K4D | Knowledge, evidence and learning for development

# Children in care institutions

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## Question

*What does the literature tell us about how many children worldwide are in institutions/orphanages; how likely they are to be exploited and in which ways; and what interventions are most effective in preventing this?*

## Content



## 1. Overview

An 'institution' for children is defined as "as a group living arrangement for more than ten children, without parents or surrogate parents, in which care is provided by a much smaller number of paid adult carers. Residential care implies an organised, routine and impersonal structure to the living arrangements for children (e.g., all children sleep, eat and toilet at the same time) and a professional relationship, rather than parental relationship, between the adults and children." (Browne, 2009:1). This definition may include children in boarding school, summer camps, prison and asylum detention centres. This report focuses mainly on residential homes in developing countries.

It has been estimated that approximately 2.7 million children under 18 years old are living in institutional care worldwide (Petrowski, Cappa, and Gross, 2017), although the quality of available data from many countries is poor and under-reporting is a problem, as many institutions are unregistered and the children living them are not officially counted (Petrowski, Cappa, and Gross, 2017, p. 394; UNICEF, 2009, p. 19; Bunkers et al., 2014). Most children in institutions are not orphans – 50 to 90 per cent have at least one living parent (Bunkers et al., 2014). Most children in residential care are placed there not as orphans, but due to poverty; the parents'

inability to provide care (in some cases due to poor health due to HIV and AIDS or other chronic diseases); and the perception that better care and education could be provided at an institution (Bunkers et al., 2014, pp. 6-7). Children with disabilities are at a high risk of institutionalisation (Bunkers et al., 2014, p. 7). Many case studies below show parents seeing institutions as a means to provide education for their children. In a few of these institutions, children do report to independent reviewers that they are happy and well cared-for, and experience better conditions than they would at home.

The potential for exploitation in care institutions is huge. Many care homes are unregulated, meaning staff are poorly trained, recruited without background checks, and unaccountable (van Doore et al., 2016). Children who are abused, neglected or subject to violence have no recourse to legal or civil reparations (van Doore, 2016).

The most common forms of abuse reported are physical violence such as beatings as punishment, sexual violence perpetrated by staff or peers, neglect, undernutrition, and bullying (Sérgio Pinheiro, 2006). Some of these are categorised as exploitation. A clear form of exploitation is child labour within the institutions. It is very commonly reported that children cook, clean and wash clothes in their care home, to an unacceptable degree in some places. A further form of exploitation is the trend for orphanages to recruit vulnerable children from their families as a profit-making enterprise (van Doore et al., 2016). Many orphanages in Sub-Saharan Africa and South East Asia rely on donations and international volunteers, and children are often used as a commercial entity to attract funds and may be sent out to beg or perform on behalf of centres. In some cases, children are kept in destitute or unhealthy conditions to appeal to donors and volunteers. Evidence is already pointing to alarming irregularities, including recruitment of children for international adoption, “child laundering” through altering and forgery of records, inducement of birth parents to relinquish children, and extortion of funds from prospective adoptive parents (Cheney & Rotabi, 2014). Additionally, poor regulations and oversight means that abuse is often rampant. There is a high risk of sexual exploitation by international volunteers because many residential care centres and tourism operators offering volunteer placements do not require police clearance reports, do not conduct background checks, and do not provide adequate supervision of volunteers once they are spending time with children (Cheney & Rotabi, 2014).

The most common adverse effects that children who grow up in residential care experience include: developmental delays; behavioural problems; attachment disorders; lack of life skills; institutionalisation; and difficulty forming and maintaining healthy relationships. The literature is extremely clear that residential care should be a last resort for children separated from their parents, following family support, community support, and fostering. As such, the literature strongly supports deinstitutionalisation and reintegration of families whenever possible and provision of extra support to families as the best intervention. Evidence shows that many children can recover from problems experienced in residential care when placed in family care environments, although they have incomplete catch-up compared to their never-institutionalised peers. This paper does not review deinstitutionalisation, but instead provides a few examples of interventions which have improved the quality of care in residential homes, as an immediate response or precursor to deinstitutionalisation.

- **Training:** A few case studies show good improvements in the quality of care after providing training to caregivers on child rights, caregiving practices, and violence against children. Many staff are poorly trained and resource-constrained, and providing basic training appears to be effective.

- **Improved monitoring and accountability procedures:** Many institutions do not have child protection policies, individual care plans, record-keeping on child progress, or governing bodies with a mandate for oversight. Some improvements in management structure and staff communication have improved caregiving practices. At the national level, institutions are often set up outside government and are not monitored or inspected for adherence to national standards. Improved national oversight mechanisms would help improve quality of care.
- **Legal and policy reform:** Many countries do not have laws against violence against children or child protection policies. Enforceable legislation would provide recourse for victims of abuse and would be a first step to improving care by setting a baseline standard. Individual institutions should implement child protection policies, particularly regarding background checks on staff and international volunteers, to decrease the likelihood of abuse.

# 2. Global overview

**Children in Institutions: The Global Picture**
Lumos (2015). Lumos.
http://www.bettercarenetwork.org/sites/default/files/1.Global%20Numbers_2_0.pdf

This charity estimates there may be up to 8 million children living in institutions worldwide. Over 80 per cent of the children have a living parent and the majority could be reunited with their families given the right support. Poverty is recognised as the main driver of child institutionalisation in most countries. Parents who cannot afford to feed, clothe or send a child to school have little choice. Children with disabilities are at a high risk of institutionalisation. This is often because families do not have access to the right support services or because there is no inclusive education in the local area. In some countries poor parents are offered money to give up their children. Corrupt institutions and unethical adoption agencies profit from the children through donations to their orphanage or through child trafficking.

