An Integrated Quality Framework for Community-Based Programming for Orphans and Vulnerable Children

Florence Eribenne[1*], Opeyemi Anna Kolawole[2], Ayo Amen Ediae[3], Esther Sydney[4], Rosalyn Ezeako[5]

[1]Bay Cove Human Services, Boston, MA, USA
[2]Independent Researcher, Lagos, Nigeria
[3]Independent Researcher, Edo State, Nigeria
[4]Independent Researcher, Ontario, Canada
[5]University of Central Missouri, Warrensburg, MO, USA

Abstract

Programs for orphans and vulnerable children (OVC) typically operate across health, education, economic strengthening, psychosocial support, and child protection, yet fragmented delivery and output-focused reporting often obscure whether children actually become safer and better supported. This paper uses thematic synthesis to review the OVC programming evidence base and develops a quality framework built around seven pillars, safety, family strengthening, case management, continuity, participation, equity, and accountable data use, each judged against quality dimensions spanning safety, effectiveness, timeliness, and accountability. The framework moves away from orphan status alone as a basis for targeting and instead proposes individualized assessment within a two-level model pairing community mapping with case-level decision-making. It sets out a tiered assessment and response model, safeguarding controls suited to volunteer-heavy structures, case-review and closure standards, and a balanced measurement set spanning structure, process, outcome, and unintended-effect indicators. Community-based organizations remain central to delivery, but sustaining this shift depends on professional supervision, defined referral authority, manageable caseloads, and reliable links to statutory services. The contribution is a quality architecture connecting individualized targeting to measurable outcomes without assuming that tiering alone resolves case-management burden or safeguarding gaps. The framework is offered as a testable governance model, not a validated solution, and closes by identifying the research needed to show that the shift from status to need improves outcomes for children and families, not only delivery compliance.

Keywords: orphans and vulnerable children; child protection; safeguarding; psychosocial support; family strengthening; case management; quality assurance; community-based organizations

Introduction

The term orphans and vulnerable children (OVC) has helped mobilize resources for children affected by HIV, poverty, illness, violence, disability, displacement, and family disruption. The category has also created risks: it can label children, assume uniform needs, and direct assistance according to status rather than current circumstances. Evidence consistently shows that orphanhood alone does not explain a child's educational, nutritional, psychosocial, or protection outcomes [6], [10], [13]-[16], [18]. Household resources, caregiver health, family relationships, gender, disability, community support, and access to services interact with bereavement and separation to shape whether a child thrives.

Community-based organizations (CBOs) often reach families that formal systems miss. They provide home visits, referrals, school support, psychosocial activities, parenting assistance, material support, and follow-up, and their proximity to families supports trust and contextual understanding [6], [7]. Their effectiveness, however, depends on training, supervision, safe professional boundaries, referral capacity, and coordination with health, education, and statutory child-protection authorities [3]. This positioning is not incidental: broader policy analysis of global child-health priorities has argued that OVC programming has struggled to secure sustained attention precisely because definitional disagreement over who counts as vulnerable has fragmented the advocacy coalition that might otherwise press its case [37].

Existing guidance for OVC programming is not scarce. International standards, donor guidance, and program manuals address safeguarding, case management, and monitoring separately, but they rarely integrate these elements into a single architecture that a community-based organization can audit against its own practice. The result is a common pattern in the field: strong intentions and detailed policy documents that coexist with unclear caseloads, informal referral, and monitoring systems built around counts rather than outcomes. This review responds to that gap by treating quality as a structural property of the whole support pathway rather than as a set of unconnected good practices.

This paper asks what a quality assurance framework for community-based OVC programs should measure and control. The analysis follows the pathway from identification through assessment, planning, service coordination, review, and transition, and it treats safeguarding as integral rather than supplementary, because a program intended to protect children can itself expose them to harm through unsafe recruitment, public labeling, weak confidentiality, unmonitored volunteers, or poorly managed complaints [24]. The paper proceeds in five further sections: the thematic synthesis method used to derive the framework's quality dimensions, a synthesis of evidence on community support and program risk, an integrated quality framework with supporting tables, a discussion of what individualized, tiered quality assurance changes, what it risks, and what would count as evidence that it works, and a conclusion.

This paper's contribution is best stated against three approaches already established in OVC programming. (1) Unlike PEPFAR's guidance for orphans and vulnerable children programming, which sets service-delivery standards across sectors but does not specify criteria for moving a case between levels of response [4], this framework treats tier transitions as reviewed, bidirectional decisions: escalation and de-escalation alike require a named authority and a recorded rationale (Section 4.14; Figure 1), so intensity of response, not sector coverage, is what has to be justified. (2) Unlike categorical orphan-status targeting still common in community-based programming, which screens eligibility on status rather than functioning [16], this framework substitutes a multidimensional, needs-based assessment capable of stepping a stable orphaned household down or an unstable non-orphaned household up within the same tiered architecture (Section 4.1; Table 2). (3) Unlike safeguarding guidance that treats internal policy and self-regulation as sufficient [24], this framework assigns a distinct safeguarding control to each handoff along the child-and-household pathway, from community volunteer to case worker, case worker to supervisor, and supervisor to statutory or specialist services (Figure 2; Section 4.3).

Thematic Synthesis of the OVC Programming Evidence Base

Source clusters bounding the OVC evidence base

This review draws on empirical studies, monitoring literature, intervention research, and operational standards addressing community-based programming for orphans and vulnerable children. Sources were grouped into six clusters that recur throughout the analysis: psychosocial well-being, education, household economic strengthening, community-based care, safeguarding, and monitoring and evaluation. Searches covered peer-reviewed studies, program evaluations, and normative guidance that addressed community-based delivery to this population directly, supplemented by citation tracing from an established synthesis of monitoring and evaluation practice in the field [12]. A source was retained only where it addressed the target population and delivery context, or offered evidence transferable to it through a comparable mechanism, population, or setting; sources describing institutional or clinical populations with no plausible mechanism in common with community-based OVC delivery were excluded even where they concerned children. Each cluster's findings were then treated as raw material for coding rather than as a finished conclusion, since the next step of the review reworks them into the framework's own analytical claims. Multi-country evidence on how community-based organizations design and describe their own effectiveness supplemented this source base, showing how grassroots actors

themselves define success and sustain programs once external funding cycles end [47].

Thematic synthesis: coding descriptive and analytical themes

The review follows the three-stage thematic synthesis method developed for qualitative evidence in systematic reviews [27]. In the first stage, findings reported within each of the six clusters were coded line by line: a facilitator-turnover finding in a psychosocial study, a caseload finding in a case-management evaluation, and a targeting-mismatch finding in an education-access study were each coded on their own terms rather than forced into a predetermined framework. In the second stage, these descriptive codes were grouped within and across clusters into descriptive themes that stayed close to the primary literature, such as relationship-dependent psychosocial benefit, supervision-dependent safeguarding, and status-based targeting mismatch. In the third stage, the review went beyond what any individual study claimed to develop analytical themes that answer this paper's own question about program quality: that quality in community-based OVC programming is a property of the whole identification-to-transition pathway rather than of any single service, and that the recurring mismatch between orphan status and actual need points toward individualized, tiered assessment as a more defensible basis for allocating intensity of response than category membership alone. These two analytical themes, pathway-level quality and needs-based tiering, organize the remainder of the review and generate the seven quality dimensions and the tiered framework presented in Section 2.3 and Section 4.

