Leaving No Child Behind Tanzania (LNCB-T)

Fighting mental health problems of institutionalized children in Tanzania

Credit: Edson Mwijage (2019)

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Foreword

The situation of children living in orphanages in Tanzania is urgent. They have been abandoned due to social catastrophic issues such as extreme poverty, disease, suicide and infidelity. Most babies have been found left on roadsides, in the open pit latrines and in the bus stops. In this critical issue, orphaned children are likely to be poorer and less healthy. They are more likely to suffer damage to their cognitive and emotional development, less likely to go to school and more likely to be subject to worst forms of child labor.

These children live in a high-risk environment and suffer in many ways, and often there is no other way for them to meet their basic needs but to stay in the orphanage centers. Neither the community nor centers themselves want the children to live this way, but when the government insists on sending the children back to their families, many end up to be street children, beggars and drug addicts. Their families cannot sufficiently provide the basic needs of life and security to them due to extreme poverty.

The ideal solution for children that have to stay at the center would be a foster model where they grow up in a home like normal children. But raising funding for such a model is difficult, so all children are kept together in a central building with too few staff. Unfortunately, the support by the government is too little and often embezzled by corruption. Approaching international organizations and donors like USAID also faces issues of corruption and instability. And whatever you read in their reports regarding the impact of their initiatives is not what the real situation on the ground is. Thus, most centers rely on funding by individuals and the community, which of course is also difficult.

For example, many children in our centers suffer and sometimes even die from diseases for which nobody can pay the treatment. This is why we are currently financing basic health insurance for 100 children in two orphanages in Morogoro. Through local school mates, colleagues and other friends, we were able to raise already 95% of the needed funds, which will be sustained by member commitments and bank interest over the long term. On the picture you can already see the first children holding their insurance cards. Given this success, we hope to continue to expand our initiative to improve the situation in a community approach.

This report is addressing an issue of child health that I can certainly confirm and that needs much more attention. Given the many physical diseases children have, we simply did not have the chance to think about a solution for mental health. But it is true that the children have gone through many difficulties and the staff don't have the time or the training to help them. I think that they could really benefit from professional help for them to deal with the trauma that they are suffering. The idea of having a student at the center that could help the children in a professional way is great and I would welcome this to become reality.

Edson Mwijage

Abstract

Background: Despite a slightly declining number since the AIDS epidemic in the 1990s, there are still over 140 million orphans, meaning one or both parents passed away. There is a wide consent that orphans and other vulnerable children should be retained in their family or be taken into the custody of another family, as institutionalization of children has adverse effects on Early Childhood Development (ECD) as well as safe transition into adulthood. Still, some estimates put the number of institutionalized children globally at 2,726,000. Among other interlinked problems, these children are exceptionally vulnerable to chronic mental health issues, caused by a lack of social-cultural stimulus by adult role models, as well as violence and trauma.

Purpose: This Report was initiated by the call-to-action of a Tanzanian community leader who works on improving the well-being of institutionalized children in his community. With this proposal, we hope to support his efforts by raising awareness on this issue as well as proposing one possible approach.

Literature Review: In order to address mental health issues of institutionalized children, this report looks at common interventions that address the wellbeing of African orphans and vulnerable children (OVC) in general, and institutionalized children in particular. Both Community-Based interventions, which try to support families living with OVC by providing services, and Cash-Based interventions that focus on transfers to households with OVC, are reviewed. We finally identify innovative therapeutic approaches as having the largest potential for OVC who are otherwise left behind, but also discuss limitations and risks.

The Model: Our solution focuses on the most marginalized children that are excluded from existing OVC interventions. Based on the literature, we developed the likely most cost-effective model to address mental health among OVC. Central to our proposal are civil-servants which are recruited among recent Tanzanian undergraduates and then trained in proven therapeutic intervention for OVC. These students will also interact with leaders in the community. Further, the programs will utilize innovative tele-health and digital-health innovations.

Conclusion: LNCB-T is an efficient, tested and scalable approach to mental health of OVC.

Introduction

Background

Like many other sub-Saharan countries, Tanzania has been one of the worst victims of the HIV epidemic in the last couple of decades. HIV/AIDS has severely affected large populations of Tanzania which has led to serious demographic impacts (TACAIDS, 2013). The high mortality of adults suffering from HIV/AIDS has affected the socio-economic fabric of Tanzania in several ways. One of the most significant changes to the national demographics of countries affected by the HIV epidemic is the rise in numbers of the orphan population. UNAIDS estimated in 2006 that 12% of children in Africa had lost at least one parent (Harding et al., 2019). Tanzania is expected to have an orphan population of slightly over 3.1 million children.

This proposal is an attempt to identify ways to safeguard the mental health of the institutionalized children through a community-based approach. For the purpose of this proposal, we utilise UNICEF's definition of orphans as children under 18 years of age who have lost one or both parents to any cause of death. A systematic review by Schenk (2009) found that orphans face a multifaceted problem including "increased risks of school drop-out and poor performance, impaired food security, diminished psychosocial well being, elevated risks of HIV infection and sexually transmitted infections (STIs), reduced access to healthcare and other services, and other problems associated with poverty and lacking adult care" (p.918). Further, research found that especially " children living in orphanages and other forms of institutional care are among the most vulnerable and are at risk of abuse, exploitation, developmental damage, mental distress and maladaptive behaviours" (Rukundo & Daniel, 2016) In Tanzania, the number of the most vulnerable children (MCVs) is approximately 3,000,000. It includes children living without parental care and support; double orphans (230,256), maternal orphans (462, 688), paternal orphans (1,283,067), children cared by elderly (327,514), and children cared for by siblings (200,091) (SOS, 2014). Orphans usually live in either of the two contexts- with their extended family (informal care) or within institutionalized settings like orphanages and foster care (formal care).

This proposal will exclusively focus on formal care of orphan children in institutionalized settings. This is also motivated by the notion of "leaving no one behind" that has become increasingly relevant within the sustainability paradigm and has been the foundational idea upon which 'Universal Health Coverage (UHC)' is conceived and conceptualised (IPPF, 2018). The *Global Health 2035 Report* proposed the idea of a pro-poor investment framework for the UHC (Jamison et al., 2013). It is under this framework of prioritising and providing cover for poor people's health from the very beginning, that we identify the need to draw attention towards the orphan and vulnerable children's populations in countries like Tanzania.

Further, the literature identified Mental Health as one of the key issues that affect institutionalized children most disproportionately compared to children in family based care. Mental health is defined as a state of well-being that enables individuals to realize their abilities and live a fulfilling life (WHO, 2003). From early on, psychological wellbeing was recognized as a central issue of orphans in Africa, beyond education and food (Foster, 2002).

Mental Health among institutionalized children in Tanzania

There is a diffuse terminology regarding OVC and their care status. A more general definition for children living in an institutionalized setting, i.e. in orphanages, is 'residential care'. According to the United Nations, 'Residential care' is "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" (Petrowski et al., 2017 p. 390). Unfortunately, there are not many statistics and often only estimates of the number of children living in orphanages. One regional estimate for East and South Africa put the number of children in residential care in the entire region at 163.000, which is about 120 children per 100.000 people. This would mean that there are around 72.000 children in residential care. A different estimate puts the number much lower at around 11.565 Tanzanian children in residential care (Mchomvu & Mvungi, 2012). Overall, the overall number of residential care facilities in Africa has been increasing (Mann et al., 2012).

