RESIDENTIAL CHILD AND YOUTH CARE
IN A DEVELOPING WORLD

Tuhinul Islam
Leon Fulcher

Editors

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MIDDLE EAST AND ASIA PERSPECTIVES

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DEDICATION

TUHINUL ISLAM dedicates this book to his son Musanna, and daughters
Tamanna and Tubaa.

LEON FULCHER dedicates this book to his grandchildren –
Jacob, Luke, Caitlin, Harley and Jack – and to their Carers.

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ACKNOWLEDGMENT

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Preface

Kiaras Gharabaghi[1]

I n recent years, there has been something of a revival in scholarly and professional writing on residential care and treatment, albeit largely focused on the Western, English-speaking Global North. Some publications deal with practice issues; some deal with research methods and evidence for good practice; and some deal with the systemic context about how residential care and treatment fit within the landscape of professional services for children and young people. What this writing has in common is a pre-occupation with the prevailing ideology of 'last resort', a clear preference for family-based care, and a strong orientation towards reclaiming relational practices as practice-based evidence. Islam and Fulcher offer a different kind of perspective – and context – through which we might engage residential care globally. As I will highlight below, this volume of articles on residential care in the Middle East and Asia represents a challenge to our well-established orthodoxy in this field in several important ways. Aside from allowing us a glimpse into residential care practices in geographies often unfamiliar to Western readers, this book represents a fundamental challenge to some of the core assumptions we have held for some time now. This is an enormously important and valuable collection of articles on residential care, both for obvious reasons and for more nuanced ones. Let me start by pointing to the obvious reasons.

Residential care across OECD jurisdictions suffers from a phenomenon I refer to as *cultural insulation*. Whether because of the intensity of the work itself, or perhaps the result of insecurities arising from the challenging relational episodes that happen almost every day, service providers almost everywhere tend to look inside of their services more so than looking outside. In my home territory, Canada for example, it is not uncommon for a service provider operating residential care services in the east end of Toronto to have no contact with and frankly no idea about another service provider operating similar services in the west end of the city, perhaps no more than 25km away. The cultural insulation that ensues is not strictly about the culture of young people or professionals; it is about the culture of service provision itself. This culture is almost always loosely based on relatively superficial justifications with theoretical frameworks promoting attachment theory, trauma-informed care, developmental psychology and/or ecological perspectives. Theoretical orientations

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such as these are then put into operation through agency-specific care practices, evidence-based assessments and interventions, and internal agency-driven (and largely invented) professional development and training sessions.

In this volume, readers are confronted with residential care in countries many readers would struggle to identify on a map. They are furthermore confronted with residential services that operate on low budgets that are largely unimaginable in most OECD jurisdictions (noting that some of the countries included here are in fact within the OECD). Readers learn of residential care approaches that are operating in contexts of war, violence, poverty, environmental disaster, amidst cultural norms and regulations that defy any bureaucratic assumptions we make about what is necessary to do this work well. There is enormous value in confronting one's own work in different contexts and different geographies. It offers a first clue that however one may have structured the work, it is almost certainly not the only way this can be done, and it most certainly is not always the *right way* to do it. Residential services are very much contingent on context and, in this volume, we learn about cultural and social contexts that are diverse and challenging but also rich with nuance, strength and opportunity.

Another obvious reason for the importance of this volume is that it brings into the community of students and scholars concerned about residential care individuals whose voices are not often heard in OECD, and especially in English-language discussions of the sector. We cannot deny that in countries such as the United States, Canada, Australia, New Zealand, England, Scotland and Ireland, for example, the voices readily heard and engaged in residential care are those of a relatively few individuals who are well connected in academic and professional communities. Conferences that repeatedly take up the theme of residential care feature the same keynote speakers, the same workshops and often the same ideas, and are given resources to publish those ideas in (usually English language) journals and books. It can be argued that much of our thinking about residential care is in fact the outcome of engagement with very few (usually white and often male) individuals. In this volume, we are introduced to scholars and professionals who are situated quite differently, who have not had the kind of easy and usually funded access to international communities of research and scholarship, and who add a richness and a diversity of discussion perspectives that are priceless.

But let me get to the more nuanced reasons why this book is an invaluable addition to the literature on residential care. As the editors point out in their Introduction, much of what we know and talk about with respect to residential care globally is limited to a fraction of relevance when one takes account of where children, young people, families and communities actually live. The focus on English-speaking geographic areas has to some extent blinded us to the rich diversity of thinking and practices around our predominantly non-English-speaking world. Perhaps more importantly, it has allowed us to conveniently overlook the histories of children's rights, child care, and family support around the world, including the ways in which Western colonialism and war mongering has impacted on those processes.

To the extent that we are now confronted with sometimes harsh realities in this context, we would do well to consider our own complicity as Western citizens enjoying the privileges that have accompanied the imperialist mindset of our forefathers in the West. This is particularly obvious in the context of residential care in Palestine, a region that has suffered the effects of Western political games perhaps more than most. It is similarly obvious in countries such as Yemen, where the effects of Western Middle East policies are being played out through proxy wars and armed conflict with enormous impact on children and their families. At the same time, we can look further East to the current (and historical) violence against Rohingya Muslims in Burma (Myanmar) and realize that histories of Western imperialism and Eastern systems of authoritarian oppression often collide, using faith, culture, race and poverty as excuses for victimizing entire peoples, reminiscent of the genocides committed against indigenous peoples in North, Central and South America.

More to the point, it is the issue of anti-institutionalized care that finds a great deal of challenge and counter-argument in this volume. The editors set up this theme right from the start. They readily acknowledge their strong bias toward family-based care and the dismantling of large institutions in the comparatively rich and mostly stable bureaucratic systems that operate in Western countries. But does this bias, indeed this ideology, transfer to the fragile bureaucracies, demographically much more diverse, politically unstable and environmentally vulnerable geographies of the Middle East and Asia? Can we rely on ideological moves that pre-suppose government oversight and regulation? Why assume that developing countries outside the West have the capacity to fund ongoing research and quality assurance in places where residential care seeks to respond to the needs of millions of orphans and young war refugees? Furthermore, quite differently from what is found in Canada, the UK or Australia, how do we respond to the personal survival and social needs of young people whose upbringings are often embedded in cultural and economic movements in which young people are viewed as an unsustainable surplus?

What comes through quite clearly in many of the chapters is that institutionalized care is often falsely or at least superficially constructed as 'the bogeyman'. Using a largely Global North perspective, we recognize institutions as the enemy of personal autonomy, individual rights, and opportunities for self-driven social, spiritual and economic development. These perspectives mirror well-embedded structures of neo-conservatism, in which a regulated form of private-public interaction is the norm and where state responsibility is more oriented toward the protection of the private sphere than the exercise of collective responsibility. Family becomes a euphemistic construct for intimacy as the social norm where young people, we say, deserve to grow up in family.

In this book, we learn about residential care in Yemen, in Iran, in Punjab, in many different regions of India as well as further East, in Thailand, Cambodia, the Philippines, and even Hong Kong, while Malaysia and the world's fourth most populous country – Indonesia – offer further learning opportunities. We discover very quickly that the role of the institution is quite different across these

geographies. Although there are many local variations, institutions are not simply instruments of the state; they are spaces of living and learning in relative safety, albeit not always in relative comfort. They are also spaces that allow stability in highly unstable places. Finally, they are spaces that offer what in the Global North is often taken for granted – education.

Over the course of decades, and certainly since the establishment of the League of Nations (and later the United Nations), we have learned through our work in international development that education serves as perhaps the most consistent creator of opportunity. It does this for children and young people who are abandoned, discarded, violated, injured in war, or traumatized by the events around them, and the frequently resulting migrations. In the Global North, we have had the luxury of separating our institutional responses to education from our community responses to residential care needs. But let's be clear – we continue to utilize an entirely institutional response to education, herding as we do hundreds and sometimes thousands of young people into large buildings that look and feel like institutions where they are expected to conform and be compliant with institutional rules and norms to learn (we call this 'School').

In many of the chapters we encounter in this volume, we are confronted with the simple reality that splitting the acutely urgent responses to needs with respect to education and a place to grow up is not always possible, and sometimes not desirable given outside social dynamics, cultural norms, economic realities and environmental crises. It is not that the Global North has abandoned institutionalism; it has only separated its institutionalism with respect to education from an earlier period of a parallel institutionalism with respect to places for children to grow up (orphanages, training schools, etc.). Of particular interest here is Israel, a country that easily compares with the resource and bureaucratic wealth and stability of the Global North, but that – culturally and socially – it continues to move along a spectrum of institutional responses to both education and growing up because it fits the context. Perhaps more specifically, it builds the community and sense of belonging that has assured the survival of the State of Israel.

Perhaps not surprisingly, as we work our way through the chapters of this book, we learn about hardships and challenges confronting young people, their families and their communities. But we also learn that there have in fact been responses to these challenges that have sought to maximize opportunity in context. We also learn that, unlike in the Global North, many scholars, professionals and indeed service providers, continue their journey to respond to the needs and the rights of young people living in residential care. It is not every day that we can travel from the gates to the Orient (Turkey) through the cradle of the Middle East, into the Islamic Republic of Iran and further East through lands of Islam, Sikh, Hindu, Buddhist and other traditions. This is a journey well worth taking.

Introduction

Tuhinul Islam[1] and Leon Fulcher[2]

Abstract

Residential child and youth care is examined in places from which practice-based evidence has been rarely shared with the rest of the World. Volume 1 – Global Perspectives *used the FIFA Football Confederation Regions to examine residential child and youth care in eighteen countries rarely evidenced in the field, and then twenty-three further contributions in Volume 2 –* European Perspectives. *Volume 3 –* Middle East and Asia Perspectives – *offers glimpses of extended family care as well as residential child and youth care in 25 countries never gathered together before in one collection. Nine comparative themes that frame residential child and youth care and education services in the Middle East and Asia are highlighted by way of introduction.*

Introduction

These are times of turmoil for residential child and youth care in many of the 25 countries included in this third volume *Residential Child and Youth Care in a Developing World* focusing on countries and regions of the *Middle East and Asia.* Seventeen new contributions – along with eight updated contributions from Volume 1 – highlight a geo-political history and cultural traditions that have shaped child and youth care in ways rarely considered, understood nor acknowledged by those working across the child welfare field in Western countries. Volume 3 begins with Turkey (once known as Anatolia) and historically positioned at the heart of The Ottoman Empire. The Ottoman Empire governed all the Balkan Peninsula (including what is now Greece, Cyprus, Albania, Bosnia-Herzegovina, Serbia, Croatia, Armenia, and north through Bulgaria and Hungary almost to Vienna. The Ottoman's also governed Mesopotamia (now Iraq, Kuwait, the Crimea Region of Russia – now Ukraine, western Iran, Syria and Lebanon). The Ottoman's controlled Palestine, TransJordan and the Arabian Peninsula as far south as Aden (now Yemen), along with the Holy Sites of Mecca and Medina (now Saudi Arabia),

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[2] **Leon Fulcher, MSW, PhD** has worked for more than forty years as a social worker in residential child and youth care work in different parts of the world. As a practice researcher, scholar and author, Leon has given special consideration to working across cultures and geographies, how this impacts on team working, supervision and caring for caregivers, as well as promoting learning with adult carers.

Damascus and Jerusalem (now Syria, Jordan, Israel, and Palestine), United Arab Emirates, Bahrain, Qatar and Oman. The Ottoman Empire also extended along the Southern Mediterranean territories of North Africa (now Egypt, Tunisia, Libya, Algeria and Morocco) from 1299 until the end of World War I. Note below how in the map of The Ottoman Empire prepared in 1914, the names of countries in the Middle East are still to be defined. Only the geography and historic towns and cities are highlighted. At that time, nation-states had still to be established.

THE OTTOMAN EMPIRE IN 1683
Ottoman Beylik, 1300
Acquisitions, 1300 - 1359
Acquisitions, 1359 - 1451
Acquisitions, 1451 - 1481 (Mehmed II)
Acquisitions, 1512 - 1520 (Selim I)
Acquisitions, 1520 - 1566 (Suleiman the Magnificent)
Acquisitions, 1566 - 1683
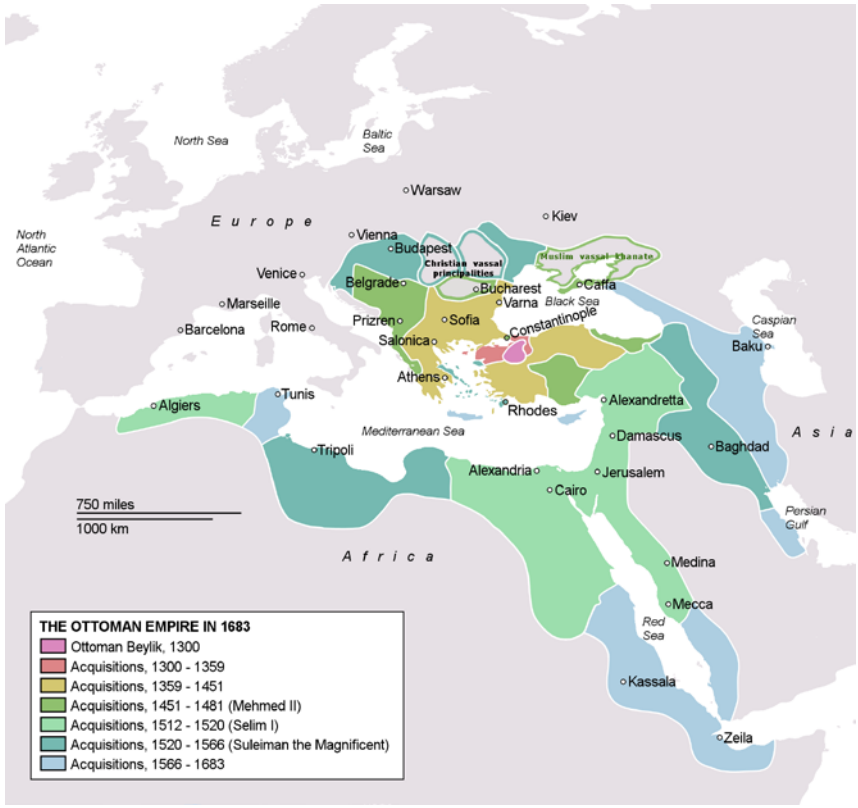
In Volume 2 it was shown how compared with Western Europe where residential institutions were established to care for orphans from the 18th Century onwards, Eastern-European and Balkan countries – formerly part of the Ottoman Empire – had long histories of community-based, extended family or kinship care. This was a qualitatively different 'policy orientation' that framed the care of orphans and disabled children. Contributions to Volume 3 from former Ottoman countries in the Middle East region are now recognised as Lebanon, Palestine, Israel, Jordan, Saudi Arabia, Yemen, Kurdistan Iraq and Iran – formerly Persia. Contributions from South Asia and the former British India shown in the map below include post-

partition countries – Pakistan and what was known until 1971 as East Pakistan and is now Bangladesh – along with the island colony of Ceylon, now the nation of Sri Lanka and Myanmar, the former British Colony of Burma. Chapters from several states of the world's second most populous country are included, with attention drawn to the mega-cities of Delhi, Kolkata and Mumbai, and how Bangladesh is surrounded by India States and Territories bordering Myanmar.
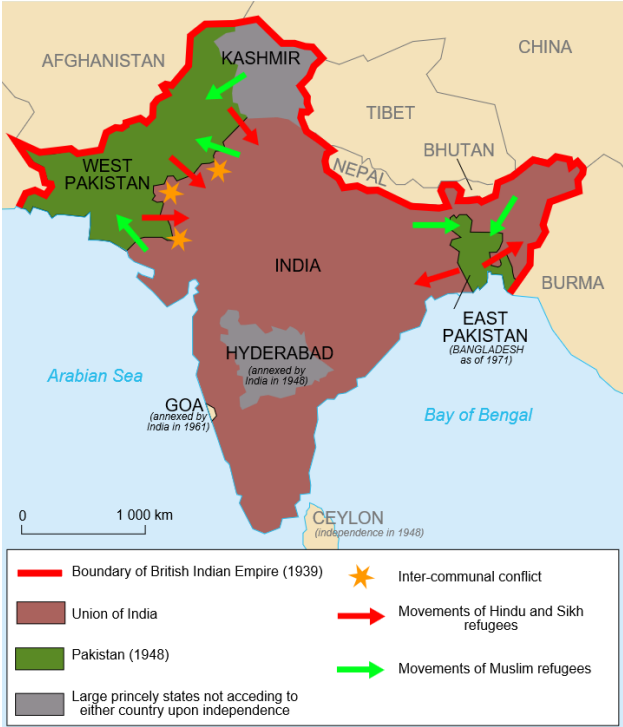
It is important to note how the Province of Kashmir remains a 'divided land' with a legacy dating from the partition of Muslim, Hindu and Sikh communities there. Military skirmishes between India, Pakistan and Kashmiri separatists continue there – seventy years later. The southern border of eastern India and Bangladesh is where the Buddhist Military Regime of the former British colony of Burma have driven Muslim Rohingya people out of Myanmar towards Bangladesh and into what has become the world's largest refugee camp in 2017.

The remaining chapters in this volume include contributions from Thailand, Cambodia, Malaysia, the former British colony of Hong Kong – now part of the Peoples' Republic of China – Japan, the Philippines and Indonesia. World War II, the Korean and Vietnam Wars as well as recent military activity in Myanmar against the Rohingya peoples have been important contextual influences on child and youth care in the region. The Middle East and Asia region has more active war zones than

any other region of the world and these important historic and economic contexts frame community life in countries and states across this vast region, shaping the delivery of residential child and youth care services everywhere. The final years of World War I saw the Battle of Beersheeba and the ousting of the Ottomans from Palestine with the help of Australian and New Zealand Cavalry (1917). This was followed thirty years later by the Battle of Jerusalem (1947) with both battles now recognised as pivotal moments in the nation-building histories for Israelis, Turks, Palestinians, Egyptians, Jordanians, Lebanese and Syrians.

The new League of Nations was established at the end of World War I to provide the World's first established forum for resolution of international disputes. The League of Nations Covenant established a mandate system that was drafted by the victors. Article 22 referred to territories which – after the war – were no longer ruled by their previous sovereign and their peoples were considered *"unable to stand by themselves under the strenuous conditions of the modern world"*. Such people's tutelage was to be "*entrusted to advanced nations who by reason of their resources, their experience or their geographical position can best undertake this responsibility*". Elitist attitudes of the victors of World War I as demonstrated in the above were arguably influential in the last half century of conflicts across the region, with territorial disputes, national and ethnic conflicts, and warfare around control of natural resources.

In 1920 the League of Nations awarded Mandates to the British for regions identified then as Mesopotamia, and for Palestine and TransJordan. A further Mandate was awarded to the French for Syria and Lebanon in 1923. It is reasonable to argue that new nation-state boundaries created by the British and the French, along with the 'election' of titular heads of state in places like Iraq and Iran, laid the foundations for a legacy of boundary disputes, ethnic cleansing and armed conflicts that have continued throughout the region for the past half century. Boundary lines drawn on contemporary maps did little to create ongoing stability and peace in the region.

From the 1930s, Anglo-American discovery of oil and gas reserves in Post-Ottoman Arabia, Mesopotamia and the Persian Gulf sparked the development of a Middle East petro-chemical industry that fuelled globalisation and regional positioning of nations around strategic reserves of oil and natural gas in the Middle East. In less than four decades, children and families transitioned from travelling across deserts in camel caravans to multi-lane motorways with fast cars and housemaid-nannies that care for the children. When oil and gas reserves were discovered, none of the Middle Eastern countries represented in this volume formally existed. For the most part, the new nation-state boundaries failed to take account of tribal boundaries or religious histories and cultural traditions that operated in Mesopotamia for centuries prior to the new post-Ottoman maps being drawn. Contemporary circumstances facing Kurdish peoples provide an important illustration of where traditional Kurdish lands were split between Turkey, Iraq and Iran, and where continuing tensions exist across that whole region. Relationships between Sunni and Shi'ite followers of Islam do not sit easily together, and yet for

the most part, post-war reconstruction of Iraq by the US-led coalition failed to take this reality into account. Kurdistan Iraq secured regional autonomy in Northern Iraq only after the Saddam Hussein regime created international outrage by using nerve gas to quell a Kurdish uprising. It is also worth noting how quickly the Shi'ite led Iraqi Government took back control of the Northern Iraqi Oil Fields after the Kurds seized these strategic reserves from ISIS with support from the US.

Significant tribal and religious groupings have lived together with long histories throughout Syria and Lebanon. Since 1947 and working within the League of Nations awarded British Mandate for Palestine and TransJordan, nation-building for the state of Israel has become a reality, and at some considerable cost for Palestinian peoples whose ancestors have lived in the region before and after the diaspora of peoples of the Kingdoms of Israel and Judah that started as early as the 8th through to the 6th Centuries BC with the Assyrian and Babylonian exiles[3]. Cultural dynamics underpinning the whole of the Middle East region emanate from religious practices carried out by leaders and followers of Sunni and Shi'ite Islam and Judaism, all of whom identify Abram or Abraham as the father of their peoples – the genealogy that identifies both the sons of Haggar and the sons of Elizabeth. Western efforts to support one or the other major centres of Sunni and Shi'ite Islam – Saudi Arabia and Iran – are fraught with dramas associated with superpower brokering between the US in support of Israel and Gulf Cooperation Countries, and Russia in support of Iran, Iraq and Syria.

Another contemporary policy issue that continues to shape residential child and youth care across the region involves the unilateral recognition of Jerusalem as the Capital of Israel by the USA. The UN resolution, co-sponsored by Turkey and Yemen, called President Trump's recognition "null and void" and reaffirmed 10 security council resolutions on Jerusalem, dating back to 1967 – including requirements that the city's final status must be decided in direct negotiations between Israel and the Palestinians. This action taken by the USA was condemned by 128 countries, two-thirds of the 193 United Nations member states because it undermines a two-State solution to lingering conflict in the region. Only nine countries supported the American recognition of Jerusalem, including Guatemala, Honduras, Israel, Marshall Islands, Micronesia, Nauru, Palau, Togo and the USA. Thirty-five countries, including Australia, Canada and Mexico abstained while delegations from twenty-one countries failed to turn up for the vote after threats were made about cuts in US aid funding for countries that did not support this latest expression of American diplomacy.

Build-up of military armaments throughout the region has been unparalleled since 1920, including nuclear weapons and weapons of mass destruction, in a region that has experienced decades of territorial warfare and armed conflict around land and natural resources. In 2017, the US and Russia, for example, announced multi-

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[3] Old Testament scholars highlight accounts by the Prophets warning the Kingdoms of Israel and Judah about turning away from Jehovah's guidance and of how failure to heed these warnings contributed to the ancestors of the Children of Israel being cast out of their Promised Land.

billion-dollar military hardware sales to Saudi Arabia, the United Arab Emirates, Qatar, Syria, and Turkey. Warfare continues to rage in Yemen, Syria and western Iraq. Refugee children and families are still living in camps established more than a half century ago following the British Mandate for Palestine and TransJordan. The UN Refugee Camps established for Palestinian peoples in Jordan, Lebanon and the Palestinian territories since 1947 still care for up to 2.5 million people. The building of Israeli settlements on occupied Palestinian territory but calling them 'neighbourhoods' does little to reduce tensions between peoples living on disputed lands.

Moving eastwards, one arrives at what was once recognised on the world maps as 'British Colonial India'. 'Brexit' from British Colonial India occurred in 1947 with 'Partition' drawn up after months of negotiations amongst political leaders. However, those negotiations failed to deliver a 'safe and planned separation' of the former British colony population along religious grounds, establishing Pakistan, India and East Pakistan, now Bangladesh. Following Partition, some two million people died in ethnic massacres as whole trainloads carrying refugees from one new district to another were hacked to death. Hindu, Muslim and Sikh peoples who had lived together for decades in relative peace throughout India found their communities ripped apart by violence and counter-violence. Ripple effects associated with Partition are still felt, today – some seventy years later – with military control of India's State of Jammu and Kashmir. 2017 saw military skirmishes between the Pakistani and Indian military. At the same time, local nationalists continue their own campaign for self-governance.

India's eastern states and territories are positioned north of Buddhist Myanmar, surrounding Bangladesh but leaving a southern border with Myanmar where contemporary ethnic-cleansing genocide carried out by the Burmese Buddhist military has resulted in half to three-quarters of a million Muslim Rohingya refugees fleeing the former British colony of Burma into Bangladesh. There they have cut down a forest and dug shelters into the hillsides and mud. Little thought has been given for the future and the annual Monsoon Season that will create mudslides and wash away refugees to their deaths. A mass movement of children, mothers and surviving young men can be found fleeing warfare throughout the region, moving into refugee camps, or other cities and countries. Those most fortunate can connect with family members via chain migration facilitated through kinship relations. Orphans without one or both parents now make up a significant proportion of the population across the Middle East and Asia region.

Dynamics of rural-urban migration feature prominently throughout the region, as children and young people seek employment and survival opportunities. Infant mortality remains high, reinforced to some extent through marriages between cousins where in-breeding increases the probability of genetic vulnerability and disabilities. Child poverty remains a significant influence – across the region's mega-cities – surrounded by a general population that is often complicit with child

labour, child prostitution and child trafficking. In rural areas where different tribes or power groups vie for control of resource-rich territories, child soldiers are frequently recruited, and child brides held for ransom. Young people labelled economic migrants continue to escape war zones in search of safety and security with young migrants and refugees living in residential child and youth care centres throughout the Middle East and Asia Region, as well as the European Region – a common destination for most migrants.

