, clothing, education, and health care services (Abebe, 2009; USAID, 2010; SADC, 2010; Faith Action Initiatives, 2015). It is indicated in the previous studies that in Tanzania many OVC are supported by the members of the extended family (SOS, 2013). However, the findings by UNICEF (2012) indicated that the number of OVC had increased due to HIV and AIDS and it had overwhelmed their extended family supporting them. Furthermore, the findings by the USAID (2010) revealed that OVC in Tanzania are most likely to become illiterate compared to children with parents because of their limited support due to poverty. For example, while children living with their families are provided food, school uniforms, and medical care by their parents, some OVC have to struggle on their own. This implies that sometimes OVC have to engage in child labour in order to get money for buying food and other necessities, denying them time to attend school.

Due to economic constraints members of the extended family have failed to accommodate more children in their families (Roelen & Delap, 2012). In addition some extended families could not afford to provide support to children under their care due to poverty, which caused some of the children to be placed in residential care centres; and some children to live in child-headed households. The findings by SOS (2014) noted that 327,514 of children in Tanzania were under the care of grandparents, 200,091 were under the care of their siblings, and 11,565 were placed in residential care centres. Although the studies have appreciated the contribution of the members of the extended family in supporting OVC, this care system is not without some risks. For example, some of the OVC had been mistreated, abused, and exploited by their relatives (Abebe, 2009; Malinga & Ntshwarang, 2011). This called for research to thoroughly assess the treatment of the OVC under the kinship care system in order to maximize children's rights.

Although a residential care centre is regarded as an option of last resort, studies have indicated an increase in the number of residential care centres and numbers of children placed in those centres (SADC, 2010; SOS, 2014). However, it had been revealed that some children placed in residential care centres have no access to adequate diet, clothing, bedding, and health care services due to limited resources (USAID, 2010; UNICEF, 2012; Save the children, 2012). In addition, some children placed in residential care centres had suffered from social, physical, and psychological problems (Save the children, 2012). This might have been exacerbated by poor attachment due to limited human resources, which meant that some children had no competent caregivers to share with their problems and worries. Previous findings recommended for promotion of a small group homes to meet the best interest of children (USAID, 2010; Save the Children, 2012; Faith Action Initiative, 2014).

For example, SOS Children's Village has been identified as an example of good practice for the residential care of OVC (Abebe, 2009; Faith to Action Initiative, 2014). This promotes a family-based care copied from western countries and had been established all over the world (Abebe, 2009). According to USAID (2010), SOS children's villages are based on four main principles, namely a caring parent (a mother), family ties (brothers and sisters), a home for each family (house), and SOS villages are part of the community.

The Department of Social Welfare under the Ministry of Health and Social Welfare is responsible for ensuring that OVC have access to basic needs and protection. It is also responsible for ensuring effective and adequate care for OVC in Tanzania. Unfortunately, the Department has not adequately addressed care and protection needs of the OVC due to limited financial, material, and human resources (MoHSW, 2011; (National Audit Office Tanzania) NAOT, 2013). The implication is that adequate monitoring and evaluation of service providers and services provided to OVC cannot be implemented, thus putting the life of the OVC at risks. This calls involvement of willing international and national partners to strengthen the Department of Social Work so that it can participate fully in ensuring that OVC care and protection are effectively met.

The Hindrances for OVC Access to Alternative Care

Various reasons had contributed to the OVC placement in alternative care systems such as HIV and AIDS, poverty, family conflicts, violence, physical and sexual abuse, and disability (Faith to Action Initiative, 2014). Although some countries are implementing formal adoption, it is considered to be very rare in Africa (UNICEF, 2010). Traditional and cultural values and practices are some of the factors that hinder children's access to alternative care (Subbarao and Coury, 2004). Those

values and practices have appeared to be inconsistent with the legal processes for formal care like adoption due to the belief that children have to be raised up in their families (Chawaula, Dobson, and Elsley, 2014). This explains the reason why about 90% of children deprived of the parental care are under the kinship care in developing countries (UNICEF, 2011; Faith Action Initiative, 2015). The national and international partners need to establish an effective strategy to support poor families taking care of the OVC to ensure that children get access to their necessities. That will help to prevent placement of children in residential care centres, and also will prent children from running away and live to the streets.

Stigma and discrimination attached to HIV and AIDS is another factor hindering OVC's access to alternative care (UNAIDS, 2015). A study of Children's Homes in South Africa revealed that there was a widespread belief in residential care centres that children living with HIV and AIDS were not suitable for adoption (Meintjes, Moses, Berry & Mampane, 2007). This means that many children who could get access to permanent care were completely left out due to stigma and discrimination. It is well known that in every country there are commissions and various organizations dealing with HIV and AIDS issues. It high time for those commissions and organizations to continue with education and sensitization programs in order to protect people living with HIV and AIDS from stigma and discrimination.

The cost of adoption which is considered to be high is another factor that has been identified as a hindrance for families interested in adoption (Forever Angles, 2013). For example, the cost for domestic adoption in Kenya ranges from $ 345-3450 (equivalent to 35,000-350,000 Kenya shillings) (UNICEF, 2008b). This means that many ordinary families with a minimum income could not afford to meet those costs and therefore, could not fulfil their dream of adopting children. Furthermore, foster

parents could not complete the process of adoption because that would mean losing the financial support they receive from the government for providing care to OVC (Gerrand and Nathane-Taulela, 2015). This calls for the policy makers, national, and international partners to revisit the costs for adoption in order to allow more families interested in adoption to complete the processes for the promotion of family-based care for OVC.

Although it is well known that in Africa, the extended family is the traditional security systems where the community is responsible for the care and protection of the OVC and sick ones (UNICEF, 2004), the increase in number of the OVC due to HIV and AIDs and poverty related issues have undermined the ability of this system to provide care to these children. This as noted earlier, has caused many children to be placed in residential care centres, live in unsupervised child-headed households, and on the streets (Phillip, 2011). Another factor hindering OVC's access to alternative care is the inadequate number of professional social welfare officers (CELCIS, 2016; USAID & UNICEF, 2011). For example, the report by the (MoHSW, 2013), indicated that Tanzania had a shortage of social welfare officers in the region of 88%. Inadequate number of professional social welfare officers hinderes effective implementation of statutory foster care because it requires comprehensive range of functions by the social welfare officers such as, recruiting, selecting, and training foster parents; and monitoring and supportng foster parents (Familiy for Every Child, 2015). CELCIS (2016) indicated that without adequate social welfare officers fostering care systems are difficult to develop, and even places where foster care has started there had been reports of ill-treatment due to limited monitoring services.

This calls for the governments, national and international partners to empower social welfare systems for the purpose of promoting effective implementation of the

statutory foster care. Strong foster care as noted by CELCIS (2016) help to promote family-based care for children who otherwise would be placed in residential care centres. For example, in South Africa the number of children placed in foster care has increased due to the government policies to prioritise foster care for OVC, from 49, 853 placements in 2000 to 418, 000 by May, 2007 (Meintjes, et al., 2007). The increase of foster care according to these authors has been drived by a case grant of R 610 for the foster carers who include relatives and non relatives.

The Potential Contribution of the Existing Child Related Laws and Policies

Children's Rights

Children are fully covered by international human rights conventions in all aspects related to their lives for their wellbeing. Established human rights standards and principles for all members of society are stipulated in national, regional, and international legal instruments such as laws, covenants, conventions, and declarations; some of which deal specifically with issues related to children as active members of society. To effectively implement the standards and principles relating to children a single international legal instrument was established in 1989 in the form of the United Nations Convention on the Right of the Child (UNCRC). The UNCRC states that every child is entitled to all the stipulated rights regardless of place of birth, family of origin, sex, religion or social, political, cultural, and economic status (UNICEF, 2008a).

Various areas of rights are covered in the UNCRC (1989) such as the right to survival, protection, participation, and development. All signatories have to abide by the UNCRC guiding principles which act as a constant reference point for directives

on the development, implementation, monitoring, and evaluation of issues related to children's rights. All children's rights based on social, civil, political, cultural, and economic principles are incorporated in the UNCRC to ensure the survival, non-discrimination, participation, and development of children. The rights of the children included in the UNCRC reflect a global picture of the children's situation as possible victims of inappropriate labour practices, sexual exploitation, human trafficking, drug abuse, poverty, discrimination, stigma, homelessness, food insecurity, disease, and other forms of rights violations.

The tragedy faced by OVC due to lack of parental care has been recognized by international, regional, and national instruments dealing with children's matters as well as research scholars. For example, article 20 of the UNCRC (1989) states that all states parties should ensure appropriate alternative care for any child who has been deprived of parental care. Alternative care systems that have been identified in the UNCRC involve foster care, adoption, *kafalah* (in the context of the Islamic law), and if necessary placement of OVC in residential care. The UNCRC further provides that the whole process of establishing alternative care for OVC should ensure that the best interests of the child are paramount. Article 21 of the UNCRC requires state parties to consider inter-country adoption as an alternative form of child care in instances where the child cannot be placed in foster care or adoption or cared for in the child's country of origin in any other suitable manner. Because of an increase in the number of OVC, especially in sub-Saharan Africa, the countries might consider reviewing the inter-country adoption policy to create opportunities for more OVC to secure international adoptive families.

In 2001, world leaders agreed on the first set of global commitments for children affected by AIDS at a United Nations General Assembly Special Session

(UNGASS) on HIV and AIDS. Article 65-67 of the Declaration of Commitment on HIV and AIDS identified children as a particularly vulnerable group and highlighted the need for policies and programming around HIV and AIDS to be child sensitive. Specifically, leaders committed to developing (by 2003 and implementing by 2005) national policies and strategies to build and strengthen government, family, and community capacity to provide a supportive environment for affected children. The first global Child and HIV and AIDS framework for the Protection, Care and Support of OVC Living in a World of AIDS was established in 2004 by the Global Partners Forum (GPF) on Children Affected by HIV and AIDS. The framework's main focus is to advocate for increased mobilization of action by governments and other stakeholders to support OVC. The framework is highly influenced by the Convention on the Right of the Child provision of the 2001 UN Special Session on HIV and AIDS, and the 2002 UN General Assembly Special Session on Children. The UN (2009) calls for state parties to establish effective care systems which will ensure family-based care for OVC to facilitate their social, psychological, and economic development. Research conducted by SADC (2010); USAID (2010); Save the Child (2012); UNAIDS (2012); and EveryChild (2012a); Euro Child (2012a); SOS (2013) called for the monitoring and evaluation of alternative care systems to promote effective care and support for OVC.

At the regional level the African Charter on the Rights and Welfare of the Child (1999) (article, 5) requires all state parties to ensure, to the maximum extent possible, the survival, protection, and development of the child. Article, 19 states that every child shall be entitled to enjoyment of parental care and protection. To respond to various challenges facing OVC the state parties in southern Africa and eastern Africa established national plans of actions (NPA) to address the impact of HIV and AIDS in

2000. According to Save the Children (2010, p. 5), NPA refers to "a plan that is based on a situation assessment and multi-sectorial consultation, sets priorities and objectives, defines strategies, identifies corresponding coordinating bodies, includes a policy and legislative review and a monitoring and evaluation strategy, and estimates costs and funding sources for priority actions". Seventeen countries in sub-Saharan Africa and 10 SADC member states participated in a Rapid Assessment, Analysis and Action Planning Initiative (RAAAP) of children's conditions and well-being between 2003 and 2005 with the support of the USAID, UNICEF, UNAID, WFP, the POLICIES project and in partnership with national OVC steering committees. Countries that were targeted in the RAAAP had high HIV prevalence and included Botswana, the Central African Republic, Cote d'ivoire, Ethiopia, Kenya, Lesotho, Swaziland, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Uganda, Zambia, and Zimbabwe. Through the RAAAP process the 17 high prevalence countries were required to develop and strengthen national action plans for OVC reflecting provision from the UNCRC, the African Charter on Rights and Welfare of the Child and the African Youth Charter. Despite global efforts to address the OVC needs there is still a gap in implementing the family-based care for OVC which suggest the need for more sustained research related to alternative care for OVC.

Adoption of a Child

As indicated by the UNCRC (2009), children have the right to live with their families unless separation is in the child's best interests (article 9), and children who are deprived of their family environment are entitled to special protection and assistance from the State (article 20). Article 27 states that every child has the right to a standard of living adequate for their physical, mental, spiritual, moral, and social development. The UNCRC states that the best interests of the child shall be the key

consideration in the adoption process (Article 21). In decisions on adoption, *kafalah* (in the context of the Islamic law), *or* other placements, the "best interests" of the child cannot be defined without consideration of the child's views. Previous studies recommend that when a child has no biological family to ensure his/her psychological, physical, and emotional well-being, there should be an effective framework to ensure that adequate alternative care is secured for the child to facilitate effective attachment. Furthermore, poverty should not be regarded as the main factor for separating OVC from their biological families.

Adoption of a child in Tanzania was governed by the Adoption Ordinance (Cap 335) of 1953 and it was regulated by the Department of Social Welfare and Adoption Rules of Court. The Adoption Ordinance (Cap 335) was introduced in Tanzania way back by the British administration and it was adapted after independence to provide for the adoption of children and related matters. The laws relating to children in Tanzania were reformed under the Law of Reform Commission of Tanzania (1994) to feature children problems under various socio-economic circumstances. The United Republic of Tanzania (URT, 1994) and Adoption Ordinance (Cap 335) was among the laws which were reformed. Currently adoption of a child in Tanzania is governed by the Law of Child Act 2009 (section 54-76) and the Adoption Rules of Court under the regulation of the Department of Social Welfare. Adoption of a child under the Law of Child Act 2009 recognizes international adoption.

However, adoption of child in Tanzania is facing various challenges such as prolonged processes which can discourage foster parents from developing interest in legal adoption (Mkombozi, 2013). The author adds that, foreigners wishing to adopt a child in Tanzania are required by the law to stay in Tanzania for about 3 consecutive years. This hinders international adoption because many foreigners cannot fulfil

condition of the law as they might be employed in their respective countries. Sometimes the foreigners might be working under contract which lasts less than three years which means they cannot qualify for adoption. Furthermore, the adoption process is closed in the sense that during the process there is no interaction of any kind between adoptive parents and the biological parents. The adoption policy is also not well known to many potential Tanzanian families who would like to adopt a child.

In order to maintain a sense of happiness, love, and security, appropriate measures must be in place to ensure that OVC are not denied their right to grow up in their communities. The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) (2010) noted that, since the adoption of the Child Development Policy of 1996 (revised in 2008) in Tanzania, no categorical laws have been enacted to ensure that there are enforcement measures against child abuse, child trafficking, and exploitation are in place. The impact of this is that OVC are not able to access necessary services related to their wellbeing in society as they might be excluded from the related laws and policies.

Tanzania ratified the Convention on the Rights of the Child (UNCRC) in 1991. It acceded to the Optional Protocol on the Involvement of Children in Armed Conflict in November 2004 and the Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography in April 2003. Furthermore, the country ratified ILO Convention No. 182 (1999) on the Worst Forms of Child Labour; in 2001, ILO Convention No. 138 (1973) on the Minimum Age Convention; in 1983, and the African Charter on the Rights and Welfare of the Child (ACRWC) in March 2003. As far as subsidiary laws on children are concerned, Tanzania enacted the Law of the Child Act in 2009. Apart from implementation of the laws which govern adoption of a

child, the literature does not show the impact of adoption policy on promotion of the family-based care for OVC in Tanzania and specifically in Dar es Salaam.

The Inter-country Adoption

The Commissioner for Human Rights (2011) recommends that adoption of children, whether in the same county or across states, raises several human rights issues which call for clear procedures for adoption guided by effective principles of identifying and acting in the best interests of the child. All national and international adoption measures should ensure that children's rights are fully protected. Globally the Convention on the Rights of the Child (the UNCRC) sets the basic standards for child adoption. Inter-country adoption is guided by the (1993) Hague Convention on the Protection of Children and Cooperation in Respect of Inter-Country Adoption (the HC). Currently 80 states have ratified the convention. This requires that states align all adoption procedures with the existing global child laws and policies, procedures, and regulations if the rights of children are to be effectively upheld. The (1986) UN Declaration on National and International Adoption and Foster Care is a useful reference for enhancing guidelines specific to adoption.

The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) (2010) noted that the laws governing adoption, according to the States Report, are laid out in the Adoption of Children Act, the Adoption of Children Decree, and the Adoption Rules and Regulations. According to the African Child Policy Forum (ACPF, 2012), (Addis Ababa-Ethiopia); there are gaps that expose adopted children to abuse and exploitation, which calls for a revision of the policy on either country adoption. Tanzanian recognizes and implements inter-country adoption but it is not yet a party to the Convention on Protection of Children and Co-operation in Respect of Inter-Country Adoption. The study by SOS (2014) has indicated that

from 2000 to 2012, only 46 Tanzanian children had been adopted by persons in the USA; 14 children had been adopted by non-Tanzanians (countries not specified in the literature); and 62 children had been adopted by the Tanzanians. The total number of adoptions in Tanzania nationally and internationally is only 122 from the year 2000 to 2012, which clearly shows that very few OVC have accessed the family-based care for OVC through adoption. Unfortunately, the literature does not clearly indicate whether the adoptive parents have Tanzanian citizenship; and it does not indicate if the adoptive parents are living in Tanzania or outside the country.

Child Protection and Social Protection

Child protection is covered in the UNCRC (1989) as an important aspect in the realization of human rights issues related to children. Child protection is provided in article, 19 of the UNCRC and it states that: state parties should be responsible for all issue related to a child's survival and protection. This is by ensuring that children are protected against all forms of abuse and exploitation by implementing appropriate legislative measures. In addition, states parties should ensure social, physical, psychological, and economic development of the child by establishing proper measures that will meet best interests of the child. States parties should also ensure that proper measures for placements of children deprived of parental care are developed, reviewed regularly, monitoring the implementation, and evaluating its impact for sustainable livehoods of the children.

Tanzania protects children from the violation of rights based on the principles of UNCRC (1989) and the African Charter on the Rights and Welfare of the Child (1999) including the right to be protected from violence, abuse, neglect, and all forms of exploitation. The recommendation of the UN Committee on the Rights of the Child in 2006 for Tanzania was for the government to strengthen its existing measures to

prevent abuse and neglect; and to take action with partners to ensure the protection of children from all forms of abuse including concrete and time-bound responses (UNCRC, 2006). Tanzania has taken a number of steps including passing the Law of Child Act (2009); a study of the violence against children in Tanzania, United Republic of Tanzania (URT) (2011); issuing Priority Responses towards a Multi-Sectorial National Prevention and Response Plan (2011-2015); the National Costed Plan of Action for children; the Tanzania Child Justice Reform (2013-2017); the National Guidelines for Improving Quality of Care, Support and Protection for the Most Vulnerable Children (MVC) (2009), the National Social Protection Framework (2008), and other measures aimed at enhancing the well-being of OVC.

Tanzania Child Justice Reform (2013-2017) has established enforcement of the child protection system (objective, 5) which states that children are protected from violence, exploitation, abuse, and neglect in all settings and have effective access to justice, both to prevent such violations of their rights and to seek redress (Ministry of Constitutional and Legal Affairs, 2012). For responding to violence, abuse, and exploitation of the rights of the child Tanzania Child Justice Reform (2013-2017) involves effective criminal response, which has to ensure investigation of the abuse, prosecution, and necessary legal measures when offenders are found guilty. Under the Law of the Child Act (2009) the court has the role of granting and enforcing supervision orders (section, 19), which allow social welfare officers to monitor the risk to children in the homes and to take steps to protect the child from harm through care orders which pursue the removal of children from significant harm (section 18 and 24). According to Save the Children (2009b) the focus of child protection in the past has been reflected in legislation on single issues such as child labour, sexual abuse, trafficking, discrimination, stigmatization, exploitation, neglect, HIV and

AIDS, and institutionalization among others. Due to an increase in the numbers of OVC (as noted in the literature) the problems facing them might be complex requiring comprehensive responsive measures. The nature and complexity of problems facing OVC necessitate a more systemic approach to child protection (Wulczyn, Fluke, Feldman, Glodek, & Lifanda, 2010).

Recommendations from international organisations such as UNICEF, Save the Children, the UN Commissioner for Refugees (UNHCR), UNAIDS, and others include that efforts to strengthen child protection programmes should be carried out in line with the systems approach (Wulczyn et al., 2010), in order to manage risks associated with social, political, cultural, and economic factors affecting children. This implies that, to ensure effective protection of children there should be deliberate and coordinated efforts from stakeholders such as families (including the extended family), states, communities, FBOs, national and international NGOs, and all other actors involved in children's issues. To respond to the international recommendations and the rapid increase in OVC Tanzania has developed effective interventions for scaling up protection, care, and support of the Most Vulnerable Children (MVC) which incorporates OVC through the National Costed Plan of Action (NCPA, 2007-2010).

NCPA saves as a reference tool for the government and other stakeholders in their efforts to improve the lives and protect the rights of children. NCPA is linked to the national multi-sectorial HIV and AIDS strategic plan and the national AIDS policy. It also extends to the country's MVC responses with support from the government organizations, UN agencies, bilateral organisations, international NGOs, and civil society. NCPA was developed based on the experience and outcomes of all significant responses to MVC in Tanzania following the RAAAP (URT, 2008).

Despite important measures taken to improve the legal framework for the prevention of the violation of the rights of children in Tanzania, many children face violation of human rights due to neglect, violence, exploitation, and abuse (UNICEF, 2011) which calls for research on exploring the existing alternative care for OVC to ensure effective family-based care for OVC.

The Tanzania National Guidelines, for Improving Quality Care, Support, and Protection for MVC (NSPF) define social protection as traditional family and community support structures and interventions by state and non-state actors that support individuals, households, and communities to prevent, manage, and overcome the risks threatening their present and future life, and to enhance opportunities for their social and economic development (URT, 2008). Social protection, according to Sabates-Wheeler and Pelham (2006, p.4) refers to "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised". The objective is to reduce the level of economic and social vulnerability of the poor, the vulnerable, and the marginalised in society.

Developing countries have participated in the development of various policies and programmes regarding child development and child protection. With regard to resources allocated in realization of these policies in Tanzania, their implementation in achieving the intended goals faces many challenges (REPOA, 2013). One of these challenges is lack of effective targeting mechanisms to enable OVC to access quality social services, care, and protection. Some programmes which were established and implemented were neither cost effective nor sustainable and thus failed to address the needs of OVC. The reason behind this has been related to gaps in OVC social protection policy and legislation (REOSA, 2010).

Existing literature shows that all SADC member states have specific policies focusing on OVC. The main problem is that programmes lack sustainability (the focus of the programmes is based on OVC's immediate needs) (SADC, 2010). The requirement, as indicated in the literature, is that established programmes should meet not only the immediate needs of OVC, but also long-term physical, emotional, legal, and economic needs as a basic right. The East and Southern Africa analysis of the policy environment according to the Regional Emergency Office for Southern Africa (REOSA) (2010), revealed the following gaps: inadequate policies and legislation regarding livelihood-based social protection; lack of effective and meaningful collaboration among government departments and other stakeholders (such as NGOs) and international agencies providing care and support to OVC; and inadequate resources allocated for livelihood-based protection.

Greenblott (2008) developed four mechanisms of social protection. The first mechanism was based on the *protective measures* such as social assistance for the poor such as disability benefits and old age pensions. These measures protect households' income and consumption, and include social assistance programmes such as cash transfers, school feeding programmes, and social services fee exemptions and waivers to vulnerable groups as well as in-kind transfers. Second, *preventive measures* such as food for work schemes, school feeding programmes, initiatives to safeguard health, including (Anti-Retroviral Therapy) ART and Prevention of Mother-to-Child Transmission (PMTCT) programmes, and social insurance schemes such as community health insurance and other subsidized risk pooling mechanisms to deal with consequences of livelihood shocks. The main aim of preventive measures is to alleviate poverty by preventing economically vulnerable groups from falling into poverty. The *proportional income or promotive measures which* deal with enhancing

households' ability to engage in various economic activities to generate income for sustainable livelihoods, was the third mechanism. This includes enhancement through life skills, vocational, and agriculture training for youth, as well as increasing access to credit through microcredit opportunities. The fourth mechanism was *transformative measures* involving awareness raising, stigma reduction campaigns, psychosocial support, and therapy, as well as policies and laws to protect OVC such as protection of inheritance rights. These measures are intended to address social inequality, exclusion, and discrimination, for example programmes which address gender inequality and gender based violence, promotion of child rights, HIV and AIDS anti-stigma campaigns, and advocacy programmes for raising public awareness to enhance equity and inclusion.

The Stockholm Declaration on Children and Residential Care (2003), the UN Convention on the Rights of the Child (2009), EveryChild (2012), Save the Children (2012a), and many other initiatives related to children wellbeing, are guided by the principle that the best place for a child to develop and grow up in order to realize their potential is within a loving, supportive family, and that families should be provided with the necessary assistance and protection to fully carry out their responsibilities. Roelen and Delap (2012) concluded that social protection may have an important role to play in enhancing parental care and providing for children's care choices. In addition, social protection may play an important role in minimizing negative impacts and suffering due to loss of parents based on its coverage outside parental care and its positive impact on quality care. It is envisaged that social protection could reduce the hardships children often experience in situations of resource constrained households headed by grandparents, for example, the potential to mitigate stress caused by such hardships, and improving relationships within the home (Roelen & Delap, 2012).

Social protection can address other issues occasioned by these situations and improve relationships within the home environment.

Promotion of Family-based care for OVC

The supportive family environment has been identified as the most effective approach for sustainable wellbeing of the child who has been deprived of parental care (Commission to Promote Sustainable Child Welfare, 2012). This calls the attention of the national and international partners providing care and support to OVC to ensure that children without parental care are enabled to secure appropriate alternative care under the family setting. The family-based care for OVC might create more opportunities for OVC to secure care and support within their respective communities. OVC also will get to learn and practice their values, norms, culture, and traditions and finally contribute to the development of those communities. The family-based care can be established under the kinship, supported child-headed households, community based care, statutory foster care, and adoption (UN, 2009).

However, some of the family-based care arrangements may not be suitable for children even if they are deprived of their parental care. This relates to situations where for example families are very poor, alcoholic, or abusive (Williamson & Greenberg, 2010). As noted by Roelen &Delap (2012), families for the children deprived of parental care must be supportive and must be committed to support and protect children under their care. To make sure that children continue to live with their poor families, national and international partners have to support poor families through provision of material and financial resourses (Roelen & Delap, 2012). This is essential because it will help the families to provide basic and social needs to their children.

Similarly finding by the UN (2009), has recommended the development of an approach to integrate services to ensure that the needs of children and families are effectively met for the purpose of retaining children within their biological or kinship

care. Furthermore, to achieve a sustainable family-based care for OVC environment, it has been recommended to enhance community based care programmes and projects in order to support poor families (UN, 2009). The report by the UNCRC (2009), revealed that some children who are placed in alternative care systems have been separated from their biological parents mostly due to poverty that has hindered parents from meeting children's needs.

Permanency Planning for OVC

Permanency planning as noted by North Carolina Division of Social Services (2009, p. 1), "is a social work practice philosophy that promotes a permanent living situation where every child is entering the foster care system with an adult with whom the child has a continuous, reciprocal relationship and within a minimum amount of time". Permanency planning came to prominence in the 1970s first in the USA and later in the UK; after influential research studies in the United States and the United Kingdom (Fernandez, 2006). The permanency planning involves strategies established to ensure effective care and support of OVC within family settings that are positive and optimal for their emotional, psychological, and physical development.

The research on permanency planning has identified three areas of permanency planning: family reunification, long term out-of-home care (i.e. placement with relatives) and adoption (Carnochan and Austin, 2013; Tilbury and Thoburn, 2008; Tilbury and Osmond, 2006). It is indicated in the literature that there is no evidence suggesting that one of these options is better than others, and therefore it may be applied globally (Barber & Delfabbro 2005; Parkinson 2003; Thoburn 2003). The permanency planning of care consists of three different dimensions: relational, physical, and legal (Stott and Gustavsson, 2010, p. 619). "***Relational*** permanency refers to the experience of having positive, loving, trusting and nurturing

relationships with significant others (e.g. parents, friends, siblings, family, carers); ***physical*** permanency is stable living arrangements and connections within a community; and ***legal*** permanency refers to legal arrangements associated with permanency, such as who has guardianship".

Appreciation of these dimensions as indicated in the literature, recognizes that permanency planning is much *more than placement* (Tilbury and Osmond, 2006). It affirms that children require: consistent, predictable and loving relationships; a sense of connectedness and belonging to families/communities; and a stable place which they call 'home' (Brydon, 2004). Permanency planning, according to the literature is embedded in research-supported rationales (Tilbury and Osmond, 2006). According to attachment theory early childhood relationship experiences with significant caregivers are important in determining positive or negative psychosocial outcomes (Jordon and Sketchley, 2009). This argument supports the research findings by (Dunn and Webb, 2003; World Vision, 2005; Save the Children, 2012a) claiming that due to limited care and support in an institutional setting a significant number of OVC have suffered from emotional and psychological problems. Research has indicated that children who have managed to access family based care through permanency planning are more likely to develop competent life skills into adulthood and experience a range of life successes (Howe, Dooley & Hinings, 2000).

"Planning for permanency starts with a focus on reunification but if this is or may not be possible, then planning needs to be undertaken from the outset to explore other possibilities such as with extended family or friends, through adoption or another permanent family arrangement" (British Columbia, 2011, p. 9). The research shows that there are international organizations that are working towards ensuring that OVC secure permanency care such as Save the Children' which is the world's leading

international organization for children. It operates in 120 countries with the aim of saving children's lives, fighting for their rights, and helping them to fulfil their potential. Save the Children, as part of the NGO Working Group on Children without Parental Care, played a key role in the development of the Guidelines for the Alternative Care of Children, (2009) as a tool to enhance the CRC and help governments and organizations to focus on family based care (Save the Children, 2012). Another organization 'EveryChild' is an international developmental charity working to prevent children from growing up vulnerable and alone. Its vision is a world where every child enjoys the right to a childhood in a safe and caring family, free from poverty, violence, and exploitation. It operates in Cambodia, Georgia, Guyana, India, Kenya, Malawi, Moldovia, Nepal, Russia, Tajikistan and Tanzania. Developing permanency planning in Tanzania would help in strengthening the existing alternative care systems hence promotion of family based care for OVC.

Best Practice Strategies for Family Based Care for OVC

There had been several best practice strategies for the family-based care for OVC in various parts of the world. This is to appreciate that children are best brought up in a family environment for their welbeing (UN, 2009). Those best practices include Bethany Global (Ethiopia), Caring and Lovingdg Children (Mymar), the Akola Project (Uganda), Casa Viva (Costa Rica), Buckner Children and Family Service (Kenya), and Care for Children (China). The Kidsave Family Visit Model is another best practice strategy for OVC which had been practiced in the USA, Colombia, Sierra Leone and Russia. The section that follows describes the case studies (established by the Christian Aliance for Orphans –CAFO, 2015) for the projects in Uganda and Kenya; and Kidsave Family Visit Model (establishid by the Kidsave International, 2011), to gain some knowledge on best practice strategies for

family-based care for OVC. The researcher believes that these best practice strategies can be used to guide the implementation of family-based care for OVC in Tanzania.

Buckner Children and Family Service (Kenya)

The mission of this project is the transitioning of lives of vulnerable children and building up strong families based on christian values. According to (CAFO, 2015), the agency consists of 1,400 domestic and 350 international employees who are saving 400,000 lives each year. Buckner was established in 1879 as an orphanage centre by Pastor R.C.Buckner in Texas (CAFO, 2015). The centre started its transition into family-based care from the 1990s, and became full tansitioned after almost ten years. The first step in the transition process was based on engaging stakeholders dealing with children issues suc as the executive leadership, the government, community members, and educational leaders. In preparing stakeholders the organization shared its mission and philosophy to the community members, communicated evidenced based research and anecdotal information. The organization employed local Kenyans to contextualize the message to the international partners. In the process many employees trasitioned to foster and adoptive parents.

Buckner engages in family strenthening, kinshp care, foster care, national adoption, and international adoption. The main goal of the organization is to establish permanence care of children in a family environment (family-based care). Buckner provides support of vocational programs (to enable families engage in various economic activities), and parental education and counselling programs (to prevent family separation and abandonment of children).Permanent promoting practices are used to strengthen families engaging in foster care and adoption.

The process of recruiting foster and adoptive parents is primarily conducted through churches. Kenyan employees take families interested in foster care and

adoption through screening process to assess the age of the parents, location, economic status, faith, and family size. Buckner examines child eligibility for her/him to be placed in care through care giver status, possibility of care by other family members, and vulnerability to maltreatment or abuse. If there is a member of the extended family available he/she is given the first priorityto care for the child permanently. This family will be supported for a specific period of time in case addition support is required. Kinship care is given the first priority because it is mostly practiced in many African countries, and it is offers easy transition for children. Buckner provides members of he extended family intended to provide kinship care financial support, food, school allowances, health care, spiritual support and case management. There are about 264 children in kinship care in Kenya currently. The organization initiated domestic adoption in 2013 and since then 6 adoptions have been finalized and 10 families are on the licencing process to become adoptive parents (CAFO, 2015).

The Akola Project (Uganda)

Women empowerment for the aim of establishing powerful families and communities if the mission of this the Ankola Project. Women involved in the project chose the name ‘Akola’ which has the mining-‘she works’, as they believe dignified work is a gift from God and one of their greatest blsessings (CAFO, 2013, p. 19). Many trained Ankola women care for 10 or more children in their homes, often including biological and orphaned children. This project helps keep children in families through economic strengthening, training, and community development. Ankola started as an orphanage centre in 2006 by Brittany Merrill Underwood, who raised $1,000,000 to construct an orphanage and drill and drill wells (after she met caring for 24 street children in her small home in Uganda) (CAFO, 2015). After

realizing that constructing an orphanage was not cost effective, the project was transitioned in supporting family-based care for OVC.

The project began by building water wells, a vocational centre, and roads in remote community to provide infrastructure. Ankola offers a place for training, employment, and holistic programming. It works with the local church and community leaders to identify women with the least supportand greatest number of dependants. These women are trained to create products that sell in the global marketplace. After selling the products, the profits are reinvested into organisation's social mission. This has enabled Ankola women to generate higher income than average, enabling them to care for mor children.

Ankola does not recruit or assess families because they alternatively invest in families already formed, many of whom provide care to OVC. It also does not place children in families because families typically form due to caregivers knowing and responding to the needs of local OVC. Ankola provides support in the holistic care programming such as health care services, education, business, savings, and loans. Ankola continues to partner primarily with the local church, works with Peace Corps for Volunteer, and health seminars in Uganda. Currently, Ankola works with about 400 women who care for more that 3000 children(CAFO, 2015). Ankola is committed to monitoring and evaluation, and they trained Ankola members to become Monitoring and Evaluation Officers.

The Kidsave Family Visit Model

The Kidsave Family Visit Model under a slogan 'because every child needs a family' is one of the family-based care approach which has implemented permanency planning care for children deprived of parental care. This organization was established in 1999 in Washington DC for the aim of establishing families and

connection for children without parental care (Kidsave, 2011). The model has been successfully applied in four different regions of the world – Russia, Colombia, Sierra Leone and the United States. The model had been applied to children who had been placed in orphanage centres and those under the foster parents who are not committed to adoption. The Kidsave Family Visit Model has facilitated the increase number of children moving out of orphanages into permanent families through adoption, moving children out of orphanages and place them into family care with foster families, and creating relationships for the children with mentors. According to Kidsave (International 2011, p. 4) for the child "to successfully navigate the transition to adulthood depends in large part on the support, guidance, and resources offered by families". In addition, while legal permanency, such as adoption and guardianship, offers the best chance for a lifelong connection, committed mentoring relationships from foster parents and other unrelated individuals can provide the support necessary to help orphanage youth complete school, find housing and jobs that enable them to be productive members of society. The best practices of Kidsave Family Visit model has identified important elements of its relevance as follows:

Initial involvement of the OVC and those who knows him/her.

This approach is sometimes called 'case mining' which happens when social workers seek through a child's history in order to identify relatives or friends who can offer permanency care for the OVC through teachers, coaches former foster parents who might relevant information regarding the OVC; who have been involved with the OVC previously or who have shown interest/concern about the OVC (Kidsave International, 2011). Children involvement can enable them identify people not listed in their casework file like parents of friends, staff from previous placements, neighbors, youth group leaders, as well as non-traditional families. Family group (or

team) can be used for conferencing which will bring together families and family's network support to discuss and plan for the OVC safety, well-being and permanency care. According to O'Brien (1999) one successful program, 'You Gotta Believe!' found that about half of the people from a teen's life circle that they approach are willing to learn more about the adoption process.

"Customer"-focus emphasizing inclusion.

It is noted in the literature that many government agencies are not implementing effective measure to ensure foster care or adoption inquiry are handled over in a timely, friendly manner/in a way that engages more people (Kidsave International, 2011). Some families who show interest of adoption to the responsible agencies drop because of long time used in screening qualified people. Social welfare agencies should consider families as their "customer" to be effective in accessing permanent homes for the OVC.

Child specific recruitment

This refers to strategies used to find a family for a given OVC. This approach is believed to be effective to old children according to Casey Family Programmes (2003). The approach might child's picture and profile in recruitment materials. Youth can be involved in developing recruitment materials and profile. According to Kidsave International (2011), the approach can include some efforts to identify people who already know the child in exploring their ability to support the child in achieving permanent placement.

A combination of media and interpersonal communication

When mass media which is well known for building awareness on specific issues is combined with two types of interpersonal education (i.e. Word of mouth from a friend, information from a professional organization or a message from a

religious institution); might have an additive impact in getting a target audience to adopt a new behavior (Hornik, 2002). Advertisement combined with a child story in the television/radio/newspaper; information on the social network (e.g. Facebook or included in the community social network) might increase the opportunity to generate inquiries in support of a specific OVC.

Opportunity for potential families and OVC to know each other

It is believed that foster care parents are the mostly adopters of foster children. As noted by Flynn et al., (2004), 64 percent of foster parents in the United States of America adopted their fostered children. Kidsave International (2011) ads that by hosting older foster youth as guests in a home for short period of time (i.e. weekends, school vacations) has the potential to build bonds between families and children that would not otherwise be developed.

Theoretical Framework

The most important scientific principles that guide scientists is "being able to pose significant questions that can be investigated empirically, linking research to relevant theory, and providing a coherent and explicit chain of reasoning" (National Research Council) NRC, 2001, p.1). The researcher acknowledge that different theories could be used to explain and respond to problems facing OVC in accessing alternative care in a family environment. However, this study used ecological systems theory to inform and guide the study. It was complemented by attachment theory that promoted an understanding of the importance of the roles of various individuals in providing care and support to OVC for their wellbeing.

Ecological Systems Theory

The theoretical underpinnings of OVC care, support, and protection can be conceptualized as being informed by systems theory (Bertalanffy, 1962) and

Bronfenbrenner‘s ecological theory of human development (Bronfenbrenner, 1979). The concept of the system has been presented by Anderson (1999) as organised wholes comprising component parts that interact in a distinct way and endure over time. Rasaili and Titus (2007, p. 17) indicated that “The systems theory is primarily concerned with problems, relationships, structures, and interdependence of various parts of the system”. The main focus of this study is on strengthening existing alternative care systems providing care and support to OVC in Tanzania such as kinship care, adoption, foster care, community-based care, group homes, supervised child-headed households and institutional based care. The systems approach can be related to social work practice where people interact with organisations in examining problems facing vulnerable groups to realize social work goals. As noted by Pincus and Minahan (1973) there are four basic systems in social work practice namely: the change agent system (social workers); the client system (individuals, groups, families) who seek help from the change agent system; the target system (individuals, agencies, organisational practices that the change agent system might need to change to achieve its goals); and the action system (people with whom the change agent system works to achieve its aims).

The state of disequilibrium between individuals, systems, and sub-systems of which they are a part may create problems. For example when the child is transferred from the streets to an institutional care centre or foster family she/he may face problems associated with exposure to the new care environment. This might contribute to the fear that the child has had born out of bad life experiences related to challenges encountered in his/her streets or other life. It is the role of social workers to mediate between the individuals and the systems affecting their lives. This, according to Payne (2005), can be done by influencing environmental forces so that they can

respond to people's needs to increase individuals' personal resources to help them develop coping strategies for life. To fulfil people's needs, there will be interaction between different systems which will require coordination as well as other actions that are organized in relation to the intended goals (UNICEF, 2008a). For example, for the OVC to realise positive changes in life; education, health, water, and sanitary and legal systems have to work together to address OVC problems.

Bertalanffy (1962), Anderson (1999), Norlin, Chess, Dale, & Smith (2002) and Greene (2008) note that, general systems theory has some important features that might inform this study as follows:

- A social system can be studied as a network of unique, interlocking relationships with discernible structural and communication patterns. (This *can be related to alternative care for OVC such as the extended family, statutory foster parents, adoptive parents, institutional care centres, community-based care programmes, education services, health services, social welfare department, government, NGOs, donor agencies and other environmental systems).*
- All systems are subsystems of other, larger systems. *For example, families are part of the wider community system which in turn, is part of the government system, and all are embedded in a wider regional, national and global system.*
- Boundaries of varying degrees of permeability give a social system its identity and focus as a system, distinguishing it from other social systems with which it may interact. (*Some boundaries between systems, such as the institutional care and community-based health care groups may be relatively impermeable as their respondents seek to maintain their distinct identities).*

- There is an interdependency and mutual interaction between and among social systems. *(It is important that, in catering for OVC with different challenges, various players recognise their interdependency and facilitate team working).*
- A change in any one member of the social system affects the nature of the social system as a whole. *(OVC with various needs can disrupt the wider systems to which they belong; for example, OVC can be the source of major disruptions in a classroom or school system).*
- Social systems vary in the extent to which they are purposive, goal-directed, and in constant state of interchange with their environment. *(Some social systems, like dysfunctional families, appear to lack purpose, goals and positive exchanges with their environments, such as schools).*
- Systems may be open or closed, depending on the degree to which they engage in exchanges with their environment (both receiving inputs and delivering outputs). *(Foster families, adoptive families, institutional care centres, and community-based care groups can vary in the extent to which they are open to others and for their members).*
- Systems reach a 'steady state' or equilibrium with respect to their exchanges with the environment. *(Changing the equilibrium reached by various systems may face resistance –for example placing OVC from child-headed households with foster families or institutional care centres).*

Bronfenbrenner (1979) recognized the significance of the relationship between child, family, and society and creating change through environmental interaction and supporting the child at the same time. An ecological perspective also directs attention to the organisational impacts and policy consequences that are directed at issues related to child development. Ecological theory is practically based on the "person-in-

environment" concept, acknowledging the contributions of social support in practice based on different social interactions. Historically, the social work profession has been committed to the person-in-environment conceptualization during problem solving. Drawing from the systems model and ecological theory, the social work profession has adopted the ecological systems model as a basic theoretical framework to promote understanding of human behaviour and to inform assessment and interventions on problems facing vulnerable groups (Hepworth, Rooney, & Larsen, 2010).

Bronfenbrenner (1979, p. 21-22) conceptualizes the environment as a set of five embedded levels. The first level is the *micro-system* defined as "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics". *The micro-system* includes the immediate environment in which the child directly participates and interacts with family, friends, neighbourhood, and school. The second level is *the meso-system* which according to Bronfenbrenner (1979) "consists of the interaction among two or more settings in which the person actively participates" such as the school or church. The third level is *the exo-system* defined as "one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (p.25). For example this may include conflicts in parents' work environment or school policies which can affect the financial status of the family hence poor nutrition or poor health services which in turn might affect the academic progress of the child. The fourth level is *the macro-system* which consists of economic, social, political, educational, and legal systems and in which each area is defined by its proximity to the individual (Bronfenbrenner, 1979).

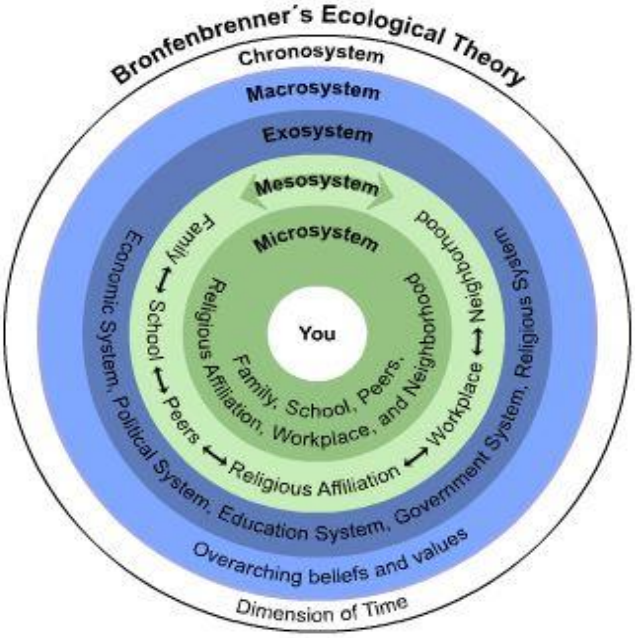

Figure 1: An adapted illustrated model of Bronfenbrenner's ecological theory of human development. Adapted from Alan (2014, p. 84).

The fifth level is *the chrono-system* which was added by Bronfenbrenner to his original theory where four levels were already developed (Coleman, 2012). Bronfenbrenner acknowledged that, like physical ecologies, human ecologies change over time. More precisely, in every generation there are events and people that alter the course of history. He postulated that chrono-systems can extend over short or lengthy periods of time. Furthermore, any system of this nature includes roles and rules that can strongly influence development. An example in relation to OVC is divorce or separation in marriage for couples with children. When this happens, children may be affected socially, psychologically, and financially. Some children may fail to cope with the situation and end up terminating their studies or dropping out of school and maybe joining peer groups where they might learn new behaviours like alcohol or drug abuse. Finally the child may decide not to return home due to fear of punishment and end up living on the streets or under challenging or dangerous conditions.

Bronfenbrenner (1979, p. 25) is particularly concerned with the "growing chaos" in the "everyday environments" in which people live, which might interrupt and undermine "the formation and stability of relationships and activities that are essential for psychological growth". For example inadequate care and support of OVC such as poor nutrition and inadequate protection can contribute to poor performance in schools or failure to continue with education. He pointed out that the nature of the relationship between the child's home and school together with the lessons learned are some of the necessary conditions for academic performance. Bronfenbrenner (1979, p.60) noted the significance of reciprocal activity occurring within dual relationships for development and learning in the following hypothesis:

"Learning and development are facilitated by the participation of the developing person in progressively more complex patterns of reciprocal activity with someone with whom that person has developed a strong and enduring emotional attachment and when the balance of power gradually shifts in favour of the developing person".

Relevance of ecological systems theory to the study

The ecological systems theory in this study will offer the researcher a clear framework within which to conceptualize the relationship between the child and his/her environment. It will direct the attention of various systems to the life situation of the OVC in different care settings and the problems they face enabling the establishment of effective strategies to address the problems. The ecological systems theory considers practitioners working with OVC to be able to set goals which will enhance the fit between the young person and the environment to facilitate their sustainable development in all aspects of life. The care and support of the OVC requires stakeholders dealing with children's issues to work within and across different aspects of the ecological context that influences the child's daily life.

Bronfenbrenner's (1979) influence in relation to OVC care and support is evident in the ways in which practitioners manage varied terrains in environmental aspects of developing and implementing projects and programmes related to OVC. A very vital theme as indicated in the literature is the importance of the interaction between children and those who provide them with care and support (Bronfenbrenner, 1979; Maier, 1991; Krueger, 2000; 2002). "An interactional/attachment orientation recognizes that basic to human development is the existence of assured closeness (attachment) to another person…" and that attachment is formed through "…ordinary daily care interactions" (Bronfenbrenner, 1979, p. 395). Ferguson et al. (1993a), Krueger (2000, 2002, 2005); Phelan (2003), and White (2007) had similar observations focusing attention on the relational nature of Child and Youth Care practice and the significance of the complexity of daily interactions.

The literature has consistently noted that no single system will manage challenges facing OVC due to their diverse and complex nature (Hyder & Mc Veigh, 2007). This supports the view that a systemic approach will be required to ensure a holistic approach in meeting needs of the OVC. Bronfenbrenner's ecological approach has influenced the daily interactions between child/youth and practitioners, as well as efforts to enhance the well-being of young people across the range of ecological contexts. As noted by Krueger (2000, 2005) the practitioner providing care and support to OVC does not only work directly with them in their environment but also interacts with other ecological contexts such as family and community in their efforts to bring about positive change in these systems.

Limitations of the ecological systems theory

Ecological systems theory has been applied to studies in different population groups in social work and other social science disciplines in attempting to address

social problems such as child abuse (Garbarino, 1977), child development (Bronfenbrenner, 1979), and juvenile delinquency (Frazer, 2004), to mention just a few. It has also received some measure of criticism.

