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FAMILIES, NOT ORPHANAGES

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Better Care Network (BCN) invited John Williamson and Aaron Greenberg to write this paper. BCN is committed to improving the situation of children without adequate family care. This paper is being published to share the findings of the authors and to stimulate debate and further research on this topic.

The findings and conclusions expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

The views expressed in this paper are those of the authors and not necessarily those of United Nations Children's Fund (UNICEF).

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AIDS and other diseases, armed conflict, natural disasters, forced displacement and extreme poverty leave millions of children orphaned, separated, or on the brink of family breakdown. These children need and have a right to protection and care, and governments have an obligation under law to respond. The Convention on the Rights of the Child outlines these obligations; Article 20 is specifically concerned with alternative care for children, though several other articles relate to child care and protection. Regrettably, the fundamental “best interests” principle of the Convention is honoured more in principle than in practice with regard to the placement of children in potentially harmful residential care.¹

The number of children in institutional care around the world is difficult to determine due to inadequate monitoring by governments. Based on extrapolations from limited existing data, UNICEF estimates that at least two million children are in orphanages around the world, acknowledging that this is probably a significant underestimate.² The unfortunate fact is that many governments, particularly those that lack adequate resources, do not know how many orphanages exist within their borders, much less the number of children within them. Although governments generally have policies that require organizations to seek authorization to establish residential care for children and to register such facilities, privately run children’s institutions have been allowed to proliferate. In many countries, local or international organizations have been able to open and operate such facilities with little or no government oversight.

With particular attention to lower income countries, this paper examines the mismatch between children’s needs and the realities and long-term effects of residential institutions. Evidence presented in this paper indicates that the number of orphanages is increasing, particularly in countries impacted by conflict, displacement, AIDS, high poverty rates or a combination of these factors. The paper examines available evidence on the typical reasons why children end up in institutions, and the consequences and costs of providing this type of care compared to other options. The paper concludes with a description of better care alternatives and recommendations for policy-makers.

Based on the available evidence and our respective field experience, our position is that residential care is greatly over-used in many parts of the world. However, in some countries and in some specific cases, it may be acceptable. For example, some adolescents living on the street are not willing or able to return to their family of origin or live in a substitute family, and some type of residential care may be a first step in getting the child off the street. For some children, residential care is the best currently available alternative to an abusive family situation, and it can be a short-term measure until the child can be placed with a family. In all too many

ⁱ In this paper, “orphanages,” “residential care,” “children’s institutions,” “residential institutions” and “institutions” are used synonymously to refer to residential facilities in which groups of children are cared for by paid personnel.

countries, though, institutional care remains the default option for children without adequate family care. We believe that better family-based alternatives should be developed and that inadequate imagination and resources have thus far been directed to doing so.

It is not the intention of this paper to demonize residential care. They can be well managed and run with only the best intentions for children. There are many groups and individuals around the world who support, manage, work or volunteer in orphanages. Some of this work is rooted in good practice - integrated with the surrounding community, staffed by qualified staff caring for no more than 8-10 children, active in family tracing and reunification, and linked with broader systems (formal state structures and informal community mechanisms) to ensure every child's case is regularly reviewed with the aim of placing that child back into family care.

Neither does this paper seek to idealize family care. As the United Nations Study on Violence against Children has revealed, neglect and abuse occur in families at an alarming rate.³ If supportive interventions cannot improve a family situation where there is serious neglect or abuse, the child should be placed with a family that will provide a nurturing environment. The concept of a "good enough" family has been put forward as a way of recognizing the inherent imperfection in families while also placing a premium on love, care, continuity, commitment and facilitation of development,⁴—all of which are better fulfilled in a family setting. Although applied in the context of child and family welfare in the developed world, in many ways the concept is relevant to the arguments presented in this paper. A "good enough" family may not be the ideal family, but it is often far better than the alternative in terms of what the evidence shows is in the best interests of the child.

In November 2009, the United Nations welcomed the "Guidelines for the Alternative Care of Children."⁵ At the heart of the document is a call for governments to prevent unnecessary separation of children from their families by strengthening social services and social protection mechanisms in their countries. The Guidelines acknowledge that some residential care will be needed for some children. However, the emphasis and priority is on developing and supporting family-based care alternatives. This paper aims to underscore and further articulate this position with evidence from around the world, which has and accumulated for over 100 years.