A distinctive feature about residential child and youth care across the Middle East and Asia Region is found in how residential care and education commonly go together in a part of the developing world where boarding school education is viewed as a comparatively normative experience. Public school education starting with pre-school and primary school, through intermediate, secondary and even tertiary level is available to all children and young people at minimal cost for the general population in Western countries. Such educational opportunities are not readily available for all children with any consistency when travelling across the Middle East and Asia region, or is found selectively in countries like Israel which uses residential boarding schools as a central strategy of nation-building for Israeli youths. Across the region, education is very much a matter of "have's" and "have-nots". Poor families throughout this region rarely 'have' enough money to pay for their children to receive an education. Thus, when education can be obtained for the children of poor families along with board and lodgings in a residential home, school or centre, there are big incentives for families to seek such opportunities for their children. Western visitors need to become more familiar with the ways in which care and education go hand in hand, regardless of what names are used to identify residential child and youth care – be that madrasah, sekolah tunas bakti or rumah kanak kanak.

Charity, the giving of alms and evangelical proselytising are prominent features of residential child and youth care practices across this region, and also internationally. Followers of Islam are admonished to give in support of orphans and widows, also supporting education pathways for young people without family connections. Begging is a widely accepted practice by mothers and children throughout the region. Western Christians gift generously to support missionary projects that involve 'saving' children and helping them have a 'better' life. Sadly, it is not uncommon for those establishing missionary homes and schools for children to benefit generously in lifestyle and social status. Access to a steady flow of Western money into countries where missionary work of this kind is legally possible, as in Thailand, Cambodia and the Philippines, opens alternative pathways for potential corruption and risks of selective exploitation of children by international volunteers. Throughout what was once known as Mesopotamia, Palestine and TransJordan, residential child and youth care remains heavily dependent on charitable funding to provide services where governments have been incapable of meeting needs.

In Southeast Asia, a Buddhist mind-set is said to be "*do good to die good, do what you believe to die what you believe*". Such a mind-set commonly generates confusion around the care of South Asian children. If it was the child's "fate" to be born, it is also that child's "fate" to develop, live and die into the next pedestal of growth toward Nirvana. Such beliefs impact societies like Thailand, Cambodia and rural Malaysia where fate is a well-established dynamic in the cultures of this region. You get what the "gods" want you to get and you only overcome because you are shrewder than the "gods". In the end, all is fate. Adults may commonly assume that the child, born out of need or pleasure, has a future of fate. If good happens to them, it is because they are good. If evil occurs and they become possessed by evil, – it is assumed – that this is because they have done something bad in a previous existence that is negatively affecting their path towards perfection. In many respects, this cultural dynamic associated with fate contradicts the basic optimism embedded in the UN Convention on the Rights of the Child (1989).

North American and European campaigns that promote radical de-institutionalisation are commonly ill-informed about the daily lives of children and families living in villages and cities across the Middle East and Asia region. There is a similar level of cross-cultural naivety about much of Africa. De-institutionalisation campaigns rarely grapple with cross-cultural realities associated with public education that is very different in nature, format and resources from what is taken for granted in the West. The countries, regions and states included in *Residential Child and Youth Care in a Developing World: Volume 3 – Middle East and Asia Perspectives* have rarely appeared in the professional child and youth care or social work literature, nor in education journals. Taken together, the 25 chapters included in this volume offer lenses through which to illuminate what is happening with children, young people and families in places where 1.9 billion people live, or twenty-five percent of the World's population of 7.6 billion people!

It is worth noting that in 2016, comparative populations for what might be known as '*the English-speaking world*' accounts for less that fifteen percent of the populations represented in this Volume. Tally the numbers: the USA (323.1 million); Canada (36.29 million); the UK (65.64 million); Ireland (4.77 million); Australia (24.13 million); New Zealand (4.69 million); and South Africa (55.91 million). The population for the whole of the English-speaking world totals just over 500 million people (514.53 million) and yet all that is written about residential child and youth care practice is written through this English voice! Most international consultants engaged in well-funded and politically endowed de-institutionalisation initiatives in Africa, the Middle East and Asia come from the West, are Western educated and/or have little practical experience working with children, young people and families on the ground in these 'far away from the West' places. Neo-colonial attitudes and strategies are all too readily visible as European and North American faces arrive with the word 'Expert' stamped in their passports. Little time is spent learning to engage with local cultural and religious practices such as rituals associated with the Holy Month of *Ramadan*, *Dewali* or the Chinese New Year.

Residential Child and Youth Care in a Developing World

In 2015, an invitation was sent to child and youth care practitioners, educators and researchers from all over the world seeking contributions from an extensive residential child and youth care knowledge base of traditions, systems, policies and practices, as well as knowledge about children's needs, rights and upbringing in many home countries about which little was known. In the end, more than 90 responses were received! *Residential Child and Youth Care in a Developing World: Volume 1 – Global Perspectives* – highlighted 18 countries from around the world, while Volume 2 focused on 23 European countries (Islam & Fulcher, 2016; 2017). The overwhelming response to our invitation yielded a unique range of stories about turbulence, resilience, and triumph in the provision of residential care and education for children and young people across the Middle East and Asia Region.

Since the end of the 20th Century, the literature about residential child and youth care has developed extensively, especially material available in English written in the USA and Canada, the United Kingdom and Europe. The field has seen and heard arguments in support of evidence-based practices (Peters, 2008) and outcomes-based research (Cameron & Maginn, 2009). Paradoxically, the 'dominant focus' of Western research still assumes that residential child and youth care is provided sparingly, that care and education are separate programmes, and these services are only for children diagnosed as '*mad, bad or sad*' whose needs require therapeutic or trauma-informed care with trained professionals. Smith (2015) explained how in Eastern Europe, more attention is given to notions of care and upbringing, while in the USA and the United Kingdom, the focus is directed towards treatment. A medical orientation is prominent in American writing, shaped in a policy environment where health insurance requires a medical diagnosis before funding can be released by insurance companies for treatment. Boarding schools are rarely included in this literature. 'Last-resort' status means that children placed in UK residential child and youth care services demonstrate significant social and emotional challenges. All research highlights the influences of culture, context and value-orientations when seeking to achieve better outcomes with children, young people and their families (Peters, 2008).

Middle East and Asia Perspectives highlight the ways in which residential child and youth care is shaped by geo-political histories, cultural traditions and contrasting social values when identifying best practices and seeking positive outcomes for children in need of care – including young war zone refugees. The practice narratives that follow provide glimpses of how residential child and youth care has featured and continues to feature in the re-construction processes that follow nearly three decades of life in Middle East and South Asia war zones. It is still our scholarly assertion that residential child and youth care "places" exist everywhere in our World – whether called homes, orphanages, hostels, schools, centres, residences, colleges, refugee camps or institutions. Unlike Courtney & Iwaniec (2009) or Whittaker *et al* (2015), our definition of residential child and youth care purposely includes private boarding schools, madrasah, seminaries and

religious schools, educational hostels for rural children, college and university residential colleges and halls of residence, refugee camps, and other religious and military training centres. Think of families and youth courts that turn to religious service and military training as diversionary options for teenagers facing court or personal challenges, and whom family members and the community considered "at risk". Whilst the purpose, mission or licensed mandate may change, the organisational dynamics in a residential school or centre remain the same. Residential child and youth care with education is expanding across the Middle East and Asia Region and these places are not being de-institutionalised.

Residential child and youth care involves living and learning environments that operate with 24-hour, life-space activity-based care and education – whether on-site or nearby, 7 days a week for designated periods of time measured by cohort, semester, term, season or year. Adopting the United Nations definition of 'Youth' – as applies in most countries of the Middle East and Asia – 'youth status' is retained in most places until aged 25 or older. Residential child and youth care places were once located in isolated sites but are now more commonly found in local communities. Other centres may involve loosely-defined and multi-purpose campus communities or villages. Within or beside local communities, families maintain involvement with their children living in the village where services like health and dental care may be offered to all who attend the village school.

Unlike social work, there is no unified definition of residential child and youth care. Definitions vary from country to country, at different times in history, and from culture to culture. Definitions of residential child and youth care are dependent upon socio-religious as well as politico-economic influences, as seen through the different care practices employed with children without parents for 500 years under the Ottoman Empire and continued in the Islamic countries that emerged in the Middle Eastern region. Most agree that social pedagogy or child and youth care work – as with 'good enough parenting' – fundamentally involves relationships through which children and young people learn social competencies and personal achievements are promoted. Opportunities for a 'good enough up-bringing' oriented towards healthy living and holistic personal development need to be available for each child – every day – along with educational pathways that nurture and empower (Cameron *et al*, 2015).

The public image of residential child and youth care in Western countries has not been a positive one, frequently condemned for damaging children's development and compromising their rights (Swales *et al*, 2006; UNICEF, UNAIDS & USAID, 2004), weakening family ties and offering poor educational and health outcomes (Courtney & Iwaniec, 2009). Most importantly, residential child and youth care has been criticised and attacked for its inadequate preparation of young people leaving care and transitioning towards independent living (Biehal *et al*, 1995; Mendes & Moslehuddin, 2004; Stein, 2012). A review of the research literature over the past twenty-five years in the United Kingdom, Australia, New Zealand, North America and Western Europe challenges any sweeping claims that institutional care is, without

exception, damaging to children. The evidence more accurately shows that particular children and young people are vulnerable, especially very young children and those with disabilities. Residential group living is highly indicated for young people involved in education, for the care and education of youthful war refugees, and for youths preparing to leave care. Major advances in the field of residential child and youth care have seen enhanced use of evidence-based practices and a heightened importance of outcomes-based research (Ward, 2006; Cameron & McGinn, 2009; United Nations, 2010; Davidson *et al*, 2016; Smith, Cameron & Reimer, 2017).

Middle East and Asia Perspectives on Residential Child and Youth Care

Contributors from across the Middle East and Asia Region have highlighted a variety of ways in which residential child and youth care is provided there to support children, young people and families during times of turmoil. Readers are offered glimpses of what child protection and child care looks like in this region, starting with Turkey, then moving south to Lebanon, Palestine, Israel, Jordan, Saudi Arabia, Yemen, Kurdistan Iraq and Iran. Kinship care was the dominant influence during the Ottoman period, but residential homes and orphanages are now stretched to capacity in most of these countries, especially Yemen, where warfare has raged between Iran-backed Houthi Tribesmen and Saudi-backed Yemen nationals. Kurdistan Iraq received limited regional autonomy after the Saddam Hussein regime used nerve gas to quell regional unrest. More recently, the US-backed Kurds helped to rid their lands of ISIS who as remnants of the Saddam Hussein regime had taken control of the northern Iraqi oil field and thousands of Syrian tribespeople were massacred. Iraqi government forces quickly resumed control of the northern oil fields in Kurdistan Iraq at the end of 2017.

The use of residential child and youth care also has a long history in South and East Asia in countries like India, Pakistan, Sri Lanka, Bangladesh, Hong Kong and Japan, and in Pacific Nations like the Philippines and Indonesia. Residential orphanages have operated in Japan since 500 AD, while Hong Kong and Malaysia embraced British residential child care practices historically. Some contributors from both large and small countries in the Asia-Pacific region were unable to obtain permission to publish, so had to withdraw. The large island nations of the Philippines and Indonesia were heavily influenced by religious education with the Catholic Church playing a key role in residential child and youth care in the Philippines and religious boarding schools or madrasah being very influential in the spread of Islam throughout the Indonesian islands and in southern Philippines. Care and education are not separate elements as found in Western countries. Instead, residential care with education is a major influence motivating parents to place their children in such centres, and where most of these children receive better educational opportunities than had they stayed at home with family or extended family.

Questions for Small Group Discussion or Guided Reflection

1. *At the end of World War I, the new League of Nations established a mandate system under Article 22 of the League of Nations Covenant drafted by the victors to administer territories which after the war were no longer ruled by their previous sovereign. Their peoples were not considered "able to stand by themselves under the strenuous conditions of the modern world" calling for such people's tutelage to be "entrusted to advanced nations who by reason of their resources, their experience or their geographical position can best undertake this responsibility".* How might you explain to local people that they are not considered "*able to stand by themselves*" and needed "*tutelage from advanced nations capable of undertaking such responsibilities*"?

2. *When oil and gas reserves were discovered, none of the Middle Eastern countries represented in this volume formally existed. Lines drawn on maps in Europe failed to take account of tribal, religious and cultural traditions that operated in Mesopotamia for centuries prior to the new post-Ottoman maps being drawn.* What tribal, religious and cultural traditions were influential in shaping child and youth care practices in different countries across the Middle East?

3. *Since 1947, nation-building for the state of Israel following the British Mandate has come at a cost for Palestinian peoples who lived in the region throughout the diaspora of peoples of the Kingdoms of Israel and Judah that started as early as the 8th to the 6th Centuries BC with the Assyrian and Babylonian exiles*? What did the Old Testament Prophets have to say about the children of Israel and Judah being cast out of The Promised Land?

4. *Refugee children and families are still living in camps established more than a half century ago following the British Mandate for Palestine. The UN Refugee Camps established for Palestinian peoples in Jordan, Lebanon and the Palestinian territories since 1947 still care for up to 2.5 million people.* What must it be like growing up in a Refugee Camp where your people have lived since 1947?

5. *All is fate. In Southeast Asia, adults may commonly assume that the child, born out of need or pleasure, has a future of fate. If good happens to them that is because they are good. If evil occurs and they become possessed in its influence that is assumed they have done something bad in a previous existence that is negatively affecting their path toward the state of perfection*? To what extent might this ancient cultural tradition around fate conflict with the ways in which the United Nations Convention on the Rights of the Child views children?

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Residential Child and Youth Care in Turkey

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Abstract

A brief overview of population dynamics in Turkey is offered showing how almost one third of the population are children under the age of 18. Then, an historical overview is provided to explain how the child protection system has developed in Turkey. Family-oriented services now include social and economic support services, the adoption service, foster family services as well as different types of residential care services. Child support services for young people involved in crime are also outlined. Circumstances facing unaccompanied asylum-seeking children arriving in Turkey are summarised.

Introduction

Children are entitled to enjoy their rights – basic health, welfare and education; rights associated with spare time, cultural activities, along with civil rights and freedom. Turkey signed the UN's *Convention on the Rights of the Child* on 14 October 1990. With this, the responsibility for protecting children from dangerous

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and harmful situations and avoiding risks was assigned to the government (Söğütlü & Keçe, 2014: p.7). At the end of 2014, the population of Turkey was 77,695,904, of whom 22,838,482 were children. According to the United Nations definition, children between the ages of 0-17 made up 29.4% of the general population, with 4 out of 5 being under the age of 14 years (82.7%).

Reasons for children requiring State help include poverty, parental issues, violence, physical and mental inabilities of parents, death of mother, father or both, neglect, abuse, adolescent marriages, and abandonment because of a birth outside marriage. In these conditions, staying with the family can cause important risks for children and also for the public (FSPM, 2014: p. 72). In Turkey, the reasons for protecting children include:

- economic and social problems (69.5%);
- abandonment by parents (33.4%);
- mother or father incarcerated (21.2%);
- sexual abuse and other abusive treatment within or outside of the family (7.7%);
- children rejected by step-mother or step-father, natural disasters or terror (6.6%);
- death of mother or father (5.7%); and
- parents' physical and emotional abuse (1.5%).

The most important reasons for protecting children are family financial difficulties, abandonment (generally considered as unwanted births outside marriage) and parental abuse (Yazıcı, 2012: p. 515). Identifying the reasons children are taken into care is very important for the development of policies and practices concerning child protection and care. For example, if the family is unable to take care of the child because of poverty, it is important to tackle the causes of the poverty.

This chapter first examines the basic characteristics of services for children in need of care and protection in Turkey and then briefly outlines the historical background of child protection services there. In Turkey, services for children in need of care and protection basically depend on two models: a family-oriented services model and an institution-based child services model. Different practices in both models are summarised, offering a review of services currently operating in Turkey.

Historical Development of the Child Protection System in Turkey

The very first child protection services began in Selçuk during the Ottoman era. However, the period of Tanzimat (when the Ottoman Empire was radically reformed beginning in 1839) is generally accepted as the time when traditional

methods and traditional child policies started to change. In Turkey, the most important reasons why social policies and protection systems started later than in Europe relate to the later development of industrialisation in Turkey. Powerful social support systems like family and neighbours have continued to exist and also been influential in this period of delay (Salim, 2011: p. 33). During the Ottoman rule, however, one can see the beginnings of policies to protect children in the modern sense. For example, institutions were established that provided supervision and care to children whose family members had died in wars during the 19th century. The migrations that happened towards the end of the Ottoman Empire also had a major effect on these policies. Institutions were founded in order to protect orphan children and help them find employment as well as keeping them away from crime. Furthermore, non-Muslim and Muslim children received education together in this system (Koç, 2007, cited in Salim, 2011: p. 45). In 1917, the Istanbul Himay-ı Etfal Community was founded to protect children whose families had died or were severely wounded in one of the wars. The opening of the first children's home occurred in 1917 in Firz Ağa. The institution was basically founded to undertake the medical examination and treatment of children as well as providing protection services. In 1923 food aid was given to children, in 1924 free and paid milk aid, in 1926 education aid, in 1928 children's play parks were opened, in 1929 dental examination and dental treatment services began. In the same year – 1929 – the School of Child Care was opened (Çavuşoğlu, 2009). In 1925 the Atatürk Child Nursery opened; and in 1935 Himay-ı Etfal Community's name was changed to become a Children Protection Institution and the institution became an association for public benefit in 1937. At the top of children's care services, there are child nurseries. Atatürk Child Nursery, for example, built in 1925 in Ankara, has provided a boarding service for many children. In 1983, this service became the responsibility of the Social Policies Ministry. In addition, this Ministry assumed responsibility for providing social services to old people, handicapped people, families and young people as well as becoming responsible for developing and providing public policies to these areas.

Child Protection Law Number 5395 marked a very important milestone in the provision of basic services to children and young people. Previously, the term "indigence of protection" had been used in Law Number 2828; now the term for a child "in need of protection" has come into use. Focusing on children's rights and their value in the understanding of social services, instead of the term 'indigent' was an important paradigm shift indeed (Söğütlü & Keçe, 2014: p7). In the earlier context, all children were placed in the protection area including children who came into conflict with the law as well as those who were at risk.

Until recently, children in need of protection mostly stayed in nurseries or orphanages depending upon their ages. Similarly, in the scope of Turkey's children protection policies, children in need are placed in "institutions" but these practices were seen by experts to have many negative impacts upon children. The result of one particular survey supported these observations. Out of date barracks-style

institutions started to be abandoned and priority was given to practices that let children stay with their families as much as possible. Contemporary child policies primarily support children's families or relatives with financial and in-kind aid; the intention being to encourage families to continue caring for their children. In circumstances where this is not possible, it is now preferable to place children within a foster family or organise their adoption. If none of these options is possible, institutional care is another option for protecting such children. After years of criticism, beginning in 2005, institutional care homes started to be known as "Children's Homes" or "Love Houses" instead of child nurseries and orphanages (Söğütlü & Keçe, 2014: p. 8).

As this new understanding of child protection became accepted, it created important opportunities for change, including the physical structure of care homes and the development of more child-centred policies. In 2011, a new ministry called the Family and Social Policies Ministry was founded in Turkey. The work of foundations like Social Services, the Child Protection Institution and other institutions that had provided social services and social assistance continued their activities together in the new Ministry of Family and Social Policies. A new Child Services Head Office was founded within the new ministry specifically to serve children. Activities and policies for children in need of care and protection in Turkey are now carried out by this Child Services Office which is part of the Family and Social Policies Ministry. Now practices and policies for children in need of care and protection are carried out by the Child Services Department. The child protection system, as a service, is mostly provided by governmental departments in Turkey. The number of non-governmental organisations and private groups which work in this area is very low (Söğütlü & Keçe, 2014: p. 8). The main focus of the child protection system includes family-oriented care, improving foster family services and ensuring rights-based, protective-preventive practices for all children. Historically, child protection was provided by various voluntary or charitable associations and foundations frequently of a religious nature. In the Republic era, the fragmented structure of the past has evolved into one integrated foundation.

Services for the Children in Need of Care and Protection

In Turkey, services provided for children in need of care and protection generally fall into two categories: family-oriented or institution-based services. The main policy of the Child Services Head Office is, if it is at all possible, to let children take advantage of family-oriented services rather than have children placed in governmental institutions. Family-oriented service models include social and economic support services, the adoption service and foster family service. The primary aim for children who are under the care of institutions is to have them return to their parents, adoption service, or protective family service but in circumstances where these options are not possible, to help children take advantage of the institutions.

Family-Oriented Services

Social and Economic Support Services

Social and economic support is offered as family-oriented services to parents experiencing difficulties looking after their children because of poverty. This service is offered on the understanding that the most appropriate environment for looking after these children is with their own parents. The family-oriented support practices provide targeted social assistance with the aim of strengthening economic and social supports for these children to help maintain contact with birth parents. The most important of social and economic support functions involves protecting the unity of the family and ensuring that a child stays with its parents. In 2014, 58,182 children were provided with social and economic services without requiring institutional care (Table 1). Families can request that their children be placed under a protection order by applying to the appropriate governmental establishments.

Table 1
Number of People Who Take Advantage of Social and Financial Supports Service by Education Groups (November 2014)

Support Group	Number	Percentage
Children in Preschool	10,462	17.98
Children in Elementary School	38,161	65.59
Children in Secondary Education	8,241	14.16
Children go to the School in Secondary Level	887	1.53
Children in Higher Education	110	0.19
Adults	321	0.55
Total	58,182	100.00

Source: (FSPM, 2014: 66)

If their request is based on economic problems, care of these children is provided as social help and other protective, preventive, supportive and formative services by the Child Services Head Office. Since 1986 these services have been provided by the Family and Social Policies Ministry through 81 provincial directorates, offered as an alternative to institutional care to people who are destitute and in need of protection. As of May 2015, there were 62,995 children's families or relatives supported with 582 Turkish Liras (US $ 210) per month for each child through a child protection decision (FSPM).

By the end of May 2015, economic support was provided at the rate of 582 TL per month for families or relatives with a protection decision for a total of

62,995 children (FSPM). These social and financial support services are greatly valued by families and children (FSPM, 2014). Neither the children nor their families want their children to return to institutional care. Targeted social and economic support services directed into families contribute positively to children's psychological progress as well as reducing family violence. Positive improvements were seen in children's education like attendance in school, academic success, desire to continue to higher education, and a decrease in the rate of school drop-outs. Generally, children feel safe within their family. However, not all families consider this support to be wholly positive. According to the findings of the study, some families find the aid inadequate; children become distanced from social and cultural activities; and the houses that some children live in are in a bad state (FSPM, 2014: p. 177). Still, despite all that, children generally do better staying with their families than staying in an institution.

Adoption Service

The next family-oriented service is the adoption service offered to children who are unable to live with their biological parents and need long-term care. It differs from the Foster Family Service in that adoption is covered by the legal and regulatory rules of Turkey. In the past and as today, many families who do not have their own children adopt children of closely-related blood relatives (like siblings and cousins) as if they were their own children. The families which give their children up for adoption are frequently poor, who have had children they didn't want, or they already have more children than they can look after (Salim, 2011: p. 93). Adoption is a relationship that is covered by court order under the Turkish Civil Code Number 4721. Adoption means that children whose parents are unknown and cannot be cared for by their own parents become a full member of another family. The child officially enters the care of the adopted family, takes their surname and becomes an heir (Yazıcı, 2014: p. 251). According to the Child Services Directorship, it is estimated that approximately 700 children are adopted each year (FSPM). When the adoption system is compared with the care in an institution, the standard of care offered by the family is generally far superior, particularly when considering that it is continuous, long lasting and provides much better protection of the child and her/his welfare.

Foster Family Service

The foster family service began as a protective measure for children in need of protection in Turkey in 1947. In 1983, this law was replaced by The Law of Social Services and Child Protection Institution (Number 2828) and the foster family service was accepted for children in need of protection. After the Family and Social Policies Ministry was founded, practices which brought improvements to the foster family service were officially accepted in 2012 (Yazıcı, 2014: p. 253). In the Child's Rights Contract dated September 2, 1990, the importance of trying

to keep children with their parents was emphasised. Where this is not possible, attempts should be made to let the child live in an environment of an appropriate family. With this contract signed by Turkey, the foster family service gained more importance. The children placed in foster families have been assessed as being in need of protection but whose families are unable to care for them – at least in the short term. These children also cannot be adopted because of various reasons; they can be of either gender; healthy or handicapped; be an only child or have siblings; and are determined appropriate to be placed within a foster family by a Social Worker (FSPM).

People who want to be a foster family must have a Certificate of Foster Family by taking the basic parenthood training, as well as the first and the second level education. The basic family training provides people with the basic skills required of parenthood. First level training provides training about raising children outside his/her own environment, in an environment of another family. Second level training provides foster families with instruction in how to assist children in need of care and have special challenges. People who complete the training are awarded with the "Foster Family Training Certificate of Participation". Additionally, if the families want, their insurances may be paid by the government, an incentive aimed at increasing the number of foster families (Yazıcı, 2014: pp. 253-254). Anyone who wishes to be a foster parent is required to be a citizen of the Turkish Republic and living in Turkey, between the ages of 25-65, be a primary school graduate, and have a steady income. A sum of money is paid monthly to foster families for the children in their care and is designed to cover meals, education, clothing, school bus fares and other primary needs. For children with special needs who require special care, the monthly payment is increased by 50%. Psychological and psychiatric services are provided to foster families and their children by experts who work at related university departments (FSPM).

A Voluntary Family Service also exists to assist children in institutions. These families visit the children in an institution and contribute their own skills, interests, abilities and education to assist staff and children in the institution. The families may also help by hosting children in their own homes during the weekends or on public holidays and on special days (FSPM). As with family foster care, this service is aimed at providing additional supports to children at a troubled and complex time of their lives.

Foster Care with Relatives and Close Neighbours

This is a service provided by closely-related blood relatives, who interact with the child and are known by the child, or someone who lives nearby like neighbours, or persons or families who have completed the parenthood training course (FSPM).