There are several disadvantages to institutionalization, but the most important issues addressed revolved around a lack of psycho-social stimulus during important stages of child development. In plain language, the lack of love and affection that children would normally receive in a family setting is leading to mental health problems. Two main drivers are associated with mental health issues of children in alternative care. One reason is insufficient and inadequate caregiving. Such a lack of simple social stimulus through adults is linked to adverse Early Childhood Development (ECD) among institutionalized children (Engle et al., 2011). In most of the studied centers, the caretaker-child ratios of 2:25 (age 8-12 years) and 2:35 (age 13+ years) recommended by the Tanzanian government were rarely met (Msoka & Holroyd, 2018). The second general reason is the common use of corporal punishment and general physical violence by caretakers in orphanages (Hermenau et al., 2011).

Problem Statement

The idea for participating in the Geneva Health Challenge was triggered by the call-for-action by a Tanzanian community leader, Edson Mwijage, who is trying to improve the well-being of institutionalized children in his community in Morogoro, Tanzania. He reached out to the authors of this report to investigate how the situation of orphans in Tanzania could be improved. In his problem statement, he addressed both the physical and mental health of children in residential care. Further, his accounts indicated that exiting public programs and interventions seemed to neglect these children.

Our initial research showed that, while institutionalization has received considerable attention in the aftermath of the HIV epidemic, it is being lost from the radar of policy makers and donors, primarily due to its negative reputation. Also orphanages initially established and financed by wealthy individuals and organizations such as the international church are being abandoned and left to their devices. The residential care facilities addressed by Mr. Mwijage depend completely in the support of their community in terms of financial and human resources.

In the following, this report will first review the literature on common interventions for OVC in general and institutionalized children in particular. There will also be a review of existing

policies and programs in Tanzania. The report will also feature a case Mgolole orphan center in Morogoro as an illustrative example.

Based on our findings and a critical reflection, this report concludes that the mental health of institutionalized children does not receive enough attention. We therefore propose a solution to address the issue of mental health among institutionalized orphans, vulnerable children & youth, specifically in Tanzania.

Literature Review

Interventions for Orphans and Vulnerable Children

The connection between mental health and poverty is well-established and documented in the academic field (Patel and Kleinman (2003), Lund et al., (2011), Haushofer and Fehr (2014), Kilburn et al. 2016). However, poverty being defined as an increasingly multidimensional phenomena, it is important to state that not only economic deprivation, food insecurity and lack of basic amenities contribute to mental problems, but also factors of social causation like social exclusion, stress and restricted access to social capital (Lund et al. 2011). Therefore, the factors that contribute to mental problems of orphans are not only economic deprivations that they experience, but also the low quality of social care that they receive due to high child/caretaker ratio.

In order to understand whether this connection means that poverty reduction programs positively influence mental health of recipients, we need to look at social safety nets and other related projects actually implemented in the field.

Community-Based Service Interventions

Most people probably heard of the African proverb "It takes a village to raise a child". It is in fact widely practiced custom that children in many African societies are raised in an extended family and even community (Foster, 2000). The HIV/AIDS epidemic however overwhelmed this traditional system of communal care. As an entire generation of parents died and the old were simply not able to care for, the children that were left behind, many slipped through these communal safety nets (Foster, 2000).

From the very beginning, most interventions targeting OVC in Africa tried to strengthen the capacity of communities to prevent the need for centralized and institutionalized care. Many leading organizations dealing with orphans such as UNICEF, pushed the idea that is was always preferable to retain OVC in the custody of extended family or other members of the immediate community (Rukundo & Daniel, 216). Quite generally, programs covered six service areas: physical and mental health, nutrition, support for education and material well-being, and day- and after-school care (Kidman, Petrow & Heymann, 2008 p. 327). Many programs also address very practical but central issues such as will-writing for HIV-positive adults to prevent land grabbing, and training and job support, and HIV-prevention (Schenk, 2009). Centralized day care, something that seems so naturalized in high-income societies, has a completely different meaning in AIDS affected communities in Africa, where it is a trade-off for households that have no capacity left to cater for preschool-aged children and earn a livelihood. Programs with a decentralized approach try to strengthen the capacity of households through material support and by dispatching social workers to regularly visit families for counseling (Kidman, Petrow & Heymann, 2008). School-aged children and adolescents are most vulnerable to mental health issues, thus the focus of programs are on providing psychological counseling as well as education training (Kidman et al., 2007, Schenk, 2009).

A successful modality, specifically for decentralized OVC programs, is a community based approach. Many of these programs work with local volunteers that are trained in basic routines for checking on children's general physical well-being and school attendance, but also psychological support. They have focussed on creating local ownership by letting communities select the volunteers, and by engaging local leaders to build support (Schenk, 2009). However, attracting volunteers without sufficient compensation is difficult, and simple service provision is often not enough to address all issues of OVC (Shenk, 2009). Overall, while centralized approaches are better at controlling the quality of their services, decentralized interventions proved to be the most cost-effective and scalable way to help OVC (Kidman et al., 2007, Schenk, 2009). A key lesson from established OVC programs in the early 2000s is that "community motivation, long term external funding, and technical support" (Schenk, 2009 p. 934) are crucial for the sustainability of community based models.

Cash-Based Interventions

There is a number of programs implemented in the African Great Lakes Region, many of them specifically targeted at orphans and vulnerable children. One of the best examples is the Kenya Cash Transfer for Orphans and Vulnerable Children (CT-OVS), realized in the period from 2009 to 2018 by the Department of Children's Services at the Ministry of Home Affairs of Kenya with the support of the World Bank. The project implied unconditional cash transfers to ultra-poor households (lowest expenditure quantile) that had at least one orphan or vulnerable child (OVC) under the age of 18. These households were provided with a monthly cash transfer of 1,500 Kenyan shillings (USD $21), which is equal to approximately 20% of monthly household expenditure (Perreira 2006). As a result of regular cash transfers many children stayed within the family instead of being taken to foster care due to lack of financial resources, which positively affected their mental well-being (Lund et al. 2012). Among the full sample of youth, those living in households that had received the transfers were 24% less likely to have depressive symptoms compared to those who did not receive them (Lund et al. 2012).

A similar program was implemented in Malawi, but was targeted at young girls. The Zomba Cash Transfer Program provided young females (13-22 years old) with monthly transfers (conditional and unconditional) for a period of two years. The intervention improved the mental health of its beneficiaries (Baird et al. 2013). The evaluation study found that girls receiving conditional transfers were approximately 17% less likely to be suffering from psychological distress than those in the control group during the program. However, it is important to mention that these effects had become smaller and statistically insignificant soon after the program ended. When talking about mental health, it should be stated that approximately half of all mental health disorders begin by age 14, and three-quarters by age 24 (Kessler et al., 2005). Also, young people with depression are at increased risk of educational under-achievement and unemployment, later anxiety disorders, and attempted suicide (Fergusson and Woodward, 2002). Therefore, a child is most vulnerable during their childhood and adolescence and, if implemented during this period, a program improving their mental health might in fact have long-lasting effects.

