BINDURA UNIVERSITY OF SCIENCE EDUCATION
FACULTY OF SOCIAL SCIENCES AND HUMANITIES

AN INVESTIGATIVE COMPARISON BETWEEN FAAMILY-BASED AND INSTITUTIONAL-BASED CARE IN RESPONSE TO THE NEEDS OF ORPHANS AND VULNERABLE CHILDREN. A CASE STUDY OF CELEBRATED IVORDALE HOME.

By

B213191B

A Dissertation Submitted to Bindura University of Science Education in partial fulfillment of the requirements for the Bachelor of Science Honors in Social Work

Bindura, Zimbabwe
2025

I APPROVAL FORM

Supervisor

I certify that I have supervised AMOS A. MUCHENJE (B213191B) for the research entitled 'An investigative comparison between family based care and institutional based care in response to the needs of orphans and vulnerable children. A case study of Celebrated Ivordale Home, in partial fulfillment of the requirements of Bachelor of Science Honors Degree in Social Work (HBScSW) and recommended that it proceeds for examinations.

Supervisor

Name………………………………Signature……………Date…………………………….

Chairperson of Department Board of Examiners.

The department board of examiners is satisfied that this dissertation report meets the examination requirements and I therefore recommend to the Bindura University to accept a research project by AMOS A. MUCHENJE (B213191B) for the research entitled 'An investigative comparison between family based care and institutional based care in response to the needs of orphans and vulnerable children. A case study of Celebrated Ivordale Home,, in partial fulfillment of the requirements of Bachelor of Science Honors Degree in Social Work.

Chairperson

Name……………………………. signature……………………date………….

II RELEASE FORM

I AMOS A MUCHENJE studying for Bachelor of Science Honors Degree in Social Work truly declare that

- The dissertation report titled ‘An investigative comparison between family based care and institutional based care in response to the needs of orphans and vulnerable children. A case study of Celebrated Ivordale Home.’ is a result of my own work and has not been plagiarized
- I have followed research ethics in pursuit of social work research
- I grant permission to the university to use this report for educational purposes.

Student Name…………………...Signature………………………Date……………….

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III DEDICATION

I dedicate this dissertation to my Lord and Savior Jesus Christ thank you for always being there for me and for giving me this opportunity to do this degree to serve your kingdom. I also dedicate this project to my mother J. Muchenje, for the continuous support she has given to me from birth up to this juncture as well as moving forward. You have been a pillar of strength and a beacon of light in my life, I forever love you mom. To my late father A. Muchenje, I would like to thank you for everything you did in my life and for instilling in me a good work ethic and determination. I also dedicate this project to my father and mentor Dr. B. Demeh thank you for being the father figure in my life and for being there for me guiding and protecting me. I also dedicate this dissertation to my sisters, thank you for your love and support. I wouldn’t have completed this dissertation without the help of my supervisor who taught me and guided me, thank you.

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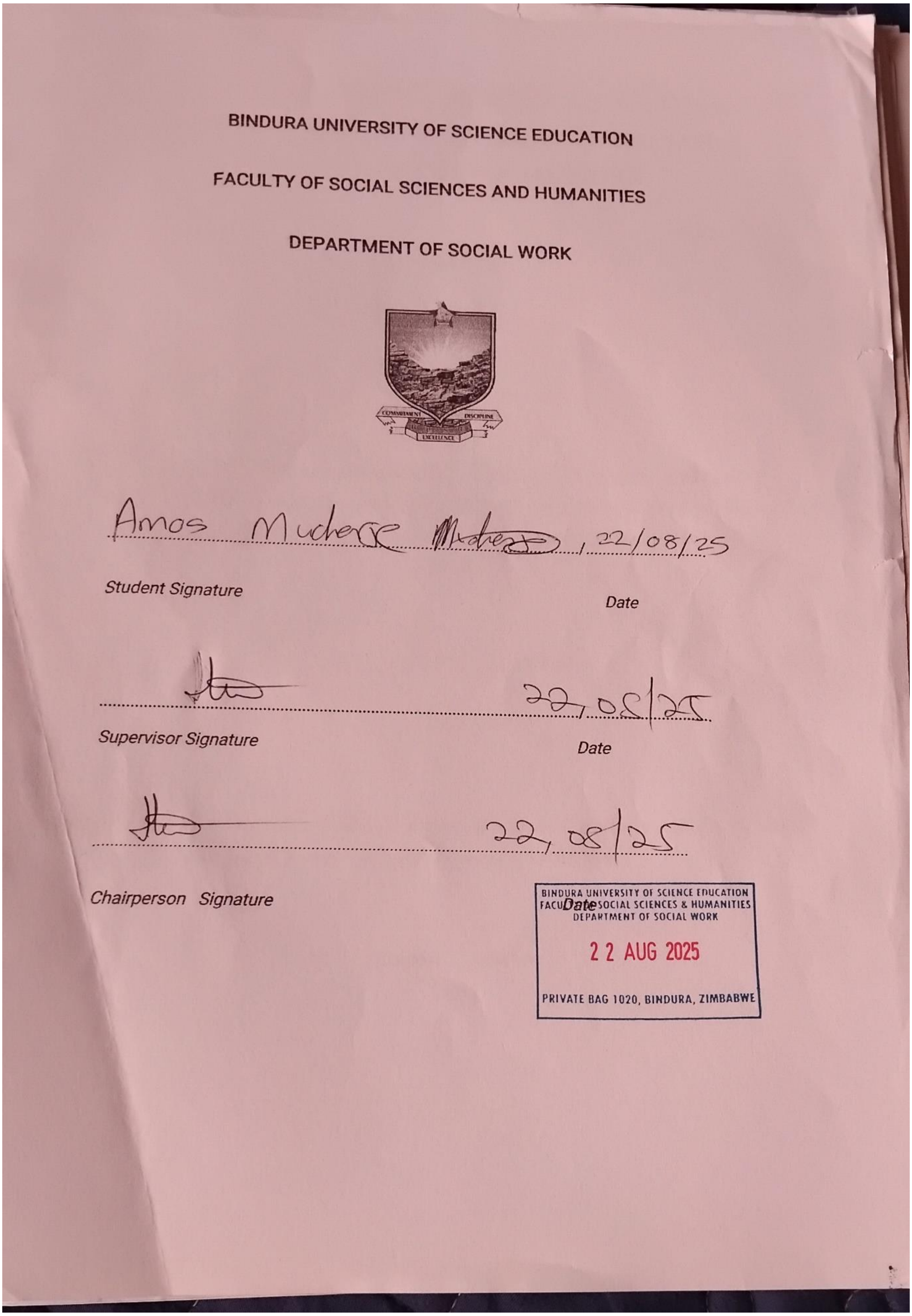

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MARKING GUIDE: UNDERGRADUATE RESEARCH PROJECT

Chapter 1 INTRODUCTION	**Possible Mark**	**Actual Mark**
Abstract	**10**	
Background to the study- what is it that has made you choose this particular topic? Include objectives or purpose of the study	**20**	
Statement of the problem	**10**	
Research questions	**15**	
Assumptions	**5**	
Significance of the study	**15**	
Limitations of the study	**5**	
Delimitations of the study	**5**	
Definition of terms	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**15**	

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Chapter 2 LITERATURE REVIEW

Introduction- what do you want to write about in this chapter?	**5**	
Conceptual or theoretical framework	**10**	
Identification, interpretations and evaluation of relevant literature and citations	**40**	
Contextualisation of the literature to the problem	**10**	
Establishing gaps in knowledge and how the research will try to bridge these gaps	**10**	
Structuring and logical sequencing of ideas	**10**	
Discursive skills	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**20**	

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Chapter 3 RESEARCH METHODOLOGY

Introduction	**5**	
Research design	**10**	
What instruments are you using to collect data?	**30**	
Population, sample and sampling techniques to be used in the study	**25**	
Procedures for collecting data	**15**	
Data presentation and analysis procedures	**10**	
Summary	**5**	

Total	**100**	
Weighted Mark	**25**	

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Chapter 4 DATA PRESENTATION, ANALYSIS AND DISCUSSION

Introduction	**5**	
Data presentation	**50**	
Is there any attempt to link literature review with new findings	**10**	
How is the new knowledge trying to fill the gaps identified earlier	**10**	
Discursive and analytical skills	**20**	
Summary	**5**	
Total	**100**	
Weighted Mark	**30**	

Comments

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Chapter 5 SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction- focus of the chapter	**5**	
Summary of the whole project including constraints	**25**	
Conclusions- have you come up with answers to the problem under study	**30**	
Recommendations(should be based on findings) Be precise	**30**	
References	**5**	
Appendices i.e. copies of instruments used and any other relevant material	**5**	
Total	**100**	
Weighted mark	**10**	

Comments

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SUMMARY:-

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Chapter 1 ________________________________

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Chapter 3 ____________________________________

Chapter 4 ____________________________________

Chapter 5 ________________________________

Total ________ __________

V ABSTRACT

The study was a investigative comparison between family-based care and institutional-based care models' responsiveness to the needs of orphans and vulnerable children (OVCs) a case study of Ivordale Celebrated Home. Five research objectives that served as the basis of this study are as follows to assess the psychosocial well-being of children in family-based and institutional based care at Celebrated Ivordale Home, to compare educational outcomes between family-based and institutional-based care models at Celebrated Ivordale Home, to evaluate the health outcomes of children in family-based care versus institutional-based care living at Celebrated Ivordale Home, to examine the cost-effectiveness of family-based and institutional-based care models at Celebrated Ivordale Home and to identify challenges and opportunities in implementing institutional-based and family-based care models at Celebrated Ivordale Home.Using qualitative research design and guided by the constructivist philosophy to get adequate information on the responsiveness of the two models of care to the needs of OVCs, a case study which was comparative in nature was used, focus group discussions and interviews were the research methods that were employed by the researcher on gathering information. 12 children from both models of care were interviewed and also participated in focus group discussions, 6 care givers and 2 social workers were also interviewed. The research found out that in terms of psychosocial well-being family based care holds significant advantages over institutional based, in educational outcomes institutional based care is superior to family based, in terms of health outcomes institutional based care emerged stronger than family based , family based care came out as cheaper in terms of operational costs compared to institutional based care, but however, invisible economic and psychological cost on care givers in family based care are often overlooked, the study confirms that both models are constrained by policy gaps, bureaucratic barriers and under-resourced social service. The study recommends the developing of a national hybrid model in child care in Zimbabwe combining strengths of institutions and family care models.

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CHAPTER ONE

1.1 Introduction

The care and protection of orphans and vulnerable children (OVCs) have become a central concern globally, especially in regions with high poverty levels and public health crises such as Sub-Saharan Africa. The devastating impact of HIV/AIDS, coupled with socio-economic challenges, has led to an increase in the number of children who require alternative care arrangements. Two primary models of care giving dominate the discourse: family-based care and institutional-based care. Family-based care, encompassing kinship care, foster care, and community-based approaches, is often lauded for its ability to provide a nurturing, culturally grounded environment for children. Conversely, institutional-based care, including orphanages and residential facilities, offers a structured and resource-intensive approach to caregiving. Despite the global shift toward family-based care as the preferred model, institutional care persists due to its perceived capacity to manage large numbers of children efficiently. However, the effectiveness of these care systems in addressing the psychosocial, educational, and health needs of children remains a subject of ongoing debate.

This study seeks to contribute to this debate by conducting a comparative analysis of family-based and institutional-based care systems, with a specific focus on Ivordale Celebrated Home. Located in a context marked by socio-economic vulnerabilities, Ivordale provides a unique case for exploring the practical implications of institutional care while juxtaposing it with family-based alternatives. The study is guided by the premise that understanding the strengths and limitations of each care model is critical for designing effective child welfare policies. By examining psychosocial well-being, educational achievements, health outcomes, and cost-effectiveness, this research aims to provide evidence-based recommendations to inform policymakers, caregivers, and stakeholders in child protection. Ultimately, the study aspires to highlight the most sustainable and impactful practices for improving the lives of OVCs.

1.2 Background of the study

Globally, the care and protection of orphans and vulnerable children (OVCs) has been a critical challenge, particularly in developing regions where socio-economic factors exacerbate vulnerability. The United Nations Children's Fund (UNICEF, 2023) reports that over 153 million children worldwide are orphans, with the majority residing in low- and middle-income countries. The HIV/AIDS pandemic, armed conflicts, and poverty have significantly contributed to the rise in the number of OVCs, especially in Sub-Saharan Africa. Governments and non-governmental organizations (NGOs) have adopted diverse approaches to care giving, predominantly falling into two categories: family-based care and institutional-based care. While family-based care is increasingly recommended for its ability to foster emotional and social development, institutional care is still widely practiced due to resource constraints and logistical challenges in implementing family-based systems.

In Africa, the burden of orphanhood has largely been attributed to the HIV/AIDS crisis, which has claimed the lives of millions of parents, leaving children dependent on extended families or formal care systems (UNAIDS, 2022). South Africa, for example, has pioneered family-based models through the use of foster care grants and community-based support programs, reflecting a shift toward localized and culturally aligned solutions. However, challenges persist in countries like Kenya, where institutional care remains a dominant model due to limited capacity to support family-based care at scale (Murungi& Muthoni, 2021). Empirical studies highlight the psychosocial disadvantages of institutional care, such as limited personal attention and stigmatization, which often undermine children's long-term well-being. Despite these challenges, institutional care remains a necessary option in areas where extended family systems are strained or non-existent.

Zimbabwe faces a similar dilemma, with thousands of children requiring alternative care due to the HIV/AIDS epidemic, economic hardships, and recent climate-related disasters such as Cyclone Idai. National statistics indicate that over 1.3 million children in Zimbabwe are categorized as vulnerable, many of whom rely on care systems for survival (Zimbabwe Vulnerable Children’s Program, 2021). In response, the government and NGOs have promoted family-based care through kinship fostering, community child care forums, and financial support mechanisms such as the Basic Education Assistance Module (BEAM). However, institutional care facilities like Ivordale Celebrated Home remain critical in bridging the gaps where family-based systems fail due to socio-economic pressures. Institutions often provide structured environments with access to education, healthcare, and nutritional support, albeit with challenges in emotional and social integration.

Ivordale Celebrated Home, situated in Mashonaland East, Zimbabwe, exemplifies the role of institutional care in addressing the needs of OVCs amidst systemic challenges. The home operates within a socio-economic context marked by high unemployment rates, food insecurity, and limited public welfare resources and caters for thirty (30) orphans and vulnerable children. While the home provides essential services such as education, healthcare, and psychosocial support, questions persist about the long-term developmental outcomes for its residents. Comparatively, children in family-based care often benefit from stronger emotional bonds and community integration but face challenges such as resource limitations and inconsistent care giving. This study, therefore, seeks to explore the effectiveness of both care models in addressing the developmental needs of OVCs within the local context, contributing to the global discourse on child welfare strategies.

1.3 Aim

To evaluate and compare the effectiveness of family-based care and institutional-based care in meeting the developmental needs of orphans and vulnerable children, using Ivordale Celebrated Home as a case study.

1.4 Statement of the problem

The increasing number of orphans and vulnerable children (OVCs) worldwide, particularly in Sub-Saharan Africa, presents a significant challenge to child welfare systems. Despite global efforts to prioritize family-based care due to its emphasis on cultural integration and emotional well-being, institutional-based care continues to be widely used. This is especially true in resource-constrained environments where extended family networks are overstretched. Zimbabwe exemplifies this dual challenge, with over 1.3 million children categorized as vulnerable due to socio-economic crises, the HIV/AIDS pandemic, and natural disasters (Zimbabwe Vulnerable Children’s Program, 2021). While family-based care is promoted as the ideal model in Zimbabwean policies, it is often underfunded and inconsistently implemented, leading to the reliance on institutional care facilities such as Ivordale Celebrated Home. However, the long-term developmental impact of these two care systems remains underexplored, particularly in local contexts. Questions arise about whether institutional care compromises psychosocial and emotional development compared to family-based care, which often lacks the resources to meet the holistic needs of children.

Although both care systems aim to protect and nurture children, they exhibit distinct strengths and limitations. Family-based care fosters a sense of belonging and aligns with the cultural values of kinship and community responsibility, yet it is often hindered by financial instability and inadequate caregiver capacity (Murungi& Muthoni, 2021). On the other hand, institutional care offers structured environments with access to education and healthcare, but it may fail to provide the personalized attention and emotional support that children require for holistic development (Browne, 2021). Empirical evidence suggests that children in institutional settings are more likely to experience attachment disorders and social stigmatization, while those in family-based care may face inconsistent caregiving and poverty-related challenges (Williamson & Greenberg, 2020). The lack of comparative studies in Zimbabwe, particularly focusing on localized outcomes such as psychosocial well-being, educational achievements, and health status, creates a significant gap in understanding which model is more effective. This study addresses this gap by evaluating the developmental outcomes of OVCs under both care systems at Ivordale Celebrated Home, aiming to provide evidence-based recommendations for improving child welfare strategies in Zimbabwe.

1.5 Objectives

1. To assess the psychosocial well-being of children in family-based and institutional-based care at Celebrated Ivordale Home.
2. To compare educational outcomes between family-based and institutional-based care models at Celebrated Ivordale Home.
3. To evaluate the health outcomes of children in family-based versus institutional-based care living at Celebrated Ivordale Home.
4. To examine the cost-effectiveness of family-based and institutional based care models at Celebrated Ivordale Home.
5. To identify challenges and opportunities in implementing family-based and institutional-based care models at Celebrated Ivordale Home.

1.6 Research questions

1. What are the psychosocial outcomes for children in family-based and institutional-based care?
2. How do educational achievements differ between children in the two care models (Family-based care and institutional based care)?
3. What are the health outcomes associated with family-based and institutional-based care?
4. Which care model is more cost-effective between family based and institutional based care?
5. What are the challenges and opportunities in family-based and institutional-based care systems?

1.7 Assumptions

Family-based care provides better psychosocial support than institutional care.

This assumption is grounded in Attachment Theory, which emphasizes the critical role of close and consistent caregiver-child relationships in fostering emotional well-being and secure attachments (Browne, 2021). Family-based care, often involving kinship ties, is thought to provide an emotionally supportive environment that nurtures trust and resilience. The rationale is that personalized attention and cultural alignment in family settings promote better psychosocial outcomes for orphans and vulnerable children. However, this assumption may be limited by factors such as economic hardship, caregiver fatigue, and inconsistent care, which can negatively affect children's emotional well-being in some family-based care scenarios.

Institutional care offers more structured educational support compared to family-based care.

Institutional care environments often have dedicated resources, such as trained staff and facilities, that focus on children’s academic development (Williamson & Greenberg, 2020). The rationale for this assumption lies in the structured nature of institutions, which allows for regular schooling, homework supervision, and access to educational materials. This is particularly relevant in resource-constrained contexts where families may lack the financial capacity to support consistent education. However, the limitation of this assumption is that institutional care may prioritize academic structure at the expense of individualized attention, potentially neglecting the unique educational needs of some children.

Health outcomes are influenced by access to care services in both family-based and institutional care.

Institutional care settings often ensure access to healthcare services through organized programs and partnerships with health organizations, which may not always be available in family-based care (Murungi& Muthoni, 2021). This assumption justifies the belief that institutional settings can provide better health monitoring and preventive care. However, family-based care is believed to offer more personalized attention to children's health needs due to caregivers' intimate knowledge of the child. The limitation of this assumption is that the quality of health outcomes in family-based care depends heavily on caregivers' capacity and knowledge, which can vary widely.

Family-based care is more cost-effective than institutional care.

Family-based care leverages existing community and family resources, making it a potentially more sustainable and affordable option for OVCs (Tsegaye, 2019). The rationale here is that family-based care integrates children into existing family structures, minimizing overhead costs associated with running large institutional facilities. However, this assumption is limited by the uneven availability of financial and social support for families, which can lead to inconsistencies in care giving and resource provision.

Children in family-based care face fewer social stigmas than those in institutional care.

Family-based care allows children to grow up in environments that closely resemble traditional family settings, reducing the risk of societal labelling and discrimination often associated with institutionalization (Browne, 2021). The rationale is that societal perceptions of “normalcy” are more closely aligned with family-based care, helping children integrate better into their communities. However, this assumption is limited by cases where fostered children may still face stigmatization due to their orphan status or be marginalized within their foster families.

1.8 Significance of study

This study provides a critical analysis of family-based and institutional-based care models for orphans and vulnerable children (OVCs) in Zimbabwe, focusing on Ivordale Celebrated Home. It is significant as it addresses the urgent need for evidence-based insights into the effectiveness of these care systems, especially in resource-constrained contexts. Understanding the impact of each model on children’s psychosocial, educational, and health outcomes can directly inform child welfare policies and practices.

The study is particularly relevant in light of the growing number of OVCs globally and locally due to socio-economic challenges, the HIV/AIDS pandemic, COVID-19 pandemic and climate-related disasters. Policymakers and practitioners face dilemmas in determining the most effective care model. By providing empirical evidence, this research helps resolve these dilemmas, contributing to a more sustainable and impactful approach to care giving. The findings will align with international efforts such as UNICEF's frameworks and the Sustainable Development Goals (SDGs) aimed at improving child welfare globally.

In terms of contributions, this study adds new knowledge by offering a comparative perspective, bridging theoretical insights from Attachment Theory and Bronfenbrenner’s Ecological Systems Theory with practical outcomes in care giving. It highlights the localized challenges and opportunities unique to Zimbabwe, enriching the global discourse on OVC care.

The findings have practical implications for multiple stakeholders. Policymakers can use the results to design effective, context-sensitive child welfare interventions. Social workers and caregivers will gain actionable insights to improve their care giving practices. NGOs and international donors will be equipped with evidence to prioritize investments and interventions that best support children's development. This study's originality lies in its holistic approach, offering a nuanced understanding of the interplay between cultural, social, and economic factors in OVC care giving, setting it apart from existing research that often focuses on one model in isolation.

1.9 Key definitions

Orphans and Vulnerable Children (OVCs)

Orphans and vulnerable children (OVCs) are defined as children under the age of 18 who have lost one or both parents or whose well-being is threatened by factors such as poverty, illness, or displacement (UNICEF, 2023). These children often face multiple deprivations, including limited access to education, healthcare, and social support. Scholars such as Williamson and Greenberg (2020) highlight that vulnerability extends beyond orphanhood to include risks such as abuse, neglect, and exploitation. In the context of Sub-Saharan Africa, where the HIV/AIDS epidemic has contributed significantly to orphanhood, the term OVC encompasses children whose caregivers are incapacitated or who live in fragile socio-economic conditions. This definition underscores the urgency of implementing targeted interventions that address their multifaceted needs.

Family-Based Care

Family-based care refers to care giving arrangements where children are raised in familial settings, including kinship care, foster care, or adoption, rather than in institutional environments (Tsegaye, 2019). This model is rooted in the belief that children thrive best in environments that replicate traditional family structures, promoting emotional attachment and cultural integration. According to Browne (2021), family-based care aligns with Attachment Theory, which emphasizes the importance of consistent, nurturing relationships for healthy child development. However, the effectiveness of family-based care often depends on the availability of resources and the stability of the care giving environment. In Zimbabwe, family-based care is a culturally significant practice, often facilitated by extended family networks and community support systems.

Institutional-Based Care

Institutional-based care involves the provision of care for children in formal facilities such as orphanages, children’s homes, or residential institutions. This model is characterized by structured living arrangements, centralized services, and professional care giving (Murungi& Muthoni, 2021). Institutional care is often used as a last resort when family-based options are unavailable or unsuitable. Proponents argue that it ensures access to essential services, such as education and healthcare, particularly in resource-limited settings (Williamson & Greenberg, 2020). However, critics highlight its potential to hinder emotional development, as children may experience a lack of individualized attention and difficulties in forming secure attachments (Browne, 2021). In the Zimbabwean context, institutional-based care serves as a critical safety net for children who cannot be placed in family settings due to socio-economic constraints.