Temporary Foster Care

Temporary foster care is used, for example, in an emergency when a child is in need an urgent placement, or a service plan has not yet been formed for the child and has not yet been placed in residential care or is unable to take advantage of the service planned for him/her – for various reasons. Temporary foster care lasts for a brief period, between a few days to a maximum stay of a month. Such care is provided by professional persons or families who have completed the parent training course, first level foster family training as well as second level foster family training (FSPM).

Time-Limited Foster Care

Time-limited foster care is used for children who are unable to return to their own families, or for children who cannot be placed within a permanent family. Preferably, this is provided by persons or families who have taken the basic parenthood training and the first level foster family education for children in need of care (FSPM).

Specialist Foster Care

Specialist foster care services are provided for children who have special difficulties and needs. People who provide this care must be a primary school graduate and have completed the parenthood education course as well as first and second degrees of foster family education (FSPM).

In 2014, there were 1046 children in foster care, a total that increased to 4406 by July 2015. Foster care is an important and affirmative service because children's care is provided within a family. Living in a long-term placement where adults are not constantly changing provides foster children with considerably enhanced psychological and social support. Additionally, it is a system which provides greater opportunities for children to develop relationships based on trust between the child and the family (Şimşek & Erol, 2008; Şenocak, 2005 cited in Yazıcı, 2014: p. 264).

However, there are still risks associated with foster care. Many children placed with a foster family have experienced traumas and negatives issues resulting in distrust, feelings of self-reproach and communication difficulties. These may present challenges for foster families and may result in some children returning to institutional care. In some situations – like choosing an inappropriate family for the child or continuing dissension between birth family and foster family – living with a foster family may affect the child negatively (Karataş, 2008: p. 52, cited in Yazıcı, 2014: p. 265).

Institution-Based Care

If children are not placed with a foster or adoptive family, and do not receive social and economic supports, they are likely to be placed with the institutional care service. There are many types of institution, depending on sociological, economic

and cultural contexts. As well as large scale institutions, there are also units where eleven or more children of all ages live together. Institution types can be described as "open and closed", "barracks type", "school type" and "home type" (Şenocak, 2005: p. 95; Yazıcı, 2012: p. 507). Some children stay in big buildings and crowded dormitories together in barracks-style residential accommodation. There are insufficient employees who are managed through a central administration (Şimşek & Erol, 2008: p. 137; Yazıcı, 2012: p. 507). Barracks-style institutions depend on authoritarian structures largely because of the number of children living together. Although this system continues to exist, there have been some changes to ensure that fewer children share a room. Table 2 outlines the number of institution types, the occupancy capacity of each, and the number of children accommodated in the institutional service as at May 2014.

Table 2
Institutions Accommodating Placements for Children in May 2014

Type of Institution	Number	Capacity	Number of Children
Children's Homes (0-18)	959	5,566	4963
Child Nurseries and Girl Orphanages (0-18)	8	799	506
Child Nurseries (0-12)	19	1,412	764
Boy Orphanages (13-18)	26	1,702	913
Boy Orphanages (unaccompanied-refugees) (13-18)	3	118	63
Girl Orphanages (13-18)	3	180	102
Girl Orphanages unaccompanied-refugees) (13-18)	1	30	7
Family Group Homes or Love Houses	68	5,416	4147
Total	1,087	15,223	11,465

Child Nurseries

Child Nurseries are broadly speaking social service departments that care for children between the ages of 0-12 with the aim of helping them develop a healthy personality, providing them with physical, educational, psychological and social supports. Child Nurseries are separated into two age groups: 0-6 and 7-12. Table 2 outlines the number of children who stayed in child nurseries as at May 2014 (FSPM).

Orphanages

Historically orphanages were the first and oldest method of caring for children in Turkey. They are, broadly speaking, social service foundations for children and young people between the ages of 13 and 18. They are responsible for providing protection and care, helping them find jobs, and generally helping to raise them as good citizens. In 2001, a total of 9,006 children were cared for in 96 orphanages; by 2009 this had increased to a total of 10,000 (Salim, 2011: p. 99). However, when the data of 2014 was reviewed, it could be seen that the number of children staying at orphanages has started to decrease (Table 2).

Children's Homes Sites

A Children's Home Site or complex is a place where care is provided with buildings created to resemble a family environment and with small detached buildings where children can receive care through relationships with consistent staff. According to data taken from the Ministry, this service is given to 4610 children in 77 Children's Home Sites (FSPM).

Children's Homes

Children's Homes represent a new care model where 6 children live together in small, community-based family group homes developed as an alternative to collective institutional care. By creating a home environment for 6 children between the ages of 0-18 there is a considerable improvement in their physical, social and psychological progress. These homes have become widespread since 2005.

The first pilot study of children's homes was implemented in Ankara and, after a successful trial, many more started up in all the provinces. The locations of each of these Children's Homes were carefully chosen in all provinces, commonly in urban centres, and located near schools and hospitals so that children have the greatest opportunities to develop socially, culturally and physically. The houses are designed to fit in with other buildings in the area. When looked at from the outside, it is important that they are built to be similar to other public housing in the area to make sure that the children are not stigmatised. Each home has a foster mother who takes care of that particular group. Surveys reveal that this model is a more successful practice than others (Başer, 2013; Yaşar & Dağdelen 2013).

The positive features in Turkey's Children's Homes include the reduced number of children, with care staff being more personally involved and who do not change frequently – important for children's personal development and feelings of trust. People who have stayed at Children's Homes have jobs, places to work and marriage financial assistance for girls. Children experience less stigmatisation because they have a home, they can invite their friends from school or from work and live in a neighbourhood where they can feel they belong and feel they are fully involved members of society. Life experiences received in the Children's Homes can be applied to their next stage of life, when the protection is gone, and this

provides real advantages to the children. Young people develop confidence and the courage to live by themselves. Siblings can live together in the children's homes, so that self-esteem, personal confidence, and feelings of togetherness can improve easily. In the older orphanages, where so many people live so closely together, it is very hard to achieve all of these. Educational achievements and university entrance amongst those who have stayed in Children's Homes is better than the achievements obtained by children who stayed in orphanages (Yazıcı, 2012: p. 513).

Children's Homes do, however, include some negative aspects. Occasionally, some children selected to be raised in Children's Homes can cause real problems. If children have lived on the streets for any period, they may start playing truant from dormitories, and become bad examples to other children in the home. Another negative aspect is the possibility that a caregiver may present unacceptable behaviour, and may abuse, hit or otherwise inflict violence on the children. Such incidents were reported in the press during the first years of the new Children's Homes. Moving or changing care staff can also have very negative effects, particularly on children younger than the age of 3 years. Furthermore, when monthly wages for care personnel are low, this can negatively impact on staff motivation (Yazıcı, 2012: p. 514).

Findings from a study entitled *"A Study for the Socio-cultural and Psychological Improvements on Children of Passing from the Child Orphanages to Children's Homes to Raising Children in Indigence of Protection: The Case of Isparta"* carried out by Yaşar and Dağdelen (2013) show that the situations of children who stay in children's homes are better than those from orphanages. Firstly, the survey sought to discover if there was a meaningful connection between the places where children lived and their happiness, anxiety levels, and psychological circumstances. According to the data, children and the young people who stayed in the smaller children's homes felt happier, worried less often and rarely suffered from sleeplessness. In addition, the resilience of children from children's homes was stronger, so that they dealt with challenges more easily. One research focus that was specifically examined was the quality of children's social relations. When siblings live together in the same home or meet up frequently with one another, their relationships are much closer and healthier. Rates of addiction to cigarettes, alcohol and substance abuse after growing up in a children's home were also compared with youths who stayed in orphanages, with lower rates found amongst youths who stayed in children's homes. Interestingly, the youths with the highest levels of substance addiction were girls who stayed at the female orphanages. This study concluded that most of the children who have trouble do so because of not living with their families. The smaller children's homes were evaluated as a service that provides children with considerable opportunities for progress (Yaşar & Dağdelen, 2013: pp. 219-220).

Child Support Centres

Child Support Centres are specifically designed for children who are victims of crime, perhaps trafficked into crime or someone living on the streets and at risk.

In Child Support Centres, the aim is to help children turn their lives around and to purposefully integrate them back into society. It aims to meet these children's basic needs, to intervene where necessary by determining the physical, emotional, psychological and social needs of the children with a view to eventually returning to their families, or kinship care environments and foster care (FSPM). Child Support Centres include villa-type living units on a campus, places where young people can work and take up occupations, use open and closed playing fields, hobby gardens, animal shelters, training studios, therapy rooms and interviewing rooms. These centres have the capacity to serve 40 young people living in villa-type houses each built for 10 children, incorporating single and triple rooms. Activities and placement of the children are carried out according to each child's situation, whether involving victimisation, delinquency, living on the streets, maternity, substance addiction, by age groups (11-14 ages / 15-18 ages) and gender in these centres. Children taken under protection and care orders under the age of 11 are commonly placed in family foster care or from Children's Homes and Child's homes sites. A total of 1,116 children stay in Child Support Centres (FSPM).

Child Support Centres for Young People involved in Crime

These are for children who have been investigated and charged with committing a criminal act and have needed psychological and social assistance. (FSPM).

Child Support Centres for Child Victims of Crime

These are for children who are victims of an act defined as a crime committed against them, including children for whom care decisions have been taken, as well as children detected as needing psychological and social help (FSPM).

Child Support Centres for Children Who Live on the Streets

These are for children who have less – or no – contact with their families, were kicked out of their home, or who ran away from home and now spend all their time on the streets, getting all or most of needs met there, and who need psychological and social assistance (FSPM).

Child Support Centres for Unaccompanied Refugee Children

In Turkey, services for unaccompanied children who come by a migratory route and seek international protection under the Child Protection Law Number 5395 are managed by the appropriate court. This is particularly true with regard to care and sheltering services for unaccompanied children who escape from Syria, seeking refuge and shelter in Turkey under the statute of "temporary protection" for people with special needs (FSPM).

Child Support Centres for Pregnant Children and Child Mothers

Child Support Centres also provide services to pregnant children in need of protection and child mothers, partly so that they can stay with their babies, and partly so that the basic needs of pregnant children and child mothers are met. After the court allows children to be accepted into a centre, all necessary security and health precautions are taken. Pregnant children can stay in the centres so that the relationship between the child mother and their baby can grow. This period can be extended in line with mother and baby's requirements. The baby is registered in the civil registry and decisions are taken about the baby too. Pregnant children and child mothers with their babies younger than three years old can stay in the centres (FSPM).

Child Support Centres for Child Substance Users

CSC also offers services for volatile and drug-addicted children. These children are accepted into centres with the purpose of helping them re-unite with their families and their social environment (FSPM).

Care for Unaccompanied Asylum-Seeking Youths

Although there is no official data on the exact number of unaccompanied minors in Turkey, according to General Directorate of Security data, 876 unaccompanied children have applied for asylum between 2005 and 2012 but, according to FSPM data, 428 children were to be placed with the institutional care service (Atasü-Topçuoğlu, 2012: p. 64).

Children, who enter the country, are faced with three choices:
1. Just as they enter the country through illegal means, they may try to remain invisible and transit to a European country as quickly as possible, again through illegal means.
2. They get registered by applying to the police or the United Nations High Commissioner's Office for Refugees (UNHCR) after reaching their target province (this is sometimes Van, the province through which the entries take place most frequently, and sometimes such major provinces as Istanbul, Ankara, or İzmir following entry into Turkey.
3. The unaccompanied children can be identified by law enforcement units and get registered.

Unaccompanied minors, whose applications are received, evaluated, and the asylum process is started by the Turkish security units and UNHCR
1. Are kept in organisations affiliated to Ministry of Family and Social Policies and the application for asylum and processes about the child begin here. One of the initial actions taken in the meantime is the taking of the child into "care" through a decision of the court.

2. The child, whose process has been initiated and whose application has been accepted, is placed in a care institution in one of the satellite towns.

Unaccompanied children are taken into care and protection in these orphanages until they reach the age of 18. Unaccompanied minors sometimes leave without permission from the organisations where they were placed and travel to other cities like Istanbul or Ankara, work there and contact their acquaintances. While some of these children return, or are apprehended and surrendered to these organisations, may continue to live as illegal immigrants. Some of these children then leave the country and transit to other countries through illegal means (Karataş et al, 2014).

Unaccompanied children arrive in Turkey for the following reasons (Karataş *et al,* 2014: p. 53):

- civil wars, armed conflicts, or lack of security of life in their countries of origin;
- running away from becoming a child soldier;
- parents killed in their country of origin;
- political, religious, or sectarian pressures;
- poverty and young people trying to find a way to improve their circumstances;
- the positive image of Turkey where they think they will find better living conditions;
- finding a job: they think that migrants can find a job and save money;
- education since unaccompanied children think that they can receive education in Turkey, which is not possible in their home countries;
- those with health problems come for treatment; and
- some came to transit into Europe.

Daily Lives of Unaccompanied Children Staying in Institutions (Karataş et al, 2014)

The daily lives of children staying in these institutions are generally arranged in such a way that they wake up altogether in the morning, have breakfast, have some leisure time, have lunch, take an afternoon nap, have dinner, and sleep. The children do not go to school and there are generally no continuous activities. The organizations that were visited have football fields, table tennis, and gymnasiums and the children can use these facilities whenever they wish during the day.

"Almost all of them experience psychological timidity." *(Organization Personnel, SHU, Ankara)*

"I am about to burst because of keeping everything inside. You cannot trust anyone. You tell your secret one day and they make it public the next day." *(Unaccompanied minor, Female, 16).*

"The language problem is valid both for them and for us. We experience problems about the support of the Directorate of Security. I have never seen any Somali child coming with an interpreter to the Ataturk Orphanage." *(Organization Personnel, Ankara).*

Conclusion

Care and protection services for vulnerable children in Turkey need to include the following features in care planning:

- supporting the child within its own family or with relatives wherever possible, in its own city and district;
- providing family-oriented care through adoption;
- offering care within a foster family; and
- placing the child in an institution when taking care of the child within a family is unfavourable or not possible.

Supporting children socially and financially within their own families is arguably the most effective way of providing care and protection for children. Research also shows that supporting children when they stay with their families is more influential than institutional care.

The "Support within Family and Returning to the Family Project" carried out in 2005, showed that the number of children who stay in institutions has decreased. In recent years, the crowded barracks-type living arrangements have started to be abandoned in Turkey. Detached houses have begun to be built for children. Single beds are now provided instead of the bunk beds formerly used in crowded orphanages. The capacity of buildings where children stay has been reduced; institutions that used to accommodate at least 10-15 children in one room have been transformed into a home where 1-3 children stay together. Contemporary furnishings are used to create a warm and comforting place, wardrobes, personal material and mirrors are provided and children can feel that they really belong. In this way, residential care centres have been transformed, reorganised and divided into small groups, with units located near the children's home environments.

In the new homes, children must have opportunities to study, watch television and do different activities in their spare time. Playing fields, grassy areas, sand pits,

basketball and soccer fields are also provided. In the provinces where winters are heavy, winter gardens are now built in which young people can spend time and play games. Children who are taken into care and protection are all different, like all other people in every walk of life. From the moment that a child is taken into care and protection until he or she leaves, many factors must be taken into consideration: the child's age, the reasons for being considered in need of protection, the length of time spent at the institution, the care model provided, the child's interests and abilities, and the nature of their relationship with their biological family.

Questions for Small Group Discussion or Guided Reflection

1. *At the end of 2014, the population of Turkey was 77,695,904 – 22,838,482 of whom were children. According to the United Nations definition, children between the ages of 0-17 made up 29.4% of the general population, with 4 out of 5 under the age of 14 years (82.7%).* How does this proportion of young children in Turkey's population compare with the number of children in the population where you live, and what challenges might this present to service planners and policy-makers?

2. *In Turkey, the most important reasons why social policies and protection systems started later than in Europe relate to the later development of industrialization in Turkey. Powerful social support systems like family and neighbours have continued to exist and also been influential in this period of delay.* To what extent might it be said that industrialisation has been a significant influence in the development of residential child and youth care services where you live?

3. *The most important reasons for protecting children in Turkey are family financial difficulties, abandonment (generally considered as unwanted births outside marriage) and parental abuse.* How might these reasons for care and protection intervention in Turkey compare with the reasons for foster care and residential child and youth care placements where you live?

4. *In Turkey, services which are given to children in need of care and protection generally fall into two categories: family-oriented or institution-based services.* In what ways might these two service categories explain how care and protection services for children are provided in <u>your</u> community?

5. *In Turkey, services for unaccompanied children who come by a migratory route and seek international protection under the Child Protection Law Number 5395 are managed by the appropriate court. This is particularly true with regard to care services for unaccompanied children who escape from Syria, seeking refuge and shelter in Turkey under the statute of "temporary protection" for people with special needs.* How might the care of unaccompanied asylum-seeking youths be 'managed' as immigrants where you live and work?

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Residential Child and Youth Care Practices in Lebanon

Ghada Jouny[1]

Abstract

This chapter outlines the conditions for children deprived of parental care in Lebanon, highlighting the extent and causes of this phenomenon. Forms of welfare along with policies and programmes offered to these children are considered, focusing on how they are influenced by community culture, legal frameworks, local legislations, and international conventions. External care involving support services directed into families and day care are highlighted although internal care involving institutional placements are by far the most common response. Questions are posed concerning the role taken by the Lebanese government and community agencies towards these children, given how Lebanon was an early signatory to the UN Convention on the Rights of the Child.

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Introduction

Residential care institutions in Lebanon date, for the most part, from the mid- to late-Nineteenth century (MoSA & UNICEF, 2007: p. 8). The number of private institutions has increased in recent times for several reasons, including the failure by the State to assume child welfare responsibilities, different religious authorities undertaking social work and welfare, and the current social conditions in Lebanon that lead to establishing care and protection agencies (MoSA & UNICEF, 2007: p. 8). The principal causes for increasing numbers of child and family welfare agencies and the children benefitting from the services they provide is poverty and delays with post-civil war re-construction.

With the expanding role and importance of charitable organisations in society, the Ottoman Empire found itself obliged to issue a law defining and specifying the goals of these organisations. The Law on Non-Governmental Organisations was issued on August 3, 1909 and that law is still in force, albeit with some amendments during the French Mandate and complementary legislation enacted following Independence. These non-governmental organisations are not licensed as residential welfare facilities, only as community organisations registered with the Ministry of Interior.

The Law on Non-Governmental Organisations does not specify any standards related to caring for children and providing them with shelter, despite multiple dangers associated with caring for a child. Establishing specific standards to protect these children as well as the institutions caring for them, however, is indispensible. The Law on Non-Governmental Organisations reflects the absence of legislative efforts to establish standards for services provided by non-governmental organisations, thereby enforcing traditional attitudes toward social welfare.

Since the Ottoman law of 1909, the State has not issued any new laws that consider the various services offered, officially recognising that some institutions may operate beyond public interests or in breach of the UN Convention on the Rights of the Child. This is even though in Lebanon, the term "non-profit" is ambiguous and poorly classified compared with contemporary international expectations about 'not-for-profit' and non-governmental organisations (NGOs) elsewhere. In Lebanon, the State and NGOs share nothing more than a business relationship wherein the latter offer services in exchange for specific sums of money, as with the relationship between parties in joint contracts. Such an arrangement highlights the absence of an actual partnership between the governmental sector and its civil counterpart in planning for and making decisions pertaining to society.

Until 1995, NGOs operated without supervision by the State or any ministry evaluating their performance. NGOs were only required to submit the minutes of the election meetings of their administrative bodies to the Ministry of Interior, and in some cases, their annual budgets. This mode of operation, surprisingly common, has resulted in an increase in the number of children placed in welfare institutions.

It is worth noting that many of these institutions are contractual parties with the Ministry of Social Affairs and receive financial support for every child in their care. This helps to explain the increase in child welfare institutions, and subsequently the increase in the number of children benefitting from this particular form of welfare, at the expense of the other alternative care options that might be considered.

The table below highlights the increasing numbers of children receiving aid between 1997 and 2010 (Ministry of Social Affairs of Lebanon, 2010), distinguishing between orphans and social care services they receive within the institution. The data shows an increase in the number of orphans and social cases between 2001 and 2010, even though Lebanon has not in recent times experienced wars, financial crises or natural disasters. The proportion of child social cases has been increasing while the number of orphans has decreased.

Year	Orphans		Social Cases		Grand Total	
	Numbers	%	Numbers	%	Numbers	%
2001	1377	14.19	8,323	85.81	9,700	100
2002	1245	12.73	8,530	87.27	9,775	100
2003	1296	11.68	9,796	88.32	11,092	100
2004	1242	11.00	10,004	89.00	11,246	100
2005	1013	9.00	9,430	90.30	10,443	100
2006	840	9.14	9,186	90.86	10,026	100
2007	1051	10.32	10,176	89.68	11,227	100
2008	939	10.32	9,098	89.68	10,037	100
2009	No data collected during this year					
2010	986	10.21	9,748	89.79	10,634	100

The need for support of children at risk is generally caused by the separation of the parents, sickness or incarceration of one of the parents, or insufficient financial means to satisfy the family's needs. At first glance, one might ask whether it may be possible for some budgeted funding that supports institutional programmes to be diverted towards caring for these children within their own families or extended family networks. It has become reasonably clear that poverty is the primary cause of children being abandoned in the Lebanon, particularly in families where a single mother is the head of household. Such situations are further

exacerbated when poverty is coupled with an absence of basic services and social protection policies. In such cases, families with children deprived of basic services and their right to education find themselves seeking assistance from welfare institutions to help fulfil basic child care needs, including education. At the same time, there are financial incentives for welfare institutions in the Lebanon to receive placements since they receive a quota of income for every child placed in these care and education centres.

Residential Care Institutions in Lebanon

Our focus in this chapter is on large institutions, those in which the number of children exceeds 200. One or two institutions in the same province as cited in the lists of the Ministry of Social Affairs are examined in what follows. Information was also retrieved about the institutions from the media, along with personal visits to each institution to meet the people in charge.

Dar al-Aytam al-Islamiyya

In the wake of the tragic repercussions of World War I, a small orphanage, then called "*al-Maytam al-Islami* (The Islamic Orphanage)", was established in Beirut in 1917. From this orphanage began the development of what is known today as "*Dar al-Aytam al-Islamiyya* (The Islamic Home for Orphaned Children)", under which are subsumed about 39 welfare institutions in sixteen areas of Beirut and other regions of the country.

Considering the variety of institutions and services available, attention here is limited to those providing care for deprived children. "*Dar al-Hadanah* (Nursery)" receives new-born babies and provides them with all the necessary care and attention. As a child gets a little older, s/he goes to "*Dar al-Tofoulah* (House of Childhood)", a unisex institution housing seven to ten-year-old orphans or children living away from their parents by force of circumstances. It is worth noting that this home often receives children who have not had the opportunity to enrol in school. Thus, an educational initiative was started in 1967 through "*al-Saf al-Nashit* (The Active Classroom)", attending to the educational needs of ordinary children rejected by regular schools. *Dar al- Aytam al- Islamiyya* has also been receiving foundlings or abandoned children from the State authorities since 1945. Their number has increased through the years, and these children receive care and education until they become independent – when the females get married and the males start working.

In 1967, because of this increase in the number of foundlings, the institutions established networks of sponsorship that complies with both Islamic law and current national laws. Thus, children with no family member to support them may become part of a 'sponsoring' family, which is comprised of a husband and wife, resident in Lebanon and able to provide for and raise the child. After the sponsorship application is submitted, the institution conducts social investigations

and prepares a comprehensive dossier. Later, an *ad hoc* committee convenes to examine the application thoroughly and either accepts or rejects it. The committee's recommendation is then submitted to the body responsible for making the final decision.

The children of "*Dar al- Aytam al- Islamiyya*" pursue their studies in the surrounding public schools. Initially, children were restricted to a specific number of public schools but, in the interest of wider social integration, these children are now enrolled in many different public schools surrounding the institution, with no more than eight children in any classroom from the institution.

Beit al-Yateem al-Derzi (The Druze Orphanage)

Beit al-Yateem is a non-profit, social philanthropic institution founded at Abey by the late Arif al-Nakadi with the assistance of the Social Welfare Service http://www.druze-orphanage.org/ In 1968, after receiving financial contributions from donors and foundations in Lebanon and abroad, and working in cooperation with the Social Welfare Service, the institution took possession of the main building, a new school building, an administration building and three separate buildings for housing the children. The institution provides care and accommodation for around 900 orphans and socially challenging children ranging in age from 3 to 21 years.

Al-Mabarrat Association

Al-Mabarrat Association was founded by the late scholar Sayyed Mohammad Hussein Fadlullah in 1978, with institutions now spread across the whole of Lebanon (www.almabarrat.org). When first established, the Association aimed to care for orphans who had lost one or both parents due to the civil war. However, *Al-Mabarrat's* work continued to develop and has grown to include children's educational and cultural welfare as well. In addition to the orphanages, this Association has opened many schools throughout Lebanon, from kindergartens to secondary schools, providing education for literally thousands of young people.

The Association mainly houses orphaned children, in addition to very limited numbers of children suffering from socially difficult conditions, and provide care for children in two forms:

- Internal: for orphans whose families lack the nurturing, cultural, and social capabilities to care for their children, making them eligible for enrolment in the institutions' internal section.
- External: for orphans whose mothers demonstrate basic capacity for providing for the daily living requirements of their child(ren), their nurturing, and social circumstances that enable them to take care of their children. In such cases, the children remain with their families and are supervised there by professionals.

Children who live away from their families live in units of ten to fourteen children of the same sex (the only exception to this being in the nurseries) and of approximately the same age. A male or female caretaker supervises the children and implements a pedagogical programme aimed at teaching them basic life skills, as well as social, cultural, and religious skills.

The Lebanese Maronite Order

The orphanage of the Lebanese Maronite Order was established in 1922 in Mayfouq. It houses children from ages 4 to 15 years. The internal section is limited to boys who live in very large groups of forty to fifty, each supervised by a superintendent. According to the director, superintendents are responsible for overseeing all aspects of study, entertainment, nutrition, and education. The younger children are supervised by a caretaker who tends to their needs. Most of these children suffer from difficult social conditions within their families. The school welcomes students from all over the region and its education is not limited to the children receiving support from the welfare department.