**Children, Orphanages, and Families: a Summary of Research to Help Guide Faith-based Action**
Bunkers, K., Cox, A., Gesiriech, S. and Olson, K., (2014). Faith to Action Initiative. http://www.bettercarenetwork.org/sites/default/files/attachments/Children%20Orphanages%20and%20Families%20-%20Summary%20of%20Research.pdf

This resource provides a concise overview of a robust evidence base that informs approaches to caring for children who have been separated from parental care. Research studies over many years in a wide range of cultures and contexts have consistently demonstrated the positive impact family care has on children's growth and development. It has also illustrated the harmful effects that living outside family care can have on children.

Globally, it is estimated that there are approximately 153 million children who have lost a parent; 17.8 million of them have lost both parents. UNICEF estimates that at least 2.2 million children in the world live in orphanages. This number is considered by many to be a significant underestimate, given that many orphanages around the world are unregistered and the children living within them are not officially counted. Depending on the region, upwards of 50-90 per cent of children living in orphanages have at least one living parent, and most children have a family network that could care for them, given the right support. Unfortunately the number of children

living in orphanages appears to be rising. This increase contradicts global guidance and the stated policies of many governments directing the scaling down of orphanage care.

Poverty, not lack of caregivers, is often cited as the reason for placing children in orphanages. Parents and other caregivers struggling to provide for their children may feel compelled to use orphanages to address an immediate problem. In many regions where material poverty is prevalent, evidence demonstrates the "pull factor" of residential care as the means of meeting such basic needs as food, access to education, and other services for children.

**Kinnected: Keeping Children in Families.**
ACCI Relief (2016). http://www.bettercarenetwork.org/sites/default/files/Kinnected%20-%20Keeping%20Children%20in%20Families.pdf

The United Nations estimates that up to 8 million children around the world are living in residential care institutions. 80 per cent of these children have families, and are in residential care for reasons of poverty. Desperate families will place their children in an orphanage in order to ensure the child accesses food, clothing and education. 60 years of global research has shed light on the detrimental effects that residential care can have on children's development and overall wellbeing. The most common adverse effects that children who grow up in residential care experience include:

- Developmental delays
- Behavioural problems
- Attachment disorders
- Lack of life skills
- Institutionalisation
- Difficulty forming and maintaining healthy relationships

Orphanages continue to receive widespread support from overseas donors and visitors, which results in vast amounts of resources directed towards residential care services disproportionate to need. To meet the demands of donors, orphanage staff often actively recruit children from poor families by convincing parents that their children will have a better future by going to live in the orphanage. They often keep the children undernourished and in poor conditions to elicit donations from tourists. There are cases of orphanages recruiting and trafficking children to fill their orphanages for fundraising purposes. When orphanages open their doors to well-meaning volunteers, they also make a way for predators to gain access to the children. Predators are known for seeking opportunities to volunteer and work within orphanages to access children. Whilst good screening can reduce the risk, it is not always possible to identify a child abuser and therefore volunteering does expose children to risk.

**Does family matter? The well-being of children growing up in institutions, foster care and adoption.**
Schoenmaker, C., Juffer, F., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2014). In "Handbook of child well-being" (pp. 2197-2228). Springer Netherlands.
http://link.springer.com/referenceworkentry/10.1007/978-90-481-9063-8_179

In this chapter of the Handbook of Child Well-Being, the authors review the findings from research on the cognitive and social-emotional development of children exposed to various

natural experiments in which the quality of parenting or family environment could be placed on a continuum**.** The authors conclude that the findings strongly support the notion that the family environment and high quality parenting do matter for children's well-being. They note that the lack of stable and continuous parenting in institutional care appears to have dramatic negative effects on child development and well-being, and that the major delays found in institutionally reared children's cognitive and social-emotional development might have their roots in the experiences of structural neglect in institutions. On the other hand, the transition from institutional care to family foster care proved to be an effective intervention for children's cognitive and social-emotional development, although the experiences of the early adversities during institutionalisation had some lasting effects and resulted in incomplete catch-up in the foster children compared to their never-institutionalised peers. They note that developmental outcomes of children placed in adoptive families confirm the importance of family care experiences for children's healthy development and well-being, with better developmental outcomes for earlier placement in adoptive families**.**

# 3. Exploitation and child protection

## Quality of care

**The risk of harm to young people in institutional care.**
Browne, K. (2009). Save the Children. http://resourcecentre.savethechildren.se/library/risk-harm-young-people-institutional-care

Information available from UNICEF and other international organisations suggests that the use of residential care for children is increasing, especially for countries in economic transition, conflict or disaster zones. In sub-Saharan Africa recent reports indicate that the number of privately funded institutions has risen rapidly. A contributing factor is the concern about where to place the growing numbers of children orphaned by HIV/AIDS.

The evidence suggests that early institutional care is typically detrimental to all developmental domains of children. Features of institutional care that contribute to developmental delays include low staff to child ratios/interaction; low levels of staff experience and autonomy; strict routines; poor provision of books and play equipment; children's lack of personal possessions and individuality (e.g., birthday celebration); and children's lack of 'everyday' experiences and trips outside the institution. Often the staff are inadequately trained and poorly supervised, making basic mistakes.

Research over the last decade has confirmed earlier findings that institutional care in early life predisposes children to intellectual, behavioural and social problems later in life. Disinhibited attachments and emotional vulnerability shown by these children place them at risk of physical and sexual abuse, as their craving for attention may result in a readiness to trust teenage and adult strangers and make them obvious targets for substance misuse and sexual exploitation. In 2000, UNICEF carried out a national survey in Romania on "Child abuse in residential care institutions". The study found that 37.5 per cent of children in residential care institutions report that they have been victims of severe physical punishment or "beatings" (approximately two-thirds were boys and one-third girls). 77 per cent of cases reported residential care staff as the perpetrators. 19.6 per cent (approximately half boys and half girls) claimed to have been blackmailed for sexual activities and a further 4.3 per cent claimed that they were "constrained" to have sex. The reported perpetrators of these acts of sexual abuse were older residents of the same sex (50 per cent), older residents of the opposite sex (12 per cent) and institutional staff

(1.3 per cent), as well as relatives (3.9 per cent), other young people (2.6 per cent) and adults (1.3 per cent) outside the institution.