Seven dimensions for judging OVC program quality

The analytical themes described above resolve into seven dimensions used to judge quality throughout this review: safety, effectiveness, child-centredness, timeliness, continuity, equity, and accountability. Safety concerns protection from abuse, exploitation, neglect, and program-related harm. Effectiveness concerns meaningful child and household outcomes rather than service receipt alone. Child-centredness requires age-appropriate participation, consistent with established minimum standards for meaningful engagement with children in program decisions [5]. Timeliness addresses urgent response. Continuity measures whether referrals and plans persist across services and transitions. Equity examines barriers to access and outcome. Accountability covers documentation, complaints, supervision, and corrective action. These seven dimensions are evaluative criteria, distinct from the seven substantive pillars, safety, family strengthening, case management, continuity, participation, equity, and accountable data use, that the framework in Section 4 is organized around; a pillar can be present and still perform poorly against one or more of these dimensions, which is precisely the gap this review treats as the definition of low quality, consistent with standards-based approaches to OVC service quality that separate defining, measuring, and improving quality across comparable core service areas rather than assuming a completed service package is sufficient on its own [32].

The child-and-household pathway and who acts along it

The pathway-level quality theme identified through thematic synthesis treats a child-and-household support pathway, spanning identification, multidimensional assessment, planning, service delivery, review, transition, and safeguarding response, as this review's unit of analysis, rather than any single worker, instrument, or organization. This choice guards against a common error in the literature: attributing outcomes to one component when results actually emerge from an interdependent pathway. A child may receive a competent first response and still experience harm because a subsequent provider is unavailable, information is transferred unsafely, or review never occurs.

The relevant actors, children, caregivers, community volunteers, schools, health providers, social workers, statutory protection bodies, civil-society organizations, and funders, differ in incentive, authority, knowledge, and exposure to risk. Frontline workers often see urgent facts but lack formal authority; managers control resources but may see only aggregated reports; children and caregivers hold essential knowledge about safety and acceptability

Table 1: OVC quality domains

Domain	*Minimum standard*	*Example measure*
Safety	No child experiences program-related harm; concerns receive a timely, survivor-centred response	Time from concern raised to protective action
Effectiveness	Services produce verified change in the child's safety, stability, or functioning, not only receipt of a service	Change in a validated outcome measure from baseline to review
Child-centredness	Children influence decisions that affect them in an age-appropriate way	Proportion of plans documenting the child's own stated priorities
Timeliness	Urgent risk triggers a response within a defined window regardless of caseload	Proportion of urgent referrals actioned within the stated timeframe
Continuity	A plan and its responsible worker persist across services and transitions	Proportion of transitions with a documented handover and no service gap
Equity	Access and outcome do not depend on orphan status, disability, gender, or geography	Disaggregated comparison of service intensity against assessed need
Accountability	Decisions, complaints, and corrective action are documented and reviewable	Proportion of complaints resolved with a recorded outcome and complainant feedback

but often hold unequal power. A quality framework must therefore specify who decides, who bears the consequences, who receives information, and who is accountable when coordination fails, consistent with workforce guidance that assigns distinct authority, supervision, and reporting duties to each role within the social service system for child protection [3].

Distinguishing genuine quality constructs from monitoring proxies

Quality is treated here as the degree to which a system produces appropriate, safe, timely, equitable, and person-centred action under real operating constraints, not as compliance with a checklist. A service can complete every required form while failing to secure a needed response, and while procedural completion is not worthless, it is weak evidence of substantive success. This distinction matters specifically for OVC monitoring, where trust is routinely conflated with satisfaction, referral issuance with service receipt, training attendance with demonstrated competence, and data completeness with data validity, a pattern of proxy substitution that earlier reviews of monitoring and evaluation practice in this field have identified as a persistent weakness [12]. Distinguishing these constructs allows evaluators to locate failure along the causal pathway rather than assuming that any single proxy stands in for outcome.

The evidence base coded into this synthesis spans legal instruments, normative standards, qualitative studies, observational research, program evaluations, and conceptual models, each of which answers a different question. Legal and normative texts define duties and accepted principles [1], [2], [5]; qualitative research clarifies experience and mechanism; observational studies estimate association; and program evaluations examine performance under specific delivery conditions. Strong causal claims require comparative empirical evidence, while operational propositions may also draw on convergent qualitative findings and established rights standards; the coding process recorded the strength of inference behind each theme rather than treating every source as equally probative.

Ethical limits on reviewing vulnerability evidence

This conceptual paper does not support public identification of children as OVC, and the coding process itself was constrained accordingly: no case-level narrative, photograph, or identifying detail from any source was reproduced beyond what was already published in de-identified form, and illustrative examples in this review describe mechanisms rather than individuals. Data collection recommended by the framework should serve care or legitimate evaluation, use the minimum necessary fields, and protect location and family information.

Child assent and caregiver permission should follow applicable law and safeguarding procedures, consistent with the participation and best-interests principles set out in international standards [1], [5]. These limits apply to the review process as much as to the programs it studies, since a synthesis that models poor information discipline undermines the standard it is trying to establish.

Table 1 summarizes the resulting quality domains, their minimum standards, and example measures used throughout the framework.

Evidence on Community Support and Program Risk

Psychosocial support works through relationships and context

Structured group activities, mentoring, caregiver support, and community-based mental-health approaches show promise, but outcomes vary with facilitator skill, cultural relevance, duration, and referral capacity [6]-[11], [13]-[15], [19]. A qualitative systematic review of participant experiences in community-centred psychosocial support programs across conflict-affected settings similarly finds that consistency of relational engagement, not curriculum content, is what participants identify as valuable [28]. Psychosocial support should include supportive relationships, safe routines, grief-sensitive engagement, opportunities for participation, and specialist referral when needed, since children who present with co-occurring trauma and behavioral dysregulation often require an integrative treatment-planning framework that combines cognitive behavioral and dialectical behavior therapy techniques rather than a single modality [51]. It should not be reduced to recreation or one-time events, and programs that treat psychosocial activity as a stand-alone deliverable, rather than as one component of a coordinated plan, have struggled to demonstrate durable benefit once external funding and facilitation end. Peer-led models extend this logic to youth living with HIV: a qualitative study of a community-based, peer-led treatment-support model found that participants valued being supported by someone who shared their diagnosis and lived experience, not only by a trained but unaffected worker [44]. The mechanism appears to run through relationship continuity rather than activity type: children who see the same trusted adult across multiple sessions report more disclosure and better emotional regulation than children exposed to the same curriculum delivered by rotating or poorly supervised facilitators, which is why staffing stability and supervision belong inside any quality standard for psychosocial support rather than being treated as separate workforce concerns.

Family strengthening often protects better than parallel systems

Where safe and appropriate, strengthening family care avoids unnecessary institutionalization and sustains daily protection. Useful supports include parenting skills, access to social protection, school retention, food security, caregiver mental health, disability inclusion, and household economic strengthening. Cash or livelihood support requires safeguarding and monitoring because household stress and control over resources affect the child [17], and the protective value of such support has been shown to vary with orphan status and household assets rather than operating uniformly [21]. Programs should therefore avoid a single uniform transfer design and instead assess who controls the resource within the household, whether support arrives predictably enough to change caregiver behavior, and whether it reduces or inadvertently increases a child's exposure to labor, neglect, or conflict, since a family-strengthening intervention that improves aggregate household income can still fail the specific child it was intended to protect. Evidence on deinstitutionalization confirms the stakes of this choice: professional accounts of moving children out of residential care report significant implementation barriers absent parallel investment in family-based alternatives [35], and cross-national review of deinstitutionalization and foster-care development finds the transition succeeds only where it is treated as a rights-based systems reform rather than a facility-closure exercise alone [36].