Lebanese Association of SOS Children's Villages

SOS Children's Villages were established in the 1960s, the first established in Southeast Beirut near Mount Lebanon in 1969. Today, SOS Children's Villages provide care for children in four different villages, for children in need care for one of four reasons: (i) if a child is illegitimate or born out of wedlock; (ii) if one of the child's parents has died; (iii) if one of the child's parents is incarcerated; or (iv) if their parents have divorced.

Every village contains several separate houses with each house having a female caregiver who assumes the role of a mother, while the father figure is the village director who lives in a separate house in the village with his 'real' family (wife and children). Every house consists of a family group of six to eight children of different ages organised to resemble — as much as possible — the care provided within an ordinary family. Children may be admitted into the village from the day they are born up till fifteen years of age and attend regular schools. After reaching the age of fifteen, the children move to Youth Homes where males and females live separately and where they can stay until the age of eighteen. Later, they are expected to lead a semi-independent life, with the Village providing them with a residence outside its grounds. Until then, independence is only partial, in that young people continue to receive support until they are financially and emotionally independent.

The population of the SOS Villages and Youth Homes is currently around four hundred children. A "Prevention of Child Abandonment Programme" is also operated by SOS Children's Villages which aids poor families at risk of abandoning their children. The programme offers emergency financial assistance that may cover school, medical and nutritional expenses, supporting families to keep their children within their own family networks.

In summary, the following conclusions might be made about Lebanon's welfare system. All social welfare institutions in Lebanon are of a religious, partisan, or regional nature. However, even though none of the institutions has a policy prohibiting their receiving children of religious affiliations, parents commonly turn to the institution that they feel is most sympathetic to their own religious affiliations. Such claims are supported by the fact that all social welfare institutions have religious teaching and guidance programmes that comply with the religious background or the religious authority they follow. Children may be accommodated in one of two care arrangements. In the first arrangement, groups of ten to twelve children live together with a supervising carer who attends to their needs. In the second arrangement, very large groups – ranging from fifty or more children – are housed together under the supervision of a superintendent.

Many of the institutions considered in this chapter have their own schools. In some cases, these schools are only open to the children in the institution. Other institutions allow children from families living in the community to join their classes. A third possibility is where children of the institution pursue their studies in surrounding public schools, and in a few limited cases, in private schools. Most institutions hire female caretakers, but they do not specify the academic and personal requirements of the job. Other institutions have female caretakers for young children and male caretakers for older children. As previously mentioned, this task may be delegated to the superintendent, in which case, supervision is commonly restricted to administrative and general matters.

All the institutions, without exception, allow parents and guardians to visit their children and check on them during the week. However, many parents do not maintain contact with their children. Some institutions send the children home on a weekly or bi-weekly basis. In those cases where relatives or guardians do not come to pick them up, children are likely to stay at the institution for weeks on end. Some institutions offer entertainment programmes and activities on weekdays after the children finish their schoolwork, or during the children's stay on days off. Other institutions only offer educational services.

Some institutions try to keep brothers and sisters together, while others, by virtue of their procedures, do not allow for boys and girls to live together. None of the institutions considered in this chapter had a team of experts in either psychology or social work despite the dire need for such personnel. These children are in desperate need of support to overcome the problems they face at the scholastic, social, and psychological levels. The quality of services varies from one institution to another, but such is the level of confidentiality and control over information relating to these institutions, that it is impossible to draw any useful conclusions. This encouraged a closer examination of the extent to which Lebanese welfare institutions have implemented the conventions and laws that are currently in force.

The Reality of Lebanese Welfare and International Conventions Today

Lebanon signed the United Nations Convention on the Rights of the Child in May 1991, vowing to commit to it completely by submitting progress reports every five years to the Committee on the Rights of the Child (UN-CRC). The Convention always takes precedence over national legislation, so that where there is conflict between the two, the Convention's articles come into force. Article 19 (The Convention on the Rights of the Child 1989) concerning institutional care stipulates that States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable laws and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately, and a decision must be made as to the child's place of residence. Furthermore, Article 25 (The Convention on the Rights of the Child 1989) stipulates that States Parties recognise the rights of a child who has been placed by the competent authorities for the purposes of care, protection, or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

To date, Lebanon has submitted three progress reports to the UN-CRC. After discussing the report at hand, The Committee expressed its concerns and made suggestions and recommendations concerning children's residence in social welfare institutions. The most significant concern and recommendation expressed by the UN-CRC states:

"The Committee is concerned about the insufficient measures taken to ensure that the principles and the provisions of the Convention are made widely known to children and adults". The Committee also suggests that the State undertakes a comprehensive study to examine the implications of the principle of the "best interests of the child" in relation to Lebanese laws and their implementation as well as to administrative practices in all relevant fields.

The UN-CRC (2002) voiced other recommendations and concerns related to Lebanon's 1998 report: The Committee is deeply concerned at the large number of children placed in institutions, a significant majority of whom are placed there because of socio-economic problems affecting their families, with decisions made without judicial procedure. The Committee thus recommends that the Lebanese government:

a. takes effective measures to implement fully the legislation relating to alternative care of children to ensure that a child is not separated from his or her parents against his or her will, except when competent

authorities, subject to judicial review and procedures, determine that such separation is necessary for the best interests of the child;

b.   pursues its plans to review its policies resulting in many children being placed in institutions and improves the monitoring and evaluation of services provided by non-governmental organisations in this regard.

The UN-CRC (2006) reiterated these concerns, the most significant of which were:

The Committee continues to be deeply concerned at the high number of children placed in institutions, and at the lack of the possibility for having the placement decision reviewed by a civil court. It notes with concern the lack of information and statistics at most institutions regarding the children in their care, these children's progress, and the nature of services provided. The Committee notes with concern that many professionals and volunteers working with children deprived of a family environment are not familiar with the existing laws and regulations protecting the child.

The Committee urges the Lebanese government to:

1.   take immediate preventive measures to avoid separation of children from their family environment by providing appropriate assistance and support services to parents and legal guardians in the performance of their child-rearing responsibilities, including through education, counselling and community-based programmes for parents, and to reduce the number of children living in institutions by fully implementing the laws relating to family-type alternative care and by addressing the root causes of separation, including socio-economic problems faced by parents; and

2.   ensure that the need for the placement of each child in institutional care is always assessed by a competent, multi-disciplinary group of professionals and that the initial decision of placement is done for the shortest period and subject to judicial review by a civil court.

Although Lebanon signed the UN Convention in 1990, 12 percent of its institutions were established and contracted with the Ministry of Social Affairs after that date. At least sixty percent of the Ministry's budget is allocated to institutional care each year. The Table below shows the number of residential care institutions contracting with the Ministry and the number of children residing in these institutions. Based on the reports submitted to the UN-CRC and its feedback on these reports, the following conclusions can be made. The annual flow of new children into welfare institutions, paid for by the Ministry of Social Affairs, contradicts one of the fundamental principles of the Convention; that the best care

the child receives is within his or her own family environment. In those cases where a child is deprived of her/his own family environment, the best and most suitable alternative care should be ensured. Although the most suitable care is case-specific, it is generally agreed that institutional care should be the last resort on the grounds that Article 9 of the convention stipulates that the child should not be separated from his or her parents. Institutional care does not fulfil this condition, nor does it provide a family-type environment.

Year	Number of Residential Care Institutions	Total Number of Children
1997	163	23759
1998	197	25985
1999	244	26623
2000	179	24177
2001	180	24040
2002	160	23789
2003	168	23941
2004	170	23305
2005	176	23606
2006	176	23458
2007	176	23138
2008	185	23490
2009	186	23098
2010	185	22966

Another study (MoSA & UNICEF, 2007) showed that the main reason for admitting children into welfare institutions in Lebanon is neither the loss of parents nor difficult, life-threatening situations. Rather, it is poverty. This is the issue that needs to be addressed by the State, civil society, and non-governmental organisations when caring for children. In such cases, all efforts should be made to address the issue of poverty to support children remaining within his or her family, whenever possible.

General trends are emerging in relation to the two modes of care. *External Institutional Care* (i.e. non-residential care where children may stay with family members) occurs when the Ministry contracts with several agencies to provide children with comprehensive services that address all his or her needs except for lodging (food and drink, clothing, education, physical health, entertainment, mental health, and transportation). This type of contracting must comply with specific standards. It should be noted that the contracts of most institutions include internal

care, and they tend to opt for this type of care for unofficial, arbitrary reasons without consulting any competent authority. *Internal Institutional Care* (i.e. residential care) targets difficult social cases that are, by definition, impossible to manage and treat within the family. In some cases, extreme poverty and difficult situations may come into play. Alternative care is not a substitute for the family's role in caring for this category of children. It is seen as an inevitable choice in cases of family breakdown or the absence of family care.

Conclusion

In conclusion, the alternative care offered to children deprived of a family environment in Lebanon has many shortcomings. Adoption is limited to the Christian religious denomination because Islamic traditions do not recognise adoption. The Children's Villages offer a different approach with small 'family groups' of children living with a female care worker or mother figure. Foster care in Lebanon is yet to be fully examined as an alternative care option. Institutional care continues to be the dominant form of care and education provided for children and young people in different parts of the country. However, the framework regulating institutional care in Lebanon is extremely lacking in all aspects – legislative, organisational and administrative. Institutional care impacts on communities at large and the futures of those communities. Thus, as a matter of urgency, attention amongst policymakers and politicians alike, needs to carefully review what standards of care and education are being provided for all of Lebanon's children and young people living in institutions and identifying what is known about family involvement in the lives of these young people.

When placements in institutional care are made, it is important to consider whether such placements are made in the child's best interests and justify separating him or her from family members. Regardless of where a child or young person might be placed for care and education, maintaining the child-parent relationship is essential for empowering the child psychologically and preparing him or her to face life challenges. Extended use of family support services or day care may offer opportunities for learning and living that are much more in the child's best interests.

Questions for Small Group Discussion or Guided Reflection

1. *The Law on Non-Governmental Organisations in Lebanon was issued on August 3, 1909 and that law is still in force, albeit with some articles amended during the French Mandate and complementary legislation enacted following Independence. These non-governmental organisations are not licensed as residential welfare facilities, only as community organisations registered with the Ministry of Interior.* What do you think are likely outcomes associated with the care and education of vulnerable children and young people in Lebanon when legal authority is handed over to non-governmental organisations to determine national care and education standards?

2. *In Lebanon, the State and NGOs share nothing more than a business relationship wherein the latter offer services in exchange for specific sums of money, as with the relationship between parties in joint contracts.* How might such arrangements be different from contemporary Western practices that use 'purchase of service contracting' with Governments, or 'user-pays', to obtain residential child and youth care services with education?

3. *Lebanese families with children deprived of basic services and their right to education find themselves seeking assistance from welfare institutions to help fulfil basic child care needs, including education. ... There is incentive for welfare institutions in the Lebanon who receive a quota of income for every child placed in these care and education centres to maintain residency numbers.* What incentives are there to promote community services, kinship and foster care or residential child and youth care placements where you live?

4. *All social welfare institutions in Lebanon are of a religious, partisan, or regional nature.* How would you explain this distinction between the *religious, partisan or regional nature* of a residential child and youth care service, and what institutions can you identify where you live that might be comparable?

5. How might the care of unaccompanied asylum-seeking youths be 'managed' as immigrants where you live and work?

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Residential Child and Youth Care in Times of Instability and Uncertainty in Palestine

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Abstract

Provision of residential care services in Palestine is examined during times of instability, uncertainty and dependence on foreign aid. Some of the strengths and weaknesses in service provision for Palestinian children and young people are highlighted. A general background to the political and demographic situation in the Palestinian territories is provided, and then a description is given about the current situation of residential care, drawing on three different examples of NGO service providers. Some thoughts are shared about the way forward for residential child and youth care in occupied places like Palestine.

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Introduction

Throughout contemporary history, Palestinians have been subjected to outsider/external powers' control in ways that have prevented them from developing their own autonomous systems of governance. Only in 1994, did Palestinians gain *some* authority over some parts of their land as part of the agreements in the Oslo Accords. Soon after the establishment of the Palestinian Authority, the newly fledged Ministry of Social Affairs started to develop governance of the systems of child protection and residential care inherited from earlier administrations. Since its establishment, the Ministry has worked under exceptionally harsh conditions of uncertainty, fragility and dependence. These factors have resulted in insufficient capacity in providing social services including residential care services. This, in turn, has resulted in several non-State actors stepping onto the scene to provide residential care and protection services in the Palestinian territories[3]. According to law, these organisations must work according to the State's protocols and under the Ministry's supervision. Unfortunately, due to a set of complex factors outlined later, this supervisory relationship has not been possible. Additionally, the lack of State sovereignty – due to Israeli occupation – requires this Ministry to go about their duties in unhealthy living and working circumstances.

This chapter addresses some of these aspects related to the provision of residential care services during times of instability, uncertainty and dependence on foreign aid. It seeks to highlight some of the strengths and weaknesses in service provision for Palestinian children and young people. The intention is to draw from lessons learnt and use these as guides for developing social and alternative care services in rapidly-changing places in the World. The chapter provides a general background to the political and demographic situation in the Palestinian territories, and then it describes the current situation of residential care in Palestine, drawing on three different examples of services providers. It also reflects on some aspects of the services provided, by addressing some of the challenges in this field. The chapter concludes with some thoughts on the way forward in this field in contexts like Palestine.

Background

The 'Palestinian territories' is a term used to refer to the areas occupied by Israel after the 6-day war in 1967 including the Gaza Strip, the West Bank and the eastern part of Jerusalem. These territories are surrounded by Israel on all sides. The territories have only some short borders with Egypt in the South (in Gaza Strip) and with Jordan in the East (in the West Bank) but Palestinians have no sovereignty in these lands.

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[3] 'Palestinian territories' is a term that is usually used to describe the areas occupied by Israel in 1967. It includes the West Bank, Gaza Strip, and East Jerusalem. However, the statistics here include only the West Bank and Gaza Strip.

Demography of the Palestinian Territories

It is estimated that the overall number of Palestinians reached 11.8 million people at the end of 2013 but only 38 per cent of them live in the Palestinian territories (4.5 million) while the others live in Israel or are spread throughout the World in the diaspora (PCBS, 2013b). Refugees[4] compose a significant proportion of the Palestinians who live in the Palestinian territories (44.2%), roughly two thirds of the population of Gaza Strip (67.4%) and less than one third in the West Bank (PCBS, 2013b: p. 30). The Palestinians territories, and especially Gaza Strip, are amongst the most densely populated places on earth (Muhanna, 2013: p. 5). This is because of the very limited area of the territories, high fertility rates, and low mortality rates compared with neighbouring countries (Muhanna, 2013: p. 5). Although the fertility rate in the Palestinian territories has decreased since 1997 (4.4 births in 2008-2009), it remains higher than neighbouring Arab countries and other countries in the region (Klaus, Suckow, & Nauck, 2007: p. 527; PCBS, 2013b). This rate is even higher in the Gaza Strip where it reached 5.2 births in 2008-2009 (PCBS, 2013b: p. 21).

At the same time, life expectancy remains high (72.9 years in 2013) (PCBS, 2013b: p. 21) due to the provision of health services by the UNRWA (Efrat, 2006; cited in Muhanna, 2013). Although life expectancy for Palestinians is lower than the average rates for industrialised countries, it is generally higher than the average of neighbouring countries in the Middle East (Pedersen, Randall, & Khawaja, 2001). Palestinian society is demographically a very young society (PCBS, 2013c) with more than half the Palestinian population on the national level (52.7%) comprised of persons aged (0-19 years).

Political History of the Palestinian Territories

The Palestinian territories are currently under the partial governance of the Palestinian Authority which was established after the peace negotiations and Oslo Accords in 1994. Throughout the Twentieth century, the territories were ruled by successive external powers, including the Ottoman Empire, British Mandate, Egyptian and Jordanian rule and the current Israeli occupation, making it one of the least autonomous and least independent entities in the World. A brief historical background may help to situate the use of residential care in Palestine.

The State of Israel was established in May 1948 at the end of the British Mandate on Palestine. The mandate, which was imposed in 1920, ended after the United Nations partition plan that allocated 56.5% of Palestine to a Jewish state and 43% to an Arab state with international enclave around Jerusalem (Palestine Studies, n.d.). The partition plan was seen as unfair to Palestinians. The result was the eruption of the Arab-Israeli war through which Arab troops crossed the

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[4] The 'refugees in the Palestinian territories' context is the term which is used to refer to the first, second, and third generations of refugees who were forcibly displaced out of their home villages at the time of Al-Nakba.

borders to fight against the Israeli troops. The Israeli troops' conquest resulted in their occupying most of the *historic Palestine*[5] except the West Bank and the Gaza Strip. Before, during and after the *war,* Zionist groups[6] forced more than 800,000 Palestinians to flee their home villages, resulting – at the time – in the biggest refugee crisis in modern history.

This political situation continued until the eruption of the Six-Day War in 1967, which was initiated by Israel against Syria, Egypt and Jordan, and resulted in the Israeli occupation of the Gaza Strip, the West Bank and East Jerusalem (i.e. the last remaining parts of the whole *historic Palestine*), the Golan Heights (Syria), and the Sinai Peninsula (Egypt). This War resulted in another wave of forced migration of Palestinians to other countries around the world. Following its territorial conquests in 1967, Israel quickly established a regime of military occupation over the West Bank and the Gaza strip, and innumerable military orders have shaped civilian life there ever since (Hart & Lo Forte, 2010: p. 5).

The Israeli *direct* occupation of the Palestinian areas continued until the launch of the peace process marked by the Oslo Accords in 1993. As per the Accords, the Palestinian Liberation Organization (PLO) and the State of Israel agreed, in principle, to end the occupation of the lands occupied by Israel in 1967 (West Bank, Gaza, East Jerusalem). Moreover, they agreed to establish the Palestinian Authority as a *temporary* self-governing system to facilitate the establishment of the State of Palestine after an interim period of five-years (i.e. to be completed in 1999). The Authority, through its established executive, legislative and judicial bodies, took the responsibility of governance and the delivery of public goods to Palestinians in *parts* of the West Bank and the Gaza Strip (Muhanna, 2013: p. 7). This included the provision of social security services to the population under its jurisdiction. Child protection and residential care for children and young people are significant parts of these services.

An Overview of Residential Care for Children in Palestine

In the form we know it today, residential care started in Palestine during the last decades of the Nineteenth Century. Since then, the service, its providers, and beneficiaries have all gone through different stages of evolution in response to the political and social contexts mentioned above. The following section outlines the current situation of residential care for children and young people in Palestine, based on data collected from practitioners and professionals in this field in both the Gaza Strip and the West Bank. Residential care of children and youth everywhere involves different categories of beneficiaries. In Palestine, two main categories can be considered relevant to this discussion: children in conflict with the law, and orphaned or abandoned children.

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[5] Historic Palestine is a term that is used to refer to lands under the British Mandate on Palestine 1920-1948.

[6] At a later stage, after the establishment of Israel, the Zionist groups formed Israeli Defence Forces.

Given availability of space, Palestinian institutions that deal with children in conflict with the law will not be addressed here, but it is worth noting that the number of young people in these institutions is very low. Most of the residential care services are run by non-governmental organisations that work under the supervision of the Ministry of Social Affairs (MoSA). According to a recent census of establishments, there are 26 residential establishments in the Palestinian territories. These differ in the type of institution (governmental, non-governmental, charity, private, etc.), the scale, the number of children and young people in placement, and the residential protocol they use. The key service providers in Gaza include Al-Amal Orphanage, SOS[7] Children's Village, Mabarit El-rahma, and Al-Rabie Juvenile Center. In the West Bank, this includes SOS Village, Dar Altifl, and Creche. These organisations provide unique services and follow different strategic goals and philosophies about the care and protection of children. To understand something of the reality of residential care for children in the Palestinian territories, it is necessary to give details about *some* of the key service providers. Because of the limited space available here, only three service providers are described to give an overview of residential conditions in Palestine. The first operates in Gaza, the second operates in the West Bank and the third operates in both territories.

Al-Amal Institute for Orphans – Gaza Strip

The Institute was established in 1949 following the forced migration of 800,000 Palestinians to other cities in Palestine or to neighbouring countries. It was established to respond to the emerging need to shelter the increasing number of children whose parents died or were lost during the 1948 massacres. Even though the Institute was established to temporarily serve children because of these massacres, its work has extended and continued. Nowadays, the Institute serves more than 500 children from different areas of the Gaza Strip. Its services include the provision of food, shelter, health, social and psychological services from birth up to the age of 15, and sometimes until the age of 18. Occasionally, the Institute welcomes non-orphaned children who live in exceptionally poor social and physical environments that do not fulfil children's basic needs and rights to survival, protection and development. Most of the services are provided inside the Institute, which uses the closed-system of residential care. Boys and girls are divided from adolescence onwards because of the conservative nature of Gaza. Children live in large numbers together and move between sleeping rooms, dining halls, playgrounds and the other available facilities. However, they do not perform any art or craft activities. They wear a uniform during their stay at the Institute. The Institute is funded by charitable persons and organisations – mostly from Arab and Islamic countries. Because of the project-based funding, the quality and the sustainability of services depend highly on the donations pledged from one year to another.

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[7] SOS Villages in Gaza Strip and in the West Bank are part of the international alliance of SOS villages.

Creche de Bethleem

Creche de Bethleem is considered the oldest residential care centre in Palestine, established in Bethlehem-Palestine in 1884. It is now registered as a non-governmental organisation that works under the supervision of MoSA. Historically, it worked under the successive authorities of Ottoman, British, Jordanian, and then Israeli rule, Palestinian people adapting to each rulers' forms of governance.

The shelter receives abandoned children (aged 0-5 years) from different places in the West Bank and from different religious backgrounds. It also serves as an alternative temporary shelter for children faced with very difficult social situations. Unlike most residential care centres in Palestine, this centre does not provide services for orphans. At the time of the interview, the centre was serving around 40 children, half of them without known lineage and the other half being children who live in exceptionally poor social environments or whose parents are not competent to protect them. The centre employs a closed-shelter residential care system, in which different services, including education, play, social and psychological care are provided to children inside the centre.

As a faith-based organisation, Creche values are partially inspired by Christianity. However, religion is not a criterion for placement and it does not affect the treatment of the non-Christian resident majority. Besides the religious values, Creche believes in ethical professional values (i.e. privacy, confidentiality), the United Nations Conventions on the Rights of the Child (CRC) and its basic principles (e.g. participation, non-discrimination, and best interest of the child). These values are particularly important, as children benefiting from the services do not usually have any social connection with a family because they are either abandoned or have no known lineage. Most Creche activities are funded by personal donations from Europe, and the institute is mostly run by volunteer nuns.

SOS Children's Villages – Gaza Strip and West Bank

The villages are part of an international alliance that provides residential care services in 130 countries for orphaned and abandoned children. The alliance has two villages in Palestine: the first was established in Bethlehem in 1966 and the second, established in 2001, is based in Rafah in Gaza Strip. Each village targets around 110 children who are divided into 12-14 groups of 7-9 children. Each group of children lives together with an alternative *mother* in a house that aims to provide a physical and emotional environment similar to the environment where children live with biological parents. The children (0-12 years) stay in these houses before moving to youth houses at the age of 13 when girls and boys are separated, and they stay in the youth houses until the age of 18. In each of the youth houses (three in Gaza and four in Bethlehem), young people live together under the supervision of a SOS-appointed *leader*.

The villages provide a variety of services on their premises, including shelter, education, entertainment, etc. As a result, children do not leave the village except

for family visits on weekends and some *ad hoc* visits. The premises in the village include classrooms, houses, a clinic, a kindergarten, playgrounds, etc. Each village is served by around 50 staff including social workers, a physician, *mothers, leaders, sisters and brothers*. These names are usually used in this alliance of villages to simulate the normal life of the child who lives with his or her biological parents. The villages receive not only orphaned and abandoned children but also children whose parents may violate children's rights to protection and survival. The villages in Palestine receive their funds through personal and institutional donations with some support from the international alliance of SOS Villages.

A Short Reflection

As demonstrated in the examples of service providers in the previous section, the services in the Palestinian territories vary widely, based on whether children are abandoned or orphaned, sources of funding, whether local, international benevolent persons or philanthropic organisations, the values that underpin these organisations (religious, aid programme or UN values, along with the scale of services. Unlike education and psychosocial activities in the Palestinian territories that are usually funded by international donor organisations, residential care providers rely on the generosity of charities and benevolent persons. CRECHE is exceptional, however, because of the age and its type of beneficiaries.

Interviews conducted with practitioners in this field demonstrated that many of these organisations depend on foreign aid to provide their activities. Because of the religious and cultural values that support caring for orphaned and abandoned children, these organisations work with the support of local communities. Because of this, many local enterprises allocate some of their profits for these organisations. Unfortunately, these organisations do not receive sufficient support from the government. There are many reasons, including the absence of residential care on the social and political agenda, limited autonomous government funding, and the absence of international donors who support the public-sector interest in child and youth care. Limited funds, along with some of the cultural barriers and limited international contacts, make it more difficult for these organisations to keep up with contemporary trends in residential care. In fact, some of the interviewees expressed their interest in following the *European model* in residential care but acknowledged that this is not possible in the current spatial and temporal environment.

Challenges Facing the Provision of Residential Care

The unstable political and economic situation in the Palestinian territories has undermined the effectiveness of State institutions, and their capacity to provide public good for the population under its jurisdiction. This has pushed many non-governmental organisations (NGOs) to step into the scene, attempting to act as a substitute for governmental obligations. This has resulted in a complex set of challenges that have made the provision of residential care for children and young

people in Palestine even more difficult. These challenges are sometimes related to the legal status and political situation of the Palestinian Authority (PA) while other challenges are related to the social and cultural values as well as attitudes in Palestinian society.

