The psychological well-being among institutionalized orphans and vulnerable children in Maputo
THE PSYCHOLOGICAL WELL-BEING AMONG INSTITUTIONALIZED ORPHANS AND VULNERABLE CHILDREN IN MAPUTO*

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In sub-Saharan Africa, poverty and its consequences hit orphan and vulnerable children (OVC) the hardest. As the once protective safety net dissipates, many OVC are forced to live in overcrowded and understaffed orphanages. In the attempt to meet survival needs, psychological health is pushed into the background. The aim of this study is to increase the understanding of psychological well-being among institutionalized OVC in Maputo, Mozambique. Qualitative interviews (N=12) and field observations in orphanages (N=6) were analyzed through the hierarchy of needs model. Institutionalized OVC were found living under poor general care with few opportunities for ludic, educational, and social growth. Also among the finding were neglect and abuse, attachment difficulties and traumatic stress symptoms. Nonetheless, this study opposes the disuse of orphanages and suggests interventions to improve the children’s psychological well-being.

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All children placed in orphanages\(^1\) in Maputo, Mozambique are not orphans. An orphan is herein defined as “a child under 18 years of age whose mother, father or both parents have died from any cause” (UNAIDS, UNICEF, & USAID, 2006, p. 4). While institutions frequently house parentally bereaved children,\(^2\) they are also the home of many so called vulnerable children. Vulnerability is a concept that varies with culture, era, country, and context. In this study vulnerable children are defined as those who have not lost their parent(s), but face similar difficulties as children who have. In the destitute conditions of many African countries, all children, and not only orphans, can be considered vulnerable (Cluver & Gardner, 2006).

Given that the present study will investigate matters regarding both orphaned children and those made vulnerable by other circumstances, the term OVC\(^3\) will be used. This is controversial as international NGOs oppose its use, claiming it “becomes used at the community level to identify particular children” (UNAIDS, UNICEF, & USAID, 2004, p. 6). Nevertheless, many researchers, studies, and organizations (e.g. UNICEFa) have found the term’s breadth and flexibility useful. In the following text, OVC will be used as it allows the possibility that not all orphans are vulnerable, and more importantly; not all vulnerable children are orphans.

The literature revised below includes studies from Africa as well as from other continents as it is believed that some aspects of institutionalized life are universal. The inclusion of non-African research is further motivated by the paucity of studies conducted in orphanages in the area. This can be contrasted with the well researched Romanian orphanages; studied by groups of researchers such Rutter and the ERA study team (1998, 1999) or Zeanah and the BEIP core group (2005, 2006).

Also, studies on non-institutionalized children in Africa will be included. These studies are deemed valuable as both groups of children share a similar past; for instance, studies show that both groups drop out of school as a consequence of difficulties at home (Gilborn, Nyonyintono, Kabumbuli, & Jagwe-Wadda, 2001). The revision of the literature is followed by a presentation of Maslow’s hierarchy of needs.

The state of OVC in the world

The highest number of orphans owing to all causes is found in Asia with 87.6 million\(^4\) (UNAIDS et al., 2004). Despite Asia’s large population, the proportion of orphans is low. In fact, the percentage of the child population who are orphans in Latin America (6.2%) is approximately the same as in Asia (7.3%).

Experts explain Asia’s percentage by alluding to the low HIV-rates (Meier, 2003). However, there is reason to pause; first, the epidemic is in its early stages and has yet to spread into the general population (Zhao et al., 2007). Second, even minute increases in HIV/AIDS prevalence could result in millions of infected people given Asia’s large population (UNAIDS & WHO, 2005).

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\(^1\) The terms orphanages and institutions will be used as synonyms (e.g. “an institutionalized child” is the same as a child living in an orphanage).

\(^2\) The same as an orphan child.

\(^3\) For a complete list of abbreviations and acronyms, see Appendix C.

\(^4\) All figures should be understood as estimates; figures may vary despite the source remaining the same.
Though Asia has the highest number of orphans, sub-Saharan Africa has the highest proportion. With its 12.3% it has approximately the same percentage as Asia, Latin America, and the Caribbean combined (UNAIDS et al., 2004). Also, where Asia’s orphan population is estimated to decrease by 600 000 in 2010, AIDS alone will lead to an additional 3.7 million orphans in sub-Saharan Africa (UNICEF, 2007). In 2005 the region, 48.3 million children were orphans due to all causes. Said number for Mozambique was 1.5 million (UNAIDS et al., 2006). Reliable data on how many OVC live in institutions in sub-Saharan Africa have not been found.

The psychological well-being of institutionalized OVC in Africa is not well studied. An all-fields search in PSYCArticles for “Africa” and “Orphanages” returned 30 unique results out of which seven focused on psychological aspects of institutional life. Of these, three were conducted in Eritrea by the same head researcher (see Wolff & Fesseha, 1998, 2005; Wolff, Dawit, & Zere, 1995).

In general, studies on non-institutionalized OVC appear more common than studies on institutionalized OVC. However, it is not common for research on non-institutionalized OVC to focus on psychological aspects. Instead, socioeconomical, physical, and material characteristics are targeted (see Atwine, Cantor-Graae, & Banjunirwe, 2005; Foster, 2002; Makame, Ani, & Grantham-McGregor, 2002). Existent research concerned with psychological aspects of orphanhood mainly investigates consequences of HIV/AIDS (e.g. Ansell & Young, 2004; Cluver & Gardner, 2006, 2007). In fact, of the above result from PSYCArticles, 19 out of 30 studies focused on HIV/AIDS-related matters. This should come as no surprise as the region has been grossly affected by the pandemic. In 2007, 1.6 million children and adults died of AIDS in sub-Saharan Africa, a figure that can be compared to the 58 000 AIDS-related deaths in Latin America (UNAIDS & WHO, 2007).

Although the moral and intellectual force behind the large numbers of HIV/AIDS-related studies is understood, the dearth of research on children orphaned by other causes remains. How important such information would be is reflected in numbers; 36.3 out of 48.3 million orphans in sub-Saharan Africa were orphans due to causes other than HIV/AIDS (UNAIDS et al., 2006).

 Causes of parental bereavement in the area are manifold. Examples are:

- **Poverty.** In Mozambique 70% of the population exist below the absolute poverty line (United Nations [UN], 2002).
- **Natural disasters.** Floods and cyclones are common in the area, and Mozambique has been recurrently hit (BBC News Online, 2000; CNN, 2001; Reliefweb, 2008).
- **Diseases.** Out of the 1 million people who die of malaria worldwide each year, 90% are Africans (UNICEFb, n.d.).

**Kinship and traditional care for OVC**
Fostering of OVC by extended families is the preferred choice of care for many sub-Saharan countries (Nyambedha, Wandibba, Aagaard-Hansen, 2003; Rose, 2005). This

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5 Other items and databases were searched, none of which returned a larger number than 30.
care, commonly provided by grandparents, is referred to as *kinship care* (Glaeson, 1995; Roby & Shaw, 2008). It is said to be one of “the oldest traditions in child rearing and the newest phenomena in formal child placement practice” (Hegar & Scannapieco, 1999, p. 17).

ISS and UNICEF (2004) estimated kinship care to be “the most significant ‘alternative care’ solution in a wide variety of countries” (p. 2). Indeed, it is a global phenomenon; in Alaska, the law requires kinship care to be considered first (Children’s Defense Fund, 2005), in Romania two thirds of orphans are estimated to live with substitute families (NPDC, n.d.), and in China, a study showed that 89.4% lived with a blood relative as opposed to 1.2% in orphanages (Zhao et al., 2007). It is also preferred in for instance Botswana, Kenya, and Mozambique (Miller, Gruskin, Subramanian, Rajaraman and Heymann, 2006; MMAS, n.d.; Nyambedha et al., 2003).

The policy behind kinship care is based on the traditional belief that children belong to the entire community (Beard, 2005). As such, it has many vantage points; for instance, Miller and colleagues (2006) suggest that “in most cases, children can find stability, love, and emotional support in relatives’ homes” (p. 1429). Also, it ensures that the ties to family, community, and culture are not severed and can prevent that children go through multiple placements (ISS & UNICEF, 2004). However, researchers have found that kinship care is dissipating as a result of:

- **Urbanization.** Kinship duties are eroded as rural families are forced to move away from their communities and into major sub-Saharan cities (Ansell & Young, 2004; Milligan & Williams, 2001).

- **HIV/AIDS.** The pandemic has resulted in kinship care being under an immense amount of pressure (Stover, Bollinger, Walker, & Monasch, 2006; Ntozi & Mukiza-Gapere, 1995). As the number of orphans steadily and rapidly grows, families in impoverished countries cannot keep up (Miller et al., 2006; UNICEF, 2006).

- **Finances.** OVC cared for by kin are likely to live in poor households that struggle to make ends meet (Bhargava & Bigombe, 2003; Sengendo & Nambi, 1997). Without external support, the families’ expenses grow while their resources diminish. As a result, families become reluctant to take in orphans (Miller et al., 2006).

- **Psychological stress.** Families have difficulties providing emotional support for the OVC they take in, especially when they themselves are grieving (Atwine et al., 2005; Sengendo & Nambi, 1997). In a study from Kenya, grandmothers found themselves occupying too many roles, leading to elevated stress (Oburu and Palmérus, 2005). Similarly, while studying orphans and their caregivers, Manuel (2002) found that caregivers were more depressed and received less social support. This might explain why children fostered by grandparents have the least chance of staying in school after being orphaned (De Wagt & Connolly, 2005; Sengendo & Nambi, 1997).
**Orphanages and the needs of OVC**

The problems delineated above raise the discussion of the orphanages’ to be or not to be. The discussion was thrust into the limelight in 1951 with Bowlby’s paramount study for the WHO, *Maternal care and mental health* (Bowlby, 1951). The main findings, i.e. that institutions were harmful because they lacked opportunities for children to attach to one or a few caregivers, lead to the conclusion that orphanages should be avoided where alternatives exist (Ansell & Young, 2004; Bowlby, 1986). From then on, most experts subscribe to the idea that institutionalization is unhealthy and will significantly increase the risk for future psychopathology and emotional problems (Browne & Hamilton-Giachritsis, 2005; Yang, Ullrich, Roberts, & Coid, 2007).

A 15-month long study that surveyed 33 European countries in 2003 suggested that no “child under three years should be placed in a residential care institution without a parent/primary caregiver” (Browne & Hamilton-Giachritsis, 2005, p. 5). If orphanages have to be used as an acute solution, length of stay should not exceed three months (Judge, 2003).

A common argument against orphanages concerns post-institutional effects. Studies have shown that even if children are adopted, having spent the first years in an orphanage can have negative consequences for many years to come (Judge, 2003; Nelson et al., 2007). As an example, researchers found that four-year-old orphans who had spent two years in an institution to be less secure and less able to understand emotions than non-orphans (Voria et al., 2006). Orphans also scored lower on cognitive development; a skill the authors suggested might need more time to develop.

Commonly used as an argument against orphanages in sub-Saharan Africa, is that they are not culturally acceptable whereas foster care by kin is (Beard, 2005; Subbarao, Mattimore, & Plangemann, 2001). Also, they are considered one of the most expensive solutions available (Freundlich, 2005; Salaam, 2004). This makes orphanages unsustainable in the long run given that they are dependent on donations, foreign aid, volunteers, and governmental subsidies (Subbarao et al., 2001; UNICEF, 2003). A related finding is that the destitute circumstances force priorities to be reorder so that physical and survival needs come first (Bicego, Rutstein, & Johnson, 2003; Browne & Hamilton-Giachritsis, 2005). As a result, few if any researchers believe orphanages can provide a stimulating environment or meet the children’s emotional needs.

However, the front against orphanages is not completely united. Since the mid-90s, researchers have shown that orphanages are better than many of the alternatives available to OVC (e.g. Aring, 2001; McKenzie, 1996; Sigal, Perry, Rossignol, & Ouimet, 2003; Wiener, 1998; Zmora, 1994). After comparing orphanages and foster homes in Malawi, Zimmerman (2005) writes that “if the priority is meeting the maximum number of needs for a large group of orphans in the most efficient manner, then orphans in Malawi are better off in orphanages than they are in foster homes” (p. 55-56). In a similar way, Subbarao et al. (2001) concluded orphanages were costly and should be a last resort, but conceded that they were effective in the provision of orphan care. However, most institutions need to be improved in order for them to be considered a valid alternative. For instance, Zimmerman (2005) called for cooperation between NGOs and the government in order for solutions to be integrated into the community.
Wolff and Fesseha (1998) proposed orphanages should work towards closer relationships between employees and children and that children’s individuality and autonomy be respected. In a later study, the same authors suggested care for orphans ought to “include a nurturing and authoritative style of parenting” (2005, p. 483), and that responsibilities for activities involving the children should be shared.

A more positive attitude towards orphanages has also been reported from Ghana (Akpalu, 2007), and from Mozambique where Roby and Eddleman (2005) found that 91% of terminally ill mothers preferred to place their children in orphanages rather than with relatives. The decision was based on the belief that their financially deprived next of kin would not be able to provide education or food to the same extent as an institution would.

