



SOS CHILDREN'S
VILLAGES
INTERNATIONAL



European
Commission



TOWARDS THE RIGHT CARE FOR CHILDREN

Orientations for reforming alternative care systems
Africa, Asia, Latin America



Centre for excellence
for local after children in transition

With the collaboration of



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This publication and its annexes are available in electronic form on
<http://capacity4dev.ec.europa.eu/topic/children-youth> and
<http://www.sos-childrensvillages.org/publications/publications/research>

ISBN: 978-92-79-63466-6

doi:10.2841/069502

Catalogue Number: MN-05-16-004-EN-N

Luxembourg: Publications Office of the European Union

2016 – 40pp – 21x29.7 cm

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Table of Contents

PART 1: INTRODUCTION	5
1.1 Background	6
1.2 The research base for the report	6
1.3 Concepts and terminology	7
1.4 Approach and preliminary considerations	8
1.5 Diverse and complex country situations	10
PART 2: WHY ARE CHILDREN IN FORMAL ALTERNATIVE CARE SETTINGS?	11
The myriad effects of “poverty”	12
Education: both a key driver and a magnet	12
Orphanhood	13
HIV/AIDS	13
Parents and children on the move	13
Discrimination	13
Abuse, neglect and exploitation	14
Disability	14
Other reasons	14
Active recruitment of children into residential care	14
PART 3: WHERE ARE CHILDREN IN ALTERNATIVE CARE?	15
3.1 Informal care settings	16
3.2 Formal family-based care	16
3.3 Residential care	19
3.4 A key to reform: how alternative care is financed	20
PART 4: RECOMMENDATIONS	21
4.1 General considerations	22
4.2 Encouraging and enabling the Government to take control	22
4.3 Summary conclusions and specific recommendations for the EU	23
1. State influence and control through law, policy and effective regulation	23
2. Funding	25
3. Workforce	25
4. Prevention	26
5. Cultural values and formal vs informal care	26
6. Complementary development of alternative care options	27
7. Ensuring quality care	27
8. Data collection and analysis	28
9. Child participation	28
4.4 Taking forward evidence-based reform in country-specific contexts	29
4.4.1 Securing basic knowledge	29
4.4.2 Determining the respective influence of the State and non-State actors	32
4.4.3 Determining basic country profiles	33
4.4.4 Refining country-specific support	33
LIST OF ANNEXES	34

Foreword

SOS Children’s Villages was delighted to undertake this project, as a contribution to increasing knowledge about children in alternative care, raising the profile of this important aspect of child protection systems, and leading the way towards positive and carefully considered EU action and investment in improving alternative care options for children without parental care or at risk of being separated from their families.

For more than a decade we have joined forces with other stakeholders and the European institutions to achieve today’s tools and instruments for de-institutionalisation, integrated child protection systems and investment in children in Europe. As a worldwide federation with origins in the heart of Europe, we are all the more pleased to be able to help the European Union broaden these efforts towards three more continents. In 2016, we adopted our **“Strategy 2030: No Child Should Grow Up Alone”**, which revolves around the United Nations Guidelines for the Alternative Care of Children and the 2030 Agenda for Sustainable Development: this report reflects the universality that these frameworks call for and a child rights focus.

This report is based on research carried out by global experts in this field and we are proud that child participation methodologies have brought children’s own views into the research as well. Confirming that the question is not black-and-white, the report shows that while the effects on children of unnecessary and unsuitable alternative care are universal, the context for efforts towards “de-institutionalisation” is very different from those in Europe and the former Soviet Union.

It attempts to enable European Union decision-makers in particular to make better informed strategic decisions about alternative care system reform in its partner countries, as part of the EU’s bilateral relations and development cooperation. In doing so, the report provides valuable ideas for any country about how to look for concrete actions that will make a sustainable difference for their most vulnerable young citizens. It is a basis for learning to situate alternative care firmly within the child protection systems framework, using this knowledge to look critically at existing services and programmes, facilities and donors and to advocate for reform and support to quality care services.

We hope that this systems approach to de-institutionalisation will allow for the implementation of quality control and prevention work that can inhibit unnecessary and unsuitable alternative care placements, instead finding the “right care” for each child touched by the risk of family separation. This is important to ensure that those children can fully enjoy their rights, in a supportive and nurturing environment. It will also contribute to ensuring that children without parental care have equal chances to be included in society as they grow towards adulthood.

SOS Children’s Villages International looks forward to continuing our partnership with the European Union and other relevant stakeholders – in Africa, Asia and Latin America as in Europe – on the development of strategies to shape robust child protection systems that realise children’s rights in any country around the world.

Siddhartha Kaul

President of SOS Children’s Villages International

Photo © Kristin Svorte



Part 1

Introduction

1.1. Background

In order to increase its knowledge on the possible issue of de-institutionalisation in developing countries and how it could be addressed, the European Commission Directorate-General for International Cooperation and Development (DG DEVCO) commissioned SOS Children's Villages International to conduct the present study. Its general objective was to "conduct a research on the possible issue of institutionalisation in six South and Central American, Asian and African countries in order to strengthen the knowledge of the European Commission on the nature, the extent and scope of institutionalisation and feasibility of de-institutionalisation (alternative care for children). On the basis of its results, the research would give recommendations for future possible initiatives (pilot programmes, social protection system reforms, for example) to be supported by the EU in developing countries." The present synthesis report, *Towards the Right Care for Children*, presents the findings of the study as well as recommendations for EU external action.

The three specific objectives of the study were to: map and summarise the existing knowledge on (de-)institutionalisation in the three continents concerned; increase the knowledge base on (de-)institutionalisation in 6 specific countries; and provide guidelines for future EU strategies on (de-)institutionalisation in developing countries. The research team proposed to examine the broader context of alternative care for children, to explore the range of factors that cause children to be living out of the protection of their family and to find themselves in suitable or unsuitable alternative care placements, including institutional care.

The need for knowledge about alternative care in the EU's partner countries on other continents follows considerable advances in the area of de-institutionalisation made since 2009 in Europe, including Common European Guidelines on the Transition from Institutional to Community-based Care, and considerable investment in de-institutionalisation in Eastern Europe and Central Asia, as well as within the EU. However, a comparison with European alternative care systems was not among the study's objectives. As this report demonstrates, the characteristics of country situations in other regions of the world are generally so different from those in Europe and Central Asia that such reference points are of limited use for determining strategies and policies.

Within the EU's external action, the EU Action Plan on Human Rights and Democracy 2015-2019 includes a specific action on supporting partner countries to "strengthen child protection systems" and a revised EU Guidelines on the Protection and Promotion of the Rights of the Child will be adopted early in 2017. In light of these levers towards respect for children's rights the approach of this research (described in more detail below) situates alternative care within the national child protection system, encouraging states to assume responsibility for their obligations under the Convention on the Rights of the Child, and thus ownership of their alternative care systems. The framework for determining country-specific strategies that it proposes aims at identifying the gaps in a country's child protection system that allow for harmful alternative care practices. Suggestions towards reform range from preventive child protection measures to initiatives designed to reduce reliance on unsuitable forms of residential care.

The present synthesis report brings together the key elements of extensive desk reviews for each of the three continents under consideration as well as six in-depth country studies (Chile, Ecuador, Indonesia, Nepal, Nigeria and Uganda). Given the substantial geographical scope of this report, it can only reflect selected findings from these studies. A large collection of documents of various kinds has been assembled and consulted. Inevitably, there are many more sources for some countries than for others and it is recognised that there may be documentation that could not be obtained.

1.2. The research base for the report

Research methodology for the desk review and field work was developed and utilised by a team of key experts including practitioners and academics from CELCIS in the University of Strathclyde and two international expert consultants. A literature search was carried out using web-based search engines and a set of specific search terms. In addition, source documents were provided by key informants during field visits. The literature was reviewed by assessing the relevance of information to seven key research questions in order to examine all relevant aspects of child protection and alternative care systems including relevant actions of prevention, care placement, reunification and leaving care. In total, the literature review for the

regional and country reports included the sourcing and consideration of over 685 documents in English, Spanish, Portuguese and French undertaken by the team of six professional international experts.

The field work was assisted by five qualified national consultants. Based upon a respondent profile, purposive sampling methods were used to identify the most appropriate key informants able to provide detailed and rich insights into the child care context and current issues in their country. The development and application of an interview guide allowed for consistency in the process of seeking information in each of the six countries during a series of semi-structured interviews, whilst permitting for flexibility in the sequencing of questions and additional probing in accordance with the expertise and knowledge of individual interviewees. In total 244 key informants were interviewed, including representatives of: relevant government departments; national non-State bodies working on child care and running institutions; international agencies such as UNICEF and Save the Children; regional agencies if present in the country; social workers and other child care workers; and foster/kinship carers and parents. Verbatim transcripts were made of all interviews and group discussions with key informants, and these were imported into NVIVO 10 software. This allowed for a text query process to extract and collate ‘instances’ of similarities and variances in relation to the child care system and deinstitutionalisation in each of the six countries under study. In addition, utilising specifically designed participatory methodology, group work and individual interviews were also carried out with 170 children and young people with current or previous experience of alternative care.

Reliance and validity of data collection and analysis has been ensured through the use of a common sample frame, allowing interviewees to fully express their views; accurate categorisation of data, sufficient evidence as to validity of data interpretation, and a precise portrayal of findings through a transparent analytical process.

1.3. Concepts and terminology

Descriptors of care settings – and translated versions thereof – differ widely among countries and regions of the world. References to “foster-care” and “adoption”, for example, often denote purely informal arrangements that would be more generally known as kinship care. Similarly, residential facilities are called by a variety of names, only in part reflecting the diversity of their nature, size and purpose. In particular, the term “institution” is frequently – indeed, invariably – used in most countries as the equivalent of “residential care” whereas the latter covers a broad range of settings, from family-like and small group homes through to the largest facilities.

In developing the research for this project and formulating the present report, all those concerned have been fully aware of, and responsive to, the pitfalls of taking the terms used in studies and by informants at face value. While for the most part leaving the original terms encountered during the research as they are in the country studies, the present report relies more especially on the interpretation of definitions as one or other of three basic categories of care settings specified in the Guidelines for the Alternative Care of Children, approved by the United Nations General Assembly in December 2009 (hereinafter “UN Guidelines”):

Informal care – any private arrangement whereby a child is taken into the home of persons other than his/her parents (usually the extended family or others in the community known to the child), with no intervention or decision of an administrative or judicial body. This is usually termed “informal kinship care”.

Formal family-based alternative care – placement in a family home – including the home of an extended family member – by decision or with the express approval of an administrative or judicial body, on a temporary or longer-term basis. This is usually termed “foster care” (“kinship foster care” in the case of placement in the extended family).

Residential care – any arrangement, whether or not decided or approved by an official body, whereby a child is entrusted to a State or non-State facility, ranging from a “family-like” or “small group” home to larger establishments often known as “institutions”, and thus including settings

such as transit centres, “children’s homes” and so-called “orphanages”. All placements in residential facilities – whether initiated by the family, the competent authorities, the facility itself or third parties – are considered to constitute a “formal” alternative care arrangement. This is largely because all care providers should either be the State itself or be registered and authorised to operate by the State.

The frequently interchangeable use of the terms “residential care” and “institutions”, noted above, creates confusion in terms of envisaging formal care provision. The confusion is dangerous, particularly because of the (justified) very negative connotation of the term “institution”. This usage is to some extent, and regrettably, reinforced by the mention of “placement in suitable institutions” in the CRC (Article 20.3) as the only explicit form of residential care constituting an alternative to family-based care settings. “**Institutions**” are characterised only minimally in the UN Guidelines, as “large” residential facilities. There is in fact no globally agreed definition of this term, but facilities qualified as “institutions” usually have additional features that may or may not be connected to their size: among these are an impersonal regime, isolation from the community, and goals essentially limited to ensuring day-to-day basic physical needs of food and shelter. Consequently, such “institutions” do not comply with conditions set for residential care in the UN Guidelines, and the latter call for the development of national strategies to phase out their use. In contrast, forms of “residential care” are provided for in those Guidelines.

Given the diversity of informal and formal alternative care settings and realities throughout the world, however, it would be wrong to look on these categories as reflecting absolute and watertight concepts. It would be equally wrong to draw definitive conclusions as to whether any such category is intrinsically “better or worse” than another. In a very small minority of cases, even relatively large facilities may not have the other harmful attributes of “institutions”, for example. However an alternative care option is defined, **the important factor is the extent to which it provides necessary and quality care, respecting the rights and best interests of the individual child concerned, and catering to his/her specific needs, characteristics, situation and, as far as possible, wishes.**

Two fundamental principles underlie the UN Guidelines:

- the “**necessity principle**”, which requires that admission to formal alternative care be limited to cases where informal care arrangements and community-based services are assessed as not being viable options for the child and family in question. Respecting this principle optimally implies the existence and development of a variety of effective preventive services, such as family strengthening and support, day-care and “respite care” (enabling parents to be relieved of their responsibilities for short periods, particularly those who face the special challenges of looking after a child who is disabled or chronically ill). It also implies the promotion of, and support for, appropriate customary alternative care arrangements;
- the “**suitability principle**”, which has two main implications: first, any provider of formal alternative care must be deemed generally apt to look after children in an appropriate manner that promotes and protects their rights; second, the specific care setting chosen must correspond to the needs and circumstances of the individual child concerned.

One key component of responding properly to the requirements of both the above principles is a functional **gatekeeping mechanism**. Gatekeeping involves vetting all potential admissions to formal alternative care provision and, if it is deemed that a given admission is indeed necessary, determining the most appropriate setting in which that care should be provided. It also “opens gates” for children to exit the formal care system when a review of the placement demonstrates that it is no longer necessary. To be effective, gatekeeping should be assured by a body (e.g. a committee or team) vested with the authority to decide, taking account of all other possibilities, whether or not formal alternative care is required, and if so, to allocate the child to the most suitable care provider in light of his or her situation.

1.4. Approach and preliminary considerations

The approach taken by the present exercise is grounded in giving practical effect to the provisions of the Convention on the Rights of the Child (CRC), in line with the UN Guidelines that were developed to provide detailed policy orientations to that same end. The UN Guidelines, while non-binding, have taken on special importance due in part to their systematic use as a basic standard by the Committee on the Rights of the Child.

It is taken as read that there is no longer any need to set out the potentially serious and lasting harmful effects for children of “institutional” placements as characterised above. These are now well-documented and almost universally accepted, as well as being fully reflected in the orientations given in the UN Guidelines.

However, and as noted above, this report recognises **the difference between the specific type of facility known as an “institution” and “residential facilities” as a whole.** The UN Guidelines indeed propose that a full “range of options” be in place in order to meet most appropriately the individual needs and situations of children requiring alternative care. In some cases, for various possible reasons, family-based care would not do so. This range therefore includes residential care settings that comply with the standards for such “non-family-based” placements established in the UN Guidelines, notably as to the individualised attention offered and the rights protection provided.

Furthermore, a vital condition set by the UN Guidelines is that residential care is resorted to only when it is deemed to respond better to a child’s characteristics and circumstances, at a given time and subject to regular review, than any other form of alternative care. The evidence from the country studies tends to show that, at present, “suitable” residential care options are few and far between, however.

It is against this background that the question of “**de-institutionalisation**” is broached as an element of an alternative care reform process within the wider child protection system. Here again, the way this is tackled in the UN Guidelines indicates the basic thrust to be espoused: the development of country-specific strategies that will result in the progressive elimination of unsuitable institutional facilities. This implies above all the objective of de-institutionalising the alternative care system as a whole – transitioning towards prevention to reduce “necessity” and the development of more community-based settings to improve “suitability” – rather than concentrating on the removal and reallocation of children currently in “institutions”. This is by no means an “either/or” approach – to be sure, efforts can validly be made to reintegrate children in their families and communities, under appropriate conditions, whenever this is possible. However, the strategy must first and foremost be directed at preventing the perceived need for, and undue offers of, alternative care placements.

Unless this path is taken, the sustainability of reform will be unavoidably and seriously jeopardised.

While the negative effects of “institutional” placements are well-known, the serious risks associated with all **family-based forms of alternative care, both informal and formal**, are often underestimated or even ignored. The findings of the country studies unequivocally confirm that these risks are very real. The generally accepted policy objective of enabling children to grow up in a family environment should therefore not result in ill-considered moves that see family-based care as an unconditionally desirable response. The UN Guidelines indicate measures to be taken, and standards to be respected, to ensure best possible provision of family-based care and to avoid the dangers to which any given care setting may give rise. It would be facile to suggest that alternative care reform can repose in good part on the development of family-based solutions without ensuring that these quite stringent conditions are met – which, the country studies clearly show, is by no means the case at present.

Finally at this stage, there is an identifiable marked tendency to see **formalising and officialising care arrangements** as the best guarantor of protection for children unable to live with their parents. This is a cause for concern. Attempts by actors in industrialised countries to “export” formal models to societies where informal solutions are the socio-cultural norm – in this field as in many others – need to be examined carefully. There is cause for concern if investment to ensure rigour and standards are not applied to the process. Notable in this respect, for example, is the disconnect frequently identified between State social workers or judicial procedures and local communities, and the mistrust of the latter towards official interventions, as illustrated in certain of the country studies. As mentioned above, the wide range of risks that children can run in informal kinship care is fully recognised, but this in no way should detract from supporting and building on those existing customary practices that are respectful of children’s rights, rather than promoting alien concepts of alternative care. Working towards a fully-fledged child protection system, in which alternative care itself is just one element, would improve protection for all children, including those cared for informally.

1.5. Diverse and complex country situations

The six countries examined cover a wide spectrum of demographic, economic and cultural conditions. They range from two of the world's most populous countries (Indonesia – 4th with 260m and Nigeria 7th with 187m) to those with far more modest population sizes (Chile 63rd with 18m and Ecuador 67th with 16m), between which lie Uganda (35th with 40m) and Nepal (45th with 31m). On the Human Development Index (HDI, out of a total of 188 countries) Chile stands at 42nd whereas Uganda is 163rd. Poverty rates vary between 8% in Chile to 25% in Nepal, 38% in Uganda and 50% in Nigeria (up to 80% in the north-east of the country).

The Latin American countries are almost entirely Christian, whereas Hinduism predominates in Nepal and Islam is the main religion in Indonesia. Nigeria is reportedly more or less evenly split between Christians and Moslems, while Uganda is described as 85% Christian and 12% Moslem. In all cases, religion is noted as being a strong force in society, including the way it determines, among many other things, how children are cared for in their communities and how formal alternative care is perceived and approached. Significant here is the **role played by faith-based charity** in funding residential care, especially in relation to facilities whose stated aim is essentially educational rather than providing necessary alternative care as such, and whose numbers are growing in some countries, e.g. Uganda. In Nepal, Buddhist families commonly send children to monasteries for religious education.

There are nonetheless certain macro-commonalities among country situations: **informal care arrangements are by far the most prevalent form of alternative care everywhere**, for example, and the use of residential placements far outstrips that of formal family-based placements such as foster care.

Similarly, there are specific problems that need to be addressed virtually everywhere. One such concerns the **striking inadequacies of data collection and analysis by the State**: what data are gathered are invariably purely quantitative, incomplete in coverage and often shallow, missing important elements that would enable light to be shed on trends, causes and effects. Even in the relatively rare cases where States themselves analyse such data, the latter therefore provide no meaningful evidence-base for policy and programming decisions. **Regulation, inspection and oversight of alternative care provision are seriously deficient**. The **ways in which alternative care settings are funded** – and thus are prioritised – need to be reviewed everywhere. Too little consideration is given to **developing the workforce** – both direct carers and those in related social services – in terms of training, status and conditions of work. “Alternative care” is perceived as an issue apart, not an integral component of the broad child protection system. And the degree of **“political will”** needed to broach these problems in a comprehensive, strategic and appropriate manner is, in general, far from being achieved.

This is already a formidable agenda in itself, highlighted by the country studies. But these studies also demonstrate the extent to which, behind those global phenomena, the picture is far more complicated and disparate. This means that, while we can quite easily determine global or otherwise significant phenomena that should be tackled or promoted, in line with international standards, **the ways of pursuing such objectives will necessarily be very different according to the country situation**.

The present report therefore seeks not only to pinpoint the main common areas of concern but also – and particularly – to show how the factors and realities underlying those concerns are vastly different from country to country and must therefore be thoroughly assessed in order to devise optimal strategies in each.



Part 2

Why are children
in formal alternative
care settings?

The regional and country reports reference many studies and sources providing information on the reasons for which children come into the alternative care system.

This information first and foremost demonstrates a **key distinction between countries where a significant proportion of children are placed by the authorities on protection grounds and those where “self-referrals” predominate**. In Chile and Ecuador, for example, being at risk of, or subject to, abuse and neglect is given as the predominant reason for children entering formal alternative care, and it is stressed that this is often linked with both an overall culture of violence as well as with individual parental incapacity due to alcoholism, drug addiction and mental illness. In contrast, in Indonesia most children are brought in and placed directly by their parents or relatives, with minimal to no assessment or gatekeeping, due to “poverty” and (partly in consequence thereof) lack of access to basic services, in particular education (Save the Children, DEPSOS RI and UNICEF, 2007). Similarly, in Nepal, informants noted that, although some children are placed in alternative care due to problems such as abuse and exploitation, residential facilities are catering principally to the needs of children affected by poverty. In the middle is a country such as Uganda where it is reported that, for children entering the alternative care system, 28% are referred by relatives, 42% by the police and social workers, 7% by ‘local leadership structures’ and 8% admitted directly by facility staff (Strong Beginnings report).

However, it is clear that the recorded reasons are invariably “primitive” in nature and fail to reflect with sufficient accuracy cause-and-effect factors, the interplay among them, and cumulative conditions. There is never, for example, an attempt to determine the extent to which recourse to formal care occurs because no informal kinship arrangement is possible or despite the fact that such a possibility exists – or, again, because the goal of placement is wider than simply “to relieve a financial burden”,¹ but includes elements such as access to education that available kinship care options could not provide.

The regional and country reports provide indications of how the reasons given need to be approached in a more nuanced manner in order to constitute valid bases for tailored country strategies.

The myriad effects of “poverty”

It is increasingly agreed that poverty in itself is not the reason for children being placed in alternative care – at least in the formal system. At the same time poverty is undoubtedly closely linked with such placements in many ways.

As noted for Uganda, for example, while the significance of material poverty and strain on families and communities leads to children becoming separated from families, research is showing that often it is a combination of factors beyond poverty (sometimes known as “Poverty Plus”) that is leading to children being placed in residential care, including a wide range of family problems and child protection risks. Poverty increases vulnerability but does not explain alone recourse to placement in alternative care.

Similarly, poverty, in terms of both income poverty and the exclusion of vulnerable elements of the population from basic social services, is identified as a significant driving force behind children’s placement in care in Asia. Parents who are unable to provide basic food, accommodation, education, and health care for their children may seek institutional care as an option for their children, to meet these needs.² In Indonesia, the majority of children were placed in residential care due to poverty and lack of basic services, in particular access to education (Save the Children, DEPSOS RI and UNICEF, 2007).

In Ecuador and Chile, although poverty itself is not a driver, it is relevant to placements in alternative care from another angle. Thus, while abuse is a major reason for such placements (see below) and pervades all socio-economic strata of society, informants noted that the authorities feel better positioned to intervene with families from the poorer echelons of society to secure the removal of a child from their care.

Education: both a key driver and a magnet

Hand in hand with poverty, lack of access to education constitutes a strong motivation to place children in facilities where it is on offer, more especially in Africa and Asia. Even when education is in principle provided free by the State, inability to pay certain costs that it nonetheless

1. Ministry of Social Affairs Veterans and Youth Rehabilitation of Cambodia, 2016

2. UNICEF South Asia Regional Office, 2008

implies, coupled in many cases by perceptions that quality of education in State schools is poor, leads families – including extended families providing kinship care – to place their children in “orphanages” in countries such as Nigeria, Uganda, Nepal and Indonesia.

The Indonesian country study notes that, in some Moslem communities, religious belief leads families to send their children to an Islamic-run facility, which may be a pesantren (Islamic boarding school) but may also be a simple “social welfare” establishment. Informants in Uganda reported that in some districts there has been a significant growth in residential mosque-based schools (Madrassas), which are usually funded by local Asian businessmen and are typically unregistered and unmonitored. The Talibe pattern typical of West African countries is another example of a confusing offer for pious and aspirational parents.

Orphanhood

No region or country studied gives orphanhood as a major cause, in itself, of placement in alternative care. Consistently, research shows that only a small percentage of children in residential care have no living parent. In Ecuador, for example, the figure is 3%.

HIV/AIDS

Surprisingly, perhaps, there is little hard information of the degree to which children who are affected by HIV/AIDS – either because they themselves are infected or because they have been orphaned as a result – are looked after in formal alternative care settings as opposed to being cared for informally.

Parents and children on the move

Several countries in Asia – including Indonesia, Philippines and Sri Lanka – are significant source countries of migrant workers. **Parents going abroad to work** seem overwhelmingly to rely on informal kinship care for looking after their children. In some countries, such as Indonesia, internal migration is also common, and many children

(over 50% in Indonesia) do not migrate with their parents. Again, kinship care is by far the most frequent solution found in these cases.

Parental migration is also noted as an issue in Latin America, but no data are available. It is not mentioned as a reason for placement in alternative care in Africa, but **cross-border movement of children** themselves (e.g. from Nigeria to other West African countries) is a cause of concern in many countries in the region – the children are often victims of trafficking and require a safe haven when discovered.

Many countries in all three regions are particularly susceptible to severe **natural disasters**, and the aftermath of such events has inevitable repercussions for temporary alternative care, sometimes involving internal displacement.

Internal displacement because of **armed conflict**, such as in Nepal and Nigeria, is said to have had significant repercussions on demand for alternative care – in the case of Nigeria, reportedly “almost to breaking point”. This can be ascribed not only to material destitution and the death of primary caregivers, but also to the break-up of communities and thus of their capacity to respond through customary care mechanisms. Armed conflict also results in cross-border displacement and need for alternative care: children who fled the conflict in Colombia with relatives have reportedly been abandoned in Ecuador.

It did not prove possible, however, to obtain precise indications of the degree to which disasters have impacted the need for, and provision of, formal alternative care.

Discrimination

Various forms of discrimination leads to placement of children in alternative care.

Children born out of wedlock are reported as being particularly vulnerable to being placed in a residential facility in, for example, Nepal and Indonesia.

Children from **ethnic minorities** and **indigenous communities** are noted to be significantly over-represented in

residential facilities in certain Latin American countries such as Brazil and Ecuador.

Abuse, neglect and exploitation

The proportion of children in formal alternative care who have been placed due to violence, neglect or exploitation varies in particular according to the **degree to which official bodies (law enforcement, social workers) are in a position to intervene**. Their ability to do so depends in good part on their number (ratio to population) and qualifications.

In Cambodia, for example, it is estimated that every year approximately 200-300 children rescued from sexual exploitation are placed in child-care centres, managed by NGOs, as a temporary or a long-term solution.³

Children in Indonesia did not mention violence as a reason for family separation, but 27% came from families where violence occurred.

In Nigeria, informants noted that the experience of violence within the family or in informal settings was an important precipitating factor in children being taken into care, mostly by the police and social welfare departments. Broadly, in Africa and Asia abuse and exploitation are not major causes of placement. In contrast, these factors account for the majority of placements in Latin America. Thus, for example, in Ecuador, the main causes for children being admitted into residential facilities have been identified as abuse (23%), maltreatment (23%) and neglect (16%), whereas in only 0.1% of cases was placement ascribed to household poverty.

In 2015, it was estimated that 11% of all institution admissions in Paraguay were children who had been living on the streets.⁴

Disability

Interestingly, the proportion of children whose placement in residential care is motivated by disability does not seem to be particularly high in any of the regions. However,

since the definition of “disability” can vary widely, the data available on this question must be treated with particular caution.

According to the country studies, indicative rates given were 4% for Uganda and 7% Chile, for example. Figures for other Latin American countries tend to confirm this – approx. 7% for Panama and 8% for Costa Rica, and even just 1.1% for Mexico. Of the estimated 8,000 residential care facilities in Indonesia, just over 150 are dedicated to children with disabilities.

Some informants suggest that these low numbers – to the extent they reflect the reality – would be explained by a reluctance on the part of many care providers to admit children with disabilities to their facilities, in part because they are not equipped to care for them.

Other reasons

A wide range of other reasons for some children being in formal alternative care were given. Among them are: parental separation and re-marriage, parental imprisonment; family dysfunction; teenage or unmarried pregnancy; and runaways (to escape abuse, for example).

Some reasons are specific to one country or to a small group of countries. Examples of these include escaping child marriage (Nigeria and Uganda) and child sacrifice (Uganda).

Active recruitment of children into residential care

Over and above the various reasons that may lead families or State agents to place children in alternative care are the reported actions of residential care providers that actively recruit children into their facilities. These initiatives are particularly common in (though not unique to) countries where “self-referral” is prevalent, and all the more so where access to education – real or promised – is an important factor.

This issue is taken up under the “how alternative care is financed” at section 3.4 below.

3. ECPAT International, *Plan International, Save the Children, UNICEF and World Vision, 2014*

4. SOS Children's Villages International & RELAF, 2010, p.20



Photo © Björn-Owe Holmberg

Part 3

Where are children
in alternative care?

3.1 Informal care settings

In all countries in the three regions – and as in almost all countries globally – the vast majority of children not living with their parents are cared for under informal kinship arrangements. Unfortunately, **there is no data set, even in highly developed countries, that compiles the numbers of children in informal care.** Depending on the society concerned, such arrangements may involve more especially grandmothers or aunts and uncles, and may differ according to the sex of the child. In rare instances, responsibilities are codified: the Cambodian Civil Code obliges relatives to provide support to orphaned children in the order of: cohabiting relatives; lineal relatives by consanguinity (blood); adult siblings; and, in special circumstances, an obligation on relatives up to the third degree.⁵

Such arrangements have several advantages over formal placements, the first being that they are “owned” by the communities and societies concerned, having been developed in accordance with each one’s socio-cultural norms and values. In addition, they usually provide continuity in personal relationships, socio-cultural environment and physical location.

At the same time, country reports highlight many problems associated with informal care, ranging from the material impossibility of extended families to take responsibility for bringing up children through to deliberate discrimination and exploitation by caregivers.

While many of these problems are well-known – particularly those relating to discriminatory attitudes in comparison with the carer’s biological children and exploitation of the child’s labour within or outside the home – others have been less readily recognised.

Thus, for example, concerns are expressed about children being moved from one relative to another, with very little long-term stability,⁶ or ultimately being placed in residential care after a spell in kinship care.

Clearly, many kin caregivers experience serious financial difficulties when faced with looking after an extra child. Indeed, one reason given for not placing a child with relatives is the latter’s inability to ensure access to education,

meaning that placement in a residential facility offering education may be preferred.

The fact that, by definition, the State plays no role in organising informal care arrangements potentially has three major consequences:

- both quantitative and qualitative data are lacking;
- informal carers do not qualify for assistance or support;
- the oversight of child protection in such settings is usually a far more difficult task, both actually and potentially, than is the case for children in formal care arrangements.

The country studies prepared for this project confirm that all three indeed apply in all those countries.

3.2 Formal family-based care

While foster care is overwhelmingly the most common type of formal family-based alternative care, it is by no means widely practised in the three regions as a whole. Of the six countries studied for this project, only Chile reported substantial use: about one-third of children in alternative care are in foster homes, although in fully 80% of the cases, the foster carers are members of the child’s extended family (formal kinship foster care). Elsewhere, the role played by foster care reportedly ranges from minor to insignificant or even non-existent.

There are several reasons that account for reticence towards the development of formal foster care programmes.

1

First and fundamentally, taking in a “stranger child” – especially though not only on a potentially temporary basis – is not a culturally-accepted practice in many societies. The report from Nigeria, for example, notes that there are still strong cultural barriers to formal non-relative fostering which in some communities is seen as a western imposition. **Foster care is often seen as an unwelcome substitute for kinship care** and as a contributing factor to the gradual surrender, in some societies, of informal caring responsibilities. Even in Chile, it appears that foster care in non-relative families is not yet a widely culturally-accepted practice. Spontaneous applications to foster

5. UNICEF, 2011b, page 62

6. Save the Children, 2010

are insufficient and – again taking the Chilean example – this is particularly so for children with disabilities, sibling groups and older children.

2

Second, one argument often advanced in favour of foster care is its far lower cost compared to a residential placement. This argument only stands up, however, under certain conditions and – albeit quite validly – taking into account the long-term costs to society of the consequences for children of poor quality residential placements. In fact, a foster care programme worthy of its name implies a fully-fledged support system covering selection and preparation, matching, and on-going supervision and guidance. This requires **substantial and continuous investment, notably in qualified human resources**: informants in Chile highlighted the expense of home visits, psycho-social profiling and intensive training during which carers are continually assessed. Whatever the longer-term benefits, such up-front investment is neither currently nor potentially available to any significant degree in most countries.

3

Third, **compensation and allowances for foster carers are often a stumbling-block**. Where no such payments are envisaged, offers to foster are considerably reduced. However, where payments are foreseen, tensions with birth families – who might have kept their child with them if support had been available – and informal carers in the community, who receive no subsidies, can easily be created. In addition, concerns are expressed about the possible financial motivations of foster carers, whose recruitment and supervision then requires all the more attention.

The promotion of foster care is therefore clearly problematic from these angles, both ethically and practically. But in addition, account must be taken of the fact that this formalised alternative care option, even when long-standing and relatively well-resourced in industrialised countries, has failure (breakdown) rates that can reportedly reach as high as 50%. In that light, it may be questionable to propose that similar programmes be developed in societies unfamiliar with the concept.

In most cases to date, attempts to introduce foster care have been initiated as small-scale “pilot projects” by

NGOs, but with little attention as to how these might realistically be “scaled up” and – important in that regard – without necessarily being carried out as part of a cooperative effort with government. The tentative conclusion from that state of affairs is that neither the NGO nor the authorities would be in a position to “roll out” foster care at the national level, even if the pilot initiative demonstrated the required degree of success under the conditions in which it was conducted.

While governments in some countries – e.g. Indonesia – have shown interest in developing foster care, the reverse is true elsewhere. Thus, while pilot projects initiated and run by NGOs had been under way in Ecuador for some years, the authorities decided to put an end to support for foster care programmes in early 2016, for reasons that have so far not been fully elucidated.

Two other forms of formal family-based care are mentioned. Kafala of Islamic Law is reported to exist in certain countries studied, but little is known about either the extent of its use among Moslem communities there or the conditions and outcomes of the measure. In addition, kafala can have very different implications in practice from one country to another and may even only involve financial sponsorship. References to various forms of “guardianship”, limited to certain countries, are similarly inconclusive as to whether this measure constitutes “alternative care” as such, since it does not necessarily imply the child being cared for on a day-to-day basis by the guardian.

In the light of the research carried out for this project, and essentially for the reasons outlined above, we are prepared to “go against the grain” and **not make a blanket recommendation to support the development of formal family-based care such as foster care**, either as a potentially large-scale formal care option in itself or as a means of facilitating de-institutionalisation. There may well be country situations, determined on a case-by-case basis, where foster care or analogous measures could be validly promoted under certain strict ethical and material conditions, including the establishment of a truly effective assessments, support and monitoring system. However, in societies where informal care arrangements have been and still are the norm, it must be recognised that a move towards formalisation is not necessarily acceptable, desirable or feasible.



Photo © Claire Ladavicius

3.3 Residential care

Clearly, and by far, residential care options predominate in all countries of all regions for children deemed to need formal alternative care. In the countries studied, direct State provision of residential care is very much the exception – it is very much left in the hands of the non-State sector. The Uganda country study, for example, records just three State-run facilities out of over 600 (or, according to some estimates, over 800). In Indonesia, more than 90% are run by private organisations, including religious or civil society organisations, although a significant proportion receive government subsidies.

Facilities are diverse in size (the Nigeria country study notes a range in capacity from eight to at least 500 children, for example), in nature (from arrangements described as “clustered foster care” to large institutions) and in quality and objectives. In some cases, particularly in Africa and Asia, one of their main stated aims is to provide access to education, and their consequent assimilation as “boarding schools” may set them on a borderline in terms of being considered as providers of alternative care.

The objectives of working towards **the child’s reintegration in his or her own family and of preparing the child for leaving the facility** often figure in legislation and official technical guidance. References in the country studies to programmes that reflect those aims, however, essentially concern initiatives by non-State actors and isolated non-State care providers, sometimes with a degree of State support (e.g. Chile). At the same time, some residential facilities in certain countries (e.g. Ethiopia, Haiti) are clearly intent on – and may even be officially designated to facilitate – the formal adoption of children in their care, for the most part abroad.

Four major concerns stem from the findings:

1 Many countries – more especially in Africa but also in Asia – have seen a **vertiginous rise in the number of residential facilities** operating, particularly during the 1990s and early years of the present century. Figures for Liberia, for example, show an increase from 10 in 1989 to 110 in 2008, with a similar picture in Ghana (10 in 1998 and up to 148 in 2006) and an even more striking increase in Uganda, from an estimated 35 in the mid-1990s to some 800 today. Reports attest that, in Indonesia, there was a proliferation in the establishment of residential facilities from the 1990s until 2006, with an estimated 8,000 now operating. In Latin America, however, the general reported trend is the opposite, with significant decreases in certain countries.

2 An alarmingly **high proportion of residential facilities in many countries operate without registration, approval and monitoring**. This problem is, for example, “central” to the considerations in the Uganda country study, which notes that “the great majority” have never been registered, let alone authorised and inspected. Even in those countries where inspections are carried out, they are often very infrequent and are not thorough: they may rely more especially on paperwork and rarely comprise, for example, private exchanges with the children in care. Where more frequent inspections are conducted – such as in Chile, Ecuador and to some extent Nepal, they still do not provide evidence regarding the fundamental question of how well children are being cared for.

3 **Facilities that are financed essentially by private sources abroad** are of special concern (see 3.4 below);

4 **Facilities actively recruit children from their families and are not subject to gatekeeping**. This phenomenon, present more especially in Africa and Asia, is often linked to possibilities for securing additional funding, sometimes from the State on a “per head” basis, but mainly from private sponsors. Where education is a significant driver, such as in Indonesia, spikes in such recruitment have been noted just prior to the start of the academic year. Recruitment also takes place with a view to inserting the

child into intercountry adoption programmes but the facilities concerned may fall outside surveys: for example, a FHI report⁷ from Ethiopia specifically excludes homes set up to prepare children for intercountry adoption on the grounds that placements there were short-term by definition.

Many country situations seem to be characterised by all four of these features.

3.4 A key to reform: how alternative care is financed

The country studies underscore how crucial the question of funding sources is for the way care provision operates and, thus, for developing reform strategies.

The case studies covered **no country where alternative care is essentially the domain of direct State provision and financing**. In such cases, strategies to secure the reallocation of funds as one means of achieving reform could clearly be targeted almost entirely at the government.

Country studies show that financial support from the State for family-based care programmes is generally limited or non-existent, with the notable exception of Chile. This means that currently these **States are not well-positioned to influence the quality and quantity of foster care provision** – with the exception of so far unusual moves, such as that of Ecuador, to close down foster care programmes across the board.

In all the countries examined, **non-State providers also ensure the bulk of residential care** – and in most cases overwhelmingly so. That said, the degree to which the State contributes to non-State care provision varies considerably. In “better case” scenarios, such as Chile and Ecuador, an estimated 35-50% of residential care costs are covered by State grants, whereas in Nepal, for example, the State contributes nothing to non-State residential facilities.

The shortfall (thus, up to 100%) is therefore filled by contributions from private sources. To take the examples of

the same countries, these sources are reported to be exclusively domestic in the case of Chile, and almost exclusively so for Ecuador, whereas residential facilities in Nepal are primarily supported by donors in industrialised countries – both individuals and associations – as well as by “voluntourists”. In Indonesia, funding of child care facilities comprises government subsidies, private donations, funding from businesses, social organisations, international organisations or foreign governments, funding through a facility’s parent organisation, as well as income from its own small business enterprise (Save the Children, DEPSOS and UNICEF 2007). Support from abroad is preponderant in Uganda, where over 80 per cent of funding of private facilities – mostly run by faith-based (“Pentecostal”) bodies – comes from outside the country (Walakira et al., 2015), often through “child sponsorship” by individuals and churches abroad.

The development of “**voluntourism**” has so far mainly aroused concern because of the potential consequences for children of allowing untrained and non-vetted foreigners working for short periods in residential child care facilities. However, this practice is also relied on for securing financial and other support, from the volunteers themselves and from their sponsors and contacts. In Nepal, it is alleged that children may be separated from their families in order to populate care facilities “to attract fee-paying volunteers” and other tourists. Similar preoccupations have been expressed regarding Cambodia, and “orphanage tourism” is also reported to have begun in Myanmar.

Website searches carried out for this project also highlight the extent to which “orphanages” advertise for donations and – still – foreign volunteers who will pay to work there.

It is notoriously difficult to persuade private donors to contribute to any form of alternative care other than “bricks and mortar” facilities, as well as to preventive programmes such as family strengthening and customary arrangements. It is therefore all the more problematic to confront the perpetuation of residential care when the latter is essentially provided and financed by non-State actors.

7. Family Health International (2010) “Improving Care Options for Children in Ethiopia through Understanding Institutional Child Care and Factors Driving Institutionalization”.

Photo © Benno Neeleman



Part 4

Recommendations

4.1 General considerations

On the basis of the information summarised in this report, and taking account of the influential situation of the EU, particularly as regards its direct access to the highest levels of government, the recommendations made here are directed to ensuring the value-added and optimal impact of a potential EU strategy in favour of alternative care reform.

Before setting out the key conclusions and recommendations, a number of remarks are necessary.

First, the overall aims of the approach taken are five-fold:

- Clearly locating alternative care within the overall child protection system
- Ensuring that the State is the main pro-active generator and guarantor of change, as well as that it brings on board all actors concerned in as cooperative a manner as possible
- Enabling simultaneous actions that tackle identified priority concerns regarding both the reasons for which children come into alternative care and the quality and appropriateness of the care they receive (“necessity” and “suitability” principles)
- Prohibiting care provision that does not meet minimum criteria
- Dealing with demand for alternative care – rather than just attempting to change its nature

Second, neither “legislative reform” nor “policy development” is specifically advised in the listing. Overall, the findings of this research exercise point to **failures (sometimes chronic) in implementing existing laws and policies rather than to inadequacies in those texts**. Clearly, there are gaps in national legislation as well as questionable policies that could usefully be addressed. At the same time, legislative reform is invariably an arduous long-term task that, in addition to having an uncertain outcome, will be pointless if emphasis has not been placed on systems and mechanisms to ensure that the law is complied with. As regards policy, not only does a similar analysis apply but also the orientations given in the UN Guidelines can act as a default reference basis where national policy proves to be inappropriate or inadequate.

Third, while it is fully recognised that many of the factors that generate recourse to alternative care need to be tack-

led from a primary prevention perspective (e.g. universal access to basic services such as education and to social security, etc.), their inclusion in this listing would go beyond the realistic goals to be set in the context of this exercise, and would risk unduly diluting the approach suggested. In that light, the option adopted here proposes **support for responses that take account of the broader context and situation of each country**, which will likely barely change in the foreseeable future, rather than including in those responses specific efforts to bring about any significant shift therein.

Fourth, it is clear that **sustainable reform can only be envisaged as a long-term process**, not least because it usually requires a substantial change in attitudes and practice. An important implication of this is that, however positive they may be in themselves, initiatives taken outside of a fully-fledged, pre-determined strategy with defined objectives are unlikely to have any substantial or lasting impact. There are always exceptions but the country studies found overall, for example, that small-scale attempts by non-State actors to launch formal foster care programmes as “demonstration projects” have remained small-scale and geographically limited. This is put down largely to a lack of planning, from the start, for on-going evaluation in the context of an agreed plan and methodology for scaling up. A key lesson to be learned from these experiences is that “pilot projects” should not be envisaged or supported without such a realistic plan in place in the framework of a comprehensive reform strategy.

Finally, **the national context will necessarily determine the weight to be given to each element of the proposed approach**. The latter will clearly be very different in a country where children are mainly placed by families in non-State facilities predominantly financed from abroad, as opposed to one where most children are brought into alternative care by officials as a result of abuse or neglect and are looked after in State-run or subsidised facilities.

4.2 Encouraging and enabling the Government to take control

The whole approach is predicated on the absolute necessity of the authorities being both motivated and enabled to have effective influence, control and oversight of alter-

native care provision as part of an overall child protection policy. There is little prospect of sustainable, coherent and comprehensive reform unless this is the case.

This goes far beyond securing “political will” at the highest possible level, although that will be at least desirable and more probably vital as a springboard. However, governments and civil servants change, and the requirement will therefore encompass the **identification and/or establishment of a ministerial focal point for responsibility in this sphere**. According to the situation, this may need to be an inter-ministerial grouping, although experience shows that such bodies can often be ineffective, meeting irregularly and having insufficient powers and influence to launch, maintain and/or develop any initiatives that they seek to undertake.

At the same time, it is no less important to **ensure that the government promotes and secures concerted efforts among all actors** on whom reform will depend in some way. These include lower levels of government (provincial, local), non-State bodies and organisations, religious leaders, social work and other professionals, care providers and their staff, and local communities. Consultation and cooperation with all concerned are seen as vital aspects of any sustainable reform drive.

4.3 Summary conclusions and specific recommendations for the EU

The research project identified nine areas in particular to which prior consideration would seem to be vital for devising and detailing both the overall and the country-specific approaches to alternative care reform. In conjunction with the acquisition of knowledge on the issues set out in the schema on pages 30-31, with which these areas intersect, these recommendations should be taken into account when the EU considers proposing support to given States.

In doing so, the EU can take a lead on calling for implementation of global standards of alternative care. **By raising the profile of the alternative care agenda, the EU can demonstrate its commitment to the universal rights of the child**, consistent with work already done in Europe. The nine areas are set out below, together with specific indications as to the recommended response on the part

of the EU. These recommendations include concrete measures towards implementing the EU’s 2015 Human Rights Action Plan, its new Consensus for Development, the post-Cotonou framework and the EU Guidelines on the Promotion and Protection of the Rights of the Child, among others, and should serve EEAS and the EU delegations, the European Commission’s DG for international development, and Member State decision makers.

1 State influence and control through law, policy and effective regulation

The research demonstrates that, while there are clearly certain inadequacies and gaps in national legislation and policies, the level of standard-setting is in fact generally sufficient. Consequently, legislative review and policy development are not overall priorities for effecting reform of the alternative care system. In contrast, implementation of existing requirements concerning registration, authorisation, monitoring and inspection of care providers ranges from, at best, fair to – more frequently – poor or very poor. With certain exceptions and nuances, States are abdicating too many of their legal and moral responsibilities in regard to alternative care for children. Counting on the responses of the non-State sector – however laudable those responses may or may not prove to be – and largely leaving that sector to its own devices to organise and finance care provision as it sees fit basically precludes any realistic expectation of comprehensive and sustainable reform. However challenging in certain country situations, **the basic condition for progress is that the State has to be both the driver and the effective supervisor and guarantor of reform**.

→ Recommendation 1.1

The child rights components of the EU’s Human Rights Dialogues with third countries should always make reference to child protection systems, including the CRC obligation to protect children who, for whatever reason, are unable to live with their families or have been removed from their care. States should be encouraged in particular to report on:

- the presence of **non-State residential care facilities on their territories**, the conditions, standards and oversight of their operation, the numbers of children involved and the justification for their placement;



- measures that seek to **identify and monitor informal care settings**, for the purpose of support, in the interests of promoting economically and culturally viable alternative care options that meet children's needs appropriately.

→ Recommendation 1.2

The EU's bilateral relations with partner countries, and especially budget support schemes, should include concrete measures linked to nation-wide child protection systems, including alternative care provision. Such measures, laid out in National Indicative Programmes, should involve local authorities in order to cover the implementation gaps. Alternative care system reform can be an entry point for further system reforms and improved governance more broadly. Just as ESIF funding is conditional on the development of de-institutionalisation strategies in European countries, the EU's aid and/or trade packages could for the sake of consistency include provisions on the development of long-term strategies for alternative care system reform.

2 Funding

The way that alternative care is financed is demonstrably the key factor in devising both the content and the targets of any strategy for reforming alternative care provision. Funders determine not only the kind of provision available (family-based or residential) and the quality of that care, but also the number of children admitted into residential facilities, including those whose placement is unwarranted. This is all the more the case where non-State facilities are largely funded by private donors, especially those overseas. In addition to reinforcing State authority and oversight over the alternative care system and improving regulation of these facilities, strong efforts must be made to inform donors of the full consequences of their financial support.

→ Recommendation 2.1

Philanthropists, faith-based groups, grassroots fundraisers and concerned citizens of European and other industrialised countries should be targeted with information about practices that are harmful to children. In the context of Development Education and Awareness Raising (DEAR), **the European public can learn about the challenges of defending children's basic rights**. Private donors, main-

ly concerned with alleviating poverty and helping "abandoned" children and "orphans", are susceptible to mistaking material wealth for quality of life and lack knowledge about the risks of unnecessary family separation and of placement in unsuitable alternative care. Rather than giving financial support in a way that can lead families to relinquish their children to obtain food, shelter and access to basic services, donors and sponsors should learn to support family strengthening, community-based care and the provision of education, health and other essential services, with special attention to deprived and remote areas.

→ Recommendation 2.2

When devising and providing child-focused support to basic services and facilities (including alternative care), the EU, Member State development donors and all other **institutional donors need to be aware of the risks of unnecessary family separation** that can be linked to access to such programmes. The choice of location of a school or health centre can result in relinquishment of children from remote areas. The EU can lead in donor forums by promoting awareness and good practices, both at global and regional levels as well as through joint programming efforts in-country. In emergency contexts, donors must make every effort to ensure any temporary shelters they support clearly aim towards reintegration into families and communities and meet quality standards as outlined in the UN Guidelines.

Internally, the EU can provide training by key experts to relevant EEAS, DEVCO and ECHO staff with a view to helping them review and assess the suitability of EU-funded programmes in light of unnecessary resort to alternative care.

3 Workforce

Workforce development emerges from the country studies as a clear and significant need that enables necessary reforms to take place. This concerns as much the training and conditions of work of direct carers as the qualifications and numbers of those contracted to provide services such as social work, child protection, gatekeeping and inspection, as well as key decision-makers on formal alternative care placements such the judiciary and police.

→ Recommendation 3

In its bilateral relations with partner countries as well as through the reprioritisation of direct grants to non-state and local authority stakeholders, the EU can directly support programmes to improve:

- **training of informal carers and care professionals**, whether offering alternative care in family-based settings or residential facilities, that is grounded in children's human rights and internationally accepted standards regarding alternative care;
- the **qualifications and capacity of social workers and para-social workers**, and hence the recognition of their professional status, both formally and in popular perception;
- the **professional education and development** of all others involved in decision-making with regard to alternative care, including the judiciary, law enforcement and members of the medical professions.

In the latter half of the EU's current Multi-annual Financial Framework, child welfare objectives could focus on child protection training for professionals in contact with children. Alternative care and child protection workforce development could be a priority for external action instruments in the next MFF.

4

Prevention

Country studies make it plain that preventing the need, or perceived need, for recourse to formal alternative care is not a recognisable feature of the child protection or wider social protection systems within which it should logically be integrated, although it may figure in ad hoc non-State programmes. **Addressing the causes** of the out-of-home placement of children, **providing community-based support** and **establishing effective gatekeeping mechanisms** are all elements of prevention that need to be developed.

→ Recommendation 4

The risk of unnecessary or unsuitable alternative care placements should be borne in mind when implementing EU external policies aimed at:

- enhancing **resilience**: considering family resilience (as opposed to family breakdown) a basic unit of broader community resilience

- combatting **violence and exploitation**: key child protection grounds for removal of children from their homes and communities
- facilitating **access to basic services**: a pull-factor for aspirational parents, leading to the proliferation of care facilities, the potential for unsafe or exploitative informal care, fake boarding schools and manipulation resulting in the adoption (often inter-country) of non-orphans.

5

Cultural values and formal vs informal care

All country studies highlight the great significance of socio-cultural factors, including religion, as determinants of attitudes and practice regarding care for children unable to live with their parents. Some explicitly noted how residential care was introduced during the colonial era but, equally, how formal foster care is also alien to customary practices and is viewed with reticence or in some cases even hostility. The prevailing push towards formalising alternative care arrangements, coupled with the often forceful promotion of one imported formal care practice (foster care) essentially to replace another (residential care), must therefore be the subject of very serious assessment, including – but not limited to – ethical and practical considerations.

→ Recommendation 5

There should be no automatic assumption that formal foster care can or should be established to replace residential care in any country, or country-wide. In seeking to broaden the acceptable alternative care options, States and other actors should first examine how to build on local customary practices and especially enabling informal care arrangements to fulfil their protection role optimally, rather than concentrating principally on reorganizing formal care options. Above all, attention is required to preserve and promote existing care practices that meet suitability criteria set out in the UN Guidelines, as these are likely to be the most sustainable. **The acceptability and viability of foster care should be assessed**, including a realistic consideration of the scale at which it can be implemented as a quality care option.

6 Complementary development of alternative care options

All country studies point to the need for promoting and supporting a range of “suitable” alternative care options, including those of an informal nature under appropriate conditions, and of course hand-in-hand with preventive programmes. **Building incrementally on culturally acceptable options** in line, notably, with the orientations and standards set by the UN Guidelines, is “the red thread” running through country-specific recommendations. Since one country study indicated a deliberate reversal in State policy vis-à-vis one such ostensibly “suitable” option, there is also cause to remain vigilant with regard to potentially retrograde moves.

→ Recommendation 6

Child protection authorities in the EU’s partner countries should be encouraged to identify and evaluate the quality and impact of existing acceptable alternative care options. This reflection can contribute to a long-term strategy of alternative care system reform.

7 Ensuring quality care

While certain “unsuitable” settings are clearly unable, endemically, to provide appropriate care to children, the country studies confirm the approach of the UN Guidelines which see **quality care as being potentially attainable under both informal and formal arrangements, and in both family-based and residential settings**. The studies also highlight the other side of that mirror: that quality care is in no way assured simply by the nature of the arrangement or of the setting. Among many other things, the setting must above all correspond to the child’s individual psycho-emotional needs and family circumstances, the placement must be regularly reviewed as to its appropriateness, and leaving care must be a supported process both before and after the event itself. It appears that these constituent elements of “quality care”, together with others, tend to be overlooked.

→ Recommendation 7.1

When developing a “de-institutionalisation” policy in line with the UN Guidelines, critical focus should shift from a blanket negative view of all residential facilities. It should be recognized that, when placements are considered on a case-by-case basis, suitable forms of residential care can be more appropriate and constructive than any other option in responding to the situation of certain children and at certain points in their lives. **Quality improvements in existing care settings (e.g. training, care planning, rather than material quality) also need to continue during attempts to change the nature of the available alternative care options (e.g. during de-institutionalisation processes)**. Attention to the following should be simultaneous:

- **prevention initiatives** ranging from family strengthening and reintegration to gatekeeping processes
- **forms of suitable care**
- **quality issues** such as workforce development, care planning and provisions for leaving care.

→ Recommendation 7.2

Adopting this approach, the EU and partner countries should focus on systems, targeting recourse to formal alternative care on three levels simultaneously:

- From above: “tackling the worst first” – e.g. securing, as an initial priority, the closure of unregistered (and any registered) unsuitable residential facilities, and then moving on to focus on the next most pressing protection issue in the specific country context. Ensuring the registration of those residential facilities considered suitable is an additional initial action from above that will allow for official assessment and monitoring.
- From below: promoting secondary and tertiary prevention (awareness-raising in the community, supporting appropriate informal care arrangements, access to support and basic services including education, family reintegration, etc.)
- On both sides of the middle: improving workforce capacity (social work, gatekeeping and caregiving), to include multi-disciplinary consultations and enhancing the proficiency, conditions, status and recognition of the workforce.

8 Data collection and analysis

While the studies show that the availability of statistical data on alternative care varies from one country to another, they are unanimous in questioning their comprehensiveness (particularly in relation to non-State residential facilities) and in lamenting the almost total absence of any qualitative information in general. They also pinpoint the lack of any reliable indications of whatever kind regarding recourse to informal kinship care. When data are made available, they do not provide an evidence base for policy development – there is too little emphasis on trends, on qualitative indicators and on issues vital to fully understanding the realities of alternative care provision – and in addition they are not usefully analysed to that end. In one case, worryingly, public access to official data is in fact prohibited. All that is implied by **improved “data management” is crucial to developing sustainable strategies for reform**, and this is therefore an area requiring special attention.

→ Recommendation 8

The EU, as part of its effort to achieve Sustainable Development Goals, should **encourage statistical offices to disaggregate for care status**, ensuring that children without parental care and children living outside of households are identified and counted. Surveys to secure additional qualitative data should also be exploited. Continuing efforts to **promote birth registration and identity documentation** is critically important for protecting children, and aids in the monitoring of alternative care practices and settings. **Comprehensive and reliable data collection** is a crucial step enabling States to take due responsibility for the protection of children, especially those who lack parental protection. To develop their responses, States should not only aim to understand which children are in both informal and formal alternative care, the reasons for their placement and in which kind of care settings they find themselves, but also the longer-term qualitative outcomes of those children’s care experience.

As stated in the new Consensus on Development (para 68), the EU and its Member States will support capacity building in partner countries for monitoring frameworks, quality data collection, disaggregation and analysis. Alternative care offers a valid starting point. **The EU should support partner countries to improve and expand data collection methodologies to ensure all children are rep-**

resented. The EU should support full scale review and assessment of partner countries’ current alternative care systems with a view to both improving data and identifying priority areas for reform.

9 Child participation

The country-based research for this project sought to garner the experiences and opinions of children with current or recent experience of alternative care, both via face-to-face exchanges and through the use of methods ensuring anonymity. The views and sentiments they expressed reveal a range of positive and negative experiences, not all of which necessarily tie in completely to the “optimal solutions” generally espoused at present. While these findings are anecdotal and do not automatically put into question the way reform is habitually envisaged at the present time, they do underline two issues in particular. First, **the way that alternative care is provided must be a response to the situation – and wherever possible the wishes – of the individual child concerned**, so that it stands the best chance of being a positive (or at least not negative) experience for that child. Second, no reform efforts should be promoted or made without ensuring both the prior and the on-going consultation of children in all forms of informal and formal care.

→ Recommendation 9.1

Child participation should be established as an important input to alternative care system reform efforts as well as to placement decisions concerning individual children. **The EU should therefore insist that empowerment of children to know their rights and express themselves be ensured** to these ends. Evidence of children’s participation in policies and decisions that clearly impact on them should become a quality criterion of the development of joint bilateral strategies and documents (such as National Indicative Programmes), in the same way as Civil Society consultation and other factors.

→ Recommendation 9.2

Children’s views should likewise be taken into account in the implementation of the above recommendations.



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4.4 Taking forward evidence-based reform in country-specific contexts

It is clear from the examples given in this document that the alternative care landscape differs widely from region to region and country to country, as do the nature, scope and effectiveness of the overall child protection system within which alternative care operates. It follows that strategies to promote effective alternative care reform must be tailored to each country situation. They must be grounded in the integrated, multidimensional analysis of a variety of factors that should provide clear indications of where support is most likely to have an impact.

This does not mean “starting from zero” in each country context, however. Key characteristics of the alternative care situation can be identified and used as elements for determining to which of a number of basic profiles the country in question corresponds. This should provide guidance

for the overall strategy orientations to be adopted. With that established, the precise strategy to be proposed can be adjusted to take account of factors specific to that country.

4.4.1 Securing basic knowledge

The following schema attempts to set out in six spheres of knowledge, the basic information required for determining which changes would be both desirable and feasible in principle, and to where efforts should primarily be directed in order to secure that change.

Securing basic knowledge

OVERVIEW OF CURRENT SITUATION

- characteristics of children in formal care
- drivers for placements (push and pull factors)
- types of formal care and degree to which each is used (family-based + residential)
- degree of reliance on informal care/customary care arrangements
- gatekeeping
- family support / Strengthening
- preparation and support for leaving care
- child protection system

Knowledge Outcome

Snapshot of the present provision of alternative care to provide indications of priority issues to be addressed.

ATTITUDES TOWARDS / PERCEPTIONS OF THE CURRENT SYSTEM

- central government
- provincial/local authorities
- care providers
- front-line workers
- communities
- families
- children in the system or with experience thereof

Knowledge Outcome

The success and sustainability of reform efforts requires goals being agreed as fully as possible with all actors, taking due account of children's views.

HUMAN RESOURCES FOR THE CURRENT SYSTEM

- social workers
- para social workers
- volunteers
- judiciary
- foster carers
- residential care workers
- supervisors/inspectors
- "voluntourists"

Knowledge Outcome

The adequacy of numbers and qualifications of staff within the wider alternative care system (including prevention) needs to be established, including in terms of potential needs in the context of reform.

The question of recourse to foreign volunteers in residential facilities requires special attention.

FINANCIAL RESOURCES FOR THE CURRENT SYSTEM

- State: direct provision
- State: for non-State providers
- domestic non-State funding
 - Faith-based
 - Other
- foreign non-State funding
 - Faith-based
 - Other
- official bilateral / multilateral aid

Knowledge Outcome

Sources of funding of alternative care provision must be clarified so that they can be engaged with in order to facilitate the reform process.

STATE OVERSIGHT

- collection and analysis of reliable and pertinent data as an evidence base for policy
- regulation of alternative care
- registration of care providers
- authorisation of care providers
- monitoring/inspection of care providers

Knowledge Outcome

The degree to which the State is in an informed position to set policy and is able to enforce respect for that policy is crucial to reform.

UNDERSTANDING THE NATURE OF INFORMAL CARE PROVISION AND WHY THE CURRENT SYSTEM OF FORMAL ALTERNATIVE CARE IS IN PLACE

- actual and projected capacity of informal coping mechanisms
- degree to which informal care settings currently respect children's rights
- origins and development of residential care
- development of formal family-based care settings

Knowledge Outcome

The potential for promoting and supporting appropriate **informal** care arrangements should help determine the role that informal care could be called on to play in the reform strategy. The history of **formal** alternative care provision, and particularly that of residential facilities, provides vital background for developing reform strategies.

4.4.2 Determining the respective influence of the State and non-State actors

On the basis of the information gleaned from the exercise above, it should be possible to respond, first of all, to two key questions:

A) What role does the State play in providing, funding, regulating and supervising alternative care for children?

The obligation of the State is to “ensure alternative care” for a child who is deprived of, or cannot remain in, his or her family environment (CRC Art 20.2). The term “ensure” is strong and absolute, but the obligation may be met by both direct provision of that care and/or making certain that it is provided by third parties. The aim of alternative care is “special protection and assistance” (CRC Art 20.1), which implicitly requires an acceptable level of quality, and this level is detailed in the UN Guidelines.

It follows from this that **the fundamental role that the State must play concerns the regulation and supervision of alternative care arrangements**, whether or not these are provided and/or funded directly by the State. Hence, the following should be clarified:

- To what extent does the State require support for effective **regulation** (policy development, registration and approval of care providers on the basis of thorough and established criteria) and **supervision** (monitoring, inspection, response)?
- If any care arrangements are **provided directly** by the State, does the State also require support for their effective regulation and supervision?
- If the State is **funding non-State providers**, does the State also require support for their effective regulation and supervision?

B) What roles do non-State actors – domestic or foreign – play in financing alternative care provision and thus in determining the nature, quality and extent of that provision?

The State cannot require non-State actors to fund alternative care, but may allow them to do so as a means of meeting its obligations to “ensure” alternative care. Non-State bodies proposing to provide alternative care choose the kind of care they are prepared to offer and, collectively, determine the extent of that provision. Absent any effective regulation and supervision on the part of the State, they also determine the quality of the care offered.

Non-State care providers rely variously on domestic or foreign funding, and in a small minority of cases on a mix of the two. Domestic funding may involve both State and private sources; foreign funding for residential facilities is essentially private in nature, whereas for family-based care and preventive and family reintegration activities, the funding source is more usually international NGOs.

The vast majority of all alternative care funding to non-State actors, regardless of source, is channelled to residential care. Where State funding is concerned, this corresponds to a choice made by that State. Where non-State funds are concerned, it results predominantly from the requests of the providers coupled with the desires and demands of the donors.

A limited number of non-State actors aim to develop, and manage to finance, formal foster care services, invariably as “pilot projects” or tantamount thereto, within a defined geographical area. An even smaller number are both willing and able to engage in family support or strengthening programmes and/or in promoting and supporting appropriate customary arrangements for children without parental care.

It follows that **any efforts to reform an alternative care system must focus on the sources of funds from which its providers benefit**. Where States are concerned, the issue is essentially at a policy level. For non-State funders, the focus involves both enhanced control by the State and “donor education”.

Support to a State's efforts to institute reform should therefore take account of the following issues:

- If the **State is contributing to residential care provision** by non-State actors, how and under what conditions could the allocation of resources away from residential care be achieved?
- If the State permits non-State care providers to be financed by **private domestic sources**, could it set conditions on this that would enable a reform policy to be pursued – and does it need an enforceable policy?
- If the State permits non-State care providers to be financed by **private foreign sources**, could it set conditions on this that would enable a reform policy to be pursued – and does it need an enforceable policy?
- If **non-registered/unauthorised non-State care providers** are financed by private foreign sources, could the State act to close such funding channels?

4.4.3 Determining basic country profiles

In addition to giving detailed information on country situations, the overall responses to the above questions should provide vital indications as to where the decision-making and financial powers lie. This can be translated into a series of basic multidimensional profiles serving as the foundation on which individualised support strategies can be built. The main elements of these profiles would be grounded in determining the position of the country in question on various spectrums, notably:

- Degree of **direct State provision** of alternative care as opposed to non-State provision
- Degree to which **alternative care placements are initiated** by families, as officials, or care providers themselves
- Degree to which the **State finances alternative care provision** by regulated non-State providers
- Degree to which **non-State providers are effectively subject to regulation** to operate (i.e. have received authorisation and are monitored and inspected) or are operating without licence
- Degree to which **regulated non-State providers are financed** domestically or from abroad
- Degree to which **non-regulated non-State providers are financed** domestically or from abroad

4.4.4 Refining country-specific support

Once the responses to these questions have identified where the decision-making and financial powers lie – and therefore where efforts to promote reform should be targeted – two further questions can be posed in order to tailor the approach to the precise country situation:

A) What changes to the system would be desirable from a human rights standpoint and potentially acceptable in the specific socio-cultural context?

The fundamental considerations for determining the direction and nature of reform to be proposed will need to embrace in particular:

- Priority to efforts to enable the child to be cared for by his or her parents and family (CRC 7.1, 20.1 among others), and to preventing unwarranted placements (ensuring gatekeeping, tackling “recruitment”)
- Initiatives to enhance support to informal caregivers and to ensure children's basic needs are met when in informal care settings (e.g. CRC 27.3)
- Degree of current and potential acceptance of caring for non-relative children in the domestic setting

B) How can the State be enabled to promote and carry through such changes, in conjunction with all concerned actors?

Determination of the resources required will need to cover:

- Technical cooperation, with a capacity-building focus, on the development of a long-term strategy and its effective oversight, monitoring and periodic evaluation;
- Workforce development, notably in relation to authorisation and inspection of care providers, gatekeeping, social work and para-social work, the judiciary and law enforcement, as well as front-line caregivers;
- Financial assistance, as necessary and appropriate, for certain key phases (e.g. mapping of formal care provision) and key activities (e.g. dealing with unregistered facilities, surveys regarding informal care, awareness campaigns), again with a capacity-building focus.

The ability of the State to carry through reform will also be facilitated by efforts to educate foreign donors (and “voluntourists”) as to the negative ramifications of supporting residential care, an objective to which the EU's wider action could and should contribute significantly.

List of annexes

Continental Desk Reviews:

- Alternative Child Care and Deinstitutionalisation in Asia: Findings of a desk review. By Catherine Flagothier.
- Alternative Child Care and Deinstitutionalisation in Central and South America: Findings of a desk review. By Dr Chrissie Gale.
- Alternative Child Care and Deinstitutionalisation in Sub-Saharan Africa: Findings of a desk review. By Dr Ian Milligan, Mr Richard Withington, Dr Graham Connelly, Dr Chrissie Gale.

Country Case Studies:

- Alternative Child Care and Deinstitutionalisation: A case study of Chile. By Dr Chrissie Gale.
- Alternative Child Care and Deinstitutionalisation: A case study of Ecuador. By Dr Chrissie Gale and Mg Patricia Calero Teran.
- Alternative Child Care and Deinstitutionalisation: A case study of Indonesia. By Claire O’Kane and Sofni Lubis.
- Alternative Child Care and Deinstitutionalisation: A case study of Nepal. By Dr Chrissie Gale and Mr. Chandrika Khatiwada.
- Alternative Child Care and Deinstitutionalisation: A case study of Nigeria. By Dr Graham Connelly & Ms Saater Ikpaahindi.
- Alternative Child Care and Deinstitutionalisation: A case study of Uganda. By Dr Ian Milligan

Acknowledgements

The authors have so many individuals to thank that all can not be mentioned here, for reasons of space and in some cases confidentiality. On four continents individual children, parents, caregivers, social workers, professors and managers, officials and authorities have given their crucial time to share significant insights with us. We sincerely thank each individual and “key informant” who took time to meet with us and share their views and experiences.

In Chile: The author Dr. Chrissie Gale sincerely thanks Ms. Alejandra Riveros and Mr Alejandro Tsukame of Aldeas Infantiles SOS Chile for their dedicated efforts to make the field visit a success. Further thanks go to Melissa Erazo of Aldeas Infantiles SOS Chile for conducting the group activities with children and young people. Thanks also to Ms Nadia Garrido, Director of Programmes and Ms Patricia Sainz, both from SOS Children’s Villages Latin America and Caribbean Regional Office.

In Ecuador: The authors Dr. Chrissie Gale and Patricia Calero Teran would like in particular to thank Elizabeth Garcia for her wisdom, support and expert translation during the field work, as well as Veronica Legarda from Aldeas Infantiles SOS Ecuador who supported the planning and implementation of the field work. Thanks also to Ms Nadia Garrido, Director of Programmes and Ms Patricia Sainz, both from SOS Children’s Villages Latin America and Caribbean Regional Office.

In Indonesia: The authors Ms Claire O’Kane and Ms Sofni Lubnis wish to thank SOS Children’s Villages Indonesia staff Ms. Tri Lestari Dewi Saraswati and Ms. Angela Sri Untari; Mr. Tata Sudrajat and Mr. Agus Noor Alamsyah in Save the Children; Ms. Florence Martin from the Better Care Network; Mr. M. Ihsan and Mr. Jasra Putra in Muhammadiyah; and Mr. Yanto, Chairman of Social Welfare Institution National Forum. Further thanks are due to: Ms. Kanya Eka Santi, Ms. Rohika Kurniadi Sari, Ms. Yosi Diani Tresna, Dr. Irwanto, Ms. Astrid Gonzaga Dioniso, Ms. Pipin Latifah, Ms. Yuyum Paryani, Ms. Tuti, Mr. Nelson, Mr. Tugiman, Mr. Sotar Sinaga, Mr. Imron Rosadi, Ms. Emily Delap, Ms. Kate Riordan, and Mr. William Gali. Finally, for their support, Mr. Rajeev Kumar from the SOS Asia regional office; and Mr. Gregorius Hadiyanto Nitihardjo from SOS Indonesia.

In Nepal: The authors Dr. Chrissie Gale and Mr. Chandrika Khatiwada are grateful to Ms. Shusma Pokhrel of SOS Children’s Villages Nepal for her dedicated efforts and invaluable support in coordination, organisation and expert facilitation of the fieldwork.

In Nigeria: The authors Dr Graham Connelly and Ms Saater Ikpaahindi would like to thank Eghosa Erhumwunse, Director of SOS Children’s Villages Nigeria, and the many members of his team who supported them in arranging for the field work in both Lagos State and the Federal Capital Territory. They also wish to thank the many adults and children who willingly spoke to them.

In Uganda: The author Dr Ian Milligan offers thanks to the National Office of SOS Children’s Villages in Uganda and particularly to staff member and Project Manager of the ACCoSS project, Mr Ronald Ssentuuwa. Further thanks are due to national researcher Dr Betty Kwagala and her two research assistants, Ms Shilla Omuriwe-Buyungo and Mr Bryan Naduli.

The coordination wishes to thank Maxence Daublain from the European Commission’s DEVCO Unit B1: Human Rights, Gender, Democratic Governance; CELSIS for support to its team and to ours; Sara Oviedo for her comments and her persistence to be involved; Irina Papancheva from Lumos and Alessandro Negro from Hope and Homes for their advice on the recommendations.

From SOS Children’s Villages International, we wish to thank Truphosa Amere, Nadia Garrido, Rajeev Kumar, Radostina Paneva, Kelig Puyet, Douglas Reed, Patricia Sainz, and Stewart Wilms. Thanks also to the EU team, especially Caroline van der Hoeven; the IPD team, especially Barbara Stricker; Carina Rendl, Ruw Jayasuriya and Isabell Meenen.

Finally, the project team members would like to thank each other for their specific contributions, bringing together great intellects, hard work and a fantastic spirit of mutual support. Throughout the process we have all counted on Nigel Cantwell’s sound advice and turns of phrase; Chrissie Gale’s bold research leadership and fearless refusal to let anything from a detail to a case study fall through the cracks; Ian Milligan’s experience and good cheer; Claire O’Kane’s passionate and professional expertise on child participation methodologies; Catherine Flagothier’s fresh and professional comprehension of Asia; Graham Connelly’s adventurous, can-do attitude; Alan Kikuchi-White’s teamkeeping skills and practical solutions; and Samantha Chaitkin’s perspective on the requirements and the audience.

Convention on the Rights of the Child

ratified by 196 countries to date

Article 20

①

A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

②

States Parties shall in accordance with their national laws ensure alternative care for such a child.

③

Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

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