end the silence:

the case for the elimination of institutional care of children

hope and homes
for children

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ACKNOWLEDGMENTS

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CONTENTS

EXECUTIVE SUMMARY

Institutional care is harmful to children.

Decades of research prove that growing up in institutions has detrimental psychological, emotional and physical implications including attachment disorders, cognitive and developmental delays, and a lack of social and life skills leading to multiple disadvantages during adulthood.

A catalogue of child rights violations has been documented within, and as a result of, institutional care. A 2006 UN study found that children in institutions are particularly at risk of violence compared to children in other settings, including verbal abuse, beatings, excessive or prolonged restraint, rape, sexual assault and harassment.

Institutional care is not necessary.

Contrary to popular belief, the majority of children in orphanages are not orphans, but have either one or both parents alive. Virtually all have extended family. Even when children are without parental care and alternative care is needed, it should be provided with kinship or foster families or in a family-like setting in the community, as recommended by the UN Guidelines on Alternative Care.

Institutional care is deeply unjust.

As a system, it attracts children coming from situations of poverty or from families with a history of institutionalisation, marginalisation and discrimination. Children with disabilities and children belonging to ethnic minorities are over represented in institutional care and the system sets them up for a life of vulnerability and abuse.

Institutional care is intrinsically connected with the poverty of families and communities and the inadequate provision of services. Poverty is the most common underlying risk factor leading to children being separated from parents. Institutional care leavers suffer multiple disadvantages in adult life including reduced economic opportunities, social exclusion, increased tendency to substance abuse, mental health problems, high suicide rates, exposure to criminal activities and exploitation.

Almost all countries in the world ratified the UN Convention on the Rights of the Child (UNCRC), whose preamble is clear in recognising that children should grow up in a family environment. Furthermore the United Nations General Assembly endorsed the Guidelines for the Alternative Care of Children in 2009, which set the overall objective to phase out institutions as a care option.

Eliminating institutional care is necessary and possible.

A number of governments across the world have already started to reform out-dated child protection systems relying on institutional care, re-integrating children into families and communities, developing family strengthening and family alternative care. Yet, with millions of children still warehoused in institutions, and several million more at risk, we face a truly global problem.

While protecting, respecting and fulfilling children's rights is primarily a responsibility of the State, coordination among a number of actors is critical to achieve a global breakthrough. Hope and Homes for Children calls on all the stakeholders that play a role in developing, running, supporting or influencing national care systems to join forces in a collaborative action to eradicate institutional care once and for all.

Photo: Ada in her very own bedroom in her new foster home.

Photo: HHC/Alexandra Smart

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WHAT IS INSTITUTIONAL CARE?

Despite decades of evidence documenting the ways in which institutional care is profoundly damaging for children[1], it is still difficult to provide a clear and all-encompassing definition of "institutional care of children". This is due to the great diversity of cultural and legal frameworks, the vast array of residential care facilities that have developed across the world, and the diverse ways in which specialists have used the terminology to date.

Commonly used terms include 'institutions', 'orphanages', or 'children's homes'[2]. Whatever they're called, institutional care facilities govern the daily lives and shape the development and life chances of a very large number of children. Ample research exists to show that the inherent characteristics of institutional care hinder emotional, physical, cognitive and psychosocial development during childhood as well as outcomes in adult life[3]. Even the best-resourced institutions cannot replace the nurturing and individualised care that a loving family can provide.

1.1. Core characteristics

Besides being residential facilities, one of the most frequently cited characteristics of institutional care is its size, meaning the number of places available for children in any given facility[4]. However, size is only one indicator among other fundamental features that might describe institutional care appropriately. The larger the setting, the fewer the chances to guarantee individualised care for children in a family-like environment, and the higher the chances for certain dynamics to appear[5].

For the purpose of this paper, we will refer to institutional care facilities as often large, long term, residential facilities displaying a number of distinctive features that are harmful for children across three core features: care provision, family and social relationships and systemic impact.

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1. See among others, Bowlby, J. (1951 and 1969) and Browne, K. D. (2009).
2. Other expressions commonly used include 'internat' (particularly in Central and Eastern Europe/CIS) and in some cases 'boarding school'. Although boarding schools and healthcare facilities are considered by some as falling outside of the category of institutional care, the defining line can be blurred. Some children in such facilities may return to communities and families regularly but others may not, leaving them vulnerable to abuse and to the problems associated with loss of attachment. See Delap, E. (2011).

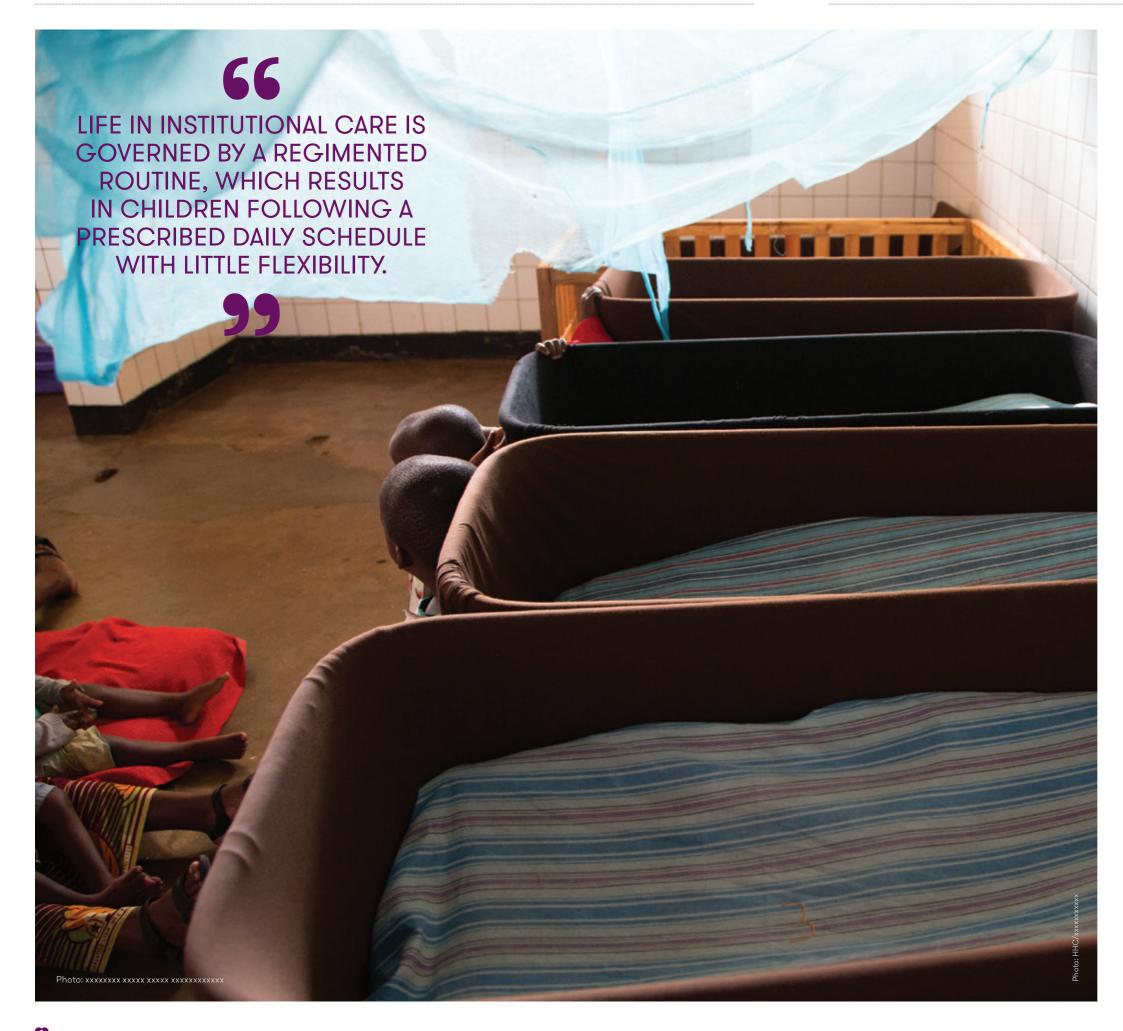3. For a more detailed analysis of the impact of institutional care on children, refer to Chapter 2.2.
4. See Guidelines for the Alternative Care of Children, endorsed by the United Nations General Assembly in 2010. The Guidelines use the term 'institutions' to describe 'large residential facilities' (§ 23).
5. See Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based care (2009).

> ## LIFE IN INSTITUTIONAL CARE IS GOVERNED BY A REGIMENTED ROUTINE, WHICH RESULTS IN CHILDREN FOLLOWING A PRESCRIBED DAILY SCHEDULE WITH LITTLE FLEXIBILITY.

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1) In institutional care the delivery of care and protection is inadequate, the evidence showing that children experience delays in their emotional, cognitive and physical development, whilst being at heightened risk of developing challenging behaviours and being victims of emotional, physical, and sexual abuse. Institutional care facilities can hardly meet the requirements of suitable individualised care that responds to the needs and circumstances of each and every child.

• Life in institutional care is governed by a regimented routine, which results in children following a prescribed daily schedule with little flexibility. A fixed timetable is usually enforced and children are 'processed' in groups, without consideration for privacy or individuality. The result is children sleeping, eating, playing, and sometimes even going to the bathroom at the same time or in a set order, regardless of their individual needs.

• Institutional care, by its own nature, leads to depersonalisation, reducing children to a file in the system. Children are not encouraged or supported to develop and show their personal preferences and individuality. Clothes, towels and toys are often shared within the group and living space doesn't allow for privacy.

• The inadequate ratio of carers to children and the nature of their interaction is typical of institutional care. Children usually experience multiple caregivers throughout their stay and even on a daily basis. The instability and insufficiency of caregiving deprives the child of the opportunity to form a healthy attachment with a significant adult, which in turn leads to attachment disorders and difficulties with a wide variety of social relationships in later life. Staff lack adequate training, supervision and often time, which hinders the quality of care. In institutions where the lack of interaction and systematic neglect are more severe, children can develop a set of typically 'institutional' behaviours[6], such as self-stimulation, stereotypical behaviours (e.g. rocking, head banging) and sometimes self-harming.

• Institutional care facilities, whether funded privately or by the State, have a significant number of administrative and back-up services (kitchen, cleaning, driving etc.) that are delivered by personnel, often more numerous than those who are directly responsible for actual care and are not trained to be part of the support system. This results in an uneven allocation of human resources within the institutional care system, impacting the direct delivery of care and protection to children.