Many of the problems observed in samples of severely deprived children, such as stereotyped behaviours and eating problems, show rapid improvement once the child is removed from institutional care and placed in a supportive family environment. The age of placement into a kinship, foster or adopting family and the quality of the subsequent family care are important factors in the outcomes of children who have experienced institutional care

**Someone that matters. The quality of care in childcare institutions in Indonesia.**
Martin, F., and Sudrajat, T. (2007). Save the Children UK.
http://resourcecentre.savethechildren.se/library/someone-matters-quality-care-childcare-institutions-indonesia

There are an estimated 7000 childcare institutions across Indonesia caring for up to half a million children. The vast majority of these institutions were set up privately, particularly by faith based organisations, while the government owns and runs fewer than 40. While many receive some financial support from the government, most do not come under any type of supervision or monitoring. Despite an overt emphasis on supporting orphans, almost 90 per cent of children in the institutions surveyed still had at least one parent, while more than 56 per cent had both parents. The great majority of these children were neither parentless nor were they abandoned by their families. Instead they were placed in the institutions by their families primarily as a result of the economic situation in which they found themselves.

Indonesian institutions emphasise access to education as the primary aim for most of the institutions. Combined with an understanding of children's needs as primarily material (food, a place to stay and the costs of education) or religious/ spiritual (religious teaching and practice), this means that little attention is given to children's emotional, developmental or psycho-social needs. None of the childcare institutions had really assessed whether a child needed residential care in the first place or whether a more suitable family based alternative was available, whether in the child's own extended family or in another family.

The use of violence, in particular physical and psychological punishment, was found to be prevalent in the great majority of institutions. Government childcare institutions tended to have a militaristic style of operating with 'call-up', 'lining up', 'public hearings' and in terms of sanctions, push ups, roll overs, crawling and running or even in one instance collective beatings. Faith based institutions with strong regimes of rules and practices, in particular some of the more traditional Islamic based child care institutions, emphasised abiding by religious rules and teachings. Sanctions usually involved further religious teachings and exhortation, caning, hitting, public humiliation by shaving heads or soaking in dirty water. Children clearly felt that humiliating and degrading treatment including verbal abuse was just as bad as physical punishment and in some cases even worse. The constant 'belittling' of children and pejorative references to their status as 'neglected, abandoned children, orphans or children of destitute families' in some of the institutions not only undermined children's self-esteem and feelings of dignity, it contrasted starkly with the high ethical and religious values professed by these institutions.

The research found that children were generally expected not only to take care of themselves but also to do most of the caring for other children. In almost all of the institutions children were obligated to carry out a range of chores that were not simply about learning 'life skills' as often presented but which were indeed crucial to the actual running of the institutions. In most of the

institutions the children were not just providing support to adult staff but they were actually carrying out work instead of staff, such as laundry, cleaning, and cooking.

Despite some positive signs in a few instances, it was deeply worrying to find that only one institution out of the 37 assessed under this research had a child protection policy in place or any type of mechanism to identify and respond to violence against children.

**All Children Count: A Baseline Study of Children in Institutional Care in Malawi.**
UNICEF Malawi (2011). The Ministry of Gender, Children, and Community Development of Malawi; Centre for Social Research (CSR) of the University of Malawi.
http://www.bettercarenetwork.org/library/the-continuum-of-care/residential-care/all-children-count-a-baseline-study-of-children-in-institutional-care-in-malawi

This study describes the situation of children in institutional care and creates a database containing all institutions in Malawi catering for children requiring alternative care. Most children reported being happy because they had access to services not available at home, despite expressing a sense of loss for family and community. Nonetheless, frequent problems such as limited contact with families, a lack of management committees as required under government regulations, poorly trained staff and a lack of regular complaint systems, as well as specific children's rights violations were identified as needing to be addressed. Disturbingly, the institutions reported a total of 57 deaths of children in the institutions over the previous 12 month periods, although no information as to causes was available.

Most children reported that the care they received was better than they had enjoyed before entering the institution. Children said that they had received many things, listing items such as clothes, toys, shelter, body lotion, blankets, shoes, slippers, soap and suitcases. Some also slept on good beds and mattresses, which were not available at home because of poverty. Guardians and parents were also aware of the care the children received and said that these things were not available at home, which was why they had sent children to an institution. Children in institutions attended school and they were given writing materials, uniforms and text books. Their school fees were also paid. Some institutions had clinics. Where there was no clinic on site, sick children were taken to health facilities where costs were covered by the institution. In most institutions, even though some children complained about the food, they were assured of three meals a day. They could therefore concentrate on their studies, because they did not feel hungry all the time.

However, some problems were mentioned. These included a shortage of learning materials, poor meals, a lack of electricity in dormitories, having to get up early to do chores before going to school and not being allowed to visit their homes. In some institutions children were involved in activities such as cooking and physical exercises before school started in the morning. They said that by the time they got to class they were tired and lost concentration. There were instances when children were not able to practise their own religion. If children misbehaved they were advised, warned or given a punishing task (for example cleaning toilets or digging pits). Corporal punishment was said to be rare.