**Risk factors and psychopathology**

How well the children’s physical health is looked after in the orphanages or how accessible medical services are to them varies greatly between and within countries (Crampin et al., 2003; Masmas et al., 2004; Nyambedha et al., 2003). In contrast to these varying reports on children’s physical health, many researchers are united in the belief that institutions leave emotional needs unmet (Makame et al., 2002; Vorria et al., 2006).

**Attachment difficulties.**

Researchers believe that infants are born with an innate capacity to relate to others, but that this predisposition needs a healthy environment in order to develop ( Bowlby, 1969; Trevarthen & Aitken, 2001). Perhaps indicating that orphanages seldom represent this healthy environment, attachment relationships in institutions are commonly portrayed as disturbed or disrupted (Rutter & Taylor, 2002; Vorria et al., 2006).

Neurological aspects are vital to the development of attachment (Schore, 2001a). With appropriate stimulation, the brain will cultivate abilities that help make social and emotional information understandable for the child (Schore, 2001b). However, if an infant is neglected, abused, or traumatized, this will not occur, instead increasing the risk for an attachment disorder (Glaser, 2000; Tarullo, Bruce, & Gunnar, 2007). In fact, many adult mental health problems have been related to disturbances of early attachment (Chisholm, 1998; O’Connor et al., 2003).

An attachment disorder commonly found in studies of institutionalized children is **reactive attachment disorder** (RAD; Boris & Zeanah, 1999, 2004; Wilson, 2001). RAD has been defined as “problems with the formation of emotional attachments which onset before the age of five years in response to serious deficiencies in care-giving” (Browne & Hamilton-Giachritsis, 2005, pp. 8-9).

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6 Herein understood as “an enduring affectional relationship between child and caregiver” (Sperling & Berman, 1994, p. 161).
There are two subtypes of RAD, **inhibited and disinhibited**. The inhibited subtype is in part characterized by trust issues, by the child being emotionally withdrawn, or not wanting to seek out support from caregivers – not even when hurt or crying (Dulcan, Martini, & Lake, 2003; Rutter & Taylor, 2002; Wilson, 2001). Illustrating this is the case of small children who have abandoned crying as a form of communication. A healthy infant will use crying to convey a need. If a caretaker appears and the need is satisfied, the tactic is deemed successful. If not, a “disuse related extinction” (Perry & Pollard, 1998, p. 43) may occur, meaning that the behavior is discarded because it did not have the desired result.

In institutional settings, the disinhibited type of RAD appears to be more common than the inhibited type (Boris & Zeanah, 2004). Disinhibited RAD is expressed through a seemingly insatiable need for adult attention, affection, and proximity (O’Connor & Zeanah, 2003; Zeanah et al., 2004). This has also been described as social promiscuity (Wilson, 2001) as children exhibit indiscriminately friendly behavior towards strangers, sometimes even approaching them for comfort when distressed (Chisholm, 1998; Stafford, Zeanah, & Scheeringa, 2003). Also, the children behave unsafely (e.g. run off without checking back to the caregiver) and appear unable to understand social cues (Zeanah & Fox, 2004).

Attachment difficulties found in orphanages are commonly explained with lack of stimuli due to orphanages being short-staffed (Giese & Dawes, 1999; Vorria et al., 2006). As a result children grow up “typically deprived of the supportive, intensive, one-on-one relationship with a primary caregiver” (Browne & Hamilton-Giachritsis, 2005, p. 7).

**Symptoms of traumatic stress.**

In psychology and psychiatry, trauma is often defined in relation to post traumatic stress (APA, 2000; Zero to Three, 2005). Stress symptoms may include depersonalization, dissociation, feeling emotionally numb, having intrusive thoughts, anxiety, etc (Solomon & George, 1999). Traumatic stress reactions that are severe and follow within the first month of experiencing the traumatic event are commonly diagnosed as **acute stress disorder**. When these symptoms become more persistent (i.e. last longer than one month), they can be diagnosed as PTSD.

PTSD symptoms such as reexperiencing, avoidance, and increased arousal have been described in children as nightmares, repetitive play, and difficulties concentrating (Armsworth & Holaday, 1993; Findling, Bratton, & Henson, 2006; Lothe & Heggen, 2003). Also, stomach aches or headaches are often reported from OVC both inside and outside of institutions (Gilborn et al., 2006). These symptoms may present as a result of chronic physiological arousal or reflect the actual quality of care that orphans and vulnerable children receive. They may also indicate non-verbal ways of expressing suffering (Cluver & Gardner, 2006; Makame et al., 2002).

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7 The disorder has many names; e.g. disorder of nonattachment, disinhibited attachment disorder, reversed attachment, promiscuous attachment disorder. For ease of reference, DSM-IV-TR terminology will be used.
However, there are researchers who believe PTSD is an unfit diagnosis for children as their reactions to chronic abuse, neglect, and other events are seen as more intricate than those delineated in manuals (van der Kolk, Weisaeth, & van der Hart, 1996). For instance, Gaensbauer and Siegel (1995) believe trauma impacts children on five different levels:

1. **The direct impact of the trauma itself.** Consequences directly related to the traumatic event will generate symptoms such as reexperiencing, avoidance, and increased arousal.

2. **Associated emotional reactions.** These are unique for each child, and specific to the trauma experienced. Children may experience great remorse for something they cannot control, or have feelings of responsibility for the occurred. Studies have shown that OVC feel guilty as they take (unfounded) responsibility for their parents’ demise (see also Cluver & Gardner, 2007; Gilborn et al., 2006).

3. **Effects on concurrent developments tasks.** Whatever phase-specific skill the child was trying to master at the time of the trauma is believed to be affected. Attachment relationships, sense of autonomy, and sleeping patterns are some examples.

4. **Effects on future development.** The authors claim that upcoming developmental challenges will be negatively affected if professional help is not received when the trauma is first experienced.

5. **Effects on social interactions.** Social difficulties are very common in traumatized children as it impacts on how children interact, connect, and relate to others.

**Social difficulties.**

It has been well documented that orphans suffer from both disturbed social interactions (Richter, Manegold, & Pather, 2005; Sengendo & Nambi, 1997), as well as peer relationship problems (Cluver & Gardner, 2006, 2007; Tarullo et al., 2007). Difficulties in social settings can result in children showing symptoms of depression, something that in turn can be expressed through aggressive behavior (Crenshaw & Mordock, 2005; Crenshaw & Garbarino, 2007).

In a study conducted in Cape Town, 60 orphaned children were compared to matched controls (Cluver & Gardner, 2006). One of the results was that 97% of orphans did not perceive themselves as having a close friend. The children also reported that stigma and myths surrounding AIDS caused them to be isolated, bullied, and shamed.

Accusations of causing their parent’s death through sorcery have been reported elsewhere and seems to hinder the children’s possibilities to talk about their pain and loss (Human Rights Watch, 2006; Jacob, Smith, Hite, & Cheng, 2004). Despite AIDS being a major reason for stigmatization and discrimination, orphan children are being discriminated based solely on their status as orphans (Roby & Eddleman, 2005; Subbarao et al., 2001).
Experts believe that if children are respected and cared for, their visibility in society increases. However, this visibility tends to dissipates once they become parentally bereaved, neglected, or abused, and when this happens, the distance to open discrimination is not far (UNICEF, 2005). Social support is also important in terms of education and psychological health as it has been shown to play a fundamental role in the prevention of future mental health problems (Davidson & Doka, 1999; Schmitz & Crystal, 2000), in the advancement of psychosocial well-being, and the decrease of psychosocial distress among orphans (Gilborn et al., 2006).

**Education.**

Experts believe that without the above described social support, children will “lose the opportunity for education and for the maximum development of their potential” (UNICEF, 2007, p. 42). It has been well documented that education is seriously and negatively affected by orphanhood (Bicego et al., 2003; Mishra, Arnold, Otieno, Cross, & Hong, 2007). These and other negative effects begin long before the parents’ death and affect all areas of the children’s lives (De Wagt & Connolly, 2005; Salaam, 2004).

Compared to non-orphans, parentally bereaved children are more likely to drop out, have attendance problems, have less money for school expenses, suffer from emotional distress, and not complete primary school (Ansell & Young, 2004; De Wagt & Connolly, 2005; Salaam, 2004). In Mozambique, less than 5% of school aged children complete secondary school (Fitzpatrick, 2007). Orphans who remain in school are less likely to be found at an age-appropriate grade level (Kamali et al., 1996; Nyamukapa & Gregson, 2005).

Reports on how and if institutionalized children receive education or schooling varies in the literature. Some orphanages pay for uniforms and books, others encourage children to attend school outside the institution in order for them to be able to interact with the community (Akpalu, 2007; Zimmerman, 2005).

Last but not least, all children’s education – whether institutionalized or not – is indirectly affected by HIV/AIDS as the disease kills more teachers than can be trained and replaced. In Mozambique more than a thousand teachers die each year (Reuters, 2007; Salaam, 2004).

**Maslow's hierarchy of human needs**

Maslow outlined the basics of what would later be known as the hierarchy of needs model in 1943. The needs-based motivational theory stemmed from Maslow’s work as a clinician and an interest in the healthy population. The model has been used in psychological studies, for instance to understand children who are gifted, neglected, or in crisis (Dubowitz et al., 2005; Groth & Holbert, 1969; Harper, Harper, & Stills, 2003).

Maslow believed that human beings were motivated by the needs yet to be satisfied, and that these were organized from lower to higher order. Even though the model for the hierarchy of needs model (commonly conceived of as a pyramid) has been revised and
steps have been added (Koltko-Rivera, 2006), this study will make use of the original five-levels model.\footnote{The decision to use the model from 1943 was mainly based on the fact that most subsequent developments focused on expanding levels above self-actualization, something not deemed relevant for the study at hand.}

![Figure 1: The hierarchy of human needs. Adapted from Maslow (1943).](image)

The first four levels were governed by what Maslow (1999) called D-values as these were motivated by deficiencies in the individual. The highest level was motivated by values of being (B-values), like justice, uniqueness, playfulness and truth. Below, the five levels will be described from a lower to a higher order of needs. They should however not be understood as being “in a step-wise, all-or-none relationships to each other” (Maslow, 1943, p. 388). Each level as described in Maslow (1943) is first presented in general terms, and later related to child-specific circumstances.

**Physiological needs**: The needs required to stay alive include oxygen, water, food containing protein, salt, and sleep. If these needs aren’t satisfied, the individual will ignore higher needs. For instance, a person who is starving will be more motivated by the lure of a meal than the promise of a balanced soul.

It is believed that all infants are born with a set of physical needs such as food, shelter, and clothing that require satisfaction or survival is threatened (Dubowitz et al., 2005). Malnutrition can affect a child already in the womb and has been related to premature birth and low birth weight (Martorell & Gonzalez-Cossio, 1987), as well as
kwashiorkor.\(^9\) Malnutrition in the child has been found to result in reduced activity, physical delays, hypoglycemia, and failure to thrive (Desai, 2000; Krugman & Dubowitz, 2003). Kwashiorkor has been related to abdominal distension, anemia, hair and bone changes, edema, stunted growth, death, and susceptibility to infections, as well as skin, mouth, and eye lesions (Desai, 2000; Rosanoff, 1938). For reference, 24% of all Mozambican children under five are moderately to severely underweight, and 41% are moderately to severely stunted (UNICEF, 2007).

The psychological effects of starvation are numerous; misery, nervous irritability, fatigue, apathy, concentration difficulties, and permanent cognitive deficits have all been reported (Balbernie, 2001; Beckett et al., 2006; Desai, 2000). This makes it unrealistic to expect that children who suffer from a chronic lack of basic needs will be able to cope in school – let alone attend. According to Maslow’s theory, these children will be focused on attaining food, not scholastic knowledge.

**Safety needs:** The individual is now motivated by security through for instance order and law, or desire to live in a safe area, have job security, good finances, and medical insurance. Safety needs were also believed to become more salient when the individual was frightened (Maslow, 1998).

Maslow (1943) believed that most children preferred a safe and predictable world where there is “something that can be counted upon, not only for the present but also far into the future” (p. 377). Related to this view is Osòfsky’s (2004), who writes that safety is something that occurs when a child experiences “the feeling of being safe and free from danger or threat” (p. 160). Both these quotes include elements that are utterly lacking for institutionalized OVC, especially in the developing world.

**Love needs:** These needs are characterized by their interactive and relational aspects such as to give and receive love. Also, the desire to connect to others, to a group, to have personal relationships and enjoy friendships are now motivating. It should be noted that love is considered a D-value, and as such it is believed necessary for survival (Maslow, 1999).

In the same way as Maslow believed humans had an innate need for love, experts believe everyone is born with a desire to form affectional relationships (i.e. attachments) to a primary caregiver (Sperling & Berman, 1994). Given that time for interaction in orphanages with low staff-to-children ratio is limited, this need is met with difficulty (Bolton & Day, 2007; Kreppner et al., 2007).

Ludic activities can also be understood as generating a sense of belonging, as children who are members of a team might develop an identity in relation to their team mates. However, it is difficult for financially struggling orphanages to engage children in leisure and play given that even a football might be difficult to come by (Right to play, n.d.). Society also plays a role in children feeling excluded and unloved if they are stigmatized and discriminated against (UNICEF, 2007).