Another Malawian program, Social Cash Transfer Program, was also evaluated in terms of its effects on mental health (Angeleset al. 2019). The project provided unconditional income support to ultra-poor, labor-constrained households and had a substantive and statistically significant impact on youth mental health. The probability of suffering from depressive symptoms was reduced by about 17–24% with a particularly strong effect on females (Angeleset al. 2019).

Institutionalized Care

The range of quality among orphanages and other residential care facilities is huge (Rukundo & Daniel, 2016). A prime example of a high-quality care provider is the renown international NGO "SOS Children's Villages" which operates good facilities with trained staff, providing children with western-standard education and care (Abebe, 2009). Well organized and funded facilities like the SOS children villages also follow a family-model, where children are organized in groups with 'mothers' and 'aunties' that ought to resemble natural family settings as much as possible (Abebe, 2009). While this may be an extreme example, literature on institutionalized children shows that the material well-being of orphans are in most cases at par or even better than that of their peers (Rukundo & Daniel, 2016, Hermenau et al, 2014, Msoka & Holroyd, 2018). However, this also creates a 'Lucky Orphan' paradox that at times caused friction in affected communities and even created perverse incentives to institutionalize children without need (Abebe, 2009, Rukundo & Daniel, 2016). In a recent case of post-earthquake Haiti, the number of internationally funded orphanages increased by 150% to 750, together receiving over US$100.000 annually (LUMOS, 2017). However, 80% of children in the orphanages had at least one living parent (LUMOS, 2017). Alternatively, such institutionalization could be avoided by instead providing material and service support to the families directly.

While institutionalized children are not worse off in terms of food, education and clothing, institutionalization comes at the great cost of psycho-social wellbeing. Despite these well studied adverse effects, institutionalized children rarely received adequate counselling

provided by these facilities (Rukundo & Daniel, 2016, Hermenau et al, 2014, Msoka & Holroyd, 2018).

OVC Programs in Tanzania

Kizazi Kipya - Community-Based Service Program

One example of a large scale OVC intervention run in Tanzania is Kizazi Kipya which is a USAID program run in all districts of Tanzania. It was created as a 5-year program in 2017 and already reached over 800.000 OVC (USAID, 2019). The program is implemented by Pact and run jointly with the Tanzanian Ministry of Health, Community Development, Gender, Elderly and Children, Department of Social Welfare, under the National Integrated Case Management Framework (NICMF) that was established in 2016. Case Management is here referring to the process of "identifying, providing support, referring and following up MVC[1] cases" (USAID Kizazi Kipya Project, 2017 p.1).
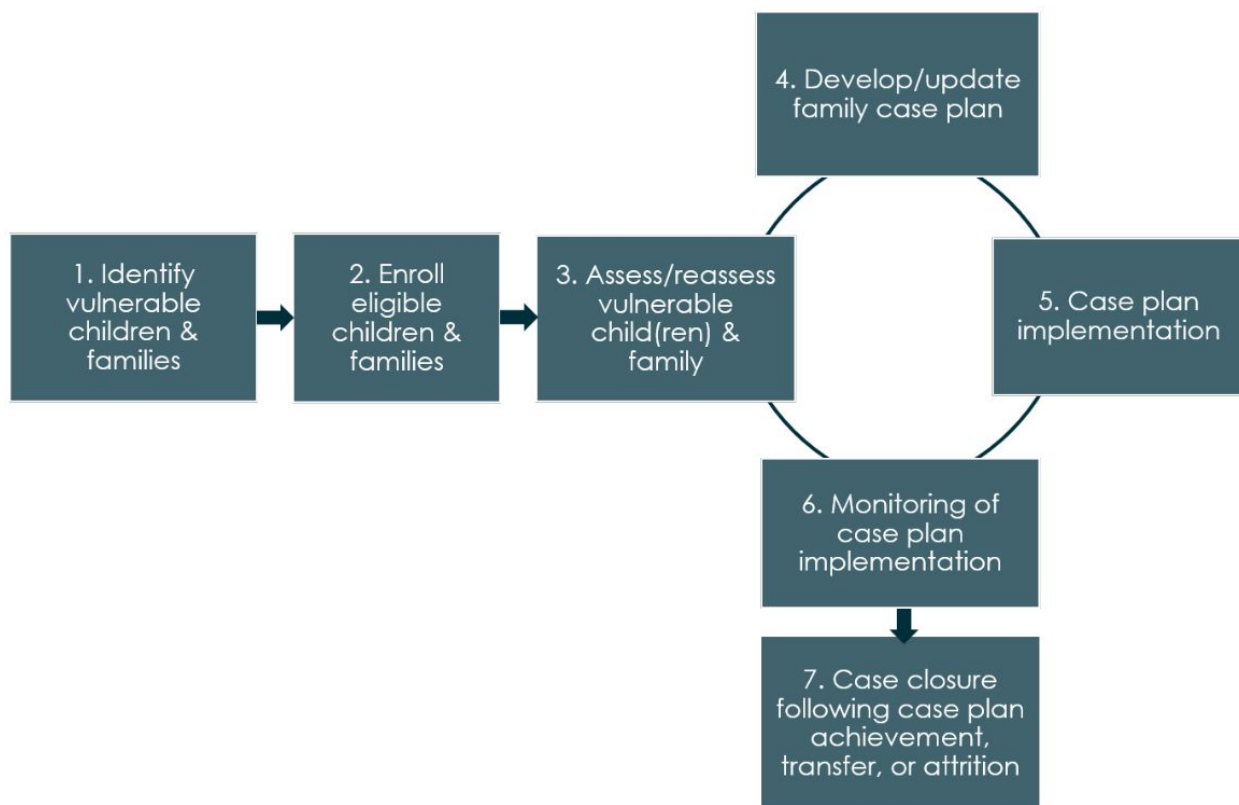
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[1] Most Vulnerable Children

Figure 1. Case Management Work Plan (Source: Gobin & Foley, 2019a p.10)