The theory has been claimed to be too abstract and impractical for the applied practice nature of social work (Wakefield, 1996a). This criticism is in line with Meyer (1988) who indicated that ecological systems theory is not a model with prescribing modes of application to addressing problems. It does not relate to a specific theory of personality and it does not specify outcomes. Green, (1999, p. 253) noted that "assessment involves drawing an arbitrary boundary around the client system, deciding what the system is, and what is the environment, and thereby knowing who to take into consideration". For example when a child is not behaving properly in the residential care centre (perhaps being very aggressive); general systems theory does not offer advice on where the boundary should be when addressing that problem (i.e. the boundary should be around the child and care taker; child, care taker, and teacher; child, care taker, teacher and school). The question here remains as to how inclusive one should be in integrating the systems interfering in a client's life? In what direction should intervention be focused? The above limitations have made some scholars regard ecological systems theory as a perspective that "offers lens" (Greifand Lyuch, 1983, p. 53) from which to view problems and practice rather than an appropriate theory related to intervention (Frazer, 2004).

It is claimed by Green (1999, p. 254) that "some of the major concepts such as homeostasis and systemic stability, may be used to promote ideas of social systems remaining the same or constant rather than changing; which is a serious concern when dealing with issues of power and equality of women, the poor and people of colour". In addition, stability may be used as an excuse for oppressive systems and

maintaining the dominant paradigm. It is however believed that when applied appropriately the ecological theory provides a positive framework for understanding systems and social issues such as equality and diversity (Green, 1999).

The researcher in this study applied ecological systems theory as a framework to guide the analysis of the findings to help understand alternative care for OVC and related issues, which enhancing the development of their wellbeing. As noted by Gamble and Hoff (2005), social workers in the face of globalization and rapid social and economic change should advance ecological systems theory to construct mechanisms of practice and research through incorporating development principles.

Attachment Theory

John Bowlby developed attachment theory based on ethology (science of animal behaviour), cybernetics, information processing, developmental psychology, and psychoanalytical concepts (Ainsworth & Bowlby, 1991). According to Bowlby (1988) attachment theory is concerned with explanation of human attachment and related attachment behaviour which play important roles in human development. Human attachment refers to a biologically pre-determined tendency for human beings to establish affection bonds with others for the purpose of safety, care, love, and support. The author adds that, attachment behaviour is any behaviour which occurs in a person acquiring or sustaining proximity to an identified individual who is considered able to manage the world and to provide the necessary protection and containment. In his conclusion on the study of attachment theory, Bowlby argues that to grow up in a condition of good health "the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bowlby, 1951, p. 13). Bretherton (1991) says attachment theory is a theory of

interpersonal relationships which is valuable to service providers like social workers in understanding experiences of OVC and addressing adverse attachment relationships at work places, schools, families, and communities.

Howe (1995) argues that it is only by being in social relationships that we can actually form a sense of self and become human because relationships underpin psychological development, social competence, and personal well-being. He adds that psychological development occurs as we make sense of social experience and recognise it as meaningful. It is therefore important for stakeholders providing care and support to OVC to ensure access to the quality family-based approach for OVC that will provide interpersonal relationships for effective personal, social, and psychological development. Howe (1995) indicates that the more limited, incomplete or distorted the social experience of a human being the less adequate or coherent will be the mechanisms for making sense of future social experiences. If mechanisms are weak or unpredictable, the individual's ability to make sense of the experience and cope with it will be impaired. Threats to OVC's well-being might be due to factors that are "internal to the child (hunger, illness, pain) or external to the child (danger, violence, threat, fear) and the loss of the caregiver physically, emotionally or psychologically" (Howe, 1995, p. 152).

Ainsworth et al. (1978) reinforced attachment theory later through the Strange Situation Procedure (SSP) which facilitated initial empirical explorations of Bowlby's theory, particularly the identification of the patterns of attachment, namely secure attachment, avoidant attachment, anxious attachment, and disorganized attachment (Bretherton, 1992). The child who is in a secure relationship seeks help from the caregiver when experiencing stress or concern about a certain problem. For example OVC who is placed under stable alternative care system will communicate to the

caregiver about a friend or a teacher who has threatened him/her. The caregiver will always respond positively to the child with comfort and readiness to offer reasonable help (Ainsworth, Blehar, Waters, & Wall, 1978). This will enable the children to return to their normal state and be able to continue with other exploration which will later impact their life and that of other people in the community in which they live in a positive manner. By contrast, avoidance attachment refers to insecure relationships between the child and the caregiver. It indicates the extent of the child's disturbed relationship with the caregiver and strives to maintain independent behaviour and emotional distance from the caregiver (Ainsworth et al., 1978). For example the child can downplay his distress and suppress emotion in order not to provoke the caregiver's anger. This situation will make the children appear independent and self-sufficient but in reality they will be facing insecurity and distress which will affect their future.

Anxious attachment indicates the degree to which the child worries that a caregiver will not be available and responsible in times of need (Ainsworth et al., 1978). For example this is a situation which may face a child who has no parental care or whose parents are very sick or very poor due to various factors. Children in this situation may lose confidence in their caregivers and the latter's' ability to manage their emotional needs. This may prevent children from communicating to a caregiver about the threat they may be facing from friends or teachers; and if they communicate they may intensify a display of emotion by being very fussy or demanding to ensure that they are not ignored. By contrast, children with disorganized relationships suffer from emotional problems for long periods of time because of lack of appropriate strategies to deal with their distress (Ainsworth et al., 1978). This may result in some contradictory behaviour where the child shows fear to the caregiver and avoiding or

moving away from the caregiver. Disorganized attachment is considered to arise when OVC experience the caregiver as frightening in situations where the caregiver is helpless or unable to provide reassurance and protection to the child (as when the caregiver engages in physical or sexual abuse of the child) (Ainsworth et al., 1978).

Relevance of Attachment Theory to This Study

Much of the early research on attachment theory as noted by Bowlby (1969/1982) focused on mother-infant bonding. He adds that the current concepts of attachment theory have agreed that children form attachments to many caregivers such as fathers, grandparents, day care providers, teachers, and others. This indicates that these caregivers are willing to fill the attachment gap left by the mothers by responding positively to children's social, physical, and psychological needs. According to Bowlby (1969/1982), the function of the attachment system is to protect a person from danger by assuring that he or she maintains proximity to caring and supportive others (attachment figures) who provide protection, support, and relief in times of adversity. Application of attachment theory to this study leads to the understanding of how various systems of care for OVC become secure bases of attachment which influence OVC potential growth and development. Through the provision of care, support, security, and protection OVC will regain the secure base necessary for positive development that was lost through death of parents or other reasons.

This theory contributes to understanding how OVC who have suffered from disruptive care failed to develop interpersonal relationships and sometimes became aggressive. This can be explained by the fact that OVC lack attachment strategy which could guide the way the child reflects his/her behaviour based on his/her primary attachment person during infancy (Ainsworth et al., 1978). The strategy that

develops is very crucial and adaptive to the particular relationship with the primary attachment person but it is reflected in all other relationships as a pattern of behaviour. Attachment theory will help service providers to understand why children without parental care are confronted with emotional and psychological problems as well as difficulties of establishing reasonably good relationships (Save the Children, 2012a). As they seek to promote well-being of the OVC, social workers and other service providers have to ensure healthy relationships between the caregivers and the children. As identified by Howe (1995) OVC developmental well-being (physical, emotional, psychological, and behavioural) depends to a large extent on the standard of all care systems and upon children's relationships with their carers and peers.

Attachment theory will help those who provide care and support to OVC as it will increase their understanding about what children may carry with them into new relationships. This will therefore, assist caregivers to help children modify their unwanted behaviours and develop new, positive relationships which will enhance their well-being (Howe, 2005). The concepts of attachment theory are considered useful in child welfare matters as they can be used to explain the reasons why some children have had a negative relationship foundation with peers, caregivers, and teachers and this helps to guide them on methods of addressing behaviour problems. Attachment theory also provides a framework for understanding how early adverse experiences influence later emotional and behavioural development. By using attachment theory caregivers will be enabled to help children who have had disturbed relationships in the past to establish positive attachment to new caregivers (Howe, 2005).

Limitations of Attachment Theory

One of the limitations of attachment theory as indicated in the study is the (nurture) assumption which relates a child's behaviour to the nurturing role. Harris (1998) believes that parents do not shape their children's personality or behaviour. Peers' influence, as noted by Harris (1998) has a greater influence than that of parents. This is because, when a child wants to fit into a peer group, he/she will be forced to adopt some of the group behaviour. This explains the fact that some of the OVC who are living on the streets and even in some care centres might have family members/relatives/friends that could take care of them, but because they want to fit into their peers' context, they run away from their homes. Harris (1998) argues that if a child is brought up in a crime ridden area, he might be susceptible to committing the same kinds of crime due to the fact that there is a high rate of peer pressure and he wants to fit into that group.

The view that the mother is a primary attachment figure is another limitation to attachment theory. According to Field (1996) a father or a sibling can have the same type of attachment with the infant at the same time. Another limitation is that attachment is confined to the infancy and early childhood period, ending as noted by Bowlby (1969/1982) during puberty. Field (1996, p. 545) argues that "attachment theory does not consider attachments that occur during adolescence (the first love); during adulthood (spouses and lovers); and during later life (strong attachments noted between friends in retirement)". The attachments identified by Field (1996) are very relevant to an individual's development and an individual might be affected socially and psychologically when these attachments are negatively affected by poor relationships. This assertion explains the fact that a child's behaviour can change when he/she exits the alternative care systems as OVC will interact with their new

environment (employment, higher education, marriage) and form new attachments. Athough this claim might be true it might not be simple because of some environmental challenges. However, Field (1996) notes that the effect of early experiences (up to age 6) have the greatest influence on the development of basic personality.

Conclusion Remarks

This section has reviewed the literature which describes a prominent theme relating to the nature of alternative care systems for OVC. The literature in terms of the discussion on empirical findings of previos studies to a lager extent set out the framework of this study, with regard to feeling the reseach gap. A range of care systems such as the kinship care, foster care, adoption, community-based care, residential care, group home care, and child-headed households have been explored. It is evidenced from the literature that there has been a number of studies conducted around the world, in Africa, and Tanzania in particular. However, none of these studies have considered the potential of strengthening the existing alternative care systems in an effort to promoting family-based care for OVC in Tanzania. Thus, researching this subject in Tanzania, a country that is facing very high number of OVC suffering from inadequate care and protection, has become necessary.

In addition, most of the studies focused mostly on challenges facing the alternative care for OVC and its impact to their wellbeing without considering promotion of effective initiative (family-based care) that would offer adequate care to those children. Furthermore, a few studies such as those of Phillips (2011) and Kijo-Bi Simba (2011) attempted to explore protection of OVC. However, there is limited knowledge on the contribution of the existing child related policies and legislations towards enhancing alternative care for OVC which calls for more research. For the

purpose of this study, the researcher applied the ecological systems theory and, with the support of the attachment theory explained the means through which stakeholders working with OVC in different settings can conceptualize the relationship between children's behavior and their environment. This will enable them to establish a framework for effective strategies to address OVC problems. The next chapter presents the methodology of this study.

CHAPTER 3-RESEARCH METHODOLOGY

This section presents the research methodology that was used to carry out the study. Research design, research methods, study site, sampling design, and techniques are discussed as to how they were reflected in the research process. Various data collection techniques such as survey, focus group discussions, face-to face interview, and observation are described. Ethical considerations related to research on human subjects, some limitations that affected the study as well as possible solutions are also considered in this chapter.

Research Design

Research design as noted by Creswell (2014) refers to the type of inquiry within qualitative, quantitative, and mixed methods approaches which help to determine a specific direction for procedures in a research study. The author adds that, research design reflects the purpose of the study which can be characterised as explorative, descriptive, explanative, and evaluative. A given study can utilise more than one of these purposes (Babbie, 2013), which makes it meaningful to examine the research purposes separately as each has different implications in the research design. This study is based on exploratory and descriptive purposes.

Exploratory research is conducted when a researcher has examined a new interest and when the study in the area is relatively new (Babbie, 2013). Exploratory research can be conducted through a literature review, FGDs or case studies (Creswell, 2014) and data from exploratory research tend to be qualitative in nature. The reasons for undertaking an exploratory study were to gain insights into new areas of inquiry for the purpose of investigating the magnitude of problems related to alternative care systems for OVC and to generate new ideas about the problems (Bhattacherjee, 2012). The exploratory design helped the researcher to scrutinize the

behaviour, perspective, experiences, and feelings of the OVC stakeholders on ways to strengthen the existing alternative care systems to promote family-based care for OVC. Furthermore, the exploratory research design helped the researcher to identify boundaries of the environment, challenges, problems, and opportunities for future research (Bhattacherjee, 2012).

Descriptive research on the other hand, involves making careful systematic observations and collection of detailed information of phenomena under study (Creswell, 2014). A researcher in a social science study as noted by Babbie (2013), observes an event, situation or a problem; and then describes what was observed based on a scientific method to ensure that observation was precise and replicable. Descriptive research involves collection of data which describes events and afterwards organises, tabulates, depicts, and describe the data (Glass & Hopkins, 1984). According to Babbie (2013), descriptive research can be qualitative or quantitative in nature. Descriptive data for quantitative research are gathered using observational and survey methods whereas observation, semi-structured interviews, case studies, and FGDs methods are used to collect qualitative data (Borg& Gall, 1989). The descriptive research was used in this study because it has one or more guiding research questions and not normally driven by structured research hypotheses (Babbie, 2013).

Through descriptive research, quantitative and qualitative data were gathered to the nature of the existing alternative care systems for OVC to provide an accurate account of the characteristics such as behaviour, perceptions, opinions, beliefs, knowledge, and experiences of the particular individual, events or group as they naturally occur (Burns & Groove, 2003).

Data were also collected to understand the demographic information of the respondents such as the age, sex their level of education, and professional experiences. In addition, data were collected on the potential contribution of the existing child related laws and policies towards the enhancement of alternative care for OVC. Furthermore, data were collected to examine stakeholders' perceptions on promotion of the family-based care for OVC in Dar es Salaam.

Research design, according to Crotty (2003), has four main features including epistemology that informs the study; the philosophical stance which underlies the methodology (i.e. post-positivism, constructivism, pragmatism, advocacy/participatory); the methodology, the techniques, and procedures to be employed in the research design for data collection. This study was based on a pragmatic paradigm which has been confirmed as one of the paradigms which provides an underlying philosophical framework for mixed methods research (Tashakkori & Teddlie, 2003). The underlying assumption of the pragmatic paradigm as maintained by these authors is that social science inquiry cannot access the truth about the real world by the application of a single scientific method.

Pragmatic paradigm is "concerned with action and change and the interplay between knowledge and action" (Goldkuhl, 2012, p. 2). The author further maintains that research approaches should get researchers involved in the world and not merely observe the world. This study therefore, advocate for OVC care, love, and protection and raise awareness of stakeholders (i.e. families, NGOs, government) to come together to address the problem faced by OVC on accessing care in a family environment. It was hoped this could help to prevent OVC from engaging in criminal behaviours which are dangerous to the rest of society. The pragmatic paradigm as noted by Wahyuni (2012), does not question ontology and epistemology but rather

reflects on the research question to determine a research framework. Wahyuni (2012) adds that pragmatists believe that objectivist and subjectivist views are not mutually exclusive.

As indicated by Morgan (2007, p. 72), in the pragmatic approach there is no problem "with asserting both that there is a single 'real world' and that all individuals have their own unique interpretations of that world". It is indicated in the study by Fendt, Kaminska-Labbe & Sachs (2008, p.478) that "more important than truth are our personal beliefs of the facts and the ultimate test of a belief is the willingness to act on it". The pragmatism paradigm, as noted by Creswell and Plano-Clark (2007), does not force researchers into choosing between the two traditional dichotomies (i.e. positivism and constructivism). Furthermore, the researchers are not bound to any particular research method or approach (Robson, 1993). The study therefore employed the mixed methods research design that is claimed to offer a practical approach to addressing research problems and questions through qualitative and quantitative research approaches (Graff, 2012) (which was implemented concurrently).

Mixed Methods Research

Mixed methods research refers to a research process where the researcher collects, analyses, and integrates qualitative and quantitative data in a single study (Creswell, 2014). There are four major types of mixed methods research designs (Creswell & Plano Clark, 2011) namely concurrent triangulation design, the embedded design, explanatory sequential design, and exploratory sequential design. According to Creswell and Plano Clark (2011) concurrent triangulation refers to collection and analysis of qualitative and quantitative data separately but within the same timeframe (concurrently). The data from the two strands are merged during the

interpretation stage for the purpose of validating the findings from one strand, gaining comprehensive understanding of the phenomena or confirming the results. The authors revealed that the embedded design occurs when data from qualitative strand are embedded in the quantitative strand or vice versa, concurrently. The purpose is to use the findings from one strand to support or explain findings from the other strand. This as noted by Creswell and Plano Clark (2007), occurs when interviews or observations are embedded in a quantitative data set to understand the process or experiences of the participants.

The explanatory sequential design involves collection and analysis of quantitative data followed by collection and analysis of qualitative data. The findings are then integrated at the interpretation phase for the purpose of explaining and interpreting the relationships (Creswell & Plano Clark, 2011). Exploratory sequential design includes collection of data in two phases where priority is normally given to the first phase. For example, the first phase that of quantitative data and results, is useful in interpreting qualitative findings. The second phase that of qualitative study, can be used to inform the quantitative phase that was conducted in the first phase. The purpose for this strategy will be to use qualitative findings to guide the development of the questionnaire or to guide theory development.

In this study the researcher employed the concurrent triangulation design which has four variants namely: convergence model, data transformation model, validating quantitative data model, and multilevel model (Creswell & Plano Clark, 2011). The convergence model according to these authors, involves separate collection and analysis of quantitative and qualitative data on the same phenomenon as described above. In data transformation model, collection and analysis of quantitative and qualitative data are also conducted separately. The researcher

employs different procedures to transform one type of data into the other data type. The process is known as quantifying qualitative data or qualifying quantitative data (Tashakkori & Teddlie, 1998). In addition, validation of quantitative data model occurs when the researcher wants to validate and expand on the quantitative findings from a survey by including open-ended qualitative questions. The same survey instrument is used to collect both data types. Multilevel model employs different quantitative and qualitative methods to address different levels within a system. The findings from each level are merged during the overall interpretation to make multiple inferences (Tashakkori & Creswell, 2007). In this study the researcher employed a multilevel model where quantitative data were collected from the residential care centres providing care and support to OVC; and qualitative data were collected from the OVC, social welfare officers, caregivers, community leaders and the key informants.

Figure 2: Multilevel concurrent triangulated mixed methods design. Adapted from Creswell, 2014.

In utilising a mixed research design, researchers are confronted with a number of decisions (Creswell, 2014) in order to clearly define the mixed method design to be applied in the study. The decisions are based on different ways in which the qualitative and quantitative strands of the study relate to each other (Creswell, 2014). Strand is defined as an element of a study that consists of the main process of carrying out the qualitative or quantitative research through the research question, data collection, data analysis, and interpreting the results based on that data (Teddlie & Tashakkori, 2009).

Four main decisions are involved in mixed methods research as noted by (Creswell, 2014). The first decision is on timing or implementation sequence of qualitative and quantitative strands; which refers to a temporal relationship between the two strands. The researcher in this study applied concurrent timing where the researcher was able to implement both qualitative and quantitative strands during a single phase of the study. The second decision is to the priority given by the researcher to the relative importance of qualitative and quantitative methods answering the research questions. Some studies place equal weight to both qualitative

and quantitative research methods and some prioritize either of the two methods (Creswell and Plano-Clark, 2007). Previous studies noted that priority is based on the collection, analysis, and interpretation of quantitative or qualitative data (Creswell and Plano-Clark, 2007; Tashakkori and Creswell, 2007). According to Morgan (1998), pragmatic paradigm suggests for either equal or unequal weighting of the qualitative and quantitative research, based on the research questions. In this study, the researcher gave more weight to the qualitative than quantitative research which is the best suited method to address the purposes of this research (Morgan, 1998) which are exploration and description. The third decision is the mixing (decision to be made on how to mix the qualitative and quantitative strands). Creswell (2014) notes that data can be mixed during data collection, level of design, data analysis, and data interpretation. The researcher in this study integrated data from the two strands during data interpretation. This allowed the researcher to compare and contrast findings from the two data sets. The fourth decision is the theoretical perspective (whether a theoretical perspective guides the entire design of the study).

The following four-step process essential in concurrent triangulation design which was outlined by Creswell & Plano Clark (2011) was used in this study:

a. Concurrently collected both quantitative and qualitative data in which one type of data did not depend on the other.
b. Analysed the two data sets separately and independently of each other, using typical quantitative and qualitative analytic procedures.
c. Once the two sets of initial results were complete, merged the results of the two sets of data. The merging included directly comparing the separate results.
d. Interpreted how the data from the two sets related to each other and/or combined to create a better understanding in line with the study's overall purpose. (p. 78)

The concurrent triangulation mixed methods research design was applied in this study because of its strenghts. As noted by Creswell and Plano Clark (2011), this design made intuitive sense in that it is efficient and each type of data can be collected and analysed separately with appropriate techniques for analyzing qualitative and quantitative data. Concurrent triangulation mixed methods research design also helped to answer a broad scope of questions because the research process was not confined to one research method (Johnson & Onwuegbuzie, 2004).

Rationale for Proposing Mixed Method Research Design for the Study

It is indicated in studies by Tashakkori and Teddlie (2003), Greene (2007), Tashakkori, and Creswell (2007) that the combination of quantitative and qualitative research methods in the same study is recently gaining popularity. The concept of mixing the two main research methods is considered to have grown to a large extent in recent years (Leech & Onwuegbuzie, 2009) although it emerged in the 1960s. The premise underlying the mixed method research design is not necessarily on choosing between the two traditional research methods (quantitative and qualitative), but to consider how the strengths of each approach can be combined within a mixed approach in order to capture trends and details of the phenomenon under study (Greene, 2007). The implication is that results obtained through mixed method research will enrich and improve understanding and foster new insights about strengthening existing alternative care systems for OVC in Dar es Salaam. This will provide answers to questions that may be difficult to answer by the use of one research approach. For example, the study used a questionnaire to solicit information on the nature of alternative care for OVC in Dar es Salaam from representatives of residential care centres providing care to OVC. In order to obtain clarification on important areas like the type and quality of services provided to OVC by the existing

alternative care systems focus group discussions were conducted with the OVC, social welfare officers and caregivers.

The purpose of employing the mixed method research design in this study was complementarity and triangulation. Complementarity was used to increase depth and confidence in interpretation, as results from one method (i.e. face-to-face interviews) helped to clarify or illustrate results from the other method (i.e. survey) (Greene, 2007; Desimone, 2009). Triangulation has been defined as the composition of methodologies in the study of the same phenomenon, which involves use of more than one approach to investigate a research question (Denzin, 1978). The author further identifies four types of triangulation as data, theory, investigator, and methodology triangulations. Triangulation was applied for the purpose of enhancing validity of results as combined methods offset biases of either an independent quantitative or qualitative study. This helped to "overcome the validity weakness in quantitative methods and the reliability representative weaknesses of qualitative methods in the study" (Babbie, 213, p. 153).

Although mixed research methods have gained popularity in social science research, social work researchers commonly practice four interrelated mechanisms of research namely quantitative, qualitative, programme evaluation, and single-subject design (Tripodi & Potocky-Tripodi, 2007). The study by Menon and Cowger (2010, p. 612) outlines three advantages of integrating qualitative and quantitative methods in social work research as follows: "it proffers increased validity due to the triangulation of methods, provides an opportunity to take advantage of the strengths of each approach, and it conforms to the principles of social work to study things holistically". The advantages mentioned above motivated the researcher to choose the

mixed method research design in studying the alternative care systems for OVC in Dar es Salaam.

Qualitative Research Method

Hollyway and Wheeler (2002, p. 30) define qualitative research as “a form of inquiry that focuses on the way people interpret and make sense of their experience and the world in which they live”. According to Creswell (2014) qualitative research involves establishing explanations of the social phenomena to help understand on why people behave the way they do; how they develop opinions, attitudes and perceptions.The qualitative research method, as noted by Babbie (2013), is useful when the researcher is exploring a new phenomenon. It also helps to understand how people are affected by issues around them. The rationale for using the qualitative approach in this study was to help explore behaviour, perspectives, experiences, and feelings of the participants on alternative care systems for OVC based on the nature, situation of OVC, and potential contribution of existing child related laws and policies towards the enhancement of alternative care systems. The knowledge gained by a qualitative research method was more informative and offered understanding of ways to promote family-based care for OVC (Babbie, 2013). The qualitative research was based on the ontological assumption that there exist multiple realities instead of one reality (Creswell, 2014), because reality is subjective and multiple as seen by the participants in the study.

Data Collection Procedures

Data for the qualitative phase was collected through the use of observation, semi-structured interviews, and focus group discussions. Below is a brief discussion of the tools.

Observation

Observation is regarded as a basic tool which helps the researcher to discover complex interactions in a natural social context (Baker, 2006).The researcher in this study employed the observation method to complement other data collection tools. Observation helped the researcher to obtain first-hand information about the OVC and caregivers providing care and support to OVC in the residential care centres. It helped the researcher to collect patterns of behaviours and relationships between the OVC and their caregivers; as well as the condition of the immediate environment surrounding them. Observation was conducted at residential care centres providing care and support to OVC, and institutional administrators were informed of the presence of the researcher and the purposes of the research. In this study, the researcher became observer as participant where she identified herself as a researcher and was a member of the group being studied (Kawulich, 2005). The researcher observed OVC and caregivers in the residential care centres and recorded observations rather than participating in activities. This is due to the belief that every action and behaviour that was portrayed by the participants had a purpose that made it meaningful. Observation was conducted in 20 residential care centres sampled for this study; and participants were observed only once. The researcher had an opportunity to walk around and in some residential care centres she was given an opportunity to view the bedrooms, dining halls, and kitchens. *(See Appendix II for an observation tool).*

Semi-structured Interviews

Semi-structured interviews involve a number of open-ended questions based on the areas that need to be covered by the researcher (Mathers, Nick, & Amanda, 2002). The open-ended nature of the questions defines the topic under study and also

provides opportunities for the interviewer and the interviewee to discuss some critical areas in detail. In this type of interview the interviewer is willing to probe in order to elaborate or clarify the original response. Semi-structured interviews are believed to be very useful in exploratory research when little is known about the subject area (i.e. Teen Focus Group) (Efken, 2002). Semi-structured interviews according to Bernard (1988), are best choice when it is not possible for the interviewer to get more than one chance to interview a person and also when sending several interviewers out into the field to engage in data collection.

In this study, the researcher used semi-structured interviews to facilitate data collection process where three interviewers were engaged in the process using an interview guide. Key informants and community leaders were recruited for semi-structured interviews. The interviews with the key informants were conducted in their respective offices; whereas interviews with community leaders were carried out at the local government offices. The average length of each interview was forty minutes. Interviews helped to explore the participants' feelings, experiences, and perceptions regarding the nature of the alternative care systems in Dar es Salaam; situation of OVC in various alternative care systems; potential contribution of existing child related laws and policies to enhancement of alternative care for OVC; and perceptions of stakeholders on promotion of the family-based care for OVC. This method also allowed collection of relevant data which could not be captured by other methods such as FGDs and surveys.

The raw data from qualitative interviews were captured by taking notes and tape recording. Permission had been sought to record the conversations in order to capture all relevant data. Tape recording helped to manage the amount of time spent to each interview as the interviewer did not have to pause to write down responses. It

also helped maintain the flow of thought and communication without the need to stop and repeat points for the record.

Designing the interview guides.

Interview guide refers to a list of topics or areas to be covered in a semi-structured interview. The interview guide is normally linked to the research questions and it is developed by the researcher before commencing the interview (SAGE, 2004). The interview guide has to reflect aspects which will lead the researcher when collecting data through interviews (Babbie, 2013; Newman, 2012).

The interview guide was developed specifically for community leaders and key informants to explore their knowledge, experiences, feelings, and perceptions regarding the nature of alternative care systems for OVC in Dar es Salaam, to examine the situation of OVC in various alternative care systems, potential contribution of the existing child related laws and policies to the enhancement of wellbeing of OVC, as well as perceptions of stakeholders with regard to promotion of the family-based care for OVC. Various themes and sub-themes were established in relation to the research objectives of the study and were reflected in the interview guide *(See Appendix IV, V, VI, VII, and VIII).*

Focus Group Discussion

A Focus Group Discussion (FGD) is referred to as a rapid assessment, semi-structured data collection method that allows a researcher to conveniently choose a set of participants for discussion of issues related to the key themes of the study which have been established by the researcher based upon the research objectives (Kumar, 1987). The FGD technique is believed to have originated from marketing researchers who sought to gain an understanding of qualitative data from quantitative consumer

surveys. It is indicated in the literature that FGD has gained currency due to the fact that it can provide a quick method of learning from the target group (Debus, 1988).

FGD is a tool which is used to inquire about people's thoughts, feelings, perceptions, and experiences (Sherraden, 2001). In this case it served to obtain in-depth information about alternative care for OVC in Dar es Salaam. Through FGD the study explored information regarding the nature of the existing alternative care arrangements, situation of OVC in various alternative care systems, issues related to alternative care for OVC such as policies and regulations, and understanding of OVC stakeholders of ways to promote the family-based care for OVC in Dar es Salaam. It is recommended that people involved in the FGD should possess similar characteristics (creating a homogeneous group) and should consist of 6-12 participants. Hancock, Windrdge, & Ockleford (2007) noted that conducting FGD with fewer respondents could limit interaction among people; while having more participants could deny some participants an opportunity to fully participate in the discussion. Furthermore, to ensure effectiveness, the time for one FGD should not exceed one and half hours. The facilitator, during FGD, created an effective environment which motivated participants to share their knowledge, experiences, and perceptions on the subject (Sherraden, 2001). Three to six focus groups are recommended in a study (Krueger, 1994; Morgan, 1997; Onwuegbuzie & Collins, 2007). This technique helped the researcher to collect additional information as an adjunct to quantitative data collection.

The researcher in this study conducted FGD with OVC themselves, caregivers, and social welfare officers, dealing with children's matters. These comprised the OVC (a group of 60 OVC was divided into six groups to explore children voices); two groups involved caregivers and two were for social welfare officers. FGD with

children is considered relevant when the researcher is interested in children's experiences (Gibson, 2012). The group discussion can motivate children to contribute as they watch and listen to other children sharing their experiences. This is because FGD creates a safe environment which reflects the type of small group setting, such as a classroom with which children are familiar through classroom activities (Mauthner, 1997).

The researcher, as a moderator, informed the group of the purpose of the discussion and reminded them of the need to share their thoughts and experiences in a trustworthy manner. To maintain FGD best practices the researcher ensured that ground rules for the focus group were clearly outlined on a flip chart before initiating them discussion. The researcher also went through the ground rules of the focus group with the participants. After the introductions and review of the ground rules, the researcher facilitated the focus group discussions. A research assistant took notes and sought participants' consent to tape record the discussions. The notes were particularly important for keeping a record of nonverbal gestures and clues that could not be captured by the tape recording. The notes would serve as a back-up source of data in case the tape recorder was destroyed.

Quantitative Research Method

Quantitative research method refers to any research which involves manipulation of numbers to make claims, provide evidence, describe phenomena, determine relationships or determine causation (Babbie, 2013). The research is related to "maximisation of objectivity, explicability, and generalizability of findings" (Harwell, 2008, p.149). The author adds that, to attain objectivity in quantitative research, the researcher has to be able to clarify the experiences, perceptions, biases, views, and assumptions in the research process. As noted by Lincoln and Guba

(1985), quantitative methods hold an assumption that there is a single truth that exists independent of human perception. The quantitative research method was employed in this study to help collect large quantities of data to answer the research questions (Babbie, 2013). This was through administering a questionnaire to the representatives from 20 residential care centres providing care to OVC. As noted by Creswell and Plano Clark (2011) some data which is not naturally quantitative in nature such as attitudes, experiences, perceptions, and beliefs can be collected in a quantitative manner. This is possible through the aid of a tool such as a questionnaire which helps to convert the phenomena into quantitative data which would be statistically analysed (Creswell & Plano Clark, 2011). Through the quantitative research method it was possible to generate the results of this study to the population as a whole.

Data collection procedures

Quantitative data were collected through the use of a questionnaire as discussed below.

Questionnaire

A questionnaire is most often used to refer to an approach for gathering information, from a sample of individuals regarding attitudes, characteristics or beliefs (Schenren, 2004). The study used a standardised questionnaire which helped the researcher to gather information from different respondents by utilising the same questions. The questionnaire in this study consisted of closed ended questions which were directed to the selected sample (representatives from the residential care centre). It helped to collect factual information from the respondents relating to the nature of the alternative care for OVC, situation of the OVC in various alternative care systems, potential contribution of existing child related laws and policy as well as the

perceptions of various stakeholders on promotion of family-based care for OVC in Dar es Salaam.

Use of a questionnaire also helped the researcher to reach a large number of people within a short time and at relatively low cost. The questionnaires were administered face-to-face by the researcher to the responsible offices of representatives of residential care centres dealing with OVC in Dar es Salaam. Face-to-face administration of questionnaires helped to increase the response rate. The researcher also made a follow-up of the administered questionnaires after three weeks.

Sampling

This section discusses sampling procedures that were used in the study. First, the study site is discussed followed by units of analysis, study population, inclusion/exclusion criteria, sampling techniques, and sample size.

Study Site

The study was conducted in Dar es Salaam because this is one of the largest cities in Tanzania with many street children, as noted earlier. It has a surface area of 1,800 square kilometres comprising 1,393 square kilometres of land mass with eight offshore islands, which constitute 0.91% of the entire Tanzania mainland area. The city of Dar es Salaam comprises three districts: Temeke municipality with 652 square kilometres of total landmass area; Kinondoni with 531 square kilometres; and Ilala with 210 square kilometres (Tanzania City Council Surface Area and Economic Survey, 2009).

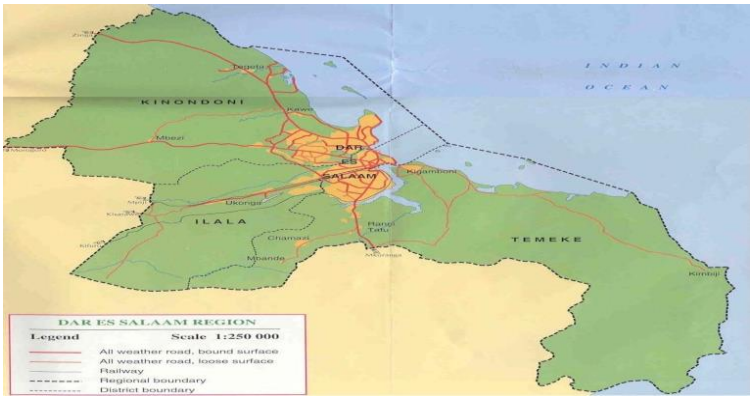

Figure 3: Map of Dar es Salaam. Source (National Population Bureau of Statistics, 2012).

It is estimated that Dar es Salaam consists of more than 40 residential centres providing care and support to OVC (SOS, 2014). As reported in the previous chapters Dar es Salaam has about 2000 OVC placed in various residential care centres, and about 3 to 5 thousands children living on the streets which is a large number as compared to other cities in Tanzania (Kind Heart Africa, 2013; MoHSW, 2011). Employment, education, and business opportunities have influenced the movement of many people from the countryside to the city; which might have attracted OVC as well. The Ministries dealing with children's issues are located in Dar es Salaam (Ministry of Health and Social Welfare, Department of Social Welfare headquarters, Ministry of Education, and Ministry of Legal and Institutional Affairs) which made it easy to access relevant information pertaining to this study.

Finally, the choice of Dar es Salaam city for the study was also informed by the fact that Dar es Salaam is among those cities in the country with slum areas where many families are living in absolute poverty (Sheuya & Patel, 2007). Considering the increasing number of OVC in Dar es Salaam the researcher wanted to explore whether there were reasons other than HIV and AIDS which have influenced this increase.

Unit of Analysis

Unit of analysis refers to things or people to be analysed by the researcher such as individuals, groups, organisations, social interactions, and social artefacts (Babbie, 2013). As noted by Yin (2013), selecting units of analysis in research is vital because this will help the researcher to identify relevant information to be collected in the study. The units of analysis for this study are the existing alternative care systems for OVC and the children (OVC in Dar es Salaam).

Study Population

Study population refers to the entire group of people about whom the researcher wants to draw conclusions (Babbie, 2013).

Table 1: Study population.

Participant	Area
OVC	Placed in residential care centres
Care givers	Employees of care centre providing support to OVC
Social welfare officers	Department of Social Welfare
Key informants	Ministry of Community Development, Gender and Children, Ministry of Health and Social Welfare and UNICEF
Community leaders	Municipalities

The researcher submitted the request and requirements to the Directors of the municipalities, residential care centres' management, and Department of Social Welfare for the selection of OVC and residential care centres providing care to OVC. This was because the residential care centres providing care and support to OVC work closely with the municipalities and Department of Social Welfare. The researcher and research assistants worked with the management (residential care centres) to select OVC based on predetermined criteria. Immediate caregivers employed by residential care centres offering care and support to OVC directly were involved with a view to

exploring their experiences, challenges, and limitations in providing care and support to OVC and how they managed challenges. The involvement of the caregivers was based on the fact that they spend most of their time with the OVC which makes it possible to learn about the behaviour and attitudes of the children. The researcher sought some support from the responsible authority of the residential care centre regarding the caretakers that were to be involved in the study based on specified criteria.

Social welfare officers from the Department of Social Welfare and community leaders were involved in the study to obtain their knowledge, experience, and perceptions with regard to various alternative care systems for OVC. Their involvement was relevant because they are responsible for the implementation of different programmes, projects, and policies related to OVC in Tanzania. Social welfare officers are also responsible for OVC care arrangements in different alternative care settings. The request was submitted to the Department of Social Welfare for selection of social welfare officers and to municipalities for the selection of community leaders.

Key informants from government departments and international organisations working with children (i.e. UNICEF, the Ministry of Health and Social Welfare, and Children, and the Ministry of Community Development, Gender, and Children) formed part of this study. This is because they are familiar with laws and policies guiding care, support and protection of OVC. Their involvement was relevant in exploring their experiences, views, and perceptions regarding the existing alternative care systems for OVC in Dar es Salaam. They are important figures in formulating and implementing policies and laws regarding OVC to ensure security and protection. Furthermore, the study involved representatives from residential care centres dealing

with OVC issues (as mentioned previously) such as the directors and administrators providing care and support to OVC. The researcher submitted the request and requirements to the care centres' management for the selection of representatives. It was expected that the respondents would provide relevant information regarding the nature of alternative care for OVC; challenges facing alternative care programmes; potential contribution of existing child related laws and policies to the enhancement of alternative care systems, and also insight into various stakeholders' perception with regard to the promotion of the family-based care for OVC in Dar es Salaam.

Criteria for inclusion

The criteria for inclusion of the participants were based on the following factors:

- ✓ Their informed consent.
- ✓ Only residential care centres providing care and support to OVC were involved in this study.
- ✓ The inclusion of OVC based on those who were placed in institutional/residential care because they were easily accessible. OVC who were selected for this study were male and female children, aged between 10 and 17 years because most of them were in primary and secondary schools. This meant that they possessed some level of understanding of the subject matter and were easier to handle during FGD.
- ✓ Caregivers who participated in this study were those working with the residential care centres providing support to OVC in Dar es Salaam.
- ✓ Social welfare officers who were involved in this study were those dealing with OVC issues related to alternative care.
- ✓ Only directors and administrators dealing with OVC matters directly in residential care centres were involved in the study (i.e. accountants were not part of the study).

- ✓ Key informants who were engaged in OVC issues formed part of this study as well as community leaders who had been involved in implementing matters related to OVC.

Criteria for exclusion

- ✓ Participants who could not provide informed consent.
- ✓ Residential care centres which did not support OVC were excluded from the study.
- ✓ Caregivers working in settings other than residential care centres.
- ✓ Social welfare officers who were not engaged in issues related to alternative care for OVC.
- ✓ OVC aged below 10 and above 17 years and those who were receiving care outside residential care centres.
- ✓ Representatives of residential care centres not dealing with OVC and key informants and community leaders who were not directly involved in OVC related matters.

Sampling Design in Mixed Methods Research

In order to determine the quality of inferences from the underlying findings, a researcher had to clearly determine a sampling design for the study (Collins, Onwuegbuzie, & Jiao, 2006). This includes the decision on how many respondents should be selected for the study i.e. sample size; and on how to select sample members. Sampling design, as noted by Onwuegbuzie and Collins (2007), represents the framework within which sampling takes place, including the number and types of sampling schemes (specific strategies used to select units, for example people, groups, events, settings; as well as the sample size (number of respondents to be selected). The authors add that sampling schemes contain methods for selecting a sample that have been traditionally associated with the qualitative paradigm (i.e. non-random sampling schemes), and those that have been typically associated with the quantitative paradigm (i.e. random sampling schemes).

Sampling Technique

Nonprobability sampling was used in the qualitative phase of this study. This refers to a sampling technique which employs subjective methods to decide on the elements to be included in the sample (Etikan, Musa & Alkassim, 2015). Purposive sampling was opted for the selection of sample because the goal was to obtain insights into phenomena in order to maximize understanding of the underlying phenomena (Onwuegbuzie & Collins, 2007). The sampling was based on the critical case purposive sampling scheme which, according to Onwuegbuzie and Collins (2007 p. 287), enables the researcher to "choose settings, groups, and/or individuals based on specific characteristics because their inclusion provides the researcher with compelling insights about phenomena of interest". To select the sample for the OVC, the researcher first selected 6 residential care centres purposively from the 20 care centres which were already selected (through random sampling) for the study. The criteria used for the selection was that, the residential care centres had provided services to OVC for five years and above; and were providing care to 30 children and above. Thereafter, the researcher and the research assistants purposively selected 10 OVC from every residential care centre to make a total of 60 OVC who were engaged in this study. This process was used to allow the FGD sessions for OVC to be conducted at the respective residential care centres for security purposes. Department of Social Welfare database was used to select purposively 20 social welfare officers; 20 caregivers were sampled from the residential care centres' data bases (one caregiver was purposively sampled from each residential care centre); 5 community leaders were purposively sampled from the municipalities' data bases, and two key informants were purposively sampled from the Ministry of Health and Social Welfare

databases, two from the Ministry of Development, Gender and Children whereas one was purposively sampled from UNICEF's database.

Probability sampling (simple random sampling) was used to select respondents for the quantitative phase. This was to ensure a sample which most accurately represented the population (Graff, 2012). For the simple random sampling, 20 residential care centres out of 45 were randomly sampled which ensured that each residential care centre selected to take part in this study was chosen without bias. This technique was appropriate given the fact that only two residential care centres had less that 30 children and one residential care centre had only older children (more than 15 years). The remaining 42 residential care centres placed older and young children, and had operated for more than five years.The institutional data bases were used to randomly select 4 respondents from each institution making a total of 80 respondents who were engaged in this study. *(See Appendix I for the Research Method Typology).*

Onwuegbuzie and Collins (2007, p. 292) identify two useful criteria for the mixed methods sampling design, namely time orientation (i.e. concurrent vs sequential) and the relationship between quantitative and qualitative samples (i.e. identical, parallel, nested or multilevel). Identical relationship indicates that exactly the same sample members participate in both the quantitative and qualitative phases of the study. A parallel relationship implies that the samples for the quantitative and qualitative component of the research are different but are drawn from the same population of interest. Nested relationship requires that the sample members selected for one phase of the study represent a subset of those respondents chosen for the other facet of the investigation. This study was based on multilevel relationship (multilevel sampling) (Creswell & Plano Clark, 2011) that involved the use of two or more sets of samples that were extracted from different levels of study (i.e. different populations).

For example, one phase of the investigation (e.g. quantitative phase) involved the sampling of the representatives from residential care centres providing care to OVC; the other phase (e.g. qualitative) involved OVC, social welfare officers, caregivers, community leaders, and key informants.

Sample Size

To increase representation, as noted by Onwuegbuzie and Leech (2007a), it is important that power analyses are conducted in both quantitative and qualitative research. Onwuegbuzie and Collins (2007, p. 288) note that "the size of the sample should be informed primarily by the research objectives, research question(s), and subsequently, the research design. The criteria for sample size in qualitative research, according to Bernard (1995) are not based on probability calculations but represent expert opinions. However, the general rule is that sample sizes in qualitative research should not be too small to make it difficult to obtain data saturation, theoretical saturation or information redundancy (Sandelowski, 1995). It is also warned that the sample in quantitative research should not be too large to undertake a deep, case oriented analysis (Sandelowski, 1995). The sample size calculations for the quantitative phase of this study were made by applying (Yamane, 1967, p.886) the formula:

$$n = \frac{N}{1+N(e)^2}$$ ……; at 5% level of precision/significance, a confidence level of 95%, and (a maximum variability) 'P' is .5. The formula is stated above where 'n' is the sample size; 'N'' represents the estimated population and 'e' is the level of precision (precision error):0.05. The estimated population from the twenty residential care centres sampled for this study was 100 employees. Given an estimated population of 100 employees, the resulting sample is 80.

The current study consisted of 60 OVC and 130 OVC stakeholders from various institutions as indicated in table 2 below. Out of the 130 participants, 80

representatives of the residential care centres supporting OVC were involved in the survey; 5 key informants and 5 community leaders were involved in in-depth and semi-structured interviews; whereas 20 social workers and 20 caregivers participated in FGD. All 60 OVC were involved in FGD.

Table 2: Number of participants.

Participants	**Total Number**
OVC	60
Community leaders	5
Representatives of the residential centres offering care and support to OVC	80
Caregivers	20
Social welfare officers	20
Ministry of Health and Social Welfare	2
Ministry of Development, Gender and Children	2
UNICEF	1
TOTAL	190

It is a well-known fact that different sample sizes are inherent in mixed methods research design because quantitative and qualitative data are usually collected for different purposes (Creswell, 2014). Some researchers who have employed mixed methods research in their studies through concurrent triangulation design tended to involve one pair of the sample from the subset of the other sample (i.e. a subset of respondents for the survey will also be engaged in the interviews) for the purpose of enhancing the comparison. However the researcher in this study used a different sample from a different population to minimise biasness. To minimise challenges related to mixing data from different sample sizes, the researcher collected a large amount of qualitative data and ensured that quantitative and qualitative questions addressed the same concepts (Creswell, 2014). This helped to facilitate the process of merging the data during interpretation of the findings.

Pilot Study

The term pilot study refers to a ‘pre-study’, which is meant to inform the actual study to be carried out. The purpose of carrying out a pilot study is to pre-test the research tools/instruments such as questionnaires and interview guides (Polit, Beck, & Hungler, 2001). Conducting a pilot study enabled the researcher to get an opportunity to train three research assistants who assisted in data collection phase of the research process. The research assistants were the graduate of social work with knowledge of social work, and academic research process. The reseach assistants were trained by the researcher on specific requirements of the study, the issues under the study, ethical issues in social science research, and their expected roles in the research process. The roles of the research assistants included being present with the researcher during interview sessions, and taking written notes for validation of data. They also worked together with the research in facilitating FGDs. The researcher engaged the research assistants in conducting the pilot study as part of their training for understanding the research process.

This research conducted a pilot study to test the study on a small scale first, in order to resolve problems that might lead to failure of the research procedures. This helped to save time, money, and energy that could be lost in conducting the study unsuccessfully. The study pre-tested questionnaires for the quantitative phase and interview schedules for the qualitative phase. The researcher pre-tested the questionnaires with five representatives from residential care centres working with OVC. The researcher collaborated with research assistants, administrators from the residential centres providing care to OVC, and the Department of Social Welfare to draw samples for the pilot study.

The researchers interviewed one community leader, two caregivers, and four social welfare officers from the study population. In addition, one focus group discussion was carried out with six OVC. Modifications were made to the interview schedules and questionnaire guide based on the interview experiences and feedback from the pilot respondents. For example, new questions were added to the questionnaire in order to address the potential contribution of the existing child related laws and policies towards the enhancement of alternative care systems. Another revision was that community leaders were engaged in semi-structured interviews instead of FGDs; and social welfare officers were involved in FGDs instead of semi-structured interviews which were planned before.

Data Analysis

Data analysis has been referred to as "an integrated part of the research design" (Parahoo, 2006, p. 375) to make sense of the data collected in the study. Data analysis in mixed methods research design is referred to as a 'mixed analysis', a term used for analysing mixed quantitative and qualitative data (Onwuegbuzie & Combs, 2011). Mixed analysis 'involves the use of both qualitative and quantitative analytical techniques within same framework, representing analytical decisions that both prior to study and during the study" (Onwuegbuzie and Combs, 2011, p. 3). Four components of the typology of mixed methods design were established by Teddlie and Tashakkori (2009) namely; parallel, sequential, conversion, and multilevel mixed data analysis.