• As opposed to family-based care, where adults act as substitute parents for children around the clock, in institutions adults are employed to work predetermined hours and have a professional relationship with the children in their care, much like a teacher or nursery assistant, which is very different from the relationship between a child and parent[7]. While this is the case in all forms of residential care, the professional relationship in institutions is further exacerbated by an unequal power relationship, often blocking attachment and bonding between staff and children.

• Institutional care is utterly disempowering and fails to provide children with a basic set of practical and life skills required to live independently. Young people in institutional care often lack the experience of preparing food, cleaning, making their own bed or managing personal finance, such as pocket money. When leaving institutional care, they are faced with living an independent life in a world for which they are utterly unprepared.

6. See chapter 2.2.
7. See Goffman, E. (1961).

2) Institutional care fails to support strong and meaningful relationships between children, their parents and siblings, and the wider family whilst isolating children and preventing them from learning relevant skills for community living. The evidence shows that most children in institutional care, are not orphans and yet they have very little or no connections with their families and communities and very little knowledge of their cultural heritage, traditions and values.

• Once placed in institutional care, children are on the whole not provided with regular contact or up-to-date information about their families. Meanwhile their families are discouraged from maintaining contact with them and are not informed of their child's progress. Children often grow up moving from one institution to another, losing track of their siblings, friends, families and communities. The opportunity to build a true sense of identity and belonging is often denied.

• To aggravate the situation, in institutional care children are often segregated according to age, gender, special needs or medical conditions. Groups of siblings are often split up and assigned to separate units, or even to other institutional care facilities at different and sometimes distant locations.

• Most of the time institutional staff and management assume the role of long-term carers, whilst often blaming and vilifying the children's parents and relatives. Prejudices against certain communities, social or ethnic groups are transferred to children. It is not uncommon for children in institutions to be told that their parents gave up on them, abandoned them and failed in their parental responsibilities.

• Institutional care facilities tend to be isolated from mainstream communities and are sometimes located in remote places, leading to children being segregated from society even further. Geographical isolation was and remains a particular feature of institutions for children with disabilities or challenging behaviour in Central and Eastern Europe and the Commonwealth of Independent States, with institutions purposely built or located in old, inadequate buildings away from broader society.

• Social isolation is a common element. In the most closed and isolated environments, children's entire lives are spent within the institution - including their education, leisure and healthcare. Even in relatively open structures (e.g. where children go to the local school), institutional care fails to provide a sense of ordinary life and belonging to the community. Institutionalised children usually lack adequate resources and professional support and have weak or no representation in schools. As a result, they tend to be stigmatised and perceived as 'different', which in turn leads to further marginalisation and exclusion.

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Photo: HfC/Alexandra Smart

3) Institutional care facilities also have systemic effects: their simple existence influences the way that authorities, professionals and communities operate and how they identify and support children who are perceived as being at risk. The evidence shows that the very existence of institutions creates a 'pull effect' offering local authorities and professionals an easy option for dealing with children and families in crisis[8].

• Institutional care is often the only available and promoted service at community level where local authorities and professionals can easily place children without parental care. In some contexts it is also wrongly perceived as being the safest option for babies and very young children in need of alternative care (including orphaned or abandoned new-born babies, premature babies or those identified as having special needs).

• Across the world, institutional care is sometimes the only mechanism available for families to access education or health services. It is not uncommon for one child from a family to be sent to institutional care in order to have access to school, medical care or other services. It is also not uncommon for children failing in mainstream education to be sent to institutional care facilities which specialise in providing education for children with learning disabilities.

• 'Specialist' institutional care is largely perceived as the best option for children with special needs, often at the advice of a doctor or institution manager. Parents lacking information, counselling and access to medical and support services will often turn to institutional care as their only available option. Children with disabilities or special needs tend to remain in the institution for their entire life or are moved into facilities for adults.

• Institutional care facilities, irrespective of their source of funding, require a minimum number of children in residence to secure their existence and financial sustainability. Either through child sponsorship mechanisms or using a cost/child approach, private donors and State agencies funding institutions create a perverse incentive for increasing or at least maintaining a critical number of children in institutional care facilities at all times. The institutional care facilities' best interest supersedes the best interest of the child, and the number of places available in any given institution becomes the main driving factor for placements.

• In some cases, children are deliberately separated from their families and placed in institutional care so that they can be used to attract fee-paying volunteers and donors or to maintain the system in existence, ensuring the employment of those working there. In the worst instances, children are also kept in poor conditions to further enhance 'the case for support'. Volunteering in institutional care facilities for limited periods of time can also contribute to the repeated sense of abandonment already felt by the children. The lack of background checks on visitors and volunteers exposes children to an increased risk of abuse and exploitation.

• Institutional care for babies falsely creates the impression that there are numerous babies and young, healthy children in need of adoption. Over the past 20 years, whilst international adoption has continued to flourish, so has the evidence showing that babies in institutional care in many countries have been systematically bought, coerced and stolen from their birth families[9].
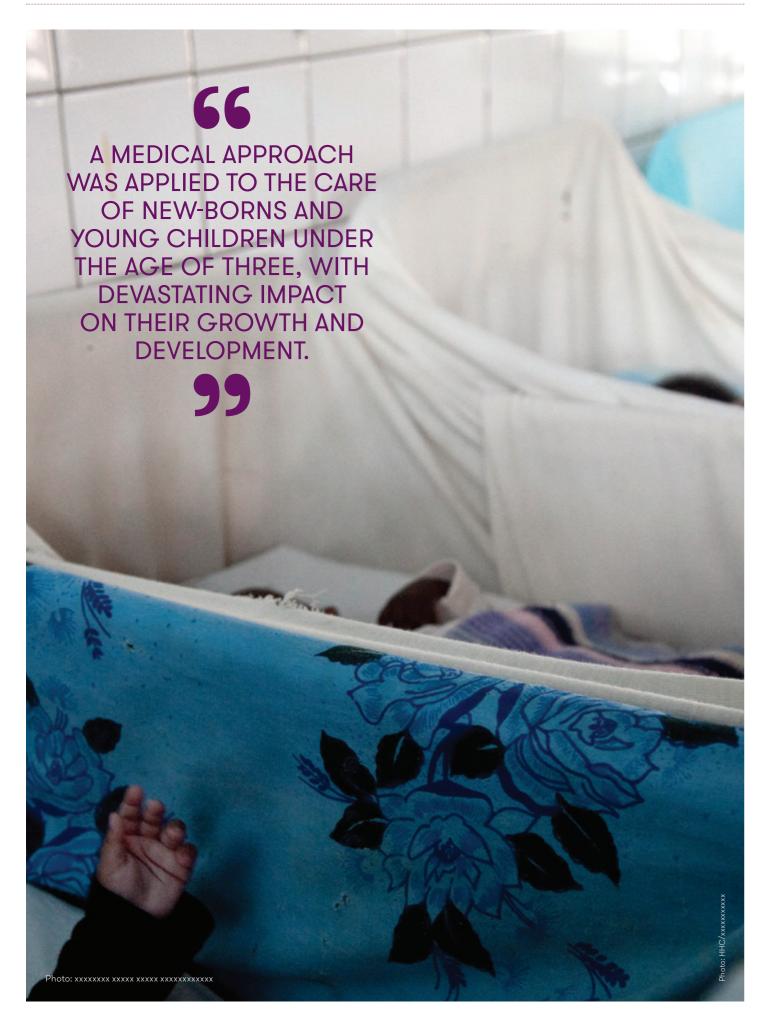
Although not all these features may manifest themselves at the same time in a given institution, institutional care can usually be identified by the presence of a significant number of characteristics described above, across the three core features: care provision, family and social relationships and systemic impact.

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IN THE WORST INSTANCES, CHILDREN ARE ALSO KEPT IN POOR CONDITIONS TO FURTHER ENHANCE 'THE CASE FOR SUPPORT'.
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8. "The very existence of institutions is reported to exert a pulling effect whereby children who would otherwise remain within their families or communities are instead placed in institutions. In some cases local authorities automatically refer vulnerable children to institutions instead of exploring other alternative solutions within the family and the community'. Ministry of Gender and Family Promotion, Republic of Rwanda (MIGEPROF) and Hope and Homes for Children (2012), p. 22. See also Bunkers, K. (2015), p. 8.
9. See, among others, Lammerant, I., and Hofstetter, M. (2007).

> ## "
> A MEDICAL APPROACH WAS APPLIED TO THE CARE OF NEW-BORNS AND YOUNG CHILDREN UNDER THE AGE OF THREE, WITH DEVASTATING IMPACT ON THEIR GROWTH AND DEVELOPMENT.
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1.2. Origins

The origins of institutional care greatly vary across countries and continents but are always revealing of a particular culture of service provision, which has in turn been shaped by national dynamics and external influences.

Across most OECD countries, the origins of institutionalisation can be traced back to the 1800's. With the development of public social systems, the State began to assume responsibility to provide food, shelter, clothing and treatment for the frailest members of the society. Initially seen as a positive intervention by public authorities, institutionalisation rapidly became a blanket solution for all categories of individuals: indigents, children without parental care, people with mental health problems, people with disabilities and the elderly. Large institutions were established, in some cases hosting hundreds of users.

In the course of the 20th century, a socio-political movement started to promote the progressive dismantling of institutions and the development of family and community-based alternatives[10]. Despite progress, however, institutions still exist in some OECD countries[11]. Moreover, donors and non-State actors from the region continue to support orphanages in low and middle-income countries.

In Central and Eastern Europe and the Commonwealth of Independent States (CCE/CIS) the development of institutional care was profoundly influenced by the ideology of the Socialist regimes, which aimed to create a society free of 'anomalies'. Families in need were perceived as a societal dysfunction to be addressed through State intervention, and the institutionalisation of children with disabilities was nearly automatic[12]. A medical approach was applied to the care of new-borns and young children under the age of three, with devastating impact on their growth and development.

Decades after the fall of the regimes, the Soviet legacy continues to dominate the child care system within the region and the global economic crisis adds a significant further risk for family separation. As a result, according to UNICEF estimates, the number of children in institutional care across the CEE/CIS region remains the highest in the world[13].

It must be acknowledged, however, that a number of CEE/CIS governments have recognised institutions as a cause of family separation and long-term social damage and many countries are – to a varying extent, and with different levels of success – engaged in some attempt of child protection system reform.