The Case Management Process is designed according to the Coordinating Comprehensive Care for Children (4Children) in the seven step process, illustrated in Figure 1. Potentially eligible children are identified and referred by local entities such as health facilities or directly by CWs. The children are then assessed for eligibility based on a set of undisclosed criteria. After this, an initial care plan is developed by the CW and the household based on need assessment. The CWs then conduct monthly monitoring visits to each household and provide "basic services (e.g., psychosocial support, nutrition assessment, child development and parenting skills, child protection, monitoring school attendance, referrals to community-level services)" (USAID Kizazi Kipya Project, 2017 p.3). Every three months, the OVC household's eligibility is re-evaluated and the care plans updated.
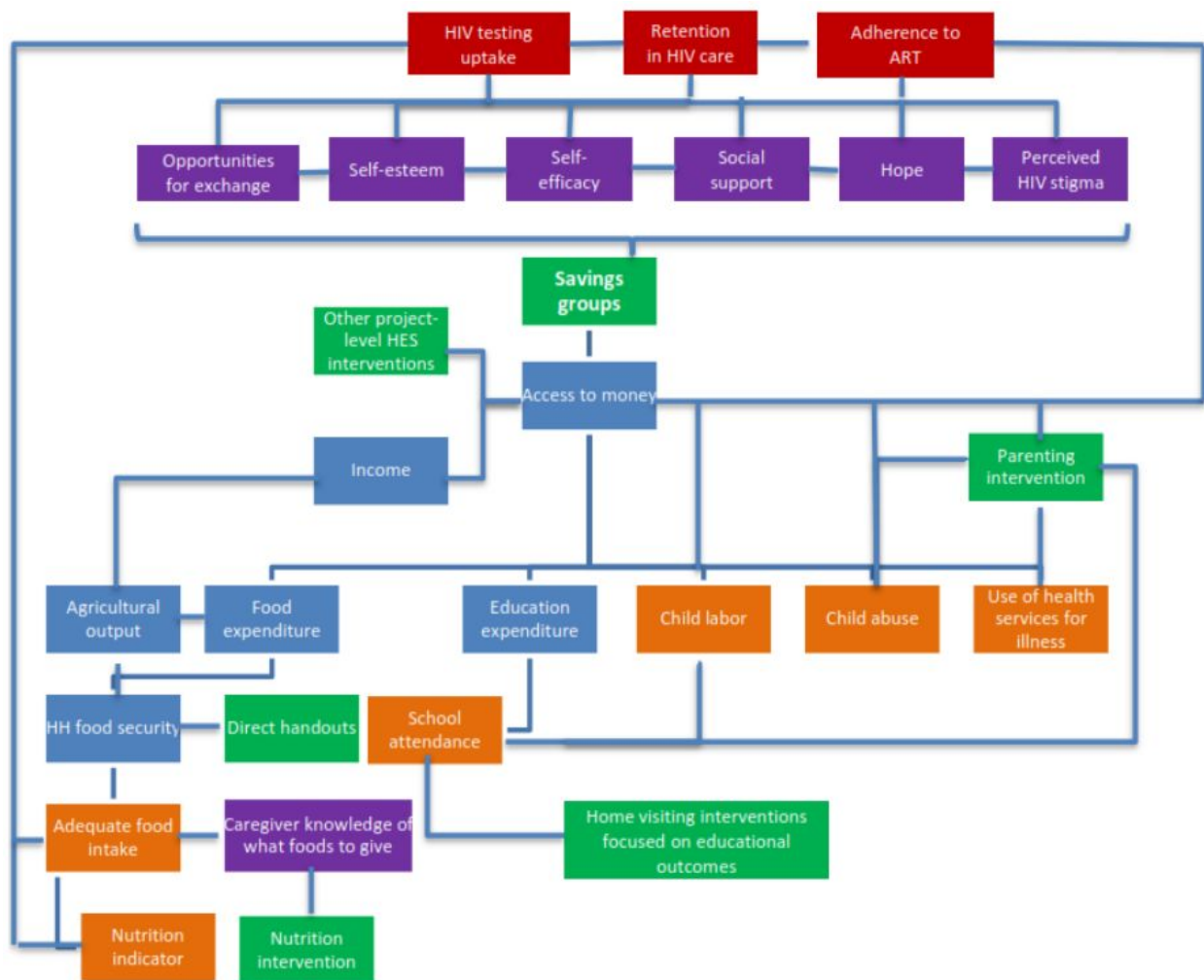
Figure 2. Theory of Change of Kizazi Kipya (Source: Chapman et al., 2018 p.75)
Note: The green boxes represent project interventions, the blue boxes represent HH-level outcomes, the purple boxes represent caregiver-level outcomes, the orange boxes represent child-level outcomes, and the red boxes represent child/caregiver HIV outcomes

Another important component in the Kizazi Kipya program is the promotion of community savings groups (see Figure 2). There are already a set of existing savings group models in Tanzania, among them WORTH, livelihoods for most vulnerable children care (LIMCA), and savings and internal lending communities (SILC) (MEASURE, 2018). Most of these groups had sub-accounts with specific savings goals. One component were Most Vulnerable Children (MVC) Fund. These funds accumulated savings to pay for school fees, school uniforms and other expenses. These funds were able to save an average of US$12.75 per child, in a study that looked at funds covering nearly 30.000 children (USAID, 2014).

The project is using 48 local Civil Society Organization (CSO) that are often initiated for the purpose of the program as intermediary administrative instance. These organizations elect

management officers that coordinate Volunteer Case Workers (CWs) who are recruited by the local branches of the Department of Social Welfare. The recruitment process involves community meetings and CW have to be able to read and write, be under the age of 55, and of course come from the village in question. An international implementing partner, John Snow Inc., trained government personnel at the national level in 2017, who then in turn trained CSO staff, who then trained CWs (Gobin & Foley, 2019).

Kizazi Kipya is one of the largest community based OVC programs in Africa with a budget of US$163.6 million for the 5-year period (USAID, 2019). Due to the large scale of the program, the cost per beneficiary are US$15.97. The average CW is covering 18.1 households including 39.2 OVC. CW receive a monthly stipend of US$21.70, of which nearly half is used by the CW for work related expenses such as travel (MEASURE, 2019). However, case worker support only accounts for 14% of the total budget. In the first year of implementation, over 56% is spend on the training, which is however expected to reduce as the hiring of new CW reduced.

Tanzania Productive Social Safety Net (PSSN)

Tanzania first initiated its pro-poor safety net program in 2000 under the Tanzania Social Action Fund (TASAF), and has since evolved it in two new phases. The third stage, TASAF III, is the Productive Social Safety Net (PSSN), initiated in 2012 by the national government. The basic component delivers a bimonthly unconditional cash transfer, targeting the bottom 10% and reaching over 1 million households (UNICEF, TASAF & REPOA, 2018). This unconditional transfer amounts to (UNICEF et. al. 2018 p. 15):

- 10,000 TZS to all enrolled households (approx. 4.50 USD)
- 4,000 TZS fixed benefit for each household if the household has a child under 18 years (approx. 1.80 USD)

Admission to the program is based on a three-stage process. First, areas are targeted geographically based on poverty maps. In the next stage, locally elected committees on the village level determine the poorest individuals in their community. These are then screened through a proxy means test before the final eligibility decision is made.

One complementary component to the unconditional cash transfer under PSSN are 'Cash Plus' benefits that apply when the household meets certain conditions.

As of 2015, the Conditional Cash Transfer provides (UNICEF et. al. 2018 p. 15):

- 4,000 TZS fixed additional for child under five, conditional on health compliance (approx. 1.80 USD);
- 2,000 TZS additional for each child (up to four children), conditional on enrollment in primary school (approx. 0.90 USD);
- 4,000–6,000 TZS additional for child, conditional on enrollment of child in lower or upper secondary school (approx. 1.80–2.70 USD); and

Next to simple cash transfers, there are also Cash-for-Work benefits "of 2,300 TZS per day (approx. 1.00 USD) for one able-bodied adult per household aged 18 and over for up to 60 days in four months" (UNICEF et. al. 2018 p. 15). Excluding the cash-for-work component, total transfers are capped at a maximum monthly transfer of TZS 38,000 (approx. 17.00 USD) (UNICEF, TASAF & REPOA, 2018).

An additional 'Livelihoods Enhancement' service component includes the promotion of savings and savings groups, as well as basic training and support with improving income generating activities. Business Plans can be supported with a 'productive grant' of about $US80 (UNICEF et. al. 2018).