Psychosocial Well-Being

Psychosocial well-being refers to the interplay between psychological and social factors that contribute to an individual's overall mental health and quality of life. For OVCs, psychosocial well-being involves emotional stability, social integration, and the ability to form meaningful relationships (Murungi& Muthoni, 2021). According to Chinyoka and Chinamasa (2020), children’s psychosocial well-being is heavily influenced by their care giving environment, with family-based care often fostering a stronger sense of identity and belonging. Conversely, institutional care, while structured, may lead to feelings of isolation or stigmatization. Understanding psychosocial well-being is essential for evaluating the impact of care giving models on the holistic development of children.

Caregiver

A caregiver is an individual who assumes responsibility for the physical, emotional, and social well-being of a child, either formally or informally. Caregivers in family-based care are often relatives or foster parents, while in institutional settings, they are trained staff members (Tsegaye, 2019). The quality of care giving significantly affects a child’s development, as outlined in Attachment Theory, which posits that secure and nurturing relationships are foundational to emotional and social growth (Browne, 2021). However, caregiver capacity can vary depending on resources, training, and socio-economic conditions. In Zimbabwe, caregivers play a pivotal role in child welfare systems, bridging the gap between policy frameworks and the lived realities of OVCs.

1.10 Summary

This chapter concentrated on the introduction, the study’s background, the problem statement, the objectives, the research questions, the assumptions , key definitions, limits and the study’s delimitations. The next chapter examines pertinent literature on the subject.

CHAPTER TWO LITERATURE REVIEW

2.0 INTRODUCTION

A literature review is the process of gathering information from previously published works that appears to be relevant to the research topic (Roberts, 2002). An investigative comparison between family based care and institutional based care on their responsiveness to the needs of orphans and vulnerable children is the main topic of this chapter. The attachment theory, developed by John Bowlby and Mary Ainsworth, and the ecological systems theory by Urie Bronfenbrenner will be used by the researcher in this study.

2.1 Theoretical Framework

This study employs Attachment Theory and Bronfenbrenner's Ecological Systems Theory to analyze the effectiveness of family-based and institutional care models for orphans and vulnerable children (OVCs). These frameworks are particularly relevant in understanding how care giving environments influence children's psychosocial, educational, and health outcomes, offering a multidimensional perspective on child development.

2.1.1 Attachment Theory

Proposed by John Bowlby in 1969, Attachment Theory emphasizes the importance of a secure and continuous relationship between a child and a caregiver for healthy emotional and social development. Bowlby (1969) argued that attachment is a biological imperative, ensuring survival and psychological stability. Mary Ainsworth's subsequent work in the 1970s further classified attachment styles secure, avoidant, ambivalent, and disorganized based on her "Strange Situation" experiments (Ainsworth et al., 1978). These attachment styles profoundly impact children's ability to form future relationships and navigate social environments.

In family-based care, secure attachments are more likely to form due to consistent and personalized interactions between caregivers and children (Chinyoka& Chinamasa, 2020). For instance, Zimbabwean family-based care often integrates children into kinship networks, fostering emotional bonds and cultural belonging. However, attachment security in such contexts can be compromised by financial instability or caregiver burnout. Conversely, institutional care, characterized by rotating caregivers and higher child-to-caregiver ratios, frequently disrupts attachment formation, potentially leading to emotional insecurity and behavioral issues (Naaz, 2023). Despite these limitations, some institutional models, like those in Zimbabwe's larger orphan care facilities, incorporate attachment-focused strategies such as assigning children to consistent caregiver groups, albeit with varying degrees of success.

Critically, while Attachment Theory underscores the significance of close caregiver-child bonds, it has been critiqued for underestimating the role of socio-economic and cultural contexts in shaping care giving practices. This limitation is particularly relevant in Zimbabwe, where economic constraints and extended family dynamics often redefine traditional care giving roles (Mupedziswa&Kubanga, 2021). Thus, while Attachment Theory provides a foundational lens for understanding individual-level interactions, it must be integrated with broader systemic perspectives to address care giving challenges holistically.

2.1.2 Bronfenbrenner's Ecological Systems Theory

Urie Bronfenbrenner's Ecological Systems Theory (1979) expands the analysis of child development beyond immediate caregiver-child interactions, situating individuals within a nested hierarchy of environmental influences. The theory identifies five systems: the micro-system (immediate environments like family and school), meso-system (interconnections between micro-systems), exo-system (indirect influences such as parental workplace policies), macro-system (cultural and societal norms), and chrono-system (the dimension of time and life transitions).

In family-based care, the micro-system is particularly significant, as caregivers play a direct role in shaping children's daily experiences and interactions. For instance, in Zimbabwean kinship care, community child care forums act as extensions of the microsystem, providing additional support networks (Mawere&Maguchu, 2020). On the other hand, institutional care often involves a structured meso-system, where children interact with multiple caregivers, peers, and institutional policies. While this can provide stability in some cases, it may also expose children to fragmented relationships and reduced cultural integration (Mutangadura, 2019).

The macro-system, encompassing cultural beliefs and policy frameworks, significantly influences both care models in Zimbabwe. Policies promoting family-based care, such as the Basic Education Assistance Module (BEAM), reflect societal values prioritizing kinship and community cohesion. However, economic constraints often limit the implementation of these policies, necessitating reliance on institutional care as a fall-back option. Bronfenbrenner's theory also highlights the chrono-system, emphasizing how care giving environments evolve over time. For example, children transitioning out of institutional care often face challenges reintegrating into society due to limited life skills training, a gap that remains underexplored in Zimbabwean research (Mupedziswa, 2021).

These theories are highly applicable to the study as they provide complementary insights into the caregiving dynamics affecting OVCs. Attachment Theory focuses on the quality of individual relationships and emotional well-being, making it essential for evaluating psychosocial outcomes. Bronfenbrenner’s Ecological Systems Theory contextualizes these relationships within broader environmental and systemic influences, offering a holistic understanding of the factors shaping children’s development.

In the Zimbabwean context, these frameworks illuminate the complex interplay between cultural norms, economic realities, and care giving practices. For example, while family-based care aligns with traditional kinship systems, its effectiveness is often hindered by socio-economic instability. Similarly, institutional care provides essential services but struggles to replicate the emotional and cultural depth of family-based settings. By integrating these theories, the study aims to generate evidence-based insights that inform child welfare policies, ensuring that interventions are culturally sensitive and contextually relevant.

2.2 Empirical Literature Review

Globally, the care of orphans and vulnerable children (OVCs) has been a subject of significant research, particularly concerning the comparative effectiveness of family-based and institutional care models. In high-income countries, family-based care is widely recognized as the preferred model due to its alignment with Attachment Theory, which emphasizes the developmental importance of consistent and emotionally supportive caregiver-child relationships (Browne, 2021). For example, research in the United States has shown that foster care systems, despite their challenges, often lead to better psychosocial and educational outcomes than institutional settings (Scott & Thomson, 2021). Similarly, studies in Europe highlight the long-term emotional benefits of kinship care, where children are raised within extended family networks. However, the reliance on institutional care persists in many low- and middle-income countries, primarily due to resource constraints and the high demand for caregiving services. A study by Naaz (2023) in South Asia revealed that while institutional care provides structured environments and access to education, it often fails to address the emotional needs of children, resulting in attachment issues and social stigmatization.

In Latin America, family-based care has gained traction through community-supported foster care programs. For instance, a study in Brazil found that community-oriented foster systems significantly improved children's psychosocial well-being and integration into society compared to orphanages (de Oliveira et al., 2019). Despite these advancements, scholars like Williamson and Greenberg (2020) argue that the global discourse on care giving models often neglects the socio-cultural contexts of care, which are critical in determining the success of either model. The ongoing debate underscores the need for localized research, particularly in Sub-Saharan Africa, where traditional family structures and economic challenges heavily influence care giving practices.

In Sub-Saharan Africa, the dual challenge of widespread poverty and the HIV/AIDS pandemic has profoundly shaped care giving models for OVCs. Family-based care, deeply rooted in traditional African kinship systems, is often regarded as culturally appropriate and sustainable. A study in Kenya by Murungi and Muthoni (2021) revealed that children in kinship care exhibited stronger emotional resilience and community integration than those in institutional settings. However, the study also highlighted resource limitations and caregiver fatigue as significant challenges, which often lead to inconsistent care giving. Similarly, research in South Africa demonstrated that government-supported foster care grants have improved the quality of family-based care but noted that bureaucratic delays in grant disbursement often push caregivers into financial distress, indirectly affecting children's well-being (Tsegaye, 2019).

In Zimbabwe, the care of OVCs is heavily influenced by socio-economic factors, with family-based care being the culturally preferred model. Chinyoka and Chinamasa (2020) observed that kinship care arrangements in Zimbabwe foster a sense of belonging and cultural identity among children, which is crucial for their psychosocial development. However, these arrangements are often constrained by economic challenges, leaving caregivers unable to provide consistent education and healthcare. Institutional care, such as that provided by Ivordale Celebrated Home, plays a vital role in bridging this gap by offering structured support systems. Mutangadura (2019) critically evaluated institutional care in Zimbabwe, noting its effectiveness in ensuring access to basic needs but also pointing out its limitations in fostering emotional and social integration. These findings emphasize the need for a balanced approach that integrates the strengths of both caregiving models while addressing their respective weaknesses. This regional literature underscores the importance of examining caregiving models within the unique socio-cultural and economic contexts of Zimbabwe. It highlights the need for evidence-based policies that consider the realities of resource constraints, cultural values, and the developmental needs of OVCs, making this study timely and relevant.

In Zimbabwe, the care of orphans and vulnerable children (OVCs) is heavily influenced by socio-economic challenges, cultural dynamics, and government policies. Local research highlights the dual reliance on family-based and institutional care systems to address the growing needs of OVCs, particularly in the wake of the HIV/AIDS epidemic and economic instability. Chinyoka and Chinamasa (2020) underscore the significance of kinship care in Zimbabwe, where extended families have traditionally absorbed orphaned children. Their study found that children in kinship care environments often experience a sense of belonging and identity, which are critical for their psychosocial well-being. However, they also noted significant limitations, including financial constraints and caregiver fatigue, which can hinder the provision of consistent support. These findings highlight the need for supplementary interventions, such as financial assistance programs and community child care forums, to bolster family-based care models.

2.2.1 Psychosocial Well-being in Care Settings

2 .2. 2 Emotional attachment and identity

The psychosocial well-being of orphans and vulnerable children (OVCs) is a central outcome in the assessment of care giving models, as it encapsulates emotional stability, attachment formation, identity development, and social integration. Empirical evidence consistently suggests that family-based care particularly kinship and foster care provides a stronger foundation for psychosocial well-being compared to institutional settings, due to the relational intimacy, cultural familiarity, and perceived permanence that family environments afford (Berens & Nelson, 2015; Save the Children, 2014). In family-based settings, children are more likely to form secure attachments with caregivers, benefit from natural expressions of affection, and engage in culturally embedded practices of belonging such as naming, storytelling, and household rituals (Naaz, 2023). These interactions contribute significantly to emotional healing, especially for children who have experienced loss, displacement, or trauma.

In contrast, institutional care often struggles to replicate these affective and relational dimensions. Studies in Sub-Saharan Africa and Eastern Europe have demonstrated that children raised in institutional settings are at increased risk of experiencing social withdrawal, low self-esteem, and disorganized attachment patterns, particularly where caregiver turnover is high or where staff-child ratios exceed optimal limits (Browne, 2021; Van IJzendoorn et al., 2020). The absence of consistent one-on-one attention deprives children of the opportunity to form emotionally secure bonds, which are critical to their psychological and social development. In Zimbabwe, Mutangadura (2019) found that children in orphanages often described their caregivers as “functional but distant,” reinforcing the idea that predictable routines cannot substitute for emotional responsiveness.

Despite the emotional benefits of family-based care, it is important to note that psychosocial outcomes in these settings are not universally positive. Several studies have identified the potential for neglect, favouritism, or emotional exclusion, especially in kinship arrangements where resources are stretched or where stigma persists around orphanhood (Chinyoka& Chinamasa, 2020; Luwiza et al., 2018). In some cases, OVCs in extended family care reported being treated as “secondary children,” excluded from decision-making or materially disadvantaged in comparison to biological children. This relational inequality can undermine self-worth and hinder emotional development. Furthermore, the absence of structured psychosocial support systems in rural areas means that even caring households may lack the tools to respond effectively to grief, trauma, or behavioural issues (Tsegaye, 2019).

2 .2. 3 Copying mechanisms

The role of spirituality and community in mediating psychosocial well-being has also been widely documented. In many Zimbabwean households, religious and cultural practices serve as informal mechanisms for emotional healing. Prayer, communal grieving rituals, and the invocation of ancestral lineage help children feel anchored within their social world (Evans, 2010; Chikadzi, 2022). However, these supports are often insufficient in cases of prolonged trauma or mental health disorders, which remain poorly understood and stigmatized in both family and institutional settings. A recent qualitative study by Gultie et al. (2021) found that caregivers often interpreted depressive symptoms as laziness or spiritual attack, thereby delaying or misdirecting appropriate responses.

In institutional care, peer bonding frequently emerged as a substitute for familial attachment. Children raised in institutions often relied on siblings or peers for emotional support, forming quasi-familial alliances that helped them navigate the emotional void left by inconsistent caregiving (Van IJzendoorn et al., 2020). While this coping mechanism fosters resilience, it does not necessarily compensate for the absence of adult-child emotional scaffolding. Moreover, the lack of individualized therapeutic interventions means that children with deep-seated trauma remain unsupported. This is particularly concerning given that many institutionalized children enter care with pre-existing vulnerabilities stemming from abuse, parental loss, or community displacement (UNICEF, 2020).

In sum, the empirical literature indicates that while family-based care offers superior conditions for psychosocial well-being, its effectiveness is highly contingent on caregiver capacity, social support, and access to external interventions. Institutional care, though capable of offering safety and structure, often fails to provide the emotional depth and relational consistency necessary for optimal psychological development. For either model to succeed, there must be deliberate investment in trauma-informed caregiver training, mental health integration, and community-based psychosocial support systems (Browne, 2021; Williamson & Greenberg, 2020). These findings underscore the importance of viewing child care not simply as a custodial task, but as a deeply relational and therapeutic process that must be intentionally nurtured.

2.2.4 Educational Outcomes in Institutional and Family-Based Care

2 .2 .5 Access to education

Education is a vital pillar in child development, particularly for orphans and vulnerable children (OVCs), as it serves not only as a pathway to socio-economic mobility but also as a protective factor against exploitation, social exclusion, and poverty in adulthood. The quality and continuity of educational access are often used as indicators of care effectiveness. Empirical studies have consistently shown that institutional care settings tend to offer more structured and reliable educational access, primarily due to formalized routines, donor support, and administrative oversight. In contrast, family-based care often presents a more emotionally supportive learning environment but faces significant constraints related to poverty, household responsibilities, and inconsistent access to resources (Williamson & Greenberg, 2020; Naaz, 2023).

Institutionalized children in many low- and middle-income countries have higher rates of school enroment and attendance than their family-based counterparts. A study by Gultie et al. (2021) in Ethiopia found that institutional care centres were more successful in ensuring school attendance, partly because education was embedded into the daily routine and supported by international donors. Similarly, Save the Children (2014) observed that in several countries across Sub-Saharan Africa, children in institutions benefited from uniform provision, payment of school levies, and after-school supervision, which were not consistently available to children in family care. These structured conditions often help institutional caregivers monitor academic progress more efficiently, particularly in larger care homes with designated education liaisons.

2. 2. 6 Quality of education

However, it is of paramount importance to note that access does not equate to educational quality or holistic development. Several studies have noted that institutionalized children often lack individualized academic support, emotional motivation, and caregiver involvement in their learning process. Browne (2021) emphasizes that high caregiver-child ratios in institutional settings hinder one-on-one tutoring or meaningful follow-up on homework and school challenges. In addition, the absence of emotional intimacy may affect the child’s academic self-concept. As Lusk et al. (2012) argue, emotional affirmation from caregivers contributes significantly to learning confidence, a factor often lacking in institutions where caregiving is treated as a procedural task rather than a relational commitment.

Conversely, family-based care, especially within kinship and foster settings, is associated with greater caregiver involvement in the child's academic journey, although this varies by context and caregiver literacy. In Zimbabwe, Chinyoka and Chinamasa (2020) found that caregivers in family settings were more likely to attend school meetings, assist with homework, and motivate children through verbal praise and symbolic rewards. These relational dynamics often boost children's academic confidence and persistence, despite the common presence of financial hardship or material deprivation. However, this model is highly vulnerable to economic shocks. In a study of rural care households in Uganda and Zimbabwe, Evans (2010) noted that school dropout was often linked to inability to pay fees, transport costs, or lack of uniforms, even when the caregiver was emotionally committed to the child's education.

Moreover, family-based care often places children in multi-generational or female-headed households where limited income and time must be divided among several dependents, making it difficult to prioritize school needs. The BEAM (Basic Education Assistance Module) program in Zimbabwe, though designed to support school access for OVCs, has suffered from inconsistent disbursement and poor communication, leaving caregivers unable to plan for their children’s educational continuity (Mutangadura, 2019). In such settings, the child’s academic trajectory becomes contingent on external actors NGOs, faith-based organizations, or community donors introducing unpredictability into an already fragile system.

Another critical difference lies in the emotional context of learning. Empirical studies suggest that emotional security enhances cognitive engagement. In family-based care, when children feel supported and accepted, they are more likely to engage actively with school. A study by Berens and Nelson (2015) concluded that emotional reinforcement through praise, encouragement, and shared learning rituals has a direct influence on school performance, particularly among vulnerable children. In institutional care, children may receive adequate tutoring and resources, but the absence of emotional investment from caregivers can result in academic disengagement, especially when the learning process becomes task-oriented rather than intrinsically meaningful.

2. 2. 7. Discrimination, motivation and confidence

In both care models, external stigma and peer comparison also play a role in shaping school experiences. Institutionalized children often face labelling and discrimination at school, with peers referring to them as “children from the home,” which undermines their self-esteem and school participation (Save the Children, 2014). On the other hand, children in family care may be seen as “second-tier” within their households, particularly where biological children are prioritized, which may in turn de-motivate children and lower their confidence as they are more accustomed to being the so called ‘second-class’ children. These socio-emotional dynamics are rarely captured in attendance data but are critical in shaping learning outcomes and academic identity.

In summary, while institutional care systems generally ensure greater consistency in school attendance and logistical support, they often fall short in providing personalized academic encouragement and emotional support, both of which are essential for long-term academic success. Family-based care offers a more nurturing environment but is hindered by resource limitations, inconsistent school access, and varying levels of caregiver capacity. These findings suggest that improving educational outcomes for OVCs requires not only material support but also integrated systems of caregiver training, psychosocial reinforcement, and community-school collaboration (UNICEF, 2020; Browne, 2021). As such, any educational intervention in OVC care models must account for both the material and emotional ecology of learning.

2.2.8 Health and Mental Health Outcomes in Institutional and Family-Based Care

2.2.9 Access to health services

Health both physical and mental is a foundational dimension of child well-being, especially for orphans and vulnerable children (OVCs), who are more susceptible to illness, emotional trauma, and neglect due to early-life adversity. The care giving model plays a pivotal role in shaping health-seeking behaviour, access to medical services, hygiene practices, and emotional support. Empirical studies across Sub-Saharan Africa reveal significant differences in how institutional and family-based care environments facilitate or hinder these outcomes (Browne, 2021; Tsegaye, 2019; Van IJzendoorn et al., 2020).

Institutional care models generally offer more structured access to physical health services. Due to their formalized nature, institutions are often linked to local clinics, private practitioners, or international NGOs that provide periodic check-ups, vaccinations, and hygiene audits. A cross-national study by Save the Children (2014) found that institutionalized children in Zimbabwe, Malawi, and Ethiopia were more likely to receive routine health screenings, immunizations, and timely treatment for common illnesses than children in family-based care. Similarly, a study by Gultie et al. (2021) in East Africa emphasized that centralized health record-keeping and the presence of designated caregivers in institutional settings improve early detection and response to illness. These conditions create a relatively stable framework for addressing physical health needs.

However, this advantage does not extend to mental health, where institutional models fall significantly short. Several studies have highlighted that psychosocial support and emotional regulation are often overlooked in institutional settings, with caregivers primarily focused on physical maintenance, discipline, and task completion. Berens and Nelson (2015) found that children raised in institutions exhibited higher rates of internalizing behaviors, including withdrawal, depression, and anxiety, largely due to the lack of emotional intimacy and individual attention. In Zimbabwe, Mutangadura (2019) reported that few institutions had access to trained counsellors or trauma-informed staff, leaving emotionally distressed children to cope in silence or through peer support, which while helpful cannot replace professional intervention.

In contrast, family-based care offers a more intimate and relational environment that supports informal emotional healing. Kinship caregivers, for instance, are more likely to provide comfort through spiritual support, empathy, and cultural rituals such as storytelling and communal prayer (Chinyoka& Chinamasa, 2020; Evans, 2010). These practices help restore a sense of belonging and trust, which is essential for children who have experienced abandonment or bereavement. However, health outcomes in family-based care are highly variable, largely dependent on caregiver knowledge, proximity to health facilities, and the household’s financial capacity. Tsegaye (2019) and Luwiza et al. (2018) report that caregivers often delay seeking medical attention due to transport costs, clinic fees, or lack of understanding of symptoms. In many rural households in Zimbabwe, caregivers rely first on traditional remedies or self-diagnosis, and only escalate to formal treatment when the condition deteriorates.

The mental health dimension in family-based care is equally complex. While emotional warmth may be more readily available, caregivers often lack the psychological training or literacy to identify and respond to trauma. Symptoms of depression or post-traumatic stress disorder (PTSD) are frequently misinterpreted as behavioural problems or spiritual afflictions. A study by Chikadzi (2022) on mental health perceptions in rural Zimbabwe found that emotional withdrawal or irritability among OVCs was often dismissed or moralized, with children being labelled as "lazy," "spoiled," or "demon-possessed." These perceptions prevent early intervention and may worsen the child's psychological distress over time.

Sanitation and hygiene practices also differ between the two care models. Institutional settings typically enforce routine hand washing, dental care, and regulated meal times, supported by access to clean water and staff supervision. In family-based care, hygiene depends largely on household infrastructure, caregiver priorities, and availability of supplies such as soap or toothpaste. In times of economic hardship, these practices are often de-prioritized. Nonetheless, some studies argue that children in family-based settings especially in well-supported households exhibit better nutritional outcomes, possibly due to traditional food preparation practices and access to household gardens (UNICEF, 2020).

2.2.10 Caregiver's influence on health outcomes

Another critical factor influencing health outcomes is the caregiver's ability to monitor and respond to symptoms. Institutional caregivers often rely on structured roll calls and visible signs of illness, but may miss subtle cues, especially in emotionally detached environments (Browne, 2021). Family-based caregivers, on the other hand, may have more instinctive awareness of behavioral shifts, but lack the formal mechanisms to document or escalate concerns. This divergence reflects the broader theme that institutions offer procedural health care while families offer relational care, and both carry risks when not supported by external health systems.

Overall, empirical evidence confirms that institutional care systems provide stronger logistical capacity for managing physical health, but remain deficient in emotional and mental health support. Family-based care provides emotional safety and trust, but lacks consistency in health literacy, service access, and early symptom recognition. Bridging these gaps requires a multi-level approach: training caregivers in trauma-informed care, integrating community health workers into household visits, and expanding mobile clinic services in rural zones. Moreover, both care systems must embed mental health services as core components of the child welfare strategy, not optional add-ons.