Case management connects fragmented services

An individualized plan should state needs, priorities, responsibilities, referral destinations, timeframes,

and review dates. Home visits without decisions or follow-up produce activity, not coordinated care. Case conferences support complex cases, but attendance should be limited to relevant actors and information sharing should follow consent and legal duties. Workforce guidance for child protection systems consistently identifies case management as the connective layer between separately delivered services, and its absence, rather than the absence of any single service, best explains why children receive fragmented, duplicative, or contradictory support even where individual providers perform competently on their own terms [3]. This logic parallels care-coordination frameworks proposed for reducing hospital readmissions among chronic-disease patients, where a structured coordinating role was likewise found necessary because readmissions stemmed from breakdowns between providers rather than from deficiencies in any single provider's care [52]. A named case manager with a manageable caseload and a defined authority to convene other actors is therefore a structural requirement rather than an optional enhancement. Programs that treat case management as informal coordination, carried out without dedicated time, documentation, or supervisory oversight, tend to reproduce the same fragmentation the function exists to resolve, because no single actor is positioned to see the whole pathway or to be held responsible when it breaks down. Longitudinal evidence on referral performance in community-based OVC programs similarly finds that programmatic and worker-level factors, not just service availability, determine whether a referral actually results in the child reaching care [38].

Volunteers require formal safeguards

Community volunteers often expand reach, and inter-agency evidence syntheses of community-based child protection mechanisms similarly find that their protective value depends on links to supervision structures and formal referral systems rather than on community presence alone [33]. Programs must still apply selection checks, role descriptions, codes of conduct, training, supervision, incident reporting, and boundaries on transport, gifts, communication, photography, and private contact. Good intentions do not replace controls, and safeguarding that rests solely on an organization's own policy and self-regulation has repeatedly proved insufficient without links to wider accountability structures [24]. Community-level violence-prevention programming shows a comparable pattern: structured, adequately supervised models report stronger protective effects than informal or under-resourced ones [22]. Case-study evidence on community-led child protection committees elsewhere similarly finds that grassroots structures function best when paired with defined links to formal supervision and resourcing, and struggle where they are expected to operate independently of both [45]. Volunteer safeguarding should therefore be audited with the same rigor applied to paid staff, covering reference checks, defined limits on one-to-one contact, mandatory incident reporting, and periodic re-screening, because an organization's reliance on unpaid labor does not reduce the risk that unsupervised access to children can create.

Monitoring has often favored outputs

Counts of children enrolled, visits completed, or items distributed do not show whether children are safer or doing better. Reviews of monitoring and evaluation practice in this field have long identified inconsistent definitions and weak outcome measures [12]. A stronger model combines service data, child and caregiver feedback, outcome measures, and safeguarding information, and it treats each source as a check on the others rather than accepting any single stream at face value: administrative counts can look strong while children disengage quietly, and satisfaction scores can look favorable while underlying safety indicators deteriorate. Data-triangulation and dashboard-development methods built for national immunization safety-monitoring illustrate how routinely collected data from separate sources can be reconciled into a single verified view for decision-making, a technique directly transferable to reconciling service, feedback, and safeguarding data streams in OVC programs [56]. Programs that report only activity counts to funders create an incentive to maximize volume rather than to solve the problems that volume figures cannot reveal, so output-only reporting should be treated as a design

flaw in the monitoring system rather than as a neutral simplification for donor convenience.

Moving beyond category-based programming

Category-based eligibility made sense when HIV-related orphanhood mobilized a rapid response. Over time, the category became too broad to guide intensity. Some orphaned children live in stable and supportive households, while non-orphaned children may face violence, disability, severe poverty, caregiver illness, or exploitation [16]. Needs-led assessment improves fairness by considering present functioning, safety, caregiving, and access rather than status alone. National systems built around the original status-based category have themselves had to renegotiate this logic as they matured: an empirical assessment of one national cash-transfer program's targeting strategy found that eligibility had to move away from orphan status as the primary criterion toward broader household-vulnerability indicators, driven less by a single policy decision than by accumulated evidence that the original category no longer matched who needed an intensive response [29].

Programs should retain population-level planning while individualizing service decisions. Community mapping identifies areas with school exclusion, weak health access, violence, or economic stress. In resource-constrained settings, weak health access is often compounded by pharmaceutical supply chain inefficiencies that leave prescribed medication unaffordable even where a facility is reachable, a pattern documented in a narrative review of medication affordability barriers across under-resourced health systems [61]. Household assessment determines the response for a particular child. This two-level model prevents the individual case plan from carrying responsibility for structural problems and prevents broad programming from overlooking urgent personal risk.

The tension between scale and relationship quality

Large programs often expand through volunteers and standardized service packages. Scale increases reach but may reduce supervision, continuity, and tailoring. Relationship quality matters because children disclose concerns gradually and caregivers respond better to trusted workers. A quality framework must therefore monitor caseload, visit continuity, supervision, staff turnover, and response to concerns, not only coverage, consistent with reviews of community-level child protection systems showing that supervision quality and workforce stability materially affect protective outcomes independent of program size [20], a pattern echoed in more recent multi-country evidence on how community-led child protection approaches are actually implemented and sustained in practice [34].

Digital case systems may improve coordination, but they also increase documentation burden and privacy risk. Programs should test whether fields support decisions, eliminate duplicate entry, and work under low-connectivity conditions. Data collection that consumes the time needed for meaningful contact undermines quality.

Preventing program-generated stigma

Targeted material assistance may identify a child publicly as orphaned, poor, affected by HIV, or involved with protection services. Distribution methods, school lists, branded events, photographs, and beneficiary stories require risk review. Universal or discreet delivery may reduce labeling. Consent for publicity should remain separate from consent for services and should not influence eligibility.

Language matters. Staff should use terms selected by children and families and avoid defining identity through vulnerability. Records may retain technical categories where required, but direct communication should emphasize strengths, rights, and goals. Community engagement should challenge discrimination without exposing individual circumstances, consistent with evidence that cultural framing of vulnerability shapes how children experience and disclose their own circumstances [19].

How the two-level model's mechanisms are expected to work

The framework rests on an explicit theory of change that begins with enabling conditions, operates through relational and organizational mechanisms, and ends in participant- and system-level outcomes [20]. Enabling conditions, leadership, workforce capacity, referral availability, accessible

communication, secure information, and supervision, support child participation, caregiver capability, stable relationships, coordinated case management, timely referral, material security, and accountable community oversight. These mechanisms shape decisions and relationships, which in turn affect safety, stable care, education participation, psychosocial functioning, health access, caregiver capacity, referral completion, and household resilience. The sequence is neither automatic nor linear: better data may reveal inequity, but only leadership action converts that finding into a corrective response, and strong community ties can support continuity while also concealing risk. The model therefore requires feedback loops in which outcomes and incidents return information to supervision, policy, and service design.

Testing the model against rival explanations and hidden failure

Because observed change can also arise from factors outside the framework, such as new funding, staff turnover, policy shifts, or seasonal migration, evaluation should pre-specify rival explanations and examine whether the proposed mechanisms actually changed before attributing outcomes to the model. A rise in recorded concerns, for example, may reflect improved reporting confidence rather than worsening practice, a distinction that earlier reviews of outcome measurement in this field show is easy to miss when definitions are inconsistent across sites [12]. Average performance figures can also conceal negative cases in which the system fails despite apparent fidelity, such as a completed referral followed by harm or a positive experience score followed by disengagement; such cases test the framework more rigorously than confirmatory instances and should be examined without seeking to excuse individual misconduct.

Adapting the model across settings, groups, and information limits

Transferability should be judged through mechanism and context rather than surface similarity. High-volume urban sites need rapid triage and clear escalation; rural settings need transport, communication redundancy, and broader worker roles, a gap that conceptual work on telehealth adoption suggests can be partly closed by extending remote clinical contact to rural and underserved populations rather than relying solely on in-person outreach [53]; and low-connectivity environments require offline procedures with controlled synchronization. A model developed in one setting can remain useful elsewhere only if its underlying mechanism stays plausible, and every adaptation should record which element changed, why, what risk was introduced, and how performance will be reviewed.