**My Heart is Here. Alternative Care and Reintegration of Child Trafficking Victims and Other Vulnerable Children**
Boyle, R. (2009). International Organisation for Migration.
http://www.bettercarenetwork.org/sites/default/files/My%20Heart%20Is%20Here.pdf

This study assesses the development, social integration and post-return reintegration issues facing child victims of trafficking and migration related exploitation in shelters and orphanages in Cambodia. A total of 133 children and 82 staff from 16 shelters and orphanages as well as a pseudofoster programme representing alternative care providers were investigated. The majority of the children (68 per cent) interviewed are long-term residents who lived at a shelter for at least one year. They are from families that are dysfunctional and fragile but not necessarily destitute. The interviewees were predominantly middle children with the typology including orphans, sexually abused, street children, domestic violence victims and those who had migrant experience (about one third), but with very few disabled or from ethnic minorities.

Most of the children appeared to be well-balanced psychologically, displaying a healthy self-esteem. They are satisfied with the level of positive reinforcement at the shelters, mainly given as verbal admiration. The most common causes for feeling unhappy are thinking about home and fighting. 56 per cent of the children found it easy to speak to the staff for behavioural related reasons. The shelter staff are the children's focal confidants, ahead of other children, teachers and parents. Main concerns revolve around children's families and future. The majority were not enthusiastic or were even very unhappy about leaving the shelter. Regarding post-shelter life, 79 per cent maintain a positive outlook based on the assumption of higher employment marketability due to the education and training received. School education was the most appreciated feature of the shelters. Children rarely or never get sick. Almost every child agreed that shelter food is better than the food at home. 92 per cent expressed that they were getting more food now and subsequently claimed an increase in weight. In addition to having more friends, toys and sport equipment to play with, the children expressed delight at the opportunities to participate in group activities, team games and novel recreation. Nearly all of the children were united in a predilection towards living at the shelter rather than at home. Most held themselves accountable for helping with shelter housework (80 per cent), taking care of younger children (65 per cent), and reporting problems to staff (62 per cent).

The staff were less optimistic regarding children's abilities with only 39 per cent ranking them on a par with community children. The staff do not have a good understanding of what promotes children's happiness, regarding good grades at school and going out to be the most pertinent factors. With all positive responses to the levels of communication (very good 56 per cent, good 26 per cent and average 17 per cent), the staff clearly does not feel the need for improvements, and ignoring the fact that many children (44 per cent) feel reluctant to talk to them. Good relations between younger and older children and towards newcomers are confirmed. Fighting frequency reported as observed "sometimes" by about 50 per cent is higher than indicated by children. Bullying is either nearly non-existing or undetected, perhaps not understood. All the staff were unanimous in declaring the atmosphere between the shelter staff and children as very good.

**Maltreatment and mental health in institutional care—Comparing early and late institutionalized children in Tanzania.**
Hermenau, K., Hecker, T., Elbert, T., & Ruf-Leuschner, M. (2014). *Infant mental health journal, 35(2),* 102-110. http://onlinelibrary.wiley.com/wol1/doi/10.1002/imhj.21440/full

The authors compared 35 Tanzanian children who were institutionalised at birth to 4 years of age with a matched group of 35 children who were institutionalised at 5 to 14 years of age. They found that children who were institutionalised in the first 4 years of life reported more types of maltreatment in institutional care and more mental health problems at primary school age than did children who were placed later into institutional care. However, concerning the lifetime amount of adverse childhood experience types, they only found a nonsignificant slightly higher amount reported by early institutionalised children. Although the groups did not differ significantly in the lifetime amount of adverse childhood experience types, they differed in the amount of mental health problems. Early institutionalised children reported more depressive symptoms, more aggressive behaviour and more internalising and externalising problems at primary school age. A great majority of the whole sample of institutionalised children reported at least one adverse childhood experience type from their time in institutional care. In countries such as Tanzania in which corporal punishment is still common placement in institutional care does not represent a protection from further maltreatment. They conclude that maltreatment in institutional care in Tanzania is a common and often neglected problem that heightens the potential harm of institutional care on the child's mental health.

## Violence against children

**Violence Against Children in Care and Justice Institutions.**
Sérgio Pinheiro, P. (2006). Chapter 5 in "World Report on Violence against Children" United Nations Secretary-General's Study on Violence against Children. UN.
https://www.unicef.org/violencestudy/reports.html

Reports from many countries in all regions show that institutionalised children are often subjected to violence from staff and officials responsible for their well-being. This can include torture, beatings, isolation, restraints, rape, harassment, and humiliation. In addition, the stigmatisation, isolation and often de-socialisation that results from these institutionalised responses place boys and girls at much greater risk of being exposed to further violence and in some cases becoming perpetrators of it.

The lack of public concern about brutality towards children in correctional institutions may reflect societies' rejection of children who do not conform to conventional social behaviour. Such stigmatisation may also be expressed in the abusive attitudes and behaviour of poorly trained staff. Stigma also contributes to violence against children with disabilities. Research has shown that they are frequently at higher risk of staff violence in institutions than other children. The violence suffered by children in institutions can be exacerbated when they are housed with adults or older children; this may lead to physical and sexual victimisation. Institutions housing children are often closed to public scrutiny. They lack a basic legal framework prohibiting all violence, and also lack adequate government regulation and oversight, effective complaints mechanisms, and inspection systems. Perpetrators are rarely held accountable, allowing high rates of violence to continue unchecked, thereby perpetuating tolerance of violence against children.