2.2.11 Cost-Effectiveness and Resource Distribution in OVC Care Models

2.2.12 Source of income and funding

Cost-effectiveness remains one of the most contested dimensions in the comparative analysis of institutional and family-based care models. While financial costs are relatively easier to quantify, a robust assessment of care effectiveness must account for both tangible economic inputs and intangible social outcomes, including caregiver labor, child development, and community-level sustainability. In policy discourse, family-based care is frequently portrayed as the more affordable and socially embedded alternative. However, empirical studies reveal a more nuanced and sometimes contradictory picture, particularly when invisible caregiver costs, donor dependency, and systemic inefficiencies are taken into account (Williamson & Greenberg, 2020; Browne, 2021).

Institutional care models are generally characterized by high operational expenses, including costs associated with infrastructure, staffing, food, healthcare provision, utilities, transportation, and administrative oversight. In a comparative study across Sub-Saharan Africa, Berens and Nelson (2015) concluded that institutions typically spend two to six times more per child annually than family-based care arrangements. These costs are justified in part by the ability of institutions to centralize services, enforce regulatory standards, and access external funding from international donors or religious missions. In Zimbabwe, institutional homes often rely on foreign funding to meet basic operational needs, such as school fees, electricity, and medical supplies (Mutangadura, 2019). However, this funding is rarely guaranteed and often subject to volatile donor cycles, leading to periods of budget shortfall, staff retrenchments, and interruptions in child services.

Furthermore, institutional models often lack internal sustainability mechanisms. A study by Save the Children (2014) found that most residential care homes in Zimbabwe did not have income-generating projects or cost-recovery plans in place. When donor support is delayed or withdrawn, the entire care system becomes vulnerable, affecting children’s nutrition, education, and psychological support. Even well-run institutions are not immune to these structural risks. In addition, per-child costs in institutions remain inflated due to overheads that are unrelated to the child's immediate needs such as facility maintenance and personnel benefits making them inefficient from a long-term investment perspective (Browne, 2021).

On the other hand, family-based care is often framed as a low-cost and culturally appropriate alternative, but this framing often underestimates the hidden and unpaid costs incurred by caregivers. In kinship care settings, extended families absorb caregiving responsibilities without state support, placing strain on household income, food security, and caregiver mental health (Luwiza et al., 2018). In Zimbabwe, where many caregivers are widows or elderly grandmothers, the care of OVCs comes at the expense of economic participation, personal well-being, and access to health care (Chinyoka& Chinamasa, 2020). These costs are rarely measured in financial terms, yet they have significant implications for caregiver burnout, child neglect, and dropout from education.

Studies have also shown that family-based care systems rely heavily on informal resource mobilization, such as remittances, church donations, community support, and subsistence agriculture (Evans, 2010; Tsegaye, 2019). While this reduces direct expenditure, it externalizes care costs to underfunded local systems, which are already stretched by economic instability and weak infrastructure. The BEAM (Basic Education Assistance Module) and HSCT (Harmonized Social Cash Transfer) programs were designed to subsidize caregiving in family settings, but empirical data shows that disbursements are inconsistent, delayed, and poorly monitored (Mutangadura, 2019). As a result, many caregivers face financial shocks when support fails to materialize, disrupting school attendance, nutrition, and medical care for children.

2.2.13 Funding versus quality of care

When evaluating cost-effectiveness, it is crucial to expand the lens beyond financial efficiency to include value for money, understood as the relationship between inputs (resources), outputs (services delivered), and outcomes (child well-being). Williamson and Greenberg (2020) argue that family-based care, despite its informality, delivers higher social returns per dollar when caregivers are supported through cash transfers, psychosocial services, and training programs. However, in the absence of these supports, family care can be just as unstable as underfunded institutions, particularly in fragile contexts.

Recent literature also calls for a hybrid investment model, where both institutional and family-based systems are resourced in complementary ways. Gultie et al. (2021) advocate for the reallocation of institutional overheads toward community-based group homes, formalized foster care, and kinship care allowances, which would maintain care quality while improving cost-efficiency. UNICEF (2020) further recommends integrating caregiver stipends, mobile health clinics, and school-linked social services into national child welfare budgets, ensuring that resource distribution follows the child, not the institution.

In summary, while institutional care provides centralized services with predictable cost structures, it remains financially unsustainable without continuous donor investment and is not optimized for relational care giving. Family-based care is more cost-effective in relational terms, but structurally under-resourced and overly reliant on unpaid labour. A fair and effective care system must therefore shift from binary comparisons to integrated financing strategies that account for the real cost of care emotional, financial, and developmental and allocate resources accordingly. This approach would not only enhance cost-efficiency but also ensure equity, dignity, and sustainability in the care of Zimbabwe's most vulnerable children.

2.2.14 Implementation Challenges and Reform Pathways

Despite widespread acknowledgment of the importance of care systems for orphans and vulnerable children (OVCs), both institutional and family-based care models in Zimbabwe face profound implementation challenges, many of which are rooted in systemic underfunding, weak policy enforcement, and fragmented service delivery. These challenges hinder the effectiveness of otherwise promising interventions, leading to inconsistent child outcomes, caregiver fatigue, and community disengagement. However, emerging evidence also points to viable reform pathways, including hybrid models, community-based innovations, and adaptive policy frameworks that respond to local realities.

In the institutional care sector, key challenges include bureaucratic rigidity, chronic staff shortages, and poor coordination with external service providers. Institutions in Zimbabwe often lack autonomy in decision-making and must navigate multiple administrative layers to access resources, approve emergency interventions, or modify caregiving strategies. This hierarchical inefficiency delays critical services and reduces caregiver responsiveness (Mutangadura, 2019; Browne, 2021). Additionally, institutional caregivers are frequently overburdened due to understaffing, limited training, and lack of psychosocial support, resulting in emotional detachment, high turnover, and in some cases, neglect. A multi-country review by Save the Children (2014) found that less than 20% of residential institutions in the region met minimum standards for individualized care, largely due to staffing constraints and low investment in professional development.

On the other hand, family-based care systems, while relationally stronger, suffer from policy invisibility, inconsistent monitoring, and lack of institutional recognition. Many kinship and foster caregivers operate informally and are excluded from formal state support, despite absorbing the majority of OVCs in the country (Chinyoka& Chinamasa, 2020). Government safety nets such as the Harmonised Social Cash Transfer (HSCT) or Basic Education Assistance Module (BEAM) are marred by unpredictable disbursements, weak targeting mechanisms, and limited geographic reach, which leaves rural caregivers unsupported. Furthermore, the absence of structured training and support means caregivers often lack the knowledge, emotional resilience, and tools needed to address trauma, behavioral issues, or chronic illness (Tsegaye, 2019; Chikadzi, 2022). Without external reinforcement, even committed caregivers may become overwhelmed, leading to unintentional neglect or secondary victimization of children.

A shared problem across both care models is the absence of reliable data systems and case tracking mechanisms. Social workers and community child protection committees are overstretched and under-resourced, making it difficult to monitor children's progress, enforce care standards, or respond to abuse and neglect cases. UNICEF (2020) notes that Zimbabwe's child protection sector suffers from low coverage, fragmented coordination between actors, and minimal investment in digital infrastructure, which prevents evidence-based decision-making and long-term case management.

In response to these challenges, several reform pathways have been proposed and piloted both locally and internationally. A promising direction is the development of hybrid care models that combine the emotional warmth of family-based care with the structural oversight and resource mobilization capacity of institutional systems. For instance, small group homes integrated within communities, with trained house parents and monitored by local authorities, offer a middle ground that addresses both care quality and scalability (Gultie et al., 2021). These models reduce the cost and impersonality of large institutions while providing consistent supervision and access to services.

Another reform direction is the formal recognition and resourcing of informal caregivers, particularly grandmothers, aunts, and siblings who take on full-time caregiving without any training or state compensation. Williamson and Greenberg (2020) advocate for the introduction of caregiver grants, linked to training, health service access, and participation in monitoring programs. Evidence from South Africa and Malawi shows that even modest stipends improve caregiver morale, reduce school dropout, and enhance food security within care households (Berens & Nelson, 2015).

In addition, the literature supports decentralization of social work services, particularly through mobile outreach units, ward-based monitoring officers, and digital case management platforms (Browne, 2021; Naaz, 2023). These approaches bring services closer to caregivers and reduce reliance on centralized urban offices, which are often inaccessible to rural communities. They also promote real-time feedback, early warning for abuse, and continuity of care when children transition between households or institutional settings.

Finally, multi-stakeholder coordination and community engagement are essential for sustainable care reforms. NGOs, religious institutions, traditional leaders, and school systems must be incorporated into an integrated child welfare framework that distributes responsibility across sectors and geographies. The 2020 UNICEF framework on alternative care calls for a shift from siloed interventions to multi-sectoral collaboration, where child protection, education, health, and justice systems work in tandem to support children and their caregivers.

In conclusion, the effective implementation of care for OVCs requires a systems-thinking approach that recognizes structural inequality, caregiver capacity, and the contextual realities of Zimbabwean communities. Rather than viewing institutional and family-based care as binary opposites, future efforts should aim to integrate their strengths through adaptive, hybrid models backed by policy reform, funding realignment, and community ownership. This transformation is not merely technical it is foundational to the realization of every child’s right to protection, dignity, and holistic development.

2.3 Knowledge Gap

Despite extensive global and regional research on the care of orphans and vulnerable children (OVCs), significant gaps remain in understanding the comparative effectiveness of family-based and institutional care models, particularly within the Zimbabwean context. Most global studies emphasize the benefits and limitations of one care model in isolation, often neglecting a direct comparison between family-based and institutional care in resource-constrained settings. For example, while Attachment Theory has been widely applied to family-based care in high-income countries, there is limited research on how its principles operate in kinship care arrangements in Zimbabwe, where economic challenges and cultural norms heavily influence care giving practices (Chinyoka& Chinamasa, 2020). Similarly, while institutional care has been studied extensively in other regions, its unique role in bridging gaps left by family-based systems in Zimbabwe remains underexplored.

Regionally, studies often generalize findings across Sub-Saharan Africa without considering the specific socio-economic and policy contexts unique to Zimbabwe. For instance, research from Kenya and South Africa highlights the strengths of government-supported foster care and community-based programs (Murungi& Muthoni, 2021; Tsegaye, 2019). However, Zimbabwe's socio-economic challenges, including hyperinflation and limited government resources, present distinct obstacles to the implementation of such models. Moreover, while regional studies have examined the psychosocial and educational outcomes of children in care, there is a lack of localized data that integrates these outcomes with health metrics, especially in institutional settings like Ivordale Celebrated Home.

Additionally, existing Zimbabwean research, while valuable, often focuses on the challenges faced by either family-based or institutional care systems in isolation. There is insufficient empirical evidence comparing the two models' effectiveness in addressing the holistic needs of OVCs, including psychosocial well-being, education, and health outcomes (Mutangadura, 2019). Furthermore, the interplay between cultural practices, economic realities, and care giving systems in Zimbabwe remains poorly understood, particularly in how these factors shape the long-term development of OVCs.

This study seeks to fill these gaps by providing a comparative analysis of family-based and institutional care models, focusing on their impacts on children's psychosocial, educational, and health outcomes in Zimbabwe. By integrating Attachment Theory and Bronfenbrenner's Ecological Systems Theory, the study will offer a comprehensive understanding of how these care systems operate within the country's unique socio-cultural and economic context. The findings will contribute to the global discourse on OVC care while offering practical, evidence-based recommendations tailored to Zimbabwe's specific needs.

2.4 Summary

This chapter explored key theoretical frameworks that underpin the study, the attachment theory and the ecological systems theory, which provided foundation for understanding the needs of orphans and vulnerable children, guiding the comparative analysis of the care models. The chapter also explores different already existing literature on the responsiveness of the two care models to the needs of OVCs.

CHAPTER THREE MEHODOLOGY

3.0 INTRODUCTION

This chapter will concentrate primarily on how the data was collected, as it will define the research design as well as the methodology engaged and the data collection methods, ethical considerations and it will also discuss the sampling techniques that were used to obtain information from children from both models of care, caregivers and child welfare officers.

3.1 Research design

This study adopted a qualitative comparative case study design, which was deemed appropriate for examining the contextual dynamics and lived experiences associated with care giving within both family-based and institutional-based care settings. The comparative case study approach allowed for a holistic, in-depth exploration of the similarities and differences between these two care models, particularly as they related to the psychosocial, educational, and health needs of orphans and vulnerable children (OVCs) in Zimbabwe. The research was situated in Ivordale Celebrated Home, an established institutional care facility in Mashonaland East Province, and included selected family-based care arrangements such as kinship and foster care. By focusing on these two distinct care giving contexts, the study was able to investigate each as a “bounded system,” revealing the embedded practices, challenges, and perceived effectiveness of care from the perspectives of children and caregivers.

The decision to employ a comparative case study was supported by the view that such a design facilitates the generation of detailed, descriptive, and explanatory data (Yin, 2018). The intention was not to generalize statistically but to develop a thick description (Geertz, 1973) of care giving within the cultural, economic, and institutional realities of Zimbabwe. This approach enabled the research to explore care giving not as a universal construct, but as a set of context-bound, socially constructed practices. By comparing the institutional and family-based environments, the study illuminated how different care giving models responded to the holistic development of children, revealing both commonalities and contextual distinctions.

Furthermore, the qualitative case study approach was consistent with the interpretivist and constructivist epistemological orientations that guided the research. These paradigms assert that reality is subjective and best understood through the meanings individuals assign to their experiences (Lincoln & Guba, 1985). The study prioritized participants' voices and centered their lived experiences as valid forms of knowledge. Through in-depth interviews and focus group discussions, caregivers, children, and social welfare officers shared insights into emotional support, caregiving routines, resource availability, and the psychological impact of the care environment. These narratives enabled the researcher to understand caregiving as a relational and dynamic process shaped by socio-economic and cultural forces.

The comparative case study design also offered flexibility to explore the multi-dimensional nature of child welfare. Caregiver fatigue, emotional bonding, discipline approaches, schooling access, health care provision, and spiritual guidance were among the elements examined through this design. As Creswell and Poth (2018) argued, case studies are particularly effective when the boundary between the phenomenon and the context is blurredan apt description of care giving practices in Zimbabwe, where social, cultural, and economic variables are tightly interwoven. Overall, the qualitative comparative case study design enabled the study to produce rich, contextually grounded insights into the strengths and limitations of both family-based and institutional care models. These insights provided an evidence base for policy recommendations and practical strategies aimed at improving care for orphans and vulnerable children in similar socio-economic environments.

3.2 Methodology

This study was underpinned by the constructivist and interpretivist philosophical paradigm, which was deemed appropriate for exploring the subjective meanings, lived experiences, and social interactions embedded within the caregiving environments of orphans and vulnerable children (OVCs). The choice of this paradigm reflected the study's overarching objective to gain a nuanced understanding of how caregiving was experienced and delivered within both institutional-based and family-based models. Constructivism posits that reality is not objective and universally observable, but rather socially constructed by individuals based on their context, interactions, and personal experiences (Lincoln & Guba, 1985). In this regard, the study was focused not on predicting outcomes, but on interpreting the diverse meanings that children, caregivers, and social welfare professionals assigned to their caregiving experiences.

The interpretivist stance informed the study's methodological choices, especially the decision to engage participants through semi-structured interviews and focus group discussions. These tools enabled participants to articulate their personal narratives, thereby allowing the researcher to access rich and layered data on how caregiving influenced psychosocial well-being, access to health and education, identity formation, and emotional support structures. Interpretivism recognizes the role of the researcher not as a detached observer but as a co-constructor of meaning, engaging in dialogic interaction with participants to derive contextual understanding (Creswell &Poth, 2018). Through this process, data were generated in a way that respected participants' voices and allowed their realities to shape the research narrative.

Furthermore, the constructivist paradigm was well suited to the socio-cultural and economic complexities of the Zimbabwean child welfare landscape. Given the diversity in caregiving structures from kinship-based family care to formally administered institutional care the paradigm provided a flexible lens through which the study could examine how caregiving practices were influenced by poverty, tradition, policy limitations, and community support mechanisms. The philosophical position of the study enabled it to capture not just what services were offered, but how they were experienced, interpreted, and internalized by the children and caregivers involved. As Mertens (2015) noted, constructivist research is especially valuable when studying marginalized or vulnerable populations, as it places emphasis on local meaning-making, social context, and personal agency.

This paradigm also aligned with the theoretical framework adopted by the study namely, Attachment Theory and Bronfenbrenner's Ecological Systems Theory. These frameworks both emphasize the significance of individual experiences within broader social systems and are congruent with the constructivist view that knowledge is situated and relational. As a result, the study was able to engage with multiple layers of meaning, including the emotional bonds formed between children and caregivers, the institutional routines that shaped children's daily lives, and the cultural beliefs that influenced caregiving expectations and stigmas.

The constructivist-interpretivist paradigm allowed the study to explore caregiving not as a technical intervention, but as a relational, affective, and contextually embedded phenomenon. It provided the space for participants to reflect on their roles, challenges, and values within caregiving environments. The result was a rich, meaningful account of how OVCs in Zimbabwe navigated their development within care systems that were often under strain, but also capable of resilience, empathy, and transformation. This philosophical orientation ensured that the study produced findings that were credible, contextually valid, and applicable to the complex realities of child welfare policymaking and practice in Zimbabwe.

3.3 Data collection methods and Research instruments

This study employed qualitative data collection methods that were consistent with the constructivist-interpretivist paradigm, aiming to explore and interpret the lived experiences of orphans and vulnerable children (OVCs), caregivers, and key stakeholders involved in child welfare. The selected methods semi-structured interviews and focus group discussions enabled the generation of detailed, contextually grounded narratives about caregiving practices and perceptions within both institutional-based and family-based care settings. These approaches were selected for their ability to elicit rich, in-depth information that reflects the complexity, emotion, and cultural specificity of care giving in Zimbabwe. As Kvale and Brinkmann (2015) suggest, qualitative interviews are not just tools for information extraction, but opportunities for meaning co-construction between researcher and participant, particularly when working with vulnerable populations.

The semi-structured interviews were conducted with a total of twenty participants, comprising children living in institutional care (Ivordale Celebrated Home) and those under family-based arrangements, as well as caregivers and social welfare officers. The interviews followed flexible, open-ended guides that allowed participants to reflect on and narrate their personal experiences in their own words. This flexibility was crucial in allowing unexpected themes to emerge, while still ensuring alignment with the study objectives namely, to examine psychosocial well-being, educational access, and health-related experiences within the care giving models. The semi-structured nature of the interviews provided a balance between structure and openness, thereby enhancing depth without compromising focus. Interview guides were tailored to each group of participants, ensuring sensitivity to age, role, and emotional capacity.

In addition to interviews, focus group discussions (FGDs) were used to capture shared perspectives among children in family-based care settings. The group setting provided a safe space for participants to reflect collectively on their experiences, compare caregiving dynamics, and express concerns or appreciation regarding their care. FGDs are particularly effective in surfacing community-level narratives and interactional insights that might not emerge in one-on-one interviews (Morgan, 2014). In this study, FGDs allowed for the exploration of peer dynamics, group coping strategies, and collective memories, especially around issues such as schooling, emotional support, and access to basic services. Each session lasted approximately 60 minutes and followed a well-developed guide structured around the three core domains under investigation, psychosocial, educational, and health-related experiences. Follow-up probing questions were used to encourage deeper reflection and clarify ambiguous responses.

The research instruments, interview guides and FGD guides were carefully developed based on the research objectives and informed by literature on child welfare, OVC care, and qualitative inquiry. They included prompts designed to elicit both factual descriptions and emotional insights. For instance, children were asked questions such as “Can you describe how it felt living at the children’s home?” or “What did your caregiver do when you were sick or sad?”, while caregivers were asked “How do you support the emotional needs of the children in your care?” and “What are the main challenges you face as a caregiver in this model?”. These instruments were pre-tested on a small group of participants to ensure clarity, cultural relevance, and emotional sensitivity before data collection commenced. As recommended by Creswell and Poth (2018), piloting the instruments helped refine the language and sequencing of questions, minimizing researcher bias and ensuring ethical responsiveness to vulnerable participants.

Field notes were also taken to capture non-verbal cues and contextual observations that enriched interpretation. All interactions were conducted in English and Shona, with translation and back-translation applied where necessary to preserve meaning and authenticity. Ethical considerations were embedded throughout the data collection process, including assurances of confidentiality, voluntary participation, and psychological support referrals where needed. In sum, the qualitative data collection methods and instruments used in this study were instrumental in surfacing the complex realities of care giving in Zimbabwean contexts. By engaging directly with children, caregivers, and social workers, the research was able to access firsthand accounts that illuminated the emotional, cultural, and institutional factors shaping OVC care. These methods provided the foundation for a thematic, grounded analysis that honors the voices and agency of those most impacted by child welfare policies and practices.

3.4 Target Population

The target population for this study consisted of orphans and vulnerable children (OVCs), caregivers, and social welfare officers who were actively involved in care giving arrangements within both family-based and institutional-based care systems in Zimbabwe. The study focused specifically on children residing in family-based care settings such as kinship care and foster care as well as those living at Ivordale Celebrated Home, a formally registered institutional care facility in Mashonaland East Province. In addition, the study engaged with adult caregivers, including kinship guardians and institutional caregivers, and social welfare professionals responsible for the oversight, regulation, or direct implementation of care giving policies and programs affecting OVCs.

The inclusion of children in the target population was central to the study's purpose, as they were the primary recipients and lived experiences of the care environments being examined. These children provided firsthand insights into their psychosocial well-being, access to health services, and educational opportunities within each model of care. Their reflections were critical in evaluating the emotional quality, consistency, and responsiveness of care received. From a constructivist perspective, children's voices were treated not simply as data points but as valid, meaning-making agents, capable of articulating their perspectives, struggles, and experiences in their own terms (Mertens, 2015). Their inclusion ensured that the study remained grounded in participant realities rather than assumptions drawn from administrative or policy-level interpretations.

The second core segment of the target population comprised caregivers who played diverse roles depending on the care model. In family-based settings, these included foster parents and kinship caregivers, often operating within constrained social and financial circumstances. In institutional settings, residential caregivers and house mothers were included, given their direct engagement with children's daily care, discipline, emotional support, and supervision. These participants were crucial in revealing the practical challenges, emotional burdens, and coping strategies of care giving in two structurally distinct models. Their perspectives shed light on how care was delivered, monitored, and sustained, and how institutional policies intersected with on-the-ground care giving realities. The narratives gathered from these caregivers offered insight into how care giving was influenced by broader issues such as caregiver-child ratios, emotional attachment, role fatigue, training, and resource availability.

Additionally, the study targeted social workers from Ivordale celebrate home and social welfare officers from Goromonzi DSD, whose inclusion was justified by their role as policy enforcers, regulatory agents, and referral actors within Zimbabwe's child protection system. Their experiences provided a macro-level lens through which to interpret the functionality, oversight, and perceived gaps within both care models. These officers offered perspectives on institutional compliance, foster care monitoring systems, and the challenges of implementing child-centered policies amid resource limitations. Their contributions enriched the study by bridging policy discourse with practice-based realities, thus offering a holistic view of the care giving ecosystem.