Equity raises a parallel version of the same problem. It is not a final disaggregation exercise appended to an otherwise neutral process; it shapes access, disclosure, decision thresholds, and exposure to intervention at every stage. Language, disability, age, gender, ethnicity, migration status, poverty, geography, and institutional mistrust can each alter who enters the system, who is screened out, who waits, and who disengages, so that a formally universal procedure can produce unequal outcomes in practice [16]. Quantitative differences across groups should trigger investigation rather than an automatic claim of either discrimination or neutrality, and participatory interpretation helps distinguish measurement artefacts from lived barriers.

The same logic bounds how much information the model may use to make these context-sensitive judgments. The framework rests on best interests, evolving capacity, meaningful assent, caregiver permission, privacy, non-stigmatization, accessible complaints, and the least restrictive safe response. Every information request, referral, restriction, or disclosure should have a defined purpose, a lawful or policy basis, and a proportionate relationship to foreseeable harm, with less intrusive options given priority where they offer comparable protection [1], [2].

Weighing orphan-status targeting against multidimensional and universal alternatives

Three broad alternatives to orphan-status targeting are relevant for comparison: multidimensional vulnerability assessment, universal community services, and the tiered child-and-family model proposed here. Orphan-status targeting often preserves institutional familiarity and simplifies initial eligibility, but it weakens coordination

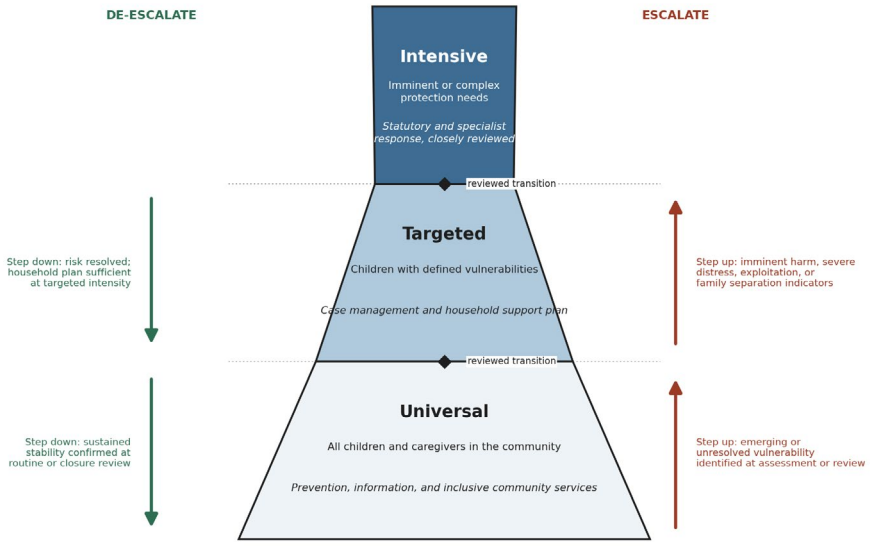

Figure 1: The tiered assessment and response model. Universal, targeted, and intensive tiers are shown as nested bands rather than fixed categories: solid arrows on the right mark step-up escalation triggered by emerging, unresolved, or imminent risk, and arrows on the left mark step-down de-escalation triggered by confirmed stability, so that a case can move in either direction as circumstances change, with every transition reviewed at the boundary it crosses.

once children outside the category present with comparable or greater need, a pattern documented in assessments of education access among orphans and vulnerable children that found status-based categories a poor predictor of actual disadvantage [16]. Multidimensional vulnerability assessment offers better standardization and a more defensible basis for prioritization, but if applied rigidly it can impose excessive uniformity and generate assessment burden disproportionate to the support ultimately offered. Universal community services extend reach and avoid labeling, but without a mechanism for identifying and escalating higher-risk cases they can under-serve children who need an intensive response.

A tiered child-and-family model, by contrast, retains common rights and data requirements across the population while permitting governed adaptation of intensity to individual circumstances. No single option dominates under every condition, and appraisal should weigh safety, workforce burden, interoperability with other systems, implementation cost, accountability, accessibility, and adaptability together rather than optimizing any one criterion in isolation. A model that performs well on data completeness but poorly on trust should not be rated as high quality, and a locally flexible model without version control and central oversight risks fragmenting into inconsistent practice over time. Decision-makers adopting any targeting model should publish the criteria and trade-offs used to select it, so that the choice itself remains open to review.

Integrated OVC Quality Framework

Tiered assessment and response

The framework translates the seven quality dimensions and the evidence review into an operational architecture spanning assessment, planning, safeguarding, measurement, sectoral integration, and oversight. Table 2 through Table 6 present the tiered response model, case-review standards, measurement set, risk-scenario controls, and assurance framework in structured form so that each can be audited and applied directly rather than inferred from narrative alone. The framework uses three tiers. Universal community supports promote safe schools, positive parenting, access to information, and inclusive services. Targeted support addresses defined risks through case management and household plans. Intensive response covers imminent harm, severe distress, exploitation, family

Table 2: Tiered assessment and response model

Tier	*Population*	*Response*
Universal	All children and caregivers in the community	Prevention, information, and inclusive community services
Targeted	Children with defined vulnerabilities	Case management and household support plan
Intensive	Imminent or complex protection needs	Statutory and specialist response with close review

separation, or complex disability and health needs through statutory or specialist services. Figure 1 shows the resulting three-tier architecture together with the bidirectional escalation and de-escalation pathways between tiers, and Table 2 sets out the population and response associated with each tier, an architecture consistent with tiered programming approaches recommended in sectoral guidance for orphans and vulnerable children [4].

Child and family plan

The plan begins with strengths and the child's views. It records urgent protection issues, household capacity, education, health, psychosocial well-being, legal documentation, social support, and economic stress. Goals should be specific and understandable to the family. Review should identify progress, emerging risk, service failure, and whether the intervention still fits.

Assessment tools should be structured enough to ensure that safety, education, health, psychosocial well-being, and economic domains are consistently covered, while leaving room for a child's or family's own account of what matters most. A purely checklist-based tool risks recording the presence or absence of a service without capturing whether the service met the need, while a purely narrative approach risks inconsistent coverage across workers and sites. The strongest approach combines a structured minimum data set with narrative space for professional judgment, and requires supervisory sign-off before a plan is finalized so that the assessment is checked rather than simply filed, consistent with guidance calling for individualized assessment and documented planning before decisions affecting a child's care are made [2]. Figure 2 traces this pathway as a swimlane diagram, showing which actor is

