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'Tear down your institutions'. Systematic review and meta-analysis of institutional care in SOS

Children's Villages

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Abstract

Typical large-group institutions for abandoned children or orphans are bad for the development of children.

A central question whether small-group care in institutional settings is the exception and does provide good-enough care? SOS Children's Villages use small group housing and try to mimic a family-like child-rearing environment. In a narrative and quantitative synthesis, the scientific evidence on the associations between growing up in SOS villages and child development in various domains is reviewed.

Searches in Web of Sciences, PubMed and Google Scholar yielded 8 eligible empirical studies on N = 1,567 children (including 894 SOS children).

Random effects meta-analyses were conducted on physical growth and mental health comparing SOS children with children growing up in typical institutions and in families.

Results showed substantial developmental delays of SOS children compared with their peers in families. Compared to children in typical institutions SOS children do better on mental health but worse on physical growth.

Key words: orphanage; institution; family; SOS Children's Villages; meta-analysis

‘Tear down your institutions’. Empirical and evolutionary perspectives on institutional care in SOS Children’s Villages

Introduction

Hermann Gmeiner, founder of SOS Children’s Villages, called several decades ago to action to “Tear down your institutions” (1 p.15). Indeed, there are good reasons for de-institutionalization. It is empirically demonstrated and generally accepted that conventional institutions with large caregiver-child ratios are bad for the physical, cognitive and socioemotional development of children (2). Institutional care is defined as group care of children around the clock (24/7) by professional caregivers who are not their (biological, foster, adoptive, kinship) parents (3). Crucial question remains whether group care in small institutional settings is more adequate and might be used as a viable option on the continuum of care (4–6). SOS Children’s Villages argue that their approach of family-like housing of small numbers of children with a more or less permanent mother figure would facilitate development and be in the best interest of the abandoned or orphaned child (1). In the current narrative and (partly) quantitative synthesis we address this question reviewing the publicly available scientific evidence on the associations between growing up in SOS villages and child development in various domains.

In a series of meta-analyses of more than 300 empirical studies including more than 100,000 children in more than 60 countries we demonstrated that institutional care predicts large delays in physical and brain growth, in cognitive development, and in socioemotional development, in the latter domain resulting in atypical, dysregulated or disorganized attachment relationships (2). We argued that dose-response associations between duration of stay in the institution and severity of the delays provide support for a causal interpretation of the meta-analytic findings based on the correlational studies. Furthermore, the findings of the Bucharest Early Intervention Project (BEIP) (7), the unique randomized control trial comparing institutional with foster care that allows for causal

conclusions, converged with the meta-analytic outcomes. This convergence solidifies the meta-analytic conclusions about the negative effects of institutionalization and the accelerated catch-up growth after the transition to family-type care (2,4).

About the ultimate causes of this bad impact on child development of institutional care we can only speculate. From an evolutionary perspective Institutional care falls outside the range of the environments of evolutionary adaptedness (8) in which the human species evolved during millennia (9). This is not because of bad intentions or lack of abilities in staff or management. Professional group-care is unique across evolutionary times (10) and the institutions' organization is atypical for any known environment for care of offspring. Some typical characteristics of institutions are their regimented nature with strictly monitored day and night routines of sleeping, eating, playing, schooling, and free-time; the high child-to-caregiver ratios compared to a regular family; the multiple shifts needed to cover 24/7 care; and the high staff turn-over because of the heavy workload, low levels of payment, incompatibility with raising children of their own, and low social respect for the profession. These components in various constellations result in discontinuous, fragmented care arrangements with too many separations and too little opportunity to establish attachment relationships in an organized way, and to feel safe and grow into an adaptive adult. Operating as total institutions (11), they show on the one hand high levels of violence between peers and between residents and staff (12,13) and on the other hand they lack meaningful activities and interactions during most part of the day (14). Structural neglect thus characterizes typical institutions (15).

Why would institutional childcare have developed at a high rate (16) at all if it is outside any environment of evolutionary adaptedness in which the human species evolved during millennia of variations, selection pressures and replications? We submit the hypothesis that orphanages (partly) replaced infanticide. Throughout evolutionary times infanticide existed at a rather high rate, for

different reasons. First, extreme lack of social and physical resources forced parents to choose between their offspring, save some and at the same time let others starve to death (17). Second, the struggle for dominance within and between groups caused infanticide by the new alpha males or leaders to increase their chances of having their own offspring (18). Last, (perceived) constitutional vulnerabilities or disabilities were seen as a liability of growing up and becoming adult without the capability to create offspring and transmit the gene pool into the next generation (19).