The justification for selecting this multi-layered population lay in its representativeness of care giving dynamics in Zimbabwe, where OVCs are embedded within a complex matrix of social, cultural, institutional, and economic forces. According to Chinyoka and Chinamasa (2020), care giving practices in Zimbabwe are shaped not only by policy frameworks but also by extended family structures, donor dependence, and societal attitudes toward orphanhood and vulnerability. Engaging with a diverse range of participants allowed the study to develop a comprehensive and triangulated understanding of the caregiving environment. It also enhanced the credibility and transferability of findings, ensuring that voices across the care giving continuum were included from those receiving care, to those providing it, to those managing its delivery. The selected target population allowed for a rich, contextually embedded exploration of the two care models under investigation, offering layered perspectives that were essential for both thematic analysis and grounded interpretation of the findings.

3.5 Sample and sampling technique

The study will employ a purposive sampling technique, to ensure a representative and diverse sample from the target population. Purposive sampling ensures that participants with relevant and rich experiences are included, while stratified random sampling guarantees balanced representation between the two care giving models.

The total sample size for this comparative analysis is 12 children, 6 caregivers and, 2 social welfare officers ,divided equally between the two care giving models. Group A will consist of 6 children from family-based care arrangements, such as kinship and foster care, while Group B will include 6 children residing at Ivordale Celebrated Home, an institutional care facility. Additionally, three caregivers from each model will be selected to provide insights into care giving practices and challenges, ensuring a comprehensive understanding of both systems.

The sample size is appropriate for a comparative case study, as it allows for in-depth analysis of each group's experiences and outcomes while remaining manageable within the study's scope and resources (Yin, 2018). Purposive sampling is justified for selecting participants with firsthand knowledge and experience, enabling the study to focus on the most relevant cases. Stratified random sampling ensures equal representation of children from both care models, facilitating robust comparisons. This smaller sample size aligns with the study's qualitative focus, enabling detailed exploration of psychosocial, educational, and health outcomes in each group. It also supports the study's objective of providing contextually grounded insights into the care giving models, ensuring that findings are both reliable and practical for informing child welfare policies and practices in Zimbabwe.

3.6 Data presentation and analysis procedures

The study employed a purely qualitative data analysis strategy, consistent with its interpretivist and constructivist paradigm. The goal was to understand the subjective meanings, patterns, and lived experiences of children, caregivers, and social welfare officers involved in both institutional and family-based care systems. The analysis was designed to explore how participants constructed meaning around care giving, emotional well-being, education, and health within their respective environments. Given the emphasis on narrative depth and contextual understanding, the study adopted thematic analysis as the primary analytical method.

Thematic analysis, as outlined by Braun and Clarke (2006), involves identifying, analyzing, and interpreting patterns (themes) within qualitative data. This method allowed for the systematic exploration of how participants described and made sense of their care experiences. The researcher followed the six-phase framework of thematic analysis: (1) familiarization with the data, (2) initial code generation, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final report. These phases ensured that the analysis remained rigorous, transparent, and grounded in the data itself rather than pre-conceived assumptions. Thematic analysis was especially suitable for this study because it offered flexibility and depth in examining the nuanced emotional, psychological, and practical aspects of care giving (Nowell et al., 2017).

Themes were developed by clustering related codes and identifying repeated ideas, emotions, or metaphors that captured the essence of participants' experiences. For example, themes such as "emotional isolation in institutional settings," "relational bonds in kinship care," and "healthcare gate keeping by caregivers" emerged as core categories that reflected cross-cutting patterns. During theme refinement, data extracts were reviewed to ensure coherence within themes and clear distinction between themes (Braun & Clarke, 2019).

The findings were then presented thematically in Chapter Four, supported by direct quotations from participants to preserve voice and context. These themes were not treated in isolation, but were interpreted within the broader ecological and cultural frameworks relevant to care giving in Zimbabwe. The use of verbatim excerpts enabled the audience to engage with the raw experiences of children and caregivers, ensuring authentic representation and transferability of findings to similar care environments.

This thematic approach allowed the study to construct meaning collaboratively with participants, illuminating not only what care giving looked like but how it felt, evolved, and was understood within both care settings. The richness of the data, enhanced through narrative accounts and systematic coding, contributed to an evidence base that was context-sensitive, emotionally resonant, and directly relevant to policy and programmatic improvements in child welfare.

3.7 Ethical issues

Ethical considerations are critical to this study, given the vulnerable nature of the target population, which includes orphans and vulnerable children (OVCs) and their caregivers. The research will adhere to established ethical guidelines to ensure the safety, dignity, and rights of all participants (Bryman, 2016).

Informed Consent

Informed consent was obtained from all participants before the commencement of data collection. For child participants, assent was sought alongside parental or guardian consent, ensuring that children understand the purpose of the study and their right to withdraw at any stage without repercussions. Consent forms were designed in simple, accessible language and translated into local languages where necessary to accommodate diverse literacy levels.

Confidentiality and Anonymity

Participants' privacy was safeguarded by anonymizing all data collected. Unique codes were assigned to participants in place of their real names, and identifying details will be removed from transcripts and datasets. Data was securely stored on password-protected devices and accessible only to authorized personnel, in compliance with data protection regulations (Creswell, 2014).

Minimizing Harm

Given the potentially sensitive nature of the topics discussed, such as experiences of loss or neglect, the study will implement measures to minimize psychological distress. The researcher utilised trauma-sensitive approaches to ensure that he handled sensitive topics with empathy and professionalism.

Voluntary Participation

Participation in the study was entirely voluntary. Participants were informed of their right to decline participation or withdraw at any stage without facing any penalties. This ensures that their involvement is based on free will, which is crucial for maintaining ethical integrity.

Ethical Approval

The study got approval from a recognized ethics committee or institutional review board before data collection begins. This process ensures that the research adheres to ethical standards and provides additional oversight for protecting participants' rights and welfare.

3.8 Feasibility

The feasibility of this study was ensured through careful logistical planning, manageable scope, and the availability of resources that supported its successful execution within the allocated timeframe and budget. The research focused on a comparative qualitative exploration of family-based and institutional care models for orphans and vulnerable children (OVCs) in Zimbabwe, specifically examining Ivordale Celebrated Home and selected family-based caregiving settings. The clearly defined research boundaries, combined with the study's targeted objectives, enhanced its practicality and operational viability.

Access to research participants was a key consideration in the design of the study. Prior to data collection, the researcher established preliminary relationships with local institutions, child care organizations, and community structures that facilitate OVC support in Mashonaland East Province. These collaborations enabled access to both family-based caregivers and institutional care personnel, as well as children currently or formerly under their care. The involvement of social welfare officers and child protection officials further facilitated ethical clearance and gate keeping, enhancing the legitimacy of the study and ensuring smooth entry into the field. Ethical protocols such as informed consent, assent procedures for minors, confidentiality guarantees, and trauma-sensitive interview approaches were rigorously followed, minimizing psychological risk and increasing trust and participation among respondents.

The study was conducted within a realistic resource framework, considering both financial and human capital. Budget allocations were made for transportation to field sites, and printing of interview and focus group tool. No high-end laboratory or statistical infrastructure was required, which made the project more affordable and aligned with the study’s qualitative orientation. The selected sample comprising 12 children, 6 caregivers, and 2 social welfare officers was appropriate for qualitative depth and remained within what could be feasibly managed given the time and resource constraints of the study.

Furthermore, the research adhered to a detailed timeline, with clear milestones for data gathering, transcription, coding, and thematic analysis. Fieldwork, including interviews and focus group discussions, was completed over a six-week period. This was followed by a two-week phase dedicated to transcription, coding, and interpretation of qualitative data using thematic analysis guided by Braun and Clarke’s framework. The sample size and thematic focus enabled the researcher to manage fieldwork and analysis concurrently in some phases, ensuring that delays were avoided.

Overall, the study was highly feasible due to its narrowed scope, context-appropriate design, and deliberate planning. The qualitative methodology, in particular, allowed the research to be conducted with minimal reliance on specialized infrastructure, while still generating rich, actionable findings. The feasibility of the project was further enhanced by the alignment between the study design and the realities of working with vulnerable children and caregivers in Zimbabwe. By ensuring ethical access, strategic partnerships, and efficient use of time and resources, the study was well-positioned to generate meaningful insights into the comparative value and impact of caregiving models within Zimbabwe’s child welfare system.

3.9 Methodological Limitations

While the study was carefully designed and executed within a qualitative constructivist framework, several methodological limitations were encountered that may have influenced the depth, scope, and interpretation of findings. These limitations were intrinsic to the nature of the study population, the sensitivity of the subject matter, and the contextual constraints of qualitative research in resource-limited settings.

Firstly, the study relied heavily on participant self-reporting, particularly through semi-structured interviews and focus group discussions. While these tools were invaluable in capturing lived experiences and constructing meaning from participants’ narratives, they were also subject to social desirability bias and selective memory. Some participants, particularly caregivers and institutional staff, may have been reluctant to disclose negative practices or admit to systemic shortcomings for fear of judgment or institutional repercussions. Similarly, children may have withheld emotionally distressing experiences or modified responses to please the interviewer. As Kvale and Brinkmann (2015) noted, qualitative interviews often reflect negotiated performances rather than objective accounts, and this interpretive nature introduces layers of subjectivity that must be acknowledged.

Secondly, the vulnerability and emotional sensitivity of the child participants posed ethical and methodological challenges. While trauma-informed techniques were used to minimize psychological harm and build rapport, some children especially those with histories of loss, abuse, or neglect found it difficult to recall certain experiences or articulate them fully. Ethical safeguards limited the depth of probing in certain interviews, which may have constrained the richness of some data. This limitation is consistent with existing research which cautions that interviewing children in alternative care settings requires a delicate balance between data collection and emotional safety (Greig, Taylor, & MacKay, 2013).

Thirdly, although the sample was adequate for qualitative inquiry, the scope and size were limited by time and logistical constraints. The study engaged a total of 20 participants, which was sufficient for reaching thematic saturation but may not have fully captured the diversity of care giving experiences across Zimbabwe. For example, rural versus urban care dynamics, denominational versus secular institutions, or formal foster placements versus informal kinship care arrangements may exhibit variations that were not fully represented. As Patton (2015) asserts, qualitative findings are context-specific and non-generalizable, and while the study produced transferability through thick description, it did not claim representativeness across all care settings.

A further limitation involved gate keeping and institutional access. Entry into Ivordale Celebrated Home and coordination with family-based caregivers required approvals from social workers and child protection authorities. While these gatekeepers were instrumental in facilitating ethical access, they may have also influenced which children or caregivers were made available for participation, potentially introducing selection bias. Participants who were more vocal, cooperative, or deemed emotionally stable may have been prioritized for participation, thereby affecting the balance of perspectives captured in the study (Hammersley & Atkinson, 2007).

Finally, translation and language interpretation posed challenges during data transcription and coding. Some interviews, particularly those conducted in Shona, required careful translation to maintain the integrity of emotional expressions and cultural nuances. Despite back-translation efforts, certain idioms, sentiments, and symbolic meanings may have been lost or diluted in the process, affecting how certain themes were interpreted. As Temple and Young (2004) explain, language in cross-cultural research is not merely a tool but a carrier of meaning, and interpretation decisions invariably shape the construction of themes.

In conclusion, while these methodological limitations did not undermine the validity of the research, they highlighted the inherent complexities of conducting qualitative inquiry with vulnerable populations in dynamic, real-world settings. The study addressed these limitations through reflexive memoing, ethical vigilance, and careful interpretation. Nonetheless, these factors should be considered when engaging with the findings, especially in terms of scope, depth, and applicability to broader care giving contexts.

3.10 Chapter Summary

This chapter defined the research methodology and research design that were used to carry out the investigation. The research population, presentation data gathering, and analysis have all been described in order to maintain track of the researcher's data collection activities. It also considered the benefits and drawbacks of employing each device. The methods of sampling that the researcher used were also examined. The study modified qualitative research methods like interviewing and questioning. The fundamental beliefs and crucial principles of ethical human behaviour are known as ethics. The study's delimitations included its boundaries, the geographic area in which it was performed, the respondents' age range, and the total number of respondents. The study's limitations included the potential challenges the researcher ran into while conducting the study and how she overcame them.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS, AND DISCUSSION

4.0 Introduction

This chapter presents the findings and thematic analysis of the study, derived from the qualitative data collected through semi-structured interviews and focus group discussions with orphans and vulnerable children (OVCs), their caregivers, and social welfare officers. The analysis was grounded in the lived experiences of participants from both family-based and institutional-based care models, with a specific focus on their psychosocial, educational, and health-related needs. The data were analyzed using thematic analysis following Braun and Clarke's (2006) framework, to ensure systematic coding, organization, and interpretation of emerging themes.

The chapter is structured thematically and guided by the study's key objectives. Each section presents and discusses findings aligned with a specific objective, supported by direct quotations from participants to illustrate the depth and diversity of lived experiences. This approach was consistent with the study's constructivist epistemology, which recognizes the importance of giving voice to participants and understanding how they construct meaning around caregiving childhood, support, and identity within their specific contexts. Demographic profiles of the participants are presented briefly to provide context for interpreting the findings. However, the primary focus of the chapter is on the narrative patterns, emotional insights, and shared experiences that emerged from the data. By organizing the findings around thematic categories, the study seeks to capture the complexity of caregiving in Zimbabwe's child welfare system and provide a contextually grounded comparative analysis of institutional and family-based care environments.The analysis does not aim for statistical generalization, but instead prioritizes depth, authenticity, and transferability of findings.

4.1 Participant Inclusion and Engagement Summary

A total of 20 participants were successfully engaged in this qualitative study, comprising 12 children, 6 caregivers, and 2 social welfare officers. These participants were purposively selected to represent both family-based and institutional-based caregiving models, consistent with the comparative case study design. Children were drawn from Ivordale Celebrated Home and selected kinship/foster care arrangements, while caregivers included both institutional staff and family-based guardians. Social workers were selected based on their administrative or regulatory roles in child protection services.

Participation was voluntary, and all individuals provided informed consent or assent (in the case of minors), with ethical clearance obtained prior to data collection. No invited participant declined to participate or withdrew during the research process. All interviews and focus group discussions proceeded as planned, and the data collected were considered sufficient to achieve thematic saturation, where no new substantive themes were emerging during the final stages of data analysis (Guest, Bunce, & Johnson, 2006).

The consistency and depth of responses across different participant categories strengthened the reliability of the findings. The successful engagement of the planned number of participants supported the study’s objective of capturing multiple perspectives on the caregiving experiences of OVCs within the Zimbabwean context.

4.2 Response Rate

The response rate is a critical metric that determines the reliability and validity of the collected data. A high response rate enhances the generalizability of findings and reduces the likelihood of non-response bias, which can distort study outcomes. In this study, the total sample consisted of 33 participants, including 12 children (6 from institutional care and 6 from family-based care), 6 caregivers (3 from institutional care and 3 from family-based care), and 2 social welfare officers. The study achieved a 100% response rate, ensuring a comprehensive dataset for analysis.

A high response rate in this study can be attributed to several factors, including effective engagement strategies, clear communication of research objectives, and the ethical safeguards put in place to ensure participant comfort. The data collection team worked closely with care institutions and family-based caregivers to schedule interviews and focus group discussions, minimizing the risk of participant dropout. Additionally, the sensitive nature of the study, focusing on the well-being of orphans and vulnerable children (OVCs), encouraged respondents to participate fully, as they viewed the study as a platform to share their experiences and challenges.

4.2.1 The response rate per category is summarized in the table below:

Respondent Category	**Targeted Sample Size**	**Completed Responses**	**Response Rate (%)**
Children in Family-Based Care	6	6	100%
Children in Institutional Care	6	6	100%
Caregivers (Family-Based)	3	3	100%
Caregivers (Institutional)	3	3	100%
Social Welfare Officers	2	2	100%
Total	**20**	**20**	**100%**

Figure 1 Response rate

The 100% response rate achieved across all respondent categories is noteworthy, as social research often encounters challenges such as non-responsiveness, reluctance to participate due to sensitive subject matter, or logistical constraints. The absence of missing responses ensures that the findings presented in subsequent sections are statistically representative and analytically robust, with no data gaps requiring imputation or adjustments.

The response rate can also be visualized through the bar chart below, which illustrates the uniform participation across all categories.

4.3 Demographics of the Respondents

The demographic characteristics of respondents provide a foundational understanding of the age distribution, marital status, education level, and employment status of the study participants. These variables are essential in contextualizing the experiences of children in family-based care and institutional care and understanding the caregiving environment.

4.3.1 Age Distribution of Children

Age Group (Years)	Family-Based Care (n=6)	Institutional Care (n=6)
Less than 5	1	1
5-10	2	3
10-13	2	1
13-18	1	1

Figure 2 Age distribution

The table above visually presents the age distribution of children in both care settings. The data indicates that the majority of children entered care between 5 and 13 years old, with relatively fewer cases of children entering before the age of 5. This suggests that most children in the study had experienced early childhood development in biological family settings before transitioning into alternative care arrangements.

A notable observation is that institutional care had a slightly higher proportion of children entering between 5-10 years, which may be attributed to late referrals from extended family or social services interventions after familial caregiving challenges became evident.

4.3.2 Marital Status of Caregivers

The marital status of caregivers is relevant in understanding the stability and support structures available within family-based care models.

Marital Status	Family-Based Caregivers (n=3)	Institutional Caregivers (n=3)
Married	2	0
Divorced	0	2
Widowed	1	1

Figure 3 Marital status of care givers

The findings show that a majority of family-based caregivers were married (2 out of 3), indicating a structured household environment, while institutional caregivers were more likely to be divorced. This distinction is relevant because family-based care relies on familial bonds and stability, whereas institutional care involves professional caregiving, where marital status is less of a determining factor in caregiving quality.

4.3.3 Education Level of Children

4.3.4 Education is a core factor in child development, and the study examined the academic attainment of children in both care models.

Education Level	Family-Based Care (n=6)	Institutional Care (n=6)
Primary	1	3
O-Level	3	2
A-Level	2	1

Figure 4 Educational levels of children

From the data, children in institutional care were more concentrated at primary education levels, while children in family-based care had a higher proportion reaching O-Level and A-Level. This aligns with existing literature suggesting that children in family-based care often receive more personalized academic support and encouragement compared to those in institutional settings, where educational progress may be hindered by the lack of individualized attention.

4.3.5 Employment Status of Caregivers

4.3.6 The employment status of caregivers is an important determinant of the financial stability of care giving environments.

Employment Status	Family-Based Caregivers (n=3)	Institutional Caregivers (n=3)
Employed	0	3
Self-Employed	1	0
Unemployed	2	0

Figure 5 employment status of caregiver

The findings indicate that a higher proportion of institutional caregivers were employed, reflecting the professional nature of care giving in institutional settings. Family-based caregivers had a higher percentage of unemployment (2 out of 3), which may suggest economic vulnerability in these households, impacting their ability to provide consistent educational and health support for children under their care.

4.4 Qualitative Data Analysis

4.4.1 Objective 1: To assess the psychosocial well-being of children in family-based and institutional-based care at Ivordale Celebrated Home.

Theme 1: Emotional Adjustment to Care Environment

The transition into care, whether institutional or family-based, was marked by profound emotional upheaval for many children. Several participants from both care models recounted initial episodes of grief, confusion, and abandonment, particularly in the days and weeks following placement. One child in institutional care recalled,

> *"At first I used to cry every night... it felt like I was left alone in the world"* (*Interview – Child, Institutional Care*). This sense of emotional displacement was echoed by another child in family-based care who stated, *"They took me in, but I didn't know anyone. I missed my mum every day"* (*Interview – Child, Family-Based Care*).

These narratives reveal that while the structural form of care differed, the psychological rupture caused by separation from biological family was a shared experience. Children in institutional care appeared more likely to experience prolonged emotional detachment, often describing feelings of isolation or emotional neglect in environments where caregiver-child ratios were high. One boy expressed,

> "*Unotogara pano asi nekuda kwekuti takawanda unogona kusatoonekwa kuti wakatsamwa kana kurwadziwa unotofanira kuita something kuti vazvizive"* (You can stay here, but no one really sees when you're sad unless you make noise) (*Interview – Child, Institutional Care*). In contrast, while children in family-based care still experienced sadness, they often adjusted more quickly, attributing it to the presence of consistent emotional figures such as grandparents or aunts. A caregiver confirmed this by saying, *"The girl came quiet, always looking down. But now she laughs. It's love that works, not money"* (*Interview – Caregiver, Family-Based*).
>
> The emotional trajectory of adjustment was shaped not only by the care model but also by individual resilience and the presence of empathetic adults (Masten, 2014). In FGDs conducted with children in family-based care, several participants described "slow healing" through routine, shared meals, prayer, and being called by affectionate names (*FGD – Family-Based Care*). In contrast, children in institutional care described relying

> on peers for comfort rather than adults, with one child stating, *Tinochema tese tobva tanzwa kureruirwa (*We cry together, then we feel okay) (*FGD – Institutional Care*).

These findings align with the literature, which suggests that children placed in any form of alternative care typically undergo an initial adjustment crisis marked by fear, sadness, and emotional withdrawal (Chinyoka& Chinamasa, 2020). According to Browne (2021), institutional care often lacks the emotional continuity and individualized attention necessary for early psychological recovery. Conversely, family-based care offers the potential for attachment security, provided the caregiver is emotionally available and stable (Bowlby, 1969; Williamson & Greenberg, 2020). Therefore, the present study confirms that emotional adjustment is not guaranteed by care type alone but depends heavily on the quality of human interaction, especially in the critical early phase of placement.

Theme 2: Sense of Belonging and Attachment

A dominant theme that emerged in the analysis was the children's perception of belonging and emotional attachment, which significantly influenced their psychosocial well-being. In family-based care settings, many children expressed a conditional but growing sense of inclusion, often framed around relational treatment and emotional recognition. One participant from family-based care explained,

> *"Tete especially panouya vaenzi vanodiudza kuti hapasi pamba pedu*"(My aunt treats me like her own, but sometimes I feel like I don't really belong when visitors come. Then they remind me I'm just staying here*)* (*Interview – Child, Family-Based Care*).

This statement reflects a nuanced dynamic where children feel accepted in daily routines but experience emotional marginalization in symbolic moments such as family gatherings. Similarly, another child admitted that while she received food and school support,

> *"they don't hug me like their own children. It's different"* (*Interview – Child, Family-Based Care*). These insights reveal how emotional attachment and symbolic acceptance go hand in hand in shaping a child's sense of belonging.

In contrast, children in institutional care have a different narrative. One boy remarked,

> *"We are just all the same one is more special than the other. We eat, sleep, and go to school"* (*Interview – Child, Institutional Care*).

Although this egalitarian sense fostered fairness and predictability, it simultaneously limited the formation of individual emotional bonds (Bowlby 1982). Caregivers in institutional settings acknowledged this limitation, with one admitting,

> *"It is hard to give each child the kind of love you would give your own. We are many, and time is short"* (*Interview – Institutional Caregiver*). However, quite number of children did describe certain caregivers as "motherly," indicating that some attachment figures emerged over time, albeit inconsistently.
>
> In the family-based FGDs, several children emphasized shared rituals such as prayer, evening stories, and being assigned chores as part of the household as critical to feeling like "a real child in the family" (*FGD – Family-Based Care*). Others described negative experiences where biological children were favored, leading them to feel "*ndiri muenzi mumba*" (like a visitor in the house) (*FGD – Family-Based Care*). These contrasting accounts underscore the importance of emotional integration, not just physical placement. In institutional FGDs, on the other hand, some participants expressed comfort in group identity, stating that *"at least here we all have the same background. No one looks down on anyone"* (*FGD – Institutional Care*). This suggests that while formal attachment may be limited, children may develop a peer-based sense of solidarity as a surrogate for familial belonging.