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\(^9\) A disease commonly found in poverty stricken countries where children’s diets are low in protein content.
**Esteem needs:** At this stage, people experience a need for self-respect, attention, and appreciation (Goebel & Brown, 1981). The motivation is to attain self-esteem through accomplishments or achievements (e.g. in academics or work), and to be esteemed and recognized for these by peers (Harper et al., 2003). Decreased self-esteem can be the result of unfulfilled expectations and form part of a demoralization process (Clarke, 2007).

It is through the desire to fit into a specific context, like a family or a group, that children feel the need to be recognized by others. For instance, forming part of the football team might motivate a child to be crowned the best dribbler. In an orphanage setting, where children sometimes live by the hundreds, just to be noticed can be a self-esteem building event. In developing countries, the act of “being noticed” can be hampered already at birth. This is due to low birth registration rates, meaning a child will start life without an official identity (UNICEF, 2006, 2007). One of the consequences of this is that children are prevented from benefitting from their most basic rights (UNICEF, 2005, 2006).

**Self-actualization:** The highest level is the most difficult to reach and includes achieving one’s full potential. According to Maslow, only 2% reached it during their lifespan (Heylighen, 1992). It is believed that if previous levels are left unmet, this will hinder the true and full pursuit of self-actualization. This is governed by a logical thought; if death by malnutrition or abuse is imminent the individual’s desires will stop at how to get the next meal.10

Given how difficult it is for adults to reach this level it would be unreasonable to assume that children (especially abused and neglected ones) could conquer this at a young age. For the sake of the argument, this fact will be overlooked. Instead, a view that supposes self-actualization is a need worthy of pursuit even for OVC will be employed. This way, their skills can be seen and enhanced instead of assumed nonexistent and ignored.

**Limitations and criticism.**
Parts of Maslow’s work have been criticized for lacking an integrated conceptual frame and for not being able to scientifically or empirically support the stringent order of the model (Heylighen, 1992; Soper, Milford, & Rosenthal, 1995). Said order has also been challenged for being rooted in unacknowledged Western, individualistic, and bourgeois cultural values (Rubenstein, 2001, para. 31). Opponents claim that in certain cultures, social needs can be equal to or below some physiological needs. To his defense, Maslow declared early on that the model wasn’t ultimate or universal, only that “it is relatively more ultimate, more universal, more basic, than the superficial conscious desires from culture to culture” (Maslow, 1943, p. 21).

Also, critics claim self-actualization cannot be measured as it is too abstract, intrinsic, and vaguely defined (Heylighen, 1992), and that the theory cannot explain how artistic people can be creative even when they blatantly disregard their basic needs (Riggs, 2006).

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10 As expressed by rap artist 2Pac “I’m tired of being poor and even worse I’m black/My stomach hurts so I’m looking for a purse to snatch” (“Changes”, 2Pac, Greatest Hits, 1998, Disc 2, track 5).
The Mozambican context
Mozambique is located on the south-eastern coast of Africa, separated from Madagascar by the Mozambique Channel. It stretches along the Indian Ocean bordering countries Swaziland, South Africa, Zimbabwe, Zambia, Malawi, and Tanzania. Even though Portuguese is the lingua franca, most Mozambicans speak other dialects (BBC News Online, n.d.).

In 1498, Vasco da Gama claimed Ilha de Mozambique in the north of the country. This marked the start of Portugal’s invasion, though it would take over 400 years to have Mozambique under direct rule (Mozambique, 2008). In 1975, the country was handed its independence. However, after being a colony for a long period of time, and as a result of the atrocious dismantling of the colony, Mozambique became and remains one of the world's poorest countries. From this point on, the nation has been dependent on foreign aid. In fact, Mozambique has received aid from Sweden since 1975, and today this aid focuses on reducing poverty and stabilizing democracy (Sida, 2007).

In the 1980s the economy worsened as an effect of civil conflicts, droughts, and corruption (BBC News Online, n.d.). The civil war that ensued lasted for 16 years ending only in 1992. In the years that followed, many economical reforms took place and the country enjoyed a period of relative politically stability (Mozambique, 2008). Still, the fragility of the country was painfully visible at the turn of the century when severe flooding, cyclones, and landslides devastated the nation (BBC News Online, 2000; CNN, 2000). Worst affected were rural communities where the majority of Mozambique's approximately 21 million inhabitants live (UNICEF, 2007; INE, 2008; Reliefweb, 2001).

Today, Mozambique struggles with every aspect of development. Approximately half the population is illiterate and 80% live under two USD a day (UNDP, 2004; UNSD, 2003). Also, the neonatal mortality ratio is currently set to 163 children dead for every 1000 born, and one of every four children is underweight in relation to their age (UNDP, 2005; WHO, n.d.). These and other factors contribute to the country being ranked fifth from last on the Human Development Index and 31st on the list of the Least Developed Countries (UN, n.d.; UNFPA & Population Reference Bureau, 2005). Related to human development is the matter of birth registration (UNICEF, 2006, 2007). As per the Convention on the Rights of the Child (UNICEF, n.d.) every child shall “be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents” (Seventh article, first paragraph).

In Mozambique most children are denied these essential rights that are crucial for the enforcement of child protection laws (UNICEF, 2007; UNICEF, n.d.). The lack of birth registration is commonly explained in financial terms; there is not enough money to implement, manage, and maintain this record keeping (UNICEF, 2006, 2007). The cost is high even at an individual level; a fee has to be paid and the registration can require long journeys and over-night stays that parents might not afford (Plan International, 2008).
Problems related to lack of birth registration can be further understood through the studying of core health indicators. For instance, maternal mortality ratio in Mozambique is 520 mothers per 100,000 live births.\(^{11}\) Life expectancy at birth is 49 years for males and 51 years for females\(^ {12} \) (WHO, 2007). This suggests that children will be left to fend for themselves at a young age (UNICEF, 2005). How an orphan child with no extended family can become registered is unclear.

**Aims of the study**

The review of the literature shows that institutionalized children grow up under circumstances that are potentially a threat to their physical, emotional, social, and psychological development. The risks are specifically salient for orphanages in developing countries, where meeting even the most basic needs is a perceptible effort.

There is a shortage of studies on the psychological well-being of institutionalized OVC in Africa. Existing studies either focus on other aspects than the psychological, or they focus on the psychological only in relation to HIV/AIDS.

The focus of this study is to increase the understanding of psychological well-being among institutionalized OVC in Maputo.

The specific aims are:

- Describe psychological difficulties common in the population
- Explore physiological and social aspects believed to affect the children’s psychological well-being

**Methodology**

The present study has a qualitative approach, aiming at a “type of research that produces findings not arrived at by statistical procedures or other means of quantification” (Strauss & Corbin, 1998, pp. 10-11). The methodological choices were mainly informed by Lofland, Snow, Anderson, and Lofland, (2006), Langemar (2006), Kvale (1995), and Thomsson (2002). In order to gather as much information as possible, the combination of interviews and field observations was chosen.

The fact that the study was conducted in a developing country by a student from a developed one warranted special attention to cultural issues (Costello & Zumla, 2000; Harris, 2004; Tomlinson, Swartz, & Landman, 2006b). In order to secure a multicultural focus and increase sensitivity towards local beliefs, four strategies were designed:

- Time in the field. Spending 16 weeks in the field made it possible to learn about local culture, customs, and unwritten rules of social reality in a day-to-day fashion.

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\(^{11}\) In Sweden; 3 mothers per 100,000

\(^{12}\) In Sweden, said number is 79 and 83 years respectively (WHO, 2005).
- **Academics.** Access was granted to the resources and the experience of professionals working in the Centre for African Studies in Maputo (UEM, n.d.).

- **Personal past.** Having spent many years in Mozambique (see below) generated a certain – albeit limited – sensitivity for the nation’s culture and people.

- **Contacts.** Local friends from diverse backgrounds were used as sources of information about the unwritten cultural rules.

A word of caution: no matter how many strategies are applied, or what the success rate of their implementation is, there will never be such a thing as total cultural unbias.

The strategies above are mere attempts that can work to minimize cultural insensitivity, not a solution to cultural bias. Instead, the study at hand agrees in full with the notion that “It is something of a sleight of hand, which entrenches the power and credibility of those writing up research, to argue that cultural issues can be resolved” (Tomlinson, Swartz, & Fitzgerald, 2006a, p. 540).

**Respondents and orphanages**

In total, 16 respondents were interviewed. Four of these interviews were used as pilots. Of the remaining 12 respondents, six worked inside the orphanages, and six worked with OVC-related issues outside the orphanages. The respondents were chosen on the assumption that they were knowable child care professionals and were able to make their views explicit. The basic inclusion criterion was that respondents should currently be working with matters concerning OVC in Maputo. Ultimately they were chosen among employees of NGOs, relevant governmental branches, and orphanages. Thus, there was a difference in how the respondents’ work related to the children.

The age span of respondents was 24 to 67 years of age. The majority were females (two were male), born and raised in Maputo. Two were of foreign descent (European and North American). The greatest difference was found in regards to education; most of the six respondents who worked outside orphanages had received education abroad. Three were psychologists, two were sociologists, and one was a physician. Out of the six respondents employed inside orphanages, only two had studied abroad. Among them, three had no formal education, two were theologians, and one was a sociologist.

In total, six different orphanages were included in the study. These were either run by the government or by private organizations. A majority of the orphanages accepted all age groups, meaning there were infants and children up to 18 years of age. Areas inside the orphanages were organized after age or gender, or both (i.e. there were dorms for infants, for young schoolgirls, for adolescent males, etc). The amount of orphans living in the institutions ranged from approximately 50 to 200. However, no set number was ever given.

Staff-to-child ratio could not be established to any great certainty, although a rough estimate would be between 1:20 and 1:30. All orphanages depended on financial aid, either allocated through the government, international NGOs, or private donations.
The selection process was similar for respondents and orphanages. In the case of respondents, an initial list of relevant organizations and people active in the field was compiled. This was done with the aid of the contact person in field, government officials, social workers, NGO staff, and personal contacts. In total 30 organizations and individuals were identified. Second, the author contacted everyone on the list by telephone or email. Out of the initial 30, a total of 16 replied in time to be included in the study (four were interviewed as pilots). No respondent who expressed interest in partaking when first contacted declined to participate once presented with the study.

In the case of orphanages, a list was made of 12 orphanages located within Maputo’s city limits. These were then contacted and authorization to conduct field observations was requested. The first six orphanages to grant permissions before the end of the research period were included in the study.

Data collection
An interview guide consisting of themes and questions was written in English\(^\text{13}\) and then translated into Portuguese.\(^\text{14}\) The guide was also proofread by a person fluent in Portuguese. The guide was created in order to make discussions more systematic and comprehensive, but it was not regarded as a definite or fixed collection of questions to be asked. Rather, it was used as a general map to frame the interviews (Anastas, 1999). The design of the guide followed the steps described in Lofland et al. (2006). A draft was written before the first pilot interview, and after each pilot the guide was modified, updated, and improved as to incorporate new and vital information. This process was also done to in order to be consistent with a reflexive method (Thomsson, 2002).

Pilot interviews. The four interviews that were used as pilots served to detect questions that did not generate information as intended or that were misunderstood. When this occurred, questions were modified or removed. In general, affected questions had in common that they required data stemming from medical records, birth certificates, or the like. Such information was usually unavailable. The pilots were further used to become familiar with the act of interviewing and to underwrite question relevancy (Kvale, 1997). They were also used to estimate interview length, something that was helpful in the subsequent recruitment of respondents.

Interviews. A qualitative semi-structured interview was designed. The aim was to allow the respondents to inform the study from their point of view, using their words (Lofland et al., 2006). All interviews were carried out between the months of May and August 2007. Ten were held in Portuguese and two in English. No translator was used. The interviews were recorded with a digital sound-recorder in nine out of twelve situations. In three instances, authorization to use a recording device was denied thus requiring extensive notes. The duration of the interviews oscillated between 45 and 70 minutes. All interviews were held at the respondents’ place of work, except one that was held in the respondent’s home. No payment was offered nor requested.

Before every interview the respondents were informed again of the purpose of the study and approximate length of the interview. Then followed information about the author

\(^{13}\) See Appendix A.

\(^{14}\) See Appendix B.
and the context of the study after which anonymity, confidentiality, and voluntary participation were discussed. Respondents were then offered a summary of the report, and finally, permission was requested for the digital recording of the interview.

The first questions placed focus on the respondents and their backgrounds, that is nationality, education, experience, etc. These questions set the respondents within their present context and made possible a general appraisal of their knowledge and experience in the field. The aim of the first topic, Historical/Social, was to find out what the respondents knew about the social aspects of the children’s lives. It is important to point out that the questions referred to the group of children with whom the respondent worked, thus eliciting general information about them and not single-case information.

The purpose of the second topic, Psychological aspects, was to gather information about the children's psychological needs and how these are perceived, handled, and understood. The topic was thus designed to capture alternative and perhaps culturally different ways of dealing with psychological matters. The third and final topic, The future, was created in order to round off the interview with questions regarding what could and should be done in the matters discussed. To close the interviews, respondents were asked if they wanted to add something or had any questions. After this, they were thanked for their participation and permission for follow-up questions was requested.