In the context of many low and middle-income countries in Africa, Asia and Latin America, institutional care did not develop organically as a domestic response to children deprived of their family environment, but often under the pressure of external actors such as non-governmental and faith-based organisations, international donors, volunteers, etc[14].

Institutions have rapidly proliferated across these regions, following real or perceived crisis situations such as conflicts, natural disasters or health epidemics[15]. Eventually, the system of institutional care started to supplant more traditional response mechanisms such as care within the extended family.

The degree of government engagement in the provision of services for children without parental care and children at risk of separation varies between countries and systems. In several countries in sub-Saharan Africa, Latin America and South-East Asia, the majority of institutional care facilities are privately run and often unregistered, which makes it virtually impossible to enforce any form of monitoring or oversight.

10. See Williamson, J. and Greenberg, A. (2010). As an example, in 1971 Italy had 150,000 children in institutional care centres. In 1998, the figure had fallen to 15,000, of which only 1,500 were in large-scale institutions. A similar process occurred in Spain as of the 1980's. See UNICEF Innocenti Research Center (2003).
11. As an example, some ninety per cent of children entering care in Japan and eighty per cent of children entering care in Israel are placed into institutions, some of which can house over two hundred children. See Maher King, M., (2014).
12. The academic discipline of 'defectology' - according to which children born with disabilities are 'defective' and to be isolated from the

community - was predominant in the region. See UNICEF, Children with disabilities and learning difficulties, at: http://www.unicef.org/ceecis/education_13373.html.
13. UNICEF (2010). This statistic should be considered bearing in mind that more (though still incomplete) data on children in institutional care is available in this region than in many other parts of the world (e.g. Africa, Asia, Latin America), where the majority of institutions are not registered.
14. Williamson, J. and Greenberg, A. (2010).
15. As an example, following the conflict in Bosnia and Herzegovina, the number of institutions increased by 300% (idem).

1.3. Global scale

Timely and accurate data about the situation of vulnerable children worldwide is crucial to improving their situation and protecting their rights. Unfortunately, there are significant challenges in gathering data for children growing up in alternative care. National statistics often collect data per household and fail to capture this specific population of children. As a consequence, evidence relating to the scale of institutional care globally is sorely lacking.

Available estimates vary between two[16] and eight million[17] children, with some suggesting the number could be higher[18]. Lack of registration and oversight of institutional facilities further complicate the picture. In some locations in Central and Southern Asia, Latin America and in many African countries, we simply do not know how many institutions exist and what the population of children confined to them is.

Given their vulnerability and isolation, the paucity of information about children in institutional care is striking. The availability of data at national, regional and global level could support better programming for children at risk of entering institutions, galvanise funding from the international community and ultimately hold States accountable to provide protection and sustainable solutions for this group of children.

Available estimates vary between

2 - 8 million

children growing up in institutional care

16. UNICEF (2009).
17. Save the Children (2009).
18. Csaky, C., (2009).
19. Ibid, p. 5.

1.4. A vicious circle

Across the world and in a variety of contexts, the issue of institutional care is still widely misunderstood and information has been slow to reach the general public. As a result, institutions are surrounded by a number of common misconceptions.

Perhaps the most prevalent myth is that institutions care for orphan children. Establishing orphanages is seen as an appropriate response to perceived 'orphan crises' linked to wars, natural disasters or health pandemics such as HIV/AIDS and Ebola. Well-intended individuals and organisations commonly fundraise to support children in orphanages in lower-income countries.

Contrary to common belief, the majority of children confined to institutions are actually not orphans but have at least one, if not both, living parents. While it is true that in crises circumstances many children lose their parents, most of those who end up in institutions are actually displaced and separated from their parents[19], rather than orphaned. Nearly all children confined to institutions have extended family that, in many cases, could be supported to care for them.

A phenomenon increasingly recognised by professionals in the sector is that institutional care creates a vicious circle, whereby the very existence of institutions is a pull factor instigating family separation. In several countries, the majority of children in institutions were placed or abandoned by parents in need who lacked sufficient means or support to care for them.

Poverty is in fact a significant underlying reason for children ending up in institutional care across the world. Many parents struggle to provide food, housing, medicine and access to education for their children, and are led to believe that placing their children in orphanages is a positive choice that will provide them with a better future. Institutional managers and staff sometimes are actively soliciting parents living in poverty to place children in their facilities, marketing their services, nutrition, shelter, access to education, health care, and improved chances for the future.

In Sri Lanka, 92 per cent of children in private residential institutions had one or both parents alive, and more than 40 per cent were admitted due to poverty.

In Zimbabwe, where nearly 40 percent 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.

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 percent of residential care placements.

In Georgia, 32 percent of children in institutions are placed due to poverty[20].

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PERHAPS THE MOST PREVALENT MYTH IS THAT INSTITUTIONS CARE FOR ORPHAN CHILDREN.
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Orphanages, therefore, do not respond to the orphan crisis: instead they actively contribute to family separation by providing a one-size-fits-all response to deeper societal problems, which are left unaddressed.

In some contexts, where mechanisms for protecting children's rights are weak, institutions have been and continue to be used to isolate specific groups of children perceived as unfit for life in the community, such as children with disabilities, children belonging to ethnic minorities or born out of wedlock, and children living with HIV/AIDS – thus perpetuating a system of structural discrimination[21].

Naturally, a smaller percentage of children have been placed in institutional care as a consequence of orphanhood, severe neglect or abuse. While care outside the birth or extended family may be necessary and in the best interest of the child, institutions can never offer an adequate solution for children without parental care. A range of family- and community-based options should be available to provide appropriate support and quality care to children in their communities[22].
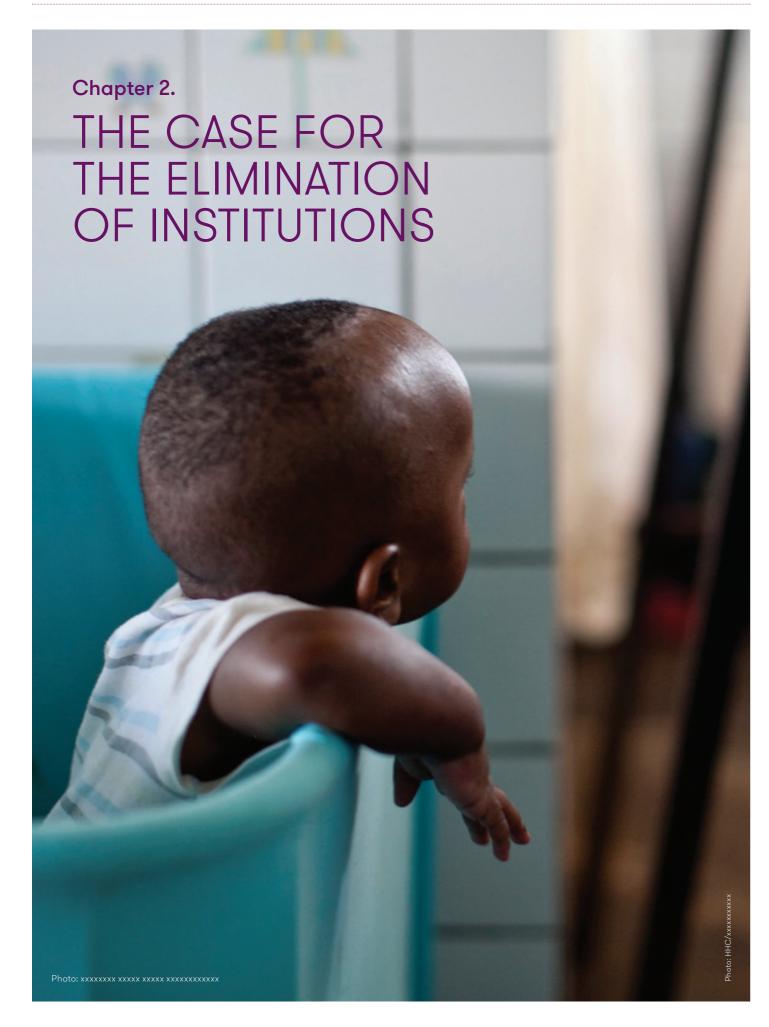
20 Williamson, J. & Greenberg, A. (2010), p. 8.
21. A 2011 report illustrates the disproportionate rate of institutionalisation of children from Roma communities relative to their weight in the overall population across several EU countries. See European Roma Rights Centre, Bulgaria Helsinki Committee, Milan Šimečka Foundation and osservAzione (2011).
22. See Chapter 3.

Chapter 2.

THE CASE FOR THE ELIMINATION OF INSTITUTIONS

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2.1. Violation of children's rights

Institutionalisation is not only a poor policy: it is increasingly acknowledged as a violation of human rights. The very nature of institutional care exposes children to a catalogue of abuses and violations of rights enshrined in international treaties such as the UN Convention on the Rights of the Child (UNCRC) and the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

The preamble to the UNCRC, which lays out the spirit of the Convention, is clear that children should grow up in a family environment – something that no institution can provide, irrespective of the quality of care.

Due to its 'one size fits all' approach, institutional care does not offer the range of options needed to respond to the individual needs, circumstances and the best interests of each individual child (Article 3 UNCRC). Institutions are also incompatible with children's rights to survival and development to the maximum extent possible (Article 6 UNCRC) because of their devastating cognitive, emotional and physical development consequences – including in some cases high child mortality rates[23].

Institutions too often break children's ties with their biological and cultural heritage and dislocate them from their families or communities, their culture and identity. This violates children's right to know and be cared for by their parents (art. 7 UNCRC), as well as the right to preserve their identity - including nationality, name and family relations - and to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests (art. 9 UNCRC).

The lack of flexibility and choice of options in the system does not provide opportunities for children to be heard and their opinions to be taken seriously (Article 12 UNCRC), children are often removed from their families without their voice being heard.

Typically, institutional care systems place very little emphasis on preventative measures to support families and help them to fulfil their primary parental responsibility. Yet the UNCRC is clear that States shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities (art. 18 UNCRC), and shall take appropriate measures to assist parents to implement a child's right to a standard of living adequate for his or her

physical, mental, spiritual, moral and social development (art. 27 UNCRC). This includes in case of need the provision of material assistance and support programmes, particularly with regard to nutrition, clothing and housing, and is also related to the right to benefit from social security (art. 26 UNCRC).