Evaluation showed significant improvement in terms of educational outcomes as well as material well being among children. However, in contrast to the widely cited CT-OVC program in Kenya, PSSN appeared to be few quantitative impacts across a range of mental and physical well-being outcomes, when compared to a control group, although the program did result in the increase of some measures of subjective well-being and aspirations (UNICEF, TASAF & REPOA, 2018). The study also did not result in changes in sexual behavior or perceived HIV risk.

Cash Plus Model for Safe Transitions to a Healthy and Productive Adulthood

"Adolescence is an intense period of physical transformation and brain development. As such, it represents a unique window of opportunity, and investments in adolescence are

often referred to as having a 'triple dividend' with benefits today, in adolescents' future adult life, and in the next generation of children" (UNICEF et al., 2018 p. 10). However, adolescents in general face many risks including poverty, early pregnancy and marriage, violence, HIV and unemployment (UNICEF et al., 2018).

Past studies have shown the link between cash transfer programs and safer transition into adulthood (UNICEF et al., 2018). However, cash transfer alone is not sufficient to address the issue in all its complexity. For this reason, the TASAF III decides to add a special component which is now rolled in a pilot. Figure 3 shows the service (demand) and material components (supply) that primarily aim to address issues related to HIV and early pregnancy. These components shall be delivered by local government personal that will be trained in a 10 week program to implement mentoring interventions on the community level (UNICEF et al., 2018). The programs objectives are to "improve adolescents' future employment opportunities and income-generating ability; delay sexual debut, marriage and pregnancy; reduce engagement in exploitative sexual partnerships and HIV risk behaviours; improve mental health; reduce levels of violence victimization; and increase levels of health-seeking for SRH/HIV services"UNICEF et al., 2018, p. 20).
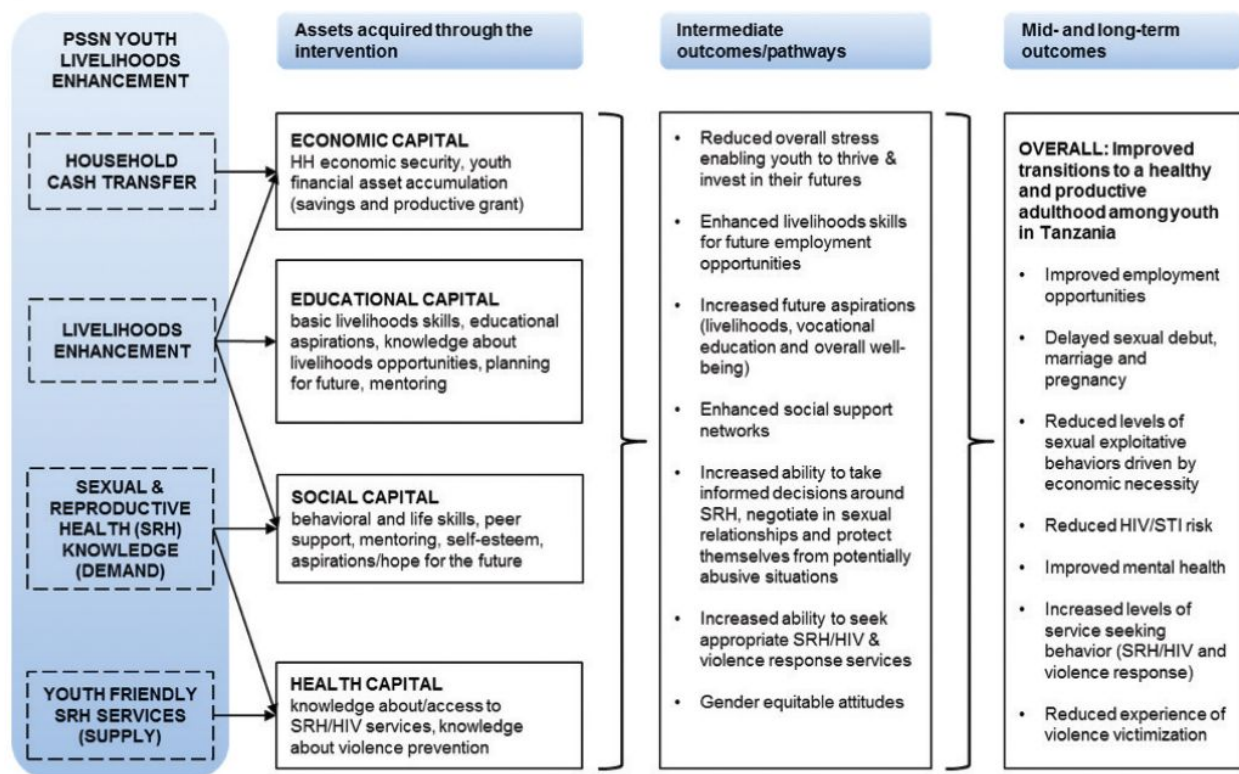
Figure 3. Theory of Change of the Cash Plus Model - Source: (UNICEF et al., 2018 p. 20)

The Case of Mgolole Orphan Center, Tanzania

Mgolole Orphan center is a residential home for OVC in Morogoro, Tanzania. Mgolole Center is a government registered facility run by the local church. It currently hosts around 68 children in custody by 7 full-time caretakers.

Orphanages like this are subject to strict regulation. They are only allowed to take on children that meet the criteria of most vulnerable children, which needs to be officially declared by the local authorities. They have to be coming from a very poor household and be half or full orphans, or children of parents with serious illnesses or drug addictions. Children are only allowed to stay within the center until they are three years of age. After this, all children need to be either returned to their family or given into the custody of an extended family. Only if no family can be found to adopt the children, they can remain in the center. Despite this regulation, there are many children in the center older than three years. Many were also simply abandoned and their identity or family is unknown. Some of

the oldest residents even visit the local university and stay at the residence during the semester break. Further, many OVC have been placed within their extended family, even if these families are extremely poor or indifferent about the well-being of the children. The evaluation of the Mgolole staff regarding the PSSP is that many families with OVC are not reached by the program. Further, even if they are reached, the transfers are not sufficient to provide the same level of material support that OVC can get at the center. Thus, children living with families are often indirectly supported by the center or have to be taken back if their physical well-being is at risk. Many children placed in such families also wish to be a return to the center. Overall, the description of the situation in Mgolole resembles observations in similar contexts made by other scholars (see Rukundo & Daniel, 2016).

Despite being a registered center, it does not receive any financial support by the government and relies entirely on support by individuals in the community and the networks outside. It was funded by German missionaries during the 90s, but all donations by his organization have been suspended due to the partial embezzlement of funds. Since then the community took ownership of the center. Next to cash-contributions, it relies heavily on the support by the local community in terms of in-kind donations and voluntary services like cooking, washing and general care-taking. Mr. Mwijage is for example now coordinating the fundraising via a WhatsApp group with around 150 members in which he regularly reports a project budget and funding gaps. This group mainly consists of community members and their family and friends. The goal is to establish a formal fund with fixed contributions.

Discussion

With the spread of cash transfer programs in the region, an additional emphasis is also being put on psychosocial and empowerment support, and in many interventions, this is an important component aimed at improving the lives of orphans and vulnerable children (Boler and Carroll 2003; Strebel 2004). The most common form of assistance offered to orphans and vulnerable children is through cash transfers (Nyawasha, Chipunza 2012). At the same time, national safety nets and cash transfers have serious limitations in the context of constrained financial resources, when often the quality of care provided to orphans and vulnerable children has to be improved with no or minimum costs. The resort to community-based services in these conditions can be an alternative option. Training

programs for community workers are an efficient way to improve the quality of health care without increases in cost (Bryce 2005).