PROBLEMS WITH RESIDENTIAL CARE

Children need more than good physical care. They also need the love, attention and an attachment figure from whom they develop a secure base on which all other relationships are built. Research in the early 1900s and work on the effects of institutional care and attachment theory beginning in the 1940s, especially that of John Bowlby, established a foundation for the current scientific understanding of children's developmental requirements⁶ that led to policy change in post-war Europe and the United States.ⁱⁱ Based on their research during the Second World War, Anna Freud and Dorothy Burlingham described the importance of family care in stark terms:

The war acquires comparatively little significance for children so long as it only threatens their lives, disturbs their material comfort or cuts their food rations. It becomes enormously significant the moment it breaks up family life and uproots the first emotional attachments of the child within the family group.,⁷

This emphasis is echoed in more recent work on social welfare policy, this time in Africa. A 1994 study by the Department of Paediatrics of the University of Zimbabwe and the Department of Social Welfare concluded that:

The potential for an inappropriate response to the orphan crisis may occur in the Zimbabwean situation, where a number of organizations are considering building new institutions in the absence of any official and enforced policy relating to orphan care... To families struggling to cope with orphans in their care, a Children's Home naturally appeals because the child is guaranteed food, clothing and an education. Programmes to keep children with the community, surrounded by leaders and peers they know and love, are ultimately less costly, both in terms of finance and the emotional cost to the child.⁸

There is now an abundance of global evidence demonstrating serious developmental problems associated with placement in residential care.⁹ For the last half century, child development specialists have recognized that residential institutions consistently fail to meet children's developmental needs for attachment, acculturation and social integration.¹⁰

A particular shortcoming of institutional care is that young children typically do not experience the continuity of care that they need to form a lasting attachment with an adult caregiver. Ongoing and meaningful contact between a child and an

ii John Bowlby's work on the effects of institutional care on children in the 1940s led to his commissioning by the World Health Organization in 1951 to author *Maternal Care and Mental Health* on the mental health of homeless children in Europe after the Second World War. The publication was highly influential and helped motivate policy changes regarding institutionalization in Europe and the United States. Mary Ainsworth also made important contributions around this time through her observations and research around the importance of maternal care in Uganda.

individual care provider is almost always impossible to maintain in a residential institution because of the high ratio of children to staff, the high frequency of staff turnover and the nature of shift work. Institutions have their own “culture,” which is often rigid and lacking in basic community and family socialization. These children have difficulty forming and maintaining relationships throughout their childhood, adolescence and adult lives. Indeed, those who have visited an orphanage are likely to have been approached by young children wanting to touch them or hold their hand. Although such behaviour may initially seem to be an expression of spontaneous affection, it is actually a symptom of a significant attachment problem.¹¹ A young child with a secure sense of attachment is more likely to be cautious, even fearful, of strangers, rather than seeking to touch them.

A rule of thumb is that for every three months that a young child resides in an institution, they lose one month of development.¹² A 2004 study based on survey results from 32 European countries and in-depth studies in nine of the countries, which considered the “risk of harm in terms of attachment disorder, developmental delay and neural atrophy in the developing brain reached the conclusion that... NO child under three years should be placed in a residential care institution without a parent/primary caregiver.”¹³

A longitudinal study by the Bucharest Early Intervention Project (BEIP) found that young children who were shifted from an institution to supported foster care before age two made dramatic developmental gains across several cognitive and emotional development measures compared to those who continued to live in institutional care and whose situation worsened considerably.¹⁴ Other research in Central and Eastern Europe has led to similar conclusions.¹⁵ Institutions like these are not only crippling children’s potential and limiting their future, they are also restricting national economic, political and social growth.

Countries with a history of institutional care have seen developmental problems emerge as these children grow into young adults and experience difficulty reintegrating into society. Research in Russia has shown that one in three children who leaves residential care becomes homeless, one in five ends up with a criminal record and up to one in 10 commits suicide.¹⁶ A meta-analysis of 75 studies (more than 3,800 children in 19 countries) found that children reared in orphanages had, on average, an IQ 20 points lower than their peers in foster care.¹⁷

Institutional care is more expensive per child than other forms of alternative care. Residential care facilities require staffing and upkeep: salaries must be paid, buildings maintained, food prepared and services provided. Actual costs vary among countries and programs, but comparisons consistently demonstrate

that many more children can be supported in family care for the cost of keeping one child in an institution. Robust cost-comparisons are found in Central and Eastern Europe. In Romania, the World Bank calculated that professional foster care would cost USD\$91 per month, per child (based on 1998 official exchange rates) compared to between USD\$201 and USD\$280 per month/per child for the cost of institutional care. High-quality, community-based residential care was estimated at between USD\$98 and USD\$132 per month, per child, with adoption and family reintegration costing an average of USD\$19 per child.¹⁸ Similar findings are observed in other regions. The annual cost for one child in residential care in the Kagera region of Tanzania was more than USD\$1,000, about six times the cost of supporting a child in foster care.¹⁹ A study in South Africa found residential care to be up to six times more expensive than providing care for children living in vulnerable families, and four times more expensive than foster care or statutory adoption.²⁰ A cost comparison in east and central Africa by Save the Children UK found residential care to be 10 times more expensive than community-based forms of care.²¹

The per-child costs cited above offer meaningful points of reference, but they do not tell the whole story. For example, they do not take into account social welfare infrastructure investments that may be needed (e.g., social work training and social welfare services that enhance the effectiveness of foster care and reunification). Also, when there is a transition to family-based care, total costs are likely to increase for an interim period because institutional care must be maintained until new family-based alternatives are developed. However, it is clear that in the medium and longer term, the resources that would have been used to sustain institutional care could be redirected to provide improved care for a much larger number of children through family- and community-based efforts. Family-based care not only tends to lead to better developmental outcomes, but it is also ultimately a way of using resources to benefit more children.