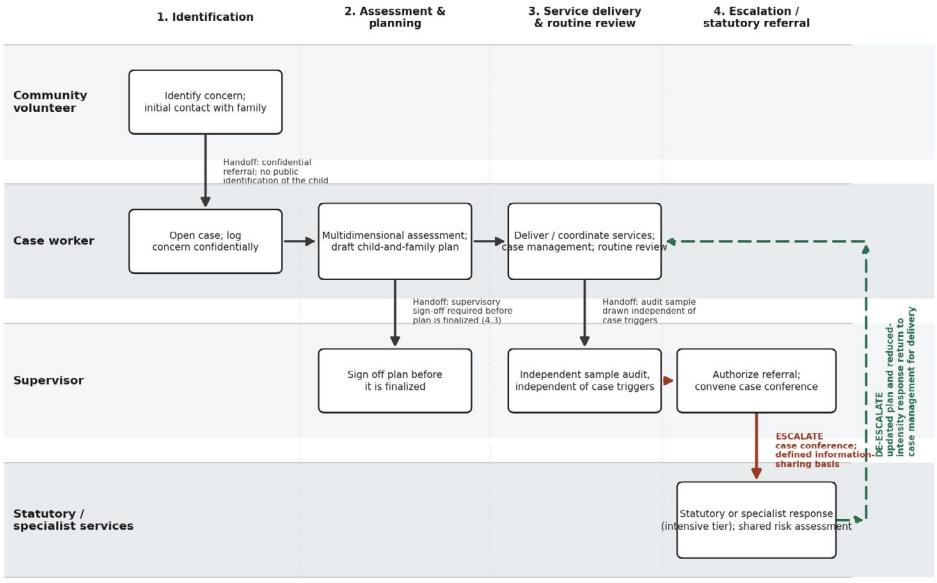

Figure 2: The child-and-household pathway from identification to escalation. Lanes show which actor, community volunteer, case worker, supervisor, or statutory and specialist services, is responsible at each stage, and labeled handoffs show the safeguarding control attached to each transfer of responsibility. The dashed return path shows that a case referred for statutory or specialist response can come back to case management at reduced intensity rather than remaining at the highest tier once opened.

Table 3: Case review and closure standards

Review type	*Trigger*	*Required elements*	*Responsible reviewer*
Routine case review	Scheduled interval or plan milestone	Safety check, goal progress, service receipt, caregiver capacity, child's views	Assigned caseworker with supervisor sign-off
High-risk multidisciplinary review	Imminent harm, severe distress, exploitation, or family separation indicators	Shared risk assessment, defined information-sharing basis, agreed action plan	Multidisciplinary panel (statutory, health, social work)
Supervisory sample audit	Independent of individual case triggers	Closed cases, unsuccessful referrals, long-open cases, repeated-incident cases	Supervisor or quality-assurance lead
Closure review	Proposed case closure	Evidence of stability, plan for residual needs, family understanding confirmed, re-entry route documented	Supervisor, independent of assigned caseworker

responsible at each stage and the safeguarding control attached to each handoff between them.

Safeguarding system

Every organization needs a designated safeguarding lead, safe recruitment, a code of conduct, confidential reporting routes, response timelines, survivor-centred incident management, referral agreements, and board oversight. Children need age-appropriate information about expected staff behavior and how to report concerns. Safeguarding within a single organization is necessary but not sufficient; it must connect to comprehensive national child-protection systems and independent oversight rather than remaining a matter of internal policy alone [24], an integration also codified in sector-wide minimum standards that treat case management, safeguarding, and coordinated referral as interdependent components of a single quality standard rather than separate compliance checklists [31]. Each of these elements should be testable rather than aspirational: a designated lead should be reachable within a stated response time, a code of conduct should be understood by staff well enough to explain in their own words, and referral agreements should specify which statutory body receives which category of concern. Where any element exists on paper but cannot be demonstrated in practice, the organization should treat that gap as an active risk rather than a documentation omission.

Case review and closure standards

Routine case review should examine safety, goal progress, service receipt, caregiver capacity, the child's views, and emerging concerns. High-risk cases require multidisciplinary review with clear information-sharing rules, and supervisors should sample closed cases, unsuccessful referrals, long-open cases, and cases with repeated incidents, because this approach detects hidden failure better than reviewing complete files alone, consistent with evidence that safeguarding review confined to an organization's own internal records is insufficient without independent sampling of exactly the cases most likely to conceal a problem [24]. Table 3 summarizes review triggers, required elements, and responsible reviewers across four review types.

Case closure should require evidence of stability, a documented plan for any remaining needs, understandable information for the family, and a clear route back to support. Age limits, grant cycles, or completion of a single service do not by themselves justify closure. Programs should follow a sample of closed cases to assess whether gains persist and whether new risks emerge after formal support ends.

Measurement and learning

The framework uses a balanced measurement model that distinguishes structure, process, output, outcome, and balancing indicators rather than relying on activity counts alone, directly addressing weaknesses in outcome measurement identified in earlier reviews of monitoring and evaluation practice for this population [12]. Assessments of whether global development actors actually involve children in evaluating the programs meant to serve them have found persistent gaps between stated commitment and practice [40], and where genuine child-participatory evaluation has been implemented, multi-country experience shows that involving children directly,

Table 4: Balanced measurement and learning set

Indicator type	*Domain*	*Example measure*	*Primary data source*
Structure	Workforce capacity	Caseworker-to-caseload ratio against the tiered response model	Human resources and case management system
Process	Case management	Proportion of plans reviewed within the scheduled interval	Case file audit
Output	Service delivery	Completed referrals as a share of referrals issued	Referral tracking log
Outcome	Child safety and stability	Time from concern identification to protective action	Case file and safeguarding register
Outcome	Education	School attendance and progression, not enrollment alone	School records and household visit data
Outcome	Psychosocial well-being	Psychosocial functioning score at intake and review	Caseworker or clinical assessment
Outcome	Access and outcome gaps	Outcome differences by disability, sex, and location	Disaggregated case data
Balancing	Unintended effects	Participant-reported burden, disengagement, or privacy concern	Participant feedback and complaints log
Process	Complaints and response	Resolution time and complainant satisfaction with outcome	Complaints register

rather than through adult proxies, changes what an evaluation is able to detect about program quality [39]. Comparative work across several African child-serving programs has translated this principle into practical, child-friendly evaluation tools spanning design through dissemination [41]. Structure measures capacity; process measures whether key actions occur; output records verified delivery; outcome captures change in safety, stable care, education participation, psychosocial functioning, health access, caregiver capacity, referral completion, and household resilience; and balancing measures detect unintended effects such as participant burden, disengagement, privacy incidents, inequitable response, and staff workarounds. Table 4 presents representative indicators across these categories.

Every indicator needs a definition, numerator, denominator, data source, owner, refresh schedule, and a stated rule for handling missing data, and targets should be reviewed whenever they appear to encourage gaming or to override professional judgment. Programs should also interpret safeguarding reports with care: an initial rise in recorded concerns may reflect greater awareness and trust rather than deterioration, so learning reviews should focus on causes and corrective action rather than blame.

School and health system integration

Schools often notice absence, declining performance, bullying, hunger, or changes in behavior before other services. Health workers may identify malnutrition, disability, chronic illness, violence, or caregiver strain. Integration should use defined referral thresholds and confidentiality rules consistent with sectoral guidance [4]. Teachers and health staff should not investigate protection allegations beyond their role; they should record observations, respond to urgent safety needs, and refer through established pathways. Referral accuracy also depends on the receiving facility's own diagnostic capacity: a review of integrated microbiology, virology, and serology workflows in infectious disease management finds that diagnostic fragmentation, not referral volume, is what most often delays confirmed treatment once a child reaches a health worker [60].

School retention measures should examine attendance, progression, learning support, and safety, since enrollment alone obscures irregular participation and exclusion. Health measures should track effective access, treatment continuity,

immunization where relevant, nutrition, sexual and reproductive health information for adolescents, and disability-related support, while programs must avoid collecting clinical detail unnecessary for coordination. Where treatment continuity depends on ongoing pharmacological care, a conceptual framework for equitable access to chronic therapies in hospital pharmacy settings suggests that continuity fails as often at the point of dispensing as at the point of referral, making pharmacy-level access a legitimate monitoring target in its own right [63].