Life in institutional care makes children particularly vulnerable to physical or mental violence, injury and abuse, neglect and negligent treatment, maltreatment and exploitation - a direct violation of art. 19 of the UNCRC.

The impact of institutionalisation on children's development - particularly at the early stages of life – is clearly hindering the fulfilment of the child's right to the enjoyment of the highest attainable standard of health (Art. 24 UNCRC). Across the world, children in care have also lower educational attainment, are more frequently excluded, have lower high school completion rates and progress less in the education system (art. 28 UNCRC).

Children with disabilities and from minority groups are disproportionately represented in institutional care, showing a clear pattern of discrimination (art. 2 UNCRC).

Yet, article 23 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) provides clear guidance in this regard: "States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting". The Convention clarifies that "in no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents".

Moreover, the UNCRPD sets out the right of all persons with disabilities (irrespective of their age) to "live in the community with choices equal to others" and requires that States develop "a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation from the community" (art. 19 UNCRPD).

Although the UNCRPD is specific to persons with disabilities, articles 19 and 23 are founded on rights that apply to everyone[24].

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23. Prior to interventions from Hope and Homes for Children, some institutions we are working to close had mortality rates exceeding 80% per month. In one European Country, an investigation conducted by a non-governmental organisation with the Prosecutor's Office revealed that 238 children died in institutional care in a ten-year period (Bulgarian Helsinki Committee, 2010).
24. OHCHR (2010), p.7.

2.2. Impact of institutional care on children

Longitudinal studies and investigations have also produced compelling evidence regarding the negative effects of institutional care for the cognitive, psychosocial and physical development of children.

Researchers documented structural and functional changes in the brains of children who grow up in institutions. Neglect, abuse or the lack of a consistent interaction with a primary caregiver in the early years of life has the potential to adversely affect brain functioning. This situation is particularly damaging for children under the age of three: the earlier age at which a child is placed in an institution the more profound the damage on the developing brain will be[25].

The lack of consistent, one-to-one caregiving in institutional care can lead to attachment disorders, particularly when institutionalisation takes place during the early years of life. With low staff to child ratios, high staff turnover (including when children are cared for by volunteers who stay for a limited period of time) and little contact with families, children are unable to form long-lasting bonds with a primary caregiver[26]. As a result, institutionalised children often display attachment disorders and poor social responsiveness such as indiscriminate friendliness or overfriendliness, severe response to strangers and separation, poor social relationships with a carer and disinhibited behaviour compared to children who had never been institutionalised or were institutionalised after the age of two[27].

Research has also highlighted negative consequences of institutional care for behaviour and psychosocial development, including social competence, play, and peer and sibling interactions. Consequences during childhood include higher levels of apathy, restlessness, disobedience, hyperactivity, anxiety, depression, attention-seeking, sleep disorders, eating disorders and stereotypical behaviours[28] (e.g. rocking, head banging, self-harming) and lower levels of social maturity, attentiveness, concentration and communication.

Institutional care is typically detrimental to the cognitive development of children. Children raised in institutional care experience delays in terms of IQ, language, speech and vocabulary. A meta-analysis of 75 studies covering over 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[29].

As a consequence of psychosocial as well as nutritional deprivation, children raised in institutional care often experience delays in physical growth, as demonstrated through studies on several indicators including height, weight and head circumference[30]. Analysis of growth data from a variety of orphanage systems in Romania, the former Soviet Union and China indicates that children lose one month of linear growth for approximately every three months spent in institutional care[31].

Children with disabilities are especially vulnerable. The institutional care environment is utterly inadequate to provide attention, stimulation and specialised care to meet their special needs. Across the world, children with disabilities are commonly left in their beds or cribs without any human contact or stimulation, or even tied or restrained to prevent them from leaving their beds or to commit self-harm. This type of neglect and harmful treatment can lead to severe physical, mental and psychological damage[32]. Children with disabilities are also more exposed to violence and abuse in institutional care, with those suffering from mental illness or intellectual impairments among the most vulnerable.

The combination of developmental delays and institutional experiences commonly results in young people entering adulthood ill equipped for independent life and unable to interact with, and contribute to, the world around them. As a consequence, young people leaving care are one of the most vulnerable and disadvantaged groups in society. Children who grow up in institutional care are more likely to have lower educational qualifications, be young parents, be homeless, and have higher levels of unemployment, offending behaviour and criminality, and mental health problems[33]. As adults they are far more likely to be separated from their own children and confine them to an institution, thereby contributing to the inter-generational transmission of the problem.

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2.3. Incidence of violence

A particularly gruesome feature of institutional care around the world is the high incidence of violence [34]—in the form of emotional, physical and sexual abuse (including sexual exploitation), neglect and negligent treatment, harmful institutional practices, and peer violence. Children with disabilities are at particular risk and may even be subjected to abuse in the guise of treatment[35].

A survey from Romania revealed that almost half of the children indicated beating as routine punishment, and more than a third knew of children who had been forced to have sex[36].

It may be argued that the intrinsic characteristics of institutional care (e.g. social and geographical isolation, low child-carer ratio, disempowerment) increase the risk factor for children to become victims of violence. Moreover, institutional staff are often ill trained and poorly paid and there may be few if any norms or standards to regulate their activities. Predatory adults who seek to abuse children may intentionally target orphanages as members of staff, volunteers or visitors. Monitoring systems are often weak and ineffective, and there is little or no access for children to safe complaint and reporting mechanisms.

In addition to abuse, children's health and survival is threatened by widespread neglect in institutions. Poor health and sickness often result from poor provision of healthcare, hygiene and overcrowded conditions. With cots back-to-back and limited environmental experiences, the development of the immune system is inhibited. Soiled clothing is often left on babies and infants for long periods of time and poor hygiene practices are widespread. Infectious diseases and serious medical illness are frequent, and children are routinely isolated when they are sick[37]. Children are frequently denied the medication and treatment that they require. Institutionalisation can, in fact, be a threat to children's survival.

Even in institutions displaying high living conditions and material standards, the very nature of institutional care has a profoundly negative impact on the cognitive, psychosocial and physical development of children.

In light of the devastating consequences of institutionalisation – particularly on babies and very young children - institutional care should be recognised as a form of violence against children in itself.

25. Browne, K. D. (2009). See also Johnson et al (2007), pp. 34-36.
26. Bowlby, J. (1961).
27. Zeanah et al (2005), pp. 1015-1028. See also Chisholm K., (1998), pp. 1092-1106.
28. Stereotype behaviours are defined as repetitive, invariant movements with no obvious goal or function (Mason, G., 1991, pp. 1015- 1037). Stereotypies are commonly associated with a number of different medical conditions, including autism, and are also known to develop in association with

atypical and especially restricted sensory environments or deprivation.
29. Van Ijzendoom, M.H. et al (2008).
30. See Johnson, D. E. et al (2011), pp. 92–126.
31. Johnson, D.E., (2001).
32. Pinheiro, P. S. (2006), pp. 185-190.
33. Stein (2006).

34. UNICEF (2002), Pinheiro, P. S. (2006) and UN (2013).
35. Pinheiro, P. S. (2006).

36. Stativa, E. (2000).
37. Miller et al (1995), Hostetter et al (1991).

2.4. Costs for society

The damage does not stop at children. Institutions are very inefficient systems, with consequences for society at large.

A common misconception is that institutions are much cheaper than family and community-based alternatives and a realistic solution in a context of scarce resources. This is based on an alleged 'economy of scale', according to which increasing the number of children hosted in an institution would decrease per capita expenditure.

First and foremost, institutional care is deeply harmful to children, whose rights and needs should never come second to financial considerations. Second, even from a financial perspective, the economy of scale of institutions has proven to be a myth. **The only case where institutions are actually cheaper is when material conditions and the quality of care are so abysmal to allow a saving, all at the expense of children's health, wellbeing and even survival.**

Community-based alternatives (...) can provide better results for users, their families and the staff while their costs are comparable to those of institutional care if the comparison is made on the basis of comparable needs of residents and comparable quality of care".

Source: Ad Hoc Expert Group on the Transition from Institutional to Community-based Care[38]

A number of studies indicate that the cost of residential care, when of high quality and matching children's needs, is higher than family-based care[39].

At systemic level institutional care is a very poor use of funds because of the following factors:

• Unnecessarily high numbers of children in care – institutional care almost always recruits children for whom the separation from the birth family is unnecessary.

• Excessive time spent in care – once children are placed in institutional care they remain in care for most of their childhood and sometimes into adulthood.

• Long-term dependency on the institutional care system – young people leaving care lack skills and capacity to become independent, to secure employment, to secure relationships and often remain dependent on the institutional care system, directly or indirectly, for their own children.

While specialised services such as therapeutic residential care, which are indeed quite expensive, might be needed for some children, the majority of children currently in institutions could be supported to live with their own families and communities. As a result of care system reforms, significant savings can be achieved by preventing children from going unnecessarily into care and promoting reintegration, foster care and other family-based alternatives.

Finally, **the assumption that institutions are cheaper fails to take into account the long-term impact of institutional care on children and the associated societal costs.** As a consequence of multiple deprivation and developmental delays, children raised in institutional care suffer poorer outcomes as they age out of care. They experience social exclusion and disadvantage in terms of health, education, income and access to employment. When social welfare, health and public security costs are brought into the equation, family strengthening and quality alternative care prove to be not only intrinsically better for children, their families and communities, but are also cost-effective in the long term.

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The economic argument for deinstitutionalisation reforms – the case of Romania

A 2013 report by Hope and Homes for Children Romania demonstrated, on the basis of hard data, that action to prevent child separation from families is essential not only to observe human rights, but also to save costs. The report shed light on the financial consequences of three different policy scenarios:

1) Preserving the status quo;
2) Singular focus on moving children out of institutions;
3) Systemic reform focused on deinstitutionalisation through the development of alternative family care and prevention.

The report assessed the cost of each scenario over eight years, while taking into account recent trends of child admissions, departures and expenditure. The medium and long-term results were unquestionably in favour of comprehensive reform measures, involving fully fledged deinstitutionalisation[40].

The Financial Impact of the Public Child Protection System Reform in Romania, 2013.

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38. Ad Hoc Expert Group on the Transition from Institutional to Community-based Care (2009), p.5.

39. H. Ward et al (2008), Ad Hoc Expert Group on the Transition from Institutional to Community-Based Care, 2009, p. 13.

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40. Comsa, R. et al (2013).

Chapter 3.