These findings echo Attachment Theory, which underscores the significance of stable, nurturing, and consistent caregiver relationships for the development of secure attachment bonds (Bowlby, 1969; Ainsworth et al., 1978). While family-based care theoretically offers more potential for individual attachment due to smaller caregiver-to-child ratios, its success depends heavily on emotional investment by caregivers (Williamson & Greenberg, 2020). Institutional settings, though less personalized, may compensate through predictable routines and peer affiliation, which provide alternative but limited sources of identity (Naaz, 2023). The study findings reinforce the notion that true belonging is not automatically created by care placement it must be actively nurtured through relational engagement, symbolic inclusion, and emotional availability.

Theme 3: Coping Strategies and Resilience

A third theme that emerged strongly from the data was the range of coping mechanisms employed by children in both institutional and family-based care settings. Despite their vulnerable circumstances, many participants demonstrated notable degrees of emotional strength, adaptive behaviour, and inner resourcefulness, which helped them navigate the psychological challenges of care life. Children described coping strategies that were both internal and external, ranging from personal rituals to social relationships. A young boy in family-based care shared,

> *"When I'm sad, I sing or I pray. That helps me feel strong again"* (*Interview – Child, Family-Based Care*). His statement highlights how spirituality and music functioned as private, emotionally restorative tools. Another girl, placed in institutional care, described how she coped by drawing pictures, saying, *"I draw my family from memory, and it feels like they are still near"* (*Interview – Child, Institutional Care*). These individual accounts speak to the symbolic strategies children used to re-establish control and meaning in environments marked by loss and uncertainty.

Some children also relied on narrative storytelling and communal memory as a way of processing trauma. In one focus group, a child recounted how they would tell stories of their parents before bedtime with peers, stating,

> *"It hurts, but talking about them with others helps me sleep"* (*FGD – Institutional Care*). This coping behavior demonstrates both grief expression and the peer-mediated construction of resilience. It was evident in multiple accounts that peer solidarity served as a protective buffer against the emotional void of separation and caregiver inconsistency. This aligns with observations by caregivers who noted that children often "form sibling-like bonds" with peers in institutions and "protect each other emotionally" (*Interview – Caregiver, Institutional*).

In family-based care, children sometimes described self-silencing as a survival tactic, particularly in environments where they felt they were not fully accepted. One child stated,

> *"When I'm not happy, I keep it in my heart. Talking can cause problems"* (*Interview – Child, Family-Based Care*). Though this strategy may prevent immediate conflict, it raises concerns about internalized distress and emotional repression. In contrast, others in family care leaned on religion as a constant companion. As one participant put it, *"I fast and pray when I miss my mother. I ask God to take care of her and me"* (*Interview – Child, Family-Based Care*). This illustrates the role of faith not only as a coping mechanism but also as a framework for meaning-making, particularly in situations where family structures have been fractured.

> Caregivers were not oblivious to these coping behaviors. One institutional caregiver observed, *"Some children cry a lot at first, then suddenly stop. That's when they start finding small ways to survive emotionally drawing, singing, clinging to one or two friends"* (*Interview – Institutional Caregiver*). Another caregiver in a family setting highlighted, *"You can see it when they're trying to be strong leaning too much, helping with everything. That's how they try to earn love or avoid being sent away"* (*Interview – Family-Based Caregiver*). These accounts reflect an acute understanding that children do not merely adapt passively; they develop tactical emotional strategies to manage both acceptance and rejection.

These findings are consistent with research by Chinyoka and Chinamasa (2020), who identified faith-based practices, peer companionship, and creative expression as key resilience tools among orphans in Zimbabwe. Similarly, Masten and Coatsworth (1998) define resilience as the "process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances," which is visibly illustrated in how children in this study used accessible, culturally embedded tools to reconstruct emotional balance. Although the presence of formal psychological support was rare in both care settings, the organic emergence of resiliencerooted in spiritual beliefs, peer bonds, and personal ritualsrevealed children's agency and capacity to adapt. Nonetheless, the coping strategies documented also signal the urgent need for psychosocial support services, especially to address internalized trauma and long-term emotional suppression.

Theme 4: Relationship with Caregivers

The nature and quality of relationships between children and caregivers proved to be a critical determinant of psychosocial well-being, often shaping how children interpreted their value, safety, and emotional stability within the caregiving environment. In family-based care settings, these relationships ranged from deeply nurturing to conditionally supportive. One child shared,

> *"My grandmother holds me when I cry and says I am not alone. That makes me feel safe"* (*Interview – Child, Family-Based Care*). Such expressions of physical and emotional closeness were less commonly reported in institutional settings, where care often followed formal routines and duty-driven interactions. A contrasting voice from a child in institutional care stated, *"Sometimes I'm scared to ask for things. The matron*

> *is kind but strict"* (*Interview – Child, Institutional Care*). This quote reflects a discipline-heavy caregiving model, where emotional availability may be present, but is often inconsistent and hierarchical in its delivery.

Caregivers in institutional care often recognized their limitations in building close emotional bonds due to time constraints, workload, and organizational culture (Johnson, 2021). One caregiver admitted,

> *"With 10 or more children to watch, you love them, but it is not the same as loving one child at home. You do your best"* (*Interview – Institutional Caregiver*). This reinforces the structural critique found in the literature that institutional settings, by design, limit opportunities for individualized emotional bonding (Browne, 2021). In family-based care, however, children were more likely to describe caregivers using emotionally resonant language. Phrases like "my mother now," "she hugs me when I'm sick," or "he listens when I speak" were recurrent in interviews and FGDs (*FGD – Family-Based Care*). Even where material resources were limited, the emotional constancy and verbal affirmation offered by family-based caregivers played a pivotal role in enhancing the child's sense of dignity and worth.

Not all family-based relationships were described positively. Some children reported experiences of emotional favoritism, harshness, or neglect. A 14-year-old boy confided,

> *"When I do something wrong, they say I'm not their real child. It hurts"* (*Interview – Child, Family-Based Care*). In such cases, the absence of biological connection sometimes manifested in verbal reminders of difference, which undermined trust and stability. This supports Naaz's (2023) observation that while family-based care is often idealized, relational breakdowns and intra-household inequality are prevalent and can deeply affect children's emotional trajectories. On the other hand, institutional care while emotionally constrained was sometimes viewed as emotionally predictable, especially in settings with structured routines and consistent staff. A child shared, *"At least here, we know what to expect. They don't shout for small things"* (*Interview – Child, Institutional Care*). This predictability provided a form of psychological safety, even if emotional warmth was limited.

Caregiver self-perception was also revealing. A family-based caregiver stated,

> “kunyange asiri mwana wangu, ndinomubata serugotwe rangu vana vanoziva rudo rwechokwadi*” (*Even though he is not my own, I treat him like my last born. Children know when love is real*)* (*Interview – Family-Based Caregiver*). In contrast, institutional caregivers often described their roles in terms of responsibility and protection, rather than emotional closeness. One institutional staff member noted, *“We make sure they eat, bathe, go to school. That’s our duty. If we show love, it’s a bonus”* (*Interview – Institutional Caregiver*). These contrasting orientations reflect how the institutional context shapes emotional engagement, often transforming care into a regulated function rather than a relational process.

These findings resonate with Bowlby’s (1969) Attachment Theory, which emphasizes the child’s need for consistent, emotionally responsive caregiving as foundational to healthy development. In institutional settings, caregiver turnover, high child-to-caregiver ratios, and standardized routines often prevent the formation of secure attachments (Ainsworth et al., 1978; Mutangadura, 2019). In contrast, family-based care can foster stronger emotional bonds, but only when caregivers are emotionally available and inclusive (Williamson & Greenberg, 2020). The study thus reaffirms that caregiver-child relationships are not inherently stronger in one model than the other; instead, the emotional investment, responsiveness, and cultural attitudes of caregivers are the decisive factors that shape relational quality and, by extension, psychosocial outcomes for OVCs.

Theme 5: Peer Interaction and Social Support

Peer interaction emerged as a significant component of psychosocial well-being, particularly in contexts where adult emotional support was inconsistent or limited. Children in both family-based and institutional care settings placed a strong emphasis on their relationships with peers as sources of comfort, validation, and identity reinforcement. In institutional settings, peer bonds appeared to compensate for the absence of individual caregiver attention. One child described his dorm mates as

> *“my real brothers. We share everything—even when we’re sad”* (*Interview – Child, Institutional Care*). Such expressions highlight the communal solidarity that institutional settings can foster, especially when children are bound by shared histories of loss, abandonment, or poverty. These peer-based networks functioned not only as

> social lifelines but also as emotional ecosystems, where children learned to regulate behavior, share coping strategies, and create informal systems of care.

Focus group discussions further supported this view. In a group at Ivordale Celebrated Home, one participant remarked,

> *"We fight sometimes, but we also cry together. Only other children know how this place feels"* (*FGD – Institutional Care*). This illustrates a profound understanding of peer empathy and mutual support, grounded in shared circumstances. The same was noted by caregivers, one of whom acknowledged, *"Sometimes when a child is down, the others step in faster than us. They are closer in their own way"* (*Interview – Institutional Caregiver*). Such observations reflect a caregiving environment where children become co-constructors of emotional resilience, creating what Goffman (1961) termed "primary adjustment communities" in closed or semi-closed systems.

In family-based care, the quality of peer interaction depended largely on the household structure. In some instances, children were placed in homes with biological children or other foster siblings, and these dynamics were marked by either inclusion or exclusion (Courtney,2020). One child stated,

> *"My cousin is like my best friend. We play, go to school together. She shares her secrets with me"* (*Interview – Child, Family-Based Care*). Conversely, another child lamented, *"They play as brothers and sisters and leave me alone. I feel like the outsider"* (*Interview – Child, Family-Based Care*). These contrasting experiences suggest that family-based care does not automatically ensure peer support social integration in the home must be actively nurtured. Some caregivers acknowledged this difficulty, especially when other children were not fully informed about or accepting of the placement. One caregiver admitted, *"My children didn't understand at first. They thought she was taking their place. It took time for peace to come"* (*Interview – Family-Based Caregiver*).

Peer interactions also extended into broader social contexts, including school and community activities (Weissberg, 2021). Children from both care models shared experiences of stigma and support from classmates and neighbors. In one FGD, a boy shared,

> *"At school, when they hear you are from a home, they start calling you names. But some friends defend me. They say I'm just like them"* (*FGD – Institutional Care*).

This mix of acceptance and discrimination underscores the social fragility of OVC identities, and how peer relationships can both buffer and intensify that vulnerability. In family-based care, children who were well-integrated into community life expressed higher self-confidence and optimism, whereas those who felt "hidden" or "treated differently" spoke about withdrawal and loneliness, even in households with siblings.

These findings align with the literature that emphasizes the protective role of peer relationships in child development, particularly among children in alternative care settings. According to Luthar (2006), peer support can serve as a moderator of stress, fostering resilience even in the absence of strong adult caregiving. Likewise, Naaz (2023) highlights that shared peer experiences in institutional contexts can reduce social alienation and facilitate adaptive behavior. However, the findings also complicate this narrative by revealing that not all peer environments are supportive, especially in cases of favoritism, stigma, or exclusion within family-based care. Therefore, while peer relationships are powerful psychosocial tools, they must be facilitated, monitored, and emotionally supported by caregivers and institutions alike to ensure they function as assets rather than liabilities in the child's developmental journey.

4.4.2 Objective 2: To compare educational outcomes between family-based and institutional-based care models at Ivordale Celebrated Home.

Theme 1: Access to Schooling and Continuity

Access to schooling was one of the most critical educational outcomes examined in this study, and it emerged as a foundational determinant of opportunity and aspiration for children in both family-based and institutional care settings. Participants across both care models indicated that school attendance was generally prioritized, yet continuity, quality, and regularity of school engagement varied significantly depending on the caregiving context and available support structures. A child from institutional care shared,

> *"ndakatanga kuenda kuchikoro pandakauya pano ndisati ndapano hapana aiva nebasa nazvo*"(I started going to school again when I came here. Before, no one cared whether I went or not) (*Interview – Child, Institutional Care*).

This highlights the stabilizing role of structured institutional systems, which often ensure that education is systematically enforced as part of the daily routine. Indeed, institutional caregivers reported that

> *"school attendance is monitored strictly; children don't just stay home unless they are sick"* (*Interview – Caregiver, Institutional Care*), underscoring the administrative consistency present in many registered children's homes.

In contrast, family-based care offered a more contextually variable experience. While many children reported being enrolled in school, they also described intermittent disruptions due to financial limitations, caregiver availability, or competing household duties (UNESCO, 2020). One girl explained,

> *"I miss school sometimes when my aunt can't afford bus fare. She tries, but it's not always easy"* (*Interview – Child, Family-Based Care*).

Some children in family-based care settings were placed in remote areas where schools were far from home, and attendance was heavily dependent on the physical and financial capacity of the caregiver. A caregiver from a rural placement confirmed this, stating,

> *"kana ndaawanawo mari pakutengesa tengesazvinhu ndobhadhra kana pasina tongomirira" (*If I get money from vending, I pay school fees. If not, we just wait) (*Interview – Caregiver, Family-Based Care*). These responses reveal that while family-based care aligns more closely with traditional community values, its access to schooling is often hindered by socio-economic volatility.
>
> Focus group discussions reinforced this contrast. In an institutional FGD, one child noted, *"We wear the same uniforms and leave for school together. It feels normal. No one knows you're* school uniforms and routine c*handiende kuchikoro nekuti ndinege ndichinyara ne uniform yangu inenge yakabvaruka" (*Sometimes I don't go to school because my uniform were torn. I was embarrassed) (*FGD – Family-Based Care*).

These remarks demonstrate that in family settings, psychosocial barriers such as stigma, appearance, and perceived neglect can also affect school participation, especially when children feel unprepared or different from their peers. Additionally, while institutional care often benefits from donor-sponsored school fees and centralized tracking, family caregivers must navigate bureaucratic delays in public assistance such as BEAM (Basic Education Assistance Module), which further disrupts educational continuity.

The literature provides strong support for these findings. According to Chinyoka and Chinamasa (2020), many children in Zimbabwe's kinship or foster systems experience interrupted schooling due to poverty, illness, or caregiver neglect, despite the government's endorsement of universal education. Tsegaye (2019) also notes that while family-based care offers emotional grounding, it often lacks the institutional mechanisms required to guarantee uninterrupted access to education. In contrast, institutional care, despite its criticisms, is often better equipped to maintain administrative records, enforce school attendance, and secure donor-funded educational resources (Mutangadura, 2019; Williamson & Greenberg, 2020). Thus, the findings of this study suggest that institutional care environments, while emotionally limited, often provide more structured and continuous educational access, whereas family-based care, despite its emotional intimacy, faces logistical and financial barriers that threaten educational consistency.

Theme 2: Academic Performance and Confidence

Academic performance and the children's confidence in their own learning abilities emerged as a core theme influencing how they evaluated their educational experience in both care settings. Children's perceptions of their scholastic abilities were shaped not only by their personal learning challenges but also by how caregivers and teachers responded to their efforts (Bandura, 1997). A child in institutional care expressed hope despite struggles, stating,

> *"I* , which was common across both groups. However, institutional caregivers noted that while academic resources were provided consistently, individualized attention was rare due to the number of children in care. One caregiver explained, *"We make sure homework is done, but we cannot sit down with each child every day. It's impossible"* (*Interview – Institutional Caregiver*). This often left academically weaker children unsupported unless external tutoring was available.

In contrast, children in family-based care generally reported receiving more personalized academic encouragement, especially from caregivers who were emotionally invested in their progress. One girl shared,

> *"My aunt claps when I pass. She says, 'well done, mwanawangu' [my child]. That makes me try harder"* (*Interview – Child, Family-Based Care*).

These emotionally reinforcing interactions appeared to foster greater confidence, even when children encountered academic challenges. A caregiver echoed this, stating,

> *"kunynge akatadza ndinoukurudzira kuramba achishnda nesimba kuchikoro chakakosha kuzama* (even if he fails, I tell him it's okay. What matters is trying. That keeps his heart strong) (Interview – *Caregiver, Family-Based Care*).

This emotional buffering against academic failure was less evident in institutional care, where disciplinary cultures sometimes overshadowed encouragement. One child noted,

> *"When you fail, they just the book. No one talks to you much"* (*Interview – Child, Institutional Care*).

Focus groups also revealed how peer comparisons and external validation influenced academic self-perception. In family-based FGDs, some children described comparing themselves with siblings or cousins, which motivated performance in some cases but triggered anxiety in others. One participant noted,

> *"When my cousin got a prize, I wanted to do the same. But when I failed, I felt useless"* (*FGD – Family-Based Care*). In institutional FGDs, children often evaluated themselves against the group, with one boy explaining, *"We all go to the same school. Some pass, some fail. It depends on how you read at night"* (*FGD – Institutional Care*).

While institutional care promoted a uniform learning environment, this did not always translate into individual academic confidence, especially for slower learners who lacked tailored support.

These findings confirm existing scholarship which emphasizes that academic achievement among OVCs is not solely dependent on school enrollment but also on the quality of support within the care environment. According to Naaz (2023), children in family-based care often perform better academically when caregivers are involved in their learning, even in the absence of material resources. Meanwhile, institutional care may provide better infrastructure and consistency but lacks the emotional encouragement necessary for building intrinsic motivation and resilience in learning (Williamson & Greenberg, 2020; Mutangadura, 2019). Furthermore, Chinyoka and Chinamasa (2020) argue that academic confidence is closely tied to psychosocial support, not just curriculum mastery. In this study, it became evident that children thrive academically when they feel emotionally affirmed, not when they are simply monitored or instructed. Therefore, while both care models present strengths and weaknesses, the presence of consistent, affirming relationships emerged as the single most important factor influencing academic self-confidence and perceived success.

Theme 3: Support Structures for Learning

The availability and consistency of support structures for learning both formal and informal played a pivotal role in shaping children's academic outcomes and educational confidence across the two caregiving models. Children and caregivers in family-based settings frequently described a close, interactive approach to homework and school follow-up, even in contexts with limited material resources. One child stated,

> *"She helps me do homework even when she is tired from the market. She says, 'your future is in that book'"* (*Interview – Child, Family-Based Care*).

This quote illustrates not only the physical support provided but also the motivational discourse caregivers used to reinforce the value of education. Caregivers themselves emphasized the priority placed on schoolwork, with one saying,

> *"Even if I don't know English well, I check the books. I ask the older brother to help. I must show interest"* (*Interview – Family-Based Caregiver*).

These examples highlight how collective household support systems can be mobilized to enhance learning engagement.

In institutional care, educational support was more formalized and structured, with children attending school in uniform and receiving time slots for homework. However, interviews and focus groups revealed that while access to learning materials was generally better, individual academic guidance was minimal. One boy stated,

> *"We have books and tables to read, but no one checks what you are doing unless you ask"* (*Interview – Child, Institutional Care*). Another shared that *"sometimes older children help, but not all are patient"* (*FGD – Institutional Care*).

These insights suggest that while the infrastructure for learning may be present in institutional settings, relational and motivational support is often lacking. Institutional caregivers acknowledged this, with one saying,

> *"We focus more on discipline and routine. Educational encouragement happens, but it depends on the child's initiative"* (*Interview – Institutional Caregiver*).

In contrast, children in family-based care often benefitted from adaptive learning environments, where support could be tailored to the child's pace and style. In one focus group, a girl shared,

> *"I read with my cousin. She explains better than my teacher sometimes"* (*FGD – Family-Based Care*).

This kind of peer-assisted learning was frequently mentioned in family care but was less emphasized in institutional settings, where , family caregivers described involving schools directly when academic problems arose. One caregiver reported,

> *"If he brings poor marks, I go to school. I ask the teacher what's wrong. We work together"* (*Interview – Family-Based Caregiver*)

. Such school-home collaboration was nearly absent in institutional care, where education and caregiving were often administered by different departments or staff.

This theme aligns with Williamson and Greenberg's (2020) assertion that effective caregiving must include educational engagement, not just logistical support like uniforms or fees. According to Tsegaye (2019), family-based caregivers, especially kinship guardians, often provide stronger educational scaffolding because of relational proximity and cultural expectations, even when they lack formal training. Conversely, institutional care may offer better learning environments but is constrained by rigid structures and high child-to-staff ratios, limiting consistent academic mentorship (Mutangadura, 2019; Browne, 2021). The present study affirms that learning thrives when support is emotionally anchored and flexible, and where caregivers take active roles in reinforcing education both at home and through partnerships with schools. The evidence suggests that while institutional care may fulfill administrative functions of education, family-based care, when stable and engaged, better supports holistic educational development through relational presence and encouragement.

Theme 4: Learning Environment and Motivation

Children's motivation to engage with school and learning was deeply influenced by the emotional climate, consistency of encouragement, and relational tone of the caregiving environment. In both institutional and family-based care, participants frequently described how positive feedback, recognition, and praise shaped their desire to succeed academically. A boy from institutional care recalled,

> *"When my teacher says I did well, I feel like I can do anything"* (*Interview – Child, Institutional Care*).

Such affirmations, though often coming from outside the care home, played a critical motivational role, especially for children who lacked strong relational bonds within the institution. Despite this, institutional caregivers reported limited capacity to provide regular, personalized encouragement, with one stating,

> *"We clap for good results in assembly, but it's hard to follow every child's progress unless they stand out"* (*Interview – Institutional Caregiver*).

In family-based care, motivation often stemmed from intimate relational bonds and emotionally charged interactions that validated a child's effort, even when results were not exceptional. One child shared,

> *"Even when I get low marks, my aunt says I am improving. That makes me want to do better"* (*Interview – Child, Family-Based Care*).

These expressions reflect the intrinsic motivation fostered by caregivers' affirming behavior, which many participants in family settings described as their primary source of academic drive. Caregivers consistently linked motivation to future aspirations, telling children they were being prepared for "a better life" or "something bigger." In one case, a caregiver said,

> *"I tell her school is her key. I didn't get to go, but she must go far"* (*Interview – Family-Based Caregiver*). Such statements frame learning as transformative and aspirational, encouraging children to internalize educational achievement as a personal mission.

Focus group discussions further revealed that motivation was socially constructed, often reinforced by peer comparison and approval. In institutional FGDs, one child shared,

> *"When someone passes, we all clap. That makes you also want to do well"* (*FGD – Institutional Care*). However, others noted that in crowded institutional spaces, *"sometimes no one notices if you pass or fail"* (*FGD – Institutional Care*),

pointing to a lack of consistent positive reinforcement. In contrast, children in family-based FGDs emphasized celebratory responses at home, such as being allowed to choose what to eat or receiving verbal praise. One child said,

> *"When I bring a good report, they ululate. That makes me feel like a champion"* (*FGD – Family-Based Care*).

These rituals of affirmation, rooted in culture and family dynamics, significantly boosted motivation in family-based settings.

This theme aligns with existing research suggesting that motivation is not merely a function of academic ability but is closely tied to perceived value, recognition, and relational context (Eccles &Wigfield, 2002). In Zimbabwean caregiving contexts, where children's identities are often shaped by loss and displacement, affirmation and symbolic validation become central to sustaining motivation (Chinyoka& Chinamasa, 2020). Studies by Browne (2021) and Williamson & Greenberg (2020) emphasize that children in institutions often suffer from motivational fatigue due to the lack of personalized support and intermittent acknowledgment. Conversely, family-based care—when emotionally invested—provides not just encouragement, but meaningful motivation rooted in love, hope, and personal investment. The current study confirms that children's motivation to learn is strongly mediated by relational affirmation and recognition, which must be cultivated deliberately within both care models to enhance educational outcomes.