The authors noted that parallel mixed data analysis occurs when statistical techniques employed in analysing quantitative data, and qualitative approaches are used in the analysis of qualitative data independent of each other. The two strands provide information about the phenomena through connecting, combining or integrating the findings. Sequential mixed data analysis is realised when the

qualitative and quantitative phase of a study are in chronological order. This is when the quantitative analysis has been constructed from the qualitative analysis and vice versa. Conversion mixed data analysis occurs when data are converted from one form to another (i.e. numeric or narrative to narrative or numeric) (Teddlie & Tashakkori, 2009).

It is noted by Teddlie and Tashakkori (2009) that, when the study consists of more than two levels (multilevel model), quantitative analysis is always conducted for one of the levels and qualitative analysis is always used for other levels involved. This study involved multilevel mixed data analysis where quantitative and qualitative data were analysed at different levels within the study (Teddlie & Tashakkori, 2009). Quantitative analysis involved data collected from representatives of residential care centres providing care to OVC, whereas qualitative analysis involved data from interviews with the key informants and community leaders. In addition, qualitative analysis involved data from FGDs with the OVC, social welfare officers and caregivers.

The analysis was reflected into the following research objectives: to describe the nature of the alternative care systems for the OVC in Dar es Salaam; to examine the situation of OVC in various alternative care systems, to examine the potential contribution of the existing child related laws and policies towards the enhancement of alternative care for OVC in Dar es Salaam; and to explore stakeholders' perceptions on promotion of the family-based care for OVC in Dar es Salaam.

Onwuegbuzie and Teddlie, (2003) established a seven-step process for mixed analyses which comprised of data reduction, data display, data transformation, data correlation, data consolidation, data comparison and data integration. The researcher

in this study adopted four out of a seven-steps that appeared common in various studies:

a. *Data reduction* where the dimensionality of the qualitative data was reduced through exploratory thematic analysis, and quantitative data using descriptive statistics such as frequency and percentages.
b. *Data display* involved describing qualitative and qualitative data pictorially through charts and figures.
c. *Data comparison* involved comparing data from qualitative and quantitative data, sources (comparing data from two different sources).
d. *Data integration* in which both quantitative and qualitative data were integrated into a coherent whole study (i.e. qualitative and quantitative) and were analysed and interpreted simultaneously.

Qualitative Data Analysis

The researcher started transcribing data from FGD, interviews, and field notes from observation by playing the entire audio file on a player in order to assess the quality of the recording. Transcription is a process of developing text from recorded information (Duranti, 2007). It allowed the researcher to familiarise herself with what she was observing which facilitated the analysis process. The researcher listened to the audio tape and typed all the information in a Microsoft word document. The researcher, in collaboration with the research assistants, reviewed the draft transcript while playing the audio in order to make important corrections that might arise. The transcribed data were then translated into English.

Transcribed data were entered into ATLAS. ti software for coding. This software allowed the researcher to input qualitative data and examine the data for common themes (Teasley & Moore, 2010). As noted by Miles and Huberman (1994)

the software does so by sorting through data, creating conceptual patterns, including larger meanings, and the identification of constitutive characteristics. The researcher reviewed the transcripts several times to examine the interview for key themes and specific topics in order to establish preliminary codes based on the emerging categories. This allowed the researcher to identify codes within the data and arrange them for ease of interpretation. Memos for each code were written and codes were refined to explore patterns that emerged in the interviews (Davidson, 2009).

The researcher examined the patterns across different groups of participants. She then discussed the coding plan and relationships among the codes with the research assistants in order to refine them for further analysis. An open coding approach was employed in order to allow data to guide the researcher to themes and ideas that were shared by participants (Teasley & Moore, 2010). Open coding, according to Strauss and Corbin (1990), refers to the process by which concepts are identified and established based on properties and dimensions. Once an initial set of codes was identified, they were used throughout the analysis while also for the emergence of new codes (Teasley & Moore, 2010). The final stage included identification of similarities and differences between the categories that emerged.

Quantitative Data Analysis

The researcher used the Statistical Package for Social Sciences (SPSS) computer software to analyse the quantitative data. Before entering data in SPSS the researcher edited the raw data for the purpose of detecting errors and omissions so that they could be corrected where possible (Kothari, 2004). The author further notes that editing helps to ensure data accuracy, consistent with other gathered data, and it facilitates coding and tabulation. After editing the data, coding followed which refers to assigning numbers or symbols to the responses in order to establish different

categories. The researcher worked with the research assistants in preparing the codebook where the variables were defined and labelled. As noted by Kothari (2004) there must be a category for every data item.

Numbers were assigned to each of the possible responses, and every question from the questionnaire was assigned a unique variable name to be used in SPSS (Pallant, 2005). SPSS version 12 was used in this study which allowed 84 characters for the variable names. Descriptive statistical analysis was conducted to obtain a demographic profile of responses to each of the study variables i.e. definition of OVC, types of alternative care systems, situation of OVC in alternative care systems, barriers that hinder OVC access to alternative care and challenges that may limit efforts to promote the family-based care for OVC. Descriptive statistics helped to provide insights into frequencies and nature of data distribution (Huck, 2008). Frequency tables were drawn and the data were presented in bar graphs and tables.

Integration of the Key Findings

In triangulation, qualitative and quantitative data are collected and analysed separately to produce two data sets of the findings; and the findings are combined or triangulated to gain a comprehensive understanding of the phenomena (Creswell & Plano Clark, 2011). The term triangulation can be used to describe corroboration between two sets of findings (Sandelowiski, 1995). However, the meaning used in this study is the one which is commonly applied in mixed methods research denoting a process of studying a problem using different methods to gain a more comprehensive understanding (Sandelowski, 1995). Several benefits of integration of data have been established (O'Cathain, Murphy & Nicholl, 2010) such as, the use of qualitative data to assess the validity of quantitative data, and the use of quantitative data to help in generating the qualitative sample or explain findings from qualitative

data. In addition, through data integration qualitative data can be used to inform development or improvement of quantitative instrument or establish hypeses in the qualitative component for testing quantitative component (O'Cathain et al., 2010). Apart from the above mentioned benefits it is claimed that the extent to which mixed methods research implement integration remains narrow (Bryman, 2006).

Several strategies for integration exist (O'Cathain et al., 2010; Creswell & Plano Clark, 2011) in which integration can be carried out at the design, methods and interpretation and reporting levels of the research. Integration at interpretation and reporting levels can occur through narrative, data transformation and joint display (Creswell, Fetters, & Curry, 2013). Three approaches to integration through narratives have been identified as follows: the weaving approach which involves writing both quantitative and qualitative results together in a theme-by-theme or concept-by-concept. The contiguous approach involves presentation of the results within a single report, but different sections are reported for quantitative and qualitative results. The staged approach occurs in multistage mixed methodas studies when the results of each step are reported based on stages and the data are analysed and reported independently (Creswell et al., 2013). In this study the researcher integrated data at the interpretation and reporting levels through narrative based on the weaving approach to integration.

Addressing Reliability andValidity

Before conducting the study the researcher has to show that the procedures applied in the study were both reliable and valid (Nunan, 1999; Lincolin & Guba, 1985; Joppe, 2000; Goswani, 2011). Reliability as noted by Goswani (2011) is the ability of the series of measurements to be consistent throughout the research process. The measurements are obtained through research instruments which are said to be

reliable only when the results of the research study are reproduced under the similar methodology (Joppe, 2000). The implication is that consistent results are expected when the measurement is applied to measure the same thing repeatedly. Nunan (1999, p. 14) noted that, “reliability deals with the consistency, dependability and replicability of the study obtained from a piece of research”.

Three techniques have been identified for addressing reliability issues, namely the researcher’s position, triangulation and audit trial (Lincolin & Guba, 1985); Merriam, 1998).

The *researcher’s position* required detailed explanation for different processes and phases of the inquiry applied in the research process to increase reliability. This involved clear description of the research design, study population, study setting and rationale for the study. The researcher applied different data collection techniques like survey, FGD, semi-structured interviews and observation for *triangulation* purposes. In addition, collection of various types of information through different sources increased reliability of data and results (Merriam, 1998). To deal with the *audit trial*, the researcher in this study, described clearly how the data were collected, analysed, how different themes were established, and how results were obtained for the purpose of enhancing reliability of the findings.

It had been indicated in previous studies that the researcher, in a specific study, must discuss any threats to internal or external validity in social science studies (Cook & Campbell, 1979; Onwuegbuzie, 2003). According to Guba and Lincoln (1998), validity refers to the quality of the instrument based on its accurateness, correctness, trustworthiness and meaningfulness. Validity in social sciences as indicated in a study by Pelvin (1984, p.48), is not restricted to measurements but to examining “the extent to which our observations indeed reflect the phenomena or

variables of interest to us". Validity in the study can be examined as "construct, internal validity and external validity (Yin, 2013, p.40-42). Construct validity according to this author is the extent to which a study established correct operational measures for the concepts/constructs under study.

In the current research, construct validity was secured through application of multiple methods and sources of data (triangulation) to ensure that other sources could be used to verify data established from one source. The triangulation was carried out to ensure that data on the nature of alternative care for OVC were not only obtained from the representatives of residential care centres. To test the validity of the questionnaire and interview guides, the researcher sought comments from the academic supervisors and experienced fellow researchers in the initial stage of developing the guides. Documentary review was used to extract information from various reports, manuals, books, and legislation. As mentioned earlier pilot study with 18 participants was also carried out to ascertain whether the items measured what they were intended to measure. This helped to guide the researcher to edit and omit some of the issues which were not understood by the participants.

Internal validity is used to examine the extent in which a causal relationship has been established in a particular study. The current research applied the theoretical framework from the previous studies to ensure that the claims made by this study are supported by the existing evidence. External validity establishes the sphere to which a study's findings can be generalised. In this study the researcher used a sample of 80 respondents drawn from 20 residential care centres engaged in this study with an estimated 100 employees. This sample is large enough to allow generalizing the findings beyond the study sample. In addition selection of the respondents was done based on objective criteria, and also, the data were collected through multiple methods

to minimize bias and increase generalizability. According to Lincolin and Guba (1985), validity does not exist without reliability, meaning that if there is no validity there is no reliability. This implies that by effectively demonstrating the validity it is adequate to establish reliability in a study.

Addressing Trustworthiness Issues

Because data in the qualitative phase are narrative in form and subjective, it complicates attainment of similar findings as compared to the quantitative phase where data or similar findings are easily obtained because they are in numerical form (Zohrabi, 2013). Lincolin and Guba (1985) suggested on reflecting on dependability and consistency of the data in dealing with the difficulties of obtaining similar results in qualitative research. The implication is to reach to a conclusion which indicates that the findings and results are consistent and dependable (Zohrabi, 2013).

Sandelowiski (1993), revealed that trustworthiness becomes a matter of persuasion whereby the researcher is viewed as having made the assumption practices and methods visible and therefore auditable. According to Gunawan (2015, p.4), a study is “trustworthy if and only if the reader of the report judges it to be so”. Trustworthiness have been divided into *credibility* which corresponds (internal validity) in positivism; *dependability* which relates to (reliability); *transferability* (a form of external validity); and confirmability which is (largely based on presentation issues) (Sandelowiski, 1993). To resolve trustworthiness issues in this study, the researcher ensured that she genuinely captured the lived experiences of the participants involved in the qualitative research phase. This was very vital to make sure that the real experiences of the subjects involved in the study were presented and not the researcher’s personal feelings. The audio recording was used during the interviews and focus group discussions to capture as accurately as possible the

intended phenomena (Tashakkori & Teddlie, 2003). Furthermore, Gunawan (2015, p.11), note that "to ensure trustworthiness, the role of the triangulation must be emphasized in the context of reducing effect of the researcher's bias. The researcher in this study, used the survey questionnaire to examine the nature of alternative care systems in Dar es Salaam; the interviewed key informants, community leaders; and lastly conducted focus group discussions with the OVC, social welfare officers, and caregivers on the same issues.

Limitations of the Study

The following were some of the limitations for this study.

- Differences between groups in FGD could cause one group to dominate the discussion which would result in group conformity. The researcher, being aware of this limitation, tried to get everyone to participate fully in issues related to the discussion.
- Over-directing during FGD could cause the interviewer to bring her/his own views, opinions, and perceptions into the discussion resulting in bias. The interviewers were reminded to desist from over directing the interviewees.
- As noted by Driscoll (2011) during observation the researcher has to be aware of the difference between observation (recording exactly what has been observed) and interpretation (making assumptions and judgements about what has been observed) in order to avoid bias. The researcher in this study used a "double entry notebook" which refers to an observation log which encouraged the researcher to separate observations from what he/she could feel or judge about the facts (Driscoll, 2011).
- Purposeful samples were not easily defensible as being representative of populations due to potential subjectivity of the researcher. Attempt to resolve this happened through the quantitative phase which sought similar information for the purpose of complementarity.

- In this empirical study, the researcher attempted to employ most suitable approaches and methodologies in order to obtain optimal results. However, she was confronted with some limitations based on choice of methodologies. One of the major challenges concerned the design of the study. Undertaking both quantitative and qualitative research methods concurrently had limitations in the process of managing and integrating data thus gathered (Johnson & Onwuegbuzie, 2004). The most challenging part was specifically on interpreting quantitative data and integrating the meaning of data obtained from quantitative and qualitative methods. The researcher consistently read available literature, and consulted supervisors for discussion of some critical areas so as to manage this challenge.
- The data for this study were gathered from different populations (multilevel relationship). This included representatives from residential care centres, key informants, community leaders, OVC, social workers, and care givers. To minimize challenges related to mixing data from different populations and sample sizes, the researcher collected a large amount of qualitative data and ensured that qualitative and quantitative questions addressed the same concepts (Creswell, 2014).
- Data collection tools (interviews and focus group discussions) were challenging as they required respondents to spend between 60 to 90 minutes out of their busy schedule to participate in this study. This lead to some targeted individuals declining the request to participate in the process. The researcher made appointments and follow-up calls two weeks before the date, which allowed some respondents to make adjustments in their timetables.
- The study was conducted in Dar es Salaam, Tanzania, which required the use of Kiswahili language in the data collection process. This made translation from English to Kiswahili necessary in the case of the instruments used (questionnaires, interviews,

and focus group discussions) and translation of data collected from Kiswahili to English. It was time consuming and very challenging to convey the meaning of words/phrases/statements in two different languages. The researcher worked hard to ensure that the fidelity of the translated version adequately conveyed the same meaning for each item in the three instruments.

Ethical Considerations

According to Hill (2005, p. 65) "the small number of well-established and accepted principles underpinning an ethical approach (autonomy/respect for persons, beneficence and non-maleficence, and justice/equity/non-discrimination), can be developed and expressed as a set of rights to self-determination, privacy, dignity, anonymity, confidentiality, fair treatment, and protection from discomfort or harm". This study involved adult and child participants which required a range of ethical issues to ensure protection against harm during and after the research was conducted.

Informed Consent

The researcher was aware of some ethical considerations regarding the study area which required her to seek permission before carrying out the study. The researcher therefore sought permission to conduct the study from University of Botswana's Institutional Review Board (IRB), the Open University of Tanzania's Review Board as well as the Department of Social Welfare in Tanzania. Informed consent in this study reflected four core principles indicated in the study by Gallagher (2009). Firstly, consent was reflected by an explicit act of the respondent, for example, verbal or written agreement to participate in the research; secondly, consent was only realised when the participants were informed about and had an understanding of the research and the role they were expected to play; thirdly, consent was given voluntarily without being forced to participate; and fourthly, consent was

open for the participants to withdraw at any stage of the research process. Participants were required to sign the consent forms before engaging in the research process and they were given a copy of the signed form *(See Appendix X for the consent form).*

Involvement of the children in the study conformed to the international guidelines related to child protection from harm during and after research, while allowing them to benefit from the research results (Powell, Fitzgerald, Taylor, & Graham, 2012). Clear and justifiable reasons were provided by the researcher for involving children in the study as well as clear proof that the information sought was not readily available elsewhere (WHO, 2011). For example, the researcher in this study involved children because they represented the key study population in relation to the rationale for strengthening the alternative care for OVC in Dar es Salaam. The findings from OVC were generalized to the entire population, to gain their insights regarding the nature of the existing alternative care mechanisms.

The researcher was responsible for anticipating any adverse consequences to ensure that the participation of children could not cause any harm (Alderson & Morrow, 2011). This was attained by making sure that all responses that were provided by OVC would be confidential. The researcher would also report immediately any case related to OVC stress to the responsible counsellor in the institution during the research process for counselling services. Although the ethical issues that need to be observed when conducting research are similar for adults, children, and young people, the implementation can be different (Tisdall, Davis, & Gallagher, 2009). The UNCR (2009) defines children and young people as all persons under the age of 18 years. This implies that children and young people are not legally competent to provide consent, which required that parents, guardians, teachers and

social workers made decisions on their behalf (Tisdall et al, 2009). Parental consent forms and assent forms were provided *(See Appendix XI and XII).*

The researcher in this study also sought consent for participation of OVC in the study from the responsible authorities of the residential centres providing care to OVC, because they were sampled from those care centres. After obtaining the consent the researcher sought assent from the OVC which was the child's indication that he/she could participate in the study (Tisdall et al., 2009).

Protection from Harm (Risks, harm, and benefits)

The researcher was obliged to assess the potential harm and risks from research and to create the best ways to minimise or alleviate them while ensuring that participants benefit from the expected results. The researcher ensured that OVC were highly protected in the study from potentially negative psychological, social, financial, emotional, and legal repercussions. One research assistant with clinical experience helped to monitor comfort levels of participants and to intervene when a need arose. This was in acknowledgement of sensitive issues related to the subject under study. As indicated in the study by Graham and Fitzgerald (2010, p. 141); "conceptualizing children as immature and incompetent involves the presumption that they are at risk and vulnerable to exploitation in the research process and therefore in need of protection". It is important to acknowledge that it could be difficult to determine all potential harm and risk at the outset of the study (British Psychological Society, 2010, p. 13). Nevertheless, the researcher strove to identify and assess potential risks and to develop effective approaches for risk management as an integral part of the study. This helped to ensure that all ethical considerations were addressed.

Privacy and Confidentiality

According to Wiles, Crow, Heath, & Charles (2008), confidentiality is a concept rooted in the principle of respect for autonomy that implies that all identifiable information regarding participants collected during the research process would not be disclosed without their permission. The researcher was responsible to ensure that confidentiality and participants' identities were highly protected (WHO, 2011) and that all interviews were conducted in private. The participants were entitled to a guarantee that all information provided by them concerning their personal life would be treated in a confidential manner and that the researcher would prevent the use and dissemination of any information that might harm the participant. The researcher was also responsible for ensuring that all research materials were anonymous in the sense that the names of participants were not identified.

Researcher's Position

The researcher appreciated and acknowledged being a part of the society where the participants who were engaged in the study reside. She understood that her own beliefs, experiences, knowledge, and perceptions might interfere with the process of generating knowledge and thus focused on the objectives of the study to enhance the quality of the findings. As a resident in Dar es Salaam city for over 25 years, the researcher is knowledgeable in relation to social, political, cultural, and economic issues and is aware of challenges facing OVC in Dar es Salaam as a result of inadequate permanent care.

The researcher believes that family is a fundamental institution for providing care to OVC but was careful that her bias did not interfere with the findings. Through sharing the idea of promoting the family-based care for OVC in Dar es Salaam, some people became very excited and some promised to take OVC into their families if

foster care and adoption processes research process would be improved. This experience could lead to bias in, but the researcher made every effort to prevent it from interfering with the findings.

Conclusion

Mixed methods research design was employed by the researcher for the purposes of triangulation and complementarity. The design allowed the researcher to use both qualitative and quantitative approaches through concurrent triangulation (collection and analysis of data were carried out separately but within the same time frame) in order to overcome weaknesses associated with reliability and validity issues. This study gave more weight to the qualitative research which is the best suited to address the purposes of this study which are exploration and description. It is believed that both explorative and descriptive data brought about relevant conclusions and recommendations which will be of value to stakeholders providing care and support to OVC. This will assist in strengthening existing alternative care systems and also promote family-based care in the best interests of OVC.

The mixed methods research was employed by this study for the purposes of complementarity and triangulation. Research methods used to collect data for the two strands were observation, semi-structured interviews, and focus group discussions (qualitative strand), and questionnaire (quantitative strand). The study was conducted in Dar es Salaam city and it involved OVC, caregivers, social workers (FGDs); community leaders, and the key informants (semi-structured interviews), and representatives from the residential care centres providing care to OVC (questionnaire). Probability sampling (simple random sampling) was used to select respondents for the quantitative strand of the study and non-probability sampling (purposive sampling for selection of participants) for the qualitative strand of the

study. The sample size for this study was 190 (80 representatives from the residential care centres), 60 OVC, 20 caregivers, 20 social workers, 5 community leaders, 5 key informants).The mixed analysis was carried out which involved the use of bot qualitative and quantitative analysis analytical techniques within the same framework. Transcribed data from the qualitative strand were entered into ATLAS.ti for coding and SPSS was used to analyse quantitative data. The researcher integrated the data from the two strands at the interpretation and reporting levels of the study. The next chapter presents demographic information for the respondents and participants who were invoved in this study.

CHAPTER FOUR-DEMOGRAPHIC INFORMATION

Introduction

This study involved 110 participants in the qualitative phase and 80 respondents in the quantitative phase of the study. As indicated in the previous chapters, data for the qualitative phase were gathered from the OVC, caregivers, social welfare officers, community leaders, and the key informants. Quantitative data for this study were collected from representatives of residential care centres providing support to OVC in Dar es Salaam city. Of the 80 questionnaires distributed, 73 (91%) were completed and returned to the researcher. Unfortunately, 4 did not return the questionnaires because they had travelled to the regions for duty, and the questionnaires could not be collected from them, while 3 reported having misplaced the questionnaires. In the presentation of the demographic information and analysis of the findings, the term *'respondents'* will be used to refer to people who answered the questionnaires in the quantitative phase of the study and *'participants'* will represent people who participated in interviews and FGDs in the qualitative phase.

Demographic Characteristics of the Respondents

Demographic information utilised the variables of sex, education level, and professional background of the respondents regarding their care and support to OVC. This is presented in Table 3 below. According to Table 3 below, on the aspect of sex of the respondents, of the 73 respondents who filled-in the questionnaires, 38 (52 %) were female and 48% male. As for their levels of education, most of the respondents 32 (43.8%) had secondary education, and those who had Master's degrees from different fields were a small group, comprising only 3 (4.1%) of the total sample. With regard to the respondents' professional status, 7 (9.6%) were social workers

while a majority 59 (80.8%) reported that they had other professions, identified as accountancy, teaching, engineering, sociology, business administration, and religion.

Table 3: Demographic characteristics of respondents (n=73).

Characteristics	% (n)
Sex	
Males	48 (35)
Females	52 (38)
Education level	
Primary education	31.5 (23)
Secondary education	43.8 (32)
Bachelor degree	20.6 (15)
Master degree	4.1 (3)
Professional status	
Social Workers	9.6 (7)
Counsellors	2.7 (2)
Nurses	5.5 (4)
Child care officers	1.4 (1)
Others	80.8 (59)

The qualitative data in this study were gathered through in-depth interviews, focus group discussions, and observations, the details of which are summarised in Table 4 below. As shown in the table, IDIs involved community leaders and key informants and FGDs involved OVC, social welfare officers, and caregivers. Community leaders and key informants were involved in IDIs because of their busy schedule, which did not allow the researcher to interview them more than once.

Table 4: Study participants and instruments used for data collection.

Respondents	Number of Participants	Instrument used
UNICEF Officer	1	In-depth interviews
Department of Social Welfare	2	In-depth interviews
MoHSW	2	In-depth interviews
Community leaders	5	In-depth interviews
OVC	60	Focus group discusions
Social Welfare Officers	20	Focus group discussions
Care givers	20	Focus group discussions
TOTAL	110	

Through IDIs it was possible for the researcher to probe further which allowed for more elaboration or clarification of some issues by the interviewees. OVC, social welfare officers, and caregivers were engaged in FGDs because the tool helped to elicit their thoughts, feelings, experiences, and perceptions of the nature of alternative care for OVC within a short period of time. A total of 10 participants were interviewed and 100 participated in FGDs. The IDIs with key informants involved an officer from UNICEF, social welfare officers from the Department of Social Welfare, and officers from the Ministry of Health and Social Welfare (MoHSW).

Before commencement of interviews and focus group discussions key informants, community leaders, social welfare officers, and caregivers were asked to provide information related to gender, profession, and education levels. OVC were asked to provide information regarding their age, sex, and education level which is also provided in this section.

Sex of the Participants

This variable is as summarised in Table 5 below.

Table 5: Sex of the participants (n=110).

Respondents	Male % (n)	Female % (n)
OVC	60 (36)	40 (24)
Key informants	60 (3)	40 (2)
Community leaders	60 (3)	40 (2)
Social Welfare Officers	40 (8)	60 (12)
Caregivers	45 (9)	55 (11)

According to information provided, 36 (60%) of the key informants and community leaders who participated in this study were male. Regarding Social Welfare Officers who participated in FGD, 12 (60%) were female and the rest were male. Participation of caregivers involved 11(55%) female, and 36 (60%) of the OVC were male.

Education Level of the Participants

Regarding the levels of education, the variables are as summarised in Table 6 below.

Table 6: Education level of the participants (n=110).

Respondents	**Primary level % (n)**	**Secondary level % (n)**	**Diploma % (n)**	**Bachelor degree %(n)**	**Master degree % (n)**
OVC	56.7 (34)	43.3 (26)	0.0	0.0	0.0
Key informants	0.0	0.0	0.0	60 (3)	40 (2)
Community leaders	20 (1)	80 (4)	0.0	0.0	0.0
Social Welfare Officers	0.0	0.0	5 (1)	90 (18)	5 (1)
Caregivers	25 (5)	60 (12)	0.0	15 (3)	0.0

Table 6 above shows that the majority of the key informants had a Bachelor's degree 3 (60%). Many community leaders who took part in interviews had Certificate of Secondary Education (CSE) 4 (80%). A majority 18 (90%) of Social Welfare Officers had a Bachelor's degree. Many caregivers 12 (60%) had (CSE) level of education and few 3 (15%) had Bachelor's. OVC who participated in this study ranged from 14 to 17 years. 34 (56.7%) of the OVC were in primary schools (standard 5 to 7) and 26 (43.3%) were in secondary schools (Form I –IV).

Professional Background of Participants

The professional background of the participants is as detailed in Table 8 below.

Table 7: Professional background of participants (n=50).

Respondents	**Social Work %(n)**	**Sociology % (n)**	**Community %(n)**	**Nursing %(n)**	**Counselling %(n)**	**No profession %(n)**	**Other professions %(n)**
Key informants	20 (1)	40 (2)	20 (1)	0.0	0.0	0.0	20 (1)
Community leaders	0.0	0.0	0.0	0.0	0.0	60 (3)	40 (2)
Social Welfare Officers	65 (13)	25 (5)	5 (1)	0.0	0.0	0.0	5 (1)
Care givers	10 (2)	5 (1)	0.0	0.0	0.0	60 (12)	25 (5)

Details from Table 7 above show that 2 (40%) of the key informants who participated in this study were sociologists. A majority 3 (60%) of the community leaders reported that they had no qualifications. A simple majority 13 (65%) of the social welfare officers had social work professional training. Several caregivers 12 (60%) reported that they did not have any professional qualification.

Conclusion.

The demographic information above will be reflected in the chapter for the presentation of the findings, and discussion of the findings of this study for the chapters that follows. Chapter that follows presents the findings for the nature of alternative care systems for OVC in Dar es Salaam.

CHAPTER FIVE-NATURE OF THE ALTERNATIVE CARE SYSTEMS FOR OVC

Introduction

This chapter presents, analyse, and interprets participants' views and perceptions of the nature of alternative care systems for orphans and vulnerable children (OVC) in Dar es Salaam (objective 1 of this study). The mode of handling the data was integrated in the sense that data from observations, in-depth interviews (IDIs), focus group discussions (FGDs), and surveys were combined. The organisation of the chapter is based on themes and categories regarding the nature of alternative care systems for OVC in Dar es Salaam, derived from the analysis of quantitative and qualitative data. Six main themes featured in this chapter: respondents' views on OVC and alternative care systems, type and quality of services provided to OVC, perceptions of participants on the roles of social workers, and challenges faced by them in implementing care arrangements for OVC.

Alternative Care Systems for Children

Alternative care systems for children without parental care in Tanzania, which is the major focus of this study, is not a new phenomenon as it was in existence before independence in 1961. However, historically those children used to receive sufficient care from members of the extended family, close friends, neighbours, and the entire community. Unfortunately, this safety net has been overburdened by an increase in the numbers of OVC due to HIV and AIDS and extreme poverty (SADC, 2010; Everychild, 2011b; TACAIDS, 2013). Studies have revealed that the number of OVC has increased to the extent that the capacity of members of the extended family and communities to provide support had been undermined (SADC, 2010; Wiliamson & Greenberg, 2010). This chapter focuses on the first objective of this study which is to describe the nature of alternative care systems for OVC in Dar es Salaam, in an

attempt to understand the issues involved in the fulfilment of the expectation of OVC care, love, and protection.The presentation of the findings from quantitative and qualitative data that follow is reflected in the identified categories, themes, and sub-themes presented in Table 8 below.

Table 8: Nature of alternative care systems for OVC.

Patterns from quantitative data	Themes from qualitative data	Sub-themes
1. Definition of OVC 2. Types of alternative care systems 3. Type of services provided to OVC 4. Quality of services provided to OVC	1. Views on the nature of alternative care systems	a. Understanding of OVC and the existing alternative care systems b. Type of services provided to OVC c. Quality of services provided to OVC
1. Perception of respondents on the roles of Social Workers	2. Participants' perceptions on the roles of Social Workers	a. Identification and assessment of children in need of care b. Prepare children and parents for reunification c. Monitoring of services provided to OVC by alternative care systems d. Counseling to OVC, caregivers, and parents
1. Challenges facing Social Workers	3. Challenges facing Social Workers in implementing care arrangements	a. Limited human, material and financial resources b. Inadequate services to OVC c. Poor monitoring and evaluation of services provided to OVC d. Illegal ownership of residential care centres e. Inadequate support services for independent living

Understanding of OVC

In order to gain knowledge on the criteria used to place children in residential care centres, a question was asked on the way residential care centres defined the term OVC. The responses are as illustrated in Table 9 below.

Table 9: Statistics on how residential care centres define OVC (n=73)

Responses:	Agree (%) (n)	Not sure (%) (n)	Disagree (%) (n)
Death of one or both parents	100.0 (73)	0.0	00.0 (00)
Living on the streets	63.0 (46)	0.0	37.0 (27)
Homeless and abused children	65.8 (48)	0.0	34.2 (25)
Living with very sick parents	64.4 (47)	0.0	35.6 (26)
Children living with disabilities	21.9 (16)	0.0	78.1 (57)

All (73) respondents in the survey as shown by table 9, agreed that their residential care centres define OVC as children whose parents (one or both) are deceased. Twenty-seven (37%) of the respondents disagreed that OVC are children living on the streets, 25 (34.2%) disagreed with a definition of OVC as homeless and abused children and 26 (35.6%) did not agree with a definition which defines children living with very sick parents. However, many 57 (78.1%) respondents indicated that the care centres do not define any OVC as children living with disabilities.

During the interviews and focus group discussions participants were asked to express their views on how they define orphans and vulnerable children. The finding revealed that an orphan is a child who has lost one or both parents. However, some of the participants reported that, according to Muslim beliefs if a father has died children become orphans even if their mother is alive. They added that if a mother dies and the father is alive then children are not orphans. One community leader said:

For most Muslim women, when a husband dies, they get remarried and might be less committed to the children which might lead to insufficient basic needs. Through experience some men who marry the widows refuse to provide care and support to the orphaned children. Many children will be sent to live with their grandparents without adequate material and financial support when their mothers remarry.

With regard to vulnerable children, paticipants revealed that these are orphans who have no relatives to provide support or children who have been neglected by

parents, guardians or relatives, street children, abused children or children living with disabilities. One key informant said:

According to the culture of many Tanzanians the extended family is mostly involved in taking care of the children after they lose parental care. Unfortunately, some of the families might be very poor and unable to provide basic needs to the children, which might push the children onto the streets. From my experience, some children become more vulnerable because they have no relatives who would foster them. The relatives might have all died of AIDS.

It was also reported during FGD with caregivers that some vulnerable children had been neglected by their biological parents due to family conflicts, poverty or disability. One of the caregivers said:

Some fathers have neglected their families because of children born with disabilities whereas some mothers have neglected children due to marriage conflicts. For example, in many cultures in Tanzania, when it happens that a child is born with disability of any kind the mother is to be blame and she is the one to shoulder the burden of care. There are many reports from the media showing fathers neglecting their families after a child is born with disability. Because in many families father is the main provider, when there is a disabled child and no father exists to povide care the mother will not manage to provide support to the rest of the children.

Alternative Care Systems

In the survey, respondents were asked to state the type of alternative care systems for OVC in Dar es Salaam they were familiar with. The aim of this question was to examine understanding of respondents on alternative care systems based on the first objective of this study. Their responses are summarised in Table 10 below.

Table 10: Types of alternative care systems (n=73).

Response:	Agree (%) (n)	Not sure (%) (n)	Disagree (%) (n)
Kinship/extended family	100.0	0.0	0.0
Residential/institutional	100.0	0.0	0.0
Foster care	100.0	0.0	0.0
Adoption	100.0	0.0	0.0
Group homes	100.0	0.0	0.0
Community-based care	91.8 (67)	8.2 (6)	0.0
Child-headed households	86.3 (63)	13.7 (10)	0.0

According to Table 10 above, respondents were unanimous in agreeing that kinship care, residential care, statutory foster care, adoption, and group homes constituted the alternative care systems. A majority of respondents indicated that community-based care (91.8%) and child-headed households (86.3%) are forms of alternative care systems. Participants during the interviews and FGDs reported that alternative care systems are models of care outside OVC's biological parents, which provide them with care and support. Participants identified kinship/extended family care, adoption, statutory foster care, community-based care, child-headed households, institutional/residential care, and group home care as the main alternative care systems. They reported that many OVC were under the care of members of their extended family because most communities believe that a child should be raised by relatives. During FGD a caregiver said:

My experience is that in many Tanzanian cultures families are taking care of children of their relatives and friends even when the children's parents are alive. This is merely to facilitate the child to attain education in the city. Sometimes one family can support more than two children and this is highly related to the traditions, norms, and cultural beliefs attached to kinship ties. Some communities believe that it is a curse to the whole clan if a child is offered for adoption.

A community leader said that some of the alternative care systems were leading in providing care and support to OVC. He added:

I can say that the care systems which are currently dominating in providing care to children without parental care are the kiship care, residential care, and group homes. There are no effective initiatives to promote statutory foster care, supervised child-headed households, community-based care, and adoption . For example, some people in the communities engage in volunteering to support children in need but there are no effective formal programmes for supporting OVC.

One of the key informants, during interviews, explained that statutory foster care and adoption were not effective in supporting OVC. He further observed that:

Formal foster care and adoption are care systems which are not active in Tanzania. This is mostly due to the cultural practices and beliefs that a child should be raised by his/her own relatives in his/her society. You would hardly find people talking about foster care and adoption because, in many cultures, children whose parents are deceased are informally fostered and adopted by the relatives.

Services Supposedly Provided to OVC under the Existing Alternative Care Systems

The researcher sought to understand respondents' opinions regarding services they perceived were provided to OVC under the existing alternative care systems. This was relevant because it helped to uncover the type of services provided to OVC. The findings are summarized in Table 11 below. All respondents in the survey concurred with an assertion that alternative care systems were expected to provide shelter, food, clothing, health care service, and education to OVC. More than 90% of the respondents shared the view that the existing alternative care systems offered recreational and psychosocial support services to OVC. With regard to services expected to be provided to OVC by the existing alternative care systems, participants reported that OVC had access to basic, social, and spiritual needs, as well as

counselling and recreational services. This according to participants might not indicate that OVC placed in different alternative care systems had access to all basic needs necessary for their wellbeing because of inadequate resources.

Table 11: Services Supposedly provided to OVC by the existing alternative care systems (n=73).

Response %	Shelter	Food	Clothes	Health	Education	Recreational	Counseling
Agree	100.0	100.0	100.0	100.0	100.0	98.6	97.3
Not sure	0.0	0.0	0.0	0.0	0.0	1.4	2.7
Disagree	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

In responding to the question on services provided by the alternative care systems from FGD, one child said:

The centre where I live provides to all children, food, school uniforms, clothes, and medical care when someone becomes sick. We also get bedding and sports facilities. Religious services are provided at the centre by Christian and Muslim teachers. I have stayed at the centre for five years and almost every month end; some people visit the centre and talk to children. When people visit the children at my centre bring fruits, sweets, and vegetables.

Another OVC gave her views saying that there are people who take care of their food and medical needs:

At my centre all children get food, school uniforms, and books. There are four employees who prepare breakfast, lunch, and dinner for us. When a child is sick she/he is taken to the health care centre. The problem which children face is that there is no playground at the centre. Children only play when they are at school.

It was revealed by the participants that alternative care systems had played an important role in providing children with necessary needs. An example was given by the participants, which indicated that residential care centres had facilitated education

which enabled many children to secure good jobs and manage their own businesses. A community leader had this to say in this regard:

When compared to children living with poor families, many children in the residential care centres are far better because they get access to basic needs and an opportunity for education and health services. I have witnessed some children from care centres that got an opportunity to continue with higher education, and now have good jobs.

The researcher, through observation, witnessed children going to school and some coming back from school. All children had school uniforms and were carrying bags which held their school books. A few children who were around at various centres and could not attend school had health issues and were under medication. In some of the care centres the researcher saw storage rooms with raw food like maize flour, rice, beans, wheat flour, and cooking oil which was an indication that those care centres had sufficient food for the children. The researcher also witnessed children taking their breakfasts and lunches together in different residential care centres. Children in these care centres appeared to be enjoying food and their time together.

Quality of services provided to OVC by the existing alternative care systems

The question on quality of services provided to OVC was intended to explore the respondents' views as to whether such services were of an acceptable standard. The responses are summarised in Figure 4 below which shows that the majority (74%) of respondents rated the quality of services provided to OVC by existing alternative care systems as moderate.

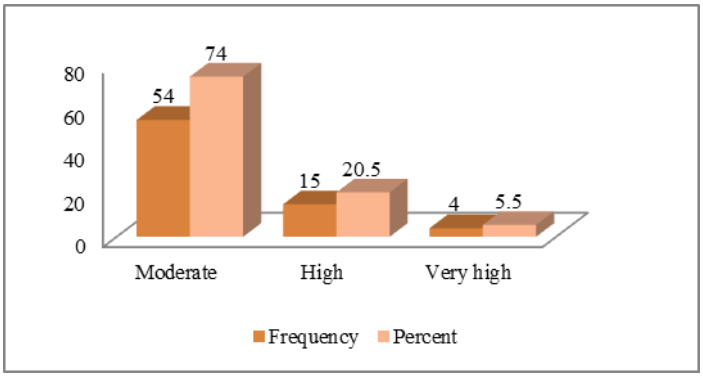

Figure 4: Respondents' perception of quality of services provided to OVC.

The results from the interviews and FGDs indicated that the participants perceived the quality of services provided to OVC by the existing alternative care systems as good. Participants reported that many children in alternative care systems were able to obtain all basic necessities for their wellbeing, which was not very different from children living with biological parents. In addition, the participants said that the quality of services provided to OVC depended on availability of resources at various alternative care systems. According to the participants, this may suggest that some alternative systems offered better services to OVC than others. One social worker said:

Many children who are under the care of some members of the extended family, institutional care, group homes, foster, and adoptive care look healthy. This is because they are able to receive two to three meals a day which is difficult for some children living in poor family households with both parents. OVC are living in appropriate shelters, they get an opportunity to attend school, and also to receive medical care when need arises.

A key informant, regarding the role of resources in the provision of quality services, had this to say:

Availability of resources determines the quality of services provided to OVC by the alternative care systems. For example, many members of the extended family and residential care centres enrol children under their care in public schools. This is different from a group home like SOS which enrols children in private schools.

Availability of resources also determines the nature of medical services provided to children. For example SOS children's village, some families, and residential care centres with good income have managed to secure health insurance for OVC who are under their care.

It was revealed by the participants that children living with poor members of the extended family or guardians were likely to experience poor and inadequate services. The participants added that some residential care centres, community-based care, and child-headed households had failed to provide proper and adequate services to OVC due to limited resources. One community leader reported that:

Poor families supporting OVC mostly live in very poor shelters, can afford one meal per day but not clothes, education, and health services for the children. They may not have adequate protection. For example, the families can easily accept the children to work as domestic workers. The services of some residential care centres and community-based care facilities are also unsuitable due to financial constraints.

Concerning quality of services, one of the OVC had this to say:

The services we receive from the centre are good because we live in proper shelter and we receive food and education. Unfortunately, the services are not sufficient, because some OVC do not have good uniforms. For example, a child can put on very old uniforms, without shoes and school bag. This makes the child feel inferior in front of other children who have proper uniform. This type of feeling demoralises the child and may result in poor school performance.

Another OVC observed that there was a problem regarding number and quality of beds, explaining that:

At the care centre where I stay there are not enough beds. Although boys and girls have different dormitories, two children share one bed. Mattresses are also very old and when two children use one bed it feels like sleeping on the floor. However, three meals are provided to children every day and the centre has a dispensary and three nurses.

From the researcher's observation, the findings showed a huge variation in physical environment of the residential care centres. The buildings of almost half of the residential care centres involved in this study were new and some had been recently renovated. The environment in those centres was clean with premises well kept. For example the surroundings, kitchens, rooms, dining rooms, and toilets were cleaned and children looked smart. Unfortunately, other care centres had well though old buildings but the surroundings were not well kept. The dining rooms, kitchens, and toilets were poorly maintained. All residential care centres had electricity and water facilities but only a few had sports grounds for the children.

Respondents' Perceived Roles of Social workers

The question was intended to elicit respondents' perceptions of the roles of these professionals who work with OVC and the challenges they were facing in implementing care arrangements for these children. The responses are summarized in Table 12 below. According to the data in Table12 below, all respondents (100%) indicated the following as the roles played by social workers: identification and assessment of children in need of care, monitoring and evaluation of the care systems, preparation of children and parents for reunification, and offering psychosocial support to OVC, caregivers and parents.

Table 12: Respondents' Perceived roles of social workers (n=73)

Responses %	Agree
Identification and assessment of children in need of care	100.0
Monitoring and evaluation of care systems	100.0
Prepare children and parents for reunification	100.0
Offering psychosocial support	100.0

Participants during interviews and FGDs identified similar roles and other roles such as psychosocial support to OVC, caregivers and parents, advocacy for resources to improve services for OVC, and child protection. In giving such information it can be said the participants are well informed that children without parental care could only be registered in alternative care systems after social workers had identified and assessed them. The participants agreed that the procedure was very important to ensure that only children that met the selection criteria were placed in alternative care systems. A caregiver shared her work experience:

I have been employed as a caregiver for more than fifteen years. I gained experience in identification and assessment of children in need of care through seminars and workshops on child care and protection. Through identification and assessment processes it was possible to discover some children who were in critical health conditions and they were referred to hospital .

During focus group discussions and interviews, participants revealed that monitoring and evaluation of the existing alternative care systems as well as services provided to OVC is an important role of the social worker. According to the participants, monitoring and evaluation helps to ensure that only registered care centres are delivering services to OVC. One of the key informants said that:

Effective monitoring and evaluation of the existing alternative care systems is very vital for the protection of children's rights. This will help to reveal any abuse and exploitation of children so that appropriate actions can be taken. I attended one seminar on child security and protection that was organised by an international partner, and learnt that through monitoring and evaluation social welfare officers were able to close some of the residential care centres due to poor services.

It was reported by participants through interviews and FGDs that in recent year child reunification and reintegration projects have been put in place by the Department of Social Welfare in the communities. All community leaders who

participated in the study said that their offices were involved in the assessment and identification of street children by the Department of Social Welfare. One of the community leaders said:

In Dar es Salaam this exercise was targeting children placed in residential care centres and those who were living on the streets. I am one of the community leaders who represented Temeke municipality. Social workers were able to engage children in the process and they (children) provided information, which enabled social workers to locate their parents/guardians. From that exercise, many street children were reunited with their parents/guardians.

It was further revealed by participants that social workers played an important role in offering psychosocial support to OVC, caregivers, and parents. Some of the participants believed that psychosocial support had been very useful especially to families with children who were living with HIV and AIDS and to children living with parents who are living with HIV and AIDS. Another community leader said:

I have an experience in this area because I took care of my own daughter who died after suffering from AIDS for more than ten years. I witnessed social workers visiting my house several times to offer psychosocial support to the patient, her two children, and my family. This brought a very big relief because these children were well prepared for the loss. Psychosocial support has been offered by social workers to the families, communities, and schools.

During FGDs with social workers, one said that assessment and identification of the children help to ensure that the placement procedures and arrangements meet the best interests of the child. The aim, according to the social workers, is to keep the children with their families or members of the extended family so that children can have an opportunity to grow in their communities. The social worker added:

As a social worker, for almost ten years, I have been involved in conducting assessment of children and families in need of social welfare services. In some special cases, some children were removed from their families and placed in residential care

centres. For example children with special needs whose families were very poor and were not able to support these children. Assessment also helps to establish early intervention and prevent some problems like abuse and exploitation.

Another social worker said that the identification and assessment process helps social workers to establish different needs that do not require the child to be placed in an alternative care systems. He added:

For example, in a couple of years, one family requested the Department of Social Welfare to place two children of a deceased relative in a residential care because this family was very poor and could not manage the care. The children stopped attending school because they had no school uniforms and exercise books. Instead of removing the children from that family, the Department of Social Welfare registered that family with a support programme and the family succeeded in securing financial support for a small business. Since then, the life of that family has changed and they managed to continue supporting the children.

A social worker shared his experience with many OVC and noted that many of them had behavioral problems, and with some being very aggressive to the extent that sometimes they hurt other children. He added that:

Some children with behavioral problems had been placed in residential care centres due to what families indicated as failure to address the problems. Some of the children had alcohol and drugs abuse problems and were very aggressive to fellow children and caregivers. I know several young people who have benefited from the services and managed to complete college and university education.

Challenges facing Social Workers

The researcher sought to explore respondents' views on challenges facing social workers in implementing care arrangements for OVC. The responses are summarised in Table 13 below which shows that all repondents agreed that social workers faced several challenges in the process of implementing care arrangements for OVC. These include inadequate human, material, and financial resources;

inadequate services for OVC; poor monitoring and evaluation of services provided to OVC; illegal ownership of residential care centres; and inadequate support for children's independent living. Data from the interviews and FGDs also show similar results. In addition, participants revealed that many public and private institutions dealing with childen issues did not employ qualified social workers, which made it difficult to provide appropriate services.

Table 13: Perceived challenges facing social workers (n=73)

Responses %	*Agree*
Limited resources	100.0
Inadequate services to OVC	100.0
Poor monitoring and evaluation	100.0
Illegal ownership of care centres	100.0
Inadequate support for independent living	100.0

A social worker said:

The problem is that social welfare officers are mostly located at the district level and only about 85 out of 169 districts have social welfare officers in Tanzania. This means that the local government offices do not have social workers who could offer services to the community members at the grass root level. People in need of social welfare services were required to take their problems to the social welfare officers in the district offices.

Some participants were of the view that limited material and financial resources hindered social workers from providing sufficient services to OVC. The participants also revealed that there was inadequate support from the Social Welfare Department to very sick children or those living with disabilities due to limited material and financial resources. Participants added that they know of cases of

marrital breakdown due to fostering of children living with disabilities. A social worker said:

There are no special programmes/projects in place by the internal and external partners to offer support to members of the extended family providing support to OVC. This has resulted in failure for those families to provide basic and social needs to children. As a result, the children have been forced to run from those families and live on the streets. Almost all residential care systems are donor supported and because they continue to receive more children, the budget becomes inadequate. This has resulted in poor and insufficient services to OVC.

In the cause of observation, the researcher found that some residential centres were running nursery schools, primary schools, secondary schools, and dispensary projects that were located at the centres. These services are offered to community members at affordable cost and the care centres manage to get money to support the children. One residential care centre had (green) vegetable gardens which were useful for the nourishment of the children. In addition, community members were buying green vegetables from the centre. Another centre had chickens to provide eggs and meat for the children.

The participants interviewed and from focus group discussions expressed concern over poor monitoring and evaluation of the existing alternative care systems and services provided to OVC. When the OVC were asked how many times they had met with the social workers within the few months, they said they had never met with a social worker. Some OVC added that sometimes the caregivers informed them that the social worker visited their centre and had a meeting with management.