It is poverty that pushes most children into institutions. Studies focusing on the reasons for institutional placements consistently reflect that poverty is the driving force behind their placement. For example, a study based on case studies of Sri Lanka, Bulgaria and Moldova found, “that poverty is a major underlying cause of children being received into institutional care and that such reception into care is a costly, inappropriate and often harmful response to adverse economic circumstances.” Furthermore, the case studies show “that resources committed to institutions can be more effectively used to combat poverty if provided to alternative, community-based support organizations for children and families.”²²

A large proportion of children in institutional care have at least one living parent, but the parent has significant difficulty providing care or is unwilling or unable to do so. In Sri Lanka, for example, 92 per cent of children in private residential institutions had one or both parents living, and more than 40 per cent were admitted due to poverty.²³ In Zimbabwe, where nearly 40 per cent of children in orphanages have a surviving parent and nearly 60 per cent have a contactable relative, poverty was cited as the driving reason for placement.²⁴ In an assessment of 49 orphanages in war-torn and impoverished Liberia, 98 per cent of the children had at least one surviving parent.²⁵ In Afghanistan, research implicates the loss of a father (which in many cases leads to exacerbated household poverty) as the reason for more than 30 per cent of residential care placements.²⁶ In Azerbaijan, where more than 60 per cent of the adult population lives below the poverty line, 70 per cent of the children living in institutional care have parents.²⁷ In Georgia, 32 per cent of children in institutions are placed due to poverty.²⁸ At the height of their popularity in the nineteenth and early twentieth centuries, most of the orphanages in New York City were full of poor, white and often immigrant children who had at least one living parent.²⁹

These statistics reflect a very common dynamic: *In communities under severe economic stress, increasing the number of places in residential care results in children being pushed out of poor households to fill those places.* This is a pattern that the authors have observed across regions, and it is particularly prevalent in situations of conflict and displacement and in communities seriously affected by AIDS. Impoverished families use orphanages as a mechanism for coping with their economic situation; it is a way for families to secure access to services or better material conditions for their own children and others in their care. Consequently, residential institutions become an expensive and inefficient way to cope with poverty and other forms of household stress. A recent review of three countries in different regions reached the same conclusion: “Research findings reveal that poverty is a major underlying cause of children being received into institutional care and that such reception into care is a costly, inappropriate and often harmful response to adverse economic circumstances.”³⁰

Long-term residential care for children is an outdated export. In the history of many developing countries, institutional care is a relatively recent import. In most cases, it was introduced early in the twentieth century by missionaries or colonial governments, replicating what was then common in their home countries.³¹ At the same time, institutional care has largely been judged to be developmentally inappropriate and phased out of developed countries that continue to support this care in poorer countries.

AIDS and conflict are fuelling a surge of institutional care in some developing countries.

In 2004, a six-country study of responses to orphans and vulnerable children by faith-based organizations in Africa found that, “Institutions are being established with increasing frequency.”³² In Zimbabwe, which has a high HIV prevalence rate,³³ 24 new orphanages were built between 1996 and 2006. Eighty per cent of these were initiated by faith based groups with 90 per cent of the funding coming from Pentecostal and non-conformist churches.³⁴ Fuelled by conflict, the number of orphanages in Liberia increased from 10 in 1989 to 121 in 1991. In 2008, 117 orphanages still existed, and more than half were unregistered and unmonitored. In Liberia, 25 of every 10,000 children are in orphanages.