Theme 5: Barriers to Educational Engagement

Barriers to education emerged as a cross-cutting theme affecting children across both care models, though the nature and intensity of the barriers varied depending on institutional context, household dynamics, and socio-economic status. In family-based care settings, financial hardship was the most frequently reported barrier. One child shared,

> *"Sometimes I miss school because there's no money for uniforms"* (*Interview – Child, Family-Based Care*).

In several interviews, caregivers echoed this concern, indicating that inconsistent income, delays in government support (such as BEAM), and high transport costs often led to intermittent school attendance or missed examinations. One caregiver expressed frustration:

> *"The form is submitted, but BEAM money delays. Meanwhile, the child sits at home"* (*Interview – Family-Based Caregiver*).

This instability often left children academically behind and emotionally discouraged, particularly when they felt singled out or different from their peers.

In institutional care, financial barriers were less pronounced due to donor support and centralized management of educational resources. However, children faced logistical and psychosocial barriers such as stigma, overcrowding in classrooms, or emotional distress that interfered with concentration. A child in institutional care shared,

> *"Even if I go to school, sometimes my mind is still thinking of my mother. I just sit quietly"* (*Interview – Child, Institutional Care*).

This reveals how trauma and unresolved grief can serve as internal barriers, particularly when psychological support is minimal. Institutional caregivers also cited lack of individualized academic follow-up, especially for slow learners. One stated,

> *"We can't afford tutors, and teachers at school just send results. That's it"* (*Interview – Institutional Caregiver*).

These limitations suggest that while basic access to education may be structurally provided in institutional care, academic responsiveness and emotional support are often lacking.

Focus group data also highlighted bullying and stigma as barriers in both settings. Children from institutions reported being labeled or excluded at school:

> *"They call us 'children from the home.' Sometimes we fight because of that"* (*FGD – Institutional Care*).

Similarly, children in family-based care shared experiences of discrimination from siblings or schoolmates, particularly when their care giving status was known. One girl recounted

> , *"My cousin says I'm lucky to eat for free. It makes me feel small"* (*FGD – Family-Based Care*).

These interpersonal conflicts, often left unaddressed by adults, contributed to lower self-esteem, anxiety, and reluctance to participate actively in class.

Another major barrier involved resource gaps, particularly in rural family-based settings where children lacked learning materials, adequate lighting, or internet access. One participant explained,

> *"I want to research like other kids, but we have no electricity"* (*Interview – Child, Family-Based Care*).

In institutional care, though materials were more accessible, some children still noted restrictions in usage or shared resources that limited study time. A child mentioned,

> *"You wait for your turn to use the dictionary. If it's late, you just sleep"* (*Interview – Child, Institutional Care*).

These examples reinforce the argument that material access alone does not equate to equitable learning opportunity, especially in emotionally complex or poorly supported environments.

The findings resonate with empirical literature highlighting that barriers to education among OVCs are multifaceted, spanning financial, psychological, social, and infrastructural dimensions. As per Tsegaye (2019), poverty remains the most immediate hurdle in family-based care, while institutional settings often struggle with individualization of support and socio-emotional integration. Williamson and Greenberg (2020) emphasize the importance of holistic educational supportone that includes psychosocial backing, mentorship, and responsive carein overcoming these barriers. Browne (2021) further asserts that education for children in care must be anchored in stable, loving relationships and a belief in their potential, not just access to school buildings or materials. This study adds to the discourse by demonstrating that barriers are not only systemic but relational, and overcoming them requires investment not just in infrastructure or policy, but in emotional safety, advocacy, and consistent caregiver engagement.

4.4.3 Objective 3: To evaluate the health outcomes of children in family-based versus institutional-based care at Ivordale Celebrated Home

Theme 1: Access to Basic Health Services

Access to basic health services was a defining indicator of children's well-being across both care models. In family-based care settings, access was highly variable and often determined by caregiver capacity, household income, and geographic proximity to health facilities. A child in family-based care recalled,

> *"When I had a fever, my aunt used hot water and waited. We went to clinic later"* (*Interview – Child, Family-Based Care*).

This illustrates the reliance on home remedies and delayed care-seeking, which was echoed by several caregivers who cited financial constraints, transport issues, and cultural reliance on informal treatment as barriers to immediate medical attention. One caregiver stated,

> *"tinombozama zvedu zvechibhoi kana zvikaramba totsvaga mari yekuchipatara" (*We first try herbs or home ways. If it gets worse, we find money for the clinic) (*Interview – Family-Based Caregiver*).

This reliance on traditional methods as a first response highlights both resource limitations and cultural practices that mediate healthcare access in family-based care.

In contrast, children in institutional care often reported more consistent and immediate access to formal health services, largely due to the institutional partnerships with local clinics and NGOs. One child noted,

> *"Here, the nurse comes sometimes. They check us and write reports"* (*Interview – Child, Institutional Care*).

Institutional caregivers confirmed that children's health records were routinely updated and that scheduled visits from health professionals, including nurses and nutritionists, were part of operational procedures. A caregiver shared,

> *"We work with the local clinic. They know our children. We send them quickly when sick"* (*Interview – Institutional Caregiver*).

These accounts suggest that systematized care protocols and funding streams in institutional settings often facilitate more reliable healthcare access compared to the informal systems in family-based care.

However, even within institutional environments, some children described occasional delays or bureaucratic approval processes before accessing specialized treatment. One caregiver admitted,

> *"For basic things, we act fast. But when a child needs tests or referral, we wait for admin clearance"* (*Interview – Institutional Caregiver*).

This reflects an organizational tension where institutional efficiency in routine care does not always extend to emergency or specialized care, a concern that can impact timely intervention in critical cases. Meanwhile, in family-based FGDs, several children indicated that distance to clinics, lack of transport money, or not being prioritized by caregivers contributed to inconsistent healthcare. One child shared,

> *"If the caregiver is busy, we wait. Sometimes she says it will go away"* (*FGD – Family-Based Care*), revealing a significant gap in perceived urgency and medical knowledge.

These findings align closely with research by Mutangadura (2019), who observed that institutional care settings in Zimbabwe often have formalized relationships with health providers, enabling routine care but not necessarily improving emergency responsiveness.

Conversely, family-based caregivers, while emotionally committed, often lack the resources, training, or logistical capacity to guarantee timely and adequate healthcare (Tsegaye, 2019). Browne (2021) also emphasizes that although community-based care is increasingly promoted, its effectiveness depends on equipping caregivers with practical health knowledge and facilitating access to services. This study affirms that access to health care is not just a matter of physical availability it is also shaped by caregiver decision-making, systemic partnerships, financial means, and socio-cultural attitudes toward illness. Thus, while institutional care often ensures standardized access, family-based care remains vulnerable to structural inequities and caregiver-level variability.

Theme 2: Response to Illness and Medical Crises

The study revealed critical differences in how illness and medical emergencies were identified and managed in institutional and family-based care settings. In institutional care, the response to illness was generally structured and prompt, driven by operational protocols and consistent staff vigilance. Caregivers described clear procedures for when a child fell ill, often involving immediate observation, documentation, and transportation to partnered health facilities. One institutional caregiver explained,

> *"When a child has fever or pain, we isolate them quickly and inform the nurse and the social worker. If needed, we rush them to the clinic"* (*Interview – Institutional Caregiver*).

Children collaborated these accounts, with one noting,

> *"They don't wait. If your head hurts or you vomit, you are sent to the sick bay or clinic"* (*Interview – Child, Institutional Care*).

Such responses demonstrate a systematized medical culture that allows for consistent detection and management of minor and major health concerns.

However, some caregivers also described limitations during medical crises requiring referrals, blood tests, or hospital admission, where internal administrative procedures sometimes delayed action. One staff member admitted,

> *"If we need to take a child to a hospital outside our agreement, we must report to the admin . That takes time"* (*Interview – Institutional Caregiver*).

These delays highlight how even structured environments can be hindered by bureaucratic chain-of-command systems, particularly when higher-level approvals or funds are needed. Despite this, institutional care retained an advantage in having designated medical staff, vehicle access, and basic medication storage, which are often lacking in family-based care settings.

In family-based care, responses to illness were more relational and reactive, often influenced by subjective judgment, caregiver fatigue, and resource constraints. Several children reported that home remedies or observation were the first lines of response, especially in cases of fever, coughing, or stomach pain. A child stated,

> *"My aunt gave me hot water and rubbed my stomach. She said we will go to the clinic if it gets worse"* (*Interview – Child, Family-Based Care*).

Caregivers justified these practices by citing cost of transport, clinic fees, and cultural beliefs, with one stating, *"Sometimes it is just the weather or the food. You wait and see. You don't rush to the clinic every time"* (*Interview – Family-Based Caregiver*).

While these approaches reflect practical adaptation to poverty, they also raise concerns about delayed intervention and underestimation of serious symptoms.

Focus group discussions supported these differences. In family-based FGDs, some children shared fears that their health complaints would not be taken seriously unless visibly severe. One boy explained,

> *"You only go to the clinic when you can't walk. Otherwise, you are told to sleep or drink water"* (*FGD – Family-Based Care*).

This indicates a threshold of severity before care is activated, which could pose significant risks for children with chronic or silent conditions. In contrast, institutional FGDs highlighted a sense of routine preparedness, with children expressing confidence that "there is always someone watching" (*FGD – Institutional Care*),

reinforcing the perception of consistent adult oversight in institutional environments.

The findings resonate with Williamson and Greenberg (2020), who argue that institutional care models despite being emotionally constrained offer better health response systems due to formal supervision and accountability mechanisms. Conversely, family-based care, while more emotionally intimate, is often vulnerable to resource scarcity, overburdened caregivers, and cultural normalization of illness (Tsegaye, 2019; Chinyoka& Chinamasa, 2020). Browne

(2021) notes that the success of family-based responses to illness hinges largely on caregiver health literacy and accessibility to support systems, both of which are inconsistent in rural and impoverished areas. This study confirms that while family caregivers are deeply caring, their responses to medical crises are often delayed by uncertainty, lack of training, and absence of institutional support, reinforcing the need for capacity building and community-based health education programs.

Theme 3: Mental Health and Emotional Support

The emotional and psychological health of children in care was one of the most delicate but revealing aspects of the study. Across both settings, children spoke about experiences of sadness, grief, anxiety, and feeling misunderstood, yet the availability of mental health support was either absent or informal in most cases. One child from institutional care shared,

> *"Sometimes I just feel sad. No one really asks why"* (*Interview – Child, Institutional Care*).

This quote encapsulates a silent emotional struggle experienced by many institutionalized children, who may appear physically well but suffer from chronic emotional neglect. Caregivers admitted that while they observed mood changes, they lacked the training or time to respond adequately. One institutional caregiver confessed,

> *"You see a child quiet for days, but you can't always follow up. There are too many, and we are not trained for that"* (*Interview – Institutional Caregiver*).

In family-based care, emotional support was more relational and spontaneous, though not always adequate. Some children described caregivers who listened and comforted them, while others shared that their sadness was dismissed or misunderstood. One child explained,

> *"When I cry or when l'm sad, my grandmother says it's the devil. She prays, but I still feel heavy inside"* (*Interview – Child, Family-Based Care*).

While faith-based responses offered comfort, they sometimes replaced necessary psychological interventions. A family-based caregiver stated,

> *"tinonamata naye mwanakana achnge akasuruwara ndomaitiro edu"* (When the child is down, we pray together. That is our way) (*Interview – Family-Based Caregiver*),

revealing how spiritual coping mechanisms were the default emotional response, rather than clinical support or counselling.

FGDs highlighted the internalization of emotional struggles, especially among boys. In one institutional group, a boy said,

> *"Crying is for girls. We keep things in the heart"* (*FGD – Institutional Care*).

Such gendered norms further inhibited emotional expression. In family-based FGDs, some children described telling stories or singing to process grief, while others said they "just sleep" when feeling overwhelmed (*FGD – Family-Based Care*). Across both settings, professional mental health services were almost entirely absent, with no reports of psychologists, social workers conducting regular sessions, or trauma-specific interventions.

These findings affirm Browne's (2021) claim that mental health is one of the most neglected dimensions of child welfare, especially in alternative care systems across Africa. According to Williamson and Greenberg (2020), emotional resilience must be actively supported through trained personnel, emotional literacy programs, and safe spaces for children to express grief or trauma. Chinyoka and Chinamasa (2020) highlight that in Zimbabwe, emotional neglect is a silent epidemic, particularly among children orphaned by HIV/AIDS or poverty. This study reinforces these concerns, suggesting that despite observable care structures, children's emotional pain often goes unacknowledged, untreated, and misunderstoodposing long-term developmental risks. Integrating psychosocial support systems into both care models is not optionalit is essential for sustainable well-being.

Theme 4: Caregiver Knowledge and Health Monitoring

The final theme revealed that caregiver knowledge, awareness, and initiative play a significant role in shaping children's health outcomes, particularly in family-based settings. In institutional care, health monitoring was procedurally driven, with staff checking for illness during morning routines, tracking attendance, and recording symptoms. One caregiver stated,

> *"We do roll-call and look at faces. If a child looks unwell, we act fast"* (*Interview – Institutional Caregiver*).

In addition, medical files were kept for each child, and some homes had basic first-aid training for staff. However, caregivers also admitted gaps in recognizing emotional signs or non-visible symptoms, especially when children remained silent.

> *"Some children hide their pain. You only know when it's bad,"* one caregiver noted (*Interview – Institutional Caregiver*).

In family-based care, caregiver health monitoring was less structured but more intuitive, often based on emotional closeness and daily observation. A caregiver explained,

> *"I know when she is not herself. Even if she says she is fine, I can tell"* (*Interview – Family-Based Caregiver*).

This relational monitoring was an advantage in emotionally close households. However, several caregivers acknowledged limited medical knowledge, particularly about nutrition, chronic illness, or signs of mental distress. One caregiver confessed,

> *"I don't know when a child has depression. If they are quiet, I think maybe they are tired"* (*Interview – Family-Based Caregiver*). This points to a critical gap in health literacy, especially in identifying less visible forms of illness.

Children also shared how caregiver attitudes shaped their willingness to report illness. One child said,

> *"The caregiver tells us to say if we are sick, but some children hide it"* (*Interview – Child, Institutional Care*). In family-based care, a child stated, *"If I say I am sick too often, they get annoyed. So I wait"* (*Interview – Child, Family-Based Care*).

These responses suggest that children's voices in health matters are not always taken seriously, potentially delaying intervention.

This theme confirms existing literature that underscores the importance of caregiver training in health literacy and monitoring. According to Tsegaye (2019), many family-based caregivers operate without formal support or guidance in recognizing and managing child illness. Mutangadura (2019) and Browne (2021) also call for investment in training frontline caregivers to observe, record, and act on health signalsboth physical and emotional. The current study echoes these recommendations, showing that while relational closeness exists in family care and structure exists in institutional care, the absence of trained, attentive, and responsive caregivers remains a universal vulnerability in Zimbabwe's child welfare landscape.

4.4.4 Objective 4: To examine the cost-effectiveness of family-based and institutional-based care models at Ivordale Celebrated Home.

Theme 1: Financial Burden on Caregivers

In family-based care settings, the financial burden experienced by caregivers emerged as a central theme, cutting across nearly all participant narratives. The overwhelming consensus among family-based caregivers was that providing for an orphaned or vulnerable child placed significant pressure on already strained household budgets. One caregiver expressed,

> *"We do our best, but sometimes there's just not enough for everything. School fees, food, clothes—it's all too much"* (*Interview – Family-Based Caregiver*).

These sentiments were echoed in multiple interviews with caregivers frequently citing school fees, medical expenses, transportation, and nutrition as the most challenging aspects of caregiving. Many of the households relied on informal income sources, such as vending or subsistence farming, which made their ability to support OVCs highly volatile and inconsistent.

The study found that even when caregivers were emotionally committed, economic insecurity compromised their caregiving capacity. In several cases, children missed school due to unpaid fees or lacked basic supplies like uniforms or stationery. One caregiver explained,

> *"Sometimes we choose: buy maize or pay school levies. We can't do both"* (*Interview – Family-Based Caregiver*).

These decisions reflect the difficult trade-offs caregivers are forced to make, often prioritizing short-term survival over long-term developmental needs. Additionally, while some caregivers received external assistance through programs such as BEAM or community church donations, they often described these interventions as irregular, delayed, or insufficient. One caregiver said;

> *"You apply for BEAM and wait. Sometimes they pay, sometimes they don't. You can't rely on it"* (*Interview – Family-Based Caregiver*).

Interviews with caregivers revealed that many borrowed money informally, rationed meals, or sacrificed their own health or income-generating activities to care for children. One participant noted;

> *"I stopped going to sell at the market every day because the child is too young to stay alone. That's lost money"* (*FGD – Family-Based Caregivers*).

These sacrifices, while commendable, reflect the invisible economic cost of care giving particularly the loss of opportunity and self-care among primary carers, most of whom were women. The financial strain also appeared to influence emotional availability and stress levels, with some children reporting tension in the home when food was low or bills were due. One child said,

> *"When the rent is due, I keep quiet. Everyone is tense"* (*Interview – Child, Family-Based Care*).

The findings are strongly supported by existing literature, which identifies poverty and financial strain as major obstacles to the success of family-based care in low-income settings. According to Tsegaye (2019), while kinship care is culturally accepted and emotionally beneficial, it often lacks formal financial support, leaving caregivers overburdened and children at risk of neglect. Chinyoka and Chinamasa (2020) similarly argue that economic precarity leads to caregiver burnout, which in turn undermines the quality of emotional and physical care provided. Williamson and Greenberg (2020) emphasize that cost-effectiveness must not only consider monetary value but also the sustainability of care over time. In this context, while family-based care is often perceived as less expensive than institutional care, the hidden costs borne by caregiversboth economic and emotionalreveal a system that may not be sustainable without consistent support, financial incentives, or social protection schemes.

Theme 2: Institutional Resource Allocation and Sustainability

Institutional care settings presented a different but equally complex picture of cost management, characterized by high operational expenses and challenges in long-term financial sustainability. Caregivers and administrators consistently highlighted the multifaceted demands of running a children's institution, which include salaries for staff, food provision, utilities, school fees, medical services, maintenance, and transportation. One institutional caregiver explained,

> *"Running this place costs a lot. Salaries, electricity, food—it adds up fast. People think it's just feeding children, but it's much more"* (*Interview – Institutional Caregiver*).

The study found that while institutions often appeared more stable in terms of resource availability, their cost structure was heavily reliant on external donors, private sponsorships, and partnerships with NGOs.

Institutions typically had structured budgets and financial reporting systems, yet even with planning, funding shortfalls were not uncommon. Administrators described situations where unexpected expenses, such as repairs or health emergencies, placed additional strain on budgets. One administrator said,

> *"We budget for food and school, but if a vehicle breaks down or many children fall sick, we are overstretched"* (*Interview – Institutional social worker*).

Unlike family-based care, where costs are absorbed into household spending, institutional expenses are formal, itemized, and continuous, making them more visible and more dependent on steady financial inflows. Caregivers described scenarios where stock run outs of essential supplies like hygiene products or cooking oil occurred during donor delays, affecting day-to-day operations.

Despite these challenges, institutions often benefit from bulk purchasing, in-kind donations, and direct partnerships with suppliers, allowing them to reduce per-child costs on some items. One caregiver noted,

> *"When we buy in bulk, it's cheaper. Also, some supermarkets donate expired goods or near-expiry food"* (*Interview – Institutional Caregiver*).

While these strategies enhanced efficiency, they also raised concerns about quality and dependency. Moreover, infrastructure costs such as building maintenance, electricity, and water were ongoing burdens that family-based models did not incur, thus skewing perceptions of cost-effectiveness. Staff salaries, particularly for qualified caregivers and social workers, formed a significant portion of the institutional budget. The Home administrator who also doubles as the social worker explained,

> *"We are supposed to have one caregiver per five children, but we can't afford that. We stretch our staff"* (*Interview – Institutional Administrator*), pointing to both financial constraints and compromised care quality.

Interviews with institutional staff further revealed a tension between financial accountability and care delivery. One participant remarked,

> *"We have to submit reports every month. If receipts are missing, the next disbursement is delayed. But during that time, the children still need to eat"* (*Institutional Staff*).

These bureaucratic requirements, while necessary for transparency, often delayed funding and created cash flow crises. Some institutions resorted to fundraising activities, including partnerships with churches, foreign missions, or local businesses, to supplement donor contributions.

These findings are echoed in the literature. According to Browne (2021), the cost of institutional care tends to be higher due to fixed overheads, infrastructure needs, and professional staffing, but it is often mistakenly perceived as more efficient because of visibility and scale. Williamson and Greenberg (2020) argue that the long-term sustainability of institutional care is questionable unless it is diversified through local government subsidies or community-based integration programs. Mutangadura (2019) also warns that while institutions may appear resource-rich on the surface, their financial fragility becomes exposed when donor support fluctuates. This study confirms that institutional care, while more formalized and better organized in terms of budgeting, is also financially intensive, operationally rigid, and highly donor-dependent, posing serious questions about its scalability and sustainability.

Theme 3: Donor Dependence and Funding Volatility

One of the most persistent challenges reported by institutional care providers was their heavy dependence on external donors, which often left them vulnerable to funding instability and operational disruption. Many institutional administrators and caregivers spoke of financial anxiety linked to donor schedules, changing priorities, and delayed disbursements. One social worker shared candidly,

"If donors pull out, we really struggle. It's like holding your breath every quarter, waiting for confirmation" (*Interview – Institutional social worker*).

This sense of uncertainty was not only tied to finances but also to program continuity—institutions sometimes had to delay activities, reduce food quality, or postpone medical visits due to delayed funds.

While institutional care homes benefited from partnerships with international NGOs, local churches, and diaspora sponsors, participants noted that such arrangements were often project-based or time-bound, rather than long-term. A caregiver reported, *"Some donors say they will help for six months or one year. After that, it's up to us"* (*Interview – Institutional Caregiver*).

This form of temporary support created gaps, especially for critical needs such as medication, school uniforms, or bedding. As a coping strategy, the institution diversified its fundraising approaches, relying on small-scale income-generating projects or local donations. However, these efforts were not always sustainable. The institutional administrator noted,

"We tried poultry. It helps, but it's not enough to cover salaries and electricity" (*Interview – Institutional Administrator*).

The implications of donor volatility were significant not just for operational logistics, but also for care quality and child stability. The institution had to reduce caregiver shifts or delay replacing worn-out bedding and clothes when funding shortfalls occurred. This created psychosocial stress for both staff and children. One caregiver remarked,

"When there's no cooking oil or soap, the children notice. They start to ask questions, and you feel helpless" (*Interview – Institutional Caregiver*).

This quote highlights how material scarcity impacts emotional morale, especially in environments where basic needs are central to daily functioning.

In contrast, family-based caregivers were less dependent on formal donor funding but still experienced indirect effects of policy-level donor shifts, especially those related to government welfare programs funded by development partners. For example, the inconsistency of Harmonized cash transfer program disbursements, funded by the government, left many caregivers stranded. As one explained,

"If the money doesn't come, I must borrow or delay fees. We are stuck" (*Interview – Family-Based Caregiver*).

Therefore, while the visible reliance on donors was higher in institutions, the ripple effects of donor volatility also reached family-based settings through the public systems that support them.

These findings mirror the arguments by Williamson and Greenberg (2020), who emphasize that institutional care is highly donor-driven, and unless local governments or communities take ownership, it remains vulnerable to collapse. Browne (2021) cautions that shifts in global funding prioritiessuch as the move toward deinstitutionalizationare leaving traditional children's homes under-resourced, often without viable transition plans. This study supports those observations, confirming that institutions operate under a constant financial balancing act, where donor goodwill plays an outsized role in determining operational stability. Without diversified, long-term funding models or public investment, institutional care remains financially precarious and strategically short-sighted.

Theme 4: Cost-Saving Mechanisms in Family-Based Care

Despite operating under significant financial strain, family-based caregivers exhibited a range of adaptive and resourceful cost-saving strategies to sustain the care of orphans and vulnerable children. These mechanisms were embedded in household routines, cultural values of sharing, and informal support systems. One caregiver explained,

> *"We eat what we have. We grow vegetables and don't buy much meat. That's how we survive"* (*Interview – Family-Based Caregiver*).

Subsistence farming, communal food pooling, and rationing were commonly mentioned strategies that enabled caregivers to stretch limited resources without completely compromising children's nutritional needs. In several rural contexts, families relied on seasonal food preservation, barter trade, and home remedies for health care, reducing their dependence on the cash economy.

Additionally, family caregivers often benefited from community-level support systems, including church-based giving, extended family assistance, and informal child sponsorship. One caregiver noted,

> *"My church sometimes helps with groceries or pays part of the fees. It's not every time, but it helps"* (*Interview – Family-Based Caregiver*).

These informal networks provided a social cushion in times of extreme need, particularly when formal welfare systems failed. In interviews, caregivers described pooling transport for multiple children attending the same school, sharing textbooks, or reusing uniforms from older siblings or neighbours . These strategies underscore how social capital replaces financial capital in resource-scarce care giving contexts.

Interestingly, many family-based caregivers viewed their frugal practices not as a limitation but as evidence of responsible, loving care. One participant shared,

> *"Even if we have little, I feel the child gets love and care here. We manage"* (*Interview – Family-Based Caregiver*).

This reflects a worldview where emotional labour and relational care are prioritized over material provision, distinguishing family-based care giving as value-driven rather than cost-intensive. While such views may mask the real effects of deprivation, they also explain why many caregivers continue to provide care despite minimal external support.

However, these savings often came at a personal cost to the caregiver, including reduced income opportunities, physical exhaustion, and emotional stress. A caregiver explained,

> *"I cannot take a full-time job because someone must be home. I do washing for people part-time, but it's not stable"* (*Interview – Family-Based Caregiver*).

This form of unpaid care giving labour, though invisible in economic calculations, represents a substantial contribution to Zimbabwe's child protection system. The study found that cost-saving in family-based care is not just about reducing expenses it often involves sacrificing the caregiver's own health, education, or future prospects.

These findings are supported by literature on informal care economies in sub-Saharan Africa. Tsegaye (2019) explains that caregivers in family-based settings often operate below the poverty line yet remain the backbone of OVC support, largely through informal resilience strategies. Browne (2021) also emphasizes that family care systems provide 'hidden subsidies' to governments, saving the state millions in potential institutional care costs. However, the current study challenges simplistic assumptions that family-based care is inherently "cheaper" by revealing the unaccounted personal and opportunity costs that caregivers bear. These findings call for rethinking cost-effectiveness not only in monetary terms but also in terms of sustainability, caregiver well-being, and long-term outcomes for children.

Theme 5: Perceptions of Value for Money and Impact

A final and highly interpretive theme that emerged was how caregivers themselves perceived the value and impact of the care they provided relative to the costs incurred. Across both institutional and family-based care models, participants consistently framed their efforts not merely in financial terms but in terms of social return, emotional fulfillment, and child transformation. One caregiver stated,

> *"Even if we have little, I feel the child gets love and care here. That's more important than how much is spent"* (*Interview – Family-Based Caregiver*).

This perspective highlights that in family-based care, caregiver satisfaction and perceived impact were tied to intangible factors such as a child's behavioural change, school progress, or emotional stability. Many caregivers viewed these outcomes as proof of success, regardless of the modest material investment involved.

Institutional caregivers, while working in more structured environments, also reflected on the impact of resources used versus outcomes achieved. One caregiver remarked,

> *"We spend a lot here yes. But when a child grows up, finishes school, or reunites with their family, we see the worth"* (*Interview – Institutional Caregiver*).

This speaks to a longer-term perspective, where institutional investments are justified by future success stories. Several staff referenced former residents who returned to visit or had graduated from college as evidence that the financial effort was not wasted, reinforcing a sense of institutional pride and mission fulfillment.

However, some participants in both models acknowledged moments of doubt or resource fatigue, particularly when outcomes were unclear, or children displayed regression. One institutional caregiver expressed frustration:

> *"Sometimes we give everything—food, education, discipline—but the child still misbehaves or runs away. It feels wasted"* (*Interview – Institutional Caregiver*). Similarly, a family-based caregiver shared, *"There are days I feel tired. I ask myself, what if they leave me one day? Will they remember?"* (*Interview – Family-Based Caregiver*).

These reflections reveal the emotional and existential toll of care giving, especially in environments with little external affirmation or support.

From a cost-effectiveness standpoint, participants in family-based care tended to define "value" not in financial terms, but in relational and moral language. Statements like *"I did my duty as a mother"* or *"At least the child is not in the streets"* were common during interviews and focus groups. In contrast, institutional actors spoke more about accountability, measurable outcomes, and institutional legacy, highlighting a difference in narrative frameworks of impact. One administrator noted,

> *"We submit reports. We show how many passed exams or got placed. That's how we prove it's working"* (*Interview – Institutional Administrator*), reflecting the formalized performance culture of institutional settings.

These findings are consistent with the literature that critiques traditional economic measures of cost-effectiveness in child welfare. According to Williamson and Greenberg (2020), the true impact of care giving should include child well-being, community integration, and caregiver sustainability, not just financial metrics. Browne (2021) argues that current models often ignore the qualitative and emotional outcomes that define care quality, especially in family-based models. Mutangadura (2019) also emphasizes that value for money in child protection should include intergenerational effects, such as breaking cycles of poverty, abuse, or illiteracy. This study affirms that perceptions of value are deeply contextual, morally informed, and relationally constructed, and that effective caregiving is not merely a function of how much is spent, but how care is experienced, delivered, and remembered.

4.4.5 Objective 5: To explore the challenges and opportunities in the implementation of family-based and institutional care models at Ivorale celebrated home.

Theme 1: Caregiver Burnout and Emotional Fatigue

One of the most striking and consistent challenges identified in family-based care was the emotional and physical toll caregiving placed on the primary caregiver, often a grandmother, aunt, or female community member. The accounts revealed a pattern of long-term exhaustion, psychological strain, and absence of respite, especially among caregivers responsible for multiple children without external help. One caregiver captured this burden clearly:

> *"Sometimes I feel I am carrying this burden alone. It's draining"* (*Interview – Family-Based Caregiver*).

These sentiments were echoed throughout the data, highlighting that while caregivers were motivated by love and obligation, they were also deeply fatigued and emotionally overwhelmed. The absence of structured psychosocial support, combined with limited financial aid, created conditions where care giving became both a duty and a source of stress (Harris, 2020).

Caregivers described struggling to balance child care with income-generating activities, household chores, and their own health. One explained,

> *"I wake up early, go to the garden, cook, clean, help with homework, and repeat. Every day is the same. There is no rest"* (*Interview – Family-Based Caregiver*).

Several participants reported health issues such as high blood pressure, body pain, and insomnia symptoms linked directly to care giving stress. Importantly, these caregivers often had no support networks or substitute carers, and in cases where their own biological children had migrated or passed away, they had become permanently responsible for OVCs without a contingency plan.

In institutional settings, while caregiving was more distributed, emotional burnout also emerged due to staff shortages, night shifts, and limited professional counselling. One institutional caregiver noted,

> *"We are always tired. Sometimes you finish one shift, then fill in because someone didn't show up. It's exhausting"* (*Interview – Institutional Caregiver*).

Although institutional staff worked within structured roles, the emotional labour involved in nurturing multiple children, resolving conflict, and managing trauma-related behaviours often led to fatigue and emotional numbness (Gohen, 2020). One caregiver admitted,

> *"You switch on your emotions. If you feel too much, you won't survive here"* (*Interview – Institutional Caregiver*).

This detachment, while understandable, may lead to reduced responsiveness to children's emotional needs.

Interviews with family-based caregivers revealed a desire for peer support spaces, where caregivers could share burdens, exchange coping strategies, and receive encouragement. One caregiver stated,

> *"If we could just meet monthly, even to talk, it would help. We need someone to listen too"* (*interview – Family-Based Caregivers*).

This reflects a gap in caregiver welfare policy, where care giving labour is unacknowledged, unsupported, and invisible in public service planning. Institutional caregivers, on the other hand, advocated for better work schedules, team counselling, and periodic wellness programs, citing burnout as a risk factor not just for staff health but for child mistreatment due to impatience or fatigue.

These findings align with global research that highlights caregiver burnout as a major risk to the sustainability and quality of child care systems. According to Tsegaye (2019), burnout in family-based settings is fueled by isolation, chronic poverty, and lack of recognition, while in institutional settings it arises from overwork, emotional detachment, and role strain. Browne (2021) and Williamson & Greenberg (2020) emphasize that any care model that fails to support the carer is ultimately unsustainable, as caregiver well-being is directly linked to child outcomes. This study strongly confirms that emotional fatigue among caregivers is an overlooked crisis, and urgent investment is needed in respite systems, peer networks, and psychological support to ensure the longevity and humanity of both family-based and institutional care models.

Theme 2: Institutional Bureaucracy and Staff Constraints

Institutional care providers consistently cited bureaucratic hurdles and staffing shortages as persistent operational challenges that hindered responsiveness and service quality. While institutions often operated under formal regulations and administrative oversight, this structure sometimes worked against timely decision-making and flexibility in crisis situations. One caregiver remarked,

> *"We follow rules, but it takes too long to get approvals for urgent needs"* (*Interview – Institutional Caregiver*).

Several institutional staff described delays in obtaining transport for emergencies, replacing damaged resources, or addressing behavioural issues due to multi-level administrative clearance systems. These bottlenecks were particularly problematic during weekends or holidays, when decision-makers were unavailable, revealing a rigid care system prone to operational paralysis during off-hours.

Staffing constraints were another central issue. Many caregivers reported high child-to-staff ratios, which resulted in limited one-on-one interaction, compromised emotional engagement, and increased staff burnout (Gordon, 2018). A caregiver shared,

> *"There are too many children for one person to handle. You supervise, not nurture"* (*Interview – Institutional Caregiver*).

This sentiment underscores how quantity-based oversight replaces quality-based interaction in environments where staff are overburdened. New or temporary staff often lacked training in trauma-informed care, further complicating efforts to manage children with behavioral or emotional issues. Interviews with caregivers revealed that lack of team coordination, irregular staff meetings, and role ambiguity frequently led to inconsistency in care giving standards..

These constraints are not new. According to Browne (2021), the "assembly-line" approach to institutional care often leads to administrative efficiency but emotional deficit, particularly where children require individualized care. Williamson and Greenberg (2020) warn that institutional settings in low-resource contexts are particularly vulnerable to staff shortages, hierarchical gridlock, and insufficient investment in human capital, which ultimately affect child well-being. This study corroborates these concerns, showing that despite having formal systems, institutions lack agile, emotionally grounded care giving capacity, often due to entrenched bureaucracy and under-resourced personnel.

Theme 3: Policy Gaps and Weak Enforcement

Both institutional and family-based caregivers expressed concern over policy-level deficiencies, weak implementation, and inconsistent monitoring of caregiving environments. One caregiver observed,

> *"The policy says children must be visited, but who visits us?"* (*Interview – Family-Based Caregiver*)

, highlighting the disconnect between policy and practice. Family-based caregivers, in particular, noted that social workers were rarely seen, and monitoring visits if they happened ere superficial. One social welfare officer confirmed this limitation:

> *"We want to follow up, but we don't have fuel or staff. There are too many children to cover"* (*Interview – Social Welfare Officer*).

This lack of monitoring weakens protective oversight and guidance, leaving caregivers unsupported and children unprotected.

Institutional caregivers echoed similar frustrations, especially regarding outdated regulatory guidelines, and slow response from authorities. A caregiver explained,

> *"We report issues, but it takes weeks to get a visit or a decision. Meanwhile, the child is suffering"* (*Interview – Institutional Caregiver*).

This reflects a fragmented and reactive policy environment, where even documented frameworks are underutilized due to logistical constraints, funding limitations, and capacity deficits.

The literature strongly supports the findings. Browne (2021) emphasizes that policy without enforcement leads to window-dressing reform, where rights exist only on paper. Williamson and Greenberg (2020) note that national child protection frameworks in many low-income countries remain under-resourced and under-implemented, often failing to translate into real change at household or institutional level. This study affirms that policy inertia and weak institutional coordination remain key barriers to effective caregiving models in Zimbabwe, calling for strategic decentralization, better funding of social work departments, and results-based supervision mechanisms.

Theme 4: Opportunities for Reform and Integration

Despite the many challenges, caregivers and social welfare officers proposed pragmatic solutions and hybrid models that could improve care giving practices and sustainability. One social worker suggested,

> *"Maybe we can mix models – small homes, trained families, and good monitoring"* (*Interview – Social Welfare Officer*).

This reflects a growing consensus that neither institutional nor family-based care alone is sufficient, but that a blended model leveraging the emotional depth of families and the structure of institutions may offer a path forward. Caregivers recommended training programs, mobile social work units, and incentives for caregivers, such as food vouchers or transport subsidies, to support quality care in both settings.

In interviews, institutional caregivers suggested decentralized group homes with fewer children, which would reduce overheads while maintaining some level of structured support. Family-based caregivers emphasized the need for peer support groups, home-based counselling services, and access to microcredit for income-generating activities. These ideas point to a strong demand for community integration, local-level empowerment, and flexible care models that are contextually grounded and resource-sensitive.

The literature supports this approach. According to Tsegaye (2019), sustainable care reform lies not in choosing between models, but in creating responsive, hybrid systems supported by trained community actors and adaptive governance. Browne (2021) similarly advocates for transitional care models and social cash transfers to enhance both the reach and quality of care. Williamson and Greenberg (2020) argue for the institutionalization of minimum standards, case management tools, and performance-linked funding as key pillars of future reform. This study confirms that caregivers and frontline workers possess both the knowledge and vision to reform the systemwhat is missing is structural support, policy coherence, and consistent investment to bring these innovations to life.

4.5 Chapter summary

This chapter presents the findings and thematic analysis of a study focused on the experiences of orphans and vulnerable children (OVCs), their caregivers, and social welfare officers. Data were collected through semi-structured interviews and focus group discussions, emphasizing the psychosocial, educational, and health-related needs of participants in both family-based and institutional care settings. Utilizing Braun and Clarke’s (2006) thematic analysis framework, the chapter systematically codes and interprets emerging themes aligned with the study’s key objectives. Organized thematically, each section discusses findings supported by direct quotations, reflecting the diverse lived experiences of participants. This constructivist approach prioritizes the voices of participants, exploring their meanings around caregiving, support, and identity. Demographic profiles provide context, but the focus remains on narrative patterns and emotional insights. The analysis aims to capture the complexity of caregiving in Zimbabwe's child welfare system, offering a contextually grounded comparative view of institutional versus family-based care environments. Depth and authenticity are prioritized over statistical generalization, enhancing the transferability of the findings.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a critical discussion of the findings from the study, which examined the comparative effectiveness of family-based and institutional-based care models in addressing the needs of orphans and vulnerable children (OVCs) in Zimbabwe. The discussion is structured around the five research objectives, synthesizing insights drawn from the thematic analysis presented in Chapter 4. This chapter goes beyond descriptive presentation and seeks to interpret the findings, relate them to existing literature, and explore theoretical, policy, and practical implications. The findings are situated within the broader socio-economic and cultural realities shaping child welfare in Zimbabwe, where traditional kinship-based care giving systems coexist with formal institutional models. In doing so, the discussion highlights the strengths and limitations of each model in responding to the psychosocial, educational, and health-related needs of OVCs, while also interrogating the cost-effectiveness and operational challenges associated with their implimentation. This chapter further explores the alignment or divergence between the study's results and prior research, including international care reform literature, African child protection studies, and Zimbabwean policy frameworks. Finally, the chapter identifies opportunities for reform and integration, drawing on the lived experiences and perspectives of caregivers, children, and social welfare professionals.

5.1 Summary of Findings

This study conducted a comparative analysis of family-based and institutional care models to assess their effectiveness in providing psychosocial, educational, and health outcomes for orphans and vulnerable children (OVCs). Using a qualitative design, through the use of thematic insights, the study examined key cross-cutting issues such as financial sustainability, emotional security, and policy-driven interventions. The findings indicate that family-based care provides superior psychosocial and educational outcomes while being more cost-effective, but financial challenges remain a critical limitation. Conversely, institutional care offers structured learning and medical access but lacks the personalized attention necessary for emotional and psychological development. The findings were organized according to the five research objectives and are discussed in detail below.

5.2.0 Summary of Findings Based on Research Objectives

This study set out to explore the comparative effectiveness of family-based and institutional care models in addressing the needs of orphans and vulnerable children (OVCs) in Zimbabwe. The research was grounded in a constructivist qualitative paradigm and employed a case study approach, drawing on in-depth interviews and focus group discussions with children, caregivers, and social welfare officers. The findings generated rich insights into the lived realities, coping mechanisms, and systemic dynamics within both care settings. Organized around the five research objectives, the findings demonstrate both points of divergence and convergence across emotional, educational, health, financial, and policy dimensions of care giving.

5.2.1 Objective 1: Psychosocial Well-Being

The study found that children in both care models entered their placements with significant emotional trauma, marked by grief, anxiety, and displacement. However, family-based care offered more emotionally nurturing environments, particularly where caregivers were invested and treated the child as part of their own family unit. Children in these settings reported quicker emotional recovery, underpinned by consistent affection, spiritual reassurance, and familial rituals such as shared meals and storytelling. In contrast, institutional care provided structure and predictability, but this came at the expense of emotional intimacy. Most children in institutional settings spoke of feeling “unseen,” and while peer bonds served as a coping mechanism, the absence of personalized attention often resulted in emotional detachment. Across both models, formal psychosocial services were almost non-existent, forcing children to rely on internal or peer-based coping strategies. The absence of therapeutic interventions was especially detrimental for children with unresolved trauma or behavioural challenges.

5.2.2 Objective 2: Educational Outcomes

Educational access was more structurally enforced in institutional settings, where attendance was monitored, school fees were often donor-covered, and children participated in scheduled routines. However, academic motivation, personalized attention, and self-esteem were consistently higher in family-based care. Children in these settings frequently reported being praised, encouraged, or assisted with homework by caregivers even when caregivers had limited formal education. Emotional reinforcement emerged as a powerful driver of learning, with children describing caregiver approval as more influential than formal teaching. In contrast, institutional learners often described education as a task rather than a relational process, and while learning materials were available, there was little individualized guidance. Stigma and peer comparison also shaped school experiences—children in institutional care were more likely to report feeling labelled or “different” at school, while those in family-based care sometimes felt isolated or inferior when compared to biological siblings or cousins.

5.2.3 Objective 3: Health Outcomes

Health outcomes presented a mixed picture. Institutional care was generally superior in terms of access to basic healthcare services, including vaccinations, hygiene education, and regular medical assessments facilitated by clinic partnerships. Children in institutional homes benefited from structured routines that reinforced cleanliness and disease prevention. However, emotional health was consistently neglected, and very few institutions had any form of mental health services. In family-based care, the approach to health was more relational and intuitive. Caregivers relied on traditional remedies, and formal care was often delayed due to financial constraints or transport issues. Children in these homes occasionally received emotional comfort through prayer or caregiver attention, but health literacy among caregivers varied significantly. Mental health challenges were misunderstood or spiritualized, and most children bore emotional burdens silently. The absence of structured mental health interventions in both settings was a major gap, leaving emotionally vulnerable children with minimal support.

5.2.4 Objective 4: Cost-Effectiveness

The comparative analysis of cost-effectiveness revealed a complex picture. Family-based care appeared less resource-intensive on the surface, but this masked the significant, often invisible costs borne by caregivers, including lost income, chronic stress, and personal health deterioration. Most family-based caregivers were already living in poverty and absorbed additional children without receiving consistent support from the state or NGOs. Their cost-saving strategies subsistence farming, rotating school uniforms, or support from neighbours and church highlighted a form of informal resilience, but also underscored the fragility of the model without external reinforcement. Institutional care, while structurally more expensive due to salaries, overheads, and operational costs, benefited from donor funding and economies of scale. However, institutions were highly dependent on external partners, making them vulnerable to funding shocks. The findings suggest that neither model is intrinsically more cost-effective than the other rather, each operates under different financial logics, with institutional care absorbing costs through formal systems, and family-based care dispersing them informally through the household economy and unpaid labour.

5.2.5 Objective 5: Implementation Challenges and Opportunities

Both care models were constrained by systemic, operational, and policy-level weaknesses. Family-based caregivers frequently reported burnout, isolation, lack of training, and absence of formal monitoring or respite services. Institutional caregivers, while working in structured environments, struggled with under-staffing, rigid protocols, and delays in decision-making. Social welfare officers acknowledged that policy frameworks existed on paper but were rarely implemented due to resource shortages, staffing deficits, and bureaucratic fragmentation.

Despite these challenges, caregivers and stakeholders across both models articulated practical ideas for reform suggesting hybrid models such as small group homes, community-based foster networks, and rotating care support systems. Informal networks churches, neighbours, community health workers emerged as critical but undervalued actors in sustaining care systems. Participants called for more decentralized support structures, integrated psychosocial services, and policy recognition of the care giving burden carried disproportionately by low-income families.

5.3 General Conclusions

This study set out to conduct a comparative investigation of family-based and institutional care models in responding to the psychosocial, educational, health, economic, and systemic needs of orphans and vulnerable children (OVCs) in Zimbabwe. Grounded in a qualitative, constructivist paradigm and informed by the voices of children, caregivers, and social welfare professionals, the research has illuminated the multi-dimensional realities shaping child care in contexts marked by poverty, trauma, under-resourcing, and cultural complexity. The conclusions drawn from this study are not simplistic endorsements of one model over another, but rather a nuanced synthesis that recognizes the complementary, yet fragmented, nature of Zimbabwe’s child care ecosystem.

Firstly, in terms of psychosocial well-being, the study concludes that family-based care holds significant advantages, particularly where caregivers are emotionally present, spiritually nurturing, and culturally embedded within the child’s social network. Children in family care more frequently experienced emotional healing, a sense of belonging, and relational affirmation factors foundational to identity formation and resilience. However, this care model is not without flaws. It is heavily dependent on individual caregiver capacity, which is undermined by poverty, lack of respite, and systemic neglect. Meanwhile, institutional care, though often emotionally detached, provided structure, routine, and peer companionship that helped children stabilize in the absence of personalized attention. Yet, the absence of consistent one-on-one emotional bonding in institutions raises long-term concerns about attachment security and behavioural outcomes.

Secondly, regarding educational outcomes, the study reveals a dual reality. Institutional care guaranteed routine school attendance, provision of uniforms, and consistent academic tracking, which are commendable in terms of access. However, learning often occurred in emotionally neutral environments, lacking personalized encouragement. In contrast, children in family-based caredespite financial disruptions and inconsistent school access exhibited higher academic motivation and self-esteem, largely attributed to caregiver praise, household support, and informal mentoring. These findings suggest that emotional reinforcement plays an equal, if not greater, role than infrastructural support in shaping educational success.

Thirdly, in the domain of health outcomes, institutional care was stronger in terms of preventive health routines, medical record-keeping, and partnerships with clinics, but struggled to address children's emotional and mental health needs. Conversely, family-based care offered relationally embedded healing practices, including spiritual support and culturally rooted coping mechanisms, but lacked access to structured healthcare, often delaying treatment due to transport costs or limited knowledge. Across both settings, mental health support was conspicuously absent, leaving children to process trauma in silence or through informal channels. This represents a systemic blind spot that requires urgent intervention.