A key informant said:

In my view, the existing alternative care systems are not fully monitored by the responsible authorities such as the Department of Social Welfare. This is clearly evidenced by media reports on child trafficking and abuse by relatives, parents,

teachers, and the residential care system. The main reason is that the government has failed to provide adequate budget to the Department of Social Welfare. In addition, only a few qualified social welfare officers are employed by the government which makes it difficult to conduct effective monitoring and evaluation.

The FGD with caregivers revealed that the visits of social welfare officers in care centres were very few far too difficult. In one session caregivers said from their experience, social welfare officers might visit care centres only twice in two to three years. One caregiver shared his experience by explaining:

I have been employed by the care centre for seven years, and from my experience social welfare officers have come only once for evaluation purposes as part of the research they were conducting. There had also been some visits by social welfare officers which were not related to monitorng and evaluation services. I once talked to an adoptive parent who said that he adopted a child 5 years ago and had never been visited by the social welfare office as written in the contract.

Participants agreed that a large number of the existing alternative care systems is under the kinship, NGOs, FBOs, and CBOs. The participants reported that they were surprised to learn that some of the residential care centres which were registered as NGOs were actually owned by family members. A social worker revealed the following:

The ownership of some residential care centres is questionable because they are just registered as NGOs, but have no license for running a child care home. This is very dangerous because the Department of Social Welfare is not involved and those care centres do not follow proper procedures indicated in the Children's Home Regulations 2012. For example, a few residential care centres had been closed because of violating the regulations and legal action was taken towards the owners.

In FGD, one caregiver said that the Director of the residential care where she worked had arranged to get children from Tanga region and Zanzibar. After she established the care centre she went directly to talk to some parents and asked them to

bring their children to the centre so that they could benefit from basic needs, good education, and health services. She continued by saying:

The Director only visited families that were poor and managed to convince them to bring the children to the care centre. That made it easy because those families shared the information with other relatives and friends who also agreed to bring their children to the centre. These were girls from 3 to 5 years of age, who were placed in the care centre without involvement of the Department of Social Welfare. The care centre has operated for about five years and all children are studying at English medium schools. The Director promised that she would arrange for the children to visit their parents during holidays but that has never happened.

A community leader during an interview said that he had an experience with some residential care centres in his area although he did not know much about the requirements. He added:

What surprises me is that three residential care centres I know are using their family house to keep the OVC, where the family members and the OVC live in the same compound. Although there were some employees coming from outside, some of the members of those families also work in those centres as patrons and matrons. For example, one of those centres has two flats, where members of the family live in the upper floor and all children live on the ground floor. The other centres have houses where family members live and other houses for the children.

Participants noted that after they reached 18 years some of the children placed in residential care centres were expected to be reintegrated into their communities. Unfortunately, there were no support systems for independent living of those youths which posed a challenge for social workers. A caregiver shared her experience:

Through my experience of working I have witnessed some children who failed to cope with their family environment after reunification but went back to the streets. Some older children had been reintegrated in their communities because they did not have relatives or families but because there were inadequate support programmes for their

wellbeing they ended up in dangerous jobs like being commercial sex workers and drug dealers.

Discussion of findings

In this chapter, the transpiring issues from the first objective of this study which was to describe the nature of the existing alternative care systems in Dar es Salaam city, Tanzania, are discussed. The data from the study revealed stakeholders' perspectives of the OVC, contribution of alternative care systems, fundamental needs of the OVC, distinct views on standard of services provided to OVC, and social workers' commitment to OVC and the limitations faced. The combined sources of data from the survey, FGDs and IDIs give insight into understanding the significance of alternative care for OVC. The ecological systems and attachement theories applied to the discussion.

Tanzanians have different understandings of orphan and vulnerable childen. From a cultural perspective orphanhood means that a child has lost one or both parents. These findings are similar to those from previous studies (SADC, 2010; PEPFAR, 2013; SOS, 2014). By contrast, Islam defines orphanhood as a child who has lost a father. This is because in Muslim culture women are encouraged to remarry although step fathers may not accept children from the wife's previous marriage. This study's finding is consistent with the orphanhood definition from the Islamic Law by Sheikh Sa`ûd al-Funaysân (2008) which states that an orphan is any child who has lost his father and has not reached the age of maturity (+/-16 according to many scholars) where he/she is expected to marry and lead an independent life. The legal age of marriage in Tanzania according to the Marriage Act (1971) is 18 years for boys and 14 years for girls with the consent of the parents.

Previous studies (SADC, 2010; Save the children, 2012; PEPFAR, 2013) consistent with the findings of the present study, did reveal that vulnerable children include orphans, street children, children living with disabilities, children living in residential care centres, abused children, and children living with very sick parents. However, the data show that 40% of residential care centres did not include children living on the streets, homeless children, and abused children or living with very sick parents as vulnerable children in their definition. In addition, many residential care centres (79.1%) did not define children living with disabilities as falling into the vulnerable children category.

This study's findings contribute to the knowledge base (in this regard) by highlighting the fact that the cultutral definition of orphanhood is in line with the legal definition of orphanhood in Tanzania, which is used in targeting services and progammes related to orphans. In addition, the findings raise concern regarding the Islamic definition of orphanhood in that it excludes children living in poor conditions with their fathers from accessing services targeting orphans (such as nutrition, free education, medical services, and psychosocial support). Furthermore, the definition has an implication that children should be placed in residential care systems and denying them their right to live with their mothers. The findings also contribute to knowledge regarding specific focus on vulnerable children who might have failed to secure support from residential care centres because they did not meet the criteria. Through observation the researcher found that only one residential care centre out of 20 involved in the study was providing care to children living with disabilities. The findings of this study point towards the need for national and international partners to establish effective mechanisms that will target children living with disabilities to

ensure that they are able to access various services for their social, physical, psychological, and economic development.

With regard to contribution of alternative care systems the findings of this study appear consistent with those of other studies (SADC, 2010; USAID, 2010; EveryChild, 2012a; Save the Children, 2013) which, suggested that alternative care systems are models of care outside OVC's families of origin. The latter include kinship care, community-based care and child-headed households, residential care, statutory foster care, adoption, and '*kafala'* in Islamic Law). The qualitative data revealed narratives of participants indicating that the existing alternative care systems had contributed a great deal to the care of OVC. The findings from the FGDs and interviews revealed that kinship care is the system which leads in providing care and support to OVC based on traditional beliefs, values, and norms. This study established that residential care centres also supported many chidlren compared to group homes/childens' villages, adoption, and statutory foster care which were perceived as systems which provide care to a small proportion of children. Previous studies have confirmed that 90% of children without parental care in developing countries are under the care of members of the extended family (Williamson & Greenberg, 2010; UNICEF, 2011; Faith Action Initiative, 2015).

Save the Children (2014) found that the number of children placed in residential care centres had increased due to lack of support for the alternative family-based care for OVC. These findings are in accord with SOS International and Centre for Excellence for Looked after Children in Scotland (CELCIS), (2014) findings which noted that Benin, Tanzania, Kenya, Zambia, and Togo had many residential care centres compared to other alternative care systems such as foster care and adoption. The reason was stated as being that many countries provided support to

residential care centres instead of supporting families to manage the care of their children or other people's children (Save the Children, 2014).

The findings of this study further revealed that the participants appreciated the contribution of community-based care and supervised child-headed households in offering permanent care to OVC. However, they further revealed that there were no effective initiatives to promote community-based care and supervised child-headed households for managing care of OVC. Community-based care involves different initiatives such as programmes responsible for the care of OVC and provision of shelter, food, education, health services, and protection (USAID, 2010). Unfortunately, community-based care suffers from lack of material and financial resources to support OVC programmes (Mathabo & Richter, 2007). Findings by UNICEF (2007) reported that children living in child-headed households suffered from lack of adult care and support from relatives, NGOs, and government institutions.

This study's findings have empirically indicated kinship/members of the extended family constitute one of the alternative care systems which has suffered the burden of OVC care as a result of HIV and AIDS. The findings have underlined the fact that the residential care systems which are recommended as a last resort for children without parental care is used as a first priority. The findings raise concern with regard to the limited numbers of OVC placed in foster care, adoption, community-based care, group homes, and supervised child-headed households (as noted by the participants). This means that only few children receive care in a family environment, which is an indication that many children are suffering from inadequate and inappropriate care. These findings, therefore, call for stakeholders to establish initiatives that promote permanent care to OVC.

Turning to fundamental needs of OVC the study sought to ascertain from the participants the types of services they believed OVC received from the alternative care systems. The findings revealed that OVC were provided with basic needs such as food, shelter, and clothing; social needs which covered education, health care, and counseling; and spiritual services which were delivered through Christian and Muslim teachings. The findings of current study established that residential care centres had played a significant role in ensuring that all children under their care received an education. This, according to the findings, had enabled many youth who were brought up in residential care centres to secure good jobs or start private businesses.

Previous research on OVC by Abebe (2009); USAID (2010); UNICEF (2012), and SOS (2014) has acknowleged the role of alternative care systems in providing basic needs such as food, shelter, clothes, psychosocial support, education, sports, and health care services to OVC. The findings of the current study concur with those of the study by Malinga and Ntswarang (2011) on alternative care of OVC in Bostswana, which revealed that the children benefited from accessing basic needs, education, health, and spiritual services as well as pschosocial support from alternative care systems. This is due to the fact that Botswana has one of the most comprehensive social protection programme in Africa which target children (i.e. orphan basket) sponsored by the government (Botswana Institute for Development Policy Analysis, 2013).The study by the MoHSW (2011) on the situation of OVC in institutional care in Tanzania reported that many residential care centres provide all essential needs as stipulated in the Guidelines for Children's Home (2012) such as proper food, shelter, education, and health facilities as well as psychosocial support services.

These findings are relevant to social welfare officers for them to understand that the potential contribution of the residential care system in supporting OVC should not be taken for granted to undermine promotion of family-based care for OVC. This study's findings suggest that residential care centes should only be utilised as places of safety to keep children for a short period of time while preparing for transition to family based care. In addition, social welfare officers should ensure that a few residential care centres are designed to serve children who cannot secure permanent placement or are awaiting decisions on the serving of their best interests.

Regarding standard of services available to OVC, the present study's findings indicated different perspectives in relation to the quality of service provided to OVC by the alternative care systems. Participants were of the view that OVC services in many alternative care systems were moderately effective, and that a few care systems like SOS Children's Villages provided very high quality services to OVC. This, according to the findings, indicated that children were offered nutrition, love, support, education, and health care service of adequate quality. The above findings are in agreement with theTanzania Guidelines for Improving quality of care, support, and protection for the MVC (2009) which has identified dimensions of quality services based on access, safety, effectiveness, sustainability, and approprietness.

However, according to the findings of this study poor families could not afford quality services for their children, and also a few residential care centres provided poor quality and insufficient services to OVC. For example, some children had no proper school uniforms and could not get regular balanced meals. In addition, some care centres had no play grounds or dispensaries, and had insufficient beds and mattresses. These findings correspond with previous findings by Save the Children (2009) which indicated that, in some residential care centres in Liberia and Sri Lanka,

children were spending nights on the floor because of few beds, and only receiving one meal a day. In addition there were no health and sports facilities. A similar finding was reported by the Tanzania Child Rights Forum (2013) which indicated that, children placed in some prisons in Tanzania due to their involvement in robbery, drug dealer, and trafficking; physical and sexual abuse did not have adequate food, beddings, and clothing.

The findings of this study have also established that children living with poor families suffered from poor and inadequate nutrition as well as poor health, shelter, and protection and they did not have the opportunity to access education and health services. This finding is in line with those of Williamson &Greenberg (2010) and SOS (2014) which indicated the inability of members of the extended family to fulfil the needs of children due to poverty. Furthermore, inadequate services were provided to OVC by some residential and community-based care centres due to limited resources. Some respondents noted that the quality of services is dependent on the availability of resources and therefore differs from one alternative care centre to another. This finding is similar to that of MoHSW (2011) which revealed that, due to a shortage of professional and supporting employees, children in some residential care centres did not receive the required services and protection.

These findings contribute to the litertature in terms of understanding that children might experience difficulties due to inadequate care by poor families and some poorly equipped residential care centres. Thus, the findings point to the need to establish a framework for stakeholders that would help them monitor and evaluate services provided to OVC to prevent negative consequences. For example, children might suffer from malnutition due to unballanced diet and diseases such as cholera due to poor environmental conditions. The findings further point to the need to the

establishm programmes that would support poor families to manage the care of their children.

Participants aknowledged that social workers have played a significant role in implementing care arrangements for OVC. These include placement of children in various alternative care systems, monitoring and evaluation of such systems, and reunification and reintegration of children with thier families and communities. Other roles which were identified by the findings included preparation of children and parents for reunification and psychosocial support services to children, parents, and caregivers in general. The findings are in agreement on what social workers ought to do as spelt out in literature which states that social workers are required to carry out assessment to identify the needs of children (UNICEF, 2004; SADC, 2010; PEPFAR, 2012). The the UN (2009) and Save the Children (2012) suggested that assessment should be conducted to determine the appropriate family members who are interested in offering permanent placement to a child.

Respondents affirmed that monitoring and evaluation of the existing alternative care systems out to be carried out by social workers would help to protect children's rights. The findings have also indicated that monitoring and evaluation would help to identify some residential care centres which were operating without licenses from the Department of Social Welfare. These findings of the present study are in line with studies by EveryChild (2012) and SOS (2014), which show that social workers ought to be responsible for monitoring and evaluating all care systems such as community-based care, foster care, adoption, and residential care as well as evaluating all services provided to OVC. As suggested by UNICEF (2006), formal and informal care systems require effective monitoring of care arrangements and protection of children from the grassroots level and upward. This will facilitate

participation of community members in ensuring that children's rights are respected and protected by every individual in the best interest of the child. Article 25 of the CRC requires States Parties to establish a system for periodic review of alternative care systems to ensure appropriate care and protection of children. As noted by Brenfenbrenner and Moris (1998) use of the ecological perspective can help social welfare officers to identify, assess, and resolve complex issues related to children resulting from their interdependence with the environment.

The findings further revealed that there had been progress in terms of reunification and reintegration of children with their families and communities. Previous studies by UNICEF (2010), USAID (2010); SADC (2010) and Save the Child (2013), which recommended that social workers should give priority to reunification of children with their families and reintegration of children in their communities. As noted by Save the Children (2012), contact with parents or guardians of children is very vital in facilitating the reunification process. Involvement of community members and children is very necessary during the reintegration process which prepares children to live an independent life. As noted by Save the Children (2012) social workers have to prepare a conducive environment for children leaving formal care and they should participate fully in the planning process.

The findings also reveal a recognition of the role played by social workers in providing psychosocial support which was reported by respondents to be very helpful to terminally ill patients, families caring for them, and children who have lost their parents. The Child Act 2009 section 94(3) requires community authorities, in collaboration with social welfare officers, to provide counselling to parents, guardians, relatives, and children in order to resolve conflicts which might separate children from their families. The Child Act (Foster Care Placement) Regulations 2012

section 14(2) requires social welfare officers to provide support and counseling to assist children to adapt to the foster care environment. Furthermore, the act requires social welfare officers to provide counseling to older children preparing to leave formal care for independent living. Similarly, Better Care Network and UNICEF (2015) noted that psychosocial programmes are relevant to OVC because they help to address problems related to abuse, exploitation, and trauma as a result of spending a long time with very sick parents and finally their death. This concur with Everychild (2012) study that found that psychosocial support helps families to offer effective care to OVC and also to reduce stigma and discrimination of communities. USAID (2009) revealed that psychosocial support programmes for guardians and caregivers in Kenya and Tanzania had helped to promote positive behavioural change in children and minimised abuse and violence towards children.

The findings of this study in regard to this issue stimulate increased awareness about the importance of social work in addressing the needs of OVC. The findings also draw special attention to the need for social workers to monitor and evaluate alternative care systems and services provided to OVC. This will help in understanding and identifying illegal residential care centres which operate without licences and registration from the Department of Social Welfare. The question which remains unanswered is : What is the motive behind the setting up of illegal residential care centres? The findings of the study suggest that personal interests in generating income motivated people to operate illegal care centres. This calls for interventions by social welfare officers to control such care centres in order to prevent child abuse and exploitation.The findings further propose that government should ensure that only qualified social workers are employed in the public and private sector to promote the

wellbeing of OVC. They should also be engaged in developing policies and programmes to address the needs of OVC.

Another emerging issue from the study findings is that social workers face various challenges in implementing care arrangements for OVC. Limited human, material, and financial resources constitute some of the challenges revealed by the findings. The data reveal that, only 85 out of 169 districts had social welfare officers in place across Tanzania. These findings agree with those of USAID (2011) and EveryChild (2012) both of which indicated that social workers were poorly distributed and overworked because a social welfare officer located in a district had to provide services to all OVC and older people and also respond to matrimonial problems. This affirms the argument by the African Committee on the Rights and Welfare of the Child (2010) that the Social Welfare Department in Tanzania did not have sufficient human and financial resources to support children without parental care. This result is also consistent with the observation by the MoHSW (2013) on the National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018, which revealed that Tanzania had a shortage of social welfare officers in the region of 88%. The finding is also in agreement with the study findings by SOS (2014) which indicated that some of the organisations/institutions providing care and support to OVC had failed to employ qualified professional workers due to limited financial resources.

The study uncovered a gap relating to insufficient resources that had caused inefficiency in many areas related to care of OVC. For example, due to inadequate financial resources social workers had failed to establish programmes for supporting poor families caring for children living with disabilities. In addition, apparently no appropriate home visits to adoptive and foster parents are arranged due to limited

human and financial resources. The findings of the current study agree with those of USAID (2011) which found that very few social workers were interested in applying for government employment because of low levels of remuneration. It was also noted that social workers were not effectively trained in new approaches to the emerging complex problems because of the limited budget from central government. This corresponds with results of studies by UNICEF (2011) and Save the Children (2015) which found out that children in various alternative care systems suffered from poor services, abuse, insufficient food, and lack of education and health care services. The findings by Save the Children (2009) revealed that establishing an effective system to support families to manage care of their children would require resources. The findings also substantiate the view that, to strengthen kinship care, statutory foster care, adoption, community-based care, supervised child-headed households, and group homes, would require considerable material, human, and financial resources. It was also asserted by SOS (2014) that it had been challenging for the organisation to find appropriate adoptive parents for domestic adoption in Tanzania partly due to financial constraints and also because of the fact that many families have large numbers of children to support.

The findings also revealed that monitoring and evaluation of the existing alternative care systems and services provided to OVC was inadequate, and this was related to poor budgeting by the Tanzanian government. Some respondents revealed that social welfare officers had visited the care centres a few times, and that some people who had adopted children 5 years ago had never been visited by social welfare officers. The conscequences of this according to the findings included operation of unregistered residential care cantres; recruitment of children by the owners of the care centres without consulting the Department of Social Welfare; and

even child trafficking. The findings correspond with those of SADC (2010) which noted that new residential care centres were being constructed in many African countries without registration. These centres were not monitored and were not receiving support from government. This was also confirmed by the MoHSW (2011) in a draft report on assessment of children in residential care centres in Tanzania which stated that only 30.9% of the residential care centres in Tanzania were registered. According to this assessment, 66.7% of the centres had no licence from the Dipertment of Social Welfare to operate.

The interviews and FGDs revealed that some residential care centres were illegally owned and operated by family members which appeared like the violation of the guidelines for children's home. However, the National Guidelines for the Establishment and Management of Children's Home (2006) define the children's homes as individual homes owned by individual persons; institutional homes owned by NGOs, FBOs, CBOs and Trusts; and government homes owned by central government or local government. In addition, the guidelines recognise partnership children's homes. Although family members can operate a residential care centre for OVC, the problems might include violence, abuse, and exploitaion because of inadequate monitoring and evaluation of services provided by alternative care systems.

The findings of this study revealed that there was inadequate support programmes for OVC and this had pushed some youths back to the streets where they might have become involved in robberies and drug dealing. This finding corresponds with those of previous studies (SOS, 2010; Better Care Network, 2009; EveryChild, 2010; PEPFAR, 2012) which noted the importance of effective preparation of transition of youth from formal care to independent life. As indicated in the study by

Faith to Action Initiative (2014), children who have been raised in formal alternative care systems, like residential care and statutory foster care, might face many challenges in establishing an independent life. The Faith to Action Initiative (2014) further noted that it might be partly due to traumatic situations they suffered through loss of parents, abuse, exploitation or inadequate support for their wellbeing. SADC (2011) suggested that the basic needs of children and youth have to be fully met after leaving formal care to enable them to secure a better future. This would help to ensure that children reunited with their families and those reintegrated in communities continue to receive appropriate support towards their wellbeing.

The implication of this findings is that the efforts of social workers in addressing the needs of OVC are undermined by poor government support. The findings also noted poor budgeting and too few qualified social workers, employed by the public sector as social welfare officers as issues of concern. This has hindered social workers from playing their roles in an effective manner which in turn has affected the care arrangements for OVC. These findings, therefore, call upon national and international stakeholders to strengthen the social welfare workforce in order to ensure the wellbeing of OVC and other vulnerable groups.

Chapter summary.

The findings show that Tanzanians have different understandings of orphans which are based on the cultural and Islamic perspectives. Overall the findings of this study show that the existing alternative care systems for OVC have played a vital role in providing necessary serices for the survival of children. The study noted that kinship care has played a significant role in supporting OVC which is attributed to the traditional beliefs, norms, and values of many Tanzanian communities. However, many members of the extended family have failed to provide basic needs to the

children due to extreme poverty which has pushed children to live on the streets and in residential care centres. Moreover the findings showed that there were many OVC placed in residential care centres in Dar es Salaam while many others were living on the streets. This implies that many vulnerable children have not secured permanent placement in a family environment which is important for their security and protection.

It was also established that most OVC were able to access food, shelter, clothing, education, health sevices, counseling, and spiritual and recreational services in various alternative care systems where they were placed. However, the participants noted that although alternative care systems were expected to offer OVC access to the basic necessities like food, shelter, clothes, education and health care; in some cases children could not access those services due to limited resources. Availability of resources was identified as an important factor which determined quality of services provided to OVC by the existing alternative care sysytems. For example on one hand, the quality of services for children living with poor families and those placed in some residential care centres was reported to be poor as some children could not access balanced meals, education and health care services. On the other hand the findings revealed that the quality of services for children living in group homes and those placed in adoption care was very good.

The study findings revealed that, despite the commendable work done by social workers in implementing care arrangement for OVC, they still faced many challenges which hinder their effectiveness. For example, assessment and evaluation of the existing alternative care systems as well as the services provided to OVC remained poor. Illegal ownership of residential care centres with concomitant harm to children thus remained an issue of concern. In addition, support system for children

leaving formal care remained scanty which might push some of them into criminal behaviour. The chapter that follws will describe the situation of OVC in various alternative care systems.

CHAPTER SIX-SITUATION OF OVC IN VARIOUS ALTERNATIVE CARE SYSTEMS

Introduction

Alternative care systems such as kinship care, foster care, adoption, community based care, residential care, group homes, and child-headed households have played a significant role in providing care and support to OVC in Tanzania and elsewhere. However, previous studies have reported that some children in various alternative care systems have experienced poor conditions due to inadequate care (Faith to Action Initiative, 2015). For example, although many OVC are under the care of members of their extended family, some suffer from malnutrition due to poverty (Malinga & Ntshwarang, 2011). This chapter therefore, reports the triangulated data from the survey, FGDs, and interviews, to gain an understanding of respondents' perspectives on the situation of OVC in alternative care systems (objective 2 of the study). The chapter also presents views of the respondents on the reasons for the OVC placement in alternative care systems, barriers hindering OVC from accessing alternative care, and the treatment of OVC in various alternative care systems as summarised in Table 14 below.

Table 14: Situation of OVC in various alternative care systems.

Categories from quantitative data	Themes from qualitative data	Sub-themes
1.Situation of the OVC 2.Definition of the OVC	1.Views on the situation of OVC in existing alternative care systems 2.Reasons for the OVC placement in alternative care systems	a.HIV and AIDS b.Family conflicts Poverty c.Early/childhood pregnancies d.Children in conflict with the law
1.Criteria for OVC selection for placement in care centres	1.Barriers hindering OVC to access alternative care	a.Poverty b.HIVand AIDS c.Discrimination and stigmatization d.Long procedures for statutory foster care and adoption e.Limited human, material and financial resources
2.OVC relationship in alternative care systems	1.Treatment of OVC in alternative care systems	a. Abuse b. Exploitation c. Discrimination d. Labeling

Situation of OVC in Various Alternative Care Systems

The aim of this question was to explore the views of participants regarding their perceptions of the situation of OVC in various alternative care systems (objective 2 of this study). A five-point rating scale (poor, fair, good, very good, and excellent) was used to obtain the information for the survey, the results of which are summarised in Table 15 below.

Table 15: Respondents' opinion on the situation of OVC in various alternative care systems.

Response %	Kinship	Residential	Foster	Adoption	Community	child-headed	Group homes
Poor	11.0	17.8	9.6	0.0	28.8	21.9	0.0
Fair	57.5	54.8	58.9	0.0	56.2	54.8	0.0
Good	26.0	27.4	31.5	15.1	15.1	23.3	12.3
Very good	5.5	0.0	00	84.9	0.0	0.0	87.7
Excellent	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 15 indicates that respondents had different opinions regarding the situation of OVC in various alternative care systems. A majority (57.5%) of the respondents

indicated that the situation of OVC was fair in kinship, residential care (54.8%) indicated fairness, followed by foster care (58.9%); community-based care (56.2%) and supervised child-headed households (54.8%). In addition, many (84.9%) respondents felt that the situation of OVC was very good in adoption and in group homes (87.7%). The participants during the interviews and FGDs, reported that the situation of the OVC in kinship settings, residential care, foster care, community-based care, and supervised child-headed households was fair (OVC living standard was at an average level) at least OVC had access to the important needs for survival like support for basic, social, spiritual, and psychosocial support needs. In addition, the participants revealed that the situation of children placed in group homes was very good (the OVC living standard was at high level) because of adequate human, material, and financial resources. A community leader during an interview session said:

Some children I know who had been raised by members of the extended family have been very successful. Some of these families lived ordinary lives but managed to bring up one to three extra children in their homes. The most important aspect I believe was the unconditional love they offered to these new children. They did not treat those children different from their biological children. These children got all basic needs supplied as well as love, security and protection. They received good education, which enabled them to access good jobs.

Participants reported that apart from several challenges, the existing alternative care systems had played an important role in supporting OVC. The participants added that the situation of children in various alternative care systems was not similar because some care systems had more resources than others. Moreover, many children placed in various alternative care systems had managed to access

support for basic needs as well as social, intellectual, spiritual, and psychological needs. A caregiver said:

To my experience, the situation of children placed in a group home like the SOS is very good with respect to the basic needs, health, and education when compared to some residential care centres. This institution had set aside enough funds to ensure that every child has health insurance, good education, and was able to access support for all basic needs for development. This is different from some residential care centres with limited budgets where children can delay to continue with education.

During FGDs OVC revealed that there were some positive changes in their lives, such as addressing their basic needs and an opportunity to enhance their educational performance from residential care centres. One of the OVC said:

We are able to meet children who had suffered similar problems, get access to education, health services, shelter and food. We get an opportunity to be around people who love and care for us, and who listen to our problems. We feel secure, protected and confident. For example, when I performed poorly in the annual examinations my fellow children in the centre, caregiver and the administrator encouraged me and I was not punished. This built my confidence and I was able to perform well and was selected to join secondary school. Before coming to the centre I was living with my uncle who punished me whenever I failed the examinations. This is why he sent me to the centre.

The participants revealed that the situation of some children living in unsupervised child-headed households was poor because of lack of support from an adult person. Participants added that some children were living with very poor families who could not provide for their basic needs. Participants stated that some of the children are cared for by old grandparents who could not protect them from violence, stigmatisation, and discrimination. A key informant had this to say:

Many children without parental care especially in the villages are left under the care of very old grandparents and sometimes alone under unsupervised child-headed households. It turns out that children are the ones to care for their grandparents and

young siblings, which means that they cannot go to school. These children have to look for firewood for energy at home and sometimes have to work on farms to earn some money for food. These children are living under very poor conditions because of lack of addressing of basic needs.

A caregiver presented a similar perspective by saying that some children under the care of the extended family were being maltreated. He added:

I have been involved in reconciliation of cases between some relatives and the children. For example, one day a 14 year old girl ran away from home and was brought to the residential centre where I work. She said that she had been staying with her aunt who has two children (a 16 year old girl and 10 year old boy). She complained that she was supposed to do all housework like cleaning, cooking and washing clothes and did not have time to do her schoolwork. This girl added that the two children did not help her. They had time to write their homework and watch television but she had no time to finish her schoolwork and sometimes was punished by her teachers.

Reasons for OVC Placement in Alternative care systems

It was important to explore the reasons for OVC placement in alternative care systems. The responses in the survey are presented in Table 16 below. All respondents agreed that poverty, HIV and AIDS, family conflicts, teenage pregnancy were some of the reasons for the placement of OVC in alternative care. Other reasons for placement of children in alternative care include the fact that children had been living in the streets or were in conflict with the law.

Table 16: Reasons for OVC placement in alternative care systems.

Response %	Poverty	HIV and AIDS	Family conflicts	Teenage pregnancies	Street children	Children in conflict with Law
Agree	100.0	100.0	100.0	100.0	100.0	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Durig the interview and FGDs participants believed that HIV and AIDS is the main contributory factor for the placement of children in alternative care systems. They noted that HIV and AIDS had weakened the extended family's ability to support OVC.The findings established that some parents were suffering from HIV and AIDS which reduced their ability to provide physical, emotional, and economic support for their children. A community leader noted that:

To my experience the OVC problem has been intensified by HIV and AIDS. This killer disease has left many children without parents and sometimes without relatives to raise the children. In some cases, almost every family had lost some members and/or they are looking after the sick members suffering from AIDS. This makes it difficult for these families to bring in children who need their support. When it happens that children are taken into these families they tend to have insufficient basic and social needs such as food, shelter, education and health care provided for.

HIV and AIDS had apparently affected almost every family in Tanzania. The reason given was that even when there was no one infected in the family, there was a relative, a friend or a neighbour who required support. One caregiver said:

I believe there might not be a single family which can claim to have not been affected by HIV and AIDS. Some extended families have lost all children through HIV and AIDS and left behind very old people. In some households, a husband and wife have suffered from HIV and AIDS for a long time, which ruined their ability to take care of their children.

Findings from interviews and FGDs also revealed that poverty had had a significant impact on OVC placement in alternative care systems. Some OVC revealed that they were placed in care centres by relatives due to inability to meet basic needs. A few said that both parents were alive and living together but could not cater for their food, shelter, clothes, medical, and education needs; so they decided to

seek support from residential care centres. One of the OVC during FGD had this to say:

My brother and I were brought up by our father after he separated from our mother. Our father decided to sell the family farm so that he could start a business. Unfortunately, two weeks after he sold the farm our home was attacked by robbers at midnight and they took all the money. Life became very tough due to lack of food and other necessities. My brother and I could not attend school due to lack of school fees and uniforms. Four years ago, our father decided to bring us to Dar es Salaam and placed us at the care centre but we had no prior knowledge of the arrangement. We were very happy because living in the centre gave us an opportunity to go back to school. My brother is in his final year for the primary school and I am in secondary school.

Other contributing factors to the placement of OVC in alternative care systems which were identified by the participants included family conflicts which led to separation and marrital breakdown. Participants expressed concern about increased numbers of street children in big cities like Dar es Salaam due to family conflicts and child negliget. Participants observed that some men had been irresponsible with regards their families and had denied their own children care and support. A social worker stated:

Due to family conflicts, some men have abandoned their families leaving behind their wives and children in a deplorable state. This has pushed children into the streets and they ended up without education. Sometimes mothers have allowed their children to go to town with some families to work as domestic servants so that their wages would help their siblings. Sometimes these dreams never come true because the irresponsible house owners refuse to pay them what they promised. Through my work experience, I have attended several cases of this nature where children were employed as domestic servants and never received any pay. At the end some children were reunited with their families but some were placed in residential care because they could not remember where they came from.

Participants reported teenage pregnancies as a contributory factor towards OVC placement in alternative care systems. This was associated with forced childhood marriages, sexual abuse, and adolescent problems. One key informant said:

The increase in the number of OVC in alternative care systems is partly a result of childhood / early pregnancies. Sometimes parents force their girl children who are below 15 years to get married to earn some money through bride prices. The girls might be married as second or third wives. A girl can give birth to up to three children but because she did not choose that marriage, she might end up seeking separation or divorce. Children who are left behind might end up living in the streets and some might be placed in the alternative care systems.

Evidence from observation showed that there were several children who were placed in alternative care systems such as remand homes and approved schools as a result of breaching the law. These are mostly children who were living on the streets and might have been arrested because of stealing or injuring other children. Participants reported that some of these children were used by thug groups and drug dealers. They further revealed that when these children were caught by police they were placed in remand homes and approved schools for the purpose of correcting their behavior. According to participants, after they are released, some children failed to locate their home towns and therefore the Social Welfare Department placed them in different alternative care systems. During FGD, one social worker presented a case from his experience:

Some children who are in conflict with the law have biological parents or guardians who have faced parenting challenges. I have attended several cases where children said that they found themselves in problems due to peer pressure. One boy aged 12 said that his parents beat him after he dropped out of school and was asked to leave home. This was after he made friends with a group of children living on the streets. This boy, together with five other boys managed to board a train from Kigoma to Dar es Salaam and continued to live and sleep in the streets. After two months, a young

man who promised to employ him as a shopkeeper took the boy. Later, the boy and his boss were arrested after being caught carrying several property they stole from the neighborhood. The shop owner was sent to prison and the boy was placed at the remand home. After staying at the remand home for nine months this boy was released and was escorted to Kigoma by a social welfare officer. Unfortunately the boy could not locate his home and he was placed in residential care.

Barriers Hindering OVC Access to Alternative Care

The findings from the survey regarding barriers hindering OVC access to alternative care are summarised in Figure 5 below.

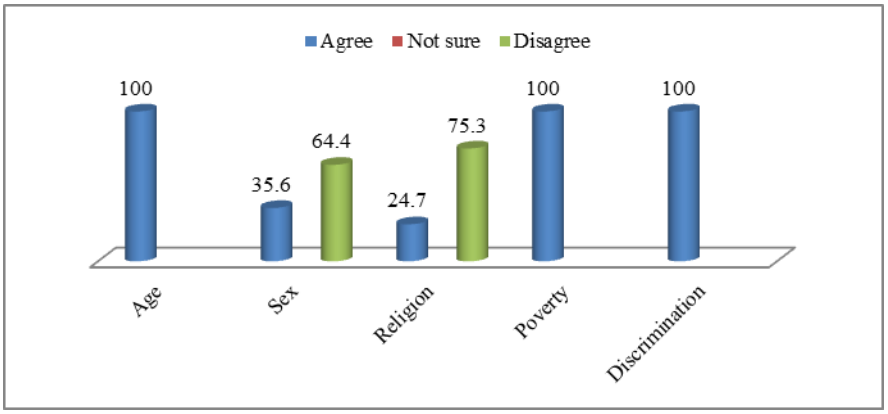

Figure 5: Barriers hindering OVC access to alternative care.

The data in Figure 5 indicate that all respondents agreed that age, poverty and discrimination were barriers hindering OVC access to alternative care. A majority of the respondents in the survey disagreed that sex (64.4%) and religion (75.3%) were barriers to OVC access to alternative care. Participants from the interviews and FGDs reported that poverty was the major barrier hindering OVC from accessing alternative care. They revealed that because of poverty some families had failed to support children deprived of parental care because they could not afford basic necessities. This, according to participants had contributed to an increase in the number of street children in big cities where they wander around begging for money and food. A community leader said:

Poverty is a very long chain which has no end because it can move from one generation to another if not addressed. For example, some families have lost the ability to support their own children which has resulted in a considerable number of youth being unemployed. This means that the youths will not be able to support their parents as expected by culture. Even families which were better off at a certain point, have been dragged into poverty due to HIV and AIDS. Families and relatives have utilised the resources to care for the sick ones, and in the end they could not absorb children left behind without parental care.

Participants identified age, gender, and religious belief of the children as barriers to OVC accessing alternative care. The participants revealed that it was very difficult for the youths to get access to adoption because many families preferred to adopt small children. Participants also reported that some residential care centres were based on religious beliefs and placement of children was linked to their religious background. The key informant said:

It is clearly indicated in the regulations for adoption that even when a family or a residential care centre is willing to support a child with a different religious background, the child should have been raised in his/her religion. To my experience, many adoptive parents would prefer to adopt children with the same religious beliefs as themselves. I also experienced that at some Muslim residential care centres, although they accept children with different religious beliefs, children would later be converted to the Muslim religion. Many people prefer to foster or adopt small children because they believe these children would easily cope with family environment.

A social worker stated that OVC access to alternative care is not a straightforward process because the formal care systems like adoption, statutory foster care, and residential care, are guided by rules and regulations. She said that it is easy for the child to access care under the kinship system because that process is guided by an informal agreement and decisions of relatives. She added:

Age and gender of the children are not problems in kinship/extended family care placements. However, age and gender can be obstacles for child placements in adoption, statutory foster care*, and residential care. Through my experience, during the application many people interested in fostering or adoption had specified a certain age and gender of a child. Some residential care centres support only boys or girls and some are restrictive on particular age of the children. For example, some care centres do not place children who are under five years of age. Placement of children under the community-based care is also much dependent on the availability of resources which can also be discriminatory of age and gender of children.*

A caregiver reported a similar perspective by saying that it was very challenging to secure adoptive parents who were interested in adopting children from six to ten years. She added:

My experience is that for many applications which are sent to the care centre where I work, applicants wanted to adopt children who were at least one to two years of age. Very few applications indicated that applicants wanted children who were above three years. For example, one year ago a couple wanted to adopt a child from the centre where I work. This couple was only interested in a one-year-old boy child. Unfortunately, the children at the centre during that time were between three and six years.

Discrimination and stigma attached to HIV and AIDS were revealed by the participants during interviews and FGDs as constanly barriers hindering children from accessing alternative care. They reported that some children believed to have lost their parents to HIV and AIDS were not welcomed by members of their extended family. The stated reason was that some members of the extended family thought that the children left behind might also be infected and might spread the disease to other family members. A social worker added:

It has happened that during reunification of children some members of the extended family denied to be related to the children. It was not until after long interviews by the social welfare officers that it was realised that those families did not want the

children to be placed in their homes. The reason was the belief that those children might have been infected by their parents who died of HIV and AIDS, and they would transmit the disease to the rest of the family members. During the interviews with children who were reunited with their relatives, some revealed that they were placed in different rooms and were not allowed to use the same facilities like toilets, plates, and bedding with their relatives' children.

The participants noted that many people perceived the processes involved in foster care and adoption as being complicated and time consuming. They added that some people complained about corruption in the process. A key informant during an interview said:

When I talk to the people who were interested in fostering or adopting children they said they dropped the idea because it was time consuming. They waited more than a year and never got feedback. Also, the expenses involved were too prohibitive. The Department of Social Welfare needs to review the processes involved in fostering and adoption. It takes far too long and creates a conducive environment for corruption as applicants seek to quicken the assessment process. People applying for fostering and adoption are employees or business men and women who need time for their work.

Participants opined that limited human, material, and financial resources hindered OVC access to alternative care systems. For example, based on the discussions, some residential care centres that were in a position to offer support to more children reported that they did not have enough resources. Participants noted that some residential care centres could offer shelter and caregivers but they had no facilities such as beds and mattresses. A key informant said that some members of the extended family could not support the children of their deceased relatives because of limited resources. He further said:

Because of financial constraints community-based care has failed to establish projects and programmes to accommodate children without parental care in the communities. This also applies to the residential care centres that have failed to

accommodate children with disabilities because of the special care needed and they cannot employ qualified care workers due to financial constraints. Some families would like to adopt or foster children but they cannot fulfill the conditions required. A family friend of mine wanted to adopt two children (a boy and girl) because they did not have children in their marriage of ten years. This family decided to quit the process when they found out that one of the requirements for adoption was to own a house.

OVC Treatment in Various Alternative Care Systems

The researcher further probed the views and perceptions of respondents regarding OVC treatment in the existing alternative care systems. Their findings are summarised in Table 17 below. The data on OVC treatment were obtained using a five-point rating scale (very low, low, moderate, high, and very high). Many respondents had different views where some (58.9%) considered treatment of OVC in kinship care, residential care (54.8%), community- based care (56.2%), and supervised child-headed households (56.2%) as good. Treatment of OVC was considered as very good in foster care (58.9%), adoption (61.6%), and group homes (64.4%). Participants during interviews and FGDs reported that treatment of OVC in various alternative care systems varied. According to these participants, some children received good treatment, but a considerable number of children were ill-treated. For example, participants' experiences from the media and police reports showed that some OVC were facing abuse, exploitation, discrimination, and stigmatisation due to HIV and AIDS or disability.

Table 17: Opinion level on the treatment of OVC in various alternative care systems.

Response %	Kinship	Residential	Foster	Adoption	Community	Supervised child-headed	Group
Poor	15.1	21.9	0.0	0.0	24.6	9.6	0.0
Fair	26.0	23.3	11.0	13.7	19.2	24.7	11.0
Good	58.9	54.8	30.1	24.7	56.2	57.5	24.6
Very good	0.0	0.0	58.9	61.6	0.0	0.0	64.0
Excellent	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Some biological parents, members of the extended family, community members, and residential care centres had been responsible for the abuse, exploitation, discrimination, and stigmatization of OVC according to participants. One key informant stated:

I can simply say that the treatment of OVC in existing alternative care systems is a bit complicated in the sense that it is not easy to understand what is going on. For example I can speak about how my nephew to whom I am providing care after death of his parents is treated in my home. Unfortunately I do not understand the treatment my neighbour offers to his brother's children he is supporting. However, according to reports from the media, police and some organisations providing support to OVC some OVC are facing abuse, exploitation, discrimination and stigmatisation especially when they are HIV and AIDS victims or disabled. That is happening within some families and in some residential care centres.

Concerning the treatment of OVC in residential care centres caregivers reported that it was good between children and employees and among children themselves. However, some caregivers said that some children had reported discrimination and abuse from the community members and fellow students. He added:

Some children reported to me that they have been called names by some community members such as pickpockets, 'panya' road (the name used to refer to a group of robbers which targeted residential houses located along the main roads). It is clear that some community members do not respect OVC as children who can be good and can do well as other children who have families. Because of the negative attitudes towards OVC. It is very painful that when something wrong happens in the class the fingers are pointed at the OVC. For example, children told me that it happens that if a fellow student loses his pen or exercise book…the OVC will be first to be asked and or searched. This is simply because of not being trusted.

Another caregiver said that some residential care centres were exploiting the children by engaging them in income generating activities which did not benefit the children. This is something the caregiver said she had come across and when she shared the information with some friends, they said that they had experienced similar situations before. The caregiver shared the following experience:

One Saturday I attended a wedding ceremony at one of the social halls in the city centre. Celebrations started around 9.00 pm. After the guests were served with food and drinks at about 11.00 pm, an announcement was made inviting a special children's group of 12 singers. These were 6 boys and 6 girls who seemed to be between 10 and 15 years of age. Before starting the song one of the children introduced the group that they were from one orphan centre in the city. These children started singing and before they ended the song, almost every guest was sobbing. It was a very sad song, which explained the life of those kids after their parents died. The guests moved from their seats to offer those kids some money as a sign of appreciation. The children left the floor after they finished the song and the money was collected and was given to the one who had introduced the group. It was announced by the master of ceremonies that those children were already booked to another wedding for the week that followed.The question that still lingers in my mind to date is: why did the residential care centre engage those children in this activity? How did the children manage to participate in weddings almost every Saturday as primary students? How about their schoolwork?

The researcher probed to find out to whether there were notable differences between care by extended families and adoption. This related to participants' response that the treatment of OVC in various alternative care systems varied.Participants reported that sometimes there might be notable differences. A caregiver said that although some parents and relatives had abused and mistreated some of the children under their care, some children might also be difficult to handle due to aggression, which might result in rejection by the people supporting them. One caregiver added:

Sometimes a difference can be noticed between orphans taken care of by relatives and those taken care of by adoptive parents. Adoptive parents can be more committed to care for OVC because they have taken the child willingly; child laws and regulations also bind adoptive parents. Social welfare officers will monitor the care of the child to ensure that his/her rights are not violated. Relatives from the extended family might agree to take care of the children but sometimes do not possess enough resources for development of the child. Some relatives will opt to take care of the children left behind in order to benefit from the wealth left behind by OVC parents. Some relatives have mistreated OVC by making them stay home (and not go to school) and perform house chores as if they were housegirls/houseboys.

Another caregiver shared a similar perspective testifying that he witnessed the suffering of a four year old girl child who was physically abused by her stepmother. This is what he had to say:

This child was placed in my institution by the social welfare department. She sustained serious burns after her step-mother poured very hot water on her back intentionally. This woman was placed in prison for five years and the father of the child could not be found even with a search warrant from the police.

During interviews and FGDs, participants also said that children might be abused and denied rights to education by relatives even if their parents left property behind such as houses, vehicles, and farms. Children might not disclose the

information due to intimidation from the members of the extended family. A community leader said:

My experience shows that some children have ended up living at the orphanage centres after mistreatment from relatives. It might also happen that some relatives decide to send OVC to the care centres because they fail to support them due to poverty. However, some members of the extended family might be enjoying the wealth left behind by their deceased brothers/sisters, while placing children left behind in care centres. This might happen especially when children are too small to understand what was left behind by their parents.

One of the OVC stated:

After my parents' death, I went to live with my aunt and my brother was taken by my uncle. My brother had no problem living with our uncle and he was able to continue with the advanced secondary education. On my side, I was supposed to join a public secondary school but my aunt did to help with all house chores when she went to work. One of my aunt's friends helped me to escape from my aunt's house and brought me to the social welfare office. I was able to access secondary education after I was placed in a care centre although I was already delayed for two years.

Through observation, the researcher noted that many children in all care centres visited looked happy and were interacting with one another, which might explain the fact that they received good treatment. However, four children from different care centres visited looked unhappy and were not interacting with others because they were sick and were being treated for malaria.

Discussion

Findings from the previous chapter revealed that the existing alternative care systems played an important role in addressing care needs of OVC. This was reported through documentary reviews from the Department of Social Welfare in Dar es Salaam and findings from previous research such as (SOS, 2014). This is why the researcher sought to examine the situation of OVC in various alternative care

systems. The main themes which will lead the discussion in this section are the diverse socio-economic conditions of OVC in various alternative care systems, determinants of alternative care, OVC access to alternative care, and maltreatment of OVC in alternative care systems.

An emerging issue in the findings is that the situation of OVC in various alternative care systems was largely dependent on resource availability. The findings revealed that the situation of OVC was regarded as fair in kinship, residential, foster, and community-based care as well as in supervised child-headed households. The main reason which was apparently that OVC in various alternative care systems had access to the fulfilment of basic and social needs. The respondents further that they believed the situation of OVC in adoptive and group homes tended to be very good due to adequate human, financial and material resources. The data from this study corroborate findings by Faith Action Initiative (2015) which indicated that many children in kinship care had access to basic necessities and education and they were not exposed to many behavioral problems such as robbery and drug abuse. However, according to the findings of this study, some OVC live with poor families and sometimes very old grandparents who have no regular income support from government institutions and NGOs. This finding is in line with previous studies (Williamson and Greenberg, 2010; Roelen & Delap, 2012) which indicated that a considerable number of extended families providing support to OVC languished in poverty. This means that children in these families suffer from inadequate food, shelter, clothing, medical care and education.

The findings from the previous studies acknowledge the fact that residential care centres constitute the best option for children with unique conditions such as those living with disability who might be in need of special care (Abebe, 2009;

USAID, 2010) . In addition, residential care centres provide short-term placement for siblings which helps children to grieve together for the loss of their parents. However, the findings by USAID (2010) revealed that large residential care centres lacked suitable therapeutic treatment for children and also expose children to abuse and exploitation. Findings by USAID (2010) and SADC (2010) indicate that children in statutory foster care and adoption programmes have benefited from proper care and remained connected to their culture. Children in group homes are attached to mothers who have been trained in parenting skills and through socialization children grow up like brothers and sisters (Abebe, 2009; USAID, 2010).

The findings of this study indicated that unsupervised child-headed households are fast proliferating but children are living in very poor conditions because of lack of supervision and resources to meet their basic needs. This is in line with the findings of Kijo-Bisimba (2011) on protection of orphaned child-headed households in Tanzania which revealed that unsupervised households of this nature are invisible, especially in places where media coverage is limited. This has caused suffering to the children due to lack of support from relatives, NGOs, and government institutions. Findings by SADC (2010) and Phillips (2011) indicate that child-headed households had emerged as a response to inefficient alternative care systems for OVC. These findings includded the suggestion that many children in child-headed households live in extreme poverty and under dangerous conditions but there were no statistics of such households.