The relevance of community-based projects is further strengthened by the fact that most traditional African cultures are built around patrilineal kinship systems, where the extended family was the traditional social safety net its members being responsible for the protection of the vulnerable, care for the poor and sick and the transmission of traditional social values and education (Foster 2000). Despite its weakening, the extended family continues to remain the predominant caring unit for sick relatives and orphans throughout Africa (Ankrah, 1993; Ntozi, 1997a). Communities and families are changing their systems of caring for orphans to cope with changes taking place within society; this illustrates the strength, resilience and adaptability of extended family coping mechanisms (Foster et al., 1995). Various studies illustrate the importance of engaging community adults to support orphans (Thurman 2008).

Therefore, community-based care war from early on emphasized as the most appropriate and effective approach to support the 43.4 million orphans in sub-Saharan Africa (UNAIDS, UNICEF, & USAID, 2004).

Needs Assessment

This research started out with a call for action by a local community leader, and came to the realization that, ultimately, the best possible approach to support institutionalized children in Tanzania would be to strengthen the financial and social capacity of their families and communities in order for them to return to and thrive in a natural environment. However, theoretically effective measures to reach this goal have already been rolled out, and it is primarily a matter of scaling them up to reach more children.

At the same time, our desk research, as well as actual accounts by local problem owners, have shown that the issue of institutionalization is still widespread in Tanzania, and is not to disappear. Just addressing the root causes will leave behind those children that will not be reached by large scale interventions in the foreseeable future.

Further, our research has shown that the material well-being of children is often the lesser issue for orphans. Focusing on the material well being of children in residential care further neglects the fact their peers in family care face these issues to. In order to avoid the 'Lucky Orphan' dilemma, external interventions should keep material support at a minimum and focus on community mobilization to build ownership.

One possible approach we considered was to support local communities in building their community and raising funds through digital technologies. However, we realized that this would only be a very marginal contribution when this is already effectively done using existing platforms such as theme groups on instant messengers and fundraising platforms. The central issue here is mainly effective leadership.

This report concludes that an effective external intervention for institutionalized children would address the issue of mental health directly. In the following section, we will introduce a pragmatic solution, that adapts best practices.

Leaving No Child Behind Tanzania - Mental Health Assistance Program for institutionalized Children

Having identified the need for mental health related assistance among the institutionalised OVC in Tanzania, we propose a two-fold model. *Leaving No Child Behind Tanzania* (LNCB-T) is designed to integrate the best practices surrounding mental health interventions in low-income contexts. Our idea is rooted in the successfully tested development practices of community engagement, grassroot monitoring systems, and digital capacity.

The first part of the program will work towards creating a sustainable ecosystem of mental health development of the OVC through the assistance of the graduate students in Tanzanian universities and community-based volunteers. The objective of this part of the program is to ensure a safe and healthy institutionalised space for the OVC to thrive in, and to identify any red flags concerning their mental health.

The second part of the program builds up on the first part to provide specialised care which is beyond the skills and capacities of the community based volunteers and graduate students. This is done largely through digital means.

Community Approach to Mental Health Assistance

Psycho-social counselling is a key element of community-based programs. However, our research showed that these interventions are mostly not targeted at institutionalized children. There is however a range of literature that is focused on psychotherapy for OVC. We selected a group therapy model that has been developed for and rigorously tested in the Tanzanian setting (Harding et al., 2019). The therapy is based on an ecological model which "describes how children's resilience can be enhanced by building on their own strengths and capabilities, building peer relationships, and community-level support. (…) Within the intervention, the goal of memory work therapy (MWT) is to create a 'safe space' in which an orphaned child can explore their life story in an individual or group setting. Memory Work draws on Narrative Therapy, which helps people to find and live out empowering parts of the stories that make up their lives. Narrative Therapy and MWT aims to identify strengths and 'empowering plots' " (Harding et al., 2019 p. 342). The MWT intervention consists of a five-day residential camp and included several established psychotherapy models for OVC (see Table 1). During the pilot study, the interventions were guided by a qualified team consisting of three social workers, and a clinical officer and a medical doctor.

The results of the program were very promising. In the context of this specific intervention, all relevant objectives were reached; "children identified their community resources, felt able to recognize their family resources, and felt empowered to use their individual strengths" (Harding et al., 2019 p. 346).

Out study aims at utilizing this study as a concrete example of an intervention that can be scaled up in a cost effective manner in order to grand institutionalized children access to appropriate psychotherapy. The MWT model described above -or any other model - could be standardized and brought into a format that can be taught to recent graduates with a background in pedagogy, psychology or medicine. Instead of being applied in a week-long session by a group of professional, the student would spend up to one year together in the facilities. Unemployment among university graduates is a common issue in many Afircan countries. In Tanzania the unemployment rate amongst young people (15-24 years old) is 13.4%, which is higher than the overall national unemployment rate (Ndyali, 2016). This

interventions would draw from this pool of qualified individuals and further given them access to relevant work experience.

Day	Activity	Objectives
1	Memory Book	To prepare a space to explore life stories through artwork
2	Memory Box	To help the children find a safe place to keep the MWT book (contains Memory Box, Tree of Life and Hero Book)
3	Tree of Life 1	To create and explore a new story that is not only about pain and suffering but that also notes courage, survival skills, values and hope through artwork
	Tree of Life 2	To build and acknowledge "a second story" about each child's life. The second story consists of the skills, abilities, hopes and dreams of each child and the histories of these through artwork
4	Hero Book	To help the children find solutions to the personal and social challenges they face through artwork
5	Issuing of Certificates of Participation	Closure of the group and recognition of their participation and achievement

Table 1. Session timetable of MWT. (Source: Harding et al., (2019 p. 342))

As a framework for the intervention, we propose a Civic Service Model that has been employed in other countries in the region, among them Kenya, Zambia, Zimbabwe and South Africa (Bodley-Bond & Cronin, 2013). Students would be recruited into the program after graduation, given the appropriate training, and dispatched to registered residential care centres all over the country. Program participants would be paid a stipend according to their skill level.

Together with students, community representatives can design relevant group activities for children with proper consideration being given to the size of the orphanage, their age and other important details. For the students the main purpose of participation in the program will be getting hands-on experience of working with children, but some type of compensation (small cash transfers or the opportunity to be hosted by the orphanage) can also be introduced.

We expect the mental health of children to improve if they communicate more with adults and learn to build social relations within the group participating in different therapy activities. The involvement of community representatives will further strengthen community ties and existing traditions of community care for vulnerable children. Adults from the community will receive important caretaker skills, and probably also basic knowledge of medicine and psychology (depending on the background of the student they will work with) and later can continue to perform the functions of a caretaker already without the help of a student-supervisor. Students will get valuable work experience that can help them find a stable employment later.

Specialised Digital Mental Health Assistance

While the first part of the program caters to reintegrating the OVC to the local community through cash transfer incentives and work experience opportunities, it also helps create a strong base for the second part of the program. A key role of the community based volunteers and the student volunteers will be to identify cases of psychosocial and learning disorders. The volunteers will also be required to watch out for emotional distress or signs of withdrawal among the children. On identification of such cases, the volunteers will try to resolve the issue using the assistance methodology they are familiar with. But in case the problems persist, the volunteers can establish contact with a network of professionals who will be available via a digital platform.