Basically the 'goal' of neo-Darwinian evolution is offspring survival into procreative age followed by enhanced inclusive fitness. Hamilton's rule might be considered to be the hidden law behind this process of adaptation (20,21). It states that costs (C) of providing care should be lower than the benefits (B) of that provision of care weighted by the degree of genetic relatedness (r) of those cared for, in short $C < B \cdot r$. If the (foreseen) costs become much larger than these weighted benefits ($C \gg B \cdot r$) infanticide might be the (unintended or culturally 'acceptable') consequence. Scheper-Hughes (17) for example describes how infanticide was made culturally and religiously acceptable because babies in their first year of life were considered to be angels instead of human beings, and when they died would go straight back to heaven.

But if abandonment would lower the costs of infanticide and (ever so slightly) elevate the chance of benefits by survival of the abandoned offspring, then the equation of $C > B \cdot r$ might change in a positive direction. Because too many newborns were drowned in the Tiber, in 1198 Pope Innocent III decreed that 'foundling wheels' should be installed to give young mothers a chance to deliver their newborns anonymously to institutional care. Even today so-called 'baby hatches' still exist in many countries, for example in Germany with an estimated 100 of such facilities. If there is even a slight chance of survival into procreative adulthood it would make evolutionary sense to use foundling wheels and institutional care that might lead to foster care, adoption or kafalah at a later stage. This might be an example of gene-culture coevolution in the service of inclusive fitness (22).

Against this evolutionary background SOS Children's Villages may be seen as a next level of institutional care for abandoned children without parental care as they claim to be radically different from the classic picture of institutional care. Founded by Hermann Gmeiner in post-war Austria in 1949, SOS Children's Villages International has become 'the world's largest non-governmental organization focused on supporting children and young people without parental care, or at risk of losing it' (1). They are active in 136 countries, operating more than 2,600 programs involving more than a million children, young people and families, and some 39,000 employees. Ideally, children in institutional care are housed in separate homes on a large compound with facilities such as (pre-)schools, medical centers, and some room for 'Schrebergarten' (allotment or family garden). In the children's houses 6 to 8 children of different ages live together with a 'mother' figure who is available day and night for most of the week and most of the year, assisted by an 'aunt' who helps with cleaning and cooking. The villages try to be open to the wider community by providing opportunities for education and medical care. SOS Children's Villages International also provides support for foster and adoptive parents, and besides institutional care they have preventive programs for strengthening families at risk of abandonment of children.

Crucial question is whether the SOS institutional arrangement is indeed a next level of family-like institutional care and up to the challenge of providing good alternative care for children without permanent parental figures. Do children raised in SOS institutions show better physical, cognitive and socioemotional development than those growing up in typical institutions? Furthermore, are SOS institutions able to promote child development with similar success compared to children raised in their family of birth or alternative family-type arrangements such as foster or adoptive care? To address these two questions, we searched for pertinent published empirical studies comparing developmental outcomes of children in SOS villages with those of their peers in

either traditional institutions or family-type of care. We present the results in a narrative way and we will complement the narrative synthesis with quantitative, meta-analytic data.

Materials and Methods

We used the broadest possible search strategy for quantitative studies on child development in SOS Children's Villages. Search terms in Web of Science (January 15, 2021) were: ts=SOS AND village* AND study. We found 42 references, of which 14 survived screening on basis of titles and abstracts. Qualitative studies, reviews, and studies not pertaining to child development were screened out. In PubMed the following string of search terms was used: (((SOS) AND (village*)) AND (study)). This approach yielded 30 hits, of which seven seemed pertinent on basis of titles. Four studies survived after reading the abstracts. All four were also included in the Web of Science search results. Furthermore, we explored Google Scholar to trace grey literature on SOS Children's Villages. However, no new scientific studies were identified that met our inclusion criteria. Following the PRISMA guidelines (23), considering the small number of studies and assessing the risk of bias of the studies, we realized that the current review and synthesis is exploratory and hypothesis-generating instead of a definite test (24).