International Legal Status for the State of Palestine

After the Oslo Accords were signed by Israel and the Palestinian Liberation Organization (PLO), both sides agreed on a 5-year interim period to establish an autonomous and independent Palestinian state (to be declared on 1999). As the final-solution issues – which included the status of Jerusalem, the borders of the new State, and the "right to return" – have still not been agreed upon, the promise of a Palestinian State has never been realised. After years of failed negotiations, the diplomats of the Palestinian Authority sought international recognition in the United Nations. However, Palestine was not recognized as a "member state" in the UN because of the American veto in the Security Council.

On November 29, 2012, Palestinians made another attempt to get symbolic recognition in the General Assembly in the UN. The members overwhelmingly voted for a resolution that gave Palestine the status of a 'state' but not as a member of the UN. This legal status has influenced policy making in Palestine including the field of social work and residential care. Although Palestine ratified many of the international instruments and conventions[8], without being obliged to do so because of their non-member status, it took few steps to enforce its legislations according to the ratified conventions. The national law of child protection and residential care is considered as 'one of the most advanced Child Laws in the Middle East and North Africa region' (Hart & Lo Forte, 2010: p. 22). This is because it is aligned with the international legal obligations towards the fulfilment of children's rights to protection by adhering to the basic principles of the UNCRC[9] (Hart & Lo Forte, 2010). It is possible that because the Palestinian Authority is not obliged to report progress made to the relevant UN committees, it has not taken serious steps to put legislation into practices of the residential care in the territories, as reported by most professionals interviewed before writing this chapter.

The lack of sovereignty over the Palestinian territories complicates the provision of services that are usually seen as less critical to the lives of the citizens. Unlike food and health, alternative care is not seen as being critical to survival. Part of this complexity is related to the lack of financial resources to put relevant national laws into practice. This can be partially attributed to dependence on foreign

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[8] The conventions ratified in 2014 include ICCPR, ICESCR, CEDAW, CRPD, CERD, CAT, CRC, and CRC-OPAC.

[9] As Child Law No.7 (2004) and its modified version (2012) follow the spirit of the CRC in its assertion on the importance of family life and *environment*. For more details, see article 19-21, 32, and 69 of the national Child Law (2004) and the preamble of the CRC, articles 9, 10, 20 and 21 related to children's separation from their parents due to institutionalisation, hospitalisation, family breakdown, adoption, or deprivation from family environment, and article 37 and 40 related to children deprived of their liberty or receiving juvenile institutional care (PCBS, 2013a, p. 53; PNA, 2004; UNCRC, 1989).

aid and donors who decide which sectors to fund[10]. It is fair to say that the unstable political situation obstructs the whole policy-based decision making and planning. This is true for social work services in particular, including residential/alternative care because most of its practices depend on decisions and resolutions on the policy level.

NGO Weaknesses

Provision of child protection services is a fundamental responsibility of the State as assumed by legal instruments and conventions (Hart & Lo Forte, 2010). Because of the awkward situation of the State institutions, non-governmental organisations stepped in to provide alternative/residential care for children and young people. Problems arose when this unorganised sector (i.e. NGOs) was left without proper technical supervision from the Ministry of Social Affairs (MoSA). This created a variety of residential care services; and many of these do not provide evidence-based-practices. A lack of supervision has also slowed the development of approaches that these organisations adopt for their work. Many of these organisations operate with little financial auditing, a matter that has contributed to corruption amongst some[11]. Most of the organisations working in the field of residential care are dependent upon donations from philanthropists and most donors do not necessarily assess the efficacy and capacity of the organisations to provide professional services. This dependence on philanthropy has made organisations less accountable to their donors and less efficient in providing alternative care.

Some of the NGOs' limitations are also attributed to the political, economic, social and cultural factors in the Palestinian territories. For example, weak capacity can be linked to the blockade imposed on Gaza, restricting the flow of funds and expertise for more than 7 years. As many of the working organisations are affiliated with Islamic groups and political parties, they usually face difficulties in receiving bank transfers from abroad. Besides, the political and social divisions in the territories have resulted in a form of discrimination between children in residential care, whose families are affiliated with different political parties. In some cases, children are subjected to social discrimination based on their social class and family party connections.

Cultural and Social Challenges

Despite the central importance of children in Arab and Muslim families, children are sometimes treated in a contradictory fashion. When one of the parents dies, or when parents divorce, family disputes may arise as to who will have custody of the child. Sending the child to a residential care centre is often the last choice of

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[10] For more details on aid dependence and aid effectiveness in the Palestinian context, see (Challand, 2008; Le-More, 2004; Shahin & Azar, 2011).

[11] It could be said that using dominant discourses about orphaned children (in religion and Arab culture) is useful for fundraising, and thus these discourses are sometimes being exploited in a corrupt way.

the extended family. This is more specific to societies where taking care of a child within his or her biological family is a matter of pride. The result is that the *extended* families avoid sending their children to residential centres as this may arouse social stigma. Thus, the children, who live in the residential care centres, are usually seen as the most disadvantaged children and this influences their social position during and after they leave. In addition, this cultural attitude influences how residential care providers and their services are viewed overall. Children are not usually consulted in this regard as they are seen to lack the necessary *logic* and rationality. Thus, the best interest of the child is mostly ignored.

Conclusion: What is Special about Residential Care in Palestine?

The development of residential alternative care services in Palestine reflects the unstable environment in which the system evolved. The long-standing governance of Palestine by successive foreign/colonial powers and the lack of sovereignty has resulted in weaknesses with the existing system. The Palestinian Authority was established and is functioning in abnormal circumstances of instability and fragility. This fragility features in the awkward legal status, dependence on aid, and inability to utilise national resources. Because of this, relevant Ministries (e.g. the Ministry of Social Affairs) fail to meet their commitments towards the Palestinian people. This is especially relevant where the demographic distribution of the population adds another burden to the government public service providers. According to the Palestinian Central Bureau of Statistics data[12], children under 14 years comprise 39.7% of the overall population in the Palestinian territories[13], while elderly people over the age of 60 years, comprised only 4.4%. Such a demographic distribution makes Palestinian society a very child dominant, youthful society (PCBS, 2014)[14].

Children and taking care of them are significant pride markers in the Palestinian culture. This can be attributed to a set of complex social, political and cultural factors. It can be said that this significance comes from the roots of the Arab and Islamic culture. In Arab culture, the child is a crucial link for the unity and continuity of the family. He represents the living person who links the past, present and future (Fernea, 1991: p. 448). The birth of a child has a special value for the family as it means the evolution of the newly married couple into complete adults in the family, and mature members of the wider society (Fernea, 1991: p. 449). From a different perspective, the birth of children means – for the family – strengthening the probability of living a better life.

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[12] Palestinian Central Bureau of Statistics PCBS is the official bureau for statistics in the Palestinian territories.

[13] Approximately half (47.5%) of the Palestinians in the Palestinian territories were under 18 in mid-2013 (PCBS, 2013a).

[14] The percentage of youth aged 15-29 is also high (30%). This makes around 70% of the Palestinian population under 30 years of age.

This traditional status/value of a child cannot be perceived without reference to the Islamic culture, which celebrates children and childhood. This attention to children is featured in the literature on children in medieval Muslim society when childhood was treated as a distinct period that needed special attention. In this sense, the Islamic traditions did not treat children as the property of their caregivers or parents. This features in the Qur'an's acknowledgement of their right to live and regards their life as sacred (Giladi, 2001: p. 310). In doing so, it rejected the pre-Islamic Arab tradition of infanticide. Relevant to residential care, jurists were aware of psychological difficulties that separating a child from its parents could cause. Thus, they stipulated that in cases where the mother needed a non-maternal nurse, nursing must take place under the direct supervision of the mother, preferably at the mother's home (Giladi, 2001: p. 316).

For the long influential legacy of the Arab and Muslim cultural traditions, children enjoy a central value in society. This value continues after the death or separation of the parents. Perceiving children as fragile and vulnerable human beings in need of protection makes it an utmost social priority to take care of children's discipline and education. For these reasons, the work of residential care centres was welcomed as the last refuge when extended families were unable to take care of abandoned or orphaned children. Residential centres understand this social value and use it to advocate for their role and sustain their services to children. Alongside this influential legacy, the fact remains that most of the young people in these centres are the sons and daughters of martyrs, who have been killed by Israel for a political cause. Donations contribute to the proper treatment of orphans in general, and these service providers.

Regardless of the quality of services provided, a negative image is frequently voiced about residential care settings and providers. Development of this sector is possible, but it will take time. By showing models of good quality services that substitute the care of biological families, and by enforcing laws of child protection, there is potential for an expanded and improved sector. Openness to international experiences, especially in similar contexts, could be beneficial for increasing the effectiveness and efficiency of services in this sector. Overall, development in this sector will not be possible with the structural barriers imposed mostly through the illegal Israeli occupation of the Palestinian territories. With State institutions empowered with full autonomy and financial independence, residential child and youth care in Palestine will be totally different.

Questions for Small Group Discussion or Guided Reflection

1. *2 out of 5 Palestinians living in the Palestinian territories are refugees in a homeland surrounded by walls, barriers and occupying forces.* What are likely to be the most important tasks for the residential care of children living in the Palestinian Territories?
2. *More than half the population of the Palestinian Territories is made up of children and young people under the age of 19.* What challenges might require daily attention when working with Palestinian young people in residential care?
3. *Unlike education and psychosocial services available in the Palestinian territories which are usually funded by international donor organisations, residential care providers rely on the generosity of charity organisations and benevolent persons.* How do you think this might shape the philosophy and practices of a residential care centre?
4. Why is Palestine's national law of child protection and residential care considered '*one of the most advanced Child Laws in the Middle East and North Africa region*'?
5. *Cultural values Palestinians hold for orphans and against orphanages slowed the development of residential care in Palestine. Inspired by Arab culture and religion these values place significant importance on raising children with their biological parents, and in case of their absence, within the children's biological family.* How might these cultural values impact on Palestine's most disadvantaged children, those living in residential care?

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Acknowledgement

Residential Education and Care for Children and Young People in Israel

Emmanuel Grupper[1] and Ron Freizler[2]

Abstract

Contrary to the general tendency in many Western countries, Israel maintains a large network of residential facilities – both religious and non-religious services provided along a continuum of care and education programmes ranging from elite populations and those requiring specialist therapeutic help to orphans and new immigrant populations – financially supported by respective governmental agencies. The relatively extensive use of out-of-home care in Israel could be explained by looking at several cultural elements, including Jewish traditions that include a generally positive attitude towards leaving home as part of normative adolescent development. Such views underpin the large network of residential schools for religious and non-religious adolescents that grow up in these residential settings – living together with peer groups.

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Introduction

Contrary to the general tendency in many Western countries, in Israel there is a large network of residential facilities with a vast variety of programmes. This works only because of important financial support from the respective governmental agencies. The relatively extensive use of out-of-home care in Israel could be explained by looking at several cultural elements: In the Jewish traditions there is generally a positive attitude towards leaving home as part of normative adolescent development. This is the basis for the large network of residential schools for religious and non-religious adolescents that have grown up – living together with peer groups. Israel is a relatively young society still going through "Nation Building" processes. Residential schools or youth villages are considered powerful social instruments that can educate young people from different ethnic groups towards fulfilling social challenges. The historical events experienced by the Jewish people during the last 100 years gave place to an extensive use of out-of-home care for children and young people. This originally arose out of the need to find comprehensive solutions for the many young people who became orphans and lost their families during the First and Second World Wars in Europe, and those who became Holocaust survivors. These children and young people travelled to Israel and were placed in residential homes or group care in Kibbutz communities. Later, residential homes or group care in Kibbutz communities were used to assist in the integration of immigrant youths coming to Israel without their parents. These young people, too, are largely educated and cared for in residential facilities.

These social and historical challenges form the origin of the large and rather unique network of youth villages and residential schools that until today operate as open settings with considerable support from the Ministry of Education. Children are not forced to stay if they do not wish to and can leave the residential programme whenever they – together with their families – decide. Alongside, there is a second network of residential facilities run by the Welfare Ministry. These are therapeutic residential care programmes where children are placed by the court or by welfare authorities. Some placements (20%) are directed to foster family placements while 80% are placements in residential treatment homes.

As found elsewhere in many countries, Israel operates two distinct kinds of residential care settings for children and young people. One pattern of residential care is focused on the rehabilitation needs of children and young people considered to be in 'high risk' situations. Examples of such situations can be homeless and street children, school dropouts, delinquent youths, along with children and young people with difficult family backgrounds or severe emotional problems.

Boarding Schools are another important pattern of residential education, acting in the service of "elite" populations, much like the English "Public Schools". These are prestigious educational institutions with well-defined programmes, aimed at maintaining the predominance of elite groups in the distribution of power among society (Lambert, 1975; Duffell, 2000). Examples of such boarding schools in many countries are maritime schools, military schools, preparatory programmes

for prestigious higher education faculties, and religious boarding schools. The two different patterns make intentional use of residential programmes that can offer a structured and relatively closed environment, with high potential to rehabilitate and empower children and young people (Jones & Fowles, 1984; Eisikovits, 1995; Kashti, 2000; Grupper, 2013; Attar-Schwartz, Ben-Arieh, Khoury-Kassabri, 2010).

However, in Israel a third and rather unique, original model of residential care and education was developed with the development of the Kibbutzim movement from the beginning of the 20th Century as communities where people share the same ideology as well as sharing their properties and economic resources. As part of this communal life, children were brought up in a children's home, run by members of the community. Since the beginning of the 1970s children sleep in the parents' apartments at night and the children's home is used only part time during the day, and thus has a reduced impact on the upbringing and education of children and young people. This community model is at the origin of many residential education and care programmes in Israel. The term "institution" is replaced by the term "youth village" and this is not just a semantic difference. The main difference is that the youth village tries to function as a community which is a normative society where children and adults live together, and young people can share a sense of belonging.

Types of Residential Care Programmes

According to the Schmid Report (2006), Israeli authorities recognise six different types of residential programmes, and allocate different levels of funding these programmes, moving from the lowest to the highest levels:

a. residential education and care programmes (residential schools or youth villages);
b. rehabilitation types;
c. therapeutic types;
d. post-psychiatric types (replacing hospitalisation);
e. residential crisis intervention shelters;
f. residential programmes for delinquent youths (under the responsibility of the Youth Protection Authority).

The **first category** – often associated with the idea of 'living in school' (Kashty, Shlaski & Arieli, 1983) – hosts 85% of children and young people being educated in Israel in out-of-home care programmes. They represent a large variety of programmes and all are supervised and financed by the Ministry of Education. The other five categories combined represent 15% of the overall figures. They are financed and supervised by the Ministry of Welfare and Social Services. The children and young people in these programmes do not apply by themselves, rather they are court-ordered or mandatory placements by welfare authorities.

Although Israel has also experienced some decrease in residential education and care (from 14% of the 12-18 group age in 1990 to 10% in 2008), this network is still largely used for young people aged 12-18 from a wide range of cultural and social backgrounds and immigrant youths, in particular. In Israel, about 15% of students aged 3 to 18 are of immigrant origin with over 14% of these, aged 12-18 educated in residential schools of the youth village type (Ben Arieh, Kosher, & Cohen, 2009).

Another peculiarity of the Israeli residential education and care network is that practitioners, policy-makers, children and parents, perceive all its different programmes as being on one continuum. Identifying the "elite" boarding schools at the one edge and the residential crisis intervention centres on the opposite side, all other models are located in-between. This means that a child placed in a residential treatment centre knows that he or she has the option of moving after a while, provided they have made sufficient progress, to a more educational type of residential school, and vice-versa.

The Continuum of Residential Education & Care Models in Israel

Religious Youth Villages

Boarding Schools   Agricultural Villages   Sports Villages   Residential Treatment Centers

For 'Elite' populations

Artistic Villages   Group Homes   Crisis Intervention Centres
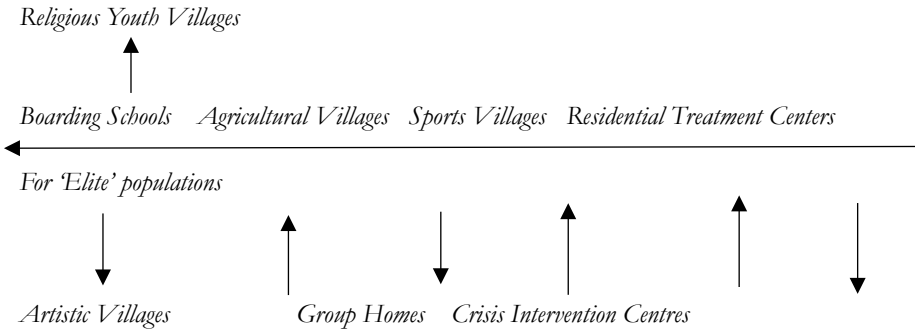
The Israeli Youth Village Model

The prototype of the leading Israeli residential education programme is the youth village model, sometimes called a residential school. It was established as part of the re-settling of the land and gathering Jewish people from all over the world to create an Israeli society, beginning at the end of the 19th Century. This is a unique type of care model that is neither a rehabilitation centre nor a boarding school, but a place where young people are "living in school" (Arieli, Kashty & Shlaski, 1983). The challenge of every youth village is to serve both educational needs and provide rehabilitation for those requiring it by creating a stimulating environment that can empower each young person (Grupper, 2008). In these residential schools, there is a tendency to bridge the gap and find appropriate educational and rehabilitative solutions for a large range of young people having the need to live outside of their home. Among the young people who are educated in youth villages are large

numbers of new immigrants who are in the midst of their own cross-cultural transition process. Others are children and young people in need of care because of family and social problems, young people seeking a second chance after having failed in local community schools, and young persons who have gone through emotional crises to name just a few.

Israeli 'Youth Village' Model

← ─── →

Boarding Schools for Homogenous Groups of Children and Young People from Elite Populations or Upper Middle-Class Families

← ─── →

Heterogeneous multi-cultural youth populations composing youth village's youth society

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← ─── →

Residential Treatment Centres for Homogenous Populations of Children and Youths in High Risk and with Great Need for Rehabilitation

← ─── →
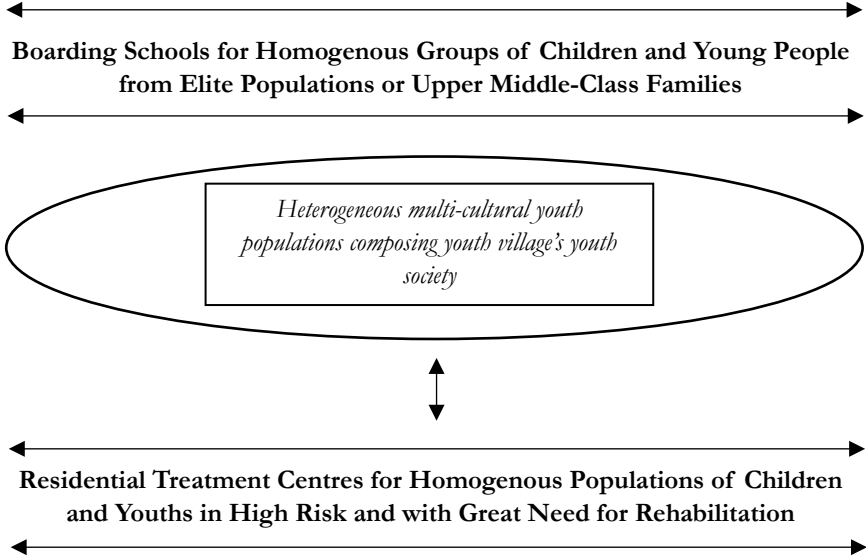
This model is founded upon Bronfenbrenner's Ecological theory (1979) based on claims that the development of a child is not influenced merely by "Micro" interactions with whom he/she is directly confronted on a daily basis. Important impact can be attributed as well to interventions of people acting on the "Meso" and "Exo" systems, or relations with other people in other settings and the organizational influences of residential school operations. Even more interventions prevail from the "Macro" level of social policy and economic decision-making. According to this conceptualisation, Israeli residential education and care settings are organised in a relatively large network, which allows each school large margins of autonomy for action. On the other hand, general educational and care principles can be applied nationwide across the whole network, supporting the introduction of policy changes, when required.

To be more explicit, take the example of a policy change that has occurred since the beginning of the 21th Century, namely, increasing parents' involvement in their child's education while temporarily living in a residential care programme. For many years, residential staff sought to minimise contacts with children's families. Nowadays, it is common knowledge that such attitudes towards parents is wrong

and harmful. Therefore, the decision-makers, researchers, scholars, media people, all acting at the Macro-level, have influenced public opinion and are shaping workers' attitudes towards this new way of interacting with parents. Programme designers, staff training programmes, supervisors, and programme directors, all acting at the "Meso" and "Exo" systems are preparing concrete programmes that can be applied by direct care staff in their daily work at the "Micro" system. Parents are now invited to share activities with their children living in care, as with: dynamic joint child-parent workshops offered on a weekly basis; inviting parents to prepare a meal for the whole group where the child is living; participating in joint children-parent summer camps; attending "family days" in the residential home several times a year; and inviting parents to celebrate festivities in the institution, starting with the child's birthday through to celebrations for National festivities.

Such activities, even though not all initiated by local staff or directors, are succeeding with creating a different "ecological environment" for children in residential education and care facilities. The same is occurring across support programmes for after-care graduates of residential care programmes that were not well developed until more recent times. Other principles applied in this model are:

Youths and Adults Living Together to Create a United Community involves:

- Creating an atmosphere of residential community living that avoids the negative effects of an "institution" in Goffman's terms.
- 24-hours in a well-designed environment is a very powerful stimulation for achieving behavioural changes among children and young people
- Relationships between young people and adults are rather symmetric, contrary to the kind of relationship developed in programmes operating under the "medical model" orientation.
- The community is based on pluralistic and multi-cultural values.

Primacy of Education over Treatment means that:

- success in educational achievements is the primary target;
- school is a normative central feature of the residential programme;
- diverse support practices help children experience educational successes;
- educational considerations have priority over therapeutic considerations in the everyday decision-making process.

Normalisation and Empowerment of Children and Staff are obtained through applying the Following Principles:

- Every activity is geared towards challenging the young person to experience success in any kind of activity, as in sports, artistic domains, post-secondary studies, and assuming leadership responsibilities in the daily routines of the community.
- Creating a heterogeneous and multi-cultural youth society in the youth village. Young people come from various backgrounds, but all are in need of out-of-home education and care for various reasons. The challenge for staff is to transform this cultural diversity into an asset rather than a burden.
- Fighting negative stigma by stimulating positive public opinion towards members of the youth community through active involvement of youths in voluntary activities in their neighbouring community, such as helping elderly people, coaching young children, or performing in ceremonies and festivities in the larger community.
- Self-governance of daily life activities by young people.
- Empowerment of young people requires their active enrolment in leadership activities through which they experience taking responsibility and experiencing the emotional rewards of having successfully accomplished particular social activities.

Developing Children's Sense of "Belonging" implies the following actions:

- Creating staff commitment to the mission statement: "No child left behind".
- Creating an atmosphere where everyone has an important place in the youth community.
- Inducing norms of collaboration and mutual support between the community's members.
- Youths have opportunities to act in an atmosphere that enables a genuine "Moratorium" or "Time-Out".
- Elaborated efforts to re-connect youths with their parents and to their society.

Professionalization of Staff without Exaggeration of Costs can be obtained by:

- Investing resources in the various components influencing the ecology of children in care, and not only concentrating on the direct care workers acting on the micro-level.

- Enacting various measures in order to maintain residential care cost per child at a relatively reasonable amount. We do believe that professionalization of residential care staff has brought many positive effects; however, it has increased dramatically the cost of maintaining a child in residential care. This has resulted in a dramatic decrease in the number of placements available in many Western countries because of financial constraints and many children in need are left with no support at all.

Why is there High Demand for Residential Education?

The "Youth Village" is a residential education and care model emphasising its multi-cultural feature, with 85% of children in care in Israel placed in such "education-oriented", residential programmes. The "Youth Village model" is neither a rehabilitation centre nor a boarding school. It tries to serve both populations together in a heterogeneous, integrated setting and to create a stimulating environment that can empower every young person around its specific expectations. In this kind of residential programme, there is a tendency to bridge the gap and find proper educational and rehabilitation solutions for a large variety of young people. Those that fit the group care concepts of the Youth Village model include new immigrants in the midst of cross-cultural transition processes, children and youths in need of care because of family and social problems, young persons who need a second chance after having failed at the community-based schooling system, refugee youths and "asylum seekers" – some of whom need rehabilitation for emotional and behavioural crises, and also those who are looking for a very specific orientation for education. Another way to define this model is found by Arieli and others in a book entitled: "Living in school: Israeli residential schools as people-processing organisations" (Arieli, Kashti & Shlasky, 1983).

Facts and Figures

As stated previously, the number of children and young people in residential education and care institutions in Israel is relatively high when compared with other countries. The exact statistics vary from one period to another, although the general features have not changed significantly since creation of the state of Israel in 1948.

Israeli Children and Adolescents in Residential Programmes

Type of Residential Programme	Number of Programmes	Number of Children in Care
Total	586	67,240
Secular (Non-Religious) Residential Institutions		
Youth Villages	70	15,800
Youth Groups in Kibbutz	7	600
Children's Homes	65	6,000
Military and Maritime Schools	6	800
Residential Schools focused on Sports	6	650
Residential Schools focused on Arts or other Specific Educational Track	27	1,000
Religious Residential Education and Care		
Religious Youth Villages	28	7,400
Youth Groups in Religious Kibbutz	6	180
Religious Children's Homes	18	1,850
Residential High School "Yeshiva" for Boys	158	14,900
Residential High School "Ulpana" for Girls	56	7,360
Religious Residential Schools with Specific Educational Tracks	26	6,350
Other Kinds of Residential Programmes		
Youth Protection Programmes	39	850
Residential Programmes with Special Education Schools	32	2,000
Family Home Units	42	1,500

(Source: National Council for Children's Wellbeing, 2008)

It is also largely accepted in Israel that residential care is not the most desirable solution for pre-school children. The 12-18 year-old age group is where most residential care placements are made in Israel. In the 1980s, it began with 14% of the age group; in the 1990s, it went down to 11%. Although the movement is in decline, it is still a significantly high proportion of the overall age group of Israeli youth. It is worth noting that two-thirds of the children and families are opting for religious residential programmes and only one-third are opting for a secular (general) kind of residential education and care.