Household economic strengthening

Economic stress affects food, schooling, health access, care arrangements, and exposure to exploitation. Assistance should begin with household analysis and social-protection eligibility. Savings groups, cash transfers, livelihood inputs, and skills training require realistic market and safeguarding assessments, and evidence indicates that the protective value of cash and asset support for orphaned and vulnerable children varies with orphan status and household assets rather than operating uniformly [21]. Programs should examine who controls resources and whether assistance increases conflict or child labour. Where formal treatment costs exceed household budgets, families frequently turn to informal or traditional botanical remedies before seeking facility-based care, and cost-effectiveness modelling comparing fresh and dried botanical preparations suggests that this substitution is not uniformly irrational, though its safety depends on dosing and preparation practices that programs rarely assess [59]. Longitudinal evaluation of a household economic-strengthening program using non-asset resource indicators found measurable improvement in household well-being for orphaned and vulnerable children when support was sustained over multiple years rather than delivered as a one-time transfer [42], and a related evaluation of the same program model found significant gains in caregiver-reported food security specifically [46]. This pattern is consistent with policy work on continuity of care for patients with cardiometabolic conditions, which finds that sustained, uninterrupted support produces better-maintained outcomes than support delivered in discrete episodes [55]. Evidence from a national cash-transfer scheme further shows that such investment can produce measurable child-health gains even without disability- or orphan-specific targeting rules [49], and household-based targeting evaluations caution that community involvement in identifying eligible households carries its own trade-offs between legitimacy and consistency [50].

Child outcomes should remain the purpose of household support. Measures should include food security, school participation, care stability, and reduced harmful coping strategies. Income change alone does not show whether the child benefited. Grievance routes are essential where targeting decisions affect community relationships.

Adolescent transition and participation

Adolescents require opportunities to influence their plans, gain life skills, access age-appropriate health information, continue education, and prepare for safe work. Participation should be voluntary and meaningful: organizations should specify which decisions participants influence, which remain professional or statutory duties, and how disagreement will be handled, rather than treating consultation after key decisions are already made as sufficient [25]. Youth advisory groups need safeguarding, inclusive selection, and protection from tokenism.

Transition planning should begin before age-based eligibility ends. The plan may address identity documents, housing, education, work, health care, supportive adults, financial literacy, and protection risks. For adolescent girls who become pregnant during this transition, health-care planning should include systematic screening for drug interaction risk in antenatal care, since a conceptual screening framework developed for this purpose finds that interaction risk is most often missed when antenatal contact is brief or discontinuous, a pattern this population's own service gaps make more likely [58]. Abrupt exit from services may recreate vulnerability.

Disability inclusion

Children with disabilities face barriers in communication, school access, transport, services, and reporting harm; caregivers of children with disabilities have described family acceptance,

community attitude, and rehabilitation services as sources of support alongside inaccessible schools, environmental obstacles, and financial strain as the main barriers to participation [26]. Assessment tools should identify functional support and accommodation needs without defining the child solely by impairment. Staff need accessible communication methods and referral links to rehabilitation, assistive technology, inclusive education, and disability organizations. Parenting-support interventions that explicitly target child protection and development outcomes for children with disabilities have shown benefit across varied low- and middle-income settings when they combine caregiver skill-building with structured follow-up rather than a single training event [30], reinforcing why disability-inclusive case plans in this framework should specify accommodation and follow-up together rather than treating accessibility as a one-time adjustment. The compounding effect of caregiver disability itself has also been documented: children whose caregivers have disabilities faced additional, largely unaddressed barriers to HIV-related care linkage in a multi-year cohort study, underscoring why disability assessment in this framework should consider the caregiver's circumstances and not only the child's [43]. Related analysis of caregiver characteristics within the same national program found that caregiver sex shaped HIV-related risk and service needs among the children in their care, a further reason individual case assessment should look beyond the child alone [48]. For children living with HIV whose caregivers also manage a disability, monitoring accuracy matters as much as access: droplet digital PCR methods for HIV viral reservoir quantification offer a more precise way to track treatment response over time than conventional viral load testing alone, a refinement that could strengthen long-term case monitoring for this subgroup [62].

Monitoring should compare access and outcomes by disability while protecting identity. Facilities, information, complaints, and activities should undergo accessibility review. Caregivers may also need respite, financial assistance, and psychosocial support.

Accountability and independent oversight

Boards and funders should receive information on safeguarding, complaints, serious incidents, audit findings, and overdue corrective actions, and should avoid incentives that reward low reporting. Independent review is appropriate for serious allegations, conflicts of interest, or systemic failures. Contracts with partners should state safeguarding standards, reporting duties, access for audit, and consequences of noncompliance.

Children and caregivers need feedback on what happened after they raised a concern, subject to privacy and legal constraints. Programs should track satisfaction with the response rather than closure alone. This shifts accountability from documentation completion to experienced fairness and safety. Independent review matters because escalation routes that remain entirely within a single organization's own hierarchy have repeatedly proved insufficient to surface systemic failures, particularly where reporting incentives discourage disclosure or where the same manager who approved a decision is also asked to review it [24]. Oversight bodies should therefore retain the authority to commission an external review without first requiring the organization's own consent.

Implementation readiness, workforce, and governance capacity

Translating the framework into practice requires readiness, competence, and governance capacity that many programs currently underfund. Readiness assessment should test leadership commitment, role clarity, workforce competence, partner capacity, information governance, accessibility, complaint handling, and emergency response before launch, using scenarios such as out-of-hours response, technology failure, or a partner's refusal of a referral rather than relying on written policy alone [3]. Data-driven frameworks for health-facility disaster-risk mitigation, which score preparedness against mapped hazards rather than generic checklists, offer a template for building this kind of readiness testing into routine governance [54]. Funders should

Table 5: Risk scenario and safeguarding control matrix

Risk scenario	*Trigger*	*Safeguarding control*	*Escalation pathway*
Public labeling	A distribution list, school roster, or funded event unintentionally identifies a child as orphaned or HIV-affected	Switch to discreet or universal delivery; review the distribution method before repeating it	Safeguarding lead reviews all planned distributions before they recur
Unsafe reunification	A child is returned to a household without a current safety assessment	Pause reunification; complete an emergency household assessment	Case conference with the statutory child-protection authority before proceeding
Volunteer overreach	A volunteer takes on unsupervised one-to-one contact, transport, or direct financial support outside their defined role	Suspend the contact; review role boundaries against the code of conduct	Safeguarding lead investigates and logs the incident regardless of outcome
Confidentiality breach	Case information is shared without consent or legal basis, on paper or by device	Contain further disclosure; notify the affected family	Data-protection lead assesses severity; board notified for high-severity events
Exclusion of non-orphaned children with comparable need	An eligibility rule anchored to orphan status screens out a child with severe need because a caregiver is still present	Apply the tiered needs-based criteria in place of the status rule	Supervisor reviews the eligibility decision and referral pathway
Service fragmentation at a transition point	A child moves between health, education, and protection services without a named worker retaining oversight	Assign a case manager to convene the transition	Program manager acts if no receiving service accepts responsibility
Premature closure	A case is closed on a funding-cycle or age ground without evidence of stability	Extend the case or flag it for a transition plan under the Table 3 closure standard	Supervisor reviews the closure decision against Table 3
Caseload surge	Demand rises faster than staffing after a shock such as drought, disease outbreak, or displacement	Activate the priority protocol for core safety cases; pause non-urgent intake	Program manager authorizes a temporary caseload ceiling
Workforce loss	Experienced supervisors or case managers leave within a short period	Reassign caseloads with supervisor sign-off; brief incoming staff on open safety concerns	Program manager reviews whether minimum viable capacity is still met
Indicator distortion	Performance targets change staff behavior in ways that inflate reported results	Cross-check the indicator trend against an independent case-file sample	Measurement lead may suspend the target pending review
Funding contraction	The program must reduce expenditure while preserving essential safety functions	Protect core safety and supervision functions first; document what will not continue	Board approves the reduction plan with stated risk implications
Severe adverse event	A child experiences serious harm despite apparent compliance with the model	Secure immediate safety and continuity; preserve evidence; offer an independent contact point	Board-level learning review with named owners and deadlines

recognize supervision, coordination, accessibility, secure records, and follow-up as direct service costs rather than discretionary overhead.