Reading the 14 studies that survived the screening process, nine unique studies could be identified. Three different papers were derived from the same sample (25–27), two papers focused on the transition out of the institution into independent living (28,29); and one paper could not be traced (30). Finally, in the study by Hasanović, Sinanović, Selimbasić, Pajević, and Avdibegović (31) on post-traumatic stress and depression of war-traumatized children from a large- and a small-group institution and from family settings in Bosnia and Herzegovina, the small-group institution seemed to have been labelled incorrectly as an SOS Children's Village (see correction note by (32)). In this

study, the small-group institution showed higher prevalence of traumatic experiences during the war and higher levels of PTSD and depression than the large-group institution, but following the correction, the study was excluded from the narrative review and meta-analysis below.

The literature search thus revealed eight unique studies on developmental outcomes of children in SOS Children's Villages. Five of these studies included various domains of child development, whereas three papers focused on oral health assessing caries, and one of these three studies also presented physical growth data (33). All studies are discussed in a narrative way. In addition, we computed effect sizes of core outcome measures wherever possible, and combined these effect sizes with a random effects meta-analysis in R (packages meta and metafor). We did not conduct moderator analyses, meta-regressions or publication bias tests because of the small number and heterogeneity of the pertinent studies. Moderators were coded independently by the authors. Intercoder agreement was .94 on average and ranged from kappa = 0.60 (SOS funding) to kappa = 1.00 (country; type of comparison sample; design) for nominal variables, and correlated maximally for sample size and the continuous moderator age.

Figure 1. Flowchart literature search.

Results

In Table 1 we present characteristics as derived from the studies included in the narrative review. The following characteristics were used to compute the risk of bias in the studies (23). First, the size of the sample was included (smaller than $N = 100$ was defined as risk of bias because of lower statistical power). Second, funding was evaluated as a potential risk of bias: when the paper explicitly mentioned SOS Children's Villages as direct or indirect funder of (part of) the study, it was deemed a risk of bias. Third, the design was coded as based on a matched or unmatched comparison group, and the latter type was considered a risk of bias. Last, whether the effect size was readily available from the paper or had to be estimated was considered, with estimation considered to be a potential risk. The sum of risks in those four categories reflects the total risk of bias, with a range of low to high risk: 0 – 3 (see last column of Table 1).

Narrative review

In a large study on mental health problems of $N = 459$ Spanish children and adolescents in various welfare care settings (institutional, foster, and kinship care, with 48.1%, 2.8%, and 8.7% children respectively) and children from families at risk involved in family strengthening programs, Vallejo-Slocker, Fresneda, and Vallejo (34) used the Strength and Difficulties Questionnaire (SDQ) to measure externalizing and internalizing problems, and the Kidscreen-10 to evaluate quality of life. Central question was how Covid-19 impacted the mental health of these youth compared to their peers before the pandemic. Here we focus on the question related to the difference between institutional care and family-type arrangements.

Unfortunately, descriptive means and standard deviations for the two measures in the four groups were absent, and a specific comparison between institutional care versus the other types of welfare care or family setting was not reported either. Overall comparisons were presented using independent t -tests and one-way ANOVAs. These were non-significant. Therefore, institutionalized children might be supposed to score similarly to children in family-type environments, but this remains a best guess (estimated effect size $d = 0.00$). It should be noted that the four modalities of care were all part of the SOS Children's Villages Spain, and the authors were faculty of Aldeas Infantiles SOS Espana, supported by SOS Children's Villages.

In Karachi, Pakistan, a study on $N = 330$ institutionalized children (age 4-16 years) by Lassi, Mahmud, Syed, and Janjua (35) compared a SOS Village small group setting (on average 8.7 children per group, total $n = 126$) with conventional institutions consisting of large groups (average group size 24.7 children, total $n = 204$). The SOS children were somewhat older (11.5 years) and had stayed longer (3.9 years) in the institution compared to the children in conventional institutions (9.7 years old; on average 2.6 years in the orphanage). In the conventional institutions 45.6% of the children lost both parents, whereas 22.2% of the SOS children had lost both parents.

Against this background it is somewhat surprising that 17.5% of the SOS children were stunted compared to 5.9% of the children in large institutions (Cohen's $d = -0.40$), and that 22.2% of

the SOS children suffered from malnourishment versus 8.3% of the children in the conventional institutions (Cohen's $d = -0.63$). Wasting rates did not differ (estimated Cohen's $d = 0.00$). For comparison with other studies we included the stunted growth parameter in the meta-analysis. Behavioral problems were measured using the SDQ, validated for completion by the caregivers ('foster mothers'). Mean total problem score for the SOS children was 15.6 (SD = 4.1) compared to a mean score of 16.6 (SD = 3.8) for the children in large institutions (Cohen's $d = 0.26$, 95% CI: 0.03, 0.48). Thus, SOS children were scoring worse on anthropometric growth indicators but slightly better on behavior problems. The authors were faculty of the Aga Kahn University, and no other financial support was mentioned.