The proliferation of residential institutions is not limited to Africa. In Sri Lanka, the Government counted 223 registered children’s institutions in 2002, up from 142 in 1991.³⁵ Following the war in Bosnia and Herzegovina in the mid-1990s, the number of residential institutions increased by more than 300 per cent.³⁶

Once established, residential facilities are difficult to reform or replace with better forms of care. Throughout Central and Eastern Europe and the former Soviet Union, the percentage of children who are in institutions has risen by 3 per cent since the end of the Cold War, despite the fact that many governments in the region have recognized institutions as a cause of family separation and long-term social damage.³⁷

Neither AIDS, poverty nor conflict makes institutional care inevitable nor appropriate. In these contexts, preservation of families and family-based alternative care have been shown to be possible. For example, a survey conducted in Uganda in 1992, in the wake of civil war and increasing AIDS mortality, found that approximately 2,900 children were living in institutional care. The survey also found that approximately half of these children had both parents living, 20 per cent had one parent alive and another 25 per cent had living relatives. Poverty was the reason most of these children were in residential care. Guided by these findings, a multi-year effort by the Ministry of Labor and Social Affairs and Save the Children UK improved and enforced national policies on institutional care reunited at least 1,200 children with their parents or relatives and closed a number of sub-standard residential institutions. A 1993 evaluation found 86 per cent of the children to be well-integrated in their families.³⁸ Unfortunately, some of this work in Uganda is now being reversed, and the trend of orphanages seems to be on the rise, apparently due to shifting priorities in policy implementation.³⁹

Considerable success has been achieved in reuniting children separated from their families due to armed conflict. For example, in both Sierra Leone and Liberia,

UNICEF reports that at least 98 per cent of demobilized child soldiers and other children separated during a decade of conflict were reunited with their families.⁴⁰ The potential for family reunification is evidenced by the fact that institutions were not required to provide ongoing care for these children, even in the face of poverty and social disruption exacerbated by war, in addition to the initial reluctance of communities to take back many of the former fighters. During the post-election violence in Kenya in 2008, large numbers of children were separated from their families and either left on their own (in child-headed households) or placed in orphanages. UNICEF reports that by the end of August 2009, a total of 7,010 children (82.3 per cent of those registered) had been successfully reunited with their families. This is in addition to at least 600 children reunited with their families by the Kenyan Red Cross and its partners.⁴¹

As these examples and many others have shown, social workers involved in reunification must be adequately trained to determine what support a family may need and to identify potential risk factors for children who may be reunited. Assessment and preparatory work with families is essential and, for children who do go home, follow-up monitoring is required.

Despite challenges, change is possible. In the early twentieth century, Dr. Henry Dwight Chapin, a paediatrician, noted that there was a critical period for development in institutionalized infants. He reported that the first noticeable effect of institutionalization was a progressive loss of weight. If weight loss got beyond a certain point, no change in the amount of food intake or environmental change could save the child. Dryness of skin, loss of hair, and dehydration accompanied this condition. The predominant cause of death was not starvation, but pneumonia. The first year of life is absolutely crucial for normal development, and the first six months of age is even more important than the second.⁴² Dr. Chapin researched the death rate of institutionalized children in nine major cities in the United States and found a 100 per cent death rate for children under the age of 2.⁴³

Dr. Chapin became convinced that infants were at a great risk for developmental difficulties and a quick death when placed in institutions. In the early 1890s, he opened the first hospital social service in the United States. He believed it was essential that infants only be institutionalized briefly, if at all. He considered foster care (what he called “boarding-out”) to be the preferred option in almost all cases.⁴⁴ Acting on this belief, Chapin began a fostering system in 1902, in which hospitalized infants were placed in the homes of private families. This became a forerunner of the foster care movement in the United States.⁴⁵

New legislation in the 1930s and 1940s brought an end to many orphanages in

the United States. By the 1960s, family foster care was the dominant placement approach for children in need of alternative care.⁴⁶ The orphanages remade themselves; with the advent of child psychology and psychiatry, they transformed their buildings into residential treatment centres for children with severe emotional and behavioural problems. Some facilities were turned into private psychiatric hospitals and residential programs that, in addition to serving children with problems, became holding facilities for wealthy families whose children were misbehaving.

A study by UNICEF's Innocenti Research Centre, *Children in Institutions: The Beginning of the End?*, describes similar transitions in Italy, Spain, Argentina, Chile and Uruguay. By addressing the underlying causes of family separation, including poverty and lack of access to basic services, these countries have become better able to provide targeted, community-based alternatives to children in need. Today, institutional care for children is rare in these countries and is usually reserved only for children with significant emotional and behaviour problems that cannot be managed at home or in the community, or for children with severe disabilities who are dependent on technological support or specialized around-the-clock nursing.⁴⁷

Change is happening in other parts of the world, as well. In Ethiopia, the Jerusalem Association Children's Homes in Ethiopia deinstitutionalized 1,000 children who had lived for up to 15 years in its three institutions.⁴⁸ In Romania, the number of children in residential care per 100,000 residents was reduced from 1,165.6 in 2000 to 625.4 in 2006, a decrease of nearly 46 per cent with the United States Agency for International Development (USAID) providing significant support for this transition.⁴⁹ In Vietnam, where poverty has been "a major cause of children's entry into institutional care," a 2003 UNICEF study led to the creation of government guidelines for alternative care and momentum to reform the social welfare system.⁵⁰ In Jamaica and Belize, pressure from civil society, coupled with responsive government leadership, has led to the adoption of appropriate legal frameworks for institutional care as well as capacity-building for social work and child care institutions.⁵¹