Workforce competence should be defined through observable performance rather than attendance at training. Staff need to recognize concerns, communicate choices, document proportionately, apply thresholds, consult supervisors, and coordinate safe action, and different roles require different competence profiles so that volunteers or contractors do not inherit responsibilities beyond their training and authority. Supervision serves operational, ethical, and developmental functions: it reviews urgent risk, supports judgment, detects drift, manages emotional burden, and identifies system barriers, and supervisors need manageable ratios, protected

Table 6: Accountability and assurance evidence framework

Domain	*Evidence or indicator*	*Review frequency*	*Responsible actor*
Leadership	Risk review records, resourcing of controls, tracked corrective actions	Quarterly	Executive leadership and board
Workforce	Competence assessment, supervision coverage, caseload ratios	Quarterly	Human resources and program supervisors
Partnerships	Referral partner performance against agreed standards	Semi-annual	Partnerships or coordination lead
Information governance	Access logs against role assignments, retention compliance	Semi-annual	Data protection lead
Participation	Evidence that feedback changed design, delivery, or complaints handling	Annual	Participation or quality lead
Accessibility	Accessibility review of facilities, information, and complaints channels	Annual	Program management with disability focal point
Decision quality	Sampled case records for documented thresholds and reasoning	Quarterly	Supervisory review panel
Incident response	Time to safety action, investigation outcomes, remedy delivered	Per incident, aggregated quarterly	Safeguarding lead
Measurement	Indicator validity, denominator stability, missing-data patterns	Quarterly	Monitoring and evaluation lead
Equity	Pathway and outcome differences by group, linked corrective action	Annual	Equity or program quality lead
Resources	Staffing, technology, and follow-up capacity against demand	Annual	Finance and program management
Sustainability	Continuity of core functions through funding or leadership change	Annual	Board and executive leadership

time, and the authority to escalate resource problems.

Information governance should specify purpose, lawful basis, minimum data fields, access rights, correction, retention, deletion, sharing, and breach response, with sensitive narrative separated from operational alerts where possible and additional logging on high-risk actions such as bulk export or external sharing. Minimum-necessary data collection supports both privacy and accuracy, since excessive collection increases exposure and often reduces data quality through rushed entry.

Governance should connect frontline decisions to executive and board oversight without exposing unnecessary personal detail: operational teams need case-level information, managers need trends and resource constraints, and boards need severity, recurrence, overdue corrective action, and evidence of participant voice. Scale should follow demonstrated readiness rather than funding deadlines, because rapid expansion can dilute supervision and overwhelm referral partners; a staged strategy should define entry and pause criteria for each new site. Sustainability, in turn, depends on integrating these functions into budgets, job descriptions, procurement, and governance calendars rather than treating them as activities that end when a grant does.

Risk scenarios and safeguarding controls

Programs should test the framework's resilience against foreseeable operational shocks rather than assume that written procedure will hold under pressure. Table 5 consolidates twelve risk scenarios drawn from the framework's core protections and common failure patterns identified in the review (public labeling, unsafe reunification, volunteer overreach, confidentiality breaches, exclusion of non-orphaned children, service fragmentation, and premature closure), together with the escalation pathway each scenario requires, reflecting evidence that structured, adequately supervised safeguarding models outperform informal or under-resourced

ones when tested against operational pressure [22]. Exercises should use real contact lists, response times, and partner commitments rather than discussion alone, and after-action reviews should separate preparation gaps, execution gaps, and external constraints so that corrective actions carry measurable completion criteria and a follow-up test confirms that the control functions under pressure. National disease-surveillance analyses linking pandemic-related disruption to shifts in the burden of other infectious diseases show how a single shock can simultaneously alter demand, risk, and service-access patterns across a community system in ways a static risk registry will not anticipate [57].

Assurance and independent evidence review

Assurance that the framework operates as intended requires evidence gathered outside the delivery line, since self-assessment alone tends toward optimistic interpretation, a concern consistent with broader evidence that safeguarding assurance confined to internal policy and self-regulation is insufficient without independent verification [24]. Table 6 sets out twelve assurance domains together with the evidence or indicator each should examine, review frequency, and the actor responsible. Reviewers should combine document examination, record sampling, interviews, observation, and data analysis, because policy documents can describe a control that staff do not understand, and administrative data can show completion without quality. Findings should rate design, implementation, and operating effectiveness separately, identify affected groups and duration, and remain open until evidence shows the underlying risk has changed rather than closing on proof of activity alone.

Decision thresholds and escalation

Decision thresholds should identify the evidence required for routine action, supervisory consultation, urgent escalation, and external referral, and should support consistent practice without presenting uncertainty as certainty. A structured threshold combines observable information, the child's or caregiver's account and preferences, contextual risk, available protective factors, and the foreseeable consequences of action or inaction, rather than resting on a single indicator. Escalation should specify who receives the concern, expected response time, interim safety steps, documentation, and closure, and when frontline teams disagree, the framework should require reasoned review rather than informal compromise. Override decisions need a named authority and a recorded rationale, and audit should examine both failure to escalate and excessive escalation, since either pattern can produce harm, consistent with workforce guidance that ties sound protection decisions to defined supervisory consultation rather than to an individual worker's unaided judgment [3].

Participation and co-governance

Participation should influence program design, delivery, evaluation, and governance, not only individual case decisions. Consultation that occurs only after key decisions have already been made offers limited accountability, consistent with systematic-review evidence that participation exercised only after decisions are finalized delivers little genuine influence over child welfare outcomes [25], so organizations should identify which decisions participants genuinely share, which remain professional or statutory duties, and how disagreement will be handled. Participation methods need accessibility, fair compensation where appropriate, confidentiality, and protection from any service consequence for raising concerns.

Co-governance arrangements can include advisory panels, paid peer roles, review of information materials, participation in indicator interpretation, and representation on quality committees, and representation should avoid asking a single participant to speak for an entire diverse population. Terms of reference should define authority, support, conflict management, and feedback, and organizations should report which recommendations from participants were accepted, modified, or declined, and why.

Failure recovery and restorative response

When harm or a serious failure occurs, the organization should first secure safety and continuity, explain known facts, preserve evidence, protect confidentiality, and provide a contact independent of the implicated service where feasible. Immediate

action should not prejudge accountability, but delay should not expose participants to continuing risk.

Recovery includes apology where appropriate, correction of records, renewed access to services, review of adverse decisions, and practical remedy. A learning review should reconstruct the system conditions that contributed to the failure and identify corrective actions with named owners and deadlines, and effectiveness checks should confirm that the correction actually changed practice, consistent with evidence that meaningful safeguarding correction depends on mechanisms beyond an organization's own internal policy and self-regulation [24]. Closure should include communication with affected people unless safety, law, or their own preference prevents contact.

Transparent reporting and cumulative learning

Public reporting should describe scope, definitions, denominators, missing data, major adaptations, outcome trends, serious risks, and corrective-action progress without exposing individuals. Selective publication of favorable indicators weakens trust and prevents learning across the sector, so reports should distinguish confirmed findings, unresolved concerns, and management interpretation from one another, addressing a longstanding weakness identified in reviews of monitoring and evaluation reporting practice in this field [12].

Cumulative learning requires consistent core measures and preservation of contextual detail. Multi-site analysis should examine heterogeneity before pooling results, and research teams should publish protocols, codebooks, and analytic decisions where ethical and lawful. De-identified data sharing needs robust disclosure review, because rare events and small populations can remain identifiable through combinations of attributes even after direct identifiers are removed.