Factors contributing to violence against children in care institutions:

- **Low priority**: the low level of importance accorded to the most disadvantaged children in society.
- **Inadequate staffing**: Unqualified and poorly remunerated staff are widely recognised as a key factor linked to violence within institutions. Low pay and status frequently result in poorly motivated employees and rapid staff turnover, and under-staffing is a serious problem. Relatively few staff in care institutions receive any special training in child development or rights, or information about issues of violence. Overwhelmed staff may resort to violent measures to maintain discipline, particularly when supervision is lacking.
- **Lack of monitoring and oversight:** Residential care and detention facilities are often unregulated and closed to outside scrutiny, especially those run by private agencies, faith-based organisations, and NGOs, or that are situated in isolated areas. In such circumstances, violence may continue for years until an extreme incident brings it to light. Moreover, individuals responsible for violence against children in care and justice systems are rarely held accountable for their actions.
- **Mixing different levels of vulnerability:** Many facilities fail to segregate vulnerable children from dangerous peers. Children who are vulnerable to violence because of age, size, sex or other characteristics are often housed together with older children with a history of violent behaviour.

**From a Whisper to a Shout: A Call to End Violence Against Children in Alternative Care**
SOS Children's Villages (2014). SOS Children's Villages and the University of Bedfordshire. http://www.bettercarenetwork.org/library/particular-threats-to-childrens-care-and-protection/child-abuse-and-neglect/from-a-whisper-to-a-shout-a-call-to-end-violence-against-children-in-alternative-care

This report draws on evidence from an extensive global literature review, and assessments of the implementation of the Guidelines for the Alternative Care of Children in 21 countries around the world. A combination of multi-layered vulnerability and enduring social conditions are the basis of much violence in alternative care. A lack of legal protection, society's tolerance and acceptance of violence and the additional vulnerabilities experienced by children who are already discriminated against can mean that they are subjected to harm with impunity. Alternative care does not inherently perpetuate violence, but rather the incidence of violence is inextricably linked to the overall quality of care and the ability of states to monitor standards. Improvements in the quality of care, including adequate planning and assessments to ensure "suitable" alternative care placements; the implementation of monitoring and effective oversight; and the provision of independent complaints mechanisms would reduce the risk of violence against children.

Physical abuse can be the result of corporal punishment, which is commonplace in many parts of the world. Children living in alternative care are highly vulnerable to physical abuse, especially under the guise of "discipline". Emotional and psychological abuse also includes a wide range of behaviours, for example: bullying; verbal abuse; ridicule; degradation; humiliation; psychological domination or control; isolation; confinement; restricting family visits; sleep deprivation; destruction of personal belongings; and degrading and menial labour. It is perhaps the lack of strong relationships that puts children in alternative care at particular risk of facing sexual abuse outside the care setting: there is substantial evidence that residential care settings may be targeted by abusers in the wider community. Neglect is one of most common forms of violence experienced by children in alternative care. It can be defined as the failure to provide for child

development, when in a position to do so, in one or more of the following areas: nutrition, clothing, supervision, and medical care. Neglect in alternative care can only occur in cases where reasonable resources are available to provide for children and therefore it is difficult to measure, resulting in a lack of international research evidence. However, the consensus seems to be that neglect is widespread, especially in residential and institutional settings. Research has found that compared to their non-disabled peers, children with disabilities are 1.8 times more likely to be neglected and 2.8 times more likely to be emotionally neglected in institutions. Peer violence refers to the different forms of violence that are inflicted on children in alternative care by other children. According to children and young people, this is one of the most significant ways they experience violence in alternative care and it is a form of violence that tends to be underestimated by carers.

The causes for such levels of harmful institutional practice have mainly been attributed to: the size of institutions; the mixing of different age groups; the lack of resources; poor management and lack of support to management; lack of clear aims and objectives; and poorly trained residential staff. Other studies attribute it to the closed and often isolated nature of institutional care and the fact that many resident children are unaware of their rights and are powerless to defend themselves, with children with disabilities often being the most vulnerable. There are also examples where staff perpetrators deliberately created institutional environments that promoted abuse.

**Abandoned By The State. Violence, Neglect, and Isolation for Children with Disabilities in Russian Orphanages.**
HRW (2014). Human Rights Watch
http://resourcecentre.savethechildren.se/sites/default/files/documents/5416cec64.pdf

Nearly 30 percent of all Russian children with disabilities live separately from their families and communities in closed institutions. Children with disabilities in state orphanages may be subject to serious abuses and neglect that severely impede their physical, emotional, and intellectual growth. This report is based on visits by Human Rights Watch researchers to 10 orphanages in 6 regions of Russia, as well as on more than 200 interviews with parents, children, and young people currently and formerly living in institutions in these regions in addition to 2 other regions of Russia. While Russia lacks comprehensive and clear statistics on children in state institutions or foster care, experts estimate that the overwhelming majority of these children have at least one living parent. Russia's high rate of institutionalisation of children with disabilities results from a lack of government and state-supported services, such as inclusive education, accessible rehabilitation, and other support that would make it feasible for children's families to raise them.

Children described how orphanage staff beat them, used physical restraints to tie them to furniture, or gave them powerful sedatives in efforts to control behaviour that staff deemed undesirable. Staff also forcibly isolated children, denied them contact with their relatives, and sometimes forced them to undergo psychiatric hospitalisation as punishment. Many children also experienced poor nutrition and lack of medical care and rehabilitation, resulting in some cases in severely stunted growth and lack of normal physical development. The findings are presented with the understanding that well-intentioned staff often engage in unacceptable childrearing methods. This is because they lack information, such as training in nonviolent disciplinary methods, and resources, such as additional personnel to help them care for large numbers of children.

## Commodification of orphans

**Addicted to Orphans: How the Global Orphan Industrial Complex Jeopardizes Local Child Protection Systems.**
Cheney, K. E., & Rotabi, K. S. (2014). *Young*, 11, 1.
https://www.academia.edu/8612550/_Addicted_to_Orphans_How_the_global_orphan_industrial_complex_jeopardizes_local_child_protection_systems

Many charitable organisations promote the building of orphanages, encourage volunteer work at such institutions, and even posit international adoption as a solution to "orphan crises" – despite their cost inefficiency or lack of support for local efforts to improve overall child protection. Persistent narratives of "orphan rescue" drive an industry that, counter to its stated goal, unnecessarily institutionalises children and even "manufactures" orphans for profit.

In Uganda, the orphan rescue discourse is more powerful, and adoption proponents more moneyed, than Uganda's child welfare system. It is driving the establishment of orphanages along with the institutionalisation of children, sometimes for the explicit purpose of international adoption. Evidence is already pointing to alarming irregularities, including recruitment of children for international adoption; "child laundering" through altering and forgery of records; inducement of birth parents to relinquish children; and extortion of funds from prospective adoptive parents. Ugandan children are not only being handpicked for international adoption from institutions but from impoverished slums and villages where "scouts" are pressuring poor parents with little understanding of formal adoption to give up their children. This is often achieved by recruiters presenting adoption as educational sponsorship – and thus an opportunity that no impoverished parent could turn down.

Looking at the whole system, the promotion of institutionalisation and intercountry adoption is not only damaging to children, families, and communities but can have a profoundly negative effect on attempts to professionalise a child welfare system that promotes family support and preservation. When intercountry adoption and the evangelical movement to rescue "orphans" takes hold over the child protection system, institutionalising a child and sending her abroad often become the first response to a child-and-family crisis rather than recognising that, according to the Hague Convention, it is a final option after all familial and in-country options are explored. That is, concerted efforts of family support, preservation, and family-child reunification for those children living in institutions are no longer a priority as social workers respond to the international demand for healthy orphans. By spuriously diverting attention to the plight of "orphans" in developing countries, the orphan industrial complex undermines child protection mechanisms for all children and has an exponential risk effect in the greater community.

**Paper Orphans: Exploring Child Trafficking for the Purpose of Orphanages.**
van Doore, K. E. (2016). *The International Journal of Children's Rights, 24*(2), 378-407.
http://booksandjournals.brillonline.com/content/journals/10.1163/15718182-02402006

This article puts forward a clear legal argument for the situation of paper orphans to be considered as a form of child trafficking under international law. The term "paper orphans" identifies children who have been who have been displaced from their biological families, fraudulently constructed as "orphans" and placed in orphanages for the purpose of profit; and "paper orphaning" identifies the process of movement of the child from the family, the creation of fraudulent documentation, often including death certificates of parents and new identity registration documents, and placement in an orphanage. The situation of paper orphans

has not previously been analysed as a form of child trafficking due to a perceived failure to meet the requirement of exploitation. In this paper, the author argues that a child's ongoing institutionalisation in an orphanage is a form of exploitation for the purposes of article 3(a) of the Trafficking Protocol. A thorough analysis of the exploitation 'at a minimum' requirement illustrated that paper orphans can be considered as experiencing included forms of exploitation such as forced labour through begging, sexual exploitation, slavery and practices similar to slavery.

Beyond the exclusionary concept of the 'at a minimum' requirement, the article argues for a broader definition of exploitation to be utilised for child trafficking which could encompass the ongoing institutionalisation of paper orphans. The practical ramifications of one child held in a brothel being considered a victim of trafficking, whilst a child institutionalised in an orphanage is not considered trafficked, seems to be a contradiction in interpretation, particularly where both children are removed from their families for the ultimate purpose of profit. For paper orphans presently suffering in ongoing institutionalisation, it is an unacceptable interpretation which effectively denies them access to remedies or justice.

**Expert Paper: International Volunteering and Child Sexual Abuse.**
van Doore, K., Martin, F., and McKeon, A. (2016). Better Volunteering Better Care. http://www.bettercarenetwork.org/sites/default/files/Expert%20Paper%20-%20International%20Volunteering%20and%20Child%20Sexual%20Abuse.pdf

Children in residential care are already at a higher risk of abuse and exploitation and are exposed to further risk of harm by unqualified and unsupervised international volunteers. In addition, residential care operators can come to see international volunteering and children in their 'orphanages' as a key means of income, fuelling the growth of residential care in the country and promoting children's unnecessary separation from their families.

In many developing nations, there are few effective regulatory systems with oversight over residential care facilities. There are often no consistent regulations requiring residential care centres or tourism operators to have a Child Protection Policy or a Code of Conduct for volunteers in place, and where they are, they are often not implemented properly or enforced. Lack of accountability and regulation in residential care centres means that abuse is often rampant. There is a high risk of sexual, exploitation by international volunteers because many residential care centres and tourism operators offering volunteer placements do not require police clearance reports; do not conduct background checks; and do not provide adequate supervision of volunteers once they are spending time with children.

Children in residential care centres are often used as a commercial entity to attract funds through donations or volunteers and they may be sent out to beg or perform on behalf of centres. This exposes children to an additional layer of exploitation – the commodification of their false status of orphanhood and maintenance in an institutional environment when they have family that could care for them. In some cases, children are kept in destitute or unhealthy conditions to appeal to donors and volunteers. In addition, there is some evidence that volunteering makes children vulnerable to other forms of harm, impacting their socioemotional development. Children become attached to multiple short-term visitors and volunteers and are then subject to repeated abandonment when these volunteers leave.

Significant overlap between international volunteering and child sex tourism has been noted in research due to the particular vulnerability of children in residential care centres, and children's perceived accessibility. However, equally alarming is an environment of unsupervised access and contact with vulnerable children that can create opportunities for individuals who did not travel for that purpose, or had not previously engaged in sexual exploitation or abuse of children, to do so.