Reflecting growing concern in Africa about the proliferation of institutional care, a major conference was held in Nairobi, Kenya, in September 2009. Over 400 participants from across the region attended the First International Conference in Africa on Family-Based Care. Participants discussed ways to improve knowledge of family-based care for children, enhance the legislative and policy environment to support family-based care for children, and improve the skills of actors in the provision of family-based care for children in Africa. The conference conclusions, while acknowledging a possible role for temporary residential care, affirmed that

that the family is the best option for effective upbringing of children in Africa. Its recommendations identify key actions needed to shift to family-based care and away from the long term institutionalization of children.⁵²

WHY DO ORPHANAGES PERSIST?

One hypothesis to explain the continued use of orphanages by governments and donors is that it can meet some of their needs fairly well. For example, the children, and the physical results of the support provided, are visible in a single location. It is, therefore, easy to see that something is being done as a result of the support. Those who donate funds to an orphanage can be sent pictures, children can write letters of thanks and visits to the orphanage may be arranged. For governments, an orphanage may seem like a quick-fix solution. But an orphanage is a simple and inadequate response to a set of complex problems. Although a well-meaning donor or government can see concrete benefits of residential care to impoverished children, it is harder to see both the long-term negative consequences and the alternatives. In contrast, the developmental consequences and social disconnection of institutional care play out slowly over years. The importance of maintaining a grandmother's love and care for a child may be less obvious than the child's torn clothes or the dirt floor of the grandmother's house. Creating a new building with good facilities may seem like a direct and generous solution, one that is more straightforward than helping poor families secure a more adequate livelihood. For children already outside of family care, an orphanage may seem like a more obvious solution than developing programs for family reunification, foster care and adoption. It is essential, however, that those who want to help understand the irreplaceable value of family care and how it can be assured.

Another significant challenge is that government ministries and departments responsible for child welfare are often underfunded and understaffed. Inadequate human and financial resources and funding make it difficult for a ministry to change the status quo or resist the building of new orphanages. Developing a new system of alternative care requires resources. Some ministries lack a concrete understanding of what alternatives to institutional care might look like or how a better system of alternative care might work. In some cases, leaders emerge in government or civil society with the vision, energy and political savvy to effect change. However, transforming national child welfare systems takes years to achieve and

requires political will, professional capacity, funding and changes in community attitudes and expectations. Once change occurs, sustaining that change can be a challenge. In the 1980s and early 1990s, some influential groups in the United States began arguing for a return to orphanages in the face of growing poverty and teen pregnancy. These efforts were successfully challenged by policymakers and academics who used the historical record around family-based care to ward off a return to orphanages.⁵³ It is crucially important that organizations committed to children work together with governments to develop the critical mass required to develop better systems of child protection and care, and to sustain that effort.

Misperceptions about orphaning due to AIDS have been a major factor. Whether initiated and sustained by local groups or fuelled by donations from abroad, residential care has become an increasingly common response to the growing number of children orphaned by AIDS. Many people have assumed that there is no alternative to orphanages in places where many children have lost one or both parents to the pandemic. The reality, however, is that the AIDS pandemic does not justify building orphanages.

Regrettably, much of the popular media coverage of AIDS-related orphaning suggests that AIDS has left vast numbers of children on their own. Statistics on orphaning reported by UNICEF and other organizations have raised global awareness, but they have also created misunderstandings. Such statistics estimate the number of children per country and globally who have lost one or both parents.⁵⁴ The vast majority of these orphans, however, are living with a surviving parent or relatives. Of the estimated 145 million children estimated to be orphans, about 9 per cent have lost both parents.⁵⁵ This important point is rarely made when the media cite orphan figures. Furthermore, evidence suggests that the vast majority of children who have lost both parents are living with an aunt, uncle, grandparent or other extended-family member. For example, a country-wide study in Zimbabwe, one of the countries hardest hit by HIV, found that 98 per cent of the country's orphans are living in a family setting.⁵⁶ In neighbouring Malawi, a survey in Blantyre, the country's largest city and one heavily affected by AIDS, found that more than 99 per cent of orphans were living in a household.⁵⁷

A small percentage of the children orphaned by AIDS are living on their own either by necessity or by their choice, but the numbers are very low⁵⁸ and these child-headed households are often a transitory arrangement. Where intervention is necessary, with funding and focused effort the relatives can often be traced to provide care, local family care can be arranged or support can be provided to the household through a community mechanism.