The findings of the present study are crucial for social welfare officers and national and international partners to understand that the wellbeing of OVC in alternative care systems is determined by the availability of resources. The study empirically demonstrated that children under the care of poor families, aging

grandparents, and unsupervised child-headed households exist under poor conditions. For example they do not receive adequate food, education, and medical care,and they are exposed to abuse, violence, and exploitation. The implication is that those children might suffer from mulnutrition and disease as well as illeteracy which would create a cycle of poverty in their future lives.These findings call for stakeholders to ensure that more research is conducted to assess the situation of OVC in various alternative care systems in order to establish effective programmes that would ensure that basic and social needs of OVC are met.

This study found that HIV and AIDS constituted the most important reason why OVC are placed in alternative care. Respondents revealed that the epidemic had affected every family in Tanzania, through loss of relatives, friends or neighbours. Studies (Foster, 2004; Abebe, 2009; Malinga & Ntswarang, 2011) done elsewhere found that some parents were suffering from HIV and AIDS, which reduced their ability to care for their children. Conscequently the number of children who had been deprived of parental care had increased as a result of the epidemic. The participants noted that, in some extended families, every group lost members or were taking care of those suffering from AIDS. This prevented them from being able to care for children or doing so in an inadequate manner. As a result those children would be placed in residential care systems while some of the children would opt to live alone in their family homes after the death of their parents. This finding is supported by previous studies (USAID, 2010; Malinga and Ntswarang, 2011; UNICEF, 2011; SOS, 2014) that found that HIV and AIDS had denied many children's right to parental care after the death of their parents and relatives. In their study on HIV and AIDS and administration in Tanzania, Mwendah and Mallya (2014) noted that the epidemic had

become a major threat to social, political, cultural, and economic development in the country. The study added that every sector had been hit by the epidemic.

Another contributing factor from the findings of the present study is poverty which had made some families to place OVC (even their own biological children) in residential care centres due to inability to provide for basic needs. This finding is in line with findings from various studies (UNICEF, 2010; EveryChild, 2011b; SOS, 2014) which cited poverty as a contributing factor for the placement of children in alternative care systems. The findings of these studies revealed that children can be pushed by poverty out of their families to go and work for wealthier families or to stay with relatives who had a higher income. The Faith to Action Initiative (2014) and Save the Children (2015) revealed that OVC in some Eastern European countries, Central Asia, and Africa had at least one living parent who made a decision to place the children in alternative care because of failure to support them due to poverty, disability or chronic illness.

Participants also revealed that family conflicts and child neglect had increased the number of children living on the streets and those placed in residential care centres. The findings by EveryChild (2009) suggest that abuse and neglect by families, relatives, and community members had resulted in loss of parental care as a result of being forced out by parents /caregivers or through decisions made by children themselves to escape the situation. EveryChild (2012) revealed that the loss of parental care affects some groups of children more than others. Children living with disabilities and those who are HIV positive are more affected by neglect, abuse, and discrimination.

Teenage pregnancy due to forced marriage, was identified by participants as another reason for OVC placement in alternative care. Participants reported that many

forced marriages had ended in divorce and children had suffered from inadequate care and support which necessitated their placement in various alternative care systems. Further, teenage pregnancies were also seen as a reason for placing children in alternative care. Early marriage might end in divorce and children from those marriages lacked appropriate care which might force them onto the streets. According to the Tanzania Demographic Health Survey (TDHS) (2010), the numbers of adolescent pregnancies were very high and one in every six girls aged 15 to 19 years was already married. The practice of bride price payment was indicated as one of the leading factors in many families marrying off their girl children (Human Rights Watch, 2014). The Law of Marriage Act (1971) which allows boys to marry at 18 and girls at 15 years contribute to this.The current study also revealed that some children were placed in remand homes and approved schools for the purpose of correcting their behaviours. A study by SOS (2012) on the status of children in Tanzania revealed that a total of 453 children had been in conflict with the law and imprisoned; 578 were in detention; 80 in retention and 80 in approved schools. Tanzania has no special detention facilities for children and therefore they are kept in adult prisons.

This study's findings on the reasons for OVC placement in alternative care systems sheds light on the fact that HIV and AIDS has affected almost every family in Tanzania. This has posed a threat to adequate care of OVC. The epidemic has reduced the number of people responsible for taking care of the children and it has also undermined the ability of the members of the extended family to support more children. The study's findings highlight the fact that HIV and AIDS have pushed some families into poverty because of the utilisation of available resources for medical care. Some families have endured conflict and separation, due to disagreements on utilisation of resources allocated for medical care of members living

with HIV and AIDS. This suggest that those families failed to provide or offer adequate care to the children resulting in their placement in residential care centres. The findings will also contribute to the gender dimension of poverty where girl children are forced into marrige in order to obtain bride price that would be used to meet the family's basic needs. Furthermore, the findings highlight the fact that, due to inadequate care, some OVC have violated the law. This accentuates the need for social welfare officers to collaborate with other stakeholders in establishing effective mechanisms to ensure that every child has access to adequate care.

The findings of the current study appear consistent with others (Malinga & Ntswarsng, 2011; UNICEF, 2012; Save the children, 2012; SOS, 2014) which revealed that many members of extended families are facing challenges in terms of meeting the needs of children due to poverty. For example, some members of extended families could not welcome additional children to their homes because of poverty. A study by Williamson and Greenbergh (2010) revealed that 50% -90% of children who were placed in residential care centres had at least one parent. The main reason for their placement was that the families believed their children could access food, education, and medical care, in such facilities, which they could not afford.

Age, sex, and religion were identified by the findings of this study as constituting other barriers hindering OVC access to alternative care in residential care centres and through foster care and adoption. This is attributed to the fact that some residential care centres tended to prefer children of specific gender, age, and religion. For example, they were mainly for either boys or girls. The findings revealed that, although many centres accepted children from different religious backgrounds, some children were converted to different beliefs after their placements. Furthermore, it was found that some families preferred to foster or adopt small children, especially those

from one to three years of age, due to the belief that these children would more easily adjust to their family environment making them easier to handle in terms of behaviour. Many families also prefered to foster or adopt children who had the same religious background as theirs. Whereas some might be interested in fostering or adopting any child, irrespective of sex, some families preferred only a boy or a girl child. The study by SOS (2014) reported that people applying for adoption in Tanzania were mostly interested in younger children. Many street children who were placed in residential care centres faced challenges to fostering because of their more advanced age.

The findings of the present study identified discrimination and stigma attached to HIV and AIDS as barriers hindering OVC access to alternative care. It was reported by some respondents that some members of the extended family refused to provide care to OVC whose parents had died of AIDS because of negative attitudes surrounding the fact that the children could be infected and might spread the virus to the entire family. Even when these children were accepted by the extended family, they still faced discrimination. For example, they might not be allowed to share bedrooms, toilets, plates, and bedding with the biological children of the family. This is supported by a previous study by UNAIDS (2015) which indicated that, in 35% of countries with available data, over 50% of women and men reported that they had a discriminatory attitude towards people living with HIV and AIDS. Similarly, the study by Malinga and Ntswarang (2011) on alternative care for children in Botswana revealed that, in many instances, adoptive parents had hesitated to adopt a child living with HIV and AIDS. The study by Abebe (2009) noted that the assessment of children placement in group homes such as SOS is to a large extent focused on children who are physically and mentally healthy.

UNAIDS (2015) reported that, in 2014, 64% of countries reporting to the organ isation had legislation to protect people living with HIV from discriminantion. Tanzania is one of the countries reporting to UNAIDS, while the Tanzania Commission for AIDS (TACAIDS) is responsible for protection of people living with HIV. However, Global Information and Advice on HIV and AIDS (2016) reported that the fear surrounding the pandemic in the 1980s still exists today. Many people, according to this report, are rejected by family members, peers, and the community at large and sometimes receive poor treatment in educational and health care systems.

Findings of the current study indicated that some families interested in fostering or adoption were discouraged by lengthy procedures and costs associated with corruption. Participants also noted that some people who applied for foster care and adoption had complained that they waited for almost a year without a response from the Department of Social Welfare. The reviewed literature confirmed that applying for statutory foster care and adoption of a child is expensive and time consuming. Findings from the Child Act (Adoption of Children Regulations) 2011 revealed that open adoption in Tanzania takes up to six months whereas closed and inter-country adoption may take between one to two years. The findings further showed that, for a foreigner to adopt a child in Tanzania, the law requires that the person could have lived in Tanzania for three consecutive years. The study by UNICEF (2008) indicated that it takes about six to nine months to complete local adoption in Kenya. Although social welfare processes related to adoption are free in Tanzania, as Forever Angels (2013) noted, the cost of hiring a lawyer can range from $ 500-2000. UNICEF (2008) revealed that local adoption applicants in Kenya drop out after three months of the fostering period because of the high costs involved. The fees charged by a lawyer in Kenya ranged from $ 345-3450 (equivalent to 35,000-

350,000 Kenya shillings) for domestic adoption (UNICEF, 2008b). This is something to be taken into consideration by internal and external partners as it might have a negative impact on the wellbeing of children. For example adoptive parents might use the costs they incurred as a bases for violating children's rights to education by engaging them in tough activities like agriculture and mining.

Limited resources were identified by the present study as a barrier to OVC access to alternative care. For example, community-based care had failed to establish sustainable programmes for providing support to children without parental care. In addition, residential care centres had failed to accommodate children living with disabilities who had special needs due to lack of facilities and human resources. Some families, according to the findings, did not manage to fulfil their ambition of adopting children because they did not own houses, which was one of the conditions for adoption. The findings concur with the study by Every Child (2011b) which revealed that there is a shortage of foster parents in many countries due to financial constraints. It is also asserted by Roelen, Edstrom, Sabates-Wheeler, & Davies (2011), that initiatives had been established in South Africa, Malawi, and Botswana to enhance foster care. The initiatives were meant to address the material and financial constraints hindering families interested in fostering from submitting their application.

This study's findings shed light on how poverty, age, sex, religion, discrimination, stigmatisation, complicated procedures, and limited resources hinder OVC access to alternative care. This is an alarming situation which highlights the reasons for the increase in the number of children living on the streets and in residential care centres. These findings are important in that they highlight the failure of policies that have been established to protect people living with HIV and AIDS. They also contribute to the existing knowledge base in respect of highlighting the

greater need for statutory foster care and adoption in Tanzania. The Department of Social Welfare set out to improve statutory foster care and adoption procedures in order to attract more families. The findings further call for stakeholders to advocate for child policies that will ensure the right to permanent alternative care by recognising the risks facing children who lack parental care.

The survey findings indicated that the treatment of OVC in kinship, residential, community care, and in child-headed households was generally good, and very good in foster care, adoption and group homes. In contrast, FGDs and interview findings indicate that the treatment of OVC in kinship, residential and foster care and adoption, community-based care, supervised child-headed households, and group homes tended to be generally poor. The reason given was that the media and police reports showed that many children without parental care were suffering from abuse, exploitation, violence, discrimination, and stigmatisation. The findings further revealed that sometimes there might be notable differences between orphans who were under the care of relatives and those who were with adoptive parents. It was found that adoptive parents might be more committed to care for OVC because they adopted children willingly and adoption is a legally controlled process. According to these findings, the members of the extended family can agree to take care of orphans but may not have enough resources to address their basic needs. Additionally, it was also revealed that the wealth left behind by deceased relatives could convince some members of the extended family to take care of the OVC. However some such people had mistreated OVC and denied them the right to education according to the findings.

Studies, by UNICEF (2010); EveryChild (2011a); UNICEF (2012); Biehal, Cusworth, Wade, & Clarke (2014), and the Faith to Action Initiative (2014), indicated that children in various alternative care systems faced abuse, violence, and

exploitation. These authors noted that children in residential care suffered from insufficient services due to financial constraints. In addition, some were affected psychologically due to attachment problems, while others had been physically and sexually abused. The findings by Bennet et al., (2006) on inheritance law in Uganda indicated that paternal relatives violated the rights of the widows and their children in regard to property ownership. This happened when the brothers-in- law took away the property left behind by their deceased brother. Furthermore, after taking the property (land, vehicles, and houses) these relatives abandoned and neglected the widow and her children. Similar findings were reported by Foster (2005b) who said that some orphans and vulnerable children in kinship care had suffered mistreatment, abuse, and exploitation. SOS (2014) argued that there was an increase in the number of OVC living with their grandparents but their basic needs were not adequately met due to poverty. According to MoHSW (2011) unsupervised child-headed households suffered from violation of their right to education, health, protection, and family care.

The findings of the present study also support those of Roby and George (2013) on perceived food and labour equity and school attendance among Ugandan children living in kinship, which revealed that children under this system faced discrimination, abuse, exploitation, and neglect. Similarly, Malinga and Ntswarang (2011) noted that children in statutory care including adoption might face abuse and discrimination from biological children of the foster and adoptive families. The findings by USAID and UNICEF (2008) on the evidence base for programming for children affected by HIV and AIDS in low prevalence and concentrated epidemic countries reported that, in Benin, children who were in foster care were treated differently to biological children. For example, when compared to the foster parents'

own children foster children were offered little food and were directed to perform extra household chores even when they were sick.

Similar findings were reported by UNICEF (2011) from its study on children in informal alternative care. These established that, although community members had assumed care responsibility for OVC, there had been reported abuse and exploitation from community-based care because of lack of kinship ties. Some community members used OVC who were under their care as household servants (EveryChild, 2011a). Furthermore, children receiving support from non-kins (and even some kins households) were treated as child servants even if the initial purpose was to send them to school.

The findings of the present study are crucial for OVC stakeholders to understand the intricacies in relation to OVC treatment in various alternative to establish an effective mechanism for the security and protection of OVC in various alternative care systems. Available literature reveals that children should grow in a family environment which provides permanent care (UN, 2009; World Vision, 2009; Save the Children, 2013). This is supported by attachment theory which notes that, for the child to grow successfully, she/he will require a positive and continuous relationship with the caregiver (Bowlby, 1951, P. 13) such as a mother or permanent mother substitute. Again, relevant procedures should be utilised in searching for alternative families for OVC. Failure to recruit effective families could result in abuse, discrimination, stigmatisation, violence, and exploitation of children. This study's findings calls for stakeholders to employ the ecological approach to child protection which seeks to understand the interaction between children, families, communities, and society and their impact on the wellbeing of the child (Wright, 2004). As indicated in the study by Bronfenbrenner (1986), ecological systems theory

recognises that many systems contribute to the challenges faced by children and families in the child welfare system. The findings of this study suggest that social welfare officers should implement the ecological systems theory during OVC placement in alternative care systems, through understanding that a new environment would always require effective strategies to enable children to cope successfully (Kassim, 1992). This implies that in supporting poor families and communities social welfare officers should establish strategies to counter expected stress and imbalance (Bronfenbrenner, 1979) which might push children into a dangerous environment such as one involving drug use and criminal behaviour.

Chapter summary.

In this chapter, the researcher examined the situation of OVC in various alternative care systems, determinants of inadequate care, OVC access to alternative care and ill-treatment of OVC in various alternative care settings. The chapter concludes that, although the situation of OVC in various alternative care systems was good (according to the findings), attention should be directed at children living with poor families, very old grandparents, and in unsupervised child-headed households. There should be sustainable programmes to ensure that their basic needs are met in accordance with their developmental progression. HIV and AIDS has been identified in the current study as a major contributing factor to the placement of children in alternative care systems. From the findings, it may be suggested that national and international partners should consider establishing an effective mechanism to support families and communities in managing the situation of children deprived of parental care.

The findings identified poverty, sex, religion, discrimination, and stigmatisation, long procedures involved in foster care and adoption as well as limited

resources, as factors hindering OVC access to alternative care. This chapter concludes that attention should be directed at strengthening sensitisation programmes on HIV and AIDS to protect those living with the illness from discrimination and stigmatisation. The treatment of OVC in various alternative care systems was reported by the participants to be poor. Examples of poor treatment being apparently daily reports related to abuse, violence, discrimination, and exploitation of children. This implies that an effective framework for security and protection of children should be established to protect their rights. The next chapter presents potential contribution of child related laws and policies to the enhancement of alternative care systems for OVC.

CHAPTER SEVEN- CHILD RELATED LAWS AND POLICIES IN TANZANIA

Introduction

The constitution is the ultimate law of the country. A Bill of Rights which contains basic human rights and fundamental freedoms to which a human being is entitled is stipulated in the constitution of Tanzania Mainland of 1977, and the Zanzibar constitution of 1984. As stated previously, Tanzania ratified the United Nations Convention on the Rights of the Child (UNCRC) in 1991 and established a Child Development Policy in 1996 (amended in 2008) aimed at providing direction and guidance on child survival, protection, and development (URT, 2008). In 2003, the African Charter on the Rights and Welfare of the Child (ACRWC) was ratified. The Law of the Child Act (2009) in Tanzania Mainland and the Zanzibar Children Act (2011) incorporated fundamental rights of children and set the foundation for child care systems (URT, 2009) in the country. The 3 objective of the study sought examine the potential contribution of existing child related laws and policies to the enhancement of alternative care for OVC (objective 3 of this study). This was pursued through a survey of representatives of residential care centres, interviews with key informants and community leaders, and FGDs with social welfare officers. The involvement of targeted participants was based on their knowledge and experience in dealing with child related legislation and policy issues. The objective was to seek participants' views and expectations with regard to the effect child related laws and policies may have on alternative care for OVC as illustrated in Table 18 below.

Table 18: Potential contribution of of the existing child related laws and policies.

Patterns from quantitative data	Themes from qualitative data	Sub-themes
1. Child related laws and policies	1. Views on child related laws and policies	1. Familiarity with the existing child related laws and policies
1. National and international rules and regulations	1. Views on the response of the government to the right to alternative care of OVC	1. Convention on the Rights of the Child (1991) 2. African Charter on the Rights and Welfare of the Child (2003) 3. The Law of the Child Act (2009) 4. The National Guideline for Improving Quality of Care, Support and Protection for the MVC in Tanzania (2009) 5. Tanzania National Costed Plan of Action for MVC phase I&II
a. Potential contribution of child related laws and policies	1. Views on potential contribution of child related laws and policies to the enhancement alternative care for OVC	a. Facilitation of development of the national guideline for the alternative care for children b. Raising community awareness about child rights and protection c. Establishment of legal status for the informal care system d. Facilitate monitoring and evaluation of the existing alternative care systems e. Facilitate children's access to justice when abused or exploited inside or outside the alternative care system
1. Challenges facing implementation of child related laws and policies	1. Challenges facing implementation of child related laws and policies	a. Poor coordination framework for stakeholders in implementing child related laws and policies b. Poor knowledge of community members on child related laws and policies c. Limited human, material and financial resources d. Use of English language in writing child related laws and policies

Familiarity with Existing Child Related Laws and Policies (N=73)

Findings from the survey (Table 18 above) revealed that all respondents had some understanding on the existing child related laws and policies in Tanzania. This question was aimed at examining stakeholders' knowledge on existing child related laws and policies. This was important as it potrayed stakeholders' involvement in the implementation of child related laws and policies. All respondents in the survey affirmed some understanding of the Child Development Policy (2008); the Law of the Child Act (2009); the Law of the Child Act (Foster Care Placement Regulation) 2012, Adoption of Children Regulations, 2012, and Children's Homes Regulations, 2012. During the interviews and FGDs participants noted that the Government of Tanzania,

in collaboration with national and international partners, had established child related laws and policies to promote the wellbeing of children.

Table 19: Familiarity with child related laws and policies.

Responses %	**Agree**
The Law of the Child Act (2009)	100.0
Child Act (Foster Care Placement Regulations) 2012	100.0
Child Act (Adoption of Children Regulations) 2011	100.0
Child Act (Children's Homes Regulations) 2012	100.0
Child Development Policy (2008)	100.0

The Child Development Policy (2008) which is the review of the Child Development policy (1996), was viewed by participants as being responsible for social, physical, psychological, mental, spiritual, and economic development of children. One of the social workers during a focus group discussion said:

Child Development Policy (2008) has been effective in health, education, water, and sanitation as well as nutritional issues but very little attention has been directed to address OVC care, love, and protection. I believe that Child Development Policy (2008) can be used to offer an effective framework on how to address problems facing children without parental care.

The participants indicated some knowledge and familiarity with the Law of the Child Act (2009) which states that every child shall be entitled to live with his/her parents or guardians. One of the key informants said:

The Law of the Child Act (2009) has identified children in need of care as orphans, children who had been abandoned or neglected by parents or guardians, children living on the streets, children living with unfit parents as well as those living with poor families. Under this law the government is required to ensure that every child is under adequate care and protection. Unfortunately, the Tanzanian Government is not adequately supporting poor families to manage basic needs of their children.

During the interviews and FGDs, the participants reported that the Law of the Child Act (Foster Care Placement Regulations) 2012 is responsible for the regulations guiding foster care placements. A social welfare officer during FGD said:

The Law of the Child Act (Foster Care Placement Regulations) 2012, states that the child who has no parental care or is living under inappropriate care should be placed under foster care by the social welfare officer based on foster care placement regulations. This could be OVC placement under guardians not related to children. However, in Tanzania many children without parental care were placed in informal foster care, where foster care arrangements were not adequately observed.

The participants reported that the aim of adoption of children as indicated in the Law of the Child Act (Adoption of Children Regulations) 2011, is to ensure that every child grows up in a family environment. A key informant had this to say:

The Law of the Child Act (Adoption of Children Regulations) 2011 provides that before undertaking adoption procedures, efforts should be made to reunite the child with his/her family. Processes of adoption of the child can proceed when it has been proved beyond doubt that the biological parents are not fit for the child due to health problems, abuse or mistreatment. Tanzania through the Department of Social Welfare and UNICEF reunited some of the children with their families, but the effort was inadequate due to limited human, material, and financial resources.

During interviews participants indicated that the Law of the Child Act (Children's Homes Regulations) 2012, requires residential care to be used temporarily as a last resort and children without parental care should be placed in a family environment for their wellbeing. A key informant said:

It is very unfortunate that residential care is not regarded as a last resort although it is so indicated in the Law of the Child Act (Children's Homes Regulations) 2012. In my view, residential care is highly utilised in placing children without parental care, and to date there are no proper initiatives for the de-institutionalisation of residential care centres in Tanzania.

In a probing question, the researcher sought to understand whether stakeholders' knowledge of child related laws and policies helped them to effectively implement alternative care for children. It was revealed by the participants that, although they possess knowledge regarding child related laws and policies, they could not effectively implement alternative care for OVC. The main reason identified by the participants was inadequate support from the government. One key informant stated:

In my view the government has played a big role in developing child related laws and policies but it has not adequately supported implementation. In reality the laws and policies exist but they are not translated into programmes and projects for effective implementation. This means that the knowledge of many stakeholdres is based on theory and not practice.

During FGDs social welfare officers noted that there was a lack of polical will regarding child related laws and policies. For example child protection has not received special attention in parliament which has hindered deinstitutionalisation. One of the social welfare officers explained this:

Experience shows that politicians are good activists in social, political, cultural, and economic issues affecting peoples' lives. Unfortunately, child protection issues related to inadequate care have not received adequate attention from the political perspective. This has contributed to continuous child violence and abuse in various alternative care systems.

Views onTanzania's Response to the Right to Alternative Care for Children

The respondents' views in this regard are summarized in Table 20 below. Based on these findings, all respondents concurred with the assertion that Tanzania had positively responded to the right to alternative care for children without parental care through the ratification of the Convention on the Rights of the Child (1991) and the African Charter on the Rights and Welfare of the Child, (2003), and development of the Law of the Child (2009).

Table 20: Views on Tanzania response to the right to alternative care for children.

Responses %	**Agree**
Convention on the Rights of the Child (1991)	100.0
African Charter on the Rights and Welfare of the Child (2003)	100.0
The Law of the Child Act (2009)	100.0
Guidelines for Improving Quality of Care, Support and Protection for the MVC (2009)	100.0
National Costed Plan of Action for MVC (2007-2010) & (2012-2017)	100.0

Respondents also aknowledged that Tanzania had established guidelines for improving the quality of care, support, and protection for the most vulnerable children (MVC) (2009), and the National Costed Plan of Action for MVC (NCPA I) 2007 - 2010 and (NCPA II) 2012-2017. The participants confirmed, during interviews and FGDs, that the government of Tanzania had established various standards and regulations to respond to the right to alternative care for children. A social worker said:

The Convention on the Rights of the Child (1991) and African Charter on the Rights and Welfare of the Child (2003) state that children have the right to live with their parents. Separation of the child from his/her parents will only be carried out when it has been established that the child is in a dangerous situation. For example, when the child is living with very sick parents who are not able to provide care and support, or when the parents are alcoholic and abusive to the child.

A key informant stated that both the Convention on the Rights of the Child (1991) and the African Charter on the Rights and Welfare of the Child (2003) have identified the family environment as the best place to raise children. She added:

While this is true experience shows that some children feel better living in residential care centres due to poor living conditions experienced in their families. The family environment needed for the wellbeing of children has been ruined by poverty,

sickness, and violence. This situation has pushed many children to the streets and residential care centres.

The participants, during the interviews and FGDs, identified the Law of the Child Act (2009) which has been used to establish frameworks for the right to alternative care for children without parental care. A community leader said:

Although Tanzania has not established national guidelines for alternative care for children, the right to alternative care is highly embedded in the child laws and policies. For example, the Law of the Child Act (2009) provides that a child should be entitled to live with his/her parents or guardians. The parents/guardians are also required by the law to offer care and love to children. Based on the Law of the Child Act (2009) several guidelines have been established such as the guidelines for foster care placement, adoption of children, and children's homes. Foster care, adoption, kinship, approved residential homes, retention homes, and approved schools are some of the residential care systems that have been identified in the Act.

A social worker remarked that the Law of the Child Act (2009) requires every individual to protect the rights of the child. He observed:

The Law of the Child Act (2009) requires every parent/guardian to protect the children under their care from all forms of abuse, violence and exploitation. The law also reguires children who have lost both parents to be provided with alternative permanent care under close relatives/guardians. This is to ensure that every child is under appropriate and adequate care.

During the interviews and FGDs participants stated that the main objective of the Plan of Action (NCPA I & II), is to identify the Most Vulnerable Children (MVC) for the purpose of ensuring that children access basic rights such as the right to the fulfilment of basic needs, love, security, protection, participation, and development. A community leader stated:

The National Plan of Action is one of the community-based approaches for identification of the MVC. I remember when it started, community members were involved in the process through local government leaders from the districts, wards,

and villages. The local government leaders were trained on how to implement the guidelines to ensure that eligible children were identified.

The participants remarked that the Guidelines for Improving Quality of Care, Support and Protection for the Most Vulnerable Children (MVC) 2009, was a tool to be used by all stakeholders in planning and implementation of projects and programmes for addressing needs of the OVC. A social worker gave further clarification during a FGD session by saying that:

The guidelines have identified the right to alternative care for children through the family-based care for OVC aimed at ensuring that the child is under the care of an adult who is willing to provide him/her with all basic needs. The guidelines have recommended community strategies for children who will not secure placement under the family-based care for OVC. This, according to the guidelines, can be foster parents as well as supervised child-headed households.

Respondents' Views on Potential Contribution of the Existing Child Related Laws and Policies

Regarding the potential contribution of the existing child laws and policies to the enhancement of alternative care for OVC the responses are as summarised in Table 21 below.

Table 21: Respondents' views on potential contribution of the existing child related laws and policies

Response %	National guidelines	Raise community awareness	Establish legal status	Monitoring and evaluation	Children's access to justice
Agree	100.0	100.0	100.0	100.0	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

All respondents concurred with the assertion that child related laws and policies were capable of facilitating development of the national guidelines for alternative care for children, raise community awareness about child rights and protection, establish legal status for the informal care systems, facilitate monitoring and evaluation of the

existing alternative care systems, and facilitate children's access to justice when their rights have been violated inside and outside alternative care systems. Participants were of the view that, through effective implementation of child laws and policies, alternative care for children would be strengthened. The reason is that stakeholders would use the laws and policies to facilitate establishment of the framework, such as the national guidelines for the alternative care for children, and ensure effective care for children deprived of parental care. A key informant said:

I am very confident that, if child laws and policies are implemented effectively, they will help in creating national guidelines for alternative care as well as form the framework for maintaining and protecting rights and wellbeing of children. The guidelines for alternative care for children are tools that will guide national and international partners in ensuring that every child is placed under the family care environment for his/her wellbeing.

A social worker said that the national guidelines for alternative care for OVC would enhance permanent care for children without parental care:

Establishment of the national guidelines for alternative care for children will enable stakeholders to establish a framework to provide material and financial resources to poor families. This means that more families will be in a position to continue supporting OVC. In addition, the national guidelines for alternative care for children will facilitate reunification of children with their families/relatives and reintegration of children into their respective communities. This will help to reduce the number of children living on the streets and in the residential care centres.

The participants were of the view that, through effective implementation of child related laws and policies, stakeholders would help to raise awareness of the community about the rights and protection of children which in turn would create more opportunities for OVC to secure permanent care in their respective communities. The participants also reported that effective implementation of child laws and policies would establish programmes for educating community members,

and creating awareness of child rights and protection. One key informant had this to say:

Community members need to be educated on matters that are related to OVC, alternative care systems as well as child laws and policies related to protecting this group. In addition, the community should be involved in projects and programmes related to OVC so that they can act as watchdogs in case of any violation. Raising community awareness on child rights and protection, as well as barriers hindering OVC from accessing care might motivate community members to engage in provision of care to OVC.

The findings also revealed that child laws and policies would help to facilitate legalisation of the informal care systems such as kinship, informal fostering, and community-based care. This would allow monitoring and evaluation of the care and services offered to OVC by the informal care system with the aim of ensuring protection of children. A community leader said:

The traditional care practice of the OVC under the members of the extended family is not monitored by any authorised system. In my understanding, members of the extended family, friends, and close neighbors might provide informal long term fostering that might lead to informal adoption of a child. I am working as a community leader but it is very difficult to know if these families mistreat children, until the information reaches my office through the neighbours or the child himself/herself. Even when neighbours report mistreatment of the child, by parents or relatives, to the office, they ask for confidentiality because they do not want to destroy the relationships. This is due to lack of legal guidelines for care by kinship, which would allow monitoring of care and services provided to the child.

Another community leader said that monitoring and evaluating care and support provided to OVC by the informal care system is very vital because some children living with their relatives had been mistreated. In addition, children might have been affected physically and psychologically due to violence and abuse from their own relatives. He added:

Two years ago, my office received a report of a child not allowed to attend school by her aunt. This twelve year old girl was required to assist her aunt in her food vending business. I decided to visit that family with a team of three officers from my office. That aunt welcomed us. I explained to her the purpose of the visit and suddenly a girl who looked very sick came out of the room. After the girl greeted us, the woman asked her to go back and sleep but she started crying loudly. We all started wondering what was wrong with the girl. Three of us were shocked when we discovered that the woman had beaten and injured her because she insisted that she wanted to go back to school. I had to call the police to intervene, and the child was taken to hospital and was admitted for a week. After she got well arrangements were made by the social welfare office to place the child in residential care. Legal action was taken against the aunt.

According to the participants, all projects and progammes related to children should be monitored and evaluated for positive outcomes. This would ensure that only registered residential care centres provide services to OVC according to participants. A key informant shared the following:

Effective implementation of child related laws and policies would ensure that only residential care centres which are registered are able to provide services to OVC. In addition, monitoring and evaluation would ensure that services provided to OVC meet sufficient standards. Monitoring and evaluation would also facilitate the process of reuniting children with their parents and relatives.

In addition, the participants were of the view that effective implementation of child related laws and policies would facilitate children's acces to justice when their rights are violated at any level. They further declared that Tanzania has good policies but the problem lies in poor implementation because of ineffective guidelines and frameworks. A social worker said:

Effective implementation of the child related laws and policies would help to establish a framework that would ensure that immediate legal action is taken against anyone who would violate rights of the child. For example; there would be a special team to

conduct thorough investigation of families suspected of mistreating children under their care or individual parents who will deny children under their care the right to education.

Challenges Related to Implementation of Child Related Laws and Policies

The researcher sought to examine challenges associated with the implementation of child related laws and policies in an effort to understand why some children can not secure adequate care. The findings from the survey are summarised in Table 22 below.The results show that all respondents acknowledged the existence of a poor coordination framework for stakeholders in implementing child related laws and policies, and community members' inadequate knowledge on child related laws and policies as some of the challenges. Other challenges identified included limited human, material, and financial resources, and the use of the English language in writing child related laws and policies.

Table 22:Challenges facing implementation of child related laws and policies.

Response %	Poor coordination framework	Limited community knowledge	Limited resources	English language
Agree	100.0	100.0	100.0	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**

The participants appreciated the government's significant role in establishing child related laws and policies but felt that the implementation had been poor due to various challenges. Some of these included a poor coordination framework for stakeholders in implementing child related laws and policies. A community leader said:

Stakeholders involved in implementing child related laws and policies include the central government through all ministries dealing with children's issues, local

government, community, families, international organisations, NGOs, CBOs and FBOs. An effective coordination framework can help in establishing networking mechanisms for effective service delivery. For example, one stakeholder would be involved in providing services which are different from those of other stakeholdres to avoid duplication. This would help in providing support to many children deprived of parental care and the services would be available both in the urban and rural areas. But currently many many OVC stakeholders have located their services in urban areas which might be the reason many children are moving into the big cities.

A follow up question was asked to elicit participants' views and opinions regarding knowledge of community members of child related laws and policies. A majority of the participants revealed that many people had very limited knowledge regarding child laws and policies. They reported that people who had adequate knowledge were those employed by public or international organisations dealing with child related matters. A key informant said that a large number of community members were not familiar with child related laws and policies which might have contributed to their poor implementation. He added that:

Some poor families have struggled to pay tuition fees for OVC under their care and sometimes these families were forced to keep children out of school when they failed to pay school fees. This is because those families had no knowledge concerning the education policy for vulnerable children, which required them to receive free education. For example, I learned from my neighbour's child that the school management sent him back home because his parents failed to pay school fees. I knew that this child was an orphan, and was living with his uncle. I asked my neighbour if the child was registered because an orphaned child can receive free education. My neighbour said that the child was not registered because he did not know the procedure. I advised him to go to the local government office with the child's birth certificate and death certificates of the parents to have the child registered as an orphans. I was happy that the child was able to continue his education after that process.

Another challenge, expressed by many participants was limited human, material, and financial resources. The participants revealed that there were insufficient numbers of experts and specialists to translate the legal and policy frameworks into programmes and projects for effective implementation. This, according to the participants, required training of all stakeholders dealing with children's issues in all sectors. One of the social workers added:

In my view the child related laws and policies have identified many crucial areas for the promotion of wellbeing of children without parental care. The main problem is that they seem to be unrealistic because insufficient allocation of resources hinders implementation. It is clearly indicated in the Law of the Child Act (2009) and in the Child Development Policy that all children should be protected from violence, abuse, and exploitation. For example, effective implementation of a child's right to protection, would require preventive programmes like financial support to poor families to help those families provide adequate care and support to their children. Unfortunately, due to insufficient funds to support poor families, many children run away from their homes and live on the streets where they continue experiencing abuse and exploitation.

Commenting on the same issue, another social worker said that there were insufficient human and financial resources for effective implementation of child related laws and policies:

The Law of the Child Act (2009) requires the states to establish juvenile courts. Unfortunately, to date, there is only one juvenile court in Tanzania. This means that many children are held in adult prisons. In terms of the right to justice, there are few probation officers and few registered lawyers. This means that children who are in conflict with the law have very limited legal representation as many families cannot afford to fund legal aid.

Language is another challenge identified in the context of the study. The participants reported that almost all laws and policies in Tanzania are written in

English which makes it difficult for many people to read and understand them. A community leader said:

Almost all laws and policies in Tanzania are written in the English language which is not the national language. This means that many people cannot read child related laws and policies. In my experience even many community leaders who have no secondary education cannot read the child related laws and policies since they are not familiar with the English language.

In addition, one of the key informants added:

Child related laws and policies need to be translated into Kiswahili for effective implementation. In my experience, Tanzania has managed to establish good laws and policies but they are not effectively implemented to meet the intended goals. I believe some of the challenges are related to the fact that the laws and policies are written in the English language which many people are not familiar with.

Discussion

The findings in chapter six indicate that OVC face various challenges in accessing adequate alternative care. This pushed children to live on the streets or in unsupervised child-headed-households and residential care centres. In addition, OVC treatment in various alternative care systems and settings were poor and some children faced abuse, violence, and exploitation. This, as noted by the findings of this study, was against the provisions of the child related laws and policies. The researcher, therefore, sought to understand the potential contribution of the existing child related laws and policies to the enhancement of alternative care for OVC (objecive 3 of this study). The discussion which follows provides insights into stakeholders' knowledge of child related laws and policies, the right to alternative care for children in Tanzania, the implication of child related laws and policies in enhancing alternative care for OVC, and the inadequacy of such laws and policies.

Participants in the current study shared their knowledge on the existing child related laws and policies as they are meant to protect children's rights to survival, nutrition, shelter, education, health, love, and protection. Participants stated that the existing child related laws and policies required every child to be raised up in a family environment for his/her wellbeing. SADC (2010) and the Tanzania Child Rights Forum (TCRF) (2013) reports noted that Tanzania had established several policies and laws with the aim of protecting children's rights. The findings are also consistent with the provision of the Law of the Child Act (Adoption of Children Regulations) 2011, section 11 (3), which states that, before hearing an application for adoption, the Magistrate shall ensure that the social investigation report contains detailed information that indicates the efforts that would have been carried out to reunite the child with his/her biological parents. The intention is to ensure that children are not separated from their families where they can receive care, love, and protection. However, the findings revealed that efforts at reunification and reintegration of children with their families and communities were inadequate due to limited human, material, and financial resources.

The findings specifically indicated that the implementation of the existing child related laws and policies was ineffective. For example, participants noted that the Development Policy (2008) had been effective in promoting the development of children through education, health, nutrition, water, and sanitation but it had directed little attention towards ensuring that every child secured placement in a family environment, which had violated children's right to adequate care. These findings support section 51(iii) of the Child Development Policy of 2008 which requires that central and local governments strengthen community and societal systems responsible for providing care to OVC. Section (53) of the Child Development Policy indicates

that children should be protected against harm, violence, abuse, and exploitation in order to grow and develop in a physically, mentally, and psychologically positive manner.

Participants also noted that, in Tanzania many children were simply placed in informal foster care without adequate background checks which is contrary to the Law of the Child Act (2009) (Foster Care Placement Regulations) 2012, that requires children to be placed in foster care only after a thorough assessment by the social welfare officer. One of the challenges with of informal foster care is that there are no records of children placed under that system, and no assessments by the Department of Social Welfare are carried out. The Law of the Child Act (Foster Care Placement) Regulations 2012 section 6 (2) requires social welfare officers to carry out an assessment for every person or family interested in fostering a child. The aim is to establish whether or not persons or families are suitable for providing care to children lacking parental care.

Furthermore, participants reported that the Law of the Child Act (Children's Home Regulations) 2012 requires residential care to be regarded as a last resort. The general principle under the Law of the Child Act (Children's Home Regulations) 2012 section (3a) states that children deprived of parental care should be placed in a family environment for their wellbeing. The principle further states that the placement of children in a residential care centre (children's home) should be temporal and used as a last resort. Unfortunately, the findings revealed that many children in Tanzania continue to be placed in residential care centres and there was no special strategy for deinstitutionalisation. According to (UN, 2010), deinstitutionalisation is an approach used to ensure that larger residential care centres for OVC are abolished.

In addition, participants noted that, although they possessed adequate knowledge regarding the existing child related laws and policies, they could not effectively implement alternative care programmes for children. The reason was that the laws and policies were not adequately supported by government to ensure effective implementation. An example provided by one participant was that, while the child related laws and policies require children to be raised in a family environment, there is no adequate financial support by government for poor families to provide for basic needs of their children. This finding is in line with those of SADC (2010) which revealed that many governments in Africa have failed to support effective implementation of legislation and policies. This has hindered children without parental care from securing adequate care and support which calls for further research in that area of concern.

The findings of the present study highlight established child related laws and policies in Tanzania which are aimed at promoting the welfare of children. However, the findings draw attention to the fact that those pieces of legislation have not adequately addressed problems facing OVC in relation to inadequate care, love and protection. This is evidenced through the government failure to support poor families and communities to manage basic needs of children without parental care. In addition, the government has not adequately supported the implementation of the legislation which hindered reunification efforts and de-institutionalisation of the residential care centres. As a result many children have faced abuse, mistreatment, and exploitation as they strive for their survival under inappropriate care. The findings further underline the negative impact of informal foster care which is most commonly practised in the country. The fact is that the best interests of the child might not be attained under informal foster care because there are no regulations to guide placement. This means

that children might experience violence and abuse which could push them into the streets. These findings suggest that there is a need for government to allocate adequate financial, human, and material resources to support implementation of the child related laws and policies in order to maximise child protection.

It is common course that every child in Tanzania has the right to alternative care and this is reflected in the existing child laws and policies. The findings suggest that Tanzania has responded positively to the right to alternative care for children through ratification of the Convention on the Rights of the Child (CRC) (1991) and the African Charter on the Rights and Welfare of the Child (ACRWC) (2003). The participants confirmed that both instruments required every child to live with his/her parents unless there is proof that the child is in a dangerous environment. This can happen if the child is under the care of very sick, poor, alcoholic or abusive parents/guardians, according to participants. Both the CRC and the ACRWC require children to be brought up in a family environment. For example, article 9 of the CRC states that children have the right to live with their parents unless there is proof that the child's life is in danger due to abuse, neglect or failure of parents to support him or her. SADC (2010), Tanzania Child Rights Status Forum (TCRF) (2013), and SOS (2014) all noted that, in addressing various problems facing children in relation to inadequate care, Tanzania should effectively implement the existing child related laws and policies. This would prevent violation of children's right to adequate care and pretection.

Participants noted that the CRC and ACRWC do provide relevant guidance in relation to alternative care for children. They explain that: Article 18(3) of the CRC states that it is the duty of states to establish and maintain rules and guidelines with regard to alternative care for children. According to the TCRF (2013) only seven sets

of regulations had been established and passed by parliament based on the Law of Child Act (2009) such as adoption of children, foster care arrangements, people living with disabilities, apprenticeship, day care, children's homes, and retention homes. This means that stakeholders dealing with children need to work together to establish more regulations based on the existing child related laws and policies to enhance OVC's access to permanent care.

Furthermore, article 27 (2) of the CRC, states that the right of children to a reasonable standard of living is the responsibility of parents, guardians or relatives who are caring them, while article 27 (3) states that, when the parents or any other person providing care to a child fails States Parties should intervene by supporting the families to manage their responsibility. However, participants indicated that the Tanzanian Government does not adequately support poor families, which might be the explanation for why many children are living on the streets and in residential care centres. Articles 24 and 25 of the ACRWC provides rules concerning adoption of children, stating that competent authorities should be responsible for carrying out adoption processes and ensure that the best interests of children are met.

The Charter recognises inter-country adoption but requires it to be considered as a last resort. This should only be considered in cases where a child cannot be placed in a foster or adoptive family in his/her country of origin. The focus is on ensuring that children grow up in their own culture in order to enable them to engage in the development of their communities. The researcher is aware of the cases of celebrities in which (Madonna) adopted baby Banda in Malawi (2006), Mercy 2007, and the twin girls (Stelle and Estere) 2009. Another celebrity, Angelina Jolie adopted baby Zahara in Ethipia and Shiloh in Namibia. The view of the researcher is that the adoptions should not be granted simply because these are celebrities, but because all

necessary procedures and legislation are fully implemented. The researcher believe that, the respective countries were guided by the procedures and their legislations in the adoption processes for those celebrities. Unfortunately, Tanzania had not experienced such cases but if happens in the future the position should be to implement the legislation and adoption procedures effectively. For example, the Law of the Child Act (Adoption of Children Regulations) 2011 requires foreigners wishing to adopt a child in Tanzania to stay in Tanzania for about 3 consecutive years. This is to say that if a celebrity will leave in Tanzania for the required period of time, and show an interest of adopting a child, all procedures should be followed to grant adoption.

The findings of this study also show that, in Tanzania, the right to alternative care is embedded in child related laws and policies. For example, participants reported that the Law of the Child Act (2009) requires every child to be raised by his/her parents or guardians. The law also requires parents or guardians to protect the children from all forms of abuse, violence and exploitation. The Law of the Child Act (2009), section 9 (4) requires children without such parental care or with substandard care to be placed under care of relatives or guardians through a court order or traditional arrangements.

Furthermore, the findings revealed that Tanzania, under the MoHSW established the National Plan of Action (2007-2010) (NCPA- I) that was used to identify the Most Vulnerable Children (MVC). The participants noted that this approach involved community leaders to ensure that every child had access to care, the fulfilment of basic needs, education, love, development, security, and protection. The findings of the current study are consistent with NCPA (I) which requires community-based care programmes to support children who have no parental care.

The NCPA (I) suggested that household level interventions support poor families through financial aid and credits to enable them engage in economic activities, in trying to support their children. Institutional care, according to NCPA (I), should be offered as a last resort, when all other alternative care strategies are not available. The NCPA (I) identified the family environment as the best place in which to raise children and provide for their developmental needs. Furthermore, the NCPA (I) requires foster care and adoption to be guided by the existing regulations (i.e. foster care placement regulations 2012 and adoption of children regulations 2011).

The findings of the current study are also consistent with those of the NCPA (II) 2012-2017, which provide guided interventions for national and international partners supporting children to implement lessons learned from the NCPA (I) and to identify newly emerging challenges. One of the strategic objectives of the NCPA (II) is to provide access to a quality family-based care and support for OVC. Interventions suggested in the NCPA (II) include to ensure that children have at least one adult person to provide care, support, and protection; to enable integration and reunification of children from residential care centres; and to support foster care, adoption, and kinship care systems. However, the study by the Tanzania Child's Right Forum (2013) indicates that, in spite of the concerted efforts at implementing NCPA, many children were under the care and support of their grandparents and some were living in unsupervised child-headed households.

This study's findings confirm that Tanzania has been very active in responding to international and regional calls to promote children's rights. The finding also crucial for social welfare officers, policy makers, national, and international partners to understand why, for many years, the child's right to alternative care has not been realized. The findings suggest the need for full

implementation of child related laws and policies to ensure that children have access to appropriate and adequate care to respond to their developmental needs.

The study revealed that effective child related laws and policies would contribute towards enhancing alternative care for children by facilitating development of national guidelines for the alternative care of children.The participants believed that the national guidelines for alternative care of children without parental care were adequate to guide national and international partners in ensuring that every child is placed in a family type environment for his/her wellbeing. In addition, they noted that the new national guidelines for alternative care of children would also help OVC stakeholders to implement issues related to child care and protection based. The findings are in line with the Tanzania NGO Report (2014) which called on the country to develop long awaited Parental Guidelines in respect of alternative care which was recommended by the previous Children's Rights Committee. The guidelines, as indicated in the CELCIS (2012) findings, will help stakeholders to establish a framework to deal with the protection and alternative care for children. The Child Development Policy (2008) noted that strategies should be developed to provide material and financial support to families to help children remain within the family environment. This is in line with the objective of the UN Guidelines for the Alternative Care of Children (2009) to ensure that children are supported to enable them to stay with their families or members of the extended family.

Participants noted that effective implementation of child related laws and policies would likely help to educate community members and create awareness of child rights and child protection. Through education and awareness raising, participants believed that community members would be motivated to engage in supporting OVC. The participants added that community members will also act as

watchdogs in terms of protecting the rights of children. The findings correspond with those of the Tanzanian Ministry of Constitution and Legal Affairs (2012) and URT (2013) which indicated that education and awareness raising on child rights and entitlements for parents, guardians, and community members was essential to enable the community to empower children to fight for their rights and for justice. The Ministry of Constitution and Legal Affairs (2012) further noted that awaireness raising should also be directed towards children's rights, in particular how they can access justice when those rights are violated. The findings are aslo supported by the TCRF (2013), which noted that awareness raising related to child rights and protection in Tanzania was very important because most parents preferred to negotiate in cases related to child sexual abuse, especially when close relatives were involved.

The participants also indicated that child related laws and policies are capable of facilitating legislation in relation to informal alternative care systems such as kinship care, informal foster care, informal adoption, community-based care, and child-headed households care. They added that legalisation on the informal alternative care systems could help social welfare officers to monitor care and services provided to OVC, and this would assist in preventing abuse, violence, and mistreatment of children. This finding is consistent with previous findings by UNICEF (2011) and Save the Children (2012) to the effect that the informal care systems in developing countries often operate without strategies to track and monitor their implementation.This makes it difficult to track down the number of informal care systems supporting OVC and the number of children receiving support in informal care systems such as kinship, informal foster care and adotion, as well as community-based care.