Field observations. It is believed that information about behaviors is best served through their direct examination, as opposed to inquiring about them (Hayes, 2000; Kvale, 1997). Therefore, six field observations were used to illustrate the findings presented in the study. These were carried out between the months of May and August 2007, and each field observation lasted between four and twelve hours.

On a few occasions, observations were carried out in the same orphanages where a respondent had previously been interviewed. However, this was never done on the same day. Two field observations were carried out during the same time period as pilot interviews were being conducted. The remaining four were conducted in-between subsequent interviews, whenever permission was granted.

During field observations, data was logged through a process involving three kinds of notes: mental, jotted, and full fieldnotes (Lofland et al., 2006). While making mental notes the mind is prepared to, at a latter point, write down what is currently being observed. Shortly thereafter, certain parts of the observation are jotted down. If for example an interaction between two children was observed, key words and location were annotated for later recall. These were written down in a small notebook, though only employed when notes could be taken inconspicuously. This was achieved by for instance logging observations made during breakfast only after the children had left the meal room. The writing was never commented on, nor did anyone stop their activity while notes were being made.

The jotting was followed by full fieldnotes. Every evening, observations were logged in chronological order. They consisted mainly of uncensored and somewhat incoherent descriptions of settings, actions, contexts, behaviors, and quotes. In addition, proto-analytical and crude ideas were included and marked as such in order to facilitate latter,
more time-consuming tasks (such as analysis and interpretation of data). As mentioned, the first two observations were done in parallel with the pilot interviews in order to inform and enhance the interview guide.

About the author.
A woman, who spent seven years of her youth in Maputo, Mozambique, speaks Portuguese fluently, and has knowledge and experience of the local culture.

Analysis
Data was analyzed using inductive thematic analysis. This means themes were created based on their commonality or discordance with previous research, and reports by other respondents (Hayes, 2000; Langemar, 2006). Also, a somewhat modified grounded theory\textsuperscript{15} was used based on Glaser and Strauss (1967), Hayes (2000) and Shank (2002).

It included collecting, coding, and analyzing data in order to generate theory, as well as avoiding to create theories from a priori assumptions. Below, the process through which data was analyzed is described in detail:

- **Transcriptions.** All interviews were transcribed, recordings were listened to again, and transcriptions were read and re-read. These processes concurred with taking notes of initial ideas, hunches, interpretations, and feelings.

- **Vertical analysis.** Performed on each interview separately. Almost the entire content was summarized into bullet form in order to avoid passing judgment on the relevancy or irrelevancy of an answer. It generated a clear and condensed overview of the complete data.

- **Coding.** All bullets were coded. For instance, a code was designated a specific disorder if it was mentioned on several occasions during one interview. This code would be re-used if any subsequent respondents mentioned the same disorder. Salient features were also marked.

- **Horizontal analysis.** Themes were searched across all interviews, collating data relevant to each code. Emerging themes were reviewed, checked against each other (to see if they were related), and named. An effort was made to make every theme specific as well as cohesive in order to match the general narrative of the analysis. Finally quotes that were believed to best inform the themes were selected.

- **Recheck.** The analysis was related back to the original study objective, the literature, and the theoretical frame of the study.

- **Hierarchy of needs model.** This model was used to organize the results after the last recheck was done.

It should be noted that movement oscillated between the steps throughout the study with the exception of the last step. For instance, a horizontal analysis could generate a need

\textsuperscript{15} “Modified” because not all aspects of grounded theory were used, and because it was not used exclusively.
for a specific group of bullets that were coded but abandoned in a previous vertical analysis.

**Ethical considerations**

An utmost effort was made to respect every respondent’s rights and needs, their expressed values and their wishes (e.g. not to be taped). This was attempted through a sensitive, civil, and appreciative approach. Also imperative was the thorough preparation on a personal, academic, and professional level. Respondents were informed that participation and consent was voluntary and could be withdrawn at any moment (CODEX, 2008). The data collected was safeguarded, and the identity of all the respondents, organizations, institutions, and orphanages was protected throughout the entire process.

Helpful in the detection of specific factors that contribute to good ethics in international research was the list compiled by Zeanah and colleagues (2006) and Tomlinson et al. (2006a). Examples include establishing collaborations with local researchers and generating information that improves local conditions. Although these solutions are rather difficult to achieve for a study of this magnitude, an awareness of what should and could be attained pushed the concept of ethics to the foreground where they belong.

**Results and discussion**

Below, findings are presented as themes according to the hierarchy of needs model. Each theme will be informed from the following perspectives:

- **Respondents from inside the orphanages.** Interviews with orphanage employees who have daily contact with OVC but less information concerning all OVC in Maputo.

- **Respondents from outside the orphanages.** Interviews with professionals who have less day-to-day contact with the children but greater insight into the general population of OVC in Maputo.

- **Field observations.** Observations made during visits on-site.

The two groups of respondents will not be differentiated in the text. All quotes may be corrected for written English (without changing the meaning of what was said).

The results from two of the three topics included in the interview guide (i.e. *Historical/Social and Psychological aspects*) will be presented through the five levels of the hierarchy of needs model. The third topic (*The future*), will be presented separately.

**Physiological needs**

Although the physiological needs mentioned in the interviews were described as “poor”, “deplorable”, or “dreadful”, most respondents focused on the fact that what the
children\textsuperscript{16} had was better than nothing: “Of course, food and water are not ideal but at least the children have something to eat and drink [and] they are not dying like others”. It was illustrated in interviews that although survival came first, emotional, social, or psychological needs were not ignored. Respondents claimed that this was a relatively new phenomenon: “Now psychological needs have been given an importance they didn’t have back in the day (...) but this is very recent and comes as a result to foreign pressure”.

Many respondents believed physiological and psychological care should be of equal importance in the care of OVC. However, there were several obstacles in the way; physiological needs were described as easier to identify and satisfy. Also, any effects of interventions made would be observed immediately: “It’s far more gratifying (...) you feed a child, she smiles, you hug a child, maybe she cries for the first 50 times before she stops”. On the other hand, psychological needs were seen as more difficult to understand and appease. Also, effects could take years to show – something a few respondents claimed was the real reason behind why orphanages did not give these needs due attention.

Placing survival above all other needs is a common practice in poverty-stricken orphanages (Bicego et al., 2003; Browne & Hamilton-Giachritsis, 2004). This is also in line with Maslow’s (1943) contention that when all needs are unsatisfied, “the organism is (...) dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background” (p. 373).

Respondents frequently reported that orphanages lacked an appropriate water source, meaning enough running water for drinking, cooking, cleaning up, washing dishes, clothes etc. Access to water was often restricted and children could not drink or wash up at will. However, children were said to have enough water to drink, even if most respondents described the water as dirty.

Through field observations it was observed that water sources were generally found to be unclean or kept in unsanitary conditions. Nevertheless, the water was used for cooking and served as potable. During several field observations of mealtimes, it was noted that children were served food without any beverage. However, on closer examination, the water was found to be served in the same container as the food. This meant water intake depended on size of container and ration of food received.

Most respondents subscribed to the fact that food was fundamental for survival and for a healthy development. However, they also believed OVC in institutions were not fed enough: “The children are always hungry, always, all they want is food, food, food (...) but sometimes they only get one meal a day”. Another concern was nutrition since children were repeatedly being served the same food, and the food had a very low nutritional content. However, not all respondents saw this as a problem: “I grew up eating the same things (...) the problem is not that serious, other things are worse like not having a family or feeling alone”.

\textsuperscript{16} From here on, “children” will refer to “institutionalized OVC” if not marked otherwise.
However, the effects of malnutrition were described by some as a serious problem that impacted all aspects of the children’s lives: “A child with only hunger, she can’t grow like the others, she can’t play (…), she can’t sing, she is no good in school, (…) she can’t do what the others do”.

Other aspects of nutrition that were criticized included that food was contaminated (i.e. rotten) or prepared in unsanitary conditions (in dirty pans, prepared too close to the ground, etc). It was mentioned in interviews that many children showed signs of kwashiorkor. The most common symptoms were abdominal distension, discolored hair, lowered activity, and delays in physical development.

In field observations it was noted that meals mainly consisted of rice, bread, xima, or mandioca. These products are rich in carbohydrates but lack enough fat and protein (Nassar & Costa, 1977; “Cassava,” n.d.; “Rice,” n.d.). Frequent observations were also made of children having spoiled food, food with bugs, no plates to eat off, eating from dirty plates, etc.

According to UNICEF (2007), undernutrition is involved in 50% of deaths of children younger than five years of age. Also, studies have shown how starvation and malnutrition can seriously affect the overall health of the child and lead to stunted growth (Akpalu, 2007; UNICEF, 2007). Effects of malnutrition and the above depicted symptoms of kwashiorkor have been described in the literature (Desai, 2000; Rosanoff, 1938).

Respondents also discussed how poor hygiene affected the children’s health. Dirty food, water, clothes, and sleeping facilities were named as precursors to many of the illnesses that are frequently seen among institutionalized OVC. Respondents worried that children were not being taught even the basic rules of hygiene: “They don’t understand about washing hands or keeping wounds clean (…) and if one gets sick they all get sick”. However, a few respondents added that orphanages had understood the detrimental consequences of poor hygiene, and tried to combat it with the few means available. Two of the most common means of combating hygiene-related issues were to use the branch of a specific tree to keep teeth clean, and for children to “wash” their hands in ashes.

During field observations it appeared that sanitation was strongly related to availability of running water. This made it difficult to differentiate between children not knowing how to keep themselves clean and not having the possibility to do so. The same could be said for the staff as it was not uncommon to observe them making unfit decisions about hygiene. For instance, the kitchen staff was not observed washing their hands before handling the food and repeatedly used the same plate to serve meals to different children.

It was also observed that some of the actions to combat poor hygiene appeared to actually contribute to the problem. For instance, in one of the orphanages the children were told to wet their hands in a bucket of water placed outside the meal room.

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17 A stiff, white, cornmeal porridge.
18 A root, also known as manioc or mandioca (Nassar & Costa, 1977).
However, the water was not changed and as a result it was quickly contaminated. Also, there was a risk of contagious diseases being spread as all children dipped their hands into the same container. In some orphanages latrines were not taken care of properly; they were unclean, and filled to the rim. In these orphanages, children were seen avoiding the latrines and instead opting to use holes in the ground. These were dug in different places of the orphanages, sometimes in the same areas where the children played.

The fact that poor hygiene leads to serious health issues and also death has been frequently reported. For instance, UNICEF (2007) reported that “An estimated 88 per cent of diarrhoeal deaths are attributed to poor hygiene practices, unsafe drinking-water supplies and inadequate access to sanitation” (p. 47). However, the use of ashes is recognized as an appropriate hygiene procedure.

In interviews, sleeping problems among the children were mainly related to material and practical problems. Many orphanages did not provide beds, mattresses, covers, or mosquito nets. A few respondents were worried this would affect the children in school: “They are tired, hungry, they haven’t slept (…) and then they have to understand in school (…). It’s unfair”. However, some respondents did not see this as a problem: “If they don’t sleep enough (…) children can sleep during the day”.

Fatigue and apathy-like behaviors were also noted in field observations. For instance, it was common to observe young children sleeping through much of the day. Others simply laid on the ground without moving for hours. These behaviors could be interpreted as a consequence of poor sleeping facilities, although it is impossible to claim this with any certainty. Nevertheless, that fatigue is related to illnesses such as HIV/AIDS or that it might reflect emotional distress has been reported (Gilborn et al., 2006; Schmitz & Crystal, 2000).

Although clothing might not be considered a physiological need, respondents frequently related lack of clothes to lack of physical health. Children were said to be cold during winter nights and unable to keep cool under the scorching sun. Also, respondents retold that shoes prevented children from being attacked by ground living insects (e.g. flesh eating maggots). A few respondents also related clothing to psychological well-being as they claimed having clean and whole clothes could make an important difference in how the children felt about themselves. Many said that children only received one new garment every year (through donations or by inheriting clothes from other OVC in the orphanage).

In the orphanages, all children were observed wearing old clothes that most of the time seemed to be too large or too small. Some children had torn clothes and no shoes, although this was not true for every child in every orphanage. Children who had shoes and clothes that fit lived in orphanages that could provide better care all-round.

In the literature, clothes have been described as an essential service that should be provided to all children (Stover et al., 2006). Also, Zimmerman (2005) estimated that 80% of the 50 orphans interviewed in her study wore clothes that did not fit them, and that all of them had dirty and torn clothes.
Safety needs
Many respondents related safety to the immense lack of clear data on OVC. “Nobody knows for sure” was a common answer when respondents were asked about numbers, records, certain conditions, and definitions. For instance, a majority of respondents could not answer how many orphans there were in Maputo and others claimed the official figures were outdated: “I would say we have at least 2 million but I think [UNICEF] says 1.6”.

Also related to safety was the fact that the government has not defined what constitutes a child. As a result, nobody knew if the law would judge an individual as a child or an adult. In one interview, a respondent pointed out: “What good are child protection laws if nobody knows who they apply to?”. That neither “orphans” nor “vulnerable children” had been defined by an official institution was also said to cause confusion.

Further, respondents criticized the fact that most orphanages did not keep records of the children. Therefore there was little or no written information about when the children arrived, where they came from, when they were born, if they had any illnesses, had been vaccinated, if their parents were alive, etc. The explanation given by some respondents was cultural: “This is not a culture of papers and records and data and information that you can research and gather, (…) we live day-to-day and nothing changes if you were born one year or the other”.