The Residential Staff

Residential direct care workers and the proper training they require are long debated issues among practitioners and researchers alike world-wide (Jones *et al*, 1986; Grupper, 1999). In many European countries a real professionalisation process has operated since the sixties with France taking the lead. A comprehensive survey on this issue carried out by FICE in 1986 was summed up in a book entitled "The social pedagogue in Europe – Living with others as a profession" by Jones *et al* in 1986. This title presents both the problems associated with this specific task, and the special ways in which its professionalisation process was undertaken. Living together with others as a profession means that there is a way to look at the everyday activities like: nutrition, health care, emotional attention, schooling support, monitoring the daily schedule, or bedtime activities in a skilful way, not just by reliance on intuition and common sense. The challenge is to educate these workers to become "reflective practitioners" (Schön, 1983). On the other hand, there is an opposing tendency looking at these care activities as resembling "parental care", which usually does not require any specific professional training.

In a paper entitled: "The desired versus the existing model of practice for residential direct care workers" (Grupper, 1999), a special focus is placed on the paradoxical fact that the neediest children are receiving care from the least experienced and most poorly trained workers, who live together with them for long and intensive hours of largely unstructured periods of time. Gottessman (1988) went further by using a strong metaphor, while speaking about residential direct care workers treating them as "The tragic heroes of the residential education and care field"... Nowadays, most countries have moved from using para-professionals towards diverse patterns of training for direct care workers either through pre-service-training in Universities or in specialised higher education schools like the German Universities for Applied Sciences (formerly Fachhochschoole), or through systematic on-the-job training. This model considers these para-professional workers as general practitioners with holistic responsibilities towards children under their care, for whom they serve as "case managers".

In Israel, considerable effort has gone into designing training programmes for residential workers, mostly based on-the-job. Several University Colleges opened special academic tracks offering their graduates a bachelor's degree in youth work, as with the Beit Berl programme and another one at the ONO Academic College in Israel. Residential workers with more than two years of practice are able to attend for two or three days a week to study in the College over a period of four years. At the end of their studies they receive a B.Ed diploma or a B.A at ONO Academic College. Other Academic Colleges have opened special programmes for Directors of Boarding programmes. Others have opened programmes for house-mothers, most of these special educational tracks being initiated and funded by the Administration for Residential Education in the Ministry of Education. All this is done without a legally supported formal requirement for employers to employ only trained people. On-going manpower statistics concerning residential direct care

workers in Israel shows that more than 50% of the workers nowadays have a University diploma in one of the human sciences disciplines, but another 50% still arrive on the job without any professional education whatsoever. The result is a high turnover and almost 50% of newly recruited workers tend to leave the job after one year.

New Trends in Residential Education and Care

Residential programmes are bound to modify themselves according to social changes occurring in the environment in which they operate. This is true everywhere and Israel is no exception. The main changes occurring nowadays in the Israeli residential network in the last ten years are focused in four areas:

Higher priority to academic achievements

Major efforts are made to guarantee youth in care receive optimal opportunities to achieve success in their high school studies, as a key element in opening future opportunities for them as adults.

Involving parents in the children's lives while being in care

Contrary to the past, it is nowadays accepted that parents, even the most vulnerable among them, must be considered as full partners in their children's education and care. This is not always easy to realise in residential programmes that used to operate as closed systems. However, today, due to the importance attached to the family, residential staff make great efforts to apply this principle in their everyday work. The staff in residential programmes are nowadays used to working closely with the family of children who are in care and even develop services to help parents improve their parenting skills. Whenever it is possible, parents are invited to take an active part in the decision-making processes related to their children.

New and better collaboration with surrounding communities

Most residential youth villages were established originally in rural and isolated areas, and the nearby community did not play any role in their functioning. Nowadays, geography has changed in the sense that the distances are smaller, and the concept of building community services has become a major component in educational and social services. Instead of looking at community-based programmes and residential ones as opposed to each other, the better approach looks for ways to conceive them both as complementary ones. New collaborations between residential institutions and surrounding communities are being developed, including the development of half-way homes and extended day programmes in the youth village that take care of the children without having to separate them completely from the family. They come in the morning by bus, participate in a

variety of extra-curricular activities in the youth village, and go back home at the end of an extended activity day to sleep at home.

Developing different kinds of programmes for supporting care leavers

Since 2008 many programmes have been developed in Israel to support care leavers, especially those lacking any kind of family support. These programmes include services rendered by the residential programmes to its graduates, such as accompanying them all during their military service, but also programmes in the larger communities where care leavers can receive support in housing and counselling as well as financial support for integrating in higher studies or vocational trainings (Benbenishty & Zeira, 2008; Zeira, 2009).

Hopes and Fears

In most industrialised countries, the use of residential education and care as a rehabilitation vehicle for children and youths at risk continues to decrease (Trede, 2008; Knorth &Van de Ploeg, 1994; De Valle, 2014). There are many reasons for this phenomenon, primarily related to the negative stigma that is attached today to any kind of institutionalised setting. In contemporary times, such programmes are considered a "last resort" solution in most European countries, a solution to be applied only when all other interventions have failed (Frensch & Cameron, 2002). Simultaneously, the ever-increasing costs of intensive care for a child in a residential therapeutic programme is encouraging policy makers to look for less expensive solutions, even though their effectiveness is often doubtful (Knorth, Harder, Zandberg & Kendrick, 2008; Grupper, 2003; Eurochild, 2010).

All patterns of residential care have become somewhat unpopular in many countries of the industrialised world. Emotional rehabilitation in residential care is often considered 'too expensive' and not in line with current trends towards empowering the family "by any means". At the same time, elite populations and even upper middle-class families are demonstrating less interest in placing their young people in boarding schools. Their daily reality is not compatible with the general ethos of "hedonism", very largely spread in industrialised countries. The result is that even the most prestigious public schools in Great Britain are having difficulties in recruiting candidates and some of them have been closed or transformed into boarding schools for young people from upper middle-class families having difficulties in their upbringing (Duffell, 2014).

Residential education and care networks in Israel were, and still are a very important social instrument for coping with complex educational and social challenges. Such programmes have proven themselves highly instrumental in obtaining the successful social integration of immigrant youths (Eisikovits & Beck, 1990; Grupper, 2013). It has also proven to be an important asset in re-integrating disconnected youth in a variety of at-risk situations.

Community life, where shared living between young people and their educators is taking place, creates vast opportunities for developing a sense of "belonging", first to the small peer-group, and later to the youth community. Hopefully this leads to the development of an adult personality that feels a sense of belonging and is positively connected to his/her family, community, and society at large. Such educational challenges cannot be achieved by residential institutions that operate as a closed or "total institution", or "Goffmanian Asylum" (Barnes, 1991).

Looking to the future, we hope that the powerful social instrument that was so efficient until now for coping with complex social challenges, will be allocated public legitimacy and sufficient governmental resources to empower new generations of young people who wish to join this kind of residential programmes and are able to take advantage of such opportunities. In 2004, the Ministry of Welfare and Social Services decided on a new policy giving priority to community-based programmes over placements of children in residential treatment homes. Ten years later they had to admit that community-based programmes were not capable of supplying solutions for complex and problematic family situations and the number of children in residential treatment programmes returned to the 2004 figures. However, this does not mean that residential programmes are considered "last resort". On the contrary, residential programmes may be the preferred option for those young people who feel that they need it and are ready to experience the challenges of out-of-home care and benefit from their empowerment and healing potential.

Questions for Small Group Discussion or Guided Reflection

1. *The historical events of the Jewish people during the last 100 years gave place to an extensive use of out-of-home care for children and young people.* What are these historical events and how do you think this may have influenced social attitudes towards residential child and youth care in a modern state?
2. *A famous pattern of residential education in Israel involves the Boarding Schools – acting in the service of "Elite" populations like the English "Public Schools" – involving prestigious educational institutions with well-defined programmes that sustain the predominance of elite groups in the distribution of power in society.* What residential education options are available near to where you live and work, and how might the populations that attend these local schools compare with the elite residential schools in Israel?
3. *Six different types of residential programmes are identified in Israel, and Government allocates them different levels of funding?* List the six different types of residential programme in Israel and note how funding is scaled by type of service. How is funding for residential child and youth care places managed where you live and work, and what comparisons might be made with parallel services in Israel?

4. *The prototype of the leading Israeli residential education programme is the youth village model, sometimes called residential school. It was established as part of the re-settling of the land and gathering Jewish people from all over the world to create an Israeli society, since the end of the 19ᵗʰ Century. This is a unique type of educational youth village, a care model that is neither a rehabilitation centre nor a boarding school, but a place where young people are "living in school".* How might you explain the Israeli 'youth village' concept of residential care and education to a colleague and the extent to which this compares with residential child and youth care services that operate where you live?

5. *The "Youth Village" is a residential education and care model emphasising its multi-cultural feature, with 85% of children being in care in Israel placed in such "education-oriented", residential programmes – in what is neither a rehabilitation centre nor a boarding school.* What would education-oriented residential programmes for troubled or troublesome youths look like – and be like – where you live and work?

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Care Leavers Looking Back on Residential Care Experiences in Jordan

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Abstract

A retrospective view of experiences is offered by a group of young Jordanian adults who grew up in residential care before their transitional journey into adult life living in the community. In a family-oriented society, children placed in residential care face particular cultural challenges in Jordanian and Arabic culture. Based on life story accounts, young adults identify factors considered influential in the quality of their transitions from care into adulthood. Despite a general bias towards challenging experiences, the chapter focuses on positive issues and good practices. Insights are offered into policy and practice implications for improving care and care leaving experiences for young Jordanians that build from inclusive aspects of Arabic society.

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Introduction

This chapter presents a retrospective view of experiences by a group of young Jordanian adults, prior to their transitional journeys from residential care to adulthood. The chapter highlights some of the main factors that had an influence on the quality of their transition from care, at least in the early stages. International research strongly suggests that post-care experience is very much influenced by the in-care experience (Stein & Munro, 2008). Jordanian and Middle Eastern child welfare systems are under-represented in the international literature. Moreover, most of what is available focuses on negative care contexts and psychosocial challenges. Deficit-based studies, however limited, are important to improve residential care and alternative care systems. It is equally important to shed light on positive experiences, good practices and 'what is working' in a context where the professionalization of social work remains at a nascent stage, minimum care standards are still being developed, and where resources are severely limited. Thus, listening to the voices of young people about existing good practices is crucial. It is anticipated that the practices highlighted here can encourage other countries with similar challenges to identify their own good practices upon which to build, in support of their youths and those who care for them.

Methodology and Participants

This exploratory study sought to understand the care leaving experiences of a stigmatised and difficult-to-find population in Jordan, as they transitioned from residential care to independence and adulthood. Purposive snowball sampling was used (Ritchie, Lewis & Elam, 2003) where the selection and eligibility criteria included a minimum of two consecutive years in residential care as a teenager and varying lengths of time out of care. Despite the suitability of purposive sampling in places like Jordan where little or no research of its kind has been completed, no claims can be made about representativeness (Courtney & Hughes-Heuring, 2005) although the findings are still informative. Recognising the importance of longitudinal research with this youth population, follow-up interviews were carried out with the same cohort to learn about longer-term developments.

Research Design, Data Collection and Analysis

In 2007, a semi-structured interview design was employed to capture the experiences of forty-two Jordanian care leavers – 21 females and 21 males. The design was inspired by early care-leaving studies conducted in the United Kingdom by Stein and Carey (1986), and by Biehal, Clayden, Stein and Wade (1995). The interview schedule followed a chronology of care leaving experiences, starting with the final phase in care and actual transitioning from care. Several life domains were then explored within each phase of post-care, including experiences with employment, accommodation, finances, relationships, types of support, identity and coping with stigma. In addition to individual interviews, thirteen participants

also participated in focus groups. All interviews and focus groups were conducted in Arabic, lasting on average one and a half to two hours. Grounded theory was adopted for analysing interviews and identifying emergent themes, while thematic analysis was used with focus groups. Data analysis was facilitated using computer-assisted NVivo analytic software.

The Participants

Close to half of the young people (43%) did not know their birth families and were categorised as having unknown or concealed families. Regardless of whether their family was known, the most likely cause of placement in an institution was abandonment or separation from family for culturally unacceptable practices on the part of the parents including sexual abuse, incest, pre- and extramarital pregnancy, and single parenthood (one parent sent to prison, mental illness, denying paternity, or disowning the child). Age at admission to care ranged from infancy to sixteen; eighty-nine percent were admitted before they were ten. The mean period spent in care was fourteen years. On average, participants moved placement four times, with a similar number of school changes. The great majority (83%) were aged eighteen or under when they left care and their experiences took place within a cultural context and care history described below.

Cultural Context and Implications for Youth with Care Histories

This study found that young Jordanian care leavers encountered very similar challenges to those faced by peers in other countries – leaving care abruptly, without preparation and without educational qualifications. These young people struggled with securing employment and homes, as well as with new relationships (Ibrahim & Howe, 2011). Despite shared experiences, the study also reported findings particular to Arab and Jordanian culture, given the demands and expectations of a family-based society with patriarchal and collective traditions, and where there are strong notions of honour.

In patriarchal systems, the status, rights, and dominance of males (and older women) take precedence over females, as do the needs of the collective family group over that of individual family members. Unlike the West, where greater emphasis is placed on individualism, the concept of self in collectivist societies is connected to an in-group (Markus & Kiatayama, 1998 cited in Dwairy *et al*, 2006). Priority within the kin group is to protect family unity and honour. Honour in this context, stems from Bedouin values and emphasises honesty, generosity, good deeds of the family and its members, and sexual purity (especially for females) (Kulwicki, 2002).

In Western societies, the State is the main welfare provider. In Arab societies, the family is the primary safety-net – socially, economically and politically (Joseph, 1996). Cultural and religious prescriptions also set the expectation to extend

support to those without their natural support networks (i.e. children in care who are considered 'orphans', regardless of whether that is truly the case). The care for orphans is held in very high regard. The paradox here is that, on the one hand, children from unknown families can be treated kindly and seen as orphans lacking a natural support network, while on the other hand, they can also be highly stigmatised and viewed as the embodiment of immorality labelled 'children of sin' (Ibrahim, 2016; Ibrahim & Howe, 2011). Both views, however conflicting, have influenced decision-making regarding institutional care placements of young people, shaping their pathways (Ibrahim & Howe, 2011).

Children are placed in care for protective reasons or may be separated from mothers at birth in order to conceal what is often seen as dishonour (such as children born as a result of sexual abuse or out-of-wedlock relationships). When in care for such taboo reasons, the ties with families are commonly severed. Disconnections from family means that young people leaving care have missed out on family life and all the entitlements that come with being part of a family kin group. These children and young people are at a major cultural disadvantage with stigma attached to their upbringing in care homes. Without family connections and not being allowed to be part of that fabric of society, young people are easily stigmatised and forced to have an individualistic identity in a collectivist culture (Ibrahim, 2016; Ibrahim & Howe, 2011). At the same time, due to cultural and religious expectations, 88% of the participants were found to have received some form of informal support during transition (in the areas of accommodation, finances, employment, relationships and mentoring). Nonetheless, survival post-care most often depends heavily on the individual him or herself, circumstances that present many care leavers with major challenges in the context of Arabic culture.

Care Context

The main form of alternative care in Jordan is residential. At any given time, there may be between 800-1100 children in the 33 care homes distributed around the Kingdom. According to Ratrout (2011), just under 50% of children were from unknown families. In all but two facilities, homes are gender and age segregated as religious and cultural prescriptions mandate segregation of non-related children at puberty. This practice leads to separation of siblings and pre-determines a minimum number of moves (2-3 for those admitted in early childhood). Studies have found that children in Jordanian care homes need psychosocial support (Gearing, MacKenzie, Schwalbe, Brewer & Ibrahim, 2013; Ibrahim & Howe, 2011, UNICEF & Allayan, 2002). Broader issues further exacerbate challenges: limited resources – human, financial and logistical; minimal care standards maintained for residential care in the Kingdom; and all this at a time when the care of vulnerable children is still dependent on social workers with limited professional qualifications (Al-Makhamreh & Lewando-Hunt, 2008). Recent policies seek to improve practices within homes (for example, most facilities are apartment-style homes with groups

of 8-9 children) and parallel the recent development of foster care services (MacKenzie *et al*, 2012).

The plight of care leavers has gained attention, resulting in the government establishing a post-care unit to support these young people with access to housing and employment. A small supervised housing project for female care leavers was established along with several non-governmental organisations. Most significantly, a royal initiative headed by Queen Rania Al Abdallah in 2007 that targeted and included care leavers was established after the first round of interviews. The Fund secures educational and vocational training scholarships for orphans, including care leavers who have been in homes for a minimum of three years. The Fund offers career guidance and development, counselling and financial support covering practical needs (housing and living costs, medical insurance, books etc.). In addition, while they have minimum acceptance criteria, the Fund operates an informal 'open door policy' for care leavers in general, and attempts to support them in whatever capacity possible, even when they do not qualify. All care leavers applying to the Fund upon leaving care are fully supported financially until employment is secured.

The Care Experience

Several themes were found to be significant as participants reflected on their care experiences that influenced post-care pathways both positively and negatively, specifically during their early careers. The focus here is on what the young people described as good practices and helpful influences.

Academic Life

In Jordan, national secondary schooling examinations are very challenging. For example, during the year that the participants were first interviewed (2007), only 58.9% of all students passed (Ghazal, 2008). The results of this study portray an inverse picture, with roughly 3 out of 5 (61%) leaving care without any qualifications. Only a third (34%) left care with qualifications, with a quarter (25%) obtaining formal vocational and academic secondary schooling certificates – five academic and five vocational qualifications, and one with a two-year vocational college degree upon discharge. Two of the young women graduates received scholarships to further their education and were at university when interviewed. One other young woman qualified for a scholarship but had not yet started university. An additional five (11.9%) had received informal vocational certificates post-care, although these are not viewed with the same esteem as academic certificates from a reputable establishment. Poor qualifications limit opportunities to enter an already competitive higher education system. Furthermore, lack of qualifications increases the future challenge of securing better employment opportunities, which are also competitive.

An alarming finding was that 8 (one in five of the whole sample) dropped out of school (one from college) due to problems encountered either while still in

care or at discharge. Examples given included running away, a disrupted or abrupt discharge, illiteracy, and one participant never having attended school. All these participants had been in care since infancy or early childhood. Like international findings, these results raise questions about an underachieving academic culture in the Jordanian care system. Despite the difficulties, some young people were successful in achieving qualifications prior to leaving care. Factors that contributed to their achievement in care included:

- *Those with fewer changes of home and school were better able to achieve.*
- *The presence of adults in their lives (carers, managers and teachers) who had high regard for education. These adults were said to be encouraging and would push them to do well. Several seemed to 'go the extra mile' to meet individual needs by tutoring them privately and staying up late with them to ensure that they completed homework and were prepared for exams. One teacher was said to have 'bent some rules' and worked with a participant according to her ability.*
- *Some participants were more aware and therefore more serious than their peers about education and planning for their future. For one, studying was an escape from difficult situations.*
- *Those who had good relationships with peers and their families that were encouraging, supportive and inclusive were more likely to be successful.*
- *It is worth noting that those who received strong academic beginnings in care were able to build on those foundations in different homes.*

An example of very positive practices is that of one young man with special needs who was allowed an extended stay in care and was supported in completing vocational college prior to being discharged. Another positive practice with positive turning points is illustrated in the cameo on the next page.

During the second round of interviews, several of those who left care with education, had managed to secure better employment than peers without qualifications. They had better opportunities to apply for scholarships and complete university or were able to re-engage in higher education later when circumstances permitted. One such young man had completed his bachelor's degree and was nearing completion of his master's degree.

Preparation and Summer Jobs

Preparation for post-care lives was provided in homes in various ways, although this was mostly sporadic and largely revolved around every-day practical skills such as personal hygiene, general cleanliness, transportation, budgeting, and psychology-oriented workshops. Preparation in other areas was provided to a limited extent. Largely, preparation and its quality depended on the presence of adults who believed that young people are in need of this knowledge prior to leaving care. Only one home had an on-going preparatory program and required

summer jobs for both males and females from the age of 14. Despite varying experiences, nearly all stated this was amongst the best and most beneficial experience that they had in care, notwithstanding its challenges, and sometimes risks.

Fairouz had been in care since infancy. She claimed to have been illiterate until she was ten. After this she was transferred to homes that prioritised education, each building on previous skills. Fairouz developed a close relationship with a teacher who acknowledged her determination to achieve and was understanding of her difficulties with literacy. She began tutoring her at her home and during school breaks. During exams, the teacher would read out the questions to Fairouz and write down her answers. Gradually, Fairouz learned to manage on her own. In addition, she came across encouraging managers when she was older.

> *All the managers I've been through used to tell us: 'You girls, you must have your degrees in your hands'… one said: 'Promise me you'll pass; take this from a mum or a sister. You have no one, if you don't have your degree no one will be of benefit to you. Even if you marry, one never knows how one's husband turns out … your degree is your backup'. I didn't really grasp what she truly meant, but still her words remained with me. And I began having the will to pass. I don't want to be dependent or a burden on anyone. Interview 38.*

Fairouz was one of the few females who managed to secure a university scholarship at that time.

Types of employment were dependent on what positions the home could obtain on their behalf. Based on accounts, the aim was to provide opportunities for exposure to life outside care along with work experience and budgeting (pocket money from care was stopped during summer jobs). Some of the main benefits include the following:

- **using public transport** through having to commute to different areas for work;
- **budgeting**, although most were excited about earning more money than they usually had and were spending it freely;
- **exposure to the adult working world** and learning to deal with different types of people (with some gaining experience and remaining in their desired field);
- **feeling privileged**, especially when feeling spoiled by employers – although one young woman stated that her 'horrible summer job' had made her rethink her priorities and begin taking her education seriously;

- **marked development in character**, especially amongst those believing themselves to be timid and isolated; and
- **development of significant future relationships with employers**. Certain employers became future referees and part of the young people's main support network. Several of the young people returned to be employed for several years by the same employers after discharge. For some, these jobs were the only positive factor when going through difficult times (such as concealed homelessness).

Although the overall benefits of this experience outweighed the disadvantages, the process surrounding summer jobs was described as mechanical and the young people were seemingly left to their own devices without support, evaluation or safety measures. One young woman was sexually harassed on her way back home while another felt at risk of sexual harassment and quit abruptly. She noted that she was too young for these issues to be adequately discussed at the home and had been accused of being 'spoiled'. Sexual harassment was never considered. One noted that some peers dropped out of school while in care, were employed in nearby establishments (such as woodwork shops) and would sniff glue and paint thinner. When planned well and when safety measures were taken to ensure that the young people are protected from any form of exploitation, the benefits (both short and long-term) can and have been plentiful for those with successful experiences. Several employers who took young people under their wing while they were still in care, maintained involvement after the young people had left care. This type of support significantly contributed to young people's professional skills, self-esteem and feelings of security. It influenced their quality of life post-care and even allowed some to support their siblings and peers. Opportunities as such, allow young people to experience various roles, thus helping them escape from what Gilligan calls 'oppressive master identities' such as 'young person in care' (2006: p. 42). Crucially, it provides significant opportunities for the young people to develop their own natural support networks that are lacking for many. During a follow-up interview, Aemon had been working for the same employer for fourteen years, since his summer job in care. Aemon has special needs, and his family is unknown.

> *He [employer] is my big brother. I was only a kid [when I started working for him]. He took me again when I left [the home]. I go to him for everything.*

Peer and Adult Relationships

The most positive outcome for most young people – regardless of the overall quality of the care experience – was the formation and/or influence of relationships with each other and with significant adults. Those describing better care experiences had stronger lasting relationships with adults in care.

Peer relationships: The most significant outcome of peer relationships was that the youths became their own nuclear and extended family. In other words, they were and became each other's primary support network. At times this also included adults from care. Asked about positive experiences, a young man who seemed to have had a continuously difficult experience did not hesitate to state that friendships from care were his most precious prize, echoing the sentiments of most youths.

> *Of course, it's friendship, the hidden bond … they are true friends, my most precious prize. (Ali)*

A strong sense of solidarity and camaraderie was reiterated over and over again, beginning in care and continuing thereafter for the majority, whether planned or not.

> *I felt the solidarity between us girls … as the saying goes 'I stand with my cousin against strangers, and with my brother against my cousin' [a saying reflecting family solidarity and strength of bonds. The closer the blood tie, the stronger the solidarity. It is also used with those who are not kin but considered to be 'like family]… we were there for each other, we dreamt together, you know my kids and your kids and so on, we planned our lives so that we'd be together and promised we wouldn't fall out of touch. This is still the case. (Hanaya)*

Some participants extended their support to younger peers or siblings who were still in care by hosting them in the holidays, giving them pocket money and encouraging them to gain qualifications. Several older siblings adopted a parental role towards younger siblings who were still in care, such as one care leaver tutoring a younger sister while she was in care. Whether related or not, the care leavers generally turned to each other when facing difficulties and in emergencies (financial, losing homes or domestic violence). The significance of these relationships was also highlighted during the second round of interviews.