The digital platform will consist of a network of mental health related professionals who will be formally collaborating with this program to provide digital therapy sessions to children who are geographically distant and are in need of help. To make this part of the program effective, we will need to ensure that every OVC institution has access to at least one computer with an internet connection and appropriate tele-conferencing software. Internet-based cognitive behavioral therapy (IBCT) is a growing phenomenon to deliver mental health services to people in low-income settings. It has been proven that IBCT interventions have led to increased functionality of patients and decreased symptoms. They have been especially helpful in addressing issues like depression, anxiety and a range of psychological disorders (Kumar et al., 2017).

Having seen that IBCT has proven to be a viable option for mental health assistance in low-income settings, this project will follow a similar approach in providing specialised mental health care to OVC. This is not only cost-effective, but also increases the scope for monitoring in a systematic manner.

Expected Structure & Cost

Overall, the organizational structure of the USAID Kizazi Kipya program as a likely role model for our intervention. Since it is unlikely that appropriate graduates will apply from all the communities of all centers, the participant selection will take place at the program level and not at the community level. The training will follow in the first stage a training-of-trainers by experts in the therapy model that will be applied. In the second stage, these trainers will teach students the methodologies to be applied in a multi week workshop. Students will then be placed in communities according to local demand and their qualification. Also religious affiliation might be and important factor to consider.

For the tele-consultation components, the staff will either be those staff that also train the graduates in the workshop, or other experienced professionals who work in part-time for the program. Due to the nature of tele-health, the program could also utilize professional living outside of Tanzania to support the student volunteers in their work.

Conclusion

Based on our analysis and the discussions presented in this paper, we believe that Leaving No Child Behind Tanzania (LNCB-T) for the Mental Health Assistance Program for the OVC in Tanzania is a much needed intervention to ensure a better childhood experience in institutionalized settings.

The program does face a few limitations. First, it is based on the assumption that there are enough graduates that would be willing to participate in such a program. Given the serious unemployment problem among recent graduates, one can however conclude that the stipend and the work experience that this program offers will provide sufficient incentives. Second, there is no finance model for this intervention as of now. We do however base the financial feasibility of this project on the existence of very similar programs that are extremely cost effective. Lastly, since its target group is relatively small, the total cost of the

program should be relatively low. Lastly, it does not address the root cause of the orphan crisis, however, it is intended for those that are otherwise left behind.

Overall, LNCB-T is a cost-effective approach to address the mental health of a population that has been neglected by policy makers so far. It used best practices as well as cutting edge methodology and technology in order to reach its objectives.

Finally, mental health is not only an issue among orphans. A rising number of children globally are affected by humanitarian crises induced by conflict and climate-related natural disasters. We need to look beyond physical scars and find effective ways to health the psychological traumas among children that affect them for a lifetime. Simple therapy approaches like LNCB-T need to be implemented to reach these children, too.

References

Angeles, Gustavo, Jacobus de Hoop, Sudhanshu Handa, Kelly Kilburn, Annamaria Milazzo, and Amber Peterman. 2019. "Government of Malawi's Unconditional Cash Transfer Improves Youth Mental Health." *Social Science & Medicine* 225 (March): 108–19. https://doi.org/10.1016/j.socscimed.2019.01.037.

Ankrah, E. Maxine. 1993. "The Impact of HIV/AIDS on the Family and Other Significant Relationships: The African Clan Revisited." *AIDS Care* 5 (1): 5–22. https://doi.org/10.1080/09540129308258580

Baird, Sarah, Jacobus de Hoop, and Berk Özler. 2013. "Income Shocks and Adolescent Mental Health." *Journal of Human Resources* 48 (2): 370–403. https://doi.org/10.1353/jhr.2013.0014.

Bodley-Bond, C., & Cronin, K. (2013). Overview of the National Youth Service Landscape in Sub-Saharan Africa. In Learning Forum National Youth Service, Employability, Entrepreneurship and Sustainable Livelihoods. Johannesburg, SA.

Boler T, Caroll K 2003. *HIV/AIDS and Education: Addressing the Educational Needs of Orphans and Vulnerable Children*. London: Action Aid International.

Bryce, Jennifer, Eleanor Gouws, Taghreed Adam, Robert E Black, Joanna Armstrong Schellenberg, Fatuma Manzi, Cesar G Victora, and Jean-Pierre Habicht. 2005. "Improving Quality and Efficiency of Facility-Based Child Health Care through Integrated Management of Childhood Illness in Tanzania." *Health Policy and Planning* 20 (suppl_1): i69–76. https://doi.org/10.1093/heapol/czi053.

Bump, J., Cashin, C., Chalkidou, K., Evans, D., González-Pier, E., Guo, Y., … Yamey, G. (2016). Implementing pro-poor universal health coverage. The Lancet Global Health, 4(1), e14–e16. https://doi.org/10.1016/S2214-109X(15)00274-0

Chapman, J., Brugh, K., Muiaya, S., Kuhwa, A., Hickmann, M., & Churyeva, Z. (2018). Monitoring well- being outcomes among Kizazi Kipya project beneficiaries: Key findings from the baseline evaluation. Dar es Salaam, TZ: MEASURE Evaluation.

Engle, P. L., Groza, V. K., Groark, C. J., Greenberg, A., Bunkers, K. M. C., & Muhamedrahimov, R. J. (2011). The situation for children without parental care and strategies for policy change. Monographs of the Society for Research in Child Development, 76(4), 190–222. https://doi.org/10.1111/j.1540-5834.2011.00633.x

Fergusson, David M., and Lianne J. Woodward. 2002. "Mental Health, Educational, and Social Role Outcomes of Adolescents with Depression." Archives of General Psychiatry 59 (3): 225–31.

Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. Psychology, Health and Medicine, 5(1), 55–62. https://doi.org/10.1080/135485000106007

Foster, G. (2002). Beyond education and food: psychosocial well-being of orphans in Africa. Acta Paediatrica, 91(5), 502–504. https://doi.org/10.1080/080352502753711588

Foster, G., R. Shakespeare, F. Chinemana, H. Jackson, S. Gregson, C. Marange, and S. Mashumba. 1995. "Orphan Prevalence and Extended Family Care in a Peri-Urban Community in Zimbabwe." *AIDS Care* 7 (1): 3–18. https://doi.org/10.1080/09540129550126911.

Gobin, S., & Foley, S. (2019). The Cost of Case Management in Orphans and Vulnerable Children Programs - Results from a Mixed-Methods, Six-Country Study. Chapel Hill, NC: MEASURE Evaluation.