Lack of clear definitions is reported from other sub-Saharan Africa, as the meaning of for instance “orphan” changes between countries (Beard, 2005). Also reported from Africa as well as other parts of the world, is the lack of systematic record keeping and its negative consequences. For instance, due to this lack many Ethiopian children who survived the famine in 1984-85 could not track their relatives that might have survived (Lothe & Heggen, 2003).

The safety net for OVC in Maputo.
Respondents stated that OVC in Maputo were often exposed to abuse, neglect, and other dangers. They related this exposure to a faulty safety net that was described as “fragile at best”. The result was a “very uncertain reality for everyone, (…) but the children are hit the hardest because they can’t create safety for themselves”.

Respondents claimed the safety net that was supposed to protect the children mainly consisted of kinship care, the community, and Social Services. However, none of them was seen as fulfilling their duties. As a result, children were exposed to abuse whether they lived in extended families, on the streets, or in orphanages.

Foster care or adoption by non-kin was so rare in Mozambique that respondents did not see it as a realistic or culturally viable alternative. It was also added that care by non-kin could in some communities be seen as “shameful” or “embarrassing”. It was because of this shame that many families decided to temporary place their children in orphanages, or leave them behind in the hospital without telling anyone.

One of the criticisms against the policies of Social Services was that they were primarily concerned with finding the OVCs extended families. A few respondents
disliked this because they believed the decision to do so was based on Social Services wanting to “put the responsibilities on someone else”. However, a majority of respondents saw this “reintegration” of OVC as both culturally appropriate and the best solution for everyone. The only concern was that Mozambique lacked a “control system (…) to protect the children. We can’t even ensure the safety of OVC in orphanages 2 km away, imagine with a family far, far away (…). It’s almost impossible”.

Also, many respondents criticized Social Services for not economically compensating foster families for school-related fees and other “critical expenses” such as food and medicine. They claimed this could place the children in a situation of danger as the families took out their anger on them. Many feared that this also forced OVC to leave school, enroll in child labor, or become child prostitutes in order to compensate the family.

That the safety net around OVC is weak has been reported in studies from many parts of the world (Akpalu, 2007; Browne & Hamilton-Giachritsis, 2004). It has also been written that it is not uncommon in sub-Saharan Africa to view foster care and adoption by non-kin as culturally inappropriate (Subbarao et al., 2001).

Further, that OVC are exposed to abuse while living on the streets, as well as under the care of extended families, are in line with the literature (Ansell & Young, 2004; UNICEF, 2005). Researchers agree that the financial and psychological burden of caring for the children might explain this abuse (Cluver & Gardner, 2007; UNICEF, 2007). Neglect is frequently reported from studies of OVC in the care of their grandparents. This has been related to elders not being able to provide discipline and socialization, and to forcing children to take on adult roles (Ansell & Young, 2004; Sengendo & Nambi, 1997). Neglect in orphanages due to lack of employees, scarce food, and medical care is also reflected in the literature (Browne & Hamilton-Giachritsis, 2004; Kreppner et al., 2007).

As mentioned, respondents claimed kinship care was part of the safety net for OVC. However, many mentioned that this type of fostering had begun to diminish after the civil war due to other conflicts, increasing poverty, and urbanization. These aspects made it difficult for families to stay together. A majority of respondents still agreed with the policy as it allowed for some aspects of the children’s lives to remain intact:

“The greatest drama is the change in the life of the child, it’s not enough they’ve lost their parents, that person of comfort, they end up losing everything, the possibility of going to school, (…) to have those clothes, to have a little money to have some fun with her friends (…) and that’s horrifying for them.”

It was believed that children needed to be close to the familiar, not to be uprooted, and to have emotional support: “(…) hopefully they can stay in their old neighborhood or city, have the same friends and stay in the same school, (…) this is where they’ll get a lot of support”.

That family ties are severed in countries impacted by financial, social, and political problems has been reported in the literature (Miller et al., 2006; Ansell & Young, 2004;
Milligan & Williams, 2001). It is also the common explanation as to why kinship care no longer can act as a social safety net for OVC (UNICEF, 2003; Kamali et al., 1996). However, kinship care is recognized as something positive that can enable children to stay within their community (ISS & UNICEF, 2004).

Interestingly, although most respondents were positive towards kinship care, they spoke briefly about the vantages and extensively about the problems associated with it. For instance, many believed children in kinship care were abused, neglected, or taken advantage of: “Between a child [living with] adoptive parents who will treat her like a maid, I prefer she stays in an institution”.

The few respondents who believed institutionalization represented a valid alternative for the city’s OVC were adamant about making clear that substantial changes had to be made: “I’m not for institutions, but I recognize the need for quality institutions with qualified staff and with means of subsistence to guarantee that children who need it can have an alternative”. Another comment made in favor of orphanages was that they were less difficult to oversee than kinship care families. As a result, improper and unacceptable conditions would be easier to discover: “(...) all institutions have to be under the direction of Social Services and the watchful eyes of civil society and they have to report abuse (...) this is not so for a family out in the ghetto.”

However, it was more common for respondents to speak of orphanages in negative terms. The main objection concerned orphanages being understaffed and overcrowded. Other frequently mentioned problems were financial in nature or the fact that they lacked proper security and showed little concern for the children’s emotional needs. That children had to spend much time alone was disliked and related to a lack of role models: “The children feel unsafe because (...) they don’t have a comforting reference (...) so they lose hope and they don’t trust in humanity making them bad citizen as adults”. A related problem concerned children spending too much time with others their own age. This was believed to stunt the children’s development in many ways; linguistically, cognitively, and emotionally.

That respondents supported kinship care but spent a lot of time discussing its limitations reflects the situation described in the literature where kinship care is considered problematic but still remains the preferred form of care (MMAS, n.d.; Nyambedha et al., 2003). Reports of financial stress among families who accept to foster OVC can explain why children were put to work in their new families (Bhargava & Bigombe, 2003; Sengendo & Nambi, 1997).

Corresponding with the literature are the respondents’ comments that orphanages should be considered a valid alternative (e.g. Aring, 2001; McKenzie, 1996; Wiener 1998; Zmora, 1994). Also in accordance is to insist that improvements have to be made if orphanages are to be employed (Sigal et al., 2003; Wolff & Fesseha, 1998; Zimmerman, 2005). However, that orphanages should be avoided where there are alternatives is more frequently reported in the literature (Ansell & Young, 2004; Bowlby, 1986). A common reason for this is the negative consequences of overcrowded and understaffed orphanages (Browne & Hamilton-Giachritsis, 2005; Vorria et al., 2006).
Structure and stability.
Respondents claimed most children now placed in institutions had been living under unstable circumstances before arriving to the orphanages. It was therefore believed that the discipline and order offered in orphanages could introduce a sense of safety into the children’s life: “With discipline comes stability, with stability comes predictability, and with predictability comes security and in some cases a feeling of belonging [and] of being a part of something”. Another respondent related discipline to caring: “It sounds almost… macabre, but being scolded for being bad at least means you are something and [that] someone cares, no? (…) ‘Somebody saw me’, that’s what it means”.

However, a few respondents believed strict discipline could have negative effects on the relationship between caregiver and child: “Some institution only focus on order and obedience so there is no room for interaction, for individuality, for personality”. A few respondents suggested that discipline should at times give way to compassion, as they believed everyone would benefit from it: “If a child feels like she is seen for being good and not always for having done something wrong she [will] feel more secure and (…) won’t cause much problem”.

It should be noted that some respondents strongly disagreed with the view of institutionalized life as ordered or stable. Instead, they described it as “unpredictable” and “very erratic”. One reason for this was the constant rotation and movement of both employees and children. Employees relocated, became ill, and left the country in search for a better life elsewhere. Children ran away, were adopted or retrieved by their families, became ill or passed away. The result was that bonds formed in the orphanages were constantly being broken up: “You can only imagine how difficult it must be for a child to first lose everything, then gain a friend, lose her, gain another, lose her, and so on.” The behaviors that followed the repeated loss of loved ones was also described:

“Children who are left behind (…) first they cry endlessly and have nightmares and they just sit and stare but then after a while (…) if this happens to them all the time, they seem like they don’t care about anything anymore. It’s almost like… they’ve given up”.

During field observations, both strict and lax employees were observed. In the first case, employees seemed almost authoritarian and the few needs that could be met, were met according to a schedule. This meant that if children were thirsty, they had to wait until a certain hour for a drink of water, if they were dirty they had to wait until it was time to clean up, etc. In contrast, a few orphanages appeared so relaxed they appeared almost careless or negligent. Children were seen coming and going at will, sleeping where they wanted, fighting and hurting each other without any reaction from the staff.

Mealtimes were observed in strict and lax orphanages and both appeared to have positive and negative aspects: in the lax orphanage children were seen singing and happily dancing about before being served. However, when the food arrived, chaos ensued and many children were left without food. In the stricter orphanage, everyone was served roughly the same portion. However, there was no singing, dancing, or laughing, and although this could be explained in several ways, the glum mood was tangible.
Maslow (1943) wrote that children need “something that can be counted upon, not only for the present but also far into the future” (p. 377). This appeared non-existent for the OVC of Maputo. Further, the unpredictability of children’s lives prior to being placed in orphanages can be understood in relation to the disappearance of kinship care (ISS & UNICEF, 2004). As no solid alternative to kinship care is offered, children are forced to move in search for a better solution. That children respond negatively to multiple placements is supported by the literature (Rutter & Taylor, 2002).

Discipline as something that can become overly authoritarian or punitive and result in negatively impacting the children has been reported (see e.g. Boris & Zeanah, 2004; Dubowitz et al., 2005). However, discipline should not be interpreted as something solely bad, in fact researchers recommend an authoritative and clear figure in the lives of the children (Wolff & Fesseha, 2005). Also, certain forms of discipline have been described as positive because they teach the children good care and healthy practices (UNAIDS et al., 2004).

**Love needs**

Respondents viewed the desire to relate to others and to belong as innate: “Children must first be loved in order to learn how to love, if not this dies and so does the soul”. However, respondents feared that many children who had lost their families or spent many years in institutions would lose this yearning: “Wanting to love can of course be lost by (…) actually not having someone left to love”. The desire to love was also discussed in relation to attachment difficulties. One respondent explained this as the children wanting “to be close and then far away, and then close, and then far away, and then want hugs and kisses and then you can’t touch them”. Others described that some children could not form strong bonds with adults, had poor relationships to their peers, and that they avoided to look others in the eye.

A majority of respondents believed these difficulties were the result of having lost the primary caregiver. Although a few claimed the difficulties stemmed only from the child not having anyone to attach to. In other words, if a child had several caregivers (e.g. maybe five or ten) it was deemed as positive.

One-on-one time between institutionalized children and employees was described as “limited” or non-existent. This was chiefly explained in financial terms: “We don’t have money to hire (…) so both parties suffer, the children are lonely and the staff is stressed out”. However, a few respondents believed that one-on-one time would remain limited even if the number of employees was increased: “it’s not only about time, it’s about culture and habits, (…) it’s not common to ‘hang out with the kids’ here”.

During field observations it was noted that the child-to-staff ratio was always high. It was also observed that employees worked, cooked, rested, or socialized with other staff members and not the children. If and when they interacted with the children it was because special attention was required (e.g. splitting up a fight, asking children to obey a rule, etc). Apart from potentially being a cultural expression, this could be related to

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19 Some respondents used the word attachment, others described behavioral patterns commonly attributed to attachment difficulties.
institutions being overcrowded and understaffed: if employees feel overwhelmed and powerless, they might choose to ignore the children instead of fighting a losing battle (Sengendo & Nambi, 1997).

The respondents’ view on love as something innate (Maslow, 1999; Schore, 2001b), and of attachment as an affectional connection between child and adult has been echoed in the literature (Bowlby, 1969; Sperling & Berman, 1994). Attachment difficulties similar to the above described have been observed in orphanages around the world (Rutter & Taylor, 2002; Vorria et al., 2006). Most often, these difficulties are related to children not having access to primary caregivers (Bowlby, 1951; Zeanah et al., 2005, 2006). However, the literature does not reflect the respondents’ view that children can thrive from having more than a few caregivers (Ansell & Young, 2004; Bowlby, 1986).

**RAD of the inhibited and disinhibited subtype.**
Although RAD was not mentioned by name or as a diagnosis; it was common for respondents to discuss features related to the disorder. For example, comments were made about OVC lacking trust in people or being too trusting: “There are always children (…) who will trust everything and everyone in every situation (…) so they leave [the orphanage] with anyone that promises them anything”.

Additionally, some children’s relationships to others were seen as “completely random” or capricious: “[children] love anyone, leave with anyone, relate to anyone, and (…) say lovely things to anyone and it can be so inappropriate”. Many respondents also worried that these behaviors might put the children at risk of abuse: “They are easy to lure (…) and they are easy targets to be taken and sold for prostitution”. In contrast, respondents described how other children did not answer when spoken to, how they rebuffed any initiative to play, and how they did not wave back when someone waved hello. Some respondents saw these as autistic-like behaviors: “(…) emotionally they’re simply not there, no emotions, blank stare, uninterested children, even when you try with things most children like, (…) like a toy.”