BUILDING A CHILD PROTECTION SYSTEM FREE FROM INSTITUTIONAL CARE

The Guidelines for the Alternative Care of children require that in countries where institutions still exist "alternatives should be developed in the context of an overall deinstitutionalisation strategy with precise goals and objectives, which will allow for their progressive elimination."

As stated in the publication 'Moving Forward: Implementing The Guidelines for the Alternative Care of Children'[41] (hereafter 'Moving Forward'), the result of the collaboration of a number of NGOs and child protection experts, the Guidelines distinguish between 'residential facilities' and 'institutions'. While high quality residential care can play a constructive role to care for certain groups of children, in a rights-based system there is no place for institutional care.

The purpose of reform is much broader than purely closing institutional facilities: the goal is to achieve a comprehensive transformation of the care system, changing the very nature of service provision in a country. Systematically targeting institutional care provides a valuable entry point into understanding the nature, location and mix of services needed in each national context in order to best support children and their families, and when separation is necessary, to provide suitable alternative care to those children.

Deinstitutionalisation is the complex and multi-faceted process of moving away from obsolete care systems that rely on institutional care for children towards modern systems based on services to prevent family breakdown and a range of family and community-based alternatives to institutional care.

Deinstitutionalisation introduces an innovative, rights-based approach leading to a radical shift in the culture of services – from a one-size-fits-all solution (institutional care) to holistic programmes based on the individual needs and best interest of each child and family.
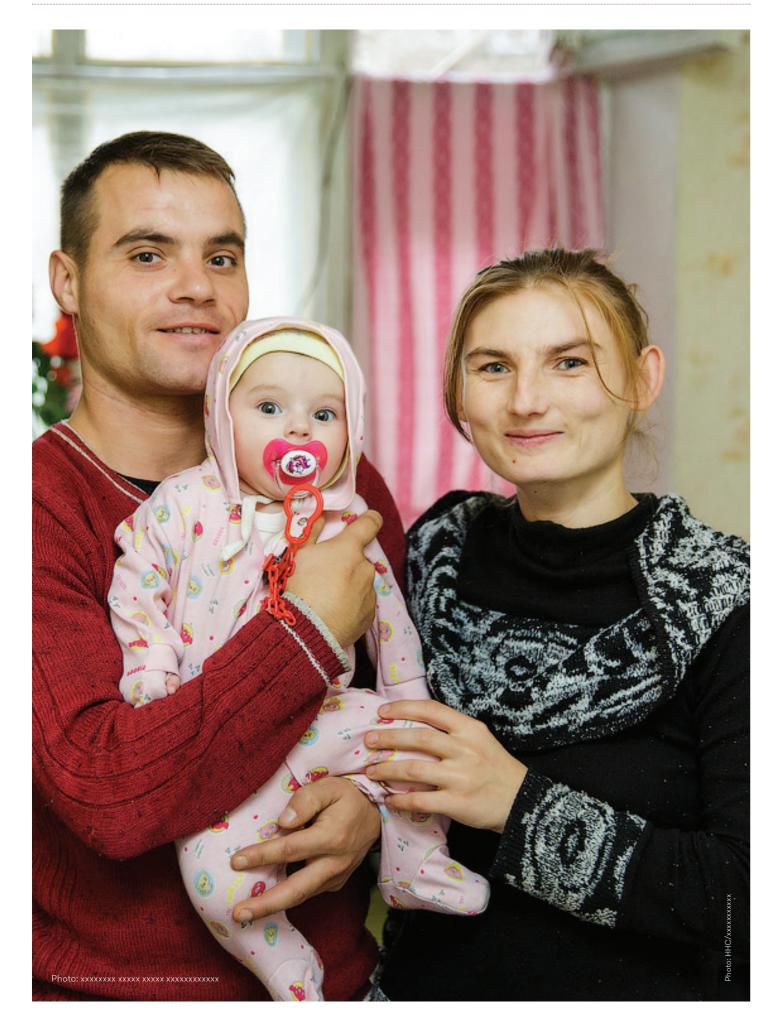
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41. Cantwell et al (2012).

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3.1. Preventing the need for alternative care

A number of elements are integral to any strategy. First and foremost, it is paramount to investigate the root causes leading to children being in vulnerable situations and pushing children into the care system, and put in place robust prevention policies to interrupt the 'entry flow' into institutions. Assessing the circumstances of separation for children in institutional care is crucial in order to design adequate prevention services that target their community of origin.

The principle of necessity embedded in the UNCRC and the Guidelines involves preventing situations and conditions that can lead to a child needing or entering the alternative care system. This means tackling a wide range of risks leading to the separation of children from their parents, in a timely and suitable fashion. Most importantly such interventions strengthen parents' capacity to care for their children, as well as discourage recourse to alternative care unless this is genuinely in the best interest of the child.

As mentioned above, the vast majority of children in institutions have at least one living parent or relative who, for different reasons, could not care for them. Responses will include measures to prevent child abandonment and relinquishment, family support and family strengthening programmes, as well as development of a variety of services in the community to support parents in their child-rearing role.

Poverty alleviation programmes, measures to address discrimination, marginalisation and social exclusion, parenting programmes, counselling and financial support services, provision of day care and specialised services for children with special needs are just some of the concrete actions that can be taken to prevent unnecessary entry of children into the care system[42].

States should also put in place structural measures to discourage recourse to, or unnecessary permanence of children in alternative care, including by ensuring robust gate-keeping mechanisms, establishing a system of referral providing help to parents in difficulty, prohibiting the active recruitment of children by care facilities, eliminating funding systems that encourage the entry of children into care, and ensuring regular review of existing placements[43].

ACTIVE Family Support

Hope and Homes for Children developed a model called ACTIVE Family Support aimed at strengthening families at risk of separation. The model enables targeted support in five integrated areas relevant to child wellbeing and builds on the family's strengths, whilst identifying the areas that make them vulnerable. These include living conditions, family and social relationships, education, physical and mental health and household economy. The key to this approach is that each intervention is building on individual strengths, addressing needs and circumstances, and empowering children and families themselves to contribute to their success.

The model allows for the identification and documentation of clusters of needs at community level that might lead to the institutionalisation of children, and addresses these by developing targeted services accessible to the whole community. The nature of the services varies from one community to another, ranging from emergency support for families, Mother and Baby services (where the most vulnerable young families can receive support without mothers and babies being separated), or Emergency Reception and/or Foster Care services where children at risk of neglect or abuse can be placed on a short-term basis. Other services provide support that helps parents to look after their families, including access to parenting skills, counselling, conflict resolution, financial aid, legal aid, access to social welfare, as well as facilitating access to other existing services.

A Day Care service offers a safe environment where children can learn and play while their parents find work. Meanwhile, life skills training can give adults the skills and encouragement they need to keep their families together – vital if the parents themselves grew up in institutions and have found it difficult to adapt to family life.

In many areas Hope and Homes for Children worked with local communities to develop Community Hubs. These are resource centres that provide a wide range of services according to local needs. Community Hubs help to break down barriers and encourage members of the community to support the most vulnerable families.

> 66
> THE PRINCIPLE OF NECESSITY EMBEDDED IN THE UNCRC AND THE GUIDELINES INVOLVES PREVENTING SITUATIONS AND CONDITIONS THAT CAN LEAD TO A CHILD NEEDING OR ENTERING THE ALTERNATIVE CARE SYSTEM.
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42. Ibid, p. 23.
43. Ibid.

3.2. Closing institutions and developing a range of alternatives

In parallel with prevention efforts, an articulated strategy should be put in place to progressively eliminate institutions as a care option. Specialist expertise is required to move all children out of institutional care and close institutions in a manner which safeguards each individual child, ensures the efficient use and transfer of resources, and results in sustainable high quality care services.

As part of the deinstitutionalisation process, a careful assessment is conducted for every single child living in institutions to trace the family of origin and check the suitability of reintegration. Reintegration of children into their birth families is the preferable solution, unless this is not possible (e.g. efforts to trace the family have failed) or not in the best interest of the child. In cases where the birth family is unknown, unwilling or unable to meet the needs of the child, even with significant support, family-based and family-like alternatives can be explored.

The choice of the most suitable care option should also follow an individual assessment, on the basis of which a range of care options is explored to match the child's individual needs[44]. This is in line with the suitability principle of the Guidelines, according to which whenever a child effectively needs alternative care, such care is provided in an appropriate way.

Quality alternative care is characterised by stable, nurturing and loving relationships between children and their carers. It can be formal or informal in nature[45]:

Informal family care is provided by members of the extended family or a non-related family identified by the community or the child, and is already widely used across the world as an alternative to institutions. With additional support when needed, informal care continues to be an important solution for children who cannot remain with their parents.

Alternative care can also be formal and regulated by the State. This includes different family-based solutions, such as kinship care – when children are supported to live with other relatives – as well as foster care, group foster care,

and guardianship.

Foster care is a particularly flexible option that varies according to the needs of the child. It can be a very short-term solution for children who need to be placed at short notice in the event of an emergency. It can also be an interim solution for children who will eventually be reintegrated with their parents or adopted, or a longer-term solution where children stay with the same family until they are old enough to start an independent life. Specialised foster care can be the best option for children with special needs such as physical disabilities and/or learning difficulties, as the child can be placed with a family that has the specialist skills required.

The Guidelines recognise that residential care is also a necessary component of the range of alternative care options, complementary to family based alternative care, provided it is as family-like as possible. Small scale residential care, designed to replicate a family environment (family-like alternative care), can be considered as a last resort where children's specific needs, circumstances and wishes require it – for instance, to provide therapeutic care or treatment for children who have suffered trauma, severe abuse or neglect, or to enable large sibling groups to remain together. In this case, children live in group homes integrated in the community with one or more specialist carers, under conditions that resemble a family as much as possible. When it comes to young children, especially those under the age of three, recourse to residential care is generally discouraged and alternative care should be provided in family-based settings.

Whatever the care setting, the highest quality standards should be guaranteed to fulfil children's rights and meet their needs. For most children, all forms of alternative family care will be a temporary measure either while support is provided to enable them to return to their own family or while a more permanent solution such as domestic adoption is found.

Adoption usually severs all family links between the child and his birth parents and extended family. It is a solution that can provide security for a child, but can also have serious implications for his/her sense of identity. For this reason, adoption should be pursued only when it is in the child's best interests and when all options for reintegration within the birth family have been explored and discarded.