The study established that children who receive support from the informal care system lacked the right to legal security and protection from their caregivers. For example, in the USA a child might be denied emergency surgery because there has to be consent by legal parents/guardians. This finding is in line with observation by Save the Children (2013) revealed that despite its existence, care under the kinship, is left out in terms of specific policies and programming required for effective care support, protection, and child wellbeing. The UN (2009) Guidelines for Alternative Care for Children call upon all states to establish an effective framework to ensure that children in informal care systems are protected from abuse, neglect, child labour, and related explotation. However, the ILO (2012), with regard to child involvement in domestic work, revealed that about 54,000 children under the age of 15 work as domestic servants in South Africa and 38,000 children between 5 and 7 years work as domestic servants in Guatemala work. In the case of Tanzania, the children who were mostly affected, according to these findings, are those in formal foster care by family members, who had never been in contact with the child before.

In the present study, respondents were of the view that by revisiting child related laws and policies would facilitate monitoring and evaluation of the existing alternative care systems. The study by Save the Children (2013) indicated that strategies and mechanisms should be established to ensure effective identification, monitoring, evaluating, and addressing of problems of children living in different alternative care systems. Similarly, PEPFAR (2012) and SOS (2014) revealed that monitoring and evaluation of projects and programmes related to children is crucial for effective planning, decision making, programme improvement, and accountability. The National Plan of Action (NCPA) (2007-2010) noted that Tanzania had no comprehensive monitoring and evaluation systems for OVC. Conscequently actual

information on the number of OVC might be missing, which would affect planning and decision making in relation to budgetary allocation. This calls for the establishment of an effective framowork for monitoring and evaluation in order to improve the services provided to OVC.

The study also established that effective implementation of chid related laws and policies would help children to access justice when their rights are violated. UNICEF (2012) revealed that there was an inadequate child friendly environment at some police stations in Tanzania which prevented children from reporting violence and abuse encountered within and outside alternative care systems. Previous studies have contributed this by reporting that Tanzania lacked separate judicial procedure for children, and that the age for criminal responsibility had been set at 10 years (Legal and Human Rights Centre (LHRC), 2010; UNICEF, 2012; Tanzania Child Rights Forum, 2013). This is aginst the Law of Child Act 2009 which defines a child as a person below the age of 18 years. Attention should therefore be directed to ensuring that the best interests of the child are met in all matters related to their wellbeing. Commission for Human Rights and Good Governance (2011) noted that in Tanzania, children were not accorded their right to counselling, eduation, health care services, rehabilitation and contact with their parents while in prisons.

The findings of the current study contribute to the discourse on child welfare in various ways. The findings stimulate awareness about the significance of child related laws and policies in enhancing alternative care systems for OVC. Hence the establishment of the new national guidelines for the alternative care of children would ensure appropriate care and protection of the OVC. The findings also suggest that community awareness on child rights and protection would enhance arranging permanent care for OVC. In addition, these findings highlight the need for

legalization of the informal alternative care systems as an important factor in protecting children from violence, abuse and neglect. This could ensure that children placed in the informal care system such as kinship, community-based care, informal adoption or child-headed households would be effectively protected. The findings further highlight the fact that effective implementation of child related laws and policies would enhance monitoring and evaluation of services provided to OVC and would facilitate children's access to justice. The findings call upon stakeholders to advocate for justice for children to ensure that their rights are effectively protected.

This study identified a number of challenges in the implementation of child related laws and policies. These include poor coordination, limited community knowledge on child related policies and laws, limited resources, and language barriers. Participants noted that poor coordination on the part of service providers has lead to duplication of services provided by stakeholders and overllaping of programmes. An example given was that many national and international organizations involved in OVC issues, provided similar support such as food, clothing, school uniforms, and books to OVC in big cities. This was cited as a reason that has attracted many children to migrate to centres located in urban areas like Dar es Salaam because the services are not extended to rural areas. The National Audit Office Tanzania (NAOT, 2013), reported that the coordination of service providers for MVC was poor both at the national and regional levels. The report revealed that some NGOs were working with the Local Government Authorities (LGAs) councils without informing the Regional Secretariats (RS) which lead to duplication of services to some areas. The report by SADC (2011) on minimum packages of services for children and youth requires stakeholders to collaborate and enhance their

capacities to realise the social, physical, psychogical, and economic development of youth and children.

Limited community knowledge on such child related instruments was viewed as a challenge which hindered effective implementation existing child related laws and policies. For example, some poor families, according to the findings of the present study, had kept their children out of school when they failed to pay school fees. The reason was that those families had not registered their children as orphans because they did not know that they were supposed to receive free education. The finding corroborate SADC (2010) observation that many countries had enacted legislation for children but that there was inadequate awareness and poor implementation of child laws and policies in some countries. Previous studies too reported that parents and community members had limited knowledge of children's rights (Tanzania Child Rights Forum, 2013; SOS, 2014; Tanzania NGO, 2014). It was also revealed that understanding of the policies and legal frameworks was limited to the staff members of the organisations as it depended in level of their education (SOS, 2014).

The current study found that although child related laws and policies had identified many crucial areas for promotion of the wellbeing of OVC, limited resources hindered its effective implementation. It was also found that, due to limited resources, there was only one juvenile court in Tanzania; which had caused children to be held in adult prisons. Findings of the present study concur with those of previous studies which revealed that limited resouces and capacity had contributed to failure to implement policies, plans, and programmes related to children (Child Frontiers, 2011; Save the children, 2012; Tanzania NGO Report, 2014; SOS, 2014). The Tanzania NGO Report (2014) and the Commission for Human Rights and Good Governance,

(2011) revealed that the Law of the Child Act (2009) in Tanzania had not established a separate system for juvenile offenders, which caused children cases to be heard often in adult courts. The findings also correspond with those of the Commission for Human Rights and Good Governance (2011) which revealed that 591 children between 13 and 17 years were in detention centres while 441 children were detained in adult prison. The report further noted that children who were in conflict with the law had very few legal representatives due to the limited number of probation officers and registered lawyers dealing with children's issues.

The participants reported that many ordinary people could not read child related laws and policies because these were mostly written in English . Such findings confirm those of the Legal and Human Rights Centre (LHRC) (2009) which noted that almost 98% of the countries laws were in the English language although a majority of Tanzanians speak Kiswahili. The Ministry of Constitution and Legal Affairs (2013) reported that the use of English as a language of law and policy records had been challenging because some law enforcement officers had scant knowledge of the English language.

From the data, implementation of child related laws and policies has not adequately addressed issues related to OVC care, love, and protection which has intensified violation of children's rights to care and protection. The study findings contribute to the knowledge base through highlighting poor coordination of service providers which has resulted in the duplication of services mostly in big cities like Dar es Salaam. In addition, the findings have implications for community members' knowledge regarding child related laws and policies implying that the rights of children might be violated by biological parents, relatives, and guardians. This study's findings further contribute to the knowledge base by raising concern with regard to

poor allocation of human, material, and financial resources to facilitate implementation of child related laws and policies. This implies that children may continue to suffer from inadequate care and protection. The study's findings draw attention to the fact that ordinary Tanzanians are hindered from reading child related laws and policies because these are written in English. The findings call upon national and international partiners to to help establish a framework that would involve all service providers for effective utilisation of available resources to enhance the wellbeing of OVC. This finding also calls for education, advocacy, and sensitisation of community members and stakeholders with regard to the laws, policies, programmes and projects related to children. In addition, the findings call for the government and other stakeholders to work together to translate child related laws and policies into the Kiswahili language to enable many people to gain knowledge regarding the rights of the child.

Conclusion.

Overall, the findings of this study show that many participants possessed adequate knowledge regarding child related laws and policies which are meant for the protection of children's rights. Although the Law of the Child Act (2009) had identified children in need of care, many of them had not secured permanent care. The regulations which had been established under the Law of the Child Act (2009) were not effectively implemented because they were not fully translated into programmes and projects. This, according to the participants, had helped intensify abuse, violence, discrimination, and exploitation against children without parental care.

The findings further revealed that Tanzania had responded positively to call for promoting the rights to alternative care for children through ratification of the international legislations and introduction of the National Plan of Action for the

purpose of improving the living conditions of OVC. However, according to the findings, the existing alternative care systems for OVC had not managed to address issues around their need for care, love and protection as expected. More research is therefore necessary to establish the best methods for addressing the problem.

The findings also noted that effective implementation of child related laws and policies would facilitate establishment of the national guideline for alternative care of children and community awareness programmes on child rights and protection issues. Furthermore, effective implementation of child related laws and policies would facilitate legalization of the informal care systems, monitoring and evalution of the existing alternative care systems, and children's ability to access justice. Nevertheless, the discussion also indicated many challenges associated with the implementation of child related laws and policies such as poorly coordinated framework, limited community knowledge, limited resources, and language barriers. This calls for stakeholders to address challenges hindering effective implementation of the children's legislation to ensure that child care and protection is realised.The next chapter describes perceptions of the respondents with regard to promotion of the family-based care for OVC.

CHAPTER EIGHT-PROMOTION OF FAMILY-BASED CARE FOR OVC

Introduction

There is a consensus in the literature that a family environment is the best to bring up children for their physical, social, psychological, and economic development (UN, 2009; EveryChild, 2012a; UNICEF, 2012; Save the Children, 2014; SOS, 2014). Unfortunately, the findings of the current study tend to show that the existing alternative care systems in Tanzania have failed to place children without parental care into a family environment. This is evidenced by the growing number of children living on the streets of big cities like Dar es Salaam, and those placed in residential care centres. This chapter presents data from the survey, FGDs, interviews, and documentary review, which were triangulated to examine respondents' views on the notion of a family-based care for OVC. The chapter further presents the findings on perceptions of the respondents with regard to promotion of the family-based care for OVC (objective 4 of this study), strategies likely to promote the family-based care for OVC and challenges that may hinder promotion of the family -based care model. Table 23 below describes sub-themes and themes that were gleaned from the analysis of quantitative and qualitative data.

Table 23: Promotion of family-based care for OVC

Patterns from quantitative data	Themes from qualitative data	Sub-themes
1. Stakeholders' views on family-based care model for OVC	1.The views of stakeholders on family-based care model for OVC	
1. Stakeholders' perceptions regarding promotion of family-based care model for OVC	2. Perception of stakeholders with regard to promotion of family-based care model for OVC	a. Support families and prevent separation b. Provision of permanent care for OVC c. Sustainable child wellbeing
1. Strategies likely to promote family-based care model for OVC	1. Strategies likely to promote family-based care model for OVC	a. Strengthen the capacity of families and communities b. Community awareness through advocacy and social mobilization c. Support family reunification and community reintegration d. Protection and support for child-headed households
1. Challenges that might hinder promotion of family-based care model for OVC	2. Challenges that might hinder promotion of family-based care model for OVC	a. Poor preventive initiatives b. Poor participation of communities and children in care decisions c. Limited human, material and financial resources d. Resistance from residential care centres

Views on Family-based care for OVC

In an attempt to understand respondents' views in regard to this theme they were asked to indicate the extent to which they agree or disagree that the existing alternative care systems constitute of the family -based care models for OVC. Their responses are illustrated in Table 24 below.

Table 24: Views on family-based care for OVC.

Response %	Kinship/extended Family	Foster Care	Adoption	Community -based care	Group Homes	Child-headed households
Agree	100	100	100	100	100	100
Total	**100**	**100**	**100**	**100**	**100**	**100**

As indicated in the survey, all respondents agreed that child care under the headings of kinship/extended family, foster care, adoption, community-based, group homes, and child-headed households fall under the theme of family-based care for OVC. Data from the interviews and FGDs show a similar perspective to the survey findings. Participants revealed that the family-based care for OVC is a framework for offering care and support to OVC in a family environment. Participants identified care

under the above headings as constituting the family-based care examples for OVC. One of the key informants stated:

In my understanding family-based care for OVC is care that provides a family environment for the child without parental care. For example children who are in foster care, kinship, and adoption systems receive care from those families under the guidance of an adult person. These children (ideally) receive social, physical, psychological, and economic support from the respective families for their wellbeing.

A caregiver added that the family-based care for OVC creates a long term care environment for children deprived of their parental care. He added by saying:

The group home, like the SOS, is one of the examples in which children are under the care of 'special mothers' employed by the organisation to take the role of a parent. Children live in different households and they are brought up like sisters and brothers under the guidance of a 'mother' who is responsible for ensuring that the children receive fulfilment of all basic needs.

However, a community leader indicated that care in child- headed households provides a family environment and siblings are able to stay together. She noted that:

Children who decide to stay together in their family home after the death of their parents are also under a family -based care model. Unfortunately, many child-headed households in Tanzania lack support and supervision from the community which make them vulnerable to abuse and exploitation.

A social worker explained that children in community-based care receive care and support from families which have been recognised by the community leadership. She added that:

Community-based care is one of the family -based care models which offers care to children deprived of parental care in family-environment. All community members are involved in matters related to OVC care, love, and protection and they participate in providing various goods and services. Sometimes communities run specific projects aimed at supporting children without parental care and some community members may offer shelter to OVC.

Stakeholders' Perceptions of Promotion of Family-based care for OVC

In relation to the respondents' perceptions of promotion of the family-based care for OVC, figure 6 below displays the responses. The survey results indicate that promotion of the family-based care is considered by respondents to be very important (95.9%) as indicated by the respondents. Participants in the interviews and FGDs perceived promotion of the family-based care for OVC as a very important measure for addressing these children's need for care, love, and protection.

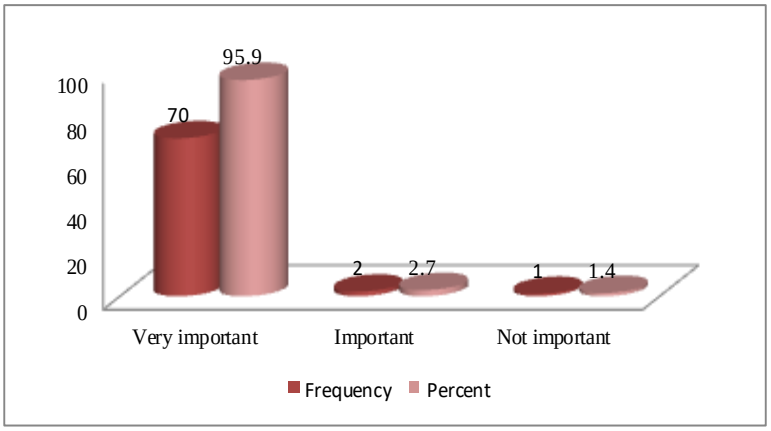

Figure 6: Perceptions of stakeholders with regard to promotion of family-based care for OVC.

One of the key informants said:

Many children deprived of parental care have not secured care under the family environment. Many children are living in insecure and unprotected environments without sufficient basic needs being met. Because the main objective of family- based care will be keeping children within a family environment, I believe children will be protected from abuse and violence.

During FGD with caregivers, it emerged that some children had been forced out of their family homes due to family conflict and violence. One of the caregivers indicated, thus:

Some of the children have been deprived of parental care due to violence by their biological parents or guardians. For example, some children have run away from

their families after being accused, and punished badly for an offense they had not committed. On the other hand, there are several children who have run away from their families because of the violence between their parents. The family-based care is important because it will help to establish programmes to prevent family separation and enable children to stay with their families.

Participants also stated that, through the family-based care many OVC would secure permanent placement for (the protection of) their wellbeing. A community leader stated:

Many children without parental care have failed to meet their expectations due to inadequate care and support. These children have suffered from lack of guidance and provision of basic needs and psychosocial support. Permanent placement will help OVC to plan for their future under the guidance of adults within their families. For example: children in supervised child-headed households will be under the guidance of an adult from the community. Through social, physical, and psycho-social support programmes from the community these children could realize their potential.

During FGD with OVC, it was revealed that the family-based care was a very important initiative because children placed in statutory foster care and adoption have an opportunity to benefit from the fulfilment of basic needs, security, and education. One of the OVC said:

My belief is that, if children can be placed under the family-based care like foster care or adoption, they will be assured of fulfilment of their basic needs, security, and protection. Children living with foster and adoptive parents have an opportunity to discuss their worries with their new parents, which enables them to reduce tension. This is different from growing up in residential care because sometimes there are no funds for further studies.

The findings further revealed that adoption of the family-based care would promote sustainable child wellbeing. This is because it would ensure provision for basic as well as social, psychological, and economic needs to every child deprived of parental care. A social worker said:

The family-based care would enable children to get their entitled right to survival, care, protection, and development for their wellbeing. The rights of many children have been violated due to inadequate care and support. Children placed in residential care centres and those living on the streets might not be well prepared for for their future. For example, residential care centres do not provide adequate support to children leaving care when they reach 17 years. The family-based care would help to support youth, who can no longer stay in residential care centres, to have an adequate independent life.

Strategies likely to Promote the Family-based care for OVC

The findings in this section address the issue of strategies likely to promote the family based-care model for OVC in Dar es Salaam. Table 25 summarizes the views of the respondents. Interviews and FGDs revealed that strengthening the capacity of families and communities would be one of the best strategies to keep children in a family environment. The participants noted that social protection programmes such as social transfers and social assistance could facilitate support for poor families and communities. The following is the view of one social worker:

Social protection strategies can be used to support families through social transfers for poor families to be provided with cash for basic needs and support for their children. This could prevent children from running away from their families and at the same time reduce the number of OVC to be placed in residential care centres. I believe many poor families would choose to stay with their children if they are given sufficient support.

Table 25: Strategies likely to promote the family- based care model for OVC in Dar es Salaam.

C/N	Responses %	Agree
1	Strengthen the capacity of poor families and communities	100
2	Community awareness through advocacy and social mobilization	100
3	Improve statutory foster care and adoption placements	100
4	Provide protection and support for child-headed households	100

Another social worker said that social protection programmes could be used to strengthen community-based care for OVC. She added:

Community-based care can offer support in the form of money to many children deprived of parental care. For example, social protection programmes can be used to offer social assistance to families and provide care for children living with disabilities, children living with HIV and AIDS, and children living in child-headed households to enhance their wellbeing.

Another suggestion is that communities could be supported in establishing vocational training centres to accommodate older children in different programmes, and it would also be possible to offer care and supervision to child-headed households within communities. A community leader said:

Vocational training centres can help many children without parental care to engage in various activities like carpentry, arts and music, electronics, catering, and mechanics. Such activities can offer job opportunities and entrepreneurship to youth who are out of residential care, children living in child-headed households, and those living on the streets.

Community awareness was also identified as another strategy. Participants were of the view that stakeholders should promote community awareness regarding OVC rights to alternative care. Participants also indicated that social mobilisation could involve recruiting of many people who would offer support to OVC through provision of resources for their wellbeing. A key informant stated:

Promotion of the family-based care will succeed if stakeholders would engage communities in issues related to OVC care, love, and protection, challenges they face in accessing alternative care as well as their rights. This will help to engage community members in providing care and support to OVC within and outside their communities. Participation of the community in providing care to OVC will create a sense of belonging because many communities in Tanzania believe that children belong to the (active) community.

Another caregiver said that engagement of communities in care and support for OVC would help in mobilising resources. He observed:

Engagement of communities in supporting OVC will motivate more families to engage in fostering and adopting of children. This will also lead communities to utilise the available resources to support OVC. For example: community members can join efforts to construct shelters for OVC and can also provide food and guidance to them.

A community leader said that community awareness and social mobilisation would help to reduce and prevent violence and abuse of OVC. He added:

Some of the children deprived of parental care and living in communities have experienced violence and abuse according to media reports from public and private radio, television, and newspapers. Awareness raising and social mobilisation will help to involve every person in protecting children against violence and abuse.

Another strategy, which was identified by participants, related to improvement of foster care and adoption programmes to encourage more applicants. It was revealed that this would help to increase the numbers of OVC placed with foster and adoptive parents. A key informant reported:

Statutory foster care and adoption systems providing alternative care for OVC are not effective in Tanzania. This is partly due to lengthy procedures involved in statutory foster care and adoption processes. This tends to discourage families from fostering or adopting children. I believe that, by improving recruitment and placement processes, many families would be motivated to submit their applications. Through my experience, many people in Tanzania believe that foster care and adoption arrangements are very complicated processes and consume a great deal of time.

A community leader explained that statutory foster care and adoption programmes have to be improved by reviewing the costs involved. These are perceived by some to be too high. He added:

I believe that reduction of the costs involved in statutory foster care and adoption will motivate more families interested in fostering and adopting children without

parental care. For example procedures for the adoption of a child involve hiring a lawyer which ranges between (100,000-400,000/=) Tanzanian shillings. This is a large amount of money which hinders ordinary families from applying for adoption. Therefore the costs involved in statutory foster care and adoption should be made friendlier to attract more families.

Some of those who took part in the study suggested that child-headed households should be protected and supported to promote the family-based care for OVC. This, according to these participants, would enable many siblings to stay together in their family home rather than been placed in residential care centres. A community leader had this to say during an interview:

In our communities there are some children who could be supported while living in their family homes. In my experience, some children have been left with good houses after the death of their parents. Unfortunately, there is no effective protection and support offered to these children and they therefore suffer from access to basic needs. This has pushed some of the children to the streets while others end up in robbery and drug addiction. Offering supervision to children living in child-headed households under an adult mentor will enable them to continue with education for their sustainable wellbeing.

Some participants indicated that child-headed households are an alternative form of care for OVC that is growing very fast. Participants believe that supervised child-headed households might be the best alternative form of care for OVC because it will prevent children from being harmed and abused. A caregiver said:

National and international partners should offer adequate support to children living in child-headed households to ensure that they have access to basic needs, education, and security. This might be an effective way to offer a family environment to children deprived of parental care free from abuse and exploitation.

Findings from OVC during FGD indicated that many children without parental care would prefer to live in supervised child-headed households. The reason given by

the participants was that supervised child-headed households would provide permanent placements for older children. Participants added that supervised child-headed households would also help reduce the number of OVC living on the streets. One of the OVC added:

Supervised child-headed households would provide homes to many children, living on the streets, who are placed in residential care centres although this is temporary alternative care. OVC face stress and tension when they reach the age limit for staying in residential care centres, which is 17 years. At this age, many children might have completed primary education but have not passed to start secondary education. When they leave residential care centres, they might end up living on the streets because they might not locate their relatives.

Challenges in Promoting the Family-based care for OVC

The researcher sought to establish constraints that might hinder efforts to promote the family-based care for OVC in Dar es Salaam. Table 26 below desplays the results from respondents. The survey shows that poor preventive masures, poor participation of communities, and children in care placement decisions, an inadequate social welfare workforce, funding issues, and resistance from residential care centres, might hinder efforts to promote the family-based care for OVC (See Table 26).

Table 26: Opinions on challenges that might hinder efforts to promote the family-based care for OVC in Dar es Salaam.

C/N	**Responses %**	**Agree**
1	Inadequate preventive measures	100
2	Poor participation of community and children	100
3	Inadequate social welfare workforce and funding	100
4	Resistance from residential care centres	100

Consistent with the survey results the findings from the interviews and FGDs indicated that inadequate preventive measures might hinder efforts to promote the family-based care for OVC. One of the social workers said:

Adequate preventive measures are critical in ensuring that children are not separated from their biological parents or guardians. Children lack parental care due to various problems such as death of parents or guardians, mistreatment, and abuse. Adequate psychosocial support to OVC should be offered to prevent separation that might occur due to their traumatic experience because of the loss of their parents. In addition, ineffective programmes to prevent problems related to violence and abuse of children like alcohol and drug use might push children away from their families.

A community leader stated that poor families had to be helped to establish income-generating activities to be enabled to support their children. She added:

Sometimes separation of children from their families is caused by conflicts which might result from poverty. The conflict might result from frustrations when children start blaming their parents for failure to support them. For example, a child who had to stop attending school due to lack of school facilities, might become aggressive which might accelerate conflict within his/her family. Income support would prevent such conflicts which could end up pushing children onto the streets and residential care centres.

In addition, the findings from the FGD session with OVC added that specific projects should be established to support children reunited with their families and those reintegrated in communities. This would ensure that every child has access to basic necessities and protection. One of the OVC said:

One year ago I was among more than thirty children who were reunited with their relatives when I was in standard five. My uncle's family was very happy to have me back and I was fairly treated but the living conditions were very poor. Sometimes there was not enough food and therefore we had only one meal per day. Although I was accepted at a nearby school I rarely attended classes because my health

deteriorated due to poor nutrition. That led my uncle to make arrangements with the social welfare office for my placement in this care centre.

Poor participation by community members and children in care placement decisions was identified from interviews and FGDs as another challenge that might hinder efforts to promote the family-based care for OVC. A key informant noted:

There is enough evidence that many programmes and projects that had not engaged communities and beneficiaries have not been effective and some collapsed. For example, water programmes which were installed in areas defined as unsuitable by the community members. Stakeholders should ensure that communities and children are fully involved in care arrangements and decisions to offer them an opportunity to express their views. This will help in establishing a strong family-based care for OVC.

A caregiver contributed to the same issue by saying that children in many Tanzanian societies are denied opportunities to decide on matters related to their lives. This is due to the cultural beliefs that children have to respect decisions taken by the elders. He added thus:

The tendency in many Tanzanian communities is that only elders are given an opportunity to decide on matters related to their families. For example in my own culture when a parent dies, relatives conduct a meeting to decide on how to raise the children left behind. Children are informed of the decision about who will provide their care and support but they are not involved in the decision making. Sometimes siblings are separated because they have to live with different relatives.

The study respondents noted that after the death of the parents some children are sent to live with their grandparents in the rural areas without the children's consent. The discussion with OVC also indicated that children do not participate in care arrangements and some fail to continue with their education due to lack of support. One of the OVC added by saying:

My experience is that, after the death of my parents, my two sisters were asked to stay with our aunt and I was sent to stay with our grandparents in the village. I had already completed primary education when this happened while one of my sisters was in secondary school and the other one was in standard six. There was a family meeting which made that decision, but none of us were involved. I decided to run away from home after receiving the information that I had to prepare to go to the village. I stayed at the police station for a couple of days and thereafter I was placed in this care centre.

The respondents also noted that, due to poor participation of community members and children in care arrangements, some children have been forced to live with relatives who were only interested in the wealth left behind by their deceased relatives. One of the community leaders said:

I have been involved in several family matters related to conflicts over the wealth left behind by the deceased parents. This happens when children start questioning the inheritance of the wealth of their parents. In one case, the uncle who took care of the two siblings after the death of their parents attempted to sell the house of the deceased brother. This was detected when those children decided that they wanted to go back to their family home. My office intervened and helped the children to win back their house.

An inadequate social welfare workforce is another challenge that might hinder the effort to promote the family-based care for OVC according to the findings of the study. A social worker explained as follows:

An inadequate number of social workers, probation officers, and counsellors would hinder efforts to promote the family-based care for OVC. Stakeholders should address the shortage of professional social welfare and probation officers to enable effective implementation of policies related to OVC. That would also enhance the assessment, identification, and placement of children in various alternative care systems. Sufficient and qualified social welfare officers will help in conducting thorough studies to establish an effective family-based care for OVC.

A caregiver added that an inadequate social welfare workforce is a contributory factor in the violation of children's rights. This has resulted in insufficient studies on violation of OVC rights to adequate care that would enable establishment of protective programmes. He added:

Promotion of the family-based care has to go hand in hand with protection of children's rights. This would require an adequate number of social welfare officers to monitor and assess services and the nature of care provided to OVC. It is through adequate availability number of social welfare officers that sufficient studies could be conducted to ensure that every individual is responsible in ensuring sustainable child wellbeing.

Participants also noted that inadequate funding of social welfare services would undermine efforts to promote the family-based care for OVC in Dar es Salaam. Participants were of the view that sufficient funding was essential in ensuring that poor families are supported and adequate numbers of social welfare officers are recruited. A social worker had this to say:

Many programmes and projects related to children's welfare have failed due to inadequate funding. To promote family-based care, sufficient funds are needed to ensure that support is provided to poor families, child-headed households, facilitation of reunification and reintegration of the OVC in their families, and establishment of youth programmes in the communities. Adequate funding would help to ensure that monitoring and evaluation of the alternative care systems is carried out continuously to secure the rights of children.

Another concern that was raised by the participants related to the resistance by residential care centres to participate in promotion of the family-based care for OVC. Participants noted that residential care centres are operated as individual projects which have offered employment opportunities to many people. A key informant said:

International and national partners should engage the owners and employees of the residential care centres in issues related to the promotion of family-based care for OVC. This would help to create a sense of respect and recognition for the contribution of residential care centres in supporting children without parental care. It will also prevent resistance from the owners and employees who depend on the residential care centres for their wellbeing to participate in the process.

A community leader observed:

In my experience some people establish residential care centres as individual projects that would benefit their families. For example, people used their retirement money to construct residential care centres and thereafter register them as children's homes. This enabled them to seek funds from different donors for running the care centres. This means that the directors of the centres and other employees receive salaries from the donors, which indicates that the idea of the family-based care for OVC might not be very much welcomed.

Discussion

In chapter six, the researcher examined the potential contribution of the existing child related laws and policies towards the enhancement of alternative care for OVC. The findings revealed that child related laws and policies highly recommend that the care of OVC should be based on a family environment as this has the potential to enhance the welfare of children deprived of the parental care. For this reason the researcher explored the stakeholders' perceptions on promotion of the family-based care for OVC in Dar es Salaam. The discussion that follows covers issues around child care in a family environment, expressing the urgent need for a family -based care model, ways of strengthening the existing alternative care systems, as well as possible obstacles in promotion of the family-based care for OVC in Dar es Salaam.

The study sought to ascertain from participants their views in respect of the family-based care for children without parental care. It was revealed through surveys,

interviews, and FGDs that the family-based care is a framework that offers care and support to OVC in a family environment. From the data, kinship care, foster care, adoption, community-based care, group homes, and supervised child-headed households were identified as alternative care systems which form part of the family-based care for OVC. These findings concur with those by Save the Children (2009) and Family for Every Child (2014) which noted that children without parental care should be placed in a family environment which ensures adequate care and protection of children. According to Save the Children (2014), stakeholders should motivate for the establishment of effective care options such as care by members of the extended family, fostering, and national adoption because such strategy will help to expand opportunities for children in need of parmanent care.

Participants reported that care under supervised child-headed households offered a family environment to children because some of them would continue to live in their family home which move siblings together. However, participants noted that child-headed households in Tanzania lacked supervision which exposed the children to abuse and exploitation. This finding supports those of a previous study by Phillip (2011) which revealed that many children living in child- headed households lacked daily adult care, support, and protection. This implies that children in unsupervised child-headed households were often overwhelmed by care roles which might deny them their right to education, and general development.

Participants were of the view that group homes too offered care to OVC within a family environment because the children in such arrangements are under the care of ‘special mothers’ who play the role of parents. This supports the finding of SOS (2014) which reported that group homes and children’s villages, like SOS, are

part of the family-based care for OVC. According to SOS (2014) in such scenarios was that children are under the care of parents (house-mothers) and they grow up as brothers and sisters.

This study's findings empirically support the view that strenghtening alternative strategies like kiship care, foster care, adoption, community-based care, group homes, and supervised child-headed households would all serve to promote effective care within a familiy environment. This is because children would have access to basic necessities and protection from harm and risk, and siblings would be able to remain together. The findings suggest that, in order for OVC to access appropriate and adequate care, social welfare officers, in collaboration with national and international partners, should establish a framework that would help to strengthen models of care in a family environment.

The findings further revealed that promotion of the family-based care for OVC is a very important measure potentially for addressing children's need for care, love, and protection. This was essentially because the family-based care would ensure adequate care and protection from abuse, violence, and exploitation. Furthermore, the family-based care for OVC would help to establish programmes to prevent family separation as a result of poverty and family conflicts to enable children to stay with their families. The findings further revealed that adopting the family-based care would enable children without parental care to fulfil their dream of adequate care, love, and support.

The findings corroborate those of previous studies which revealed that children are best cared for in a family environment because it is believed that the family unit is the most important source of love and emotional, moral, and material support necessity for a child's wellbeing (Faith to Action Initiative, 2014; the

Guidelines for the Alternative Care of Children, 2009; Commission to Promote Child Welfare, 2012; Save the children, 2012). This view is supported by Delap (2013) who reported that adequate care for children who lack parental care, is based on helping them to grow up in a permanent, safe, and caring family environment. According to Save the Children (2012), family support services are crucial in preventing violence, unnecessary family separation, and child placement in residential care centres.The findings of this study also confirm those findings by Save the Children (2013) which noted that the organisation is committed to preventing family separation and supporting family-based care and protection to achieve its goal of ensuring that no child is placed in harmful residential care and that every child secures placement in a safe family environment.

Previous studies have indicated that many children would prefer to be raised in a loving family home, especially with their own parents (Save the Children, 2007; EveryChild, 2012b; Delap, 2013). Save the Children (2009) however acknowledged the fact that some children might not have families or relatives to raise them which will require a substitute family. The findings of the present study also support the previous findings by the Commission to Promote Sustainable Child Welfare (2012) which noted that separation of children from their families might affect the children psychologically leading to poor performance in school and difficulties in establishing relationships in new placements, school, and community. However, according to Save the Children (2012) and Family for Every Child (2014), biological families efficacy should not be taken for granted because of the evidence which suggests that children around the world have been abused,exploited, and neglected by their biological parents, relatives, and foster, and adoptive parents.

This finding is particularly important as it draws attention to the need to sometimes promote the family-based care that might address the care needs of OVC. The family-based care would ensure availability of permanent placement for children to enhance their protection. This study's findings are vital because they identify initiatives that would prevent family separation as a result of poverty or conflict such as provision of support to poor families and family conflicts resolution. Different programmes to prevent family separation such as reconciliation and counselling should be in place to ensure that children remain with their families. This would help to maintain family relationships and their ability to care for their children. As a result the issue of the poverty cycle would be addressed because children would receive education which might allow them to secure employment for their welbeing and graduate from poverty. Stakeholders should advocate and lobby for the promotion of a family-based care for the wellbeing of OVC. In addition, effective measures should be adjusted to ensure that children who have no biological parents are able to secure placement in a family setting. The findings of the present study suggest that stakeholders should establish a framework for regular monitoring of OVC placed in families to prevent violation of their rights.

The findings of this study suggest that strengthening the capacity of poor families and communities and raising community awareness through advocacy and social mobilisation are some of the strategies that could promote family-based care for OVC. Participants stressed the view to strengthening the existing alternative care systems. They stressed that supporting poor families and communities would enhance their ability to provide care to a large number of children in need of parental care and community awareness raising would prevent violation of children's rights. Another stategy suggested by the findings is enhancement of statutory foster care and adoption

programmes that would provide access to permanent care for a large number of children. Furthermore, protection and support for child-headed households was considered as a strategy which would allow siblings to stay together. The findings were consistent with those of Save the Children (2009), UNCRC (2009), Delap (2013), SOS & CELCIS (2014), and Better Care Network and UNICEF (2015) which reported that supporting poor families and communities would promote the family-based care for OVC. As noted by the Faith to Action Initiative (2009) and Williamson &Greenberg (2010), the first priority in promoting the family-based care for OVC should be to provide social assistance to poor families and communities so that they continue providing care to their children. Howard et al (2006) reported that members of the extended family in rural Zimbabwe were unable to provide care to OVC due to lack of support, hence they called for support. On the other hand, families which were supported with resources to buy food and pay extra school fees managed to take care of unrelated children.

The findings of the current study indicated that social protection strategies would be used to support families and communities through social transfers and social assistance to families caring for children living with disabilities and those living with HIV and AIDS. The point is that adequate financial support may help communities establish vocational training centres for the youth who are no longer in residential care centres. These findings correspond with those of Save the Children (2014), which indicated that promotion of the family-based care requires social protection, cash benefit schemes, counselling, home visits, and referral services. Similarly, Save the Children (2012) noted that financial assistance to families and communities would facilitate economic stability for sustainable child wellbeing.

Participants believed that involvement of the community in providing care and support to OVC would create a sense of belonging. For example, many communities in Tanzania believe that a child belongs to the entire community and that every member of the community ought to be responsible for his/her care and protection. This finding supports those by Save the Children (2009) which suggested that national and international partners should raise community awareness on the importance of family and community-based care for OVC and encourage adults in fostering and adoption programmes. In addition, community members and children should be educated on the theme of children's rights to ensure that they are not violated, and should be enabled to report in case the rights are violated. Faith to Action Initiatives (2009) noted that in some African countries, groups of community members work together to address the needs of OVC. For example: The Diocese of Southern Highlands in Tanzania used trained community volunteers to conduct a house to house survey to identify OVC in their region. The information was then used to mobilise community members including church members, to distribute food, clothing, and other resources to families caring for OVC (Faith to Action Initiative, 2014).

According to Save the Children (2009), awareness raising should also also focus on the potential risks that can be caused by residential care centres. For example, most private donors do not seem to be aware of the risks associated with residential care and they do not seem to appreciate that resources they allocate to a residential care centres would support a large number of children in a family setting (Save the Children, 2009a). EveryChild (2011a) noted that in Kenya and Tanzania church based organisations were donating considerable amount of money to residential care centres. In addition, Faith to Action Initiative (2014) reported that some parents and community members in Malawi had the impression that residential

care centres were more beneficial to children because of fulfilment of basic and education needs.

Participants noted that, by improving statutory foster care, adoption recruitment, and placement processes through time and cost reduction, many families would be motivated to submit their applications for adoption. This finding confirms those of studies by EveryChild (2013) and Family for Every Child (2014) which indicated that domestic adoption is not adequately supported in many parts of the world, and there are no effective programmes for recruiting appropriate families for children who are in need of care. EveryChild (2010) revealed that, in Africa, there is a dearth of evaluated and well documented standards of good practice that could be extended. According to EveryChild (2010), some forms of 'Kafala' (in Islamic Law) could be used to offer permanent care to children without parental care. However, in some Islamic countries, 'Kafala' is restricted to children of unknown families,whereas children whose families were known tended to be placed in residential care centres (EveryChild, 2010).

The present study revealed that protection and supervision of child-headed households would be essential for promoting family-based care for OVC. Supervision of child-headed households through the support of an adult mentor would help to ensure that children obtained access to food, clothing, health, and education services. The UN (2009), Phillips (2011), and Kijo-Bisimba (2011), all noted that not all children in need of care will be reintegrated into their families and communities or absorbed by foster care and adoption. Some children, according to these findings, choose to live together in their family home after the death of parents, and some are mature youth who cannot secure foster care and adoption placements. The UN Guidelines for the Alternative Care of Children (2009) acknowledge the existence of

supervised child-headed households which can be used to provide permanent care for OVC. The UNCRC (2009) requires child-headed households to be provided with necessary legal, economic, and social protection. Unfortunately, children living in child-headed households freequently suffer from inadequate care, protection, and basic necessities (Phillips, 2011). Findings by Meintjes, Hall, Marera, Double-Hugh & Boulle (2010) indicated that the living conditions of children in child-headed households in sub-Saharan Africa, had been found to be undesirable as compared to those of other forms of households. For example, many such children had no access to proper shelter, adequate water, sanitation, or electricity (Meintjes et al., 2010). The findings by Phillips (2011) revealed that an estimated 80% of girls in child-headed households had been sexually abused while striving for a livelihood to suppport their households.

The findings of this study contribute to the existing knowledge base by reinforcing the need for social welfare officers to implement ecological systems theory in addressing the issue of OVC care, love, and protection. For the interventions to be effective, they should be directed towards addressing problems which are affecting children directly at the levels of the family, community, and society as a whole. Previous studies by Bertalanffy (1962) and Greene (2008), indicated that changes in one part of the system result in changes in the other parts of the system. For example, changes that occur after the death of parents would affect children in relation to their care, protection, education, and medical needs.The implication is that social welfare officers should establish programmes to support poor families and communities in order to help them manage care of their children. The findings also urge stakeholders to establish a holistic approach in mobilising resources from the communities to promote a family-based care for OVC. This will require social

welfare organs to engage communities in all issues related to OVC care, love, and protection in order to facilitate mobilisation of resources. As noted in systems theory, the extent to which systems attain their goals is determined by their resource capacity (UNICEF, 2009b). The implication is that interventions should involve establishment of programmes, projects, and utilisation of available resources from communities to promote family-based care for OVC in Dar es Salaam. These findings call for effective initiatives for strengthening existing alternative care systems that offer permanent care to OVC.

The study sought to establish from the research participants challenges that might hinder promotion of the family-based model for OVC in Dar es Salaam. One of the challenges identified by respondents/participants was inadequate preventive masures to ensure that children are not separated from their families. For example, lack of psychological support to address children's behavioural problems related to traumatic situations and ineffective programmes to prevent abuse of children related to alcohol and drug abuse. However, those studies of Delap (2013) and Family for Every Child (2014) admonished that the family-based care should not be treated as a one which is free from problems. Some children placed in substitute families have been treated differently from birth children in the same household. This is confirmed by MoHSW (2012) findings which revealed that many children in need of care in Tanzania had suffered abuse and exploitation within and outside family environments. Adequate initiatives should therefore be taken to strengthen the economic power of poor families and communities (Save the Children, 2009b; PEPFAR, 2012) and to empower them to provide basic necessities to their children to prevent separation. As noted by the Faith to Action Initiative (2014), deficiency of interventions to strengthen care of the children within the family environment might prompt escalation

of residential care centres. This, according to the findings, would drag more children from their families and communities.

Another challenge identified by the study was poor participation of community members and children in care placement decisions. The UN (2009) advocated for communication with the families and children in deciding whether alternative care is essential. According to Better Care Network and UNICEF (2015) participation of children and community members in decision making is essential for promoting gatekeeping which is " a recognised and systematic system procedure" (Cautwell, Davidson, Elsley, Milligan, & Quinn, 2012, p. 22), to ensure that children are only placed in alternative care when necessary and that children get access to the basic necessities for their welbeing. The findings from the NCPA (2012-2017) revealed that active participation of community members through social mobilisation and advocacy is crucial for the success of scaling-up MVC responses.

Inadequate funding of social welfare services was also noted by the findings of this study to be a challenge that might hinder efforts to promote the family-based care for OVC in Dar es Salaam. These findings correspond with those of Better Care Network and UNICEF (2015) which bemoaned the fact that donors and governments were allocating funds to residential care centres instead of supporting poor families. The reason for this, according to Better Care Network and UNICEF (2015) was the misconception held by donors and service providers that residential care centres were most useful in addressing child care needs, rights, and protection. According to Better Care Network and UNICEF (2015) inadequate investment in gatekeeping systems had contributed to a lack of sufficient and adequately trained manpower in many countries to address critical social problems. Further, professionals related to gatekeeping such as health workers, psychologists, teachers, and community workers lack the skills and

knowledge required for identification, assessment, and effectively responding to children's needs.

Save the Children (2009) and Williamson and Greenberg (2010) acknowledged that the initial expense in establishing a successful support system for families and communities might be challenging to many governments. Various expenses would be involved for recruitment, training, and monitoring of the workforce to support families and communities. They however note that the expenses would be minimised by the fact that caring for children in a family environment could help them grow into independent adults and contribute to the development of their communities. In addition, it has been revealed that the cost of supporting a child in a residential care setting is higher than in other types of care such as foster care and community-based care (Williamson & Greenberg, 2010). As indicated in previous chapters of this study, the annual cost of supporting one child in a residential care centre in Kagera region of Tanzania was put at more than USD $1000 in 1997, which was six times the cost of supporting a child in foster care (Wold Bank, 1997). The findings of the present study therefore call for stakeholders to advocate for the deinstitutionalisation and allocation of sufficient resources to promote the family-based care for OVC.

Furthermore, the findings of the current study have revealed that resistance from residential care centres to participate might hinder efforts to promote a family-based care for OVC in Dar es Salaam. These findings correspond with those of a previous study by Save the Children (2009) which indicated that institutionalisation of children had been treated as a business in some coutries. It was established that residential care centres had provided employment opportunities for a large number of people who depended on this care system for their survival. This finding is also

confirmed by EveryChild (2011a) and Faith Action Initiative (2014) which revealed that although international and national policies require all states parties to eliminated large residential care centres (deinstitutionalisation), the numbers of residential care centres and children placed in those centres was actually increasing. Faith to Action Initiative (2014) and Better Care Network and UNICEF (2015) revealed that in some countries the employees of residential care centres, teachers, and religious leaders had encouraged poor families and parents to place their children in these centres.

This study's findings therefore contribute to the literature by featuring inadequate measures to prevent separation of children from their families as one of the obstacles in promoting family-based care for OVC in Dar es Salaam. This suggests that inadequate psychologial support to address traumatic problems among the OVC might force chidren to run away from their families. In addition, effective programmes to prevent abuse and violence from parents might prevent separation of children from their families hence avoid placement in and the need for residential care centres. In addition, the findings contribute to the knowledge base by emphasising that poor participation of community members and children in care placement decisions may result in placement of children with inappropriate families. This might contribute to child exploitation and denial of children's rights to inherit property left behind by their deceased parents or denied of access to education.The findings further identified that inadequate social welfare workforce and funding of social services as barriers to promotion of the family-based care for OVC. The findings also raise concern with over apparent resistance to the promotion of the family-based care for OVC by residential care centres. Apparently reason for this is that many private residential care centres are established as sources of income for the owners, their families, and their employees. This study's findings urge social welfare officers, in

collaborration with national and international partners to educate to donors and request them to direct their attention towards promoting the family-based care for OVC rather than institutionalization. In addition, stakeholders should seek the participation of the owners and employees of residential care centres in promoting the family-based care for OVC in order to utilise their potential in establishing best practices.

Chapter Summary

In this chapter, the researcher explored participants' perceptions regarding promotion of the family-based care for OVC in Dar es Salaam. The participants confirmed that the family-based care included, care by kinship/members of the extended family, foster care, child adoption, community-based-care, group homes, and supervised child-headed households. Participants perceived promotion of the family-based care for OVC as a relevant approach for addressing OVC care, love, and protection.They noted that the family-based care would ensure permanent placement for children without parental care which in turn would help to prevent their abuse and exploitation. Participants also indicated that the family-based care for OVC could help develop a programme to prevent family separation,through enabling children to grow up within their families. This, according to participants, would allow children to fulfil their dreams through access to adequate care, love, and protection.

The findings identified several strategies that could be used to promote the family-based care for OVC, such as strengthening the capacity of families and communities through material, financial, counselling, and psychosocial support. Social protection strategies, such as social transfer and social assistance, as crucial in offering poor families and communities economic stability to facilitate the care of their children. Communities could establish vocational training centres to

accommodate older children and youth who would have graduated from residential care centres to acquire skills that would prepare them for independent living. Other strategies highlighted included community awareness raising through advocacy and social mobilisation; improvement of formal foster care and adoption programmes to attract more families; and provision of support and supervision to child-headed households.

The findings further, revealed that inadequate prevention initiatives, poor participation of children and community members in care placement decisions, and limited resources as well as resistance from the residential care centres were some of the obstacles that might hinder efforts to promote the family-based care for OVC in Dar es Salaam. Participants felt this calls for all stakeholders to work together in establishing effective gatekeeping procedures to ensure that childrens' needs are addressed fully in the quest for their sustainable wellbeing. The next chapter presents the summary of the findings, conclution and recommendations.

CHAPTER NINE-SUMMARY, CONCLUSION, AND RECOMMENDATIONS

This chapter summarises the study by recapping the key findings, conclusion, implications for social work policy, practice, and the recommendations in light of the study findings. The key findings are presented in accordance with the objectives of the study.

Summary of the Study

This thesis examined the existing alternative care systems for OVC in an effort to explore ways to strengthen them in order to promote the family-based care for OVC in Dar es Salaam. These care systems were examined in terms of their nature, situation of the OVC in those care systems, and potential contribution of child related laws and policies to their enhancement. In addition, the care systems were examined based on stakeholders' perceptions on promotion of family-based care for OVC.

The study employed a concurrent mixed methods approach. The quantitative phase of the study was based on a survey which was conducted in 20 residential care centres involving 80 representatives. Qualitative phase of the study, included 10 in-depth interviews with the key informants and community leaders; and 10 focus group discussions with OVC, social workers, and care givers. A review of policy documents, reports, research papers, and articles provided secondary data to maintain validity and reliability of data.

Major Findings of the Study

Using the research methods identified above, the study answered the four major reseach questions reflected in a brief summary of the findings in the sub-sections that follow.

Nature of alternative care systems for OVC.

The findings of this study indicate that Tanzanians have different understandings of orphanhood. From a cultural perspective an orphan is defined as a child who has lost one or both parents due to death, whereas the Islamic faith defines an orphan as a child whose father is dead. The findings revealed some disagreement in defining the term vulnerable children. For example, on one hand interviews and FGDs identified vulnerable children as orphans, street children, children living with disabilities, children living in residential care centres, abused children, and children living with very sick parents. On the other hand, data from the survey indicated that some residential care systems did not include children living on the streets, homeless children, and abused children or those living with very sick parents, and those living with disabilities as vulnerable children in their definition of OVC.