Respondents also commented on children who no longer cried: “They do not cry (…) at all, under any circumstance, they fall, they bleed, they are lonely, they are wet, they are thirsty, they are hungry, it doesn’t matter, they will not cry”. Many respondents believed children had “unlearned” or forgotten how to communicate using cries: “They used to cry, (…) at least when they were born, but now they know it won’t make a difference if they cry or don’t cry (…) so they just don’t cry”.

The opposite, children crying inconsolably, was also mentioned in interviews: “You can hear them cry but you can’t do anything because there is nothing they want from you. It makes you feel like you, (…) well actually that the human race is the problem”. Respondents described situations of trying to console children for hours without effect: “Even when the other children [in the orphanage] try they still don’t stop”. One respondent explained their behavior with crying being contagious: “This is how they’ve always been, one starts in the morning (…) then they all start, and then there’s no stopping, it’s almost contagious”. Other respondents portrayed the cries as “intolerable”, “so, so very sad”, or “sickening”.
During field observations children were observed crying and sobbing for hours, sometimes only stopping when they fell asleep. On one specific field observation, almost all children in the orphanage sobbed from when the visit began until it ended (in total, over four hours). The children in this orphanage were mostly infants and they appeared to do everything while crying or moaning; play with each other, wave hello and goodbye, drink and eat etc. In contrast, in a different orphanage, no children were heard crying at any time even though the visit lasted for over 12 hours and included events that would make most children cry. For instance, children were observed scraping their knees and older children were seen stealing objects from younger without them crying.

Symptoms of disinhibited RAD were often observed during field observations. For instance, when arriving to orphanages, children would commonly grab my arm and ask questions like “Are we going to be a family?” and say “I love you, I love you”, or “We can leave now, because you are my mother so it is ok”. This showed an utter lack of wariness of strangers and indicated that the child could superficially accept anyone as his or her caregiver. Children were also observed behaving carelessly, ignoring rules and limitations supposed to keep them safe. On one occasion, a child ran after me through the gates and onto the streets. He stopped a car and gave the driver a wide captivating smile. Afterwards, he asked if he and his mother (pointing at me) could get a ride to the city.

Children suffering from inhibited RAD have been described in the literature as not responding accordingly to social interactions, mainly because they do not understand the intention of social cues (Zeanah & Fox, 2004). Also, these children do not consistently accept or want to be consoled; in fact they are described as potentially “fearful of seeking comfort despite observable distress” (Boris & Zeanah, 2004, p. 8).

Not using cries as a response is another feature commonly ascribed to RAD (Dulcan, Martini, & Lake, 2003). Crenshaw and Garbarino (2007), who have written about children’s anger, claim the disuse of crying is common among those who have experienced repeated disruptions in attachment relationships. Instead of cries, “the kids disconnect from their affect and become like little robots. Emotional expression of all kinds becomes blunted” (p. 161). As a result, the children are said to have learned that “it does no good to cry (…). They don’t want to feel anything because it hurts too much” (p. 161).

Many of the features mentioned in interviews or noted in field observations have been reported in studies as integral parts of disinhibited RAD. Examples include trust issues (Rutter & Taylor, 2002), indiscriminately friendly behaviors (Boris & Zeanah, 1999; Chisholm, 1998), need for adult attention (O’Connor & Zeanah, 2003; Zeanah & Fox, 2004), and unsafe behaviors (Zeanah et al., 2004). Socially promiscuous behaviors are also a part of the disorder (Wilson, 2001), indicating that the conducts might indeed result in children being ensnared in prostitution.

**Symptoms of traumatic stress.**

PTSD was mentioned in almost all interviews although none of the respondents claimed the diagnosis had ever been set by professionals: “The children in the orphanages aren’t
tested at any point except for medical reasons, (...) and even then the tests are few and far between”. Most respondents spoke of PTSD as a general ailment most if not all children suffered from, some even going so far as to claim it was “(...) as common as malaria”. Below, findings related to traumatic stress are organized using Gaensbauer and Siegel (1995) model.

The direct impact of the trauma itself. Respondents’ accounts of children having nightmares that more often than not contained images from their lives before arriving to the orphanages can be interpreted as examples of reexperiencing. Increased arousal might be indicated by reported sleeping problems (e.g. not sleeping through the night, not being able to fall asleep, waking up too early etc). However, it is impossible to discern if these problems are due to traumatic experiences, starvation, lack of proper resting places, or a combination of the above. Repetitive play was only mentioned in a few interviews and described as “forced” and “unimaginative”. However, respondents believed trauma had impacted some of the children in a way that took their desire to play away: “They have lost everything so now they are in charge of their own survival (...). Play becomes tainted (...) and maybe reminds them of how it use to be when it was ok and that’s painful”.

Avoidance was mentioned by almost all respondents and was often related to trauma: “A child that has lost a mother, can she love again? Maybe not in the same way, (...) she is now afraid of loss so she might say ‘No thank you’ to love”. Avoidance was also seen as the explanation to why children were unwilling to speak of their misfortunes.

As per the DSM-IV-TR (APA, 2000), reexperiencing, avoidance, and increased arousal correspond to the criterions B, C, and D of the PTSD-diagnosis. As stated in said manual repetitive play, recurrent dreams of the event, as well as efforts to avoid conversations about it, are specific responses of children who have been through a traumatic event. Repetitive play has also been reported in studies; Findling and colleagues (2003) state that “Post-traumatic play is (...) compulsive, repetitive, literal (lacking as-if quality), and insufficient for reducing anxiety” (p. 11). Avoidance in the shape of not wanting to talk about their misfortunes has been found in studies from other parts of Africa (Makame et al., 2002) and the world (Zhao et al., 2007).

It should be noted that PTSD “ is by no means an invariable consequence” to trauma (Glaser, 2000, p. 106). Nevertheless, most of the above retold symptoms appear to fit the PTSD-diagnosis (APA, 2000). Also, PTSD has been reported in maltreated, chronically abused, or neglected children (Solomon & George, 1999).

Associated emotional reactions. A majority of respondents did not comment on specific emotional reactions during interviews. However, it was mentioned that children felt guilt or remorse for things they did not control: “They blame themselves for the death of [their] parents (...).They all think it’s their fault, that they’re evil (...) or that their parents did not love them and this is why they were abandoned”.

This guilt and groundless responsibility for the downfall of their family unit has been found in other studies (Cluver & Gardner, 2007; Gilborn et al., 2006). That few respondents mentioned emotions in relation to trauma can be explained in cultural
terms. For instance, one respondent claimed that generation upon generation of Mozambicans had been forced to put their feelings aside for the sake of survival.

**Effects on concurrent developments tasks.** A few of the experiences that were retold by respondents (such as the above mentioned attachment difficulties or sleeping disorders), can be seen as expressions of how children’s development is halted by traumatic experiences. However, only one of the respondents explicitly related trauma to impede children’s development: “Sadness and (…) tragedy can make children stop growing in a way (…), their thinking, how they talk and feel (…) is the exact same as when they were little and something happened”.

**Effects on future developments.** According to respondents traumatic experiences such as neglect, abuse, or the repeated loss of caregivers affected the children’s education: “When bad things happen and children are traumatized, they will not go to school (…) so they miss out on life, (…) it’s like they lost the game before they even start to play”. The severe effects of trauma on children’s schooling has been described in the literature (Bicego et al., 2003; Mishra et al., 2007; Rutter & Taylor, 2002).

**Effects on social interactions.** Almost all respondents discussed social difficulties in interviews. The majority of these problems concerned children acting out: getting into fights, quarrelling in school, being impulsive, or unable to “be even tempered”. It was also common for respondents to relate trauma to children isolating themselves from others and prefer not to interact.

HIV/AIDS or TBC-infected children were said to be stigmatized to such an extent that social relations were either severed or severely affected. However, it was more common for respondents to claim that children were bullied and shamed (especially in school) solely based on the fact that they were OVC and lived in an orphanage. The children whose parents had left them in the orphanages temporarily were also teased as it was deemed “embarrassing to be left behind like there is something wrong with you, (…) like you’re stupid or evil”. However, these children were described as having more status within the orphanage because there was a chance their parents might come back for them someday: “This upgrades them from the average orphan who has no chance”.

Disturbed social interactions and peer problems are common findings in studies of institutionalized children (Cluver & Gardner, 2006, 2007; Tarullo et al., 2007). It has also been reported that children who have been traumatized or suffered repeated losses take to violence instead of other means of expressing their sorrow (Crenshaw & Mordock, 2005; Rutter & Taylor, 2002).

That OVC tend to isolate themselves and avoid to interact with others is supported by other studies; for instance in South Africa by Cluver and Gardner (2006) and in China by Zhao et al. (2007). Further, there are numerous studies retelling how children affected by HIV/AIDS are severely stigmatized in their community (e.g. Atwine et al., 2005; Cluver & Gardner, 2006, 2007; Jacob et al., 2004). Also common are studies of how children are mistreated for being orphans (Roby & Eddleman, 2005; Subbarao et al., 2001; Zhao et al., 2007).
Esteem needs

In interviews, education was frequently linked to self-esteem as respondents believed it had a transcendent value: “I always say you can see in a child if he goes to school not because he speaks smart to you, no, it’s because he has sunshine in his eyes (...) because he knows he feels good about who he is”. For this reason, respondents wished foreign aid would be invested in the building of schools, paying for school-related costs, and the formation of teachers: “In school children will receive (...) a belief in themselves that no one can take away and it’s also about inspiration, the educated child will inspire the uneducated child”.

It was difficult to establish through interviews how many institutionalized OVC were in fact receiving education because it appeared to vary immensely between institutions. However, it seemed that children who lived in orphanages situated close to public schools were commonly sent there. Also, foreign-owned orphanages with better financial means appeared almost by default to provide on-site education.

Not all respondents subscribed to education as the ideal solution for institutionalized OVC: “I think we’re too early on to think we can solve problems with education (...) [institutionalized] children will never become leaders or doctors”. It was believed that as a consequence of poverty or illnesses in their families, children were in some ways damaged when they arrived to the orphanages. This had resulted in children losing the habit of attending school (or they might never have had the chance to go). For these reasons, many respondents claimed the children’s choices in terms of education or professions were limited: “I grew up [in this orphanage], and I’m happy, but I could never be a doctor”. Instead, these respondents suggested that children should be taught practical skills. However, these were also related to self-esteem: “The children are so happy when they know they can make something, that they can say ‘I did that’ or ‘I am a gardener’ (...) because they know now that they will survive”.

Education was further linked to self-esteem as respondents discussed if children should be taught within or outside the premises of the orphanages. The advantages of attending school on-site were related to improved attendance given that no fees had to be paid for transportation, uniforms, or other school-related costs. However, a negative aspect of on-site education was related to orphanages not being run by locals:

“Orphanages owned by foreigners have foreign rules and teach other values (...). Just by living there the children learn other values (...) so I believe it would be good to go to school with normal children so they learn that being they are Mozambican and this is something good”.

It was believed that if the children were sent to public schools they would enjoy and get to know children in their community and preserve their cultural heritage on a day-to-day basis. By joining non-orphan children their status as OVC, as “other”, and as “different”, could be normalized and result in improved self-esteem:

“OVC are always stuck together, like they are all the same and they are different to everybody in a bad way. (...) so I say, send them to the same school so they can [feel] they are like the others in a good way”.
Among the respondents there were those who believed that sending the children to public schools might affect their self-esteem negatively. This was mainly due to OVC being teased because they were “different in a bad way”.

Also, as a result of the poor care provided by orphanages, children suffered from illnesses, concentration difficulties, and fatigue that results in general problems in school: “[Institutionalized OVC] go to school and they suffer because they can’t keep up (…) with the others so they feel bad about themselves”.

Field observations regarding children’s education revealed that a majority received some kind of education; either through school (public or on-site), by learning a trade, or through learning how to make objects such as brooms. In some orphanages, especially those with lax discipline, children were not observed engaging in activities related to studies or education. On occasions, as some children were observed leaving the orphanages to attend school, many other children stayed behind. The reason for this was not perceived.

That children were seen as arriving “damaged” to the orphanages can be supported by reports that negative effects of orphanhood begin before the children are actually orphaned (De Wagt & Connolly, 2005; Salaam, 2004). Many studies have found symptoms of fatigue and problems concentrating among OVC (Lothe & Heggen, 2003). According to Sengendo and Nambi (1997), orphans in Uganda “who are frustrated, fearful, and depressed may fail to concentrate in class and therefore perform badly. Failure by the school and the home systems to recognize these symptoms and address them will aggravate the child’s psychological problems” (p. 107). Problems with remaining in school have also been described as difficult for OVC (De Wagt & Connolly, 2005; Salaam, 2004). However, studies did not report if on-site education would resolve the issue.

The positive effects of integrating OVC with children in public schools have been described in other sub-Saharan African countries (Zimmerman, 2005). Also, Akpalu (2007) who studied OVC in Ghana wrote that attending “schools in the neighbourhood (…) gives them the opportunity to interact with other children” (p. 1074). However, negative aspects such as being bullied were reported from Mozambique by Manuel (2002). In the above referred study by Zimmerman (2005), a child was quoted poignantly describing how her unfitting dress became the target of ridicule in class and caused her to be distracted. Bullying can also be understood as a consequence of OVC lacking social support (UNICEF, 2007).