According to international norms, inter-country adoption should be treated as a very last resort and only when all other avenues have been exhausted[46].

44. See chapter 3.2.
45. Guidelines for the Alternative Care of Children, § 29.
46. UNCRC, Art. 21 b): "(…) inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin". See also Convention of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption.

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FROM:

Family at risk → **Inaction** → **Family in crisis** → **Placement in institutional care**

Family at risk
- Unsustainable source of income
- Marginalisation
- Ill/health issues
- Lack of access to basic services
- Poor family and social relationships
- Poor parenting skills
- Death of one parent (mother)

Inaction
- Loss of income, housing
- Discrimination
- Disability
- Lack of medical support, welfare assistance, etc.
- Family breakdown
- Parents' capacity to provide adequate care to children at critical level

Family in crisis
- Children's wellbeing at risk
- Capacity to intervene and achieve positive changes in a short period of time is reduced

Placement in institutional care
- Children are separated from their families
- Families remain vulnerable and at risk

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TO:

Permanent families: reintegration, Adoption, Kafala, Guardianship, Kinship Care, Independent living

Family at risk ← **Gatekeeping** → **Emergency Care** → **Alternative Family Care**

Family at risk
- Unsustainable source of income
- Marginalisation
- Ill/health issues
- Lack of access to basic services
- Poor family and social relationships
- Poor parenting skills
- Death of one parent (mother)

Gatekeeping
- Access to welfare, health, education and early intervention services
- Day care including specialist support
- Respite care Family planning, parenting skills

Emergency Care
- Mother and Baby Units,
- Counselling Desks in hospitals,
- Emergency Reception Units
- Emergency Foster Care

Alternative Family Care
- Foster Care
- Specialist Foster Care
- Group Foster Care
- Residential Care in Small
- Family Homes
- Assisted Living
- Transition into independent life

Resilience, adequate community responses and professional gatekeeping

Professional child focused social workforce, integrated approach supporting children

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3.3. Challenges and pitfalls

Governments and organisations engaged in deinstitutionalisation are likely to encounter a number of challenges and a level of resistance from the very system they are trying to reform.

Fear of loss

Institutions provide a source of employment and income to local communities, particularly when they are located in remote and isolated places. This can add tension to the process of closure. To minimise impact on the local economy, attention can be paid to identify the potential skills and expertise of institutional staff and facilitate their re-training and deployment within the new services.

Restrictive administrative procedures

Often, local administrations are concerned about the infrastructure investment made for establishing the institution and anxious to identify a new purpose for the building. Crucially, closed institutions should not be used to host other groups of children or adults (e.g. persons with disabilities). A good practice is to transform institutional buildings into modern, non-residential services that can provide support for families and communities (e.g. schools, kindergartens, specialised day care centres, etc.)

Fear of change

The attitude and mentality of professionals and society can also concur in slowing down reform, particularly when it comes to the most vulnerable groups. For instance medical staff, child protection personnel or social workers may be sceptical or hostile to the reintegration of children with disabilities, considering them unfit for life in the community. More structurally, children with disabilities and other vulnerable groups (e.g. street children, children living with HIV/AIDS) perceived as 'problematic' are often left behind in the process of reform. If deinstitutionalisation is to be truly inclusive, education and awareness-raising efforts shall be deployed to achieve a shift in social norms and promote a culture of non-discrimination. Care reforms should adopt a rights-based approach towards all children locked away in institutions, irrespective of their abilities or circumstances.

Fear of professional accountability

Institutions are often perceived by social workers as a 'safer' option compared to reintegrating children with their birth families, where they could be exposed to violence or abuse. On the one hand, this can be a legitimate concern insofar as it relates to carefully preparing and supporting families ahead of reunification, in parallel with monitoring outcomes and developing an effective child protection system. On the other hand, it may also reveal a level of prejudice among social workers against families facing challenging situations - especially in the case of discriminated ethnic groups, single parents or very poor households. In some cases, social workers might be reticent to change the status quo as this would entail taking responsibility for the protection of children in their families and communities, whereas they would not be held accountable for the outcomes of placements in institutions.
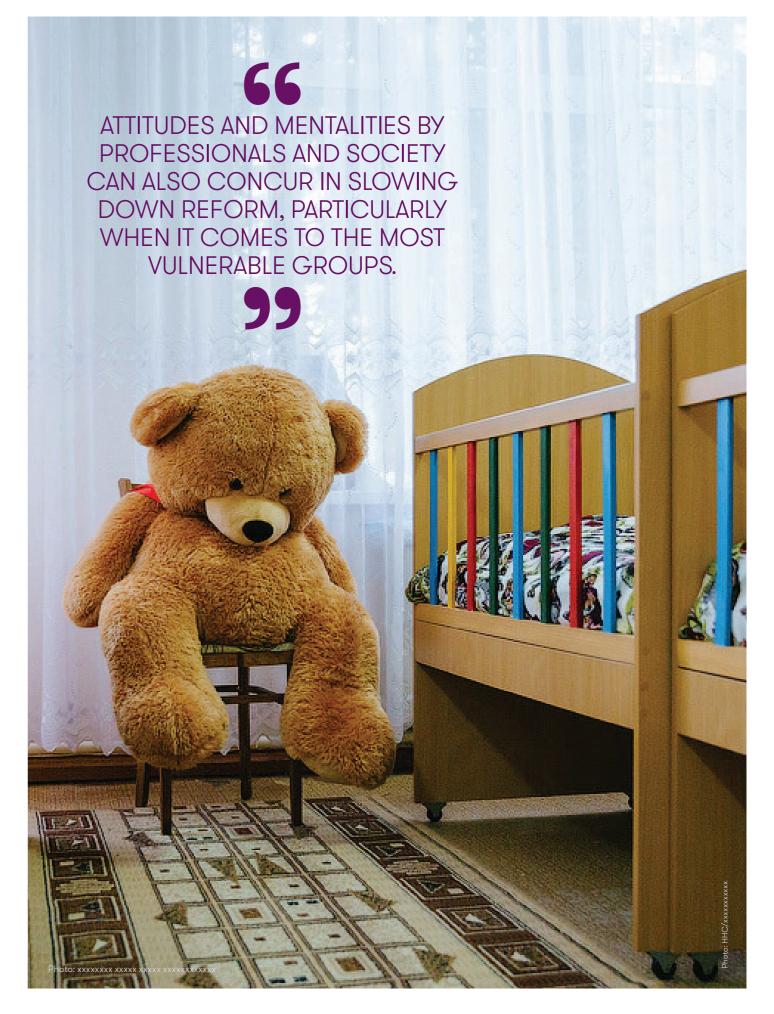
Funding incentives or barriers

Funding arrangements play a crucial role in supporting the system of institutional care, particularly when institutions are financed on the basis of the number of children cared for[47]. In fact the cost per child in institutional care is often higher than the cost of any other alternative, including community-based residential care. This funding model risks creating a distorted mechanism, where children are admitted or retained into institutions as a strategy to keep the funds coming in. There is also a disincentive to support deinstitutionalisation in countries where institutional placements are funded by central government, whilst community placements are funded by local authorities. The burden of expenditure for family support and other services can become very onerous for local administration, especially where budget lines are very inflexible and money available for institutions cannot be transferred to support prevention or reintegration at a local level. For this reason, NGOs have been advocating a principle where 'the money follows the child': whenever the decision is taken to dismantle a care facility, resources should be ring-fenced and re-invested into quality alternative care, services and family support in the community.

Disconnect between development of prevention and alternative care and the closure of institutions

Although prevention and family strengthening are a crucial component of the process, they should go hand in hand with institutional closures. In the absence of a general plan to eliminate institutions, two systems end up running in parallel – one focused on families and community services, the other still relying on institutional care – and double running costs have to be faced to resource both the old and the new system. While these transitional costs are inevitable in the short term, in the long run the financial strain of having two parallel systems can become unbearable for the State, leading to general failure of the process[48].

Failing to implement systemic change

Finally, it is important to resist the temptation of superficial transformations. Some institutions may decide to 'remodel' or 'transform' their services as an attempt to provide a higher standard of care. This generally involves changing the way in which groups of children are organised to better represent a family unit. Rather than being split by age and gender, children are regrouped into units of mixed ages, with specific staff allocated to care for each unit. In some cases, they are reconverted into 'boarding schools' or similar residential facilities allegedly providing a different type of service (e.g. education). Unfortunately this does not guarantee a substantial shift in the nature of the service, as the reorganised facilities are very likely to continue perpetuating an institutional culture. While some forms of residential care can be improved (e.g. by increasing the carer-child ratio in a small group home), institutional care cannot be reformed: it can only be dismantled and replaced with qualitatively different alternatives.

"

ATTITUDES AND MENTALITIES BY PROFESSIONALS AND SOCIETY CAN ALSO CONCUR IN SLOWING DOWN REFORM, PARTICULARLY WHEN IT COMES TO THE MOST VULNERABLE GROUPS.