Without support, family care can be inadequate. Most orphans live in families that are poor and unable to meet all their needs, and some orphans in the care of relatives are treated less well than the relative's own children. Nevertheless, action to benefit these children must begin where they are—in families—with the aim of strengthening the families' capacity and willingness to provide adequate care and building community protection systems to guard against and respond to abuse and exploitation. The most immediate and long-term needs of the orphaned children are best met by supporting and strengthening the family care that they do have, rather than by replacing it, and by developing family care for the smaller number of orphans who are living outside of families. The problem is that resources have often been directed instead to establishing new orphanages or to expanding existing facilities.

Some community-led programmes that incorporate residential care are symptomatic of the inadequate overall investment in family support services and family-based alternative care. A new approach has emerged among some residential institutions in areas where AIDS has left many orphaned children. Recognizing their own inability to absorb an increasing number of children, some institutions have begun to provide outreach and day-support for children in vulnerable households.⁵⁹ In this way, children remain part of a household but receive food and other support that they otherwise would not have. Regardless of the approach, regulation and careful monitoring is necessary to ensure that at-risk children are protected.

Communities can be organized to identify and support particularly vulnerable children and their families.⁶⁰ Local faith communities have often demonstrated that they have great capacity to mobilize limited resources and funding to benefit especially vulnerable children.⁶¹ Research in rural Zimbabwe suggests that where extended families are unable to provide care, other families are willing to take in unrelated children if they are supported with resources to pay for extra school fees and food.⁶² There is an urgent need to build on good practices and strengthen the government's role in the coordination, development and funding of these services.

A recent study by a group led by Kathryn Whetten, has suggested that institutional care may be as good or better than family care for orphaned and abandoned children in the age range of 6 - 12 years;⁶³ however the design of this study did not address some issues fundamentally important to policy and programming decisions. In five countries it compared orphaned and abandoned children in residential care with children of similar background living in families, but those in families were not necessarily benefitting from any sort of assistance, while children in orphanages presumably received food, education, and whatever services these facilities provided. As indicated above, multiple children can be

assisted through family care for the cost of supporting one in residential care. Using several measures, the Whetten *et al.* study compared the wellbeing of children in orphanages and families at a single point in time; it did not address, however, the critical longer term challenges of those who seek to reintegrate in society after growing up in an orphanage. This is an area where research is strongly needed, as the limited information currently available suggests that many young people have significant difficulty after leaving residential care. A longitudinal study comparing young people who had been assisted in family care who had lived in institutions could be quite useful.

WHAT ARE BETTER CARE ALTERNATIVES?

Central to the analysis and conclusions of this paper is the recognition that there are potential shortcomings to every type of care. Obviously, some children are neglected or abused by their own families. Also, any type of alternative care can be harmful if implemented poorly, whether it is an institution or family-based care. However, considering what children need at different stages of development and taking into account the strengths and limitations of different types of care (when well-implemented) leads to the conclusion that family-based care within a community is fundamentally better for children than institutional care. The basic approaches to family care are briefly described in the following paragraphs.

FAMILY SUPPORT AND STRENGTHENING

Strengthening families should be the first priority, always and everywhere. Supporting impoverished families who are struggling to provide care may involve strengthening their economic activities; providing cash transfers; or linking families to emotional, spiritual or social work support. Making primary education genuinely free—including the removal of hidden costs such as uniforms, school supplies, meals and transportation to and from school—would have a huge impact. Education is one of the major expenses many households face; in some cases, the costs of sending children to school are a significant factor in a parent's decision to place a child in institutional care. Treatment for a parent's alcohol or substance abuse is also needed in some cases. HIV prevention and AIDS treatment are fundamentally important interventions to support family care.

FAMILY REUNIFICATION

Children often become separated in crisis situations involving armed conflict, disasters and displacement. Economic hardship and conflict within a family pushes some children out of families and onto the street. A robust body of knowledge has been developed, based on decades of experience, concerning methods for identifying and documenting separated children and for tracing family members and effecting reunifications.⁶⁴ For example, tracing and family reunification were conducted throughout the 12 years of war in Sierra Leone, and UNICEF has reported that of the children who remained separated at the end of the war (including former child soldiers), 98 per cent were reunited with their immediate or extended family.⁶⁵

Organizations are also demonstrating that family reunification is possible for street children. For example, in the Democratic Republic of Congo from 2006 to 2009, Save the Children UK has worked together with the government and local NGOs to reunite more than 4,200 children who had been living on the street. From 2004 to 2010, over 1,000 street children in Zambia have been reintegrated into families by the Africa KidSAFE Network in collaboration with the government.⁶⁶

KINSHIP CARE

Kinship care is an alternative to institutional care that has good potential for being scaled up through adequate provision for social work services and the tracing and assessment of relatives. When a child's immediate family cannot or will not provide adequate care, the next option to consider is care by either legal or fictive kin. Legal kin are those relatives where there is a legal relationship based on blood ties, marriage or adoption. Fictive kin are chosen "relatives" where there is a close bond that is treated by the child and family as if it were a blood relationship. Both relationships represent possibilities for identifying caregivers for children.