Fourthly, in terms of cost-effectiveness, the assumption that family-based care is cheaper must be problematized. While family care incurs fewer formal expenses, it imposes invisible economic and psychological costs on caregivers who are unpaid, unsupported, and often excluded from formal child welfare systems. Institutional care, while financially heavier in operational terms, benefits from centralized resource mobilization, economies of scale, and donor engagement. However, institutions are highly vulnerable to funding volatility, and when external support lapses, services are severely compromised. Thus, cost-effectiveness must be redefined beyond budgets to include caregiver sustainability, child outcomes, emotional labor, and system resilience.

Finally, with regard to challenges and opportunities, the study confirms that both models are constrained by policy gaps, bureaucratic inertia, under-resourced social services, and fragmented community engagement. Family caregivers face burnout, operate in isolation, and are rarely monitored or supported. Institutional caregivers are overworked, emotionally fatigued, and entangled in rigid decision-making structures that limit responsiveness. Yet, the study also found hope in the adaptive capacities of caregivers, the strength of informal community networks, and the innovative ideas suggested by participants ranging from hybrid models (e.g., small group homes), to mobile social work teams, peer caregiver support circles, and integrated training systems.

In conclusion, this study has shown that Zimbabwe’s child welfare system is at a crossroads. Neither institutional nor family-based care alone can deliver comprehensive child protection outcomes. What is needed is a context-sensitive, multi-layered, and relationally grounded approach, one that values the emotional and developmental needs of children, protects and empowers caregivers, and leverages both formal infrastructure and informal social capital. This includes strengthening mental health interventions, redesigning monitoring systems, ensuring caregiver compensation or relief, and building hybrid models that combine the emotional depth of families with the stability and oversight of formal structures. This study affirms that the care of OVCs must be understood not only as a technical policy issue but as a moral and developmental imperative. Investing in care giving systems financially, institutionally, and emotionally is not just about protecting children. It is about nurturing the foundations of a resilient, inclusive, and equitable society.

5.4 Recommendations

Drawing from the comprehensive thematic findings of this study, this chapter presents strategic and evidence-informed recommendations aimed at strengthening both family-based and institutional care systems for orphans and vulnerable children (OVCs) in Zimbabwe. The recommendations target policymakers, practitioners, caregivers, and community stakeholders, with the overarching aim of promoting sustainable, child-centred, and contextually appropriate models of care. These proposals are grounded in the lived experiences of children, caregivers, and social welfare officers, and reflect the urgent need for structural reform, caregiver support, and integrated service delivery.

5.4.1 Policy-Level Recommendations

1. Develop a National Hybrid Care Policy Framework

The Ministry of Public Service, Labour and Social Welfare should spearhead the development of a national framework that promotes hybrid care models—including small group homes, cluster foster care, and kinship care supported by social workers. This policy should formally integrate elements of both family-based and institutional care, recognizing that no single model is universally applicable.

2. Strengthen and Fund Community-Based Social Work Services

The government should invest in mobile and decentralized social work units to enhance the monitoring, support, and supervision of family-based caregivers, especially in rural and high-need areas. This includes providing transport, technology, and training for local officers.

3. Establish a National Caregiver Support Grant or Subsidy

Introduce a monthly stipend, food voucher, or education subsidy for informal family caregivers, particularly grandmothers and kinship guardians. This would reduce caregiver burnout and promote child retention in family-based settings while recognizing unpaid care work.

4. Institutionalize Minimum Standards for Emotional and Mental Health Support

Require all institutions and foster care programs to employ or collaborate with mental health professionals, and integrate psychosocial support, trauma-informed care, and emotional development milestones into care giving assessments.

5.4.2 Practice-Level Recommendations

1. Implement Regular Caregiver Training and Peer Exchange Platforms
   Partner NGOs and local government departments should roll out training programs focused on emotional literacy, trauma response, basic health, and educational support, while also creating peer support forums for caregivers to share experiences and reduce isolation.
2. Strengthen School-Home Collaboration in Both Models
   Develop formal channels between schools and both institutional and family-based caregivers for regular academic updates, home visits, and emotional monitoring, ensuring that children's educational trajectories are tracked holistically.
3. Diversify Institutional Funding Streams and Introduce Internal Sustainability Models
   Institutions should be encouraged to reduce donor dependency by pursuing income-generating activities, community sponsorship, and government-matched funding. Financial planning should include contingency funding for emergencies.
4. Integrate Children’s Voices into Routine Care Assessments
   Institutional and family-based care providers should develop child feedback

mechanisms such as suggestion boxes, semi-structured check-ins, and child-friendly reporting channels to ensure that children's experiences are central to care evaluations.

5.4.3 Community-Level and Cross-Cutting Recommendations

1. Formalize and Recognize Community Support Structures
   Churches, local associations, and neighbourhood groups providing informal support to caregivers should be mapped, documented, and incentivized through local grants, seed funding, or inclusion in ward development planning.
2. Public Awareness Campaigns on Child Rights and Inclusive Care
   National and district-level campaigns should be launched to promote child rights awareness, reduce stigma against OVCs, and encourage community-based monitoring and protective involvement.
3. Support Data Systems for Monitoring and Evaluation
   Establish a centralized child care registry that tracks OVCs in all care settings (family-based and institutional), including caregiver profiles, support received, psychosocial history, and educational records. This will enhance accountability, service targeting, and policy design.
4. Invest in Youth Transitions and Exit Planning
   Care models should include clear policies and programs that prepare children for exit from care at age 18, including life skills training, psychosocial support, vocational guidance, and reintegration into communities or extended families.

The recommendations provided here are neither exhaustive nor one-size-fits-all. Rather, they represent a starting point for evidence-based dialogue and policy transformation in Zimbabwe's child welfare sector. At the heart of these proposals is the conviction that children deserve more than shelter they deserve connection, dignity, and opportunity, regardless of the care model in which they are placed. For this to be realized, reform must be inclusive, well-funded, community-driven, and above all, child-centred.

5.6 Areas of Further Study

While this study has provided a comprehensive comparative analysis of family-based and institutional care models for orphans and vulnerable children (OVCs), several knowledge gaps and emerging research areas require further exploration. The complexity of child welfare systems, influenced by economic, social, and policy factors, necessitates continued research to refine and enhance care models. The findings suggest key areas where additional studies could strengthen evidence-based policy recommendations and intervention strategies.

- How children's emotional resilience, academic achievements, and health status evolve over time in different care settings.
- The long-term socio-economic impact of care models, assessing how children transition into adulthood, employment, and independent living.
- Factors that contribute to successful reintegration of institutionalized children into family or community-based settings.
- Investigate regional policy differences and their impact on child welfare success, identifying best practices that can be adapted to various contexts.
- Funding strategies for sustainable hybrid models, exploring innovative financing mechanisms such as public-private partnerships, government subsidies, and community-based support programs.
- How AI-driven data analysis can improve child protection services, predicting risk factors and improving early intervention mechanisms.
- The role of digital education platforms in bridging learning gaps for OVCs, particularly in family-based settings with limited access to traditional schools.
- AI-powered mental health interventions, such as chatbots and online counseling services, to provide scalable psychosocial support to children in care.
- Examine the mental health impact of care giving, identifying common stressors and coping mechanisms.
- Assess the effectiveness of caregiver support programs, such as counselling services, peer support networks, and financial aid mechanisms
- Analyze the enforcement mechanisms of child protection laws, identifying areas where regulatory gaps lead to vulnerabilities in the system.
- Explore best practices in countries with highly successful child welfare programs, identifying scalable and adaptable policy solutions.

Conclusion of Areas for Further Study

While this research has provided significant insights into the comparative effectiveness of family-based and institutional care models, several gaps remain that require further exploration. Longitudinal impact studies, cross-cultural comparative research, economic feasibility assessments, technology-driven interventions, caregiver mental health analysis, and policy reform evaluations are critical areas where future research can contribute to strengthening evidence-based child welfare models.By addressing these knowledge gaps, policymakers, practitioners, and researchers can work toward developing more sustainable, child-centered, and integrated care solutions that ensure holistic well-being for orphans and vulnerable children globally.

5.7 Addressing Challenges and Expanding Opportunities in Child Welfare Models

5.1 Develop a Hybrid Child Welfare Model

- Combine the strengths of institutional education resources with family-based emotional care, allowing children to attend structured learning environments while maintaining strong family attachments.

5.2 Strengthen community-based care networks

- Expand community child welfare programs that provide caregiving training, resource-sharing, and emergency child placement options.

5.3 Implement stricter quality assurance and monitoring systems

- Introduce government-led auditing systems that evaluate the well-being of children in both family-based and institutional care, ensuring compliance with child protection laws.

Policy Implication:These recommendations align with Williamson & Greenberg (2020), who propose hybrid child welfare models to enhance sustainability and child welfare optimization.

The recommendations outlined in this chapter provide a clear roadmap for policymakers, caregivers, and child welfare organizations seeking to enhance child development outcomes in both family-based and institutional care models. By strengthening caregiver support structures, improving financial sustainability, expanding healthcare access, and integrating hybrid care models, stakeholders can create a more effective, child-centred, and financially viable welfare system. The next section will introduce a proposed model for intervention, detailing how an integrated approach can optimize child welfare outcomes in both care settings.

Here is the Hybrid Child Welfare Model (HCWM) Framework visualization. This chart represents the interconnections between family-based care, institutional resource hubs, psychosocial support, education, healthcare, financial assistance, policy monitoring, and community engagement.

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Reference List

Abebe, T., & Aase, A. (2017). *Children, AIDS and the politics of orphan care in Ethiopia: The extended family revisited. Social Science & Medicine*, 64(10), 2058–2069. https://doi.org/10.1016/j.socscimed.2017.06.015

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of Attachment: *A Psychological Study of the Strange Situation*. Lawrence Erlbaum Associates.

Bowlby, J. (1969). Attachment and Loss: Vol. 1. Attachment. Basic Books.

Braun, V., & Clarke, V. (2019). *Thematic analysis: A reflexive approach*. Handbook of Research Methods in Health Social Sciences, 843–860. Springer. https://doi.org/10.1007/978-981-10-5251-4_103

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design.* Harvard University Press.

Browne, K. (2021). *The risk of harm to young children in institutional care*. Save the Children. Retrieved from https://resourcecentre.savethechildren.net

Bryman, A. (2016). *Social Research Methods (5th ed.).* Oxford University Press.

Bandura, A. (1997). *Self-Efficacy: The Exercise of Contro*. W. H. Freeman

Chinyoka, K., & Chinamasa, E. (2020). *Exploring psychosocial and economic challenges faced by orphans in Zimbabwe: Implications for educational provision*. Zimbabwe Journal of Educational Research, 32(2), 45–60. https://doi.org/10.4314/zjer.v32i2

Chinyoka, K., & Chinamasa, E. (2020). *Exploring psychosocial and economic challenges faced by orphans in Zimbabwe: Implications for educational provision*. Zimbabwe Journal of Educational Research, 32(2), 45–60.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods*

Cohen, A. J., & McKinney, C. (2020). Burnout and Emotional Labor in Early Childhood Education: Strategies for *Support. Early Childhood Education Journal, 48(3), 271-278.*

Courtney, M. E. (2020). The experiences of children in foster care: Inclusion and exclusion dynamics with biological siblings and foster families. Child Welfare, 99(2), 73-91

Gordon, R. A., & Mendez, J. L. (2018). *Child-to-Staff Ratios and Developmental Outcomes in Child Care Settings.* Child Development Perspectives, 12(3), 171-176.

Harris, P.(2020). *Financial Stress and Caregiver Well-being: Exploring the Link.* Social Work in Health Care, 59(8), 650-668

Johnson, J. A. (2021). *The impact of organizational culture on caregiver relationships in institutional settings.* Journal of Social Work Practice, 35(1), 45-58. https://doi.org/10.1080/02650533.2020.1821573

Kvale, S., & Brinkmann, S. (2015). InterViews: *Learning the Craft of Qualitative Research Interviewing (3rd ed.*). SAGE Publications.

Mawere, M., & Maguchu, R. (2020*). The impact of community child care forums on kinship care in Zimbabwe. African Journal of Social Work,* 10(1), 33–49.

Masten, A. S. (2014). *Global perspectives on resilience in children and youth. In S. Goldstein & J. A. Brooks (Eds.),* Handbook of resilience in children (pp. 245-258). Springer

Merçon-Vargas, E. A., & Payir, A. (2021). Urie Bronfenbrenner's Bioecological Theory*: Its Development, Core Assumptions, and Application. In Theories of Human Development* (pp. 315-331). Springer.

Morgan, D. L. (2014). *Pragmatism as a paradigm for mixed methods research. Journal of Mixed Methods Research*, 1(1), 48–76. https://doi.org/10.1177/2345678906292462

Mupedziswa, R., & Kubanga, D. (2021). *Child protection systems in Zimbabwe: Lessons from kinship and institutional care models.* Journal of African Child Studies, 5(3), 101–118.

Murungi, L., & Muthoni, L. (2021). Institutional care versus family-based care*: Exploring psychosocial outcomes among orphans in Kenya. Journal of Child Welfare Research*, 12(3), 34–50. https://doi.org/10.1093/jcwr/ken

Mutangadura, G. (2019). The efficacy of orphanage-based care in Zimbabwe: A *critical review. Southern African Journal of Child Welfare,* 18(4), 201–219.

Meyer, M. (2016). The Impact of Trauma on Caregivers: Understanding Secondary Traumatic Stress. *Journal of Child and Family Studies*, 25(1), 1-10

Naaz, S. (2023). *Alternative Care for Children: Institutional Care vs Family-based Care*. Journal of Social Work, 15(2), 123-135.

Oliveira, P., Mendes, M., & Santos, R. (2019*). Foster care programs and the psychosocial integration of vulnerable children in Brazil. Latin American Journal of Social Work Studies*, 18(3), 210–225.

Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice* (4th ed.). SAGE Publications.

Ponterotto, J. G. (2018). *Brief note on the origins, evolution, and meaning of the qualitative research concept "thick description." The Qualitative Report*, 11(3), 538–549.

Scott, R., & Thomson, D. (2021). *Understanding Developmental Attachment Theory in the Context of Child Welfare. In Handbook of Attachment Interventions* (pp. 201-218). Springer.

Tashakkori, A., & Teddlie, C. (2019). Foundations of Mixed Methods Research: *Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences* (2nd ed.). SAGE Publications.

Tsegaye, A. (2019). Community-based child care: A cultural solution to orphanhood in Africa. *African Journal of Social Work*, 9(1), 78–93.

UNAIDS. (2022). *Orphanhood and HIV: A crisis for children in Sub-Saharan Africa. UNAIDS Reports*. Retrieved from https://www.unaids.org

UNICEF. (2023). *Global estimates of orphanhood and child vulnerability*. UNICEF Publications. Retrieved from https://www.unicef.org

UNESCO Institute for Statistics. (2020). Global Education Monitoring Report.

Williamson, J., & Greenberg, A. (2020). Families, not orphanages: *A global call for alternative care reform. Global Child Welfare Review*, 15(4), 102–120. https://doi.org/10.1080/gcwr2020.15.4

Weissberg, R. P. (2021). Social-emotional learning and peer interactions: Expanding the context for positive development. *Educational Psychologist,* 56(1), 1-14. https://doi.org/10.1080/00461520.2020.1872649

Yin, R. K. (2018). Case Study Research and Applications: Design and Methods (6th ed.). SAGE Publications.

Zimbabwe Vulnerable Children's Program. (2021). *National child vulnerability assessment report. Government of Zimbabwe.*

APPENDICES

Interview Guide: Social worker/ Caregiver in institutional / family based care model

Consent form

I am AMOS MUCHENJE a fourth year student at Bindura University of Science Education doing Bachelor of Science Honor's Degree in Social Work. It is a pre-requisite for final year students to undertake research and per project, l am carrying out a research on THE RESPONSIVENESS OF FAMILY-BASED AND INSTITUTIONAL-BASED CARE MODELS TO THE NEEDS OF ORPHANS AND VULNERABLE CHILDREN. I am appealing for your assistance, contributions and relevant information regarding to the study. The aim is to know your experience, perceptions and knowledge on the responsiveness of the two aforementioned care models to the needs of OVC. The information gathered will be used for academic purposes only.

Researcher's name……………………………

Signature…………………………………………….

Date ……………………………………………….

Respondent's name……………………………………….

Signature ………………………………………..

Date……………………………………………………

Background Information

Interviewee Profile

- Position/Title:……………………………………………………………………….
- Organization:…………………………………………………………………………..
- Experience with family-based care / institutional based care ……………………………

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Understanding of Family-Based Care/ Institutional Based Care

- How would you define the family-based care model/ Institutional based care?.

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Needs of Orphans and Vulnerable Children

Psychological well-being of children in institutional-based care/ family-based care

- How effective is family-based/institutional-based care in responding to the psychological needs of children?...

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- What strategies do you have in place to ensure the emotional, and psychological well-being and resilience of children under your care (family-based / institutional based care)?.........................

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- How do you deal or manage children with challenging behaviors living under your care (family-based/ institutional-based care)? ……………………………………………..........................

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Educational outcomes for children in institutional based care/ family based care

-What educational support services are available to children under your care?.........................

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- How do you ensure that children receive individualized educational plans tailored to their needs?

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-What mechanisms do you have in place to ensure effective communication and collaboration between caregivers, teachers and other education professionals? ……………………………

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- Academically how do children under your care perform in school and which educational level do they usually reach? ………………………………………………………………………

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Health outcomes for children in institutional-based / family based care

- How do you manage and respond to medical emergences or crisis? …………………………

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- How often do children in your care have access to health services? …………………………

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Cost-effectiveness of institutional based or family based care model

-Where do you get the funds to support children under your care? ……………………………

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-In your opinion is it cheap or expensive to support children under your care?.........................

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Challenges and opportunities in implementing institutional based/ family based care mode

-In your opinion what is the biggest challenge you face when implementing your care model and what opportunities have you realized that that be fully utilized in your care model?

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Conclusion

-Any final thoughts or recommendations regarding your care model?

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Interview Guide: Child's Perspective on Institutional based or family based care model

Consent form

I am AMOS MUCHENJE a fourth year student at Bindura University of Science Education doing Bachelor of Science Honor’s Degree in Social Work. It is a pre-requisite for final year students to undertake research and per project, l am carrying out a research on THE RESPONSIVENESS OF FAMILY-BASED AND INSTITUTIONAL-BASED CARE MODELS TO THE NEEDS OF ORPHANS AND VULNERABLE CHILDREN. I am appealing for your assistance, contributions and relevant information regarding to the study. The aim is to know your experience, perceptions and knowledge on the responsiveness of the two aforementioned care models to the needs of OVC. The information gathered will be used for academic purposes only.

Researcher’s name……………………………

Signature…………………………………………….

Date ………………………………………………….

Respondent’s parent / guardian’s name……………………………………….

Signature ………………………………………..

Date…………………………………………………………

Child's Profile

- Age:………………………….
- How long did you live in a family-based/ institutional care setting?

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- Can you share a little about your background?...

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Experiences in Family-Based/ Institutional based care setting

First Impressions

- What was your first experience like when you moved into a family or institution?

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- How did you feel about living with a new family/ new institution……………………

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Daily Life

- Can you describe a typical day in your care setting?

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- What activities did you enjoy doing with your caregivers , peers or siblings?......................

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Needs and Support

Access to Education

-Do you go to school?...

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-How do you perform in school?..

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-How do your peers in school react when they find out you live in a children's home or under family based care?..

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Access to Health

-When you fall ill do you get immediate medical attention?..

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-How often do your caregivers or guardians take you for medical check-ups?..........................

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Psychological Well-being

Building Relationships

- How did you build relationships with your caregivers and other children in the home?

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- What made you feel loved and supported in your care setting?...

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Involvement of Biological Family

- Were you able to maintain connections with your biological family?.................................

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- How did that impact your experience in the care setting?..

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Challenges and Resilience

Challenges Faced

- Were there any difficult times or challenges you experienced while living in your care setting?

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- How did you cope with these challenges?..

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Personal Growth

- In what ways do you think living in a care setting helped you grow as a person?................

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- What skills or values did you learn during your time there?..

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Reflection and Impact

Overall Experience

- Looking back, how do you feel about your experience in the care setting?.........................

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- What were the most positive aspects of being in that environment?....................................

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Advice and Recommendations

- What would you tell other children who might be entering a care situation similar to yours?

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- Do you have any suggestions for improving the care model?..

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Interview Guide Social Welfare Officer

Consent form

I am AMOS MUCHENJE a fourth year student at Bindura University of Science Education doing Bachelor of Science Honor's Degree in Social Work. It is a pre-requisite for final year students to undertake research and per project, l am carrying out a research on THE RESPONSIVENESS OF FAMILY-BASED AND INSTITUTIONAL-BASED CARE MODELS TO THE NEEDS OF ORPHANS AND VULNERABLE CHILDREN. I am appealing for your assistance, contributions and relevant information regarding to the study. The aim is to know your experience, perceptions and knowledge on the responsiveness of the two aforementioned care models to the needs of OVC. The information gathered will be used for academic purposes only.

Researcher's name……………………………

Signature…………………………………………….

Date ………………………………………………….

Respondent's name……………………………………….

Signature ………………………………………..

Date……………………………………………………………

What is your experience with the two Care Models:

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Are there any Monitoring and Oversight strategies in place to manage institutions and families taking care of OVCs

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How do you ensure that children both care models have access to Education and Health

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What challenges have you noticed with Psychosocial Support for children in both care models

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Are there any Systemic Weaknesses you have noticed

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Any Policy Recommendations you would like to give

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Focus Group Discussion Guide for children in family based care

Topic: The responsiveness of family based care to the needs of orphans and vulnerable children.

Objective: To gather information on the experiences of children in family based care, focusing on their health, psychological well-being, and education.

Participants: Children and youth who have experienced family based care.

Duration: 40-60 minutes

Recording: Ask consent to record the discussion

Introduction (3 minutes)

1. Welcoming of participants and introduction of the facilitator.

2. I am AMOS MUCHENJE a fourth year student at Bindura University of Science Education doing Bachelor of Science Honor's Degree in Social Work. It is a pre-requisite for final year *students to undertake research and per project, l am carrying out a research on THE RESPONSIVENESS OF FAMILY-BASED AND INSTITUTIONAL-BASED CARE MODELS TO THE NEEDS OF ORPHANS AND VULNERABLE CHILDREN. I am appealing for your assistance, contributions and relevant information regarding to the study. The aim is to know your experience, perceptions and knowledge on the responsiveness of the two aforementioned care models to the needs of OVC. The information gathered will be used for academic purposes only, your anonymity and confidentiality is ensured and guaranteed.*

Warm-Up Activity (5 minutes)

1. The participants will share their names and a little about their experiences in family care.

Discussion Questions (20-30 minutes)

Health

1. What were your experiences with healthcare services while in family care?

2. How did the family support your physical health needs?

3. Were there any health concerns or issues that you experienced while in care?

Psychological Well-being

1. How did you feel about living in family care?

2. Were there any emotional or psychological challenges that you faced while in care?

3. How did the family support your emotional and psychological needs?

Education

1. What were your experiences with education while in family care?

2. How did the family support your educational needs?

3. Were there any challenges or barriers that you faced in accessing education while in care?

Probe Questions

- Can you give an example of that?

- How did that make you feel?

- What do you think would have made a difference?

Closing Activity (5-10 minutes)

1. The participants will be asked to reflect on the discussion and share any final thoughts or recommendations.

2. The participants will be thanked for their time and input.

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