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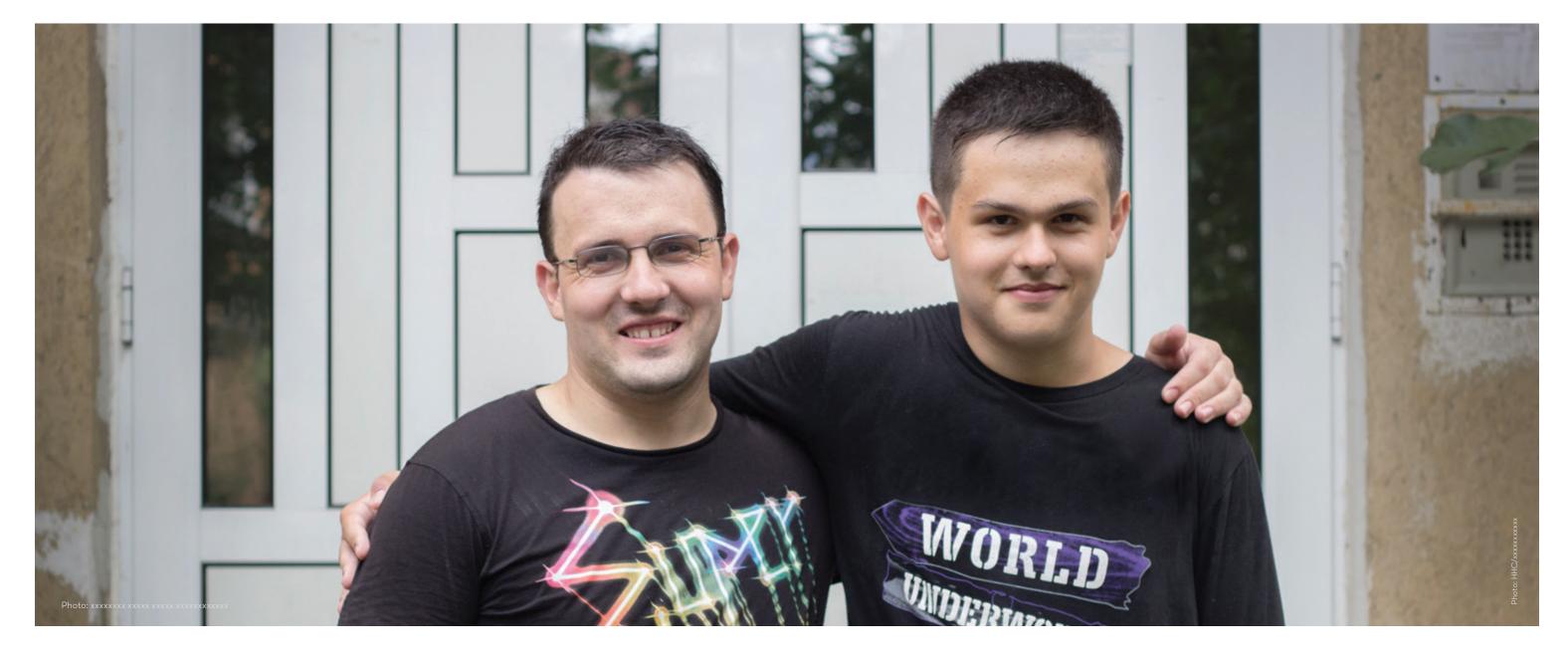## Chapter 4.

STRATEGIES TO END INSTITUTIONAL CARE

A number of countries across the world have already started to dismantle their institutional care systems, re-integrating children into families and communities. Yet, with millions of children still growing up in orphanages and several million more at risk, we face a truly global problem.

A crucial step towards the solution is to isolate the key strategic factors that can accelerate the transition from institutional to family and community-based care. Experience across a variety of contexts has proven that a set of conditions need to be in place in order that reforms take place successfully and lay the foundations for long-lasting change:

• Sustained political will at the highest level to embark on comprehensive transformation;

• Evidence and know-how available in-country to inform policy and practice for service development;

• A strong national social workforce and a coordinated civil society to support and monitor implementation;

• Access to additional funds during the transition process and government commitment to allocate resources to ensure sustainability of the system.

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4.1 Strengthening political will and governance

Strong national leadership and long-term vision are indispensable to achieve comprehensive care reforms. In fact, the State holds ultimate responsibility for implementing the UNCRC.

Political commitment is crucial to sustain change beyond the short lifespan of electoral cycles and in the face of vested interests and resistance. The strategic vision by key champions in government needs to be complemented by a strong legislative and policy framework, accompanied by measurable and time-bound action plans.

Often the process involves the designation (or creation) of a government body responsible for overseeing the process (e.g. national Child Protection Agency), with the associated institutional strengthening for that authority to fulfil its mandate and responsibilities[49].

While a specific Ministry might take political ownership for the process, coordination between Ministries and sectors (e.g. Social Affairs, Health, Education, Local Development, Finances) is vital to avoid fragmentation of responsibilities, competing agendas and most importantly to harmonise services following children as they move out of institutions. Equally important is the role of the judiciary, whose decision can directly impact on individual cases. In some instances, the creation of an inter-ministerial task force can help fostering cooperation and promote a holistic approach.

Although implementation of the UNCRC is primarily a responsibility of the State, several actors play a key role in the care reform process:

Intergovernmental organisations, such as the United Nations, are crucial allies to exert a positive influence on governments and strengthen political will.
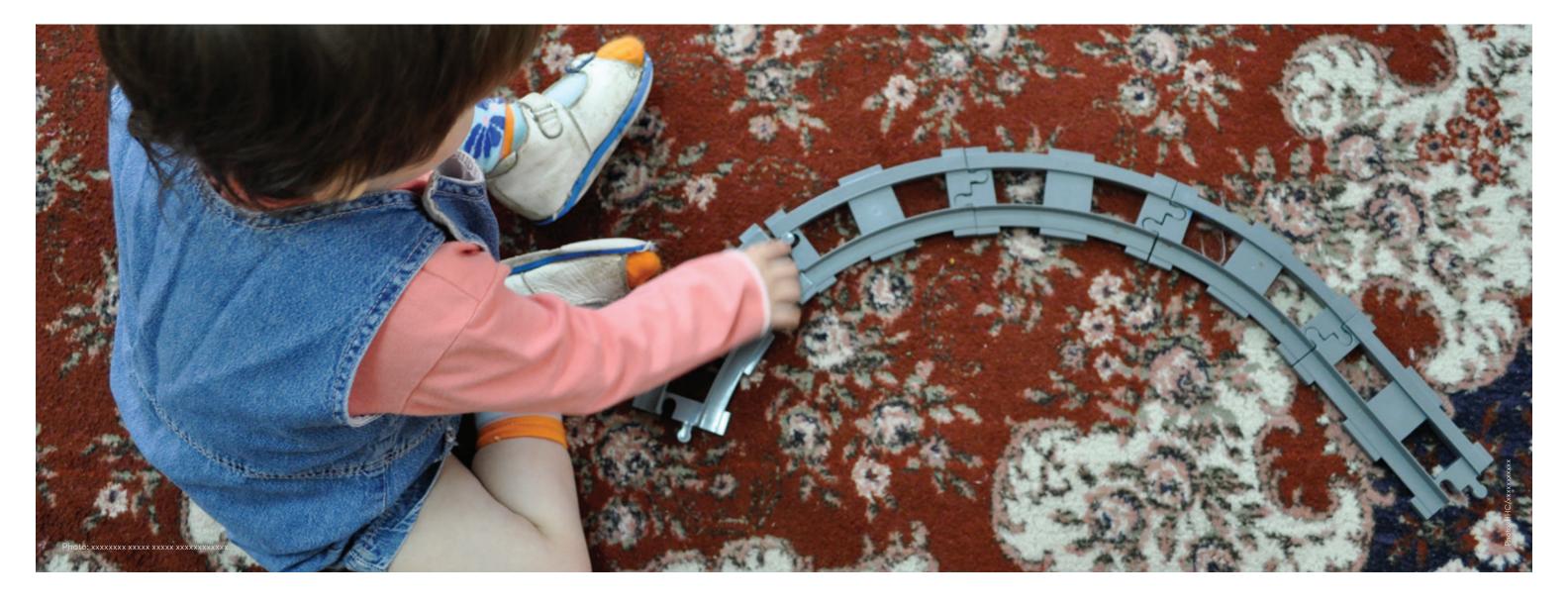
Similarly, treaty bodies responsible for monitoring the implementation of international treaties (e.g. UNCRC, UNCRPD) and region-specific human rights bodies (e.g. Inter-American Commission and Court of Human Rights, African Committee of Experts on the Rights and Wellbeing of the Child) can be of great support to highlight issues related to the rights of children in alternative care.

Regional Organisations such as the European Union, the African Union, the Organisation of American States, the Council of Europe, etc. are also very well placed to promote intergovernmental cooperation, facilitate good practice exchange and issue recommendations to governments:

• The Inter-American Commission and Court of Human Rights published in 2013 a report on 'The Right of Girls and Boys to a Family - Alternative Care - Ending Institutionalization in the Americas', urging OAS member States to end the institutionalisation of children.

• The European Commission issued in 2013 a Recommendation on 'Investing in children: breaking the cycle of disadvantage', where it encourages EU Member States 'to stop the expansion of institutional care settings for children without parental care and promote quality, community-based care and foster care within family settings instead where children's voice is given due consideration'.

49. For instance in Rwanda the reform process has established the National Commission for Children under the Ministry of Gender and Family Promotion (MIGEPROF), whose mandate it is to protect and promote the rights of children in the country. The National Commission for Children is also in charge of leading and coordinating the childcare reform process. See Bunkers, K. (2015), p. 34.

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4.2. Building the local evidence and know-how

A key element of a State's ability to protect and promote children's rights is the availability of accurate data that can be used to develop strategies corresponding to the specific needs and characteristics of the population. Yet, too often States are equipped with very weak or disperse data-collection systems, and information continues to be sorely lacking as it pertains to children without parental care and children at risk of separation from their families. In order to initiate reforms, it is vital to establish an accurate picture of the numbers and characteristics of children in care, the root causes of institutionalisation, and more broadly the function of the child protection system as a whole.

NATIONAL SURVEYS

National surveys provide the evidence base for child protection system reform planning and a baseline for monitoring progress, and are a pre-requisite for effective deinstitutionalisation planning.

Child protection systems - made up of a set of components that, when properly coordinated, work together to strengthen the protective environment around each child. These components include a strong legal and policy framework for child protection, adequate budget allocations, multi-sector coordination, child-friendly preventive and responsive services, a child protection workforce, oversight and regulation and robust data on child protection issues (Save the Children, 2009).

National surveys should take a holistic approach and assess the current status of each of these components. They may be undertaken in widely varying locations and at different points of a country's process of planning and implementing national child protection system reform.

The scope of surveys also varies, mostly depending on the particular strategy in each country. If carried out later in the deinstitutionalisation process, either as a second follow-up survey or as a first survey, they can be used to measure progress and to provide recommendations for the next stage of the reform.

Tracking progress: a measuring tool for the implementation of the Guidelines for the Alternative Care of Children

In order to track countries' progress in implementing the standards set out by the Guidelines, an inter-agency initiative has led the development of an interactive, strengths-based diagnostic and learning tool.

The tool aims to help governments and NGOs determine the extent to which a state or region has effectively implemented the Guidelines, and the priorities for change still ahead.

The initiative is co-facilitated by Better Care Network and Save The Children, and conducted in close collaboration with the Children without Appropriate Parental Care Working Groups in New York and Geneva.

The lack of tradition and know-how for the provision of social services by the State can also be a huge obstacle to system transformation. In many cases, non-governmental organisations have been instrumental in developing the skills and expertise required for the replacement of institutional care with a range of prevention and quality alternatives in the community. The experience from these pilot projects can be harvested, documented and used strategically to build the capacity of social welfare professionals at all administrative levels.