The study also found that kinship care is a system which provides care and support to a large number of OVC than other care systems. The study further acknowledged that the existing alternative care systems had played a significant role in providing food, shelter, clothing, education, health care , and psychosocial support to OVC, although the quality of services relied on the availability of resources. Poor families and some residential care centres routinely provided poor services to OVC apparently because of inadequate resources. For example, some poor families could not afford a balanced diet, bedding, mattresses, education, and health services for the OVC. In addition, the findings showed that social workers had played an important role in implementing care arrangements for OVC. However, these professionals had failed to adequately address these children's needs essentially due to inadequate resources from the government and the donor county.

The situation of OVC in alternative care systems.

The situation of OVC under the care of various alternative care systems was shown by the findings to be either fair or good or very good, basing on accessibility to provision of basic and social needs. The situation of children placed in group and adoptive homes, for example, was viewed by respondents as being very good because in theory they were expected to have adequate access to food, clothing, shelter, education, and health care. On the other hand, some of the respondents noted that the situation of children in kinship, residential, foster, and community care, and supervised child-headed households was fair because ideally such children had reasonable access to resources to address their basic needs. In addition, the situation of children in kinship, foster, and residential care systems was reported to be poor. It was indicated that children in those care systems ordinarily could not access a balanced diet, education, and health care services and might be living in poor shelters.

HIV and AIDS was identified as a key factor that contributed to placement of OVC in alternative care. Other contributing factors included poverty, family conflict, child neglect, teenage pregnancies, and conflict with the law. Poverty, age, sex, religion, discrimination and stigmatisation, and length and costs involved in statutory foster care and adoption procedures tended to hinder OVC from accessing alternative care. Evidence was adduced the fact that treatment of OVC in various existing alternative care systems had tended to be poor due to abuse, violence, and exploitation.

Potential contribution of child related laws and policies.

The findings revealed that, although stakeholders possessed adequate knowledge of child related laws and policies, they could not effectively implement the alternative care for OVC because of limited resources due to inadequate government

support. And yet, as stipulated in the existing child related laws and policy, every child in Tanzania has the right to alternative care as stipulated in the existing child related laws and policies. The question raised by these findings is why, is it that historically the child's right to alternative care has not been recognized in Tanzania?

According to the findings of the study, stakeholders were found to have high expectations regarding effective implementation of child related laws and policies. They believe that effective implementation of child related laws and policies would facilitate the establishment of national guidelines for alternative care of children. In addition, the research found that some challenges which hinder effective implenetation of child related laws and policies such as poor coordination, limited community knowledge, limited resources, and language barrier.

Promotion of family-based care for OVC.

Family-based care is understood to be the care that is instituted in a family environment. Care systems include kinship, statutory foster care, adoption, community-based care, group homes, and supervised child-headed households. Stakeholders perceived promotion of the family-based care as an important strategy for providing social, physical, pschological, and economic support to children without parental care. The findings further highlighted that the family-based care should be promoted on the platforms of advocacy and social mobilization, support for poor families and communities, raising of community awaireness on children's rights, improvement of statutory foster care and adoption programmes, and provision of adequate support to child-headed households.

A number of challenges that might hinder promotion of a family-based care were noted and these include inadequate measures to restrain children from separating from their families. Failure to support poor families and communities to develop

income generating activites to adequately support children had identified as having contributed to children being separated from their families. Poor participation of community members and children in decision making had also been identified as a challenge which had forced children into inadequate care situations. For instance, some orphaned children were placed with relatives who were only interested in the wealth left by their parents. Inadequate social welfare workforce and funding of social welfare services had also hindered efforts to promote the family-based care for OVC. In addition, resistance from residential care centres to participate in promotion of a family- based care model for OVC in Dar es Salaam was identified as another challenge. Apparently many people employed by the residential care system might perceived the family-based care for OVC as a threat to their jobs.

Study conclusion.

This study has examined the existing alternative care systems for OVC in an effort to explore methods of strengthening them and thereby promoting the family-based care for OVC in Dar es Salaam. The findings conclude that exisisting alternative care systems such as kinship, foster care, adoption, community-based care, residential care, group homes, and child-headed households have not adequately addressed the need for OVC care, love, and protection. Kinship care in an extended family situation is the most common alternative care system in Dar es Salaam. Unfortunately, this care system has been overwhelmed due to financial constraints and an unprecedented increase in the number of OVC largely due to HIV and AIDS. Lack of material, human, and financial resources has undermined the strengthening of community-based care and efforts to adequately support and supervise child-headed households. Social workers have played an important role in ensuring OVC the right to alternative care, security, and protection. However, the work of social workers is

hindered by factor like limited social welfare workforce, inadequate government funding, and a scarcity of material resources, and these challenges have undermined their effectiveness.

The findings show that the situation of OVC in various alternative care systems is fairly good essentially because most of the children have access to basic necessities, education, health care services, and spiritual, and psychosocial support. However, the welfare situation of children living with poor families, unsupervised child-headed households, and some reidential care centres was reported to be poor, mostly due to inadequate protection from abuse, stigmatization, and discrimination, violence, and exploitation. The findings revealed that HIV and AIDS, poverty, family conflics, child negligence, teenage pregnancy and conflict with the law were revealed as some reasons for OVC placement in alternative care. Age, sex, religion, poverty, and discrimination and stigmatization due to HIV and AIDS were identified as barriers which hindered OVC access to alternative care.The findings revealed that OVC had faced ill-treatment from parents, relatives, staff at residential care centres, and some community members. There was thus a call for stakeholders to join hands to address problems facing OVC within and beyond alternative care system to enable them to access justice and their basic human rights.

Previous studies that examined alternative care for children in Tanzania did not consider child related laws and policies. This study filled this knowledge gap by examining the contribution of such laws and policies to determine the extent to which they enhanced alternative care for OVC in Dar es Salaam. It emerged that while Tanzania had adopted various child related laws and policies for the purpose of enhancing the wellbeing of children, the implementation part had not been that effective largely due to inadequate and neglected regulations on issues related to care

and protection of OVC. There was conscensus that effective implementation of child related laws and policies would facilitate the development of national guidelines for the alternative care of children. Furthermore, effective implementation would help promote awareness among community members in relation to children's rights. In addition, it would facilitate the establishment of the legal status of informal care systems and also ensure that children have access to justice. Challenges associated with implementation of child related laws and policies such as a poorly coordinated framework, limited community knowledge in relation to issues around children's rights, limited resources, and language barriers should be addressed if the goal of the family-based care for OVC is to be realised.

Finally the findings also conclude that promotion of the family-based care for OVC would be very relevant because the model would offer permanent placement to OVC. The findings identified a number of strategies for promotion of the family-based care for OVC, including the capacity of families and communities and raising community awareness through advocacy and social mobilization. Strenghthening of foster care and adoption programmes, and protection and support for child-headed households were other strategies identified by the findings. It was further noted the national and international partners should address challenges that might hinder promotion of the family-based care for OVC. The challenges that need attention include inadequate preventive measures to keep children with their families, poor participation of community members and children in care placement decisions, limited resources, and resistance from residential care centres to participate in efforts to promote the family-based care for OVC.

Implications for Social Policy

Research is considered to be an effective mechanism for informing policy advocacy. In social work profession, research is believed to enhance understanding of the social phenomenon that calls for policy change (Rubin & Babbie, 2008). Tanzania has recognised the problems facing OVC as the key priority in its policy and strategic planning. In developing the policy and strategic documents the framework of sustainable socio-economic development has been used with emphasis given to poverty reduction (REPOA, 2007).

Policy discussion helps to highlight the limitations of the existing policy options and suggests for policy alternatives to address the problems facing vulnerable groups in the Tanzanian society. Thus, the findings of this study on strengthening the existing alternative care sor OVC, could be used to initiate a policy debate among the national and international partners wupporting OVC. In addition, the findings of this study can also inform the policy makers of the importance of family-based care for OVC in policy formulation and in developing a strategic plan of the country.

Against this background, the findings of this study can be used to advocates for government and national and international partners to design and develop a national guideline for alternative care for children as envisioned in the CRC. It is the conviction of this study that programmes that target OVC will cover permanent care for every child who is deprived of parental care.

Inadequate care is one of the factors which have contributed to abuse, violence, discrimination, stigmatization, and exploitation of children (UNICEF, 2012). The Law of the Child Act (2009) contends that every child should be raised in a family environment for their sustainable wellbeing. The policy however ought to be reviewed to incorporate the nature of the support that government will provide to poor

families and communities to ensure that every family is responsible for providing appropriate care for its children.

Furthermore, in the developmental social welfare approach, the findings of this study help policy makers to incorporate the existing alternative care systems' views in addressing the issues of OVC. Although the country has inadequate social welfare structure provisions that specifically benefit OVC, there are some social services which had been designed to support OVC and they are provided through the efforts of the national and international partners in Tanzania. This calls for a deliberate effort by the government to establish specific policies that clearly defines OVC benefits or services to be delivered, eligibility, organizational structure for service delivery, and funding strategies.

Implications for Social Work Practice

The findings of this study have significant practice implications for several matters related to children such as enhancing child welfare and protection, strengthening support to the family and community, promoting permanent alternative care for OVC, promoting vocational training programmes, and developing community awareness programmes. Inadequate and inappropriate alternative care for OVC is an indication of poor enforcement of national laws and policies. There is therefore urgent need to address OVC care and protection issues, and the role of social work in Tanzania is critical in this regard.

Enhancing Child Welfare and Protection

Some of the major roles of social work include to promote, support, and protect the wellbeing of every child. Unfortunately, child welfare and protection services in Tanzania are not sufficiently effective which has hindered many children from accessing adequate care. There is legislation and a considerable number of

institutions that are meant to protect children and their right to alternative care in Tanzania. These include the Law of the Child Act (2009); the Child Development Policy (2008); the National Guidelines for Improving Quality of Care, Support and Protetion for Most Vulnerable Children (2009); the National Costed Plan of Action (2012-2017); and the National Policy on HIV and AIDS to name a few. The ministries responsible for children's issues include the Ministry of Health, Community Development, Elderly, and Children, the Ministry of Consitutional and Legal Affairs, and the Ministry of Finance and Economic Affairs. However, these institutions have failed to adequately implement legislation meant to address the needs of children deprived of parental care. For example, legislation has not been effectively translated into programmes and projects that could ensure adequate care and protection for children. This has partly been a function of inadequate government funding of the social welfare services.

In addition, different institutions have overlapping and duplicated mandate. For example, the Child Development Policy (2008) noted that the main function of the Directorate of Community Development is to educate and raise awareness of the community on the rights of the child in Tanzania (URT, 2008). On the one hand, technical aspects of the implementation of child protection policies, legislation, regulations, and various frameworks are the remit of the Department of Social Welfare which is under the Ministry of Health. This calls for the Department to collaborate with the Directorate of Community Development to ensure that children's need for care and protection are addressed in the quest for their wellbeing.

As indicated in the Child Development Policy (2008) the Department of Social Welfare is responsible for ensuring that the basic rights of children are met (URT, 2008). However, government social welfare schemes as well as those of

NGOs, CBOs, and FBOs provide services to OVC but generally do not collaborate to prevent overlapping and duplication of services. This might have contributed to inefficiency and ineffectiveness of services provided to OVC. Child welfare and protection in Tanzania would be greatly enhanced if all stakeholders collaborated in establishing a framework that would ensure OVC's need for care, love, and protection are met. Issues of abuse, violence, and exploitation of children could be prevented by ensuring that every child has access to adequate and appropriate care.

Strengthening Support for Families and Communities

African families and communities remain vital in the social, physical, psycological, spiritual, cultural, and economic development of children. Interventions should be established to target needy families and communities for the purpose of helping them raise their children in a positive manner. This will help reduce the number of children living on the streetss, in residential care centres, and unsupervised child-headed households. To achieve this, social workers have to collaborate with national and international partners in efforts to advocate for and raise community awarenesss of OVC and their right to care, love, and protection, in the care of appropriately supported families and communities. Stakeholders need to establish programmes that would provide this support in the form of material, human, and financial resources. For example, social welfare officers would be required to provide psychosocial support to children, families, and community members to help them cope with the loss of their relatives due to HIV and AIDS and related factors. Social welfare officers have to establish programmes for enhancement of parental care skills to enable foster and adoptive parents to positively manage challenges they face. The Government of Tanzania has to provide adequate funding to the Department of Social Welfare so that it can establish and support programmes that would promote such care

and protection of children. In addition, poor families and communities need to be supported to engage in income generating activities for their sustainable welbeing.

Promoting Permanent Alternative Care for OVC

One of the critical areas which was identified in this study related to difficulties faced by OVC in accessing permanent alternative care in a family environment. Although in Tanzania existing alternative care systems like kinship, statutory foster care, adoption, community-based care, group homes, and child-headed households offer permanent care to children, they are not adequate. This is evidenced by the large number of children who are placed in residential care centres, living on the streets, and in unsupervised child-headed households. The existing alternative care systems need to be strengthened to enable every child to access permanent care for the enhancement of his/her wellbeing. Clearly OVC ought to be targeted for sustainable care and protection in their best interests. Alternative care within a positive family environment guarantees children fulfilment of their basic needs, education, health care services, and protection. This would, in turn enable older children to secure employnment opportunities to manage their future. Since much of the abuse, violence, and exploitation of OVC is linked to their inadequate care and protection, priority should be given to strengthening the existing alternative care systems through promoting the family-based care for OVC.

Promoting Vocational Training Centres

To ensure adequate care and protection of children who lack appropriate care, national and international partners have to develop sustainable programmes that would create employment opportunities for the youth. From the data, many OVC have acquired primary and secondary education, and some secure employment in the public and private sector. Some children who had spent a long time on the streetss, and those

living in poor families and child-headed households often did not receive adequate education that would enable them to secure satisfactory employment. It is common course that in Tanzania it is policy to remove children from residential care when they reach the age of 17 years. Some of those children might not be prepared for the future due to low level of education. These children need not only a safe and stable place in which to live but also social and life skills which are important for their sustainable wellbeing. With respect to implementation for social work practice, this study advocates for the establishment of vocational training centres that would train OVC in various skills such as carpentry, driving, catering, welding, tailoring, farming, and gardening. Such skills would enable many young people to secure employment in the public or private sectors, with some youths being able to establish their own businesses and even offer employment to others. The role of social workers will be to identification and assessment of youth from the communities, counselling services and education on health related issues, and supervision and assessment of the projects. Monitoring and evaluation of the vocational training centres would be necessary to ensure that only youths who meet the criteria benefit from the training to ensure maximisation of resources.

Development of Community Awareness Programmes

In Tanzania, some families and relatives place children their own in residential care centres for the purpose of having access to basic necessities, education, and medical services. Some families have also allowed their children to engage in dangerous jobs like commercial sex work and drug trafficking for the purpose of earning an income to support their relatives. Stakeholders need to raise awareness in the communities regarding children’s rigthts to care and protection, provide economic and psychological support to needy families and communities, and educate them on

the negative impacts of residential care to children. The programmes would also play a significant role in linking disadvantaged families and communities with relevant institutions to enable them to secure financial support for income generating activities in order to effectively manage the care of their children.

Recommendations of the Study

Provision of adequate care and protection for children reguires appropriate measures from various stakeholders. Objective 5 of the study sought to focus on this. On the basis of the findings of this study recommendations are made for the attention of policy makers, the government, national, and international partners providing support to OVC, the communit, and future researchers interested in the field of alternative care for OVC in Tanzania and elsewhere.

Recommendations for Policy Makers

Policy makers play significant role in planning and developing policies which affect the living conditions of the entire society. The policies targeted to vulnerable groups like the OVC are meant to promote their welbeing. With the current debate on inadequate alternative care for children deprived of the parental care, this stuy recommends the following:

i. *Development of the national guidelines for alternative care of children.*

There is urgent need for a social welfare policy to address support for children who lack responsible parental care. There is also a need to establish a strategy to promote family-based care of children in Tanzania following the implementation of the National Costed Plan of Action. This would help to fullfil the fundamental right of children to grow up in a loving and protected environment, for their wellbeing. Against this background, this study calls on government and national and international partners to design and develop national guidelines for alternative care for

children as envisioned in the CRC. It is the conviction of author that programmes that target OVC should cover permanent care for every child who is deprived of parental care.

ii. *Targeting OVC.*

Legislative documents such as such as the Development Policy (2008), the Law of the Child Act (2009), and other similar legislation have often appreciated the effective implementation of various policies and programmes by different private and public institutions. Unfortunately, these policies and programmes have not been adequately targeted vulnerable groups particularlt the OVC. For example, the health policy in Tanzania states that vulnerable children should receive free treatment but the question that remains unanswered is how to reach children deprived of parental care. Many children who are living on the streets or in unsupervised child-headed households might fail to access free health care services because they are not documented in the health system.There is probably need for a specific authority overseeing child welfare issues from which policies, programmes, and services can then be established.

iii. *Deinstitutionalization strategy.*

Policy makers should consider effective implementation of deinstitutionalization strategy to enhance reduction of big residential care centres and promote effective facilities for children in need of care. The residential care centres have been associated with physical and psychological problems of children accommodated therein due to abuse, violence, and exploitation (Wiliamson & Greenberg, 2010). Policies have to be enforced as envisioned by the oficial Children's Policy (2008), to ensure that every child secures care within a positive family type environment.

Recommendations for the Government

i. *Adoption of a holistic approach.*

It is recommended that Ministy of Health and Social Welfare, (which has been changed into the Ministry of Health, Community Development, Gender, Elderly and Children) (MoHCDGEC), MoHCDGEC should adopt a holistic approach to addressing alternative care for OVC in order to ensure adequate care, love, and protection of every child. Attention should be directed at children without parental care as well as children living with chronically ill parents.

ii. Training programmes for the youth.

The Ministry, in collaboration with the Youth Council of Tanzania, should embark on a programme aimed at training teenagers in order to equip them with sustainable self-employment skills.

iii. Adequate care and support to OVC

The Government of Tanzania has to support promotion of social welfare services to ensure that OVC have access to basic needs, education, and health care services. Most importantly, the Government of Tanzania, through the MoHCDGEC, has to consider inadequate alternative care for OVC a developmental indicator. Accepting this would require the design of a national plan of action to holistically address the problem. There shoud be policies and programmes which focus on targeting children without parental care, poor families, and communities. This is because children are best brought up within families, and therefore developing a two generation approach should not be optional but rather mandatory.

iv. Adequate support to social workers

Social work as a profession in Tanzania should be adequately supported by the government, to enable the Department of Social Welfare to develop sustainable programmes for alternative care of children. Legislation regarding child welfare and protection issues should be coherent and available to all authorities.

Recommendations to National and International Partners

i. *Awareness raising.*

It is recommended that the Department of Social Welfare should liaise with national and international partners to develop special programmes to educate children and community members on children's rights. This would help young people to understand when their rights are being violated and how that they be observed.

ii. *Child help desk services.*

It is also recommendad that social workers, counsellors, and police officers should promote 'child desk services' to target OVC within communities and adequately serve them.

iii. *Focus on adrressing poverty.*

It is further recommended that the social protection system develop a programme to target OVC and families living in poverty. Support for income generating activities in particular would be essential for the sustainable development of this group.

Recommendations for Future Research

The findings of this study provide direction for research relating to children without parental care in Tanzania and beyond. It should be understood that children voices are very vital in promoting child right to permanent care in a family environment. Unfortunately, this study involved only children placed in residential care centres in Dar es Salaam due to limited time. Areas for future research would therefore include: a comparative study of children in statutory foster care and those placed in residential care centres regarding their lived experiences, coping strategies, and factors that promote resilience. A research can also be conducted on poor families providing care to children without parental care with regard to major risks, future challenges, and policy recommendations.

References

Abebe, T., & Aase, A. (2007). Children, AIDS and the politics of orphan care in Ethiopia: The extended family revisited. *Social Science and Medicine 5*, 1058-2069.

Abebe, T. (2009). *Orphan hood, poverty and the care dilemma: Review of global policy trends.* Norwegian Centre for Child Research, Trondheim, Norway.

ACPF (African Child Policy Forum). (2012). The *new frontier for inter-country*. Addis Ababa: The African child Policy forum.

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46, 331-341*.

Ainsworth, M., Blehar, M., Waters, M., & Wall, S. (1978). Patterns of attachment: Assessed in the strange situation and at home. Hillsdale, NJ: Lawrence Erlbaum.

African Union. (1999). African Charter on the Rights and Welfare of the Child.

African Committee of Experts on the Rights and Welfare of the Child (ACERWC). (2010). Concluding recommendations on Tanzania report on status of implementation of the African Charter on the Rights and Welfare of the Child.

Alan, W.E. (2014). *Outdoor adventure education: Foundation, theory and research*. Indiana University.

Alderson, P., &Morrow, V. (2011). *The ethics of research with children and young people. A practical handbook*. London: SAGE Publications ISBN10: 9780857021373.

Andersson, G. (1999). Children in permanent foster care in Sweden, *Child and Family Social Work, Vol.4*. 175-186.

Averting HIV and AIDS. (2016). HIV and AIDS in sub Saharan Africa-regional review. UK.

Babbie, E. (2013). *The Practice of Social Research* (13th Ed).Wadsworth, Cengage Learning.

Baker, L.H. (2006). *Observation: a complex research method.*Board of Trustee, University of Illinois.

Barber, J & Delfabbro, P. (2005). Children's adjustment to long-term foster care. *Children and Youth Services Review, 27, 329-340*. New York NY: Springer

Bennett, V., Frank, G., Kovina, A., & Eres.T (2006). Inheritance law in Uganda: the plight of widows and children. *7 Georgetown of Gender and Law 451*.

Bernard, H. R. (1988). *Research methods in cultural anthropology*. Newbury Park, California: SAGE.

Bernard, H. R. (1995). *Research methods in anthropology*. Thousand Oaks, CA: SAGE.

Bertalanffy, L. Von. (1962). *General system theory - A critical review*. General Systems (Yearbook of the Society for General Systems Research) *7,* 1-20.

Better Care Network & UNICEF. (2015). *Making decisions for better care of children: the role of gatekeeping in strengthening family-based care and reforming alternative care systems.* New York.

Better Care Network. (2009). *Manual for the measurement of indicators for children in formal care*, New York, Better Care Network.

Bhattacherjee, A. (2012). *Social science research: Principles, methods and practices.* University of South Florida. USA.

Biehal, N., Cusworth, L., Wade, J., & Clarke, S. (2014). *Keeping children safe: allegations concerning the abuse or neglect of children in care.* University of York.

Bilson, A., & Westwood, J. (2013). *Doing social work in resource constrained settings: A review of the literature on social work with children without parental care.*University of Central Lancashire, UK.

Bilson A. (2010). *The development of gate-keeping functions in Central and Eastern Europe and the CIS: Lessons from Bulgaria, Kazakhstan and Ukraine,* UNICEF CEE/CIS, Geneva.

Borg, W.R & Gall, M.D. (1989). Educational research: an introduction. (5th Ed.) White Plains, NY: Longman.

Botswana Institute for Development Policy Analysis. (2013). *Botswana social protection assessment.* Botswana.

Bowlby, J. (1969/1982). *Attachment and loss: Volume 1, Attachment*. London: Hogarth Press.

Bowlby, J. (1988). *A Secure base: Clinical applications of attachment theory*, London: Routledge.

Bowlby, J. (1951). *Maternal care and mental health. World Health Organisation Monograph* (Serial No. 2).

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology (1992), 28,* 759-775.

Bretherton, I. (1991). Pouring new wine into old bottles: The social self as internal working model. In M. R. Gunnar and L. A. Sroufe (Eds.), *Self-processes and development: The Minnesota symposia on child development (*Vol. 23, p: 1 -41*).* Hillsdale, NJ: Erlbaum.

Brink, H. (2008). *Fundamentals of research methodology for Health Care Professionals.* (2nd Ed.), Juta & Co. (Pty) Ltd, Cape Town, South Africa.

Britich Columbia. (2011). *Residential review project phase one: Findings report.*Ministry of Children and Family Development.Canada.

British Psychological Society. (2010). *Code of human ethics.* Published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

Bronfenbrenner, U. (1986). *Ecology of the family as a context for human development: Research perspectives.* Developmental Psychology, 22(6), 723-742.

Bronfenbrenner, U. & Morris, P. A. (1998). The ecology of developmental processes. In W.

Damon & R. M. Lerner (Eds.), Handbook of child psychology, Vol. 1: *Theoretical models of human development* (5th ed., pp. 993-1023). New York: John Wiley and Sons, Inc.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Brydon, K. (2004). Barriers to permanency planning: what the literature suggests. *Children Australia, 29* (3), 16-21. Australia.

Bryman, A. (2006). *"*Integrating quantitative and qualitative Research: How is it done?" *Qualitative Inquiry 6 (1): 97–113.*

Bulmer, M. (2004). Questionnaires, 1st edition, SAGE Benchmarks in *Social Science Research Methods,* edited by: Bulmer, M., SAGE Publications, London, p. 354.

Burns, N., & Grove, S.K. (2003). *Understanding nursing research* (3rd Ed.). Philadelphia, W.B. Saunders Company.

CAFO (Christian Alliance for Orphans). (2015). *Replicable models for transitioning to family-based care*. Whittier Avenue, USA.

CAFO (Christian Alliance for Orphans). (2012). *Christian alliance for orphans on understanding orphan statistics.* White Paper.

Campbell-Hinda, S., Maroni, M., Odongo, S., & Palermo, T. (2010). Assessing the "orphan effect" in determining development outcomes for children in 11 Eastern and Southern African Countries. Vulnerable Children and Youth Studies: *An International Interdisciplinary Journal for Research, Policy and Care, 5* (1), 12-32.

Cautwell, N., Davidson, J., Elsley, S., Milligan, I., & Quinn, N. (2012). *Moving forward: Implementing the guidelines for alternative care of children.* Centre for Excellence for looked after Children in Scotland, UK.

Carnochan, S., Lee, C., & Austin, M.J. (2013). *Achieving exists to permanency for children in long-term care.* Routledge: Taylor and Francis Group. University of North Carolina, USA.

Casey Family Programme, National Centre for Resource Family Support. (2003). *Resources on individualized and targeted recruitment for adoption.* Washington.

Centre for Excellence for Looked after Children in Scotland, (CELCIS) (2012). *Movingevery forward: Implementing guidelines for the alternative care of children.* Scotland.

Chama, S.B. (2008). "The problem of African orphans and street children affected by HIV /AIDS: Making choices between community-based and institutional care practices", *International Social Work, 51*(3): 410-415.

Chernet, T. (2001). *Overview of services for orphans and vulnerable children in Ethiopia*. Paper presented for the Ministry of Local Government andSocial Affairs of the Republic of Rwanda.

Child Frontiers. (2011). *Mapping and assessing child protection systems, West and Central Africa.* Hong Kong.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Boston, MA: Houghton Mifflin Company.

Coleman, M. (2012). *Empowering family-teacher partnership: Building connections within diverse communities.* SAGE Publications Ltd.

Collins, K.M.T., Onwuegbuzie, A.J., &Jiao, Q.G. (2006). *Prevalence of mixed methods sampling designs in social science research.* Evaluation and Research in Education.

Commission to Promote Sustatinable Child Welfare. (2012). *Strengthening family-based care for OVC in a sustainable child welfare system.* Ontario.

Commissioner for the Human Rights. (2011). *Annual report of the United Nation High Commissioner for Human Rights.* Geneva, Switzerland.

Commission for Human Rights and Good Governance. (2011). *Inspection report for children in detention facilities in Tanzania.* United Republic of Tanzania.

Cohen, M.C., & Garret, K.J. (2006). Breaking the focus rules: A group work perspective on workers group research. *British Journal of Social Workers. 29:* 359-372.

Creswell, J. W. (2014). *Research Design: Qualitative, Qualitative and Mixed Methods Approaches*. SAGE Publications.

Creswell, J.W.; Fetters, M.D; & Curry, L.A. (2013). Achieving integration in mixed methods designs-Principles and practices.*Health Services Research48:6, Part II.*

Creswell, J.W.; & Plano Clark, V. (2011). *Designing and conducting mixed methods research*. Thousand Oaks, CA: SAGE Publications.

Crotty, M. (2003). *The foundations of social research: Meaning and perspectives in the research process*. London: SAGE Publications, (3rd Ed.), 10.

Davidson, C. (2009). Transcription: Imperative for qualitative research. *International Journal of Qualitative Methods* 8(2). Rock Hampton, Australia.

Davis, R. (2009). *Human capacity within child welfare systems: The social work workforce in Africa*, USAID.

Davis, R. (2006). *Emerging practices in community-based services for vulnerable groups:*

A study of social services delivery systems in Europe and Eurasia, United States Agency for International Development (USAID), Washington DC.

Debus, M. (1988). *A handbook for excellence in focus group research*. HEALTHCOM Project special Report Series. Washington, D.C.: Porter/Novelli.

Delap, E. (2013). *Towards a family for every child. A conceptual framework.* UK.

Delap, E. (2010). "*Protect for the future. Placing children's care and protection at the heart of the MDGs".* EveryChild, ChildHope, Railway Children, Consortium for Streets. Children, ICT, Retrak, Save the Children, the International HIV and AIDS Alliance and War Child, London.

Denzin, N.K. (1978). *The research act: A Theoretical introduction in sociological methods*. New York: Praeger.

Department for Education. (2010). *Family and Friends Care: Statutory Guidance for Local Authorities.* Department for Education, UK.

Desimone, L.M. (2009). Complementarity methods for policy research. In G. Sykes, Bb. Schneider, and D.N. Plank (Eds), *Handbook of educational policy research* (p: 163-1750. New York, Ny: Routledge.

Dillon, Sara. (2008). The Missing Link: A Social Orphan Protocol to the United Nations

Convention on the Rights of the Child. *Human Rights and Globalization Law Review, 2008, Vol.* 1, pp.36.

Driscoll, D.L. (2011). Introduction to Primary Research: Observation, Survey and Interviews. Parlor Press. Retrieved from http://parlorpress.com/writingspaces.

Dunn, A., Jareg, A. & Webb, D. (2003). *A last resort: The growing concern about children in residential care: Save the Children's position on residential care*. Washington, DC: International Save the Children Alliance.

Dunn, A., &Parry-Williams, J. (2008). *Alternative care for children in Southern Africa: Progress, challenges and future reactions,* UNICEF Social Policy & Social Protection Cluster Nairobi.

Dunn, A., Jareg, A. & Webb, D. (2003). *A last resort: The growing concern about children in residential care: Save the Children's position on residential care*. Washington, DC: International Save the Children Alliance.

Duranti, A. (2007). Transcripts, like shadow on a wall. *Mind, culture and activity, 13* (4), 301–310. Cambridge UK: Cambridge University Press.

Efken, C. (2002). Keeping the focus in teen focus groups. *Young Consumers, Vol.3*, (4) pp. 21-28.

Epoch Times. (2013). *The increasing problems of AIDS orphans in Africa.* New York.

Eurochild. (2012a). *De-institutionalisation and quality alternative care for children in Europe - Lessons learned and the way forward*. Brussels – Belgium.

Etikan, I., Musa, S.A, & Alkassim, R.S. (2015). Comparison of Convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics. Vol.5 (1)* pp. 1-4. Retrived from http://www.sciencepublishinggroup.com/j/ajtas on 15/08/2017.

Evans, P. (2009). *Improving gatekeeping functions of child protection systems: Background paper for 2nd Child Protection Forum for Central Asia on Child Care systems Reform* -UNICEF, CEE/CIS.

Evans, R. (2010). *The Experiences and priorities of young people who care for their siblings in Tanzania and Uganda,* Research Report, Reading, UK: School of Human and Environmental Sciences, University of Reading. Retrived from http://www.reading.ac.uk/ges/Aboutus/Staff/r-evans.aspx) on Sept. 29/2016.

EveryChild. (2012a). *A safe family for every child: An agenda for action.* EveryChild, London.

EveryChild. (2012b). Adopting better care: Improving adoption services around the world. EveryChild, London.

EveryChild and HelpAge International. (2012). *Family first: Prioritizing support to kinship carers especially older careers.* EveryChild and HelpAge International, London.

EveryChild. (2011a). Scaling *down: Reducing, reshaping and improving residential care.* EveryChild, London.

EveryChild. (2011b). *Fostering better care: Improving foster care provision around the world.* EveryChild, London.

EveryChild. (2010). Positively *caring: Ensuring that positive choices can be made about the care for children affected by HIV'*. EveryChild, London.

EveryChild. (2009a). Every *child deserves a family: EveryChild's approach to children without parental care*, EveryChild, London.

Faith to Action Initiative. (2015). *The continuum of care for orphans and vulnerable children.* Oak Foundation.

Faith to Action Initiative. (2014). Children, orphanages and families: a summary of research to help guide faith-based action. Oak Foundation.

Family for Every Child. (2014). *Why care m atters: the importance of adequate care for children and society*. London. Family for Every Child.

Family Health International (FHI). (2013). *Assessmet of community and family-based alternative care services in Ethiopia.* Addis Ababa.

Fendt, J., Kaminska-Labbé, R. & Sachs, W. M. (2008): Producing and socializing relevant

management knowledge: Re-turn to pragmatism. *European Business Review, 20* (6), 471-491.

Ferguson, R., Pence, A., & Denholm, C. (1993a). The scope of child and youth care in Canada. In R. Ferguson, A. Pence, and C. Denholm (Eds.), *Professional child and youth care* (2nd ed., p: 3-14). Vancouver: University of British Columbia Press.

Fernandez, E. (2006). *Child protection and vulnerable families: Trends and issues in the Australian Context.* New South Wales, Sydney.

Field, T. (1996). Attachment and separation in young children. *Annual Review of Psychology, 47*, 541-562.

Flynn, C., Welch, W., & Paget, K. (2004). *Field-initiated research on successful adolescent adoptions*. Final Report. Columbia: University of South Carolina, College of Social Work.

Foster, G. (2004). Safety nets for children affected by HIV/AIDS in Southern Africa. In R. Pharoah (Ed.), *A generation at risk? HIV/AIDS, vulnerable children and security in*

Southern Africa (ISS Monograph Series No. 109) (65-92). Pretoria: Institute for Security Studies.

Foster, G. (2005a). *"Under the radar – Community safety nets for children affected by HIV/AIDS in poor households in sub- Saharan Africa",* UNRISD, Geneva.

Foster, G. (2005b). "*Bottlenecks and drip feeds: Channelling resources to communities responding to orphans and vulnerable children in southern Africa*". Save the Children: London.

Forever Angles. (2013). *Caring for disadvantaged babies in Africa and rebuilding families.* Forever Angles, Tanzania.

Fox, L., & Gotestam, R. (2003). *Redirecting resources to community-based services in the changing minds, policies and lives UNICEF and World Bank series*, UNICEF Innocent Research Centre, Florence.

Fraser, M.W. (Ed.). (2004). *Risk and resilience in childhood: An ecological perspective* (2nd Ed.). Washington, D.C. NASW Press.

Gallagher, M. (2009). "Ethics" in E.K. Tisdall, J. Davis and M. Gallagher (Eds.), *Researching with children and young people: Research design, method and analysis* (11-28). SAGE Publications, London.

Gamble, D.N., & Hoff, M.D. (2005). Sustainable community development. In M.O. Weil (Ed.), *the handbook of community practice* (pp. 169-188). Thousand Oaks, CA: SAGE.

Garbarino, J. (1977). The human ecology of child maltreatment. *Journal of Marriage and the Family, 39,* 721-735.

Gibson, J. E. (2012). Interviews and focus groups with children: Methods that match children's developing competencies. *Journal of Family Theory and Review, 4, 148–159.*

Global Action for Children (GAC). (2010). *Orphan and Vulnerable Children.* Retrieved from http://www.globalactionforchildren.org on Sept.25/2016.

Global Information and Advice on HIV and AIDS. (2016). *Stigma, discrimination and HIV*. United Kingdom. Retrieved from http://www.avert.org on Sept.25/2016.

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research, 2012, *European Journal of Information Systems,* (21), *2*, 135-146.

Goswami, M. (2011). *Measurement and evaluation in psychology and education.* Neekamal publications pvt.Ltd. Hyderabad.

Graff, J.C. (2012). *Mixed methods research. Jones and Bartlett Learning*. LLC.

Gray, M., & Coates, J. (2010). 'Indigenization' and knowledge development: Extending the debate. *International Social Work 53* (5), 613-627.

Greenblott, K. (2008). Social protection for vulnerable children in the context of HIV /AIDS: Moving towards a more integrated vision. UNICEF. New York.

Greene, R.R. (2008). General systems theory. In R.R. Greene (ed.), *Human behaviour theory and social work practice* (3rd Ed.), (p: 165-180). New Brunswick, NJ: Transaction Publishers.

Greene, J. C. (2007). *Mixed methods in social inquiry* (1st Ed.). San Francisco, CA: Jossey-Bass.

Green, J.W. (1999). *Cultural limitations in the human services: A-Multi-Ethnic approach* (3rd Ed.). Boston: Allyn and Bacon.

Greif, G.L., & Lynch, A.A. (1983). The eco-systems perspective. *In C.H. Meyer (Ed.),*

Clinical social work in the eco-systems perspective (pp. 35-74). New York: Columbia University Press.

Guba, E. G., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K.

Denzin & Y. S. Lincoln (Eds.). *The landscape of qualitative research: Theories and issues* (pp.195-220). Thousand Oaks, CA: SAGE.

Gunawan J. (2015). Ensuring trustworthiness in qualitative research. *Belitung Nursing Journal 2015*; 1:10-11.

Hancock, B., Windrdge, K., & Ockleford, E. (2007). *An introduction to qualitative research*. The NIHRRDS EM/ YH.

Harris, J.R. (1998). *The nature assumption: why children turn out the way, they do.* New York: Free Press.

Harwell, M.R. (2008). *Research Design in Qualitative/Quantitative/Mixed Methods*. University of Minnesota.

Harry.R, & Srecher. S. (2009). *Encyclopedia of human relationship.*

Hepworth, D., Rooney, R., & Larsen, J. (2010). *Direct social work practice: Theory and skills.* (9th Ed.), Wadsworth Group, USA.

Hill, M. (2005). Ethical considerations in researching children's experiences. In S. Greene & D. Hogan, (Eds.), *Researching children's experience*, (pp. 61-86). London: SAGE Publications.

Holloway, I., &Wheeler, S. (2002). *Qualitative research in nursing* (2nd Ed). Oxford: Blackwell.

Hornik, R.C. (2002). *Public health communications. Evidence for behaviour change.* Lawrence Erlbaum Associates. Mahwahi: New Jersey.

Howard, B.H., Phillips, C.V., Matinhure, N., Goodman, K., McCurdy, S.A., & Johnson, C.S. (2006). Barriers and incentives to orphan care in a time of AIDS and economic crisis: A cross-sectional survey of caregivers in rural Zimbabwe. *BMC Public Health*, 6 (27).

Howe, D. (2005). *Child abuse and neglect: Attachment, development and intervention*, Hampshire and New York: Palgrave Macmillan, 277-278.

Howe, D. (1995). *Attachment theory for social work practice*, London: Macmillan Press Ltd.

Huck, M. (2008) Reading statistics and research (5th Ed). Boston: Pearson Education.

Hudson, P., &Levasseur, K. (2002). Supporting foster parents: Caring voices. *Child Welfare 81, 853-877.*

Hugman, R. (2010). *Understanding international social work. A critical analysis.* Palgrave Macmillan, Basingstoke.

Human Rights Watch. (2014). *No way out: child marriage and uman rights abuses in Tanzania.* Tanzania.

Human Rights and Good Governance. (2011). *Inspection report for children in detention facilities in Dar es Salaam*. Tanzania.

Hyder, T., & Mac Veigh, J. (2007). *Gender-based violence against children in emergencies: Save the Children UK's Response*. Gender and Development 115 (1), 81-93.

Hyun, C. (2007) "*Empowering hands' for former child soldiers in Uganda*". Retrived from http://www.unicef.org/infobycountry/uganda-40339.ttml on Dec. 16/2016.

International Federation of Social Workers. (2009). *Defining social work for the 21st century: The International Federation of Social Workers'* revised definition of social work.

Institute for Development Studies. (2008). *Participation team. Retrived from www.ids.ac.uk on Sept. 20/2016.*

International Labour Organisation (ILO). (2012). *Child domestic work: global estimates.*

ISS/IRC (International Reference Centre for the Rights of Children Deprived of their Family "*Specific case*: Kafalah," (2007). Fact Sheet No51, (Geneva).

JLICA (Joint Learning Initiative on Children and AIDS). (2009). *Home truths: Facing the facts on children, AIDS, and Poverty*. Retrived from http://www.jlica.org on Aug. 30/2016.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm

whose time has come. *Educational Researcher, 33*(7), 14-26.

Jones, D. N., & Truell, R. (2012). The global agenda for social work and social development: A place to link together and be effective in a globalized world. *International Social Work 55 (4): 454-472*.

Joppe, M. (2000). *The Research Process.* Retrieved from http://www.ryerson.ca/~mjoppe/rp.htm on Sept. 20, 2016.

Jordon, B., & Sketchley R (2009). *A stitch in time saves nine. Preventing and responding to the abuse and neglect of infants. Child abuse prevention issues*. National Child Protection Clearinghouse, 30, Australian Institute of Family Studies.http://www.aifs.gov.au/nch/pubs/issues.html on May.14, 2017.

Kasiram, M.I. 1992. *School social work service delivery: models for future practice*, submitted in part fulfilment of the requirements for the degree of Doctor of Philosophy, Durban: Faculty of Arts, University of Durban-Westville.

Kawulich, B. B. (2005). Paticipant observation as a data collection method. Forum *Qualitative Social Research 6 (2).*

Kijo-Bisimba, H. (2011). *Vulnerable within the vulnerable: protection of orphaned child heading households in Tanzania.* A thesis submitted in partial fulfilment of the requirement for the Degree of Philosophy in Law-University of Warwick, UK.

KIDSAVE international. (2011). *Building families and connection for children without parental care*. Washington DC.

Kind Heart Africa. (2013). *Special project in Tanzania building an orphanage*. Retrieved from http://www.pannaseka.comon 25/09/2016.

Kothari, C.K. (2004). *Research methodology: Methods and techniques* (2nd Ed). New Age International Publishers, India.

Kumar, K. (1987). *Conducting focus group interviews in developing countries. A.I.D. Program Design and Evaluation Methodology Report No. 8*. Washington, D.C.: U.S. Agency for International Development.

Krueger, R.A., & Casey, M.A. (2009). *Focus groups: A practical guide for applied research, 4th edition*. Thousand Oaks, CA: SAGE.

Krueger, M. (2005). Four themes in youth work practice. *Journal of Community Psychology, 33(1), 21-29.*

Krueger, M. (2000). Presence, fear, curiosity, and other themes in community youth work *Applied Developmental Science, 4(1), 21-27.*

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research*

Legal and Human Rights Centre (LHRC). (2009). *NGO report on implementation of the International Convenant on Civil and Political Rights (ICCPR).* Tanzania.

Leech, N. L., & Onwuegbuzie, A. J. (2009). *A typology of mixed methods research designs. Quality & quantity*, 43(2), 265-275. Springers Science and Business Media.

Le Grand, J. (1991). 'Quasi-markets and social policy'. *The Economic Journal, 101, pp. 1256-1267*.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: SAGE.

Loffell, J. (2008). *'Developmental social welfare and the child protection challenge in South*

Africa' Practice 20(2), 83-91.

Maier, H. W., (1991). An exploration of the substance of child and youth care practice.*Child and Youth Care Forum, 20(6), 393-411*.

Malinga, T., & Ntshwarang, P.N. (2011). Alternative care for children in Botswana: A reality or idealism? *Social Work and Society Online Journal*. Gaborone, UNICEF.

Mathambo, V., & Richter, L. (2007). *'We are volunteering': Endogenous community- based responses to the needs of children made vulnerable by HIV/AIDs",* Human Sciences Research Council.

Mathers, N; Nick, F., & Amanda, H. (2002). *Trent focus for research and development in primary health care: Using interviews in research project.* Trent Focus Group-Northern General Hospital, Sheffield.

Mauthner, M. (1997). Methodological aspects of collecting data from children: Lessons from three research projects. *Children & Society vol. (11) 16–28.*

Maundeni, T. (2009). Care for children in Botswana: The social work role. *Social work and Society*, 7(1):13-27.

Mayer, C.H. (1988). The ecosystems perspectives. *In R. Dorfman (Ed.), Paradigms of Clinical Social Work* (pp. 275-294). New York: Brunner/Mazel.

Meintjes, H., Hall, K., Marera, Double-Hugh & Boulle, A. (2010). Orphans of the AIDS epidemic? The extent, nature and circumstances of child-headed households in South Africa. *AIDS Care*, 22(1), 40— 49.

Menon, G. M., & Cowger, C. D. (2010). Integrating qualitative and quantitative research methods. *In B. Thyer (Ed.), the handbook of social work research methods (*2nd ed., pp. 609–613). Thousand Oaks, CA: SAGE.

Merriam, S. B. (2009). Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.

Midgley J., & Conley A. *(2010). Social work and social development: Theories and skills for developmental social work.* New York, NY: Oxford University Press.

Miles, M.B & Huberman, A.M. (1994). *Qualitative data analysis.* (2nd Ed.), Thousand Oaks, CA: SAGE.

Miller, C. M., Gruskin, S., Subramanian, S. V., Rajaraman, D., &Heymann, S. J. (2006). Orphan Care in Botswana's Working Households: Growing Responsibilities in the Absence of Adequate Support. *American Journal of Public Health, 96 (8), 1429-1435.*

Ministry of Constitutional and Legal Affairs. (2013).*Tanzania national action human rights action plan (2013-2017).*

Ministry of Constitutional and Legal Affairs. (2012). *Child justice: A five year strategy for progress reform (2013-2017),* Tanzania.

Ministry of Education and Vocational Training. (2010). Basic education statistics in Tanzania

Ministry of Foreign Affairs. (2013). *Country profile paper.* Danish Embassy in Dar es Salaam, Tanzania and Department for Africa.

Mkombozi. (2013). *Overview of the current adoption situation in Tanzania.*

Mkombozi Centre for Street children. (2005). *Literature review of foster care.* Tanzania.

MoHSW (Ministry of Health and Social Welfare). (2014). *Global AIDS response country progress report.* Tanzania.

MoHSW (Ministry of Health and Social Welfare)-Department of Social Welfare. (2013).*The most vulnerable children in Tanzania*. Tanzania.

MoHSW (Ministry of Health and Social Welfare)-Department of Social Welfare. (2012). *Assessment of the social welfare workforce in Tanzania*. Tanzania.

MoHSW (Ministry of Health and Social Welfare)-Department of Social Welfare. (2011). *Assessment of the situation of children in residential care in Tanzania*. Tanzania.

Morgan, D.L. (2007). Paradigms lost and pragmatism regained. Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Research, 1, 48-76.*

Morgan, D. L. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research*, 8(3), 362-376.

Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd Ed). Qualitative research
methods series 16. Thousand Oaks, CA: SAGE.

Mwendah, H. K & Mallya, E.T. (2014). *HIV/AIDS and public administration: Tanzania country foresight report.* University of Dar es Salaam, Tanzania.

NAOT (National Audit Office Tanzania). (2013). *A performance audit report on the management of identification and provision of services to most vulnerable children in Tanzania.* Tanzania.

NASW (National Association of Social Workers). (2005). *Social work and care coordination.* Washington, DC.

Neuman, W. L. (2012). *Basics of social research: qualitative and quantitative approaches.* NJ: Pearson.

Norlin, J., Chess, W. Dale, O., & Smith, R. (2002). *Human behaviour and the social environment*. Boston: Allyn and Bacon.

North Carolina Division of Social Services. (2009). Permanency planning. Family services manual: children services. USA.

NRC (National Research Council). (2002). *Scientific research in education.* Washington, DC: National Academies Press.

Nunan, D. (1999). *Research methods in language learning*. Eighth printing. Cambridge: CUP.

O'Brien: (Summer 1999). *Recruiting families for teens.* Adapted from 'Non-Traditional Recruitment for Teens and Pre-Teens' North American Council on Adoptable Children Recruiting News.

O'Brien, C. & Chanturidze, T. (2009). Assessment of the Child Welfare reform process In Georgia. Oxford Policy Management, U.K; UNICEF (2006). *Evaluation of the Family Support and Foster Care Project and the Prevention of Infant Abandonment and Deinstitutionalization Project*: Georgia. UNICEF.

O'Cathain, A., E. Murphy., & J. Nicholl. 2010. *"Three Techniques for Integrating Data in Mixed Methods Studies*." British Medical Journal 341: c4587.

Olson, K., Messinger, R., Sutherland, L & Astone, J. (2005). The promise of a future: *Strengthening family and community care for orphans and vulnerable children in Sub-Saharan Africa.* Fire Foundation, USA.

Onwuegbuzie, A. J., & Combs, J. (2011). *Data analysis in mixed methods: A premier.* Sam Houston State, USA.

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L., & Zoran, A. G. (2007, February).

Toward more rigor in focus group research: A new framework for collecting and analyzing focus group data. Paper presented at the annual meeting of the Southwest Educational Research Association, San Antonio, TX.