Kinship care is common in most societies, including wealthy ones; it is the most significant form of out-of-home care globally for children who are unable to live with their parents.⁶⁷ In traditional societies, there are often clan or tribal mechanisms that exist and can be reinforced or revived to ensure care for children who are on their own. In cases where relatives do not spontaneously come forward to provide care, an intervention can involve locating extended family members to assess their willingness and ability to provide adequate care. In some cases, it may be necessary to provide support that improves the ability of relatives to provide care.

Persistence in seeking relatives who can provide care can yield good results. For example, a church-related program working with HIV-positive single mothers in a

Nairobi slum routinely asked who could care for their children if they became too ill to do so. Of 200 mothers, half denied having any extended family members who could possibly provide care. However, a social worker with the program developed a relationship with these women and found that nearly all of them did indeed have relatives from whom they had become estranged. In almost every case, the social worker was able to identify an extended family member who was willing to provide care when the mother became too sick to do so. Moreover, the willingness of these relatives to accept the children was not contingent upon provision of cash or material assistance.⁶⁸

The most compelling reason to scale up kinship care is that living with immediate or extended family is often the preferred choice for children themselves in the event that parents are unable or unwilling to provide care. In South Africa, Botswana and Zimbabwe, for example, the children's expressed preference was: immediate family and extended family followed by community members, foster care and care in a child-headed household.⁶⁹

FOSTER CARE

The terms "foster care" and "fostering" are used to refer to a variety of approaches to child care. In the United States and Europe, foster care generally describes the State-managed placement of a child with non-relatives who are both supervised and compensated by the State. Foster care is not generally considered permanent (though it may be long-term in specific legal cases), and the State generally retains guardianship of the child during this interim period of care. Formal foster care is typically used until a child can be reunited with a parent, is permanently adopted or reaches adulthood. In Western Europe and Scandinavia, foster care is long-term, resembling adoption.

In situations of displacement or conflict, child protection agencies often arrange foster placements to ensure care for separated children, and in such contexts there may be no government capable of overseeing the process.⁷⁰ In some cases, concerned agencies and participating families assume that if tracing for a child's own family is not successful, the placement will become permanent. In others, placements are intended to be only temporary. Families receiving such foster placements may or may not receive external support. Provided that foster placements are well-planned and monitored, this can be a very appropriate form of care because it provides the cultural and developmental advantages to children of living in a family environment pending family reunification or long-term placement. However, there are risks to the children if the monitoring stops prematurely, for example, if a displaced population returns to its home area or the agency's funding

comes to an end.⁷¹ As with other forms of alternative care, foster placements should be initiated with both the children's immediate and long-term protection and wellbeing in mind.

The terms "foster care" and "fostering" are also used to describe informal, traditional care arrangements that are widely used in some regions, such as West Africa. This type of fostering involves the parents deliberately placing a child into another family, irrespective of kinship bonds. One report indicates that in nine West African countries, the percentage of households that included children not living with their parents ranged from 16 to 32 per cent, with an average of 24 per cent. The report said that the reasons for such placements can include parental illness, death, separation or divorce; mutual assistance or strengthening ties between family units; improved educational options for the child; and others. It noted that, "For the societies involved, child circulation is a characteristic of family systems, fitting in with patterns of family solidarity and the system of rights and obligations."⁷² Generally, there is no direct governmental oversight of such placements.

These different forms of foster care vary significantly in terms of what they describe and their respective strengths and weaknesses. In a particular context, it is important to be clear exactly how the term is understood and the safeguards included for children.

KAFALAH

Kafalah is the provision in Islam's Sharia law that governs the care of children without care. The Koran gives emphasis to the care of orphans.⁷³ Kafalah involves an individual making a permanent commitment to the protection, care and education of a child, but it does not permit changing a child's family name or giving inheritance rights to the child. The aim is to provide for a child's protection and needs while retaining the child's original family name and lineage connections. Algerian law, for example, defines kafalah as, "the commitment to voluntarily take care of the maintenance, of the education and of the protection of a minor, in the same way as a father would do it for his son."⁷⁴