Where centres continue to utilise international volunteers, they need to ensure that Child Protection Policies contain multiple measures to protect children. Volunteers should not reside on the same premises as children, nor should they ever be alone with children. As part of these measures, centres should systematically ensure that they conduct background and criminal checks on all potential volunteers before entering the country for placement or, if they are already in the country, prior to the commencement of that placement. Volunteers should be appropriately skilled, and focused on capacity building of local staff, without direct contact with children. Further, centres should not allow any unscreened volunteers or visitors on the premises to limit potential unsupervised access to children. Child Protection Policies should also form part of a contract with volunteers, clearly articulating the expectations of the volunteer regarding protecting children from the risk of abuse.

# 4. Interventions and what works

This section provides examples of measures that have been found to improve care in institutions.

**Childhood adversity, mental ill-health and aggressive behavior in an African orphanage: Changes in response to trauma-focused therapy and the implementation of a new instructional system.**
Hermenau, K., Hecker, T., Ruf, M., Schauer, E., Elbert, T., & Schauer, M. (2011). *Child and Adolescent Psychiatry and Mental Health,* 5(1), 1.
http://capmh.biomedcentral.com/articles/10.1186/1753-2000-5-29

The authors interviewed all children in a Tanzanian orphanage before and six months after the implementation of a new instructional system. To improve the living conditions of the children a new instructional system was implemented that placed a ban on any violent punishment by caregivers and introduced positive parenting strategies. Furthermore, all children with a post-traumatic stress disorder (PTSD) received KIDNET, a child-friendly version of narrative exposure therapy. A time period of six months allowed the caretakers to get used to the new strategies and the children to profit from the changes, but also to recover from PTSD.

The new instructional system included training sessions for the caretakers that aimed for a better understanding towards the children and for a positive relationship between caretaker and child in order to reduce violent punishment and to foster secure bonding. After the workshop a special needs teacher supervised the implementation of the new system for six months. All caretakers were informed that any use of physical punishment and other forms of maltreatment, such as punishing children by sleeping on the floor, would lead to instant dismissal. Moreover, all boys and girls of twelve years or older were also informed about this ban and about zero tolerance of violence, also among peers, and received sex education, including information on HIV/AIDS.

After six months, there was a significant drop of violence experienced in the orphanage but the expected decline in mental ill-health was statistically significant only for PTSD. As expected, the relationship between violence experienced in the orphanage and mental ill-health could not be found after six months. The findings suggest that the violence experienced in the orphanage plays an essential role in the ill-mental health of the children, even more important than the amount of violence experienced in the family of origin, before entering the orphanage, or in school and neighbourhood. Therefore, it can be assumed that the parenting style of the caretakers plays a crucial role for the mental health and development of the children. Caretakers without specific pre-training in childcare and with little formal education could understand and apply positive parenting strategies and a zero-violence policy. Even though the experienced violence declined in general, more aggressive children nevertheless reported more violence experienced in the orphanage. Aggressive behaviour in children can lead to violent reactions of

other children or caretakers, while experienced violence can correspondingly lead back to aggressive behaviour.

**From maid to mother: Transforming facilities, staff training, and caregiver dignity in an institutional facility for young children in Nepal.**
Wright, A. C., Lamsal, D., Ksetree, M., Sharma, A., & Jaffe, K. (2014). *Infant mental health journal, 35(2),* 132-143. http://onlinelibrary.wiley.com/doi/10.1002/imhj.21429/full

The Infant Care Facility Improvement Project was conducted by the International Child Resource Institute Nepal in the Nepal Children's Organization's (NCO) Bal Mandir facility, the oldest and largest orphanage in Kathmandu, Nepal, from July 2004 to June 2008. The project updated physical infrastructure, created child-friendly spaces, and trained staff in developmentally appropriate care, with the aim of improving the health, safety, and development of young children birth to age 6 years.

Two interventions were implemented to meet the project's goal: (a) facility infrastructure improvement to make spaces more safe, sanitary, and child friendly, with reduced group sizes; and (b) training of caregivers in early childhood development and effective caregiving practices, with ongoing mentoring and support. Weekly caregiver trainings and meeting sessions were conducted during the period of intervention. Each session lasted about 3 hours. The caregivers learned about children's development and ways to promote holistic development through play, gross motor stimulation, language, and other activities. In their first weekly meeting, the caregivers were asked to decide what they would like to be called by the children in Bal Mandir because the term used to designate them, Aaya (or Maid), was felt to be inappropriate and humiliating. Of the 16 caregivers participating in the discussion, the majority of them suggested the more respectful title of Aama (or Mother). This simple change in title has had a significant impact on the dignity of the caregivers; they now feel more respected and honoured, and proud of being listened to by management. Similarly, the children have felt that they have mother figures in the orphanage, creating a situation where the children are now starting to feel a sense of family within the orphanage.

After the intervention, the four rooms for young children look more child-friendly, and the children appear healthier and happier. After the intervention, they appear more confident and curious in their general affect and demonstrate more intentional actions, including jumping, crawling, walking, climbing, clapping, and speaking. Children show more signs of engagement with the caregivers, including vocalisations during play. Because the standard of hygiene improved, the incidence of illness has decreased, and the rate of infection has dropped significantly.

**Ending Legalized Violence Against Children: Prohibiting and Eliminating Corporal Punishment in All Alternative Care and Day Care Settings**
Global Initiative to End All Corporal Punishment of Children (2012) Global Initiative to End All Corporal Punishment of Children; Save the Children Sweden.
http://www.bettercarenetwork.org/sites/default/files/attachments/Ending%20Legalised%20Violence%20Against%20Children.pdf

This report provides guidance on achieving law reform which gives children in alternative care and day care the protection from all forms of corporal and other cruel and degrading punishment. In alternative care and day care settings progress towards prohibition of corporal punishment has been especially slow, with these settings often among the last in which prohibition is enacted. Worldwide, only 52 states explicitly prohibit corporal punishment of children in all group care, including institutional care. Only 40 prohibit corporal punishment of children in all formal foster

care, and only 41 in all formal day care settings. At least 123 states have no prohibition of corporal punishment in any form of alternative care or day care. Prohibition is an obligation not only in institutional settings, but also in the family- and community-based forms of care which are increasingly replacing institutions, and in all day care settings. The development in many states of properly regulated alternative care systems, child protection systems and early childhood care and education systems must also include prohibition of all corporal punishment.