Self-esteem through play. In interviews, some respondents related self-esteem to play. They believed play could develop the children’s sense of self in a positive direction: “It is simple really, if they are good at something, like running fast (…) that makes them proud so they feel better about who they are”. However, most respondents claimed that institutionalized OVC did not have enough opportunities to play as they were in charge of their own survival: “It’s either work or school or they have nothing so… unless it’s almost accidental they get few chances to play”. Many claimed this had to do with poverty as it forced children to grow up too fast and take on adult roles. As reported
above, trauma was also mentioned as something that could affect the children’s will to play.

Few organized ludic activities were noted during field observations, something that gave the impression that recreation was not a priority in orphanages. Nevertheless, children did play but had to organize everything themselves. They were also seen amusing themselves by making cell phones, watches, and other “desirable” objects out of palm tree leaves and scraps of metal. In many orphanages children would play football with flat balls.

In their work with traumatized, angry, and violent teens, Crenshaw and Garbarino (2007) explain that lack of play can be related to children having to focus on survival and hence, aren’t allowed to dream and fantasize. The authors believe that when children are repeatedly let down they protect themselves from future disappointments by adopting “a survival orientation that keeps them focused on simply remaining alive for another day” (p. 161). Based on this, the extinction of play among institutionalized OVC can be understood as a consequence of having to focus on survival instead of developing their imagination through play.

**Self-esteem through birth registration.** According to respondents, most Mozambican children from lower social classes are not registered at birth. This was also true for institutionalized OVC, although respondents added: “Children in institutions are already stigmatized (…) and not being registered when you are born… it’s just another insult (…). It means they are alone and also unknown”. In addition, OVC without official papers have less chances of finding their extended families as Social Services will not have anything to go on: “Maybe there is someone waiting for them but nobody know for sure (…). Instead, they spend their lives in an institution for no reason”.

Respondents also related lack of birth registration to self-esteem while discussing how OVC were discriminated against. When discriminated against, children were said to feel they were worth less than others. A respondent claimed: “Not knowing when or where they were born, (…) where they have extended family (…), who their parents were (…) it does nothing for their sense of self”. This was related to how difficult it was to implement child protection laws: “If we don’t even know they are born (…) how will we protect them?”. Other respondents pointed out that children could be abused and forced into marriage at a young age since nobody knew (or could prove) their age.

Low birth registration rates have been found across sub-Saharan countries (UNICEF, 2006, 2007). This despite the fact that being registered is included in the *Convention on the Rights of the Child* (UNICEF, n.d.). When UNICEF (2007) presented indicators of birth registration in developing countries, Mozambique could not provide data. However an estimated average for sub-Saharan Africa is 34% (p. 22).

**Self-actualization**

This is the highest level of the hierarchy of needs model. An orphaned child or one who is vulnerable, neglected, hungry, or ill might not be motivated “to become actualized in

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20 Numbers indicate total percentage of rural and urban children <5 years of age who had been registered at birth.
what he is potentially” (Maslow, 1943, p. 382). However, the following concepts used by Maslow can be related to topics discussed in the interviews:

**Meaningfulness.** Children wanting to make sense of their world (e.g. through play or education) and searching for their identities (by finding their families or being officially registered) can be understood as a search for meaningfulness.

**The desire to know and understand.** Respondents retold how children dreamt of and desperately wanted to attend school. Some of the children were said to view school “(…) almost like a luxury, a thirst that all children have to learn”.

**Creativity.** Maslow wrote that certain individuals have an innate creativity that did not stem from a need to be self-actualizing. Instead, they were creative *in spite* of not having fully satisfied their basic needs. This kind of creativity was observed in the orphanages as children solved problems in the face of adversity. For instance, it was observed that children had come up with a new set of specially designed football rules as the commonly known ones were not applicable while playing with a flat ball.

**Changes for a better future**

To summarize the content of the interviews, the respondents who believed in kinship care acknowledged that there were problems with the system, but maintained that these could be solved without resorting to placing children in orphanages. To combat the problems, the implementation of common practices was suggested. Respondents believed the money needed to develop and implement such practices could be supplied through international aid. However, they also claimed the efforts guiding the allocation of the funds were culturally insensitive and as a result, most of the money was wasted: “The money is tagged, it’s supposed to do this or do that (…) so if the recipients disagree or don’t believe in the solution, the money goes to waste”.

Almost all respondents believed that the future for OVC laid in leaving the orphanages as soon as possible and being reunited with their (extended) families. The respondents who were more positive towards orphanages emphasized that substantial changes had to be made inside orphanages. Most wanted to improve nutrition and health for institutionalized OVC as well as increase the amount of educated employees. According to respondents, the biggest hurdles preventing this from happening were *financial* (being a developing country), *cultural* (orphanages are not widely accepted), and *political* (the government does not want to, or cannot, take on long-term responsibility for OVC). To combat these hurdles, information campaigns about the needs of OVC were suggested.

Almost all respondents proposed funds should be put towards education. This was seen as a key element in the future improvement of the children’s lives: “Nothing is more important than to be enabled, encouraged, and supported to attend school (…) getting a diploma (…) that has to be their future”. In order for education to be more accessible for institutionalized OVC, respondents believed school-related costs should be waivered and adoptive families duly compensated.
The million dollar question

Finally the respondents were asked what they would do for the children if they were given a million dollars and the freedom to use the money as they saw fit. Almost all respondents suggested long-term and empowering solutions, especially in education for all. Below, eight quotes have been selected to illustrate the findings. The first ones exemplify the importance of education:

“How to do it (…) how to care (…) even us as parents, many times we don’t know what to do, so good parenting skills is the answer. Many of the caregivers they want to care but they don’t know how”.

“I would teach parents or caregivers… not only skills but (…) alternative ways to provide care, and yes sometimes it’s the extended family but sometimes it has to be the institutions”.

The following suggestions indirectly criticize the way financial aid is being used, primarily because interventions are seen as culturally unfit:

“I would not give just to give there are so many programs and they say ‘I will give you money, I will give you a shirt’ (…), it never works because when the money people leave the poor sit and wait for them to come back so they can ask for more (…). You have to give in order for the people to – from that moment on – give themselves and their community.”

“My action would be based on an informed decision. There are programs left and right that want to teach children a profession like (…) hairdressing but they forget to analyze who can do it! It’s not for everyone! A child with a broken arm, or no arm, or [who] has been burnt (…) she can’t become a hairdresser!”

“My million would go to mental chronic diseases, mental handicaps, that’s a chronic problem and parents all over the world need help but here the situation is desperate. Everybody focuses on other diseases and mentally retarded children are easily forgotten (…) and they need special care but the parents have to work so these children are thrown away and they need somewhere to go”.

“I would start by reminding everyone that we are capable, especially in Maputo some children grow up believing they aren’t capable because they are given things. They beg on the streets and they are given a coin, someday a shoe, the next year an old t-shirt, so they become piggy banks. Everything is borrowed and nothing is truly ours. I would have a program that would say ‘You are capable’ and then wonderful things would happen.”

The following respondent offered a community-based solution:

“I would ask (…) the women I could find that are of trust in the neighborhood and who want to look for work, go to the market, do all these things like any mother, ‘What can you do to subsidize these children?’ and they would say “I would like to sell at the market”, ok, so how much do you need? “I want 10 000”, so I would
say “Ok, here, but you will never get to ask again, and I want to see those children’s belly’s full”.

Methodological discussion

Two assumptions that governed the methodology of the study were:

- **Qualitative research is the result of interpretation.** The data for this study has been filtered through the author’s interpretation of both the respondent's perceptions (expressed in the interviews), and of things observed (in field observations).

- **Research should be a reflexive process.** Throughout the entire process, it was important to continuously reflect about intentions, interpretations, and viewpoints. Left unexamined, these could threaten to distort the results and deduct from their value. This could also be said in regards to emotions; researching in countries where children face many hardships can give rise to potentially confusing sentiments. Kleinman and Copp (1993) have written that field researchers “share a culture dominated by the ideology of professionalism or, more specifically, the ideology of science. According to that ideology, emotions are suspect” (Kleinman & Copp, 1993, p. 2). The study at hand does not support the contention that emotions are suspect, nor does it aim at researching without feelings. However, a reflexive stance was deemed necessary in order to make emotions and other potentially confusing elements explicit. In doing so, negative effects are believed to be mitigated.

The decision to use respondents from two different groups of professionals helped construct a global view of OVC in Maputo. On the one hand, employees in orphanages gave insightful and close descriptions of day-to-day life in the orphanages. On the other hand, NGO staff offered a more concise but general description of the problems facing institutionalized OVC. One of the difficulties with the inclusion of both groups concerned educational level. This affected which topics could be discussed as both groups had to be able to relate to the questions. If topics were too theoretical (e.g. too many psychological terms) respondents who lacked further education about a certain subject would not be able to relate. If topics were too general, the psychological focus of the study would be lost.

Even though the combination of field observations with interviews was deemed successful, two limitations were noted: a. The interviews might have influenced the observations and vice versa. In an attempt to limit negative consequences related to this, interviews and observations were conducted in random order. However, each new observation was not made in isolation from the previous ones, meaning for instance that the last observation might have been influenced by the preceding ones. b. Observations were not age-specific. This means they can have focused on salient behaviors and failed to observe both age-specific as well as less apparent behaviors. Although it is recognized herein that children’s needs change over time, the observations are regarded valuable as a complement to the interviews.
Ethical concerns discovered during the research period related mainly to the social and political status of the contact in field. Without her, it is possible that access to certain areas of interest would have been denied. At the same time, her status might have caused respondents to feel obligated to participate, perhaps not wanting to disappoint or let down the contact in field. In order to minimize this risk, potential respondents were contacted personally and voluntary aspects of participating were repeatedly emphasized.

It is important to note though, that the very same discussion about informed consent, anonymity, and confidentiality sometimes caused respondents to grow weary and even suspicions of the study. This is probably due to the concepts having other connotations in Maputo than elsewhere. Whenever this happened, it helped to momentarily sidestep the interview guide and discuss more personal matters (such as the author’s background, how the idea for the study came about, etc).

Culturally, conducting research in another culture is a complex endeavor containing many challenges. The culture of the host country needs to be properly understood or the study field will exist in a vacuity of context. The fact that this is a difficult and time-consuming task, might explain why culture more often than not is demoted “to an irritating ‘noise’ variable” (Tomlinson et al., 2006b, p. 529). To combat this, four strategies were created and applied: time in the field (made it possible to accommodate for the unexpected), academics (local scholars helped to explain historical events), personal past (facilitated acclimatization), contacts (provided general and cultural information).

A culturally related matter is the concept of parachute research. This involves investigators from developed countries travelling to a developing country for a short period of time with the sole purpose of collecting samples, returning home, and publishing a paper (Costello & Zumla, 2000; Harris, 2004; Tomlinson et al., 2006b). In this type of endeavor, knowledge or insight is rarely gained by the citizens or the local academic community. In fact, some may never see the finished work nor be able to understand it due to language barriers.

This study can in many ways be accused of such a calamity as it involves a researcher from a developed nation spending a few months in a less developed one in order to collect data for a study that would be presented elsewhere. As mentioned before, the solutions proposed by researchers are considered valid but out of reach for a study at this academic level. As a result, no solutions to the parachute-research problem can be offered herein, though it is believed that an awareness of the problem made for a more conscious approach. A related consequence was that an executive summary of the study (also in Portuguese) will be made available to any and all local parties that contributed, heard of, or showed interest in the study.

Finally, it has been suggested that standards of reliability and generalizability are more important in quantitative studies than in qualitative ones (Creswell, 2003). However, researchers such as Goetz and LeCompte (1994) have suggested that both validity and
reliability can be measured in ethnographic studies. This can be achieved for instance through triangulation\(^{21}\) or by comparing an original study with its replica.

Validity is regarded by most experts as the strong side of qualitative research (Anastas, 1999; Creswell, 2003). This is related to validity being strengthened by certain core aspects of qualitative studies, e.g. intimate contact with subjects during longer periods of time, observations made in everyday situations that allow repeated and general (as opposed to singular and specific) observations of the same phenomena, etc.

In order to increase validity, Goetz and LeCompte (1994) propose the use of “disciplined subjectivity” (p. 221). This refers to the researcher making clear all phases of the research process, and to the constant questioning of all decisions and interpretations made. This is supported by Creswell (2003) who suggests increased validity is obtained through systematic descriptions of circumstances. Also aiding validity according to Creswell is the clarification of the researcher’s potential bias and the presentation of information that do not necessarily support the themes.

Validity for the study at hand can be set to a reasonable level given that:

- An important amount of time was spent in the field.
- Observations were conducted in everyday situations and during many hours.
- Rich descriptions of data were given (e.g. through the usage of extensive quotes).
- Employing the method of triangulation.
- Making explicit methodological postulations as well as personal assumptions.
- Using logs and other techniques that enhanced self-reflection and thus often controlled for bias.