ADOPTION

Adoption involves a child becoming a permanent, legal member of a family other than their birth family. Most governments have legislation that outlines specific steps that govern this process. Globally, most adoptions are domestic; that is, the child and adoptive parents share the same nationality. A minority are international and inter-country, where the adoptive parents have a different nationality than the

child and typically take the child to reside in their country. Although comprehensive statistics on domestic adoptions around the world are not available, the total number of international child adoptions has been approximately 40,000 per year, about one third the total of domestic adoptions each year within the United States alone.⁷⁵ The Hague Convention on the Protection of Children and Co-Operation in Respect of Intercountry Adoption established safeguards for children and systems to ensure that these safeguards are respected by States that have ratified the Convention.⁷⁶ The Guide to Good Practice on the implementation of this Convention highlights the principle of “subsidiarity,” which, “means that States Party to the Convention recognise that a child should be raised by his or her birth family or extended family whenever possible. If that is not possible or practicable, other forms of permanent family care in the country of origin should be considered. Only after due consideration has been given to national solutions should inter-country adoption be considered, and then only if it is in the child’s best interests.”⁷⁷

In some developing countries, international adoption is more common than domestic adoption. However, the relative frequency of domestic adoption is increasing in many countries. In India, for example, local adoption was rare and faced certain cultural constraints. In 1989, India adopted national regulations specifying that at least 25 per cent of adoptions would be domestic, and the number of Indian children adopted has substantially increased. By 2005, domestic adoptions exceeded international adoptions.⁷⁸

PREVENTING UNNECESSARY SEPARATION

The effectiveness of an alternative care system is contingent upon decisions being made for the right children, at the right time. Unnecessary placements in institutions or foster care has lasting consequences for children and families, and as the evidence in this paper has shown, placements due to poverty or lack of access to basic services are made all too frequently. Ensuring that alternative care options are used appropriately requires a well-trained social welfare workforce, clear guidelines for admissions, strong legislation and policies to guide implementation and oversight to ensure adherence.

THE WAY FORWARD

Millions of children around the world currently reside in residential institutions. In most developing countries, no one knows how many children reside in such care, and in many of these countries, no one even knows how many residential institutions are currently operating. Counting these children and determining whether they have living parents or relatives would be a first step toward changing the situation. Enacting strong legislation coupled with providing constructive and cooperative oversight to alternative care providers can help ensure that the worst forms of care are eliminated or transformed into better alternatives. It is also important to develop resources and tools to assess children and families when they first come into contact with authorities and child care providers and share model programs that prevent abandonment across countries and regions. Establishing national standards for the care of children outside their own families, including “gate-keeping” protocols designed to prevent inappropriate new placements, is another vitally important area for action. In this regard, a major step forward was taken in November 2009 when the General Assembly of the United Nations welcomed the “Guidelines for the Alternative Care of Children.” This document provides a common frame of reference to guide countries in developing national standards.

Families and family-based care are imperfect, but on the whole they are better than the alternatives. Any type of care, family-based or residential, can be implemented badly and damage children. It is clear, though, that the available literature on child development indicates that families have better potential to enable children to establish the attachments and other opportunities for individual development and social connectedness than does any form of group residential care. Well-implemented family-based care is preferable to well-implemented residential care.

It is vitally important that each country develop and provide adequate ongoing support to a cadre of social work professionals and community workers who can help prevent unnecessary separations by assisting families and ensuring that children who need alternative care are placed appropriately. The Better Care Network, which brings together learning and technical exchange on these issues, together with UNICEF, recently developed the *Manual for the Measurement of Indicators for Children in Formal Care*, a monitoring guide that can help guide such work and reduce needless placements in residential institutions.⁷⁹

What would reform of current care systems include? Through a carefully planned and managed process, children can be reunited with their family or placed in

kinship care or another form of family-based care in their community. Children need permanent care within a family; and foster care can be used until permanent care is arranged. Most existing residential institutions should be phased out or transitioned to some other function (e.g., day care, education or community services). In the meantime, these facilities need to provide care that meets basic quality standards and be organized to replicate family care as much as possible. Some residential facilities may be needed to provide interim care pending reunification or placement in family-based care.

It is essential that any process of reform emphasize rigorously preventing unnecessary separations and developing better family-based alternatives. Where children are living in seriously damaging institutions, emergency issues must be addressed, but it is imperative to keep the primary focus on ensuring family care. Otherwise, improving institutions can consume the human and financial resources needed to make fundamental reforms.

There is growing interest in national cash transfer programs that have been shown to benefit the poorest children and families in many countries, which can help preserve families.⁸⁰ Alcohol and other types of substance abuse also are factors that drive placements into institutional care in many countries. In these cases, treatment coupled with supportive services and monitoring can make reunification an option for some children.

The services necessary to prevent unnecessary family separation, reunite institutionalized children and expand quality foster care and adoption require significant financial investments in the short term, but as expensive residential facilities are shut down, resources can be redirected and better used to strengthen family care. Motivating governments, international organizations, NGOs and other policy actors to invest in family support services and alternative care is not easy. Children in institutions tend to be out of sight and out of mind, but the benefits to society of reforming care manifest over time in the lives of more intelligent, functional and socially integrated children, as well as in the lives of the adults that they become.

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