Onwuegbuzie, A. J., & Leech, N. L. (2007a). A call for qualitative power analyses. Quality & Quantity: *International Journal of Methodology*, 41, 105-121.

Onwuegbuzie, A. J., & Collins, K. M. T. (2007). *A typology of mixed methods sampling designs in social science research.* The Qualitative Report. ANOVA Southeastern University.12 (2), 281-316.

Onwuegbuzie, A. J. (2003). *Expanding the framework of internal and external validity in quantitative research. Research in the Schools, 10* (1), 71-90.

Onwuegbuzie, A. J., & Teddlie, C. (2003). A framework for analysing data in mixed methods research. In A. Tashakkori and C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioural research* (p: 351-383). Thousand Oaks, CA: SAGE.

Pallant, J. (2005). *SPSS survival manual: A step by step guide to data analysis using SPSS for windows (Version 12).* Allen and Unwin; Australia.

Parada, H. (2007). *Regional perspectives from Latin America, social work in Latin America: History, challenges and rewards*. International Social Work, 50 (4): 560-569.

Parahoo K. (2006). *Nursing research: Principles, process and issues*, 2nd ed. Palgrave Macmillan, Houndsmill.

Parkinson, P. (2003). Child protection, permanency planning and children's right to family life. *International Journal of Law, Policy and the Family, 17 (2), 147-172.*

Parry-Williams, J., & Dunn, A. (2009). *Family and Kinship Care.* Presentation given at the International conference on family-based care for OVC for Children, Nairobi.

Payne, M. (2005). *Modern social tork Theory*. Third Edition. London: McMillan Press Ltd

Pelvin, L.A. (1984). *Personality*. New York, Willey.

PEPFAR (US President Emergency Plan for AIDS Relief). (2015).*Tanzania country operational plan: Strategic directional summary*. Tanzania.

PEPFAR (US President Emergency Plan for AIDS Relief). (2013). *Orphans and vulnerable children: Supporting children, investing in our future.* Institute of Medicine. Office of the U.S. Global AIDS Coordinator, USA.

PEPFAR (US President Emergency Plan for AIDS Relief). (2012). *Guidance for orphans and vulnerable children programming.* USA.

PEPFAR (the U.S. President's Emergency Plan for AIDS Relief). (2006). *Orphans and other vulnerable children programming guidance.* Office of the U.S. Global AIDS Coordinator, USA.

Pincus, M.C.B., & Mihanam, A. (1973). *Social work practice: Model and method*. Itasca, IL: Peacok.

Pittracher, B., Rudisch-Pfurtscheller, A., & Westreicher, B. (2004). *Tracking footprints* Global Report 2002/2003. SOS-Kinderdorf International.

Pitso, T; Maxhela, N; Xhongo, K., & Vazi, T. (2014). *The behavioural impact of foster care towards middle-aged children and adolescents on their families of origin: A Case Study in Alice Township*, South Africa.

Phelan, J. (2003). Child and youth care family support work.*Child and Youth Services, 25(1-2), 67-77.*

Phillip, C. (2011). Child-headed households: a feasible way forward, or an infringement of children's right to alternative care? Netherlands.

Polit, D.F., Beck, C.T., & Hungler, B.P. (2001). *Essentials of nursing research: Methods, appraisal, and utilization* (5th Ed). Philadelphia: Lippincott.

Powell, MA, Fitzgerald, RM, Taylor, N., & Graham, A. (2012). *International literature review: Ethical issues in undertaking research with children and young people*, for the Childwatch International Research Network, University of Otago.

Rasaili, T.J., & Titus, C.M. (2007). *Reunification-"A reality or an impossible Dream?"* The Perspective of Swedish Child Care and Foster Social Workers.

REOSA (Regional Emergency Office for Southern Africa) (2010). Johannesburg, South Africa.

Research on Poverty Alleviation (REPOA). (2013). *Social protection and targeting on the most vulnerable Children in Tanzania*. Tanzania.

Research on Poverty Alleviation (REPOA). (2007). *Children and vulnerability in Tanzania.*

Richter L. (2004). The impact of HIV/AIDS on the development of children. In: Pharoah R, editor. *A generation at risk? HIV/AIDS, vulnerable children and security in Southern Africa.* South Africa: Institute for security studies; pp. 210–231.

Richter, L., J. Manegold., & Pather, R. (2004). *Family and community interventions for children affected by AIDS.* Cape town, South Africa: Human Sciences Research Council and WK Kellogg Foundation.

Roby, J., Shaw, S., & George, L. (2013). Perceived food and labor equity and school attendance among Ugandan children living in kin care. *International Journal of Social Welfare*.

Robson, C. (1993). *Real world research*. Oxford, UK: Blackwell.

Roelen, K., & Delap, E. (2012). *Researching the links between social protection and children's care in Sub-Saharan Africa*-A Concept Note.Centre for Protection, Institute of Development Studies and Family for Every Child.

Roelen, K., Edstrom, J., Sabates-Wheeler, R., & Davies, M. (2011). *Child and HIV sensitive social protection in Eastern and Southern Africa: Lessons from the Children and AIDS Regional Initiative (CARI),* UNICEF ESARO, Nairobi.

Rubin, A., & Babbie, E.R. (2008). *Researh methods in social work (*6 Ed). Ca: Brooks/Cole.

SADC. (2011). *Minimum package of services for orphans and other vulnerable children and youth.*Gaborone, Botswana.

SADC. (2010). *Development of SADC minimum package of services for orphans and vulnerable children and youth: The situation of orphans and other vulnerable children and youth in SADC Region.* Regional Situation Analysis Report. Gaborone, Botswana.

SAGE. (2004).*The SAGE encyclopaedia of social science research methods*. SAGE Publications.

Sandelowski, M. (1995). Focus on qualitative methods: Sample sizes in qualitative research. *Research in Nursing and Health, 18, 179-183.* Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd= on 15/05/2015.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in nursing science* 16 (2):1-8. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd= on 15/05/2015.

Save the Children. (2015). *Understanding and improving alternative care mechanisms to increase the care and protection of children, with a focus on kinship care in East Africa.* Save the Children International, Kenya.

Save the Children. (2014). *Review of the implementation of the United Nations guidelines for the alternative care of children in Western Balkan countries*. United Kingdom: Save the Children.

Save the Children. (2014). *Institutional care: the last resort.Policy Brief.* United Kingdom: Save the Children.

Save the Children. (2013). *Save the children's child protection strategy 2013-2015.* United Kingdom: Save the Children: Save the Children.

Save the Children. (2013). *Alternative care in emergency toolkit.* United Kingdom: Save the Children.

Save the Children. (2012). *Guidelines for the alternative care of children.* Policy Brief, November, 2012. United Kingdom: Save the Children.

Save the Children. (2010). *Establishing, reviewing and implementing national plans of action for orphans and vulnerable children in Southern and Eastern Africa: Lessons learnt and challenges.* Multi-sectorial Workshop on Legal and Policy Frameworks Protecting Children. Pretoria, South Africa.

Save the Children. (2009a). *Keeping children out of harmful institutions. Why we should be investing in family-based care for OVC.* United Kingdom: Save the Children.

Save the Children. (2009b). *Protection fact sheet: The need for family and community-based alternatives to children's homes.* United Kingdom: Save the Children.

Save the Children UK. (2007). *Kinship care-providing positive and safe care for children living away from home,* United Kingdom: Save the Children.

Sebates-Whiler, R., & Pelhan, L. (2006). *Social protection: How important are the national plans of action for orphan and vulnerable children.* UNICEF.

Sewpaul V. (2003). 'Reframing epistemologies and practice through international exchanges: Global and local discourses in the development of critical consciousnesses. In: Dominelli L. & Thomas Bernard W. (eds.): Broadening Horizons: *International Exchanges in Social Work*. Hants & Burlington: Ashgate.

Sheikh Sa`ûd al-Funaysân. (2008). *The orphan in Islamic Law*. Islamic Law, al-Imâm Islamic University Islamic Law.

Sherraden, M. (2001). *Chronic poverty research center toolbox: focus group discussions.* Retrived from http://www.chronicpoverty.org/page/toolbox-focus-interviews on Sept.05, 2016.

Sheuya, S., Howden-Chapman., & Patel, S. (2007). The design of housing and shelter programmes: the social and environmental determinants of inequalities. *Journal of Ur- ban Health 84: 198–1108.*

Skinner,D., Tsheko.N., Mtero-Munyati.S., Segwabo.M., Chibatamoto., Mfekane.S., Chandiwana.B., Nkomo.N., Tlou.S., & Chitiyo.G.(2004). *Defining Orphaned and Vulnerable Children.* 'Human Sciences Research Council, South Africa.

SOS International & CELCIS. (2014). *Drumming together for change: a child's right to quality care in Sub-saharan Africa.* Published by the Centre for Excellence for Looked After Children in Scotland, UK.

SOS, Tanzania. (2014). *Assessment report of the alternative care systems for children in Tanzania.* Published in Austria by SOC Children's Villages International.

SOS, Tanzania. (2013). *A snapshot of alternative care arrangements in Tanzania*.
SOS, Tanzania (2012). *Child rights based situational analysis of children without parental care and at risk of losing parental care.* Tanzania.

Stockholm Declaration. (2003). *Children and residential care.* Department of Social Work, Stockholm.

Stott, T., & Gustavsson, N. (2010). Balancing permanency and stability for youth in foster care. *Children and Youth Services Review,* 32, 619-625.

Strauss, A.L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, C.A SAGE.

TACAIDS. (2013). *National HIV and AIDS response report 2012.* Tanzania Mainland.

TACAIDS. (2012). *Country progress reporting.* Tanzania Mainland.

Tanzania Child Rights Forum. (2013). *Tanzania child rights status report 2013.* Tanzania Mainland.

Tanzania NGO Report. (2014). *Consolidated report on Tanzania's implementation of the Convention on the Rights of the Child.* Dar es Salaam, Tanzania.

Tanzania Prime Minister's Office. (2013). *Pre-Primary, primary, and secondary education statistics*. Tanzania.

Tashakkori, A; & Creswell, J.W. (2007). The new era of mixed methods research. *Journal of Mixed Methods* 1 (1).

Tashakkori, A; & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioural research*. Thousand, Oaks, C.A: SAGE.

Tashakkori, A., & Teddlie, C. 1998. *Mixed methodology: Combining qualitative and quantitative approaches,* Thousand Oaks, CA: SAGE Publications.

Teasley, M.L., & Moore, J.A. (2010). *A mixed methods study of disaster case managers on issues related to diversity in practice with Hurricane Katrina Victims*. Florida State University.

Teddlie, C. & Tashakkori, A. (2009). *Foundations of Mixed Methods Research: Integrating quantitative and qualitative approaches in the Social and Behavioural Sciences.* Thousand Oaks, CA: SAGE Publications.

Tisdall, E.K.M., Davis, J.M. & Gallagher, M. (2009). *Researching with children and young people: Research design, methods and analysis*. London: SAGE.

Tolfree, D. (2007). *Protection Fact Sheet: Child protection and care-related definitions,* Save the Children. United Kingdom: Save the Children.

Thoburn, J. (2003). The risks and rewards of adoption for children in the public care. *Child and Family Law Quarterly,* 15 (4), 391-401.

Tilbury, C., & Thoburn, J. (2008). Children in out-of-home care in Australia. International comparisons. *Children Australia,* 33(3), 5-12. Australia.

Tilbury, C., & Osmond. (2006). Permanency planning in foster care: A research review and guidelines for practitioners. *Australian Social Work,* 59(3), September, 265-280. Australia.

Tripodi, T., & Potocky-Tripodi, M. (2007). *International social work research: Issues and prospects.* New York, NY: Oxford University Press.

Tshitswana, D. S. (2003). *Batswana cultural beliefs and practices-Implications for methods of care for AIDS orphans and other vulnerable children in Botswana*. A thesis Submitted in Partial Fulfillment of the requirements for the degree of Masters of Arts, Faculty of the Center for International Studies of Ohio University.

UN. (2010a). *Guidelines for alternative care for children.* United Nations, Geneva.

UN. (2009). *Guidelines for the alternative care of children.* Human Rights Council, 11th Session, United Nations, Geneva.

UN. (1989). *United Nations Convention on the Rights of Children (UNCRC).* New York.

UNCRC. (2009). Committee on the Rights of the Child; Fifty-first Session. General Commitment No. 12 (2009). *The Right of the Child to be heard.* New York.

UNCRC. (2006). Committee on the Rights of the Child: *The rights of the child to protection from corporal punishment and other cruel or degrading forms of punishment.* New York.

UNCRC. (2003). Committee on the rights of the child.General Comment No.3-*HIV and AIDS and the rights of the child.*Geneva.

UNAIDS, UNICEF & WHO. (2007). *Children and AIDS. A stocktaking Report.* New York.

UNAIDS. (2016). *Global statistics on HIV and AIDS.* Geneva.

UNAIDS. (2015). *Fast-track to end AIDS by 2030: focus on location and population*. Geneva.

UNAIDS. (2014). *Beggining of the end of the AIDS epidemic.* Geneva.

UNAIDS. (2012). *Together we will end AIDS*. Geneva.

UNAIDS. (2011). *UNAIDS terminology guidelines.* Geneva.

UNAIDS. (2010). *Global report.* New York: Joint UN Programme on HIV-AIDS.Geneva.

UNAIDS. (2000). *Caring for carers: Managing the stress in those who care for people with HIV and AIDS*. Geneva: UNAIDS Best Practice Collection. Geneva.

UNICEF. (2016). *Monitoring the situation of children and women.* Retrieved from:http://www.dataunicef.org on 15/03/2017.

UNICEF&MoHSW. (2012). *Baseline assessment of children living on the streets of Dar es Salaam.*Tanzania.

UNICEF. (2012). *UNICEF annual report.* United Republic of Tanzania.

UNICEF. (2011). *Children in informal care- discussion paper.* UNICEF child protection section-New York.

UNICEF. (2010). *At home or in a home? Formal care and adoption of children in Eastern Europe and Central Asia*. Geneva. UNICEF Regional Office for CEE/CIS.

UNICEF. (2009a). *Africa's orphaned and vulnerable generations. Children affected by AIDS.* UNICEF, New York.

UNICEF. (2009b). *Childhood poverty in Tanzania: Deprivations, Disperities in child well-being.* UNICEF, Tanzania.

UNICEF. (2008a). *Implementation handbook for the Convention on the Rights of the Child.* Geneva.

UNICEF. (2008b). *A technical assessment of the legal provisions and practices of guardianship, foster care and adoption of children in Kenya.* Government of Kenya.

UNICEF. (2007). *Protecting the world's children impact of the Convention on the Rights of the Child in diverse legal systems.* New York: Cambridge Press.

UNICEF. (2006). *Africa's orphaned and vulnerable generations: Children affected by AIDS.*UNICEF New York.

UNICEF. (2004). *The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS. New York:* UNICEF.

United Republic of Tanzania. (2011).*Violence against children in Tanzania: findings from a National Survey, 2009*. Tanzania.

United Republic of Tanzania. (2012). Tanzania National Statistics Bureau; *National population census.* Tanzania.

United Republic of Tanzania. (2010). Tanzania Demographic Health Survey (TDHS).

United Republic of Tanzania. (2009). *Tanzania Law of Child Act.*

United Republic of Tanzania. (2009). *Tanzania City Council for surface area and economic survey;* Dar es Salaam region.

United Republic of Tanzania. (2008). The National Costed Plan of Action for Most Vulnerable Children (2007-2010).

United Republic of Tanzania. (2008). *HIV/AIDS and malaria indicator survey.* National Bureau of Statistics and Tanzania Commission of AIDS. Dar es Salaam.

USAID. (2014*). Orphans and Vulnerable Children Affected by HIV and AIDS.* Washington D.C.

USAID & UNICEF. (2011). *Assessment of the Department of Social Welfare.* Tanzania

USAID. (2011). *Social welfare workforce strengthening for orphans and vulnerable children.* United Republic of Tanzania.

USAID. (2010). *The scale, scope and impact of alternative care for OVC in developing countries: A review of literature.* Centre for Global Health and Development Boston University. USA.

USAID. (2009). *Effects of programmes supporting orphans and vulnerable children: key findings, emerging issues and future directions from evaluations of four projects in Kenya and Tanzania.* University of North Carolina at Chapel Hill, USA.

USAID. (2008). *Tanzania National Costed Plan of Action for Most Vulnerable Children (2007-2010).* Ministry of Health and Social Welfare; Department of Social Welfare Tanzania.

U.S. Government (USG). (2009). *U.S. Government and partners: Working together on a comprehensive, coordinated and effective response to highly vulnerable children*. Third Annual Report to Congress on Public Law 109-95, the Assistance to Orphans and Other Vulnerable Children in Developing Countries Act of 2005. Washington D.C.

Wahyuni D. 2012. The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research, 10(1): 69-80*.

Wakefield, J. (1996a). Does social work need an ecosystems perspective? Part 1. Is the perspective clinically useful? *Social Service Review*, 70(1): 1-32.

White, J. (2007). Knowing, doing and being in context: A praxis-oriented approach to child and youth care.*Child and Youth Care Forum*, 36(5), 225-244. University of Victoria, Canada.

Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, 11 (5), 417-428. Routledge, UK.

Williamson, J., & Greenberg, A. (2010). *Families, not orphanages*. Better Care Network, New York.

Williamson, J. (2004). *A family is for a lifetime*. USAID Office of HIV/AIDS. Washington, D.C. The Synergy Project.

World Bank. (1997). *Coping with the impact of AIDS in confronting AIDS: Public priorities in a global epidemic*. Oxford University Press.

World Health Organisation. (2011). *Progress in scale-up of male circumcision for HIV prevention in eastern and southern Africa: focus on service delivery*. Geneva.

World Vision. (2009). *Because we care: Programming guidelines for children deprived of parental care.* World Vision, UK.

World Vision. (2005). *Small voices, big concerns; A child rights approach to HIV/AIDS*. World Vision, UK.

Wright, S. (2004). *Child protection in the community: A community development approach.* Child Abuse Review, 13, 384–398.

Wulczyn, F., Daro, D., Fluke, J., Feldman, S., Glodek, C., & Lifanda, K. (2010). *Adopting a systems approach to child protection*: Key concepts and consideration. New York: UNICEF.

Yamane, T. (1967). Statistics: An Introductory Analysis, 2nd Edition, New York: Harper and Row.

Yin, K. R. (2013). *Case study research: Design and methods*. (5th Ed). SAGE Publishers: Thousand Oaks, CA.

Zohrab, M. (2013). Mixed methods research: Instruments, validity, reliability and reporting findings. University of Tabriz, Iran.

Appendices

Appendix I-Research Method Typology

Summary Methodology to examine the existing alternative care systems for OVC in an effort to promote family-based care for OVC in Dar es Salaam city in Tanzania.

Study Objective	Method	Research Tool	Target/Data Source	Number	Sampling Method
1. To describe the nature of alternative care systems for OVC	Survey Face to face interview Focus Group Discussions (FGDs)	Questionnaire Interview guide FGD guide	• Representatives from institutions/organizations dealing with OVC • Key informants • Community leaders • OVC • Care givers • Social workers	As appropriate	Random sampling Purposive sampling
2. To examine the situation of OVC in various alternative care systems	Survey Face to Face Interviews Focus group discussions	Survey Face to Face Interviews Focus group discussions	• Representatives from institutions/organizations dealing with OVC • Key informants • Community leaders • OVC • Care givers • Social workers	As appropriate	Random sampling Purposive sampling
3. To examine the potential contribution of child related laws and policies to the enhancement of alterntive care for OVC	Survey Face to Face Interviews Focus group discussions	Survey Face to Face Interviews Focus group discussions	• Representatives from institutions/organizations dealing with OVC • Key informants • Community leaders • Social workers	As appropriate	Random sampling Purposive sampling
4. To explore the perception of stakeholders with regard to the promotion of family-based care for OVC	Survey Face to Face Interviews Focus group discussions	Questionnaire Interview guide FGD guide	• Representatives from institutions/organizations dealing with OVC • Key informants • Community leaders • OVC • Care givers • Social workers	As appropriate	Random sampling Purposive sampling

Appendix II: Observation Instrument

Date of observation:.....

Duration of observation:.....

Observer:.....

Observation areas:

Physical location

1. Where is the location of the institution?
2. Is the institution easily accessible?

Immediate environment

3. How is the insitutional setting?
4. How are the food services?
5. How do children interact with caregivers?
6. Does the caregiver feel responsible for the children?
7. Are the children cooperative and enjoy participating in activities with other children?
8. How is the cleanliness of the environment?

Expressive movements

9. Are the children physically healthy?
10. How is the children's body language? Example: Is there a child who is crying or fighting others?
11. Do some children show expression of sadness, warmth, joy, pain as caregivers continue with their work?
12. Are the children safe from abuse and exploitation?

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

QUESTIONNAIRE

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following questionnaire is designed to form part of data collection for a research study, which I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix III: Questionnaire for the Institutions/organisations

1. Background Information

Name of the Institution/Organisation.....

Current position/title……

Highest level of education:.....

Professional qualification.....

Male ___Female___

Date(s) of interview.....

Nature of alternative care

From table 1 to table 19 please use the scales given to decide on your response by putting √ sign in the boxes provided against each phrase.

2. How does your care centre define Orphans and Vulnerable Children (OVC)?

Table 1: Definition of OVC

C/N	**Residential care centre definition for OVC**	**Response %**		
		Agree	**Not sure**	**Disagree**
1	A child who has lost one or both parents			
2	A child living on the street			
3	A child who is homeless or abused			
4	A child with very sick parents			
5	A child living with disabilities and very sick children			

3. What are the types of alternative care systems for OVC in Dar you are familiar with?

Table 2: Types of alternative care systems

	Types of alternative care systems in Dar es Salaam	Response %		
		Agree	Not sure	Disagree
1	Kinship/extended family			
2	Institutional/residential care			
3	Foster care			
4	Adoption of a child			
5	Community based care			
6	Child-headed households			
7	Group homes			

4. What services are supposedly provide to OVC by the existing alternative care systems?

Table 3: Services provided to OVC

C/N	Services provided to OVC by residential care centres	Response %		
		Agree	Not sure	Disagree
1	Shelter			
2	Food			
3	Clothes			
4	Health services			
5	Education services			
6	Recreational services			
7	Counseling			

5. How would you rate the quality of services supposedly provided to OVC by the existing alternative care systems?
   a. Very Low
   b. Low
   c. Moderate
   d. High
   e. Very high

Roles of social workers

6. What do you perceive as the roles of social workers in implementing care arrangements for OVC in alternative care systems?

Table 5: Roles of social workers in implementing care arrangements for OVC

C/N	Roles of social workers	Response %		
		Agree	Not sure	Disagree
1	Identify and ssessment of children in need of care			
2	Monitor and evaluation care systems			
3	Prepare children and families for reunification			
4	Provide psychosocial support			

7. Please describe the challenges facing social workers in implementing care arrangements for OVC.

Table 6: Challenges facing social workers in implementing care arrangements for OVC

C/N	Challenges facing social workers	Response %		
		Agree	Not sure	Disagree
1	Limited resources			
2	Inadequate services to OVC			
3	Poor monitoring and evaluation of alternative care systems			
4	Illegal ownership of care centres			
5	Inadequate support for independent living			

Situation of OVC in existing alternative care systems

8. Please describe your opinion on the situation of OVC in various alternative care systems.

Table 7: Opinion level on the situation of OVC in existing alternative care systems

	Situation of OVC in	Response %					
		Poor	Fair	Good	Very good	Excellent	Total
1	Kinship/extended family						
2	Institutional/residential care						
3	Foster care						
4	Adoption of a child						
5	Community based care						
6	Child-headed households						
7	Group homes						

9. Please describe the reasons for OVC placement in alternative care systems.

C/N	Reasons for OVC placement in alternative care systems	Response %		
		Agree	Not sure	Disagree
1	Poverty			
2	HIV and AIDS			
3	Family conflicts			
4	Teenage pregnancies			
5	Street children			
6	Children in conflict with the law			

10. Please describe the barriers hindering OVC to access alternative care.

Table 10: Barriers hindering OVC to access alternative care

C/N	Reasons for OVC placement in alternative care systems	Response %		
		Agree	Not sure	Disagree
1	Age			
2	Sex			
3	Religion			
4	Poverty			
5	Discrimination			

11. How would you rate OVC treatment in existing alternative care systems?

Table 11: OVC treatment in existing alternative care systems

	OVC treatment	Response %					
		Poor	Fair	Good	Very good	Excellent	Total
1	Kinship/extended family						100
2	Institutional/residential care						100
3	Foster care						100
4	Adoption of a child						100
5	Community based care						100
6	Child-headed households						100
7	Group homes						100

Child related laws and policies

12. In your understanding, what are some of the existing child related laws and policies in Tanzania?

Table 12: Child related laws and policies in Tanzania

C/N	Child laws and policies	Response %		
		Agree	Not sure	Disagree
1	The Law of the Child Act, 2009 (Mainland Tanzania)			
2	The Law of Child Act (Foster Care Placement Regulation) 2012			
3	The Law of the Child Act (Adoption of Children Regulations) 2012			
4	The Child Development Policy, 1996			
5	National Health Policy, 1990			

13. How had Tanzania responded to the alternative care of OVC in terms of the national rules and regulations?

Table 13: National rules and regulations

C/N	National rules and guidelines	Response %		
		Agree	Not sure	Disagree
1	Convention on the Right of the Child, 1991			
2	African Charter on the Right and Welfare of the Child, 2003			
3	The Law of the Chils Act, 2009			
4	The National Guideline for Improving Quality of Care, Support and Protection for MVC in Tanzania, 2009			
5	The National Costed Plan of Action for MVC, 2007-2010			
6	The National Costed Plan of Action for MVC, 2012-2017			

14. In your opinion, what potential contributions do you think of the existing child related laws and policies could make to the enhancement of alternative care for OVC?

Table 14: Potential contribution of the existing child related laws and policies

C/N	Potential contribution of child related laws and policies to the enhancement alternative care for OVC	Response %		
		Agree	Not sure	Disagree
1	Development of national guideline for the alternative care of children			
2	Raising awareness to the community about child rights and protection			
3	Establishing legal status for the informal care system			
4	Monitoring and evaluation of the existing alternative care systems			
5	Take immediate legal actions on violation of children's rights			

15. In your opinion, what are the challenges facing implementation of child laws and policies?

Table 15: Challenges facing implementation of child laws and policies

C/N	Challenges facing implementation of child laws and policies	Response %		
		Agree	Not sure	Disagree
1	Poor coordination framework			
2	Inadequate knowledge of community members on child laws and policies			
3	Limited resources			
4	Use of English language in writing child related laws and policies			

Family-based care for OVC

16. What is your understanding of family-based care for OVC for OVC?

Table 16: Understanding of family-based care for OVC for OVC

C/N	Understanding of family-based care model for OVC for OVC	Response %		
		Agree	Not sure	Disagree
1	Informal foster care (kinship/extended family) care			
2	Statutory foster care			
3	Child adoption			
4	Community based care			
5	Group homes			
6	Supervised child-headed households			
7	Residential care homes			

17. How do you perceive the promotion of family-based care for OVC? (Please tick what applies)
    a. Very Important
    b. Important
    c. Moderately Important
    d. Slightly Important
    e. Not Important

18. Please identify the strategies likely to promote family based care for OVC

Table 17: Strategies that can promote family based care in Dar es Salaam

C/N	Stategies likely to promote family based care	Response %		
		Agree	Not sure	Disagree
1	Strengthen the capacity of families and communities			
2	Community awareness through advocacy and social mobilization			
3	Improve foster care recruitment and adoption programmes			
4	Provide protection and support for child-headed households			

19. In your opinion, identify challenges that might hinder an effort to promote family-based care for OVC for OVC in Dar.

Table 18: Opinion level on challenges likely to limit an effort to promote family-based care for OVC in Dar es Salaam

C/N	Challenges that can hinder promotion of family based care	Response %		
		Agree	Not sure	Disagree
1	Inadequate preventive measures			
2	Poor participation of communities and children in care decisions			
3	Inadequate social welfare workforce and funding			
4	Resistance from residential care centres			

Thank you very much for completing this questionnaire.

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

INTERVIEW GUIDE

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following interview guide is designed to form part of data collection for a research study, which I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix IV: Interview Guide for the Key Informants

1. Background Information

Name of the Institution/Organisation:.....

Highest level of education:.....

Current Position or title:.....

Professional qualification:.....

Male ___Female___

Date(s) of interview: .....

Nature of alternative care

1. Please share with me your understanding about alternative care for OVC.
2. How is the quality of care provided to OVC by the existing alternative care systems in Dar es Salaam?
3. What do you perceive as the roles of social workers in implementing care arrangements for OVC in alternative care systems
4. What is your opinion regarding challenges facing social workers in implementing care arrangements for OVC?

Situation of OVC in the existing alternative care systems

5. In your opinion, how is the situation of OVC in the existing alternative care systems?
6. Do you think there is any different for children who have lost their parents if

a. They are raised informally by their extended family? or
b. If they are adopted by unrelated families?

7. What do you think are the reasons for OVC placement into alternative care for OVC in Dar es Salaam?
8. In your opinion, what are the barriers hindering OVC from accessing alternative care?
9. In your opinion, how is the treatment of OVC in the existing alternative care systems?

Child related laws and policies

10. In your understanding, what are some of the existing child related laws and policies in Tanzania?
11. In your opinion, how has Tanzania responded to the alternative care of OVC in terms of the national rules and regulations?
12. In your opinion, what potential contributions do you think the existing child related laws and policies would make to the alternative care for OVC?
13. What is your opinion regarding knowledge of the community members in child laws and policies?
14. In your opinion, what are the challenges facing implementation of child laws and policies?

Family-based care for OVC

15. What is your understanding of family-based care for OVC for OVC?
16. How do you perceive the promotion of family-based care for OVC for OVC?
17. In your opinion, what are the strategies likely to promote family based care for OVC?
18. In your opinion, what challenges might hinder an effort to promote family-based care for OVC for OVC in Dar es Salaam?

Thank you very much for participating in this interview

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

INTERVIEW GUIDE

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following interview guide is designed to form part of data collection for a research study, which I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix V: Interview Guide for Community Leaders

(SEMI-STRUCTURED INTERVIEW)

1. Background Information

   Name of the Institution/Organisation.....

   Highest level of education.....

   Current Position or title.....

   Professional qualification.....

   Male ___Female___

   Date(s) of interview.....

Alternative care for OVC

2. Please share with me what you understand when people talk about the orphans and vulnerable children.
3. Please share with me your familiarity with types of alternative care systems for OVC.
4. To your understanding, what are services provided to OVC by the existing alternative care systems.
5. How would you rate the quality of care provided to OVC by the existing alternative care model in Dar es Salaam?
6. What do you perceive as the roles of social workers in implementing care arrangements for OVC in alternative care systems?

7. What is your opinion regarding challenges facing social workers in implementing care arrangements for OVC?

Situation of OVC in the existing alternative care systems

8. In your opinion, how is the situation of OVC in the existing alternative care systems?
9. Do you think there is any different for children who have lost their parents if
   a. They are raised informally by their extended family? Or
   b. If they are adopted by unrelated families?
10. What do you think are the reasons for OVC placement into alternative care for OVC in Dar es Salaam?
11. In your opinion, what are the barriers hindering OVC from accessing alternative care?
12. In your opinion, how is the treatment of OVC in the existing alternative care systems?

Policy issues

13. In your understanding, what are some of the existing child related laws and policies in Tanzania?
14. In your opinion, how has Tanzania responded to the alternative care of OVC in terms of the national rules and regulations?
15. In your opinion, what potential contributions do you think the existing child related laws and policies could make to the alternative care for OVC?
16. What is your opinion regarding knowledge of the community members in child laws and policies?
17. In your opinion, what are the challenges facing implementation of child laws and policies?

Family-based care for OVC

18. What is your understanding of family-based care for OVC for OVC?
19. How do you perceive the promotion of family-based care for OVC for OVC?
20. In your opinion, what are the strategies likely to promote family based care for OVC?
21. In your opinion, what challenges might hinder an effort to promote family-based care for OVC for OVC in Dar es Salaam?

Thank you very much for participating in this interview.

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

INTERVIEW GUIDE FOR FGD

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following interview guide is designed to form part of data collection for a research study, which I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix VI: Interview Guide for the OVC (FGD)

1. Background information.

   Age----------

   Sex----------

   Grade----------

   Name of the institution----------

   Date of interview……

Education

2. Are you currently attending school?
3. Who covers your school expenses?
4. Which grade were you during the time of placement?

Alternative care

5. Please tell me the reasons for your placement?
6. Have you been living with different families or institutions before your current placement?
7. Do you think there is any different for children who have lost their parents if
   a. They are raised informally by their extended family? Or

b. If they are adopted by unrelated families?

8. What is your relationship with those families?

a. Grand-parents, aunt/uncle, siblings, neighbor, relatives, parent's friends

b. If you were placed in another institution, what is the name of the institution?

9. What was the reason for leaving the former care?

10. To your understanding, what are services provided to OVC by the existing alternative care systems.

11. How would you rate the quality of services OVC receive from alternative care systems in Dar es Salaam?

Needs

12. What are your major needs and concerns?

13. Do you feel that you get love and support you need from the current care?

14. Do you get to participate in any activities outside the care or school?

Situation of OVC

15. How is the treatment in the institution?

16. To whom do you talk to when you are experiencing some problems?

17. How often do you meet your social worker?

18. Do you feel that people treat you differently from other children?

19. If, yes...how do they treat you differently?

Family-based care for OVC

20. What is your understanding of family-based care for OVC for OVC?

21. How do you perceive the promotion of family-based care for OVC for OVC?

Thank you very much for participating in this interview.

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

INTERVIEW GUIDE

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following interview guide is designed to form part of data collection for a research study, which I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix VII: Caregivers (FGD)

1. Background Information

   Name of the Institution/Organisation.....

   Highest level of education.....

   Current Position or title.....

   Professional qualification.....

   Male ___Female___

   Date of interview.....

OVC and alternative care

1. Please share with me your understanding about OVC.
2. What is your understanding on alternative care systems for OVC?
3. To your understanding, what are the reasons for OVC placement in alternative care systems?
4. To your understanding, what services the existing alternative care systems provide to OVC?
5. What challenges do you face in providing care and support to OVC?

6. How would you rate the quality of care provided to OVC by the existing alternative care systems in Dar es Salaam?
7. What do you perceive as the roles of social workers in implementing care arrangements for OVC in alternative care systems?
8. What is your opinion regarding challenges facing social workers in implementing care arrangements for OVC?

Situation of OVC in the existing alternative care systems

9. In your opinion, how is the situation of OVC in the existing alternative care systems?
10. Do you think there is any different for children who have lost their parents if
    a. They are raised informally by their extended family? Or
    b. If they are adopted by unrelated families?
11. What do you think are the reasons for OVC placement into alternative care for OVC in Dar es Salaam?
12. In your opinion, what are the barriers hindering OVC from accessing alternative care?
13. In your opinion, how is the treatment of OVC in the existing alternative care systems?

Family-based care for OVC

14. What is your understanding of family-based care for OVC for OVC?
15. What is your opinion in relation to importance of raising children under family-based care for OVC?
16. In your opinion, what strategies are likely to promote family-baded care for OVC in Dar es Salaam?
17. In your opinion, what challenges might hinder an effort to promote family-based care for OVC for OVC in Dar es Salaam.

Thank you very much for participating in this interview.

SOCIAL WORK DEPARTMENT

UNIVERSITY OF BOTSWANA, GABORONE

INTERVIEW GUIDE

My name is Mariana J. Makuu; a PhD candidate at the University of Botswana-Department of Social Work. The following interview guide is designed to form part of data collection for a research study, which, I am currently working on (i.e. Family Matters: Strengthening Alternative Care for Orphans and Vulnerable Children (OVC) in Dar es Salaam, Tanzania). You are therefore kindly requested to provide answers to enable the researcher to gather the necessary information for study. Privacy and confidentiality will be highly observed by making sure that any information you provide will be well secured. Please note that participation in this exercise is voluntary and you will not be forced or coerced to participate in the study. Should you wish to quit from this exercise at any time, you are entitled to do so.

Thank you.

Appendix VIII: Interview Guide for: Social workers (FGD)

1. Background Information

Name of the Institution/Organisation.....

Highest level of education.....

Current Position or title.....

Professional qualification.....

Male ___Female___

Date of interview.....

Nature of alternative care

2. Please tell me about the criteria used for placing OVC in alternative care in Dar es Salaam?
3. To your understanding, what are services provided to OVC by the existing alternative care systems.
4. How would you rate the quality of services OVC receive from alternative care systems in Dar es Salaam?
5. What do you perceive as the roles of social workers in implementing care arrangements for OVC in alternative care systems?

6. What is your opinion regarding challenges facing social workers in implementing care arrangements for OVC?

Situation of OVC in the existing alternative care systems

7. In your opinion, how is the situation of OVC in the existing alternative care systems?
8. Do you think there is any different for children who have lost their parents if

a. They are raised informally by their extended family? Or

b. If they are adopted by unrelated families?

9. What do you think are the reasons for OVC placement into alternative care for OVC in Dar es Salaam?
10. In your opinion, what are the barriers hindering OVC from accessing alternative care?
11. In your opinion, how is the treatment of OVC in the existing alternative care systems?

Child laws and policies

12. In your understanding, what are some of the existing child related laws and policies in Tanzania?
13. In your opinion, how has Tanzania responded to the right to alternative care of OVC in terms of the national rules and regulations?
14. In your opinion, what potential contributions do you think the existing child related laws and policies could make to alternative care for OVC?
15. What is your opinion regarding knowledge of the community members in child laws and policies?
16. In your opinion, what are the challenges facing implementation of child laws and policies?

Family-based care for OVC

17. What is your understanding of family-based care for OVC for OVC? (*Please provide examples*).
18. How do you perceive the promotion of family-based care for OVC for OVC?
19. In your opinion, what strategies are likely to promote family-based care for OVC?
20. In your opinion, what challenges might hinder an effort to promote family-based care for OVC for OVC in Dar es Salaam.

Thank you very much for participating in this interview.

Appendix IX: Informed Consent Form

PROJECT TITLE*:* **FAMILY MATTERS: STRENGTHENING ALTERNATIVE CARE FOR ORPHANS AND VULNERABLE CHILDREN (OVC) IN DAR ES SALAAM, TANZANIA**

Principal Investigator Professor. L-K, Mwansa, [*Ph.D.*]

Phone number(s): +267 355 2683/84

What you should know about this research study:

- I give you this informed consent document so that you may read about the purpose, risks, and benefits of this research study.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

You are being asked to participate in a research study of Mariana J. Makuu. The purpose of the study is to contribute to the understanding of the nature of alternative care for orphans and vulnerable children. You were selected as a possible participant in this study because of your knowledge and experience in the area. Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

PROCEDURES AND DURATION

If you decide to participate, you will be invited to interview will last approximately 45-60 minutes. Notes will be written during the interview. An audio tape of the interview subsequent dialogue will be made. If I do not want to be taped, I will not be able to participate in the study.

RISKS AND KUTOFARIJIKA

I understand that most interviewees might find the discussion interesting and thought provoking. If, however, I feel unconfortable in any way during the interview session, I have the right to decline to answer any question or end the interview.

BENEFITS

There are no direct benefits expected as a result of children's participation in this study. However, research like this does help to develop better understanding of problems and challenges facing alternative care systems for OVC and recommend on how to address them.

CONFIDENTIALITY

The data from this investigation will be subject to standard data use policies, which protect the annonymity of individuals and institutions. None of these will be used for commercial use.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the University of Botswana, its personnel, and associated institutions**.** If you decide not to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. Any refusal to observe and meet appointments agreed upon with the central investigator will be considered as implicit withdrawal and therefore will terminate the subject's participation in the investigation without his/her prior request. In the event of incapacity to fulfill the duties agreed upon the subject's participation to this investigation will be terminated without his/her consent.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Mariana J. Makuu _____ _____

Name of Research Participant Date

_____ _____

Signature of Staff Obtaining Consent Date

Appendix X: Parental Consent Form

Before starting the interview, the Authorized Representative from residential care centres providing care to OVC will be required to sign two copies of this form. The authorized representative will be given a signed copy.

Title of the study: Family Matters: Strengthening Alternative care systems for Orphans and Vulnerable Children in Dar es Salaam, Tanzania.

Researcher's name: Mariana J. Makuu

Researcher's phone number: +255716211283

Email address: m_josephat@yahoo.com

Children from your institution are being invited to take part in a research study to be conducted by Mariana J. Makuu, from the University of Botswana. Before you allow children to participate in this study, you should read this form and ask questions in areas you do not understand.

1. The purpose of the study is to examine the nature of alternative care systems for OVC in Dar es Salaam.
2. Children will be asked to answer interview questions related to the study in group discussions. The interview will last approximately 25-30 minutes.
3. Most interviewees might find the discussion interesting and thought provoking. If, however, a child feels unconfortable in any way during the interview session, he/she has the right to decline to answer any question or end the interview.
4. There are no risks expected as a result of your institution's children participation. One assistant researcher has clinical experiences to help monitor comfort level of the children and intervene whenever a need arises.
5. There are no direct benefits expected as a result of children's participation in this study. However, research like this does help to develop better understanding of problems and challenges facing alternative care systems for OVC and recommend on how to address them.
6. The inclusion criteria will be:

- ✓ Boys and girls aged 10-17 years.
- ✓ Children who have lost one or both parents to AIDS or pther related factors
- ✓ Street children

7. Consent to participate.

   I give my consent for the children from.....(name of the institution) to participate in the research project described above. I understand that this participation is voluntary and that I may withdraw my consent at any time without penalty. I also understand that the children from my institution may withdraw their assent at any time without penalty.

   .....

   Signature of Authorized Representative

   Mariana J. Makuu Date.....

Appendix XI: Minor Assent Form

My name is Mariana J. Makuu

I am doing research about strengtheng alternative care systems for orphans and vulnerable children. A research study is a way to learn more about people. This study is therefore intended to learn more about experiences, views, opinions and perception of orphans and vulnerable children on care and support they receive.

1. If you decide to participate in this study, you will be asked to answer interview questions in a group discussion for approximately 25-30 minutes.
2. There are some things about this study you should know. If, however, you will feel unconfortable in any way during the interview session, you have the right to decline to answer any question or end the interview.
3. There are no direct benefits expected as a result of your participation in this study. A benefit means that something good happens to you. However, research like this does help to develop better understanding of problems and challenges facing alternative care systems for OVC and recommend on how to address them.
4. When I finish this study I will write a report about what was learned. This report will not include your name or that you were in the study.
5. You do not have to be in this study if you do not want to be. If you decide to stop after we begin, that will be fine too. Your social workers know about the study too.
6. If you decide to be in this study, please sign your name.

I....., want to be part of this study.

Mariana J. Makuu Date.....

Appendix XII: Research Permit from Ilala Municipal Council

ILALA MUNICIPAL COUNCIL

[All letters should be addressed to the Municipal Director]

Tel: Tell: 20950
Fax: 2121486

Ref. No. IMC/GH.8/1/2

MUNICIPAL DIRECTOR
MISSION STREET
P.O.BOX 20950
DAR ES SALAAM
Date26/08/2015

RE: Research Permit

With reference to the above heading.

I hereby inform you that Mariana J. Makuu who is a bonafide PhD candidate of the University of Botswana has been granted a permit by the Department of Social Welfare (Ilala Municipality) to carry a research at your residential care centre about '*Family Matters: Strengthening Existing Alternative Care Systems for Orphans and Vulnerable Children in Dar es Salaam'.*

We therefore kindly implore you and the supporting staff to be forthcoming to her by availing the same any needed support which is within your reach in order to help her realize the intended objectives of this study.

Yours sincerely,

SIGN
C.Mhina
MUNICIPAL SOCIAL WELFARE OFFICER
ILALA MUNICIPAL COUNCIL

FOR: MUNICIPAL DIRECTOR

ILALA

Copy to: Mariana J. Makuu

University of Botswana

Director of the Residential Care Centre

Appendix XIII: Research Permit from Kinondoni Municipal Council

KINONDONI MUNICIPAL COUNCIL

ALL CORRESPONDENCES TO BE ADDRESSED TO THE MUNICIPAL DIRECTOR

Tel: 2170173
Fax: 2172606

MUNICIPAL DIRECTOR
KINONDONI MUNICIPAL
COUNCIL
DAR ES SALAAM
DATE: 27/08/2015

RE: RESEARCH PERMIT FOR MARIANA J. MAKUU

The mentioned is bonafide PhD candidate of University of Botswana who is doing research titled: "Family Matters: Strengthening Existing Alternative Care Systems for Orphans and Vulnerable Children in Dar es Salaam; Tanzania*"* as part of her programme for the award of PhD.

The researcher needs to collect data and necessary information related to her study at the residential care centres for orphan and vulnerable children in Kinondoni Municipal.

In line with the above information, you are being requested to provide needed assistance that will enable her to complete the study successfully.

.....
A. B. Tutuba
For: **THE MUNICIPAL DIRECTOR**
KINONDONI

Copy to: Mariana J. Makuu
University of Botswana

Director of the Residential Care Centre (engaged in the study) in Kinondoni Municipality

Appendix XIV: Research Permit from Temeke Municipal Council

TEMEKE MUNICIPAL COUNCIL

[All letters should be addressed to the Municipal Director]

Tel: Tell: +255 22-2851054
Fax: +255 22-2850640
E-mail:temekemanispaa@tmc.go.tz
Website: ww.tmc.go.tz

Temeke Municipal Council
P.O.BOX 46343
Mandela Road
Dar es Salaam
Date: 31/08/2015

Ref. No. TMC/MD/U.21/30

Directors of the Residential Care Centres

1. Kwetu Mbagala Care Centre
2. Kurasini Children's Home
3. Dar Al Arqam Orphanage Centre
4. Kurasini Children's Centre
5. New Hope Care Centre
6. VOSA Care Centre

RE: RESEARCH PERMIT

Please refer to the heading above.

This is to inform you that, permission is granted for Mariana J.Makuu; a PhD candidate from the University of Botswana to conduct research on *Family Matters: Strengthening Existing Alternative Care Systems for Orphans and Vulnerable Children in Dar es Salaam; Tanzania;* at your care centre.

Therefore, you are asked to give the said researcher necessary assistance and cooperation so that she can successful accomplish the research objectives.

For: MUNICIPAL DIRECTOR
TEMEKE

Copy to: Mariana J. Makuu
University of Botswana

Directors of the Residential Care Centres
Temeke Municipality

Appendix XV: Ethical Review and Approval Letter from University of Botswana

UNIVERSITY of BOTSWANA

Office of the Deputy Vice Chancellor (Academic Affairs)

Office of Research and Development

Corner of Notwane and Mobuto Road, Gaborone, Botswana

Pvt Bag 00708 Gaborone Botswana

Tel: [267] 355 2900
Fax: [267] 395 7573
E-mail: research@mopipi.ub.bw

Ref: UBR/RES/IRB/201

13th July, 2015

Ms. Mariana Makuu (201308195)
University of Botswana
Department of Social Work
Private Bag 0022
Gaborone
Botswana

TITLE: FAMILY MATTERS: STRENGTHENING ALTERNATIVE CARE MODELS FOR ORPHANS AND VULNERABLE CHILDREN (OVC) IN DER -ES -SALAAM TANZANIA

Thank you for submitting a new application to the University of Botswana Institutional Review Board (UB IRB) for ethics review and appraisal. UB IRB has reviewed and approved your application for a period of one year effective from 10th July, 2015. This permit will expire on the 9th July, 2016. The IRB is satisfied with the process for data collection, analysis and the intended utilization of findings from this research and is confident that the project will be conducted in accordance with local and international ethical norms and guidelines.

This permission does not however give you authority to collect data from the selected site without prior approval from a research ethics committee in Tanzania and management at the selected sites. Consent from identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the UB IRB for consideration and approval.

Furthermore, you are requested to submit at least one hard copy and an electronic copy of the report to the University of Botswana within three (3) months of completion of the study. Copies should be submitted to the relevant authorities.

Continuing review

In order to continue on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for approval at least 3 months prior to the proposal's expiration date . The form can be obtained from the Office of Research and Development (Office No 149) or can be requested by e-mail from Research& Development research&development@mopipi.ub.bw.

Amendments

During the approval period, if you propose to change to the protocol such as its funding source recruitment materials, or consent documents, you must seek permission for UB IRB approval before implementing the change. The amendment form can be obtained from the Office of Research and Development (Office No 149) or can be requested by e-mail from Research& Development research&development@mopipi.ub.bw.

If you have any questions, please do not hesitate to contact Ms. J. Gaorekwe at: Research& Development research&development@mopipi.ub.bw Tel +267 3552903

Yours Sincerely

Dr. M. Kasule
Assistant Director Research Ethics
Office of Research and Development