**Final discussion**

The purpose of the study was to contribute to an increased understanding of the psychological well-being among institutionalized children living in Maputo. Two aims were specified: to describe psychological difficulties common in the population and to explore physiological and social aspects believed to affect the children’s psychological well-being.

The interviews centered around three topics two of which were discussed in terms of physiological, safety, love, self-esteem, and self-actualization needs. The third topic, *The future*, resulted in a separate discussion about change and future opportunities.

*Physiological needs*. Comments on the status of children’s water, food, hygiene, sleep, and clothing conveyed a bleak image. These needs were either not satisfied, or satisfied through inadequate solutions (e.g. dirty water, spoiled food). The grim reality portrayed in interviews was reflected in many of the observations. However, it should be noted that orphanages with better finances (due to larger donations) could offer slightly better

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\(^{21}\) The approach of using more than one method to collect information.
circumstances (e.g. serve food three times a day). Nevertheless, how institutionalized OVC in Maputo are affected on a psychological level by nutritional and other physiological deficits have to be studied further.

Safety needs. Safety was related to lack of updated information, clear definitions, and well-kept records. This could for instance result in difficulties implementing child protection laws as there is no agreement on what constitutes a child, an orphan, who is vulnerable, how many OVC there are, etc (UNICEF, 2005). The lack of records affected children directly as some did not know where they came from, when they were born, who their parents were, etc. How this affects a child in psychological terms should be further studied.

The weaning of kinship care as the only line of defense between OVC and a dangerous existence was also discussed. Although the weakening of the system has been described in the literature for some time (Nyambedha et al., 2003; Roby & Shaw, 2008), change is coming slowly. The fact that few alternatives have been culturally and socially accepted as well as successfully implemented signals problems ahead. The lack of an official modus operandi for the care of OVC creates an uncertainty that is suffered primarily by the child (Roby & Eddleman, 2005). However, in the long run, society as a whole will suffer. It is unknown what will become of children who have to grow up without the protection of their family, community, and society. To understand this, longitudinal studies should be conducted.

Love needs. In essence, what respondents retold of the OVCs need to belong and be loved is no different than the needs of children elsewhere. However, respondents did not convey the notion that these needs were commonly satisfied in orphanages. Also, although the respondents expressed concerns for the OVCs psychological well-being, many appeared unfussed or too levelheaded about aspects of it (e.g. when discussing sleep deprivation, inconsolable crying, and PTSD). This might indicate that certain psychological problems have become so common that they have been normalized.

In field observations, children were noted isolating themselves while others were excessively eager to interact. How these behaviors relate to trauma and attachment is yet another area for future research. For instance, it was suggested in this study that disinhibited RAD can be related to child prostitution. If this is studied, programs and interventions can be specifically tailored to protect affected children.

Given that an extensive amount of symptoms were herein understood as related to RAD, it is important to repeat that the specific term was never used by respondents. Also, there are several alternative explanations to many of the cited behaviors. For instance, research has shown that the symptomatology of inhibited RAD is in many ways similar to that of autism or quasi-autism (Rutter et al., 1999). Also, Boris and Zeanah (1999) noted a “significant overlap between disinhibited behavior and inattention/impulsivity” (p. 6). Only further studies can clarify this overlap.

Additionally, it is recognized by this study that attachment difficulties among institutionalized children stem principally from the lack of primary caregivers at a very young age. In other words, the length of institutionalization as well as the age of the
child are two vital components in the development of RAD as well as other attachment difficulties (Zeanah, 1999). However, these circumstances could not be established for the children in the orphanages that formed part of this study. Further, the interviews focused on children in general and not on case-specific information, and can have contributed to prevent this information from being established.

That many psychological terms were used by respondents can be an indication that psychology is becoming increasingly important in the care of OVC. This might reflect that international NGOs have begun to include emotional, spiritual, as well as psychological elements into their social policy work (see for instance www.savethechildren.org/countries/africa/mozambique.html, www.redcross.org.mz, www.unicef.org/mozambique).

Self-actualization. It was problematic to find themes and comments that could be understood as expressing self-actualizing needs. This is most probably related to OVC having significant deficiencies in regards to all other needs. Nevertheless, points of convergence between the study’s findings and Maslow’s (1943) self-actualization construct were found.

Suggested interventions.
Despite important and disapproving forces against the concept of orphanages, and in spite of the aberrant conditions found in some of the visited institutions, this study concludes that orphanages are a valid alternative for OVC in Maputo.

Several findings support this contention. First, solutions are needed urgently; therefore it is better to use the infrastructure already in place instead of waiting for the Ministry of Health and Social Services to change their policies. Second, among the options available for OVC in Maputo today, orphanages are not the worse. Third, the problem in the city’s orphanages are not the institutions themselves but rather the quality of care that they provide. If more funds are allocated directly to institutions, instead of away from them, progress can be made. In order to improve conditions inside orphanages, the following interventions are suggested:

- **Increase education.** First, explaining and educating people who are affected by or who should implement the intervention is key. Second, both institutionalized OVC as well as their caregivers ought to receive education. Children must be supported and encouraged to attend school when one is available. The staff should receive education if they have none, even if only short courses can be arranged. Also, the great knowledge and many years of experience that employees have of OVC cannot be forgotten. Their comprehension and opinion ought to be requested and respected more often.

- **Increase individuality and autonomy:** Give OVC the right to express themselves as individuals through simple means. Examples include allowing them to adorn their beds, letting them put up drawings, write their names, make small objects – anything that expresses who they are and that they actually matter, have a value, and are not forgotten.
- **Increase the presence of adults.** More adults should be present in the lives of OVC. This does not necessarily mean educated professionals, alternatives do exist. For instance, programs could couple OVC with a “support family” outside the orphanage, or older citizens could be invited to come to the orphanages and interact with the children. Elders have generations of knowledge and wisdom that would benefit the OVC in the same way that they have historically served the community at large. However, care should be taken so that this does not lead to additional problems for OVC who already have too many caregivers.

- **More nurture, less discipline.** Although an authoritative style of care is deemed important, nurture should be equally relevant. Also, children must be included in activities and chores that concern them (see e.g. Wolff & Fesseha, 2005). This way, children will grow up in a more harmonious environment.

The following interventions are designed to specifically improve psychological well-being among institutionalized OVC:

- **Increase cooperation between NGOs and the government.** Without a political stamp of approval or local and foreign financial support, solutions will be complicated to implement. Zimmerman (2005) suggested that it was through cooperation between NGO and government that sustainable short and long term solutions could be integrated in the community. Common practices can be developed that will improve the scarcity of clear data and definitions. If NGOs in fact are placing more focus on psychological aspects of institutionalized life, know-how can be exchanged with relevant governmental branches with greater experience of local customs (UNICEF, n.d.).

- **Increase visibility.** The previously discussed cultural dislike of institutions can be turned into something positive if institutionalized OVC are made more visible in society. As areas in common increase, opportunities for the public to observe and report maltreatments to authorities are augmented.22 Similarly, if politicians are convinced that orphanages are the better option among the ones currently available for OVC, they can be encouraged to create overarching, monitoring, and protective instances under which orphanages are organized. Increased visibility could be achieved by properly including OVC in public schools through buddy programs or by building orphanages in the city instead of in remote, isolated areas.

- **Increase community-based programs.** These programs might constitute a middle ground between traditional kinship care (were the bulk of the responsibility befalls the family unit) and orphanages (were responsibility is dispersed and possibly lost among many). In these types of programs, the community has to come together and share the responsibilities. With external help provided by for instance NGOs (see e.g. UNICEF, 2007; UNICEF, n.d.), this could result in an improvement of the children’s today, as well as the country’s tomorrow.

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22 This was inspired by a quoted respondent who mentioned that a watchful civil society could aid in the protection of OVC by reporting to Social Services.
Even though the conclusion that orphanages are a valid alternative goes against what most researchers claim is a cultural value, the present study has shown that support might be changing in favor of orphanages. For instance, in a previously quoted study from Mozambique, a majority of dying mothers preferred to place their children in an orphanage rather than with kin (Roby & Eddleman, 2005). To resolutely ignore this while waiting for a perfect, culturally fit solution is immoral. Also, the search for such a solution does not exclude attempts to carry out the interventions presented above. If both directions are taken in parallel, the goal of improving children’s today as well as their tomorrow can be attained.

References


Appendix A

Interview Guide – Portuguese

1. INTRO.
Present myself, the study and its purpose. Approx. length of interview. Tell participants about anonymity, confidentiality, voluntary participation and that they can withdraw from the research at any time. The interview will be recorded with your permission and later destroyed. Offer a summary of the report.

2. Is there anything you'd like to ask me before we begin?
Taping begins.
3. Background of the respondent.
*Education – in what area and how long?
*Work – how long have you held this job position? Training for the job. Earlier experience.
4. Topics and Questions:

Topic 1: Historical/Social
-What can you tell me about the children's history? Where did they come from? How did they come to be where they are now? When did they arrive here?
-Ages? Sex? Are they urban or rural? Do they have siblings or not? Do they have any extended family? What is the role of this family?
-Is there any migration pattern that you have observed? (between rural and urban settings, from household to household, from institution 1 to institution 2, from the streets to institutions or v.v.)
-How do the children survive? What is the status of the children? What about practicalities such as water, food, shelter, medical services and education for these children?

Topic 2: Current psychological status of the children
-In your view, what are the children's primary psychological needs? Is there any room for psychological needs?
-Are you able to apply your knowledge about child psychology in your work?
-Can you tell me about the common psychological problems that the children suffer from? How are you able to observe these problems?
-What determines what kind of (psychological) help the children receive? Does HIV/AIDS or any other disease affect how and if interventions are implemented?
-Are there children (in this setting) that do better than others? If so, in what way? And to what do you attribute this?

Topic 3: The future
-What could be done? What would you like to see done? Why does it not happen?
-Biggest hurdles?
-Cultural aspects?
-What would you do for these children, if you had a million dollars?
5. Outro.
*Is there anything you would like to add?*
*Do you have any questions before we stop?*
*Thank you for your time and for taking part in the study. If I have additional questions, can I contact you again?
Appendix B

Interview Guide – Portuguese

1. INTRODUÇÃO
Se apresentar, apresentar a pesquisa e seu propósito. Informar a duração aproximada da entrevista. Avisar os participantes sobre anonimidade, confidencialidade e voluntariedade da participação e que podem se retirar da pesquisa a qualquer momento. A entrevista será gravada com sua permissão e posteriormente destruída. Mostrar um sumário do relatório.

2. Há alguma coisa que gostaria de perguntar antes de começarmos?
A gravação é iniciada.

3. Background do entrevistado.
*Educação – em que área e por quanto tempo?
*Trabalho – a quanto tempo ocupa esse cargo? Treinamento para o emprego. Experiências anteriores.

4. Tópicos e perguntas:

Tópico 1: Histórico/Social
-O que pode me dizer sobre a história da criança? De onde eles vêm? Como vieram chegar aonde estão? Quando chegaram aqui?
-Idades? Sexo? São de origem urbana ou rural? Têm irmãos ou irmãs? Eles tem mais algum familiar? Que papel essa família desempenha?
-Existe algum padrão de migração a ser observado? (entre contextos urbanos e rurais, de família em família, de instituição 1 para instituição 2, das ruas para instituições ou vv.)
-Como as crianças sobrevivem? Qual é o status das crianças? E quanto praticalidades tais como água, comida, abrigo, serviços médicos e educação para as crianças?

Tópico 2: Status atual psicológico da criança
-Do seu ponto de vista, quais são as necessidades psicológicas primárias da criança? Existe algum espaço para necessidades psicológicas?
-Você é capaz de aplicar seu conhecimento sobre psicologia infantil no seu trabalho?
-Pode me contar sobre problemas psicológicos comuns dos quais as crianças sofrem? Como esses problemas são observados?
-O que determina que tipo de tratamento (psicológico) as crianças recebem? HIV/AIDS ou alguma outra doença afeta como ou se intervenções são feitas?
-Algumas crianças (neste contexto) se desenvolvem melhor que outras? Em caso positivo, de que maneira? E a que você atribui isso?

Tópico 3: O futuro
-O que poderia ser feito? O que você gostaria de ver feito? Porquê isso não acontece?
-Maiores obstáculos?
- Aspectos culturais?
- O que você faria por essas crianças se tivesse um milhão de dólares?

5. Outro.
* Gostaria de acrescentar mais alguma coisa?
* Você tem mais alguma pergunta antes de terminarmos?
* Obrigado por seu tempo e por participar pelo estudo. Se eu tiver mais perguntas posso te contactar novamente?
## Appendix C

### Abbreviations and Acronyms

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
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<tr>
<td>NPDC</td>
<td>National Authority for the Protection of Child’s Rights</td>
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<tr>
<td>BEIP</td>
<td>Bucharest Early Intervention Project</td>
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<tr>
<td>DSM-IV-TR</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revised</td>
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<tr>
<td>ERA</td>
<td>English and Romanian Adoptees</td>
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<td>INE</td>
<td>National Institute of Statistics</td>
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<tr>
<td>ISS</td>
<td>International Social Service</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>Sida</td>
<td>Swedish Agency for International Development Cooperation</td>
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<tr>
<td>UEM</td>
<td>Universidade Eduardo Mondlane</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNSD</td>
<td>United Nations Statistics Division</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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