The difference in preschoolers' Developmental Quotient (DQ) between regular institutions and SOS Children's Villages in Greece was studied by Giagazoglou, Koulousi, Sidiropoulou, and Fahantidou (36). The samples were matched on educational experience, gender and age and the children's psychomotor development was assessed in a familiar setting using the Griffiths Test No II. Twenty children with an average age of 4.5 years lived in two SOS institutions, in groups of 6 to 8 children with a so-called 'mother' to take care of the children around the clock. Twenty-eight children with an average age of 4.3 years lived in three typical institutions, in groups of 8 to 10 children with one caregiver who was available during waking hours. She was assisted by an aide to clean the premises and prepare food.

The difference in general DQ was large and significant ($p < .01$) with higher scores for the SOS children ($M = 95.30$, $SD = 9.01$) compared to the children in the typical institutions ($M = 75.96$, $SD = 12.31$). The effect size was large, Cohen's $d = 1.75$, despite the nearly similar caregiver – child ratios (1: 8) in both types of institutions. The six sub-tests of the Griffiths (locomotor; personal; verbal; hand-eye; performance; practical) were highly correlated and showed the same patterns of differences between the two types of institutional care. The authors also included a matched sample of 48 preschoolers living with their biological parents. The family-raised children scored on average

$M = 113.44$ ($SD = 13.03$) on the Griffiths, and the difference between the SOS and family-reared children amounted to a Cohen's $d = -1.51$ which indicates a large delay in psychomotor development of SOS children compared to a matched group of family-reared peers. The authors were faculty members of universities in Greece and the UK, and did not mention other support.

In Jimma, south-west Ethiopia, the SOS Children's Village started in 2012, offering care to some 150 children in a wide age range (with a maximum age of 14 years) in 15 houses where a 'mother' and an 'aunt' took care of up to 10 children. The village also included a kindergarten, an elementary school, and a medical center. Worku et al. (37) compared 62 SOS children between 3.5 months and 6 years of age ($M = 44.6$ months) with a matched sample of 62 family-reared children ($M = 45.1$ months) on developmental status using the Denver II test, on socioemotional problems assessed with an adapted version of the Ages and Stages Questionnaire (ASQ:SE), and on nutritional status using standardized WHO measures.

SOS children showed differences in all developmental domains. Median score on the ASQ:SE was 40 for the SOS children and 25 for the comparison group, with an effect size of Cohen's $d = -1.22$ (higher ASQ:SE scores mean more socioemotional problems). The SOS children also lagged behind in Denver II scores on language ($d = -0.96$) and gross motor development ($d = -0.88$), whereas differences in personal social ($d = -0.34$) and fine motor development ($d = -0.31$) were in the same direction but not significantly different, leading to a combined effect size of $d = -0.62$. Twenty-two SOS children were observed to be undernourished with 17 of them showing stunted growth. Assuming that one family-reared child would have shown less than -2 standard deviations of (stunted) growth the estimated effect size was Cohen's $d = -0.80$ for physical growth delay in SOS children. The authors were faculty members of universities in Belgium and Ethiopia, and they declared to have received funding from Jimma University-Institutional University Cooperation program.

For the study on the 'Late consequences of psychological deprivation and subdeprivation' by Matejcek, Bubleova, and Kovarik (25–27) it was not possible to retrieve the published papers, and the information in the abstracts of the three publications in *Ceskoslovenska Psychologie* was limited. Nevertheless, it could be derived that the authors compared $n = 116$ former SOS children with $n = 93$ participants who received foster care in childhood. In adulthood the former SOS residents had attained a lower level of education. The male residents had more often committed criminal acts than their fostered peers, and they reported more problems in their romantic relationships. Most problematic appeared to be the sub-group of participants who had started institutional care very early in their lives and entered foster care at school age. In general, the authors emphasized that later mental health seemed more unfavorable for institutionalized children compared to individuals with a history of foster care. Because exact statistics are missing the best estimate would be a significant difference ($p < .05$) for mental health, amounting to a lower bound Cohen's $d = -0.27$. The first author of the series of papers on institutionalization, Zdeněk Matějček, was a co-founder of SOS Children's Villages in the Czech Republic (38).