Harding, R., Wei, G., Gwyther, L., & Miti, E. (2019). Improving psychological outcomes for orphans living with HIV in Tanzania through a novel intervention to improve resilience: findings from a pilot RCT. AIDS Care, 31(3), 340–348. https://doi.org/10.1080/09540121.2018.1533630

Haushofer, J., and E. Fehr. 2014. "On the Psychology of Poverty." Science 344 (6186): 862–67. https://doi.org/10.1126/science.1232491

Hermenau, K., Hecker, T., Elbert, T., & Ruf-Leuschner, M. (2014). Maltreatment and mental health in institutional care-comparing early and late institutionalized children in Tanzania. Infant Mental Health Journal, 35(2), 102–110. https://doi.org/10.1002/imhj.21440

IPPF. (2018). *Leaving no one behind: Universal health coverage and sexual and reproductive health and rights.* London, United Kingdom. Retrieved from: https://www.ippf.org/static/docs/Publication_-_Leaving_no_one_behind.pdf

Jamison. et al. (2013) Global health 2035: a world converging within a generation. *The Lancet Commissions.* Retrieved from: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(13)62105-4.pdf

Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Kathleen R. Merikangas, and Ellen E. Walters. 2005. "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry* 62 (6): 593. https://doi.org/10.1001/archpsyc.62.6.593.

Kidman, R., Petrow, S. E., & Heymann, S. J. (2007). Africa's orphan crisis: two community-based models of care. AIDS Care, 19(3), 326–329. https://doi.org/10.1080/09540120600608396

Kilburn, K.,Thirumurthy, H., Halpern, C.T., Pettifor, A., Handa, S. (2015). Effects of a large-scale unconditional cash transfer program on mental health outcomes of young people in Kenya. *Journal of Adolescent Health. 2015 Nov 11.*

Kumar, V., Sattar, Y., Bseiso, A., Khan, S., & Rutkofsky, I. H. (2017). The Effectiveness of Internet-Based Cognitive Behavioral Therapy in Treatment of Psychiatric Disorders. Cureus, 9(8), e1626. doi:10.7759/cureus.1626

LUMOS. (2017). Funding Haitian Orphanages at the Cost of Children ' s Rights. Lumos Foundation.

Lund, Crick, Mary De Silva, Sophie Plagerson, Sara Cooper, Dan Chisholm, Jishnu Das, Martin Knapp, and Vikram Patel. 2011. "Poverty and Mental Disorders: Breaking the Cycle in

Low-Income and Middle-Income Countries." *The Lancet* 378 (9801): 1502–14. https://doi.org/10.1016/S0140-6736(11)60754-X.

Mann, G., Long, S., Delap, E. & Connell, L. (2012). Children living with and affected by HIV in residential care. London: EveryChild

Mchomvu, A. S. T., & Mvungi, A. (2012). Status of Children in Tanzania - Child Rights Based Situational Analysis of Children Without Parental Care and At Risk of Losing Parental Care. Dar es Salaam, TZ: SOS Children' Village Tanzania.

MEASURE. (2019). The Cost of Case Management in Orphans and Vulnerable Children Programs: Findings from Tanzania. Chapel Hill, NC: MEASURE Evaluation.

Msoka, A., & Holroyd, E. (2018). Children's perspectives of their psychosocial well-being in Tanzanian orphanages. *International Journal of Nursing and Midwifery*, 10(5), 41–46. https://doi.org/10.5897/IJNM2017.0292

Ntozi, J.P.M. (1997). AIDS morbidity and the role of the family in patient care in Uganda. *Health Transitions Review*, 7 (Suppl), 1-22.

Ndyali, Lyata. (2016). Higher Education System and Jobless Graduates in Tanzania. *Journal of Education and Practice.* 7(4).
https://files.eric.ed.gov/fulltext/EJ1092388.pdf

Nyawasha, Tawanda Sydesky, and Crispen Chipunza. 2012. "An Assessment of Psychosocial and Empowerment Support Interventions for Orphans and Vulnerable Children in Zimbabwe." *Journal of Human Ecology* 40 (1): 9–16. https://doi.org/10.1080/09709274.2012.11906519.

Patel V., Kleinman A. 2003. "Poverty and Common Mental Disorders in Developing Countries" in *Bulletin of the World Health Organization.* 81(8): 609-615. October 14, 2003.

Pereira A. 2006. Cash Transfers Improve the Mental Health and Well-being of Youth: Evidence from the Kenyan Cash Transfer for Orphans and Vulnerable Children. Innocenti Research Brief

Petrowski, N., Cappa, C., & Gross, P. (2017). Estimating the number of children in formal alternative care: Challenges and results. Child Abuse & Neglect, 70, 388–398. https://doi.org/10.1016/j.chiabu.2016.11.026

Rukundo, P., & Daniel, M. (2016). Children orphaned by AIDS in Uganda: Can they thrive under orphanage care? Social Work and Society, 14(1), 1–17.

Schenk, K. D. (2009). Community interventions providing care and support to orphans and vulnerable children: a review of evaluation evidence. AIDS Care, 21(7), 918–942. https://doi.org/10.1080/09540120802537831

SOS Children's Villages International. (2014). Assessment report of the alternative care system of children in Tanzania. Austria. Retrieved from https://www.sos-childrensvillages.org/getmedia/85c469cf-d955-4b09-9565-85d4590f1397/Tanzania.pdf

Strebel, Anna. 2004. *The Development, Implementation and Evaluation of Interventions for the Care of Orphans and Vulnerable Children in Botswana, South Africa and Zimbabwe: A Literature Review of Evidence-Based Interventions for Home-Based Child-Centred Development*. Occasional Paper 1. Cape Town, South Africa: HSRC Publishers.

TACAIDS. (2013). HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS and ICF International. https://dhsprogram.com/pubs/pdf/AIS11/AIS11.pdf

Thurman, Tonya Renee, Leslie A. Snider, Neil W. Boris, Edward Kalisa, Laetitia Nyirazinyoye, and Lisanne Brown. 2008. "Barriers to the Community Support of Orphans and Vulnerable Youth in Rwanda." *Social Science & Medicine* 66 (7): 1557–67. https://doi.org/10.1016/j.socscimed.2007.12.001.

UNAIDS, UNICEF, & USAID. (2004). *Children on the brink 2004: A joint report of new orphan estimates and a framework for action.* Retrieved July 14, 2019, from http://www.unicef.org/publications/cob_layout6–013.pdf

UNICEF. (2003). Africa's Orphaned Generations. New York, NY: United Nations Children's Fund. https://www.unicef.org/sowc06/pdfs/africas_orphans.pdf

UNICEF, EDI, TASAF, & TACAIDS. (2018). A Cash Plus Model for Safe Transitions to a Healthy and Productive Adulthood: Baseline Report. Florence, IT: UNICEF Office of Research – Innocenti.

UNICEF, TASAF, & REPOA. (2018). Tanzania Youth Study of the Productive Social Safety Net (PSSN) Impact Evaluation : Endline Report. Florence, IT: UNICEF Office of Research - Innocenti.

USAID Kizazi Kipya Project. (2017, November). Technical Brief : USAID Kizazi Kipya Support for implementation of the National Integrated Case Management Framework. Dar es Salaam, TZ.

USAID. (2019). Kizazi Kipya - Fact Sheet. United State Agency for International Development (USAID). Retrieved from https://www.usaid.gov/documents/1860/kizazi-kipya

Orphans Africa. (n.d.). Tanzania at a Glance – Orphans Africa. Retrieved July 12, 2019, from https://orphansafrica.org/tanzania-at-a-glance/

WHO. (2003). Investing in Mental Health. World Health Organisation. Geneva, Switzerland. Retrieved from: https://www.who.int/mental_health/media/investing_mnh.pdf