Adults' use of corporal punishment is influenced by habit, tradition and lack of knowledge of alternatives, as well as the legal and social acceptance of this form of violence against children. For this reason, eliminating corporal punishment requires public education and awareness raising, and training of all those working with children. Staff should also be trained on child development, and on meeting the needs of particular children, including children with physical, mental and other disabilities. In addition, the elimination of corporal punishment, including in informal care settings, requires awareness raising across the whole of society about children's right to be protected from all corporal punishment. Information, advice and support should be provided to parents, other family members and all those who work with children.

Ideally, reform will lead to the enactment of legislation which explicitly prohibits "all forms of corporal punishment and other cruel or degrading forms of punishment". Prohibition of "violence", "abuse" or "inhuman and degrading treatment", or provisions protecting children's "physical integrity" or "dignity" do not amount to explicit prohibition of corporal punishment because of the deep rooted and widespread idea that a certain level of corporal punishment in childrearing is not "abusive" or does not count as "violence". Prohibition must:

- be in enforceable legislation passed by Parliament
- ensure the repeal of all defences and authorisations of corporal punishment
- clearly prohibit all corporal punishment and other cruel or degrading punishment.

**Interventions to improve supervised contact visits between children in out of home care and their parents: a systematic review.**
Bullen, T., Taplin, S., McArthur, M., Humphreys, C., & Kertesz, M. (2016). *Child & Family Social Work.* http://dx.doi.org/10.1111/cfs.12301

The aim of this systematic review was to evaluate the evidence for interventions aimed at improving the quality of contact visits between parents and their children who are in out-of-home care. Twelve studies were included in this review, from the USA, Canada and Australia. Although there was a lack of large scale, methodologically rigorous studies with long-term follow-up, some promising findings were identified: the literature indicates individual family support and group programmes have the potential to improve parent–child relationships and the quality of contact visits. In this review, contact refers to face-to-face visits with parents, when parents are no longer providing primary care to the child or young person. It focuses on supervised contact whereby a third person supervises the contact visit between the parent and child.

Most of the individual family support interventions used pre-visit planning and coaching strategies with parents during visits. Despite the limited findings from these studies, the evidence indicates that structured tailored parental support may improve interactions between parents and their children at visits. The group programmes tended to focus on parents who were less likely to be reunified with their children. All the group work programmes use structured discussion to cover topics and provide parents with opportunities to share experiences with other parents in a non-judgemental environment. These studies offer stronger evidence that these types of programmes

might be effective in improving parenting knowledge and behaviours, and may lead to improvement in the quality of parent–child interactions at visits. Parents reported improved capacity to manage their emotions and parents' satisfaction with the programmes was high. The results of this review suggest both individual family support and group programmes have the potential to improve parent–child relationships and the quality of contact visits. The promising results of studies where carers and parents jointly receive interventions are encouraging and address the needs of both parents and carers to manage visits.

**Residential care for abandoned children and their integration into a family-based setting in Uganda: Lessons for policy and programming.**
Walakira, E. J., Ochen, E. A., Bukuluki, P., & Alllan, S. (2014). *Infant mental health journal,* 35(2), 144-150. http://onlinelibrary.wiley.com/wol1/doi/10.1002/imhj.21432/full

This article describes a model of care for abandoned and neglected infants in need of urgent physical, social, and medical support as implemented by the Child's i Foundation, an international, nongovernmental organisation operating in Uganda. CiF receives abandoned children in Malaika Babies' Home. The babies aged 0 to 2 years have to be discharged within a maximum of 6 months to their extended birth families or foster/adoptive families. Eighty-four percent of children leave the babies' home within 6 months.

Following admission, babies are allocated to a social worker who seeks detailed contact information from the person who reported the abandoned child. Tracing the birth family begins within 48 hours of admission. Radio announcements are placed with local radio stations in the area where the child was abandoned. Newspaper advertisements with photographs of the child also are placed in the local language newspapers. To build a protective family environment, CiF continues to monitor and support the families with whom babies are resettled throughout Uganda for 1 to 3 years. Visits are made by social workers supported by family-support workers to monitor their progress and address any concerns that may arise. As part of the resettlement process, CiF provides a "start-up package" of a cot and/or mattress, clothes for all the children in the family, seeds for food cultivation if needed, and formula milk for younger babies. The aim of CiF's extended period of post-resettlement visits is to ensure that children are thriving and that the arrangements for care are sustainable in the longer term.

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# 6. Further resources

**Guidelines for the Alternative Care of Children UN Resolution (2010):**
https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

**Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children':**
http://www.alternativecareguidelines.org/MovingForward/tabid/2798/language/en-GB/Default.aspx

**Interagency Guidelines on Children's Reintegration (2016):**
http://www.familyforeverychild.org/report/guidelines-childrens-reintegration/

## Additional bibliography

Petrowski, N., Cappa, C., and Gross, P. (2017) Estimating the number of children in formal alternative care, *Child Abuse & Neglect* (70), http://dx.doi.org/10.1016/j.chiabu.2016.11.026

UNICEF (2009) *Progress for Children: A Report Card on Child Protection*, No. 8. https://www.unicef.org/publications/files/Progress_for_Children-No.8_EN_081309.pdf

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## About this report

*This report is based on five days of desk-based research. The K4D research helpdesk provides rapid syntheses of a selection of recent relevant literature and international expert thinking in response to specific questions relating to international development. For any enquiries, contact helpdesk@k4d.info.*

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