In Lima, Peru, $N = 37$ residents of a SOS Children's Village were included in a study on malnutrition and its relation to dental health status (33). They did not find such a relation, but they reported that 54.1% of the children suffered from malnutrition, and 21.6% of the children showed some alteration in the sequence of tooth eruption (see Table 1 in 33). Because it is not known how many family-reared children in Peru were struggling with malnutrition at the time of assessment, it is also impossible to compute an exact effect size for this growth parameter. We estimated that around 15.8% of these children would be malnourished (nutritional status < 1 SD), and this difference seems a plausible lower bound estimate, leading to a Cohen's $d = -1.50$.

Oral hygiene and dental decay was found to be problematic ($d = -0.26$) in a larger sample of 224 children and adolescents growing up in three SOS villages in Lima (39). However, in a study of 88

Croatian primary school-aged children (on average 11.45 years old) in SOS villages, Ivanišević and colleagues (40) found better dental health as indexed by the caries index (SiC) of $M = 4.69$, compared to the population of family-reared children in the city of Zagreb, with a SiC of $M = 7.4$. If this difference is estimated to be significant at $p < .05$, Cohen's $d = 0.42$, in favor of the SOS children.

Table 1: Characteristics of the studies on SOS Children's Villages and child development

Study	Country	Age	N _{SOS}	N _{comp}	Comparison	SOS funded	Design	Domain	Measure	Effect size d/ r	Risk ² of bias
Vallejo-Slocker et al., 2020	Spain	13.1	221	238	family	yes	unmatched	Behavior problems	SDQ	0.00 ¹ /.00	3
								Quality of life	Kid screen-10	0.00 ¹ /.00	3
Lassi et al., 2011	Pakistan	11.5	126	204	institution	no	unmatched	Growth (stunted)	NCHS criteria	-0.40/- .19	1
								Behavior problems	SDQ	0.26/.13	1
Giagazoglou et al., 2012	Greece	4.5	20	28	institution	no	matched	Psychomotor development	Griffiths	1.75/.66	1
			20	48	family		matched	Psychomotor development	Griffiths	-1.51/- .60	1
Worku et al., 2018	Ethiopia	3.8	62	62	family	no	matched	Psychomotor development	Denver	-0.62/- .30	0
								Behavior Problems	ASQ:SE	-1.22/- .52	0
								Growth		-0.80 ¹ /-.37	1
Matejcek et al., 1995, 1996	Czech Republic	Adult	116	93	family	yes	unmatched	Mental health	Missing	-0.27/- .13	2
Diaz-Orahulio et al., 2014	Peru	7.5	37	--	--	no	Compared to norm	Malnutrition	WHO	-1.50 ¹ /-.60	3
Mattos-Vela et al., 2017	Peru	10.5	224	--	--	no	Compared to norm	Dental health	WHO; Debris Index	-0.26 ¹ /-.13	2
Ivanisevic et al., 2017	Croatia	11.5	88	--	--	no	Compared to norm	Dental Health	SiC index	0.42 ¹ /.21	3

¹Estimated. ²higher scores indicate more risks of bias (see text)

Meta-analyses. We combined effect sizes with a random model for the comparisons of SOS children's growth and development with children growing up in typical institutions and in families. We found a combined effect size $d = 0.92$ for the comparison of mental health of SOS children with children in typical institutions, indicating SOS children were better functioning ($k = 2$; $N = 378$). We also combined the comparisons of SOS children's mental health with those of family-reared children and found a combined effect size of $d = -0.61$, that is lower mental health for SOS children compared to family-reared children ($k = 4$; $N = 896$). For physical growth the comparison of SOS children with those from typical institutions amounted to $d = -0.40$, meaning that SOS children lagged behind, but this comparison was based on only one study ($N = 330$) (35). They also lagged behind children growing up in families, with a large combined $d = -1.05$ ($k = 2$; $N = 161$).

Figure 2 Meta-analytic effect sizes (Cohen's d) for the comparison of children in SOS facilities with children in typical institutions and family-reared children, for mental health and physical growth.

Footnote: Positive combined effect sizes imply that outcomes (for typical institutions or SOS children) are worse compared to family-reared children. The base-line of zero reflects family-reared children's development.