4.3. Building the capacity of the national social service workforce and civil society

Building the technical capacity and sustainability of a strong professional social service workforce, supported, supervised and trained to be able to deliver the transition from institutional to family and community based care, is a critical component of the process.[50] Particular attention should be devoted to the workforce in charge of direct care of children.

Workforce strengthening is key at many levels, from national to community, and should include essential elements such as pre-service and in-service training, capacity building for effective case management, development and strengthening of curricula and competencies, national coordination, and establishment of a monitoring and evaluation system. Whenever possible, it is also important to strengthen traditional child protection mechanisms and develop a well-supported para-professional workforce.

Civil society organisations, as part of the social system, are also uniquely placed to facilitate transformative and sustained change. Active and organised civil society can be a key driver for reform - not only by developing know-how and innovative projects, but also by advocating for legislation, policies and funding mechanisms to protect and promote children's rights.

Civil society organisations also play a watchdog role, ensuring duty-holders are held accountable for the implementation of the UNCRC and the Guidelines. Ultimately, the development of civil society is vital for encouraging the involvement of beneficiaries and for the fundamental and democratic values of any country.

> " NON-GOVERNMENTAL ORGANISATIONS (NGOS) HAVE PLAYED A MAJOR ROLE IN PROMOTING, IMPLEMENTING AND SUSTAINING CHILD PROTECTION AND CARE SYSTEM TRANSFORMATIONS[51] "

Non-governmental organisations (NGOs) have played a major role in promoting, implementing and sustaining child protection and care system transformations[51]:

- By conducting pilot projects that proved the feasibility of deinstitutionalisation strategies and contributed to secure political commitment;

- Through their advocacy action aimed at increasing public awareness, shaping governmental policies and monitoring implementation of reform plans;

- Through direct contact with beneficiaries, to directly represent the interests of children and communities and give a voice to the most vulnerable groups.

The faith-based community is also a key stakeholder to promote and expand family-based care. Churches and faith groups across the world are closely engaged in caring for children and families in need. At the same

time, in a number of countries Non-governmental Organisations (NGOs) and Faith-Based Organisations (FBOs) have substantially contributed to sustaining or expanding the institutional care system by setting up orphanages – often without registration or governmental oversight. In part, this is due to misguided good intentions and a lack of awareness about the effects of institutional care on children.

NGOs and FBOs should abstain from setting-up orphanages and other forms of institutional care for children, and ensure their engagement is in line with, and supportive of, governmental policies and international guidelines for alternative care.

- Initiatives such as Faith to Action aim to inform and guide faith-based organisations to identify appropriate ways to respond to the needs of orphans and vulnerable children[52].

4.4. Securing funds for the transition

From experience, we know that institutional care is not a cheap or effective system to support children deprived of their family environment. However, additional resources are always needed during the phase of transition. This refers to the period when the old and the reformed systems are still running in parallel, and until resources locked into running institutional care can be used to support children in their families and communities. Transitional costs include infrastructure expenditures, costs relating to service delivery, training, capacity building and skills development, etc[53].

At the same time, it is crucial for governments to take up responsibility for the system in the long-term, to ensure national ownership and the overall sustainability of reform. This can represent a significant challenge for States engaged in transforming their care systems, particularly in low or middle-income countries. International assistance and development programmes can play a vital role in providing additional external funding for reform.

> " FROM EXPERIENCE, WE KNOW THAT INSTITUTIONAL CARE IS NOT A CHEAP OR EFFECTIVE SYSTEM TO SUPPORT CHILDREN DEPRIVED OF THEIR FAMILY ENVIRONMENT. "

Institutional donors have the ability and responsibility to support national governments throughout the process of transforming their care systems through their capacities to enhance international cooperation and development assistance.

- Recently the European Union has sent a strong message to its 28 Member States that institutional care is an injustice and it is not acceptable. The Regulations for the EU Cohesion Policy investment, adopted in December 2013, for the first time stipulate that in effect EU funds cannot be spent on building or refurbishing orphanages and residential institutional settings and include specific references to support the "transition from institutional to community-based care".

Private donors are equally important, particularly in the context of low and middle-income countries. It is quite common for private individuals to send donations to orphanages overseas, mostly with the hope of offering children a better future. Unfortunately, these well-intended but misguided interventions have helped to perpetuate institutional care in much of the world. Not only has this reinforced an obsolete and abusive system, it has also diverted precious resources that could have been used for strengthening families and communities.

Crucially, private and public funds should stop funding institutions and be re-directed towards programmes that truly support children and their families. Private donations can be reinvested, for instance, in school fees and other types of educational support, access to health care, community-based services and resources for early intervention, youth engagement, adult learning and economic development, local volunteer services, etc.

50. See Bunkers, K. (2015).
51. Ibid, p. 34: "Strong government support and recognition of the role of civil society is a core part of the childcare reform process. [...] HHC piloted the deinstitutionalisation process, which was instrumental in influencing the care reform process. This, in combination with its research to advocate for policy change, provides an example of the impactful role that NGOs can play'.
52. http://faithtoaction.org.

53. Eurochild and Hope and Homes for Children (2012).

4.5. An entry point to broader reform

Focusing on the situation of children outside family care, and especially those in institutional care, can be used strategically as an entry point for broader child protection systems strengthening[54]. The transition from institutional to family and community based care can help to strengthen the child protection system as a whole by stimulating effective investment in children and the development of a professional workforce and, at the same time, fostering inter-ministerial coordination and promoting a child centred agenda.

Efforts to de-institutionalise the care system are also likely to drive focus and resources towards community development. It is widely recognised that families affected by poverty are more vulnerable to being separated. Child protection systems based on institutional care deal with the symptoms of family separation by placing children in institutions, but have no impact on the causes and effects of poverty in a household. Institutional care is also a driver of inter-generational transmission of poverty. Across the world, the long-term consequences of institutionalisation on millions of children lead to poor education and health outcomes and social exclusion, which in turn affect children's ability to earn an income when they become adults.

Deinstitutionalisation reform, on the contrary, helps to liberate resources locked into the institutional system and re-distribute them to support the most vulnerable individuals and groups. The analysis of the factors pushing children into institutional care (e.g. extreme poverty, disability, discrimination of ethnic minorities, lack of community services in rural areas, incidence of HIV/AIDS, etc.) allows the gathering of crucial information about vulnerabilities and gaps in service provision in a given territory. Consequently, the process of family tracing and reintegration allows for the development of services and other forms of assistance in communities where they previously did not exist, reaching a number of beneficiaries which is often significantly larger than the number of children who were de-institutionalised.

At the macro level, care reforms can be situated into a coherent framework of interventions to strengthen social protection, health, education and other key policy areas crucial to supporting children and families.

54. See Better Care Network and Global Social Service Workforce Alliance (2014), pp. 19-20: "Care reform has been the entry point for reform of the whole child protection sector in Rwanda and in this way has had a significant influence on the development of a workforce at the prevention and intervention levels". See also Joint Inter-agency statement 'Strengthening child protection systems in Sub-Saharan Africa: a Call to Action', 2012.

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Photo: HHC/xxxxxxxx

CONCLUSIONS AND WAY FORWARD

Global evidence demonstrates that institutional care harms children in many different ways. Institutionalisation, particularly at an early age, results in negative outcomes that can last a lifetime. Not only do institutions violate children's rights and their life chances, they are also cost intensive and restrict opportunities for economic and social development.

A number of countries across the globe have already engaged in courageous transformations of their care systems, demonstrating that change is feasible and delivering immensely better outcomes for children, their families and communities. At a global level, a number of crucial steps can be taken to make the elimination of institutional care a political priority:

• A shared understanding of the phenomenon, its causes and solutions is critical to strengthen political will and secure commitment for care reform. Despite growing consensus about the harmful effects of institutional care, neither the UNCRC nor the Guidelines clearly define what institutional care actually is. It is vital that governments, NGOs, bilateral and multilateral organisations and funders work together to develop a common definition of "institutional care" to quantify the problem, put in place effective strategies and work toward its elimination. To ensure maximum ownership, this process should take place collaboratively among a diverse group of stakeholders and agencies.

• The paucity of information about the situation of children in care and children at risk is striking. This should be addressed as an urgent priority. A stronger evidence base is vital to support better programming and galvanise action within the international community. Equally critical to build a compelling case is to develop sufficient expertise and know-how about what works in delivering the transition from institutional to community-based care. Pockets of good practice already exist[55], but need to be harvested and shared to establish an international body of best practice.

• While implementation of the UNCRC and the Guidelines is primarily a responsibility of the State, coordination among civil society actors is critical to achieve a global breakthrough – particularly considering the number and array of non-State actors involved in running or supporting institutions worldwide. Civil society organisations should take the lead in advocating for care system reform in partnership with governments, donors and international agencies.

• A cornerstone of effective deinstitutionalisation is the availability of additional external funding to cover transitional costs. Progress has been achieved in this area, with development partners providing assistance to governments who chose to undertake a transformation of their care systems. More efforts are required to sustain and expand these programmes, coordinate donors' agendas and leverage sufficient resources for the elimination of institutional care globally.

• Ultimately, a global movement is needed to translate aspirations into reality. Across the world, national governments, civil society organisations, international agencies, human rights bodies, institutional and private donors, the faith community, academia, practitioners and committed individuals have already started to join forces to put an end to institutional care and replace it with a care system that upholds children's rights. Together we have a unique opportunity to sustain the momentum and generate a global groundswell of commitment to achieve long-lasting change.

55. A number of European countries, such as Bulgaria, Moldova and Romania, have already achieved significant progress in their child protection system reform, providing a wealth of inspiring practices on the transition from institutional to family and community-based care. In the African context, the reform process currently taking place in Rwanda offers key areas of learning that can be harnessed and shared to inspire systemic change across the region.

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Hope and Homes for Children's mission is to be the catalyst for the elimination of institutional care across the world. We work together with governments, civil society organisations, and funders and in partnership with children, their families and communities to develop institution-free child protection systems. We achieve this by strengthening child protection mechanisms, building the capacity of local professionals, developing services to support families and providing family-based alternatives for children who cannot remain with their own parents.

We also work with governments and civil society to influence policy and legislation to protect and promote children's rights.

Hope and Homes for Children recognises that there is no traditional or limited concept of family, and understands that different types of family ties exist. We do not discriminate or favour any particular family form in our work.

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