Discussion

From status to need: what tiered assessment changes about program quality

Moving from orphan-status eligibility to individualized, needs-based tiered assessment relocates what counts as quality in community-based OVC programming. Under status-based programming, quality is largely a property of coverage: a program is judged well if it reaches the defined population and delivers a defined package to everyone in it. Under the tiered model developed in Section 4, quality becomes a property of decisions: whether the right intensity of response was assigned to a particular child at a particular time, and whether that assignment was revisited as circumstances changed. This is a different theoretical claim about what doing well means, not a technical adjustment to eligibility paperwork. It implies that a program can achieve full coverage of its target population and still be low quality if its assessment process cannot distinguish a stable orphaned household from an unstable non-orphaned one, a distinction status-based eligibility cannot make by construction because it screens on category rather than on functioning [16]. It also implies that quality cannot be established once, at intake, and then assumed: because the two-level model pairs population-level community mapping with case-level decision-making, quality has to be demonstrated at both levels at once, and strength at one level does not substitute for weakness at the other. A community with excellent mapping data but case managers who never revise a plan is not a quality program, and neither is one where individual case plans are excellent but the underlying community mapping never updates as conditions change. Systems that have actually tried to make this shift describe it as a change in the underlying logic of eligibility rather than a refinement of an existing one, since the intensity of response, not category membership, becomes the thing that has to be justified and reviewed at every point along the pathway [29]. The sections that follow treat that repositioning as this paper's central theoretical claim and ask what it costs, what would count as evidence for it, and who has to act on it.

Case-management overload and safeguarding gaps in a volunteer-heavy tiered model

Tiered assessment is not a costless improvement on status-based targeting, and two risks deserve direct attention because they follow from the model's own design rather than from poor implementation. The first is case-management overload. Individualized

assessment, planning, and review generate substantially more work per child than status-based enrollment, and community-based organizations that rely heavily on volunteers and a small number of paid supervisors may not have the capacity to absorb that added workload without either reducing quality per case or quietly reverting to a simplified, status-like sorting rule under pressure. Workforce guidance for child-protection systems identifies exactly this pattern, supervision and resourcing eroding under caseload growth, as the primary mechanism by which well-designed models degrade in practice [3]. The second risk is a safeguarding gap specific to volunteer-heavy structures. Tiered assessment moves consequential judgment closer to the point of contact: a volunteer or frontline worker now effectively decides, in the act of assessment, whether a child moves toward a targeted or intensive response, a decision that carries more protective weight than simply enrolling a child in a universal program. Where that judgment is not matched by the same accountability applied to paid case managers, individualized authority can outpace individualized accountability, an imbalance consistent with broader evidence that safeguarding resting on an organization's own internal policy and self-regulation is insufficient without external checks [24]. The framework's own controls respond to both risks rather than assuming tiering resolves them automatically: the decision-threshold and escalation rules in Section 4.14 require a named authority and a recorded rationale for every tier assignment, the review-sampling standard in Section 4.4 specifically targets the closed and long-open cases where drift is most likely to hide, and the assurance domains in Table 6 make workforce ratios and decision quality, not just safeguarding policy, subject to independent review. These controls reduce the risk; they do not remove it, and a program that adopts tiered assessment without also funding the supervisory capacity these controls assume should expect the two risks described here, not treat them as remote possibilities.

Evidence that would show the framework improves outcomes, not just delivery compliance

A tiered model can be fully compliant, every case assessed, every plan documented, every review completed on schedule, while still not improving whether children are safer, more stable, or better supported than they would have been under simpler targeting. Compliance evidence and outcome evidence answer different questions, and this paper argues that only the second should be allowed to settle whether the shift from status to need was worth its added cost. Four kinds of evidence would genuinely test the claim. First, tier assignment should predict a child's subsequent risk trajectory better than orphan status alone would have; if a needs-based tier and a status-based category sort children into materially the same subsequent outcomes, the added assessment burden is not earning its keep [16]. Second, children moved into targeted or intensive tiers should show measurable improvement on the balanced measures in Table 4 beyond what a comparable group would show without tiering, ideally established through a staged or phased rollout rather than before-after comparison alone, since community-level child protection reviews have shown how much unmeasured secular change can masquerade as program effect [20]. Third, any rise in recorded safeguarding concerns after adopting the framework should be checked against independent case-file evidence before being read as either success or failure, applying the same rival-explanation discipline set out in Section 3.10 rather than assuming the direction of change is self-evident. Fourth, and most easily overlooked, community-based organizations should be able to show that the relational strengths that justified keeping them central to delivery, continuity of a trusted adult, willingness of children to disclose, are preserved rather than crowded out by the added administrative load of tiering, since recent evidence on community-based delivery of psychosocial support finds that this relational consistency, not caseload throughput, is what families actually value [28]. None of this evidence exists yet at the scale this framework would need; the propositions above are offered as the research agenda the framework requires before it is treated as more than a structured hypothesis.

Implications for donors, national systems, and community-based organizations

The shift this framework proposes has different implications for the three actors who would have

to fund, authorize, and deliver it. Donors currently reward visible service volume; a tiered model asks them instead to fund the supervisory and case-management infrastructure described in Section 4.11 as a direct service cost, and to accept balanced measurement, including the balancing indicators in Table 4 designed to surface unintended harm, in place of enrollment counts. National child-protection systems have to supply what community-based organizations cannot supply themselves: the statutory authority behind the intensive tier, the specialist services the model assumes exist at the point of escalation, and the interoperable standards that let a tier assignment made by one organization mean the same thing to another, a role illustrated by how one national OVC system had to renegotiate its own eligibility logic as it moved away from status-based categories [29], [4]. Community-based organizations face the most immediate transition cost: adopting tiered assessment is a governance and workforce change, not a form change, and organizations that pilot it on a limited caseload before wholesale rollout, with an explicit pause criterion if supervision cannot keep pace, are more likely to capture its benefits without triggering the overload risks described in Section 5.2.

These implications should be read alongside the limits of the evidence behind them. The framework is conceptual and does not itself establish causal effect; several sources supporting its governance and safeguarding reasoning come from adjacent child-welfare and alternative-care literatures rather than from OVC-specific populations [23], [24], which supports mechanism-level reasoning but not direct population inference, and publication bias likely overrepresents successful models in the wider literature this review draws on. These are reasons for the phased, evidence-gathering rollout argued for above, not reasons to defer the shift from status to need indefinitely: the cost of continuing to target by category while non-orphaned children with equal or greater need go unassessed is also a cost, and it falls on children, not on the programs that decline to measure it.

Conclusion

High-quality programming for orphans and vulnerable children begins with individualized need rather than a label. It protects children by strengthening safe families, coordinating services, supporting community capacity, and escalating complex concerns to competent statutory and specialist authorities, consistent with evidence that protection systems anchored solely within a single community-based organization cannot substitute for links to statutory and independent oversight structures [24]. The framework developed here links these principles to concrete controls, a tiered response model, safeguarding and case-review standards, and a balanced measurement set, so that program standards and measurable outcomes reinforce rather than substitute for each other.

The framework is offered as a testable governance model, not a guaranteed solution. Its contribution lies in making assumptions, responsibilities, and feedback mechanisms explicit enough to support scrutiny and revision. Future studies should test the framework across urban and rural settings, compare child and caregiver experience, examine disability inclusion specifically, and evaluate the relationship between service continuity and longer-term well-being. Community proximity remains an advantage only when programs pair it with professional supervision, safeguarding, reliable referral, and accountable learning; without that pairing, proximity alone cannot guarantee that a child is safer, more stable, or better supported than before the program began.

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