Discussion

Growing up in SOS Children's Villages does not lead to the same developmental levels as being raised in families. Physical growth of SOS children is lagging behind their peers in families. Moreover, their mental health, assessed with measures of psychomotor and socioemotional development, shows significant delays compared to family-raised children. Only their dental health appears in one study better than the dental health of children reared in families. Comparing SOS children with their peers in typical large-groups institutional settings, we found that SOS children do better in the psychomotor and socioemotional domains of development, but do worse on physical growth, although the latter finding is based on only one study (35). In general, the evidence base for these conclusions should be considered preliminary because even after 70 years of SOS Children's Villages scientifically sound empirical studies on their efficacy are rare. The preliminary narrative and meta-analytic evidence support the grounded hypothesis that SOS children show considerable developmental delays compared to family-raised children, and that they fare better than children in large institutions in the domain of mental health but stay behind with respect to physical growth.

The limitations of the studies on SOS institutions also limit the validity and generalizability of the meta-analytic findings. Limitations pertain to the heterogeneity of study designs with several cross-sectional comparisons of unmatched groups. Statistical analyses could only rudimentarily take into account potentially confounding variables, and the nesting of children within several groups or institutions was never addressed with adequate multilevel approaches. About half of the studies included too small numbers of children to achieve sufficient statistical power and to avoid false negatives or false positives. A strength of the literature are the measures used to monitor child

development, ranging from established tests such as the Griffiths for psychomotor development to the SDQ for socioemotional problems and WHO based anthropometric assessments.

It is disappointing that after 70 years since SOS Children's Villages was founded only preliminary scientific evidence is available for the effects, and that the evidence is based on a small number of studies. On average only about one empirical study per decade evaluating the efficacy is a remarkable low number. SOS Children's Villages is part of a larger NGO with a variety of activities. The total preliminary budget of 2018 was estimated to be 1,261,028,000 EUR, of which the institutions, youth, foster families and 'transit homes' were estimated to receive 577,847,000 EUR (1 p.64). It is therefore puzzling that so little research on the efficacy of these major investments has been conducted and published in peer-reviewed papers in established scientific journals.

SOS Children's Villages seem certainly interested in scientific evidence as they recently sponsored a so-called 'rapid evidence review' of institutional care which suggested some advantages of small group homes, without specifically focusing on institutional care provided by SOS (41). The rapid review however showed serious limitations, such as a very limited time window of 5 years (2015-2019) and a merely narrative approach, with potentially biased description of selected studies and findings. If the organization would spend only 1% of their budget on independent research on the efficacy of their small group homes in comparison to family-type care, some 10 million Euros would be available on a yearly basis to create a firm evidence base for this core component of SOS Children's Villages International.

Although the small-group SOS arrangements are favorably staffed and thus might be relatively expensive compared to the typical institutions, they still do not seem to stimulate child development in similar ways as (biological, foster, adoptive, kinship) family-type arrangements, and they do not seem to do better than large institutions in every domain. How can this be explained?

We speculate that structural neglect, inherent to institutional care, is not about group size only but also about the essential components of good-enough care which are contact comfort, continuity of caregivers, and a small network of attachment relationships for a child to be able to rely on in times of (di-)stress, illness or potentially traumatic experiences (42).

Not food but social interactions are crucial. In such frequent interactions between a child and a caregiver the partners learn to read and understand each other's signals, and the child's innate bias to seek comfort with protective caregivers can be satisfied when stress and fear rise to a level the child cannot cope with alone. Furthermore, continuity of care arrangement and prevention of fragmented care and of breaking attachments is central. In the long run fragmented care is difficult to implement in professional group 24/7 year-round care if these professionals have a life and a family of their own who also need their availability and interactions. Last, a network of attachment relationships is important to share the caregiving burden with the mother figure and create more stability for the child, not only in the early years but also during adolescence and the transition to adulthood and the start of their own family. This combination of essential components of 'good-enough' care (42,43) is absent in SOS Children's Villages.

Summary

Norbert Meder, CEO of SOS Children's Villages International had a dream: "We dream of a time when we no longer need to exist" (1 p.16). The time may have come to use the enormous resources of this largest NGO worldwide for children without parental care to help facilitate the transition from institutional care to genuine extended family care. The organization is in an excellent position to contribute to this transition because the whole continuum of care (4) is represented to serve as a basis for a coherent research program that includes addressing the issue of how the transition can best be made. If the organization would spend a tiny part of their budget on

independent research on the efficacy of institutional care in comparison to family-type care, and on the transition from institutional to family care, this would provide an opportunity to create a firm evidence base for the route to achieve the core goal of SOS Children's Villages to make themselves superfluous.

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