Relationships with Adults: Another set of significant relationships developed with adults, surrogate mothers, carers (some of whom had left but remained in contact), managers, volunteers in some care homes, employers from summer jobs, and in one case, a cook. As stated, a key difference between those describing poor, fair and good care experiences was the quality of relationships developed with adults, more so than with peers. Three types of relationships with adults were identified –

Short-lived and Meaningful: Such relationships were mostly described by participants with multiple and difficult placements. They did not have a significant influence but the young people appreciated these adults' good deeds, being taken for short breaks with a carer's family as well as adults intervening and standing by

them during times of conflict. Despite the lack of long-term influence one young woman stated:

> *'It's nice to know someone loves you'. (Sumaya)*

Short-lived with Lasting Positive Influences: Such relationships were short or limited in contact but brought about positive turning points in single or various inter-related areas such as educational achievement, introducing them to religion and spirituality, making them feel loved and empowered. This was especially the case when these adults were present during difficult circumstances. One young woman described, for example, an extended history of abuse from her surrogate mother. Upon transfer she developed a meaningful relationship with a supervisor. Nashmiyeh left care only a few months prior to her first interview and seemed to be adapting relatively well. After giving herself credit, she stated that responsibilities given to her by the new supervisor had increased her confidence:

> *My personality is very good. I was up to it. Auntie Miriam would put me in charge of something and I was up to it. This is what helped me. It made me have high self-confidence. (Nashmiyeh)*

Long-Term and Highly Influential: These relationships continued for extended periods. Some began by a child being directly in the care of these adults for a number of years (ranging from 3-14 years), and remaining close to them. Some have been close to these same carers (namely surrogate mothers) for 20 years, described by participants who mostly believed they had had fair or good experiences in care. Some of these relationships were closer than others with the main feature being that adults became their family (especially surrogate mothers). These relationships were continuously nurturing, providing on-going emotional and other forms of support, were part of their life, available during emergencies and sharing special occasions. For some care leavers, these adults are all they have. Retrospectively, some accepted that these individuals and relationships are not perfect, and that they had thoughts similar to those of all young people about their parents. Nonetheless, they feel enormous gratitude for having been in their care and for their many positive influences.

> *She never failed me … this is something that makes you happy. There's someone in your life who's there to help you … my [surrogate] mother. As they say I'd 'raise her above my head and walk around' [a saying about someone who is held in very high regard], and still I wouldn't have done enough for her. She is very dear to us. She brought us up and made us young men and women. (Mousa)*

Conclusion

This chapter has focused on positive experiences and good practices based on the accounts of young Jordanian adults who grew up in or spent much of their childhood in residential institutions. These positive experiences shared by Jordanian young adults took place under particularly challenging circumstances where there was a general bias towards young people in residential care having negative experiences. Insights were offered into the broader context that exacerbates challenges for young people with care histories, such as a lack of support, limited or no minimum-care standards that regulate residential care, and cultural values in a family-oriented society that can be stigmatising and socially marginalising for children in need of care and protection. There are still factors that hold promise. Strengths do exist within the current value system. To improve the alternative care system in a sustainable manner, it is important to tap into and build on these existing strengths.

Greater attention within the alternative care system needs to intentionally and consciously build on the positive aspects of the Jordanian and Arabic culture, as reflected in good practice relationships with adults in care and some employers during summer jobs. Substitute care in Jordan, as elsewhere, exists because children need care and protection that is not otherwise available to them. When children are admitted to residential care in Jordan, the State is taking on a parental role referred to in some places as Corporate Parenting – collective responsibility of the council, elected members, employees, and partner agencies for providing the best possible care and safeguarding children who are looked after by that council, entrusting care homes with children and young people for whom they will provide day-to-day care and education. However, the literature on care and leaving care experiences in Jordan points to a disparity between the purpose of substitute care and its implementation, thereby highlighting the importance of 'corporate parenting' when re-considering Jordanian policy and practice in the residential child and youth care field.

The term 'corporate parenting' is widely used in British child welfare policy debates and in the provision of UK child welfare services. The concept has also been adopted in various other countries (Bullock *et al*, 2006). The underlying principle is that the State is morally and legally obliged to ensure that 'good enough' care is provided for the children for whom it is responsible, like what any parent would provide for their children. In practice, when children are removed from their families, the *duty* of caring for them is fragmented and must be provided by several individuals and organisations. Corporate parenting encompasses the child's' community, society and other organisations that the child needs, such as public health care and education (Bullock *et al,* 2006).

The main finding from this national case study of care leavers is that strong cultural influences shape both the care experiences and transitional pathways for Jordanian youths leaving care. Jordanian policy and practice might embrace the principles underpinning corporate parenting since these can be framed by the

moral, cultural and religious values of Jordan. Examples of these values can be found in promoting the political prioritisation of children's welfare and facilitating 'the smooth introduction, integration and legitimisation of the UNCRC' (Hammad, 1999: p. 218). Another example is the establishment of the Fund for both orphans and care leavers. Corporate parenting has a strong chance of succeeding because it promotes the core values of Jordanian and Arab society, reinforcing the positive, caring and inclusive aspects of Arabic society, culture and family life.

Questions for Small Group Discussion or Guided Reflection

1. What does "*purposive snowball sampling*" mean as an approach to young care leavers in Jordan where there is rarely any snow, and where particular cultural values and attitudes shape community attitudes towards '*a child born out of wedlock*'?
2. *In this Jordanian study (43% percent) of the care leavers did not know their birth families, categorized as of unknown or concealed families.* How might this compare with birth family contacts for children in care where you live?
3. *Eighty-nine percent of the Jordanian care leavers were admitted to residential care before they were ten, spent fourteen years in care and on average, moved placement four times and experienced a similar number of school changes.* In what ways might it be said that cultural and religious views '*put these children away*'?
4. *A Jordanian paradox is that on the one hand, children from unknown families can be treated kindly and seen as orphans lacking a natural support network, while on the other hand, they can also be highly stigmatised and viewed as the embodiment of immorality labelled 'children of sin'.* In what ways might these two extremes of attitude play out in your community around the care and protection of children?
5. What was important about relationships in the life stories shared by these Jordanian care leavers?

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Acknowledgement

Residential Child and Youth Care in Saudi Arabia: A Case Study of Abandoned Children and Young People

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Abstract

Residential care is still a popular approach used in looking after children and young people born of unknown parents and designated at birth as 'orphans of unknown parents'. 'Orphans with special circumstances' and 'orphans with unknown identity' are the common names used for this population in Saudi Arabia. These children and young people are formally looked after in government-operated or non-governmental organisation-operated residential institutions in Saudi Arabia as well as in foster families. Some negative effects associated with being born of unknown parents and being placed in long-term residential care are highlighted.

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Introduction

This chapter explores how residential care is provided as one of the most popular approaches used in looking after abandoned children and young people in Saudi Arabia. *Abandoned Children and Young People* in this chapter are those who are born of unknown parents and are formally looked after by Saudi governmental residential institutions through the Ministry of Social Affairs (MOSA) or who are looked after by voluntary residential institutions. They are known as 'orphans of unknown parents, orphans of unknown identity or orphans with special circumstances'.

The chapter illustrates how care is provided within residential institutions in Saudi Arabia, highlighting some negative effects associated with being born of unknown parents and, as a result, being placed in long-term residential care. Residential care of abandoned children and young people and limitations associated with living in residential institutions are highlighted as the State seeks to meet the needs of children and young people born of unknown parents, practices that are still common in Saudi Arabia today. The first Saudi government institution providing residential care for male orphans was established in 1934. Similar provision was made in 1963 for female orphans. As shown in what follows, residential care in Saudi Arabia is still provided in traditional ways, where total care is provided "in which as many of the residents' needs as possible were met under the same roof and in accordance with the same plan" (Sinclair, 1988: p. 45-46).

To avoid any misconceptions, it is important to acknowledge that illegitimacy is not generally a factor that shapes decision-making about whether children and young people in Western countries will be placed in out-of-home care. Most Western children have their own families or some family members. For various reasons, out-of-home care may become an alternative for the placement of Western children and young people in residential care. By contrast, most Saudi children and young people in care have been abandoned by their traditional families for unknown reasons, with illegitimacy appearing to be the main reason. A common factor between Western and Saudi practices is that children and young people in residential care are not looked after by their birth parents, nor are they cared for in their own homes. Residential care workers or 'staff' become their primary caregivers. While most abandoned children and young people are looked after by foster families in Saudi Arabia, this chapter considers what happens to those who are placed in residential institutions.

The Mixed Economy of Welfare

Residential care for abandoned children and young people in Saudi Arabia is mainly provided by the public sector through governmental institutions, and through voluntary or non-governmental organisations. Community care, as a third component, plays a crucial role in providing more traditional care for this population, with these young people becoming part of 'alternative families' since

adoption, in the Western sense, is not permitted within Islam. A more recent development involves a 'Family Friend Programme' that enables children and young people born of unknown parents to have a sense of family while they live in residential institutions through being linked with family members who spend time with them during weekends and holidays.

The role of private, not-for-profit agencies or the voluntary sector in providing residential care for abandoned children and young people is limited, as governmental institutions are the most prevalent. 'Shadow state' might be an adequate label for some agencies in the voluntary sector which play a crucial role in providing both residential and non-residential care in Saudi Arabia for many orphans as well as abandoned children and young people. Within Saudi Arabia there are about 20 government-run and 15 voluntary non-profit institutions providing residential care for orphans and abandoned children and young people (Alsadhan, 2003; The Annual Statistics Book of the MOSA, 2002/2003 and 2004/2005). The total number of residents in residential care is about 2238 according to an unpublished national study (2015).

There are other residential institutions in addition to those indicated above that are not included in this chapter. Some institutions provide care for children and young people with physical or mental disabilities. Others have been established for children and young people who commit criminal acts, such as social correction agencies for juvenile delinquents, less structured institutions for children at risk of misconduct, and recently, a short-term emergency shelter for abused mothers and their children. Abandoned children and young people are referred to these institutions when they need such services. The focus here is on what happens with abandoned children and young people born of unknown parents in Saudi Arabia with no other place to live, nor family members to look after them.

Residential care in Saudi Arabia is provided for both girls and boys. However, separate institutions are established for each gender as they reach the age of maturity. Single-sex residential institutions are common in other Arab societies as well, especially residential institutions where females live during college and university studies. Such single-sex residential institutions are found throughout all the Gulf Cooperation Countries of Kuwait, Bahrain, Qatar, the United Arab Emirates, and Oman, as well as Iran, and the North African countries of Sudan, Libya and some institutions in Morocco; governmental institutions in Syria once offered residential care based on gender but recent civil war in that country has altered service patterns or purged them altogether. Males and females are housed together in some residential institutions with separate facilities in these countries, as in countries such as Jordan, Egypt, Morocco and private institutions in Syria (Alassaf, 1989). There is no market welfare or private for-profit agencies that provide residential or day care programmes for abandoned children and young people in Saudi Arabia. This is the case for most institutions that provide residential care for vulnerable people except for a few institutions that provide for disabled and elderly people (A Brief Snapshot of Voluntary Institutes in Saudi Arabia, 2001).

The Characteristics of Abandoned Young People

Abandoned young people placed in institutions have their own unique characteristics that impact upon them and their personal identities as young people. They are further impacted through being cared for in residential institutions. The rules, regulations and even the physical features of residential institutions (size and number of residents) have been coloured and shaped by the unique characteristics of the residents involved. Abandoned children and young people, because of being born of unknown parents, are more likely to stay for a long time in residential care. The length of stay in these residential institutions is usually associated with instability resulting from moving from one placement to another.

Due to the continuous supervision and restrictions imposed in residential institutions, abandoned children and young people in residential institutions are more likely to lack opportunities to practice social activities or gain new knowledge and skills compared with children who grow up in their own families. Indeed, the socio-emotional, mental, physical, linguistic growth and personality, in general, may be adversely affected because of deprivation of not having grown up within their own birth families. More are likely to lack social skills, self-trust, have poor relationships with others and be more aggressive (Molaigy 1971; Fagee 1977; Younis 1987; Hassoon 1988; Sanhoory 1991; Cannawee 1991; Alzahrani 1995; Idrees 1995; Alzaharni 2000).

Outcomes Associated with Being Born of Unknown Parents

Although the focus in this chapter is limited to abandoned young people in residential care, the impact of an early separation during childhood, and/or previous care, is considered to ascertain the important missing areas in the lives of these young people and the extent to which they have been affected by being born of unknown parents.

Attachment and Multiple Placements

As a result of constant changes of placement, instability is a big issue amongst institutionalised abandoned children and young people in Saudi Arabia (Alzahrani, 2001; Albar, 2008). It is not uncommon for an abandoned person to have many primary caregivers during his or her early childhood due to the constant changes of carers, on the one hand, and the change in age and needs of the child on the other (Alzahrani, 2000). Such movements are accompanied by changing school, teachers, and friends and beyond that the institution's staff, who may be as good a source of support and intimacy as the child or young person has ever had. As a result, instability and the likelihood of losing the carers with whom they had a positive relationship based on trust and emotional bonds, is common among abandoned children and young people in residential institutions. Being placed in an institution and having multiple placements are associated with making abandoned children and young people wonder why they live their lives in such ways. Frost and Stein (1995)

depicted such movements as disruptive experiences for young people as they lose contact with friends and former carers, with the result that such movements impact their identity, education and health. Previous attachment experiences "will initially affect the way [children] relate to new caregivers" (Watson in Nash *et al*, 2005: p. 243).

Growing Up in Care and Adulthood

Separation, after a close emotional bond has been formed, "can be so damaging to the development of [the child's and later the adult's] personality" (Bowlby, 1991: p. 9). Pietromonaco and Barrett (2000) argue that children, who have experienced inconsistent attachment with primary caregivers, often develop negative feelings about themselves. Young people in this study were assumed to be influenced by such feelings which affected their behaviour as adults towards others, including their relationships with partners. Young people classified as ambivalent, according to attachment theory, were uncertain about whether their needs would be met. This stemmed from not receiving consistent responsiveness while they were looked after. Some might seek excessive closeness to others to fulfil their needs. For others, the need for closeness is still present but they appeared reluctant to develop or maintain relationships with others, from fear of being rejected **(**Albar, 2008; Alhajaji, 2012). Hence, "it is better to reject than be rejected" (Howe, 1996: p. 12).

Identity

Feeling stigmatised and socially embarrassed about being born of unknown parents in Saudi Arabia present real stumbling blocks for abandoned children and young people in relation to their social and emotional maturation. They are more likely to have fewer positive relationships with others and be less able to participate in public social activities (Alansary, 2004). The fear of being labelled or disrespected because of their personal identity leaves them feeling insecure when contacting others. Alsadhan (2003) argues that growing up with an unclear identity and feeling confused about oneself is common among abandoned children and young people who have spent much of their life in-care. He added that they are worried about not knowing where they came from, who their families are, to whom they belong, and how they came to be forgotten and abandoned by their birth families. Such questions, with no clear or persuasive responses, lead to perplexity, making it difficult to live stable lives.

Length of Stay

Length of stay in residential institutions is another important characteristic associated with residential institutions. Females are more likely than males to stay for a long time, as they have limited choices when leaving care. According to Alssaied's (2004) study, the length of stay among females in three governmental female residential institutions in Saudi Arabia (two of which were included in this

study) is long. Negative outcomes are common for young people who have spent a long time in-care (Cheung & Heath in Stein, 1997). The impact, as found in this study, continues even after leaving care. If Abandoned Children and Young People spend a long time in residential care, they are more likely to lack the prevalent social values, conventions and generally accepted norms of their communities, usually learnt from mixing with family members rather than paid staff. Ignorance of such issues is more likely to make them feel different and to encourage them to rely on isolation, which some might already have found a useful technique. Females were more likely to remain in one, or a maximum of two institutions until they leave care. Males were likely to experience more than one placement change. The average length of stay in years among females is higher than the mean score of males – 11.87 compared with 9.33. One reason was that, whilst males experience multiple transfers from one institution to another, as reached particular ages, females were more likely to stay in the same institutions, or experience only one or two transfers (Albar, 2008).

Education and Employment

Overall, the area viewed most positively by participants was education. Education and career enhancement received the lion's share of care provision in most institutions. Most residents had the opportunity to continue their education in a proper and encouraging atmosphere, with ample support and encouragement (Albar, 2008). Despite this, many showed deterioration with low motivation for studying and planning for the future, failure at school, truancy and low educational achievement are high amongst abandoned children and young people in Saudi residential institutions. Few children of unknown parents succeed in their schooling (Alansary, 2004). The process of care itself influences the educational careers of young people in care, due to instability and feeling stigmatised (Sinclair & Gibbs, 1998). The study showed that even those who could find jobs were more likely to receive lower pay and have unskilled work (Stein, 1997). The educational careers of young people in care is influenced by the process of care itself (Sinclair & Gibbs, 1998), echoing similarities with Biehal, *et al* (1995), Baldwin (1998), and Allen (2003) who highlighted associations between poor educational attainment and the number of moves and type of care in placements. Lack of privacy, support, poor practice, restricted policy, and confusion about prospects, were listed among the common drawbacks of the residential care system in this study. Young people in institutions were less likely to interact and have good relationships with the external world (Touqh & Abass; 1981; Alssaied, 2004, Albar 2008). "Children in care are ten times more likely than others to truant" (Baldwin, 1998: p. 196) and feelings of being stigmatised prevent some young people from fully participating in their worlds (Albar, 2008).

Leaving Care

Young people leaving care with lower qualifications in education and poorer skills and preparation for labour markets, have reduced opportunities for obtaining suitable jobs and this frequently leads them to reliance on public assistance (Albar, 2008). Abandoned girls in residential institutions in Saudi Arabia, for instance, were not prepared for life after leaving care (Albaz 2001 in Alssaied, 2004, Albar, 2008, Albar & Fareh, 2015). All residents and staff members, except the girls at a female residential institution in Riyadh in Alssaied's study (2004), agreed that girls rarely learned about the mutual rights and obligations of marital relationships, despite marriage being the main reason for their leaving care. Girls aged eighteen and over represented 20.2% of all girls in residential institutions in Saudi Arabia, but only 2.5% in the sample carried on studying after the completion of secondary schooling – years 10-12 (Alssaied, 2004). As a result, young people are likely to encounter various problems once they leave care, including loneliness, debt and difficulties in obtaining appropriate accommodation. Young people may not be able to cope with everyday tasks and manage their budgets properly, so many of them end up in debt and are exploited by others (Sinclair & Gibbs, 1998). Any relationship between institutions and residents usually ceases once residents left care. With regard to after care programmes, the usual support young people receive when leaving care is directed towards finding a job, accommodation and enrolling in some training programmes or continuing their education. Many care leavers continue to receive financial assistance until they become more self-sufficient.

Tackling Challenges and Meeting Needs

In response to some of the problems highlighted above, the government of Saudi Arabia has enacted several policies and introduced different services and programmes over the years aimed at providing proper welfare for abandoned children and young people. In 1955 and later in 1960 is when State welfare for orphans and abandoned children and young people began in Saudi Arabia.

Policies and Acts of Care Provision

In 1975, the Primary Deputy of the Saudi Council of Ministers approved the Act of Children in Need of Care. The legislation indicates that care is provided for children by alternative families and children homes. The term "alternative families" is the closest there is to a term in Saudi Arabia meaning foster families. This Act identifies a child of unknown parents as a child who is born in the Kingdom of Saudi Arabia of unknown parents. The Ministry of Social Affairs is the only authorised body to provide care for any Abandoned Children and Young People through residential institutions or alternative families. Non-governmental institutions and alternative families, to provide care, must have a Saudi Identity. In other words, only Saudi families and Saudi voluntary organisations can provide care

for this population (Assemblage of Legislations and Regulations of the Labour and Social Affairs Agency, 2003).

The Act of Registry Census Office for Abandoned People

According to the Act of the Department of Registry Census issued in 1979, individuals born within Saudi lands and of unknown parents are considered full Saudi citizens unless proven otherwise. According to the Act, both male and female young people should be enabled to register at the Department of Registry Census. Those under the age of 15 can register at the Department of Civilian Status and should be given a Saudi identity card showing that they have the same rights and responsibilities as other citizens (Assemblage of Legislations and Regulations of the Labour and Social Affairs Agency, 2003).

Financial Support

In 1962, the Ministry of Social Affairs enacted the policy of social security in which orphans and Abandoned Children and Young People in need receive financial assistance, like any other vulnerable member of the population. Each child and young person, in addition to the comprehensive residential care he or she is eligible to receive, also receives a monthly payment from the institution, as pocket money. This subsidy has regularly increased since its commencement. In addition, the Ministry opens a bank account for each child and invests money for him/her. A piece of land is granted for most Abandoned Children and Young People (Alblowee *et al*, 1999) and a weekly allowance is sent to residents. Children and young people are enabled to enrol at private schools, colleges and universities when needed. They are covered by medical insurance that enables them to be treated in public and private hospitals. At the time of getting married and forming a family, each male and female from this population is given a financial subsidy of $16,000 to cover the cost of marriage. In addition, they are helped through an after-care programme to get some financial help, cover the cost of some training courses and further education as well as helping them find a job (Albar, 2008, Alessa, 2012, Albar & Fareh, 2015).

What Needs to be Done?

Although residential care, in general, was found to be a part of the problem rather than the solution (Whittaker, 2006), the literature shows that there is a group of young people for whom residential care is still the only option (Raws, 2004; Mainey & Crimmens, 2006). In order to make residential homes effective, however, they need to provide enjoyable and secure places to live, providing care with a focus on residents' dignity, stimulation and a consideration of individual needs. Residents need to feel part of the home in planning policy and services so that they see themselves as more responsible for what happens in their lives. A variety of internal and external activities and programmes that fill residents' leisure time needs to be

established and increased, as many participants in this study felt bored and complained about the shortage of activities (Albar, 2008). As suggested by many, hiring some young people from the Ministry of Social Affairs and some institutions alongside specialised workers might help in designing and implementing 'what works' better (Albar, 2008; Albar & Fareh, 2014). As one means of establishing a sense of independence and privacy, residents need to be encouraged to have a say in decorating and furnishing their rooms (DoH, 2002).

Young people need to be linked with local agencies and organisations in their communities through membership and voluntary work. Enabling them to do something different through voluntarily helping others would not only expand their community networks, but also enhance self-esteem, self-efficacy and feelings of belonging. Through interacting with others and perhaps taking risks by divulging their identity, they may increase coping skills and develop resilience (DoH, 2000; Raws, 2004; Albar, 2012; Alessa, 2011; Albar & Fareh, 2015). Many problems faced by young people leaving care could be avoided if personal and emotional stability were considered from an early age. Poor outcomes in adulthood transition are closely related to instability in child care placements (Valle, 2008). Stability and continuity gained by remaining in school longer enable young people to become higher achievers (Ungar, 2005). Accordingly, all policies and practices – including home design, alternative families, recruitment, transitions, allocation of caseloads, location and staffing of residential units, as well as payment and training of alternative family carers – still need to be formulated, giving central attention to stability for each young person (Jackson, 2002; Jackson in Raws, 2004).

Young people leaving care say it is important to avoid unnecessary moves and discharges, a view supported by Pinkerton & Dolan (2007) who argued that social and emotional changes during adolescence require additional social support. Young people, who have no choice but to live in a residential institution, need to remain in that same home as long as necessary, in a secure environment with trustworthy people. Any move needs to contribute positively to the present and future welfare of each child. *Stability of placement* is closely associated with *stability of education,* where young people stay in the same school and move with their year group, like other young people. This would help them remain in familiar surroundings, thereby supporting *stability of community*. By expanding their social relationships, by being part of a network with significant figures in their lives over time, *stability of relationships* would be fostered with staff, teachers, friends, social workers, alternative family members, neighbours and the like. Greater knowledge about their own personal histories and needs ensure that these young people are more likely to achieve greater *stability around health and wellbeing*. All these dynamics contribute to greater *stability of personal identity* where young people achieve a positive sense of who they are, feel greater self-esteem with enhanced self-efficacy, assisting them to live more pro-actively with others in institutional care, or with alternative families and society as a whole.

Smaller homes, providing more personal and individual care with fewer but better paid staff, are recommended over large institutions and might help better achieve alternative care aims (Sinclair & Gibbs, 1998; Davies, 2002; Sinclair, 2002; Mainey & Crimmens, 2006; Sinclair, 2006). In this respect, the Riyadh programme of Daar Aldyafah, was inspired by other Arab countries using this philosophy developed by the SOS Children's Villages Programme. Such programmes consider it good child and youth care practice when a small group of 5 – 7 children and young people live in a small unit supervised 24 hrs by a foster mother. If smaller homes are not easily achievable, as is the case among most Saudi Arabian institutions, staff to resident ratios need to be increased in order to provide more personalised care for each young person.

In addition, there is a need for intensive or 'satellite units' to prepare young people as they leave the wider care system and move towards independence. Again, due to the importance of stability and continuity mentioned above, it is better to establish such units in the same city in which the abandoned person grows up. In such units, the structures and routines of old-style residential homes should be avoided, and residents should be given more responsibility for their day-to-day lives. Thus, residents in such units must be in full time education, training, or employment to be admitted (Raws, 2004). Learning a variety of independent living skills should be included in an intensive, practical and flexible way.

Any effort to evaluate and increase the quality of care should first concentrate on staffing, as that is the backbone of good residential care (Sinclair & Gibbs, 1998; Albaz, 2001). The importance of staff members arises because they take the place of the birth family in providing care. Accordingly, homes should be run and staffed by those who are capable, well-trained, willing and have good attitudes towards and expertise in working with children and young people. Heads of homes should have clear and appropriate ideas and objectives relating to how to run the homes and possess the skills to motivate staff towards these objectives (Sinclair & Gibbs in Utting, 1997). But in congruence with such demands, a sense of autonomy should be shared by all components of the home (heads, staff and residents). Such demands must also be applicable to other types of care like adoption and after care.

To conclude, this chapter provides a rare glimpse into the residential care provisions for abandoned children and young people, a very precise legal term that has special social and financial meaning in Saudi Arabia. Western readers will notice how 'different' this legal category might be from what legislation requires for the care and protection of children where they live. Residential care might not always be the best answer, and great efforts need to be undertaken to improve the care provision, policies and practices within institutions and children's homes in Saudi Arabia. Smaller homes with fewer residents have been recommended. A variety of internal and external activities and programmes that fill residents' leisure time also need to be established and expanded. Many of the challenges that young people face (stigma, feeling isolated and different, and lacking social and emotional skills) can be tackled through having strong social support networks, secure attachments

and warm relationships with at least one other person. Such needs are more likely to be met through emphasising external support, whether through fostering or having regular contact with primary caregivers, friends, former caregivers and foster family members. There is a continuing need to cultivate wider relationships for abandoned children and young people in Saudi Arabia within their communities to enhance their relationships with others during their stay in homes. After listening to young Saudi care leavers who were given "legally abandoned status", asking them for examples of good and bad practice, and enquiring as to what helped them develop resiliency around leaving care and forming a family, many of these issues are still to be addressed.

Questions for Small Group Discussion or Guided Reflection

1. *Every year, millions of people from around the world make a Hajj pilgrimage to the holy site of Mecca located at the heart of Sunni Islam and maintained by the Kingdom of Saudi Arabia and Islamic scholars.* In what ways might this context be influential in shaping residential child and youth care practices in that country?

2. *Abandoned children and young people* is a legal term in Saudi Arabia for children also called '*orphans of unknown parents, orphans of unknown identity or orphans with special circumstances'.* How might orphans such as these be identified within the care and protection legislation operating where you live?

3. What different justifications can you think of (beyond simply what you believe) for providing single-sex residential centres run by staff of the same gender for young people over the age of 12 or above?

4. *Feeling stigmatised and socially embarrassed about being born of unknown parents in Saudi Arabia creates a stumbling block among abandoned children and young people in relation to their developing social and emotional maturation.* How might daily life events in care help nurture positive support (stay practical) for such a young person?

5. *In addition to the comprehensive residential care he or she is eligible to receive in Saudi Arabia, since 1962 orphans and Abandoned Children and Young People also receive a monthly payment from the institution, as pocket money. The Ministry opens a bank account for each child and invests money for him/her, a piece of land is granted, they are enabled to enrol at private schools, colleges and universities when needed and are now covered by medical insurance enabling them to be treated in both public and private hospitals. At the time of forming a family and getting married, a financial subsidy is provided to help cover the costs of marriage.* How might after care arrangements for this very specific population of abandoned children and young people in Saudi Arabia compare with arrangements that apply where you live?

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Residential Care for Children and Young People in Yemen

Amr Mohammed Alnood[1]

Abstract

Laws and policies that recognise alternative care and protection practices for children and young people in Yemen are highlighted in this chapter through a general assessment of residential care types, services, objectives, and profiles of those living in out-of-home care. Ongoing armed conflict in Yemen is creating new obstacles for residential care centres and their emergency responses to the growing numbers of children and young people in need of alternative care.

Introduction

Yemen law number (45) in 1992 on children's rights specifies the alternative social care options available and the profiles of children considered to be in difficult circumstances. Taking care of children, as seen in many Quran verses and in the curriculum of the Prophet Mohammed (PBUH), is an important Islamic principle that declares the significance of protecting children and ensuring their rights to live

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and have access to all services (Noriah, 2009). Islam has ensured the important role of the State and society in taking care of orphans and children with unknown parents through family foster care and 'kafalah' kinship networks as explained in Islamic teachings, or by suitable care institutions for children. The Government of Yemen, with the support of Non-Governmental organisations (NGOs), some International Non-Governmental organisations (INGOs) and UN humanitarian agencies have been responding to the needs of Yemeni children and young people through providing residential care centres located around the country. However, these supports are insufficient to cover all the gaps and emergency needs of the large number of displaced children and young people in need of care in Yemen.

Background

Yemen's geography and demography are influential in shaping its human environment, as noted by UNICEF in 2014.

> "Located between the Horn of Africa and the Arabian Peninsula makes Yemen a first destination or key transit point from Africa for many people seeking refuge during the humanitarian crises brought about in the region through drought, famine and conflict. Large numbers of economic migrants use this route in search of a better life and economic opportunities in neighbouring Gulf countries across the Red Sea" (UNICEF, 2014: p. 23).

The country's history and its religious, tribal and political make-up are also complex. Former President Ali Abdullah Saleh described ruling the country like "dancing on the heads of snakes". On 26 March 2015, an international coalition, led by Saudi Arabia, launched air strikes against the Houthi armed militia that had taken over the capital Sana'a and forced the Yemeni Government into exile. What was meant to be a short, sharp campaign to stop the advance of the Houthis and restore President Al-Hadi to power, escalated rapidly into a full-blown armed conflict (Crisis in Yemen, 2016).

Yemen has long suffered from poverty and instability, leaving it the poorest country in the Middle East. Before the current crisis, Yemen ranked 168 out of 188 countries on the Human Development Index (UN Development Programme, 2016). The national population was estimated at 25.6 million in 2012, of whom just over half were under the age of 18 years and almost 1 in 5 children were under the age of five years. Yemen's population growth rate was more than halved between 1990-1995 (3.4%) and 2010-2015 (2.3%), assisted by a still high Total Fertility Rate (TFR) which declined from 8.24 to 4.15 children per woman over the same period. An important factor has been the declining – although still high – adolescent fertility rate. Prior to the escalation of armed conflict in March 2015, the national population was forecast to exceed 60 million people by 2050 (UNICEF, 2014).

Before 2014, the most vulnerable population in Yemen were the growing numbers of children without parental care, living in conflict-affected areas that

resulted in the death of one or more of their parents. In areas such as Sa'ada which has experienced six civil wars between the army and armed Houthi groups, it was understood that the numbers of orphaned children exceeded the number of Internally Displaced Persons (IDP) children for whom alternative care options are almost non-existent, especially non-institutional responses that offer children better opportunities (UNICEF, 2014). Alarmingly, the situation is now worse and there are growing numbers of children and young people without parental care everywhere in Yemen due to the conflict that has been ongoing since March 2015. Existing residential centres have been incapable of responding to this demand for places, and the plight of young war refugees is likely to be one of the most serious humanitarian challenges Yemen will ever face (Humanitarian Needs, 2016).

The current crisis in Yemen has left 18.8 million people in need of protection and humanitarian assistance – including 10.3 million who are in acute need. The conflict has resulted in mass displacement, severe economic decline, and a collapse of basic services and institutions. An estimated 2.2 million people are currently identified as Internally Displaced Persons, of whom more than three-quarters are living either with host communities (1.2 million people) or in rented accommodation (480,000 people).

It is estimated that about 3.3 million Yemeni children and pregnant or lactating women are acutely malnourished, including 462,000 children under the age of 5 suffering from acute malnutrition. This represents a 63 percent increase since late 2015 and threatens the lives and prospects of all those affected. A further 11.3 million Yemeni people need assistance to protect their safety, dignity or basic rights, including 2.9 million people living in acutely affected conflict areas. Vulnerable people require legal, psychosocial and other services, including child protection and gender-based violence support. In addition, child marriage remains a serious issue, with over half of Yemeni girls marrying before age 18, and 14 percent before the age of fifteen. Rates of child marriage are reportedly increasing as families seek dowry payments to cope with conflict-related hardship. Currently in Yemen, children are among the most vulnerable groups disproportionately affected by the conflict. The Monitoring and Reporting Mechanism (MRM) verified 1,309 cases of child deaths because of armed conflict between January 2015 and September 2016, in addition to 1,950 cases of child injuries. A further 1,275 cases of child recruitment by armed groups were verified during the same period.

Serious violations of children's rights have increased, as armed conflict has continued. In the first quarter of 2016, child deaths and injuries increased by 19 percent compared with the last quarter of 2015. Furthermore, verification of 'recruitment and use' cases of children has increased by 35 percent compared with the last quarter of 2015. Abduction and the arbitrary detention of children continued throughout 2016. According to the Task Force on Population Migration Location Assessment, key informants estimate that more than 7,000 unaccompanied children are living in Internally Displaced Persons communities and more than 19,000 are living in other host communities (like relying on kinship

care when living in a war-zone). It is also estimated that up to 10 percent of IDP households were headed by minors, compared with 4 percent in host community households. As the conflict continues, more families resort to negative coping measures with sometimes irreversible effects on their children, such as pulling children out of school to engage in child labour, separating children from their families, marrying off girls at an early age, and sending children to assist armed forces. Adolescents are the most likely to adopt risky behaviour and coping measures, placing them at even greater risk of abuse and exploitation (Yemen Humanitarian Overview, 2017).

Legislation and Policies

Yemen is a signatory to several Arabic and Regional declarations and treaties on child protection, rights and care (Noriah, 2009):

- Arab Code of Ethics on the Rights of the Child, 1983.
- African Code of Ethics on the Rights and Welfare of the Child, 1990.
- Arab Plan for Protection and Development of Children and Young People 1992.
- A Comprehensive National Plan for the Culture of the Arab Child 1993.
- Declaration of the Rights and Welfare of the Child in Islam, 1994.
- Arab Framework for the Rights of the Child 2001.
- The African Declaration on the Future of Children 2001.
- Arab Convention for the Child Labour, 1999.

Yemen also signed the United Nations Convention on the Rights of the Child in 1990 and this came into effect in 1991 before Yemen issued a law for Children in 2002, Law No. 45 (Noriah, 2009). The Children Rights Law number (45) in Yemen specifies what alternative social care options are to be provided and the profiles of children considered to be in difficult circumstances. It outlined the responsibilities of the Government of Yemen and society in supporting those children, to ensure that their needs are protected, so that they can live in dignity and can have a good, healthy life with access to other appropriate services. The law (45) identifies and explains the alternative care options available through family foster care, residential care and the role of the Social Welfare Fund offering monthly financial support for families with children. The establishment of the Social Welfare Fund, the issuing of the Social Welfare Law Number (131) in 1991, and the amendment of Law Number (17) in 1996, specified the obligation to protect poor children who need special care, including street children and orphans (Lamia, 2008). A case management unit was established in Yemen during 2011, funded by UNICEF under supervision of the Ministry of Social Affairs and Labour. It was intended that the case management unit would identify and address the needs of

those children through this national initiative by referring them more readily to family foster care, residential care centres or to humanitarian and other Government agencies that may be able to assist in a timely manner.

Profiles of Yemen Children and Young People in Out-of-Home Care

In Yemen the ongoing conflict and associated socio-economic issues are the main reasons why children and young people are forced into out-of-home care. According to the Law of Alternative Care, there is a term called "*children living in difficult conditions/circumstances*" that is used to describe "groups of children without care due to personal, social, economic, safety and environmental circumstances who have been deprived of their rights to live, and have access to education, play and recreation". These children and young people are exposed to potentially serious risks, and urgently require alternative care and rehabilitation services to help re-integrate them into the social environments where they live. This clause includes street children, working children, orphans, trafficked children, children with disabilities, children who have joined armed groups, children who have been abused or violated by their family or husband, as well as child beggars, unaccompanied migrant children and young people (Hilmi Al-Shaibani, 2007).

What Alternative Care is available for Children and Young People?

Both the Government of Yemen and Non-Governmental Organisations provide alternative care consisting of Family Foster Care and Residential Care Centres.

Family Foster Care

Long-Term Family Foster Care is for children and young people who became orphans due to the death of both of their parents, or the death of their father. Yemeni law recognises the biological family adult members or close relatives "uncle/aunt, grandfather/mother" of the orphans as the caregivers who are responsible for raising the orphan. This kind of family foster care is not directly implemented or managed by the Government of Yemen nor by NGOs as this is a socio-cultural practice underwritten by Yemeni law and the Islamic religion. However, if the biological family members or relatives are not able to take care of the orphan because of financial difficulties, then this orphan will be considered a vulnerable case who could benefit from financial support from the Social Welfare Fund. Moreover, if the National Court finds that this orphan will be unsafe with the biological family or relatives, then an alternative care placement is sought either in residential child care or with a new foster care family.

Short-Term Family Foster Care provides care for children aged 1 – 12 years, with unknown parents or family, or where their biological family or relatives

have refused to take care of them. When the National Court has removed a child from the care of their biological family or relatives, a new family unrelated to the orphan will take care of him or her for a specified period of time. Sometimes a family (for example, friends or neighbours of the orphan's biological family) may request permission from the Court to take care of an orphan. The orphan may benefit from the Social Welfare Fund, receive NGO financial support, or receive support through the kafalah system.

As the Western notion of adoption is forbidden in the Islamic religion and in Yemeni law, orphans will live with the new family until they reach the age of 13 – 15, after which time this family will refer the child to a residential care centre according to the agreement they have signed with the National Court. Most of the families that have agreed to take care of orphans on a short-term basis face difficulty continuing to care for orphans when they reach the age of 13-15 and mature into adulthood. These difficulties are related to Yemeni cultural and social norms, although some families do face up to these difficulties and continue providing care and support for the orphan until he/she becomes an adult.

The Kafalah System and Its Purpose

Yemeni laws, derived from the "Islamic Sharia", do not recognise adoption. The *kafalah* system does allow, however, for foundlings and orphans to be placed in the care of State-run and civil society institutions, or in the care of individuals who meet specified legal criteria. Such children are provided with full care, including education, health, social services and day-to-day living support (Child Rights Convention, 2009). The Kafalah system may support other adolescents aged 15 – 18 years who choose to live independently. These independent young men may have some follow-up and case-management support supervised by the Ministry of Social Affairs and Labour. However, Yemeni youths are treated as men once they reach the age of 12. Accordingly, some youths live on their own if their parents are dead and they have no other family members who can take care of them. These young men believe they can live independently of family foster care or a residential care centre.

Children and young people living in long- or short-term family foster care are also able to benefit from the *kafalah* system, which includes financial support provided from the Social Welfare Fund, other private associations or NGOs. The *kafalah* sponsorship system, operated by private associations, pays monthly benefits to cover the costs of keeping an orphan with a family, covering food, health and education. Although there are no precise official figures on the number of children living with families sponsored by private associations, available data suggests that the approximate figure is 30,000 families (Child Rights Convention, 2009).

Kafalah is similar to kinship care to the extent that both generally promote continuity in upbringing in relation to children's cultural and religious backgrounds. In the practice of *kafalah*, a child is usually placed in a family that is as closely related to his or her natural family as possible without the new parents totally displacing

the birth parents. Three features distinguish *kafalah* from adoption: (1) non-severance of family ties; (2) non-transference of inheritance rights; and (3) no change in the child's family name (Assim & Sloth-Neilson, 2014). In the main, *Kafalah* is primarily a moral obligation for Muslims towards children without parents. The closest relatives usually absorb the children into their family network (on an informal, largely spontaneous and unregulated basis). Both *kafalah* and kinship care are thus able to provide stability and continuity for the progressive growth and development of children (Assim & Sloth-Neilson, 2014). An estimated 117,000 orphaned children in such foster care households were assisted through the Social Welfare Fund in 2007, while an estimated 40,000 orphans were further sponsored by NGOs every 2/3 months through their foster care *kafalah* (UNICEF, 2014). The Social Welfare Fund provided registered orphans with around $80 every three months, and the local NGOs supported other orphans with $100 every three months. Some fortunate orphans might be approved and supported by an Arabic Gulf charitable foundation and receive $300 every three months. However, because of the post-2015 armed conflict and reduced financial resources among donors, the Social Welfare Fund is no longer able to provide financial support to beneficiaries, nor have the NGOs continued to offer support for orphans (UNICEF, 2014). Fortunately, acting through its humanitarian aid initiatives, UNICEF established a partnership with the Social Welfare Fund in late 2016 to support Yemen's most vulnerable beneficiaries with 6-monthly instalments of $100 for social welfare beneficiaries, including orphans.

Residential Care Centres

Long-Term Residential Care Centres assist orphans, children with unknown parents, children of unmarried juveniles and children with a disability. These Centres may include large numbers of residents (from tens to hundreds) living in Orphanages-Residential Care Homes, Comprehensive Social Rehabilitation Services Centres, and Residential Care and Rehabilitation Centres for Children with Disabilities.

Short-Term Emergency Residential Care Centres operate to provide a quick response to the need for a residential placement with other basic services that include health, education and food. Safe children's centres operate for labouring/street children and as protection centres for child trafficked victims.

Residential Care Homes can offer long or short-term services and provide care for limited numbers of children in residential houses similar to a family environment. This type of residential care is for orphans and children with unknown parents.

Practices and Objectives of Residential Care Centres

Readers are now offered a general overview of the five most common types of residential care centres to be found in Yemen, with a brief indication of their objectives, purpose and practices as well as the types of children generally found in each.

Orphanages and Residential Care Homes and Centres

The first Orphanage in Yemen was established in 1922 in Sana'a, and the number of Orphanages has increased from 12 in 2005 to 31 in 2008 (Noriah, 2009). There are presently more than 31 Government of Yemen and private/NGO centres. Eight orphanages are managed by the Ministry of Social Affairs and Labour and two centres are managed by the Ministry of Education. The other twenty-one Orphanages are operated by NGOs and private agencies (Coordination Network, 2012). Some of these centres offered complete education and rehabilitation care services with long-term services and permanent accommodation. Day care centres provide care, education, and other rehabilitation service activities and then at the end of the day, these young people return to their wider families' compounds to sleep.

The Orphanages or Residential Care Centres cared for almost 3,000 children in Government-run facilities, and almost 2,000 children in jointly-run or NGO-run facilities. According to the National Social Protection Monitoring Survey 2012, at least 560,000 Yemeni children have one or both parents who have died (UNICEF, 2014). Statistics obtained prior to the decade of warfare show that in 2004, there were 33,180 orphans in Yemen. Only 2,432 were placed in government-run residential care institutions and 748 in NGO residential centres. The largest number of orphans were in foster care – 30,000 – with biological family members and were receiving financial aid from local and regional charities in coordination with the Ministry of Social Affairs and Labour (Situation in Yemen, 2004). Unfortunately, there are many orphans who are on the waiting list to be admitted to Residential Care Centres, to charitable foundations, or to obtain support from the Social Welfare Fund. There are many orphans who have been waiting for more than two years prior to the current conflict and this gap will grow larger because of the surging numbers of orphans.

The *kafalah* system may apply but there are again many orphans on the waiting list hoping to be accepted, even though the financial support that orphans receive is insufficient and not responsive to emergencies. Most Residential Care Centres operated by NGOs or charitable foundations used to receive most of their funds from Arab Gulf countries. However, these funds and support have dwindled or ceased altogether because of the current conflict. As a result, some centres have discontinued most of their programmes and reduced the number of beneficiaries. This means that many orphans are forced to go back to their poor relatives, live on the streets, or join the armed groups on one side of the conflict or the other.

Objectives of the Orphanages or Residential Care Centres

- *To provide comprehensive care for orphans and children who are in difficult situations through the residential care houses/centres and other programmes and activities.*

- *To achieve the principle of safe childhood.*

- *To develop the capabilities and talents of children and build their life skills through training courses on Computers – Internet – Reading – Self-Confidence – Hand Crafts – Sewing and Embroidery – Drawing – First Aid.*

- *To provide psychological and social support and assist them with Health – Education – Entertainment – Sport services and activities.*

- *To raise community awareness of their role and their responsibility towards the target groups.*

Type of Orphanages Care Homes or Service Centres

- *Social care and shelter,*
- *Education,*
- *Psychological support,*
- *Health,*
- *Sports and Entertainment,*
- *Cultural Activities,*
- *Capacity-Building and Skill Development,*
- *Clothing and Foods*

Terms of service provision

- *Should be age of 6 to 18 years.*
- *Should be an orphan because their father died, or because their mother or family could not take care of them because of financial difficulties or other reasons.*
  - *Official documents*

Follow up care after orphans leave the residential house or centre

After the orphans leave the residential house/centre when they reach 18 years old, they receive a scholarship to study at the universities, and they are referred to another residential house where they live until they have graduated from the universities. Those residential houses have few services and staff, and usually the orphans manage these houses themselves. After graduation the residential house/centres coordinate with business men and private companies to find job opportunities for those young people. They also support those orphans when they get married, by usually organising group marriage celebrations for 50-100 orphan males and females every year.

Comprehensive Social Rehabilitation Service Centres

These centres are for children in conflict with the law and are all run by the Ministry of Social Affairs and Labour. They provide food, clothing and protection along with residential programmes offering a variety of educational, rehabilitative, social, psychological and health services as well as cultural and religious activities. These centres cooperate with official and non-official institutions as well as NGOs and INGOs to address the needs of young people in these centres (Noriah, 2009). By 2014, Yemen had a total of ten of these juvenile centres, accommodating 440 boys and 100 girls across seven government-run institutions (three for girls) and serving a population of more than 3,000 young people. There is some indication of successful rehabilitative and educational interventions rather than any serious levels of overcrowding (UNICEF, 2014). These existing centres cover 10 out of the 24 governorates or provinces in Yemen, meaning that 14 of the governorates have no centres – and this is seen to be a serious problem (Coordination Network, 2012). According to some sources, most children who are in conflict with the law come from poor and marginalised communities or from large families, or they have psychological issues or social disorder behaviours as victims of family violence, or present other behavioural problems (Noriah, 2009).

Safe Childhood Centres

Safe Childhood Centres are for child labourers, street children and victims of family breakdown or domestic violence who are fleeing from their families. Yemen is experiencing increasing numbers of "street children" eking out a basic living on the streets. Such children are among the most vulnerable to exploitation and face extreme threats to their protection, such as trafficking. According to a *Higher Council for Motherhood and Childhood* report written in 2008, the number of street children in Yemen was estimated at 30,000 across 8 of the 24 governorates. One NGO study indicated that these children are as young as six years and 85 percent are boys, with 3 out of 5 working and sleeping on the streets, and a third sleeping in a temporary residence. One report to the Committee on the Rights of the Child in 2005 presented an unofficial estimate of 2 million Yemeni children living and working on the streets. This translates into a somewhat implausible figure of more than one in every four Yemeni children aged 6-17 years old living and working on the streets (UNICEF, 2014).

The Ministry of Social Affairs and Labour's response was the introduction of a Programme for the Protection and Rehabilitation of Street Children and the establishment of four Safe Care Centres in 2001. These centres, managed by NGOs in Sana'a City, Aden, Hodeida and Taiz governorates, provide basic services, protection, rehabilitation programmes, psychosocial and health care, educational opportunities, family and social reintegration through participation in civil society. In 2008, some 400 street children were assisted by these four Centres. A further 30 centres are operated by NGOs and the State to provide a range of support services for street children and child labourers (UNICEF, 2014).

Some of these children return to their families or move into orphanages or residential care centres "for children who have no families" (Child Rights Convention, 2009). Despite progress, the Committee on the Rights of the Child has voiced its concerns about the scarce availability of social re-integration as well as physical and psycho-social recovery measures for child victims. The State acknowledges the shortage of local expertise, the absence of residential centres, and the shortage of centres offering rehabilitation and assistance for social reintegration to child victims. The State also acknowledges the continuing need to strengthen the scope and technical capacities – and therefore the effectiveness – of existing responses, especially for those children living on the streets (UNICEF, 2014). However, the current conflict continues to increase the number of child labourers and street children!

Objectives of the Safe Childhood Centres

- Provision of residential, health, social, psychological support and rehabilitation for street children
- Building the children's capacities and skills
- Working on the inclusion of those children in the community and linking them with their families
- Raising awareness in families and the community of children's rights and the adverse effects on those living on the streets.

Protection Centres for Victims of Child-Trafficking

Yemen is a country of origin and, to a lesser extent, a transit or destination country for men, women, and children subjected to forced labour and sex trafficking. Some Yemeni children, mostly boys, move to the Yemeni cities of Aden and Sana'a, or travel across the northern border to Saudi Arabia and, to a lesser extent, to Oman where they are subjected to forced labour in domestic service, small shops, or as beggars. Some of them are forced into prostitution by traffickers, border patrols, other security officials, and their employers once they arrive in Saudi

Arabia, and some are forced to smuggle drugs to Saudi Arabia (Trafficking Report –Yemen, 2013).

Government efforts to protect victims of child trafficking have been largely insignificant. No formal victim identification procedures are operational to proactively identify and assist victims of trafficking among vulnerable groups, whether they have been arrested for prostitution or as illegal immigrants. The Government of Yemen has largely failed to ensure that victims of trafficking are not incarcerated inappropriately, fined, or otherwise penalised for unlawful acts committed as a direct result of their being trafficked. In 2012, an international organisation identified over 2,000 Yemen trafficking victims. The Government did not operate shelters for trafficking victims, nor did it provide protective services to adult victims of either forced prostitution or forced labour. Two juvenile detention–protection centres were established in Sana'a and Haradh for child trafficking victims, although these centres were not dedicated to providing adequate protective services to child trafficking victims, nor could they deal with the large number of trafficked victims in Yemen (Trafficking Report –Yemen, 2013).

Residential Care and Rehabilitation for Children with Disabilities

Many vulnerable disabled children and young people are at risk of abandonment by their families, some have families who cannot take care of them, and many have no families. Some rehabilitation centres provide residential care services for children and young people with disabilities through the support of a few large, well-known Disabled People Organisations. A UNICEF report indicated that 1 in 4 children aged 2-9 years of age in Yemen had at least one disability. Children with disabilities in Yemen are frequently isolated from other children and denied access to mainstream schooling (UNICEF, 2014). In recent years, these Residential Care and Rehabilitation for Children with Disabilities Centres have achieved positive outcomes through their interventions with basic and rehabilitation services, psychosocial support, education and health programmes. They have enhanced the skills and capacities of children and young people, providing the community with many success stories about the lives of children and young people with disabilities, and taking the lead in raising community awareness on the rights of people with disabilities. However, those centres cannot address all the needs of children with disabilities in Yemen given, as some NGOs sources have indicated, that there are more than 2 million disabled people in Yemen. These rehabilitation centres are few and face many difficulties because of the ongoing conflict which restricts their capacity and their ability to respond to the needs of children and young people with disabilities.

Conclusion

There are some good Residential Care Centres, where Yemeni cultural values and religious beliefs have played a very positive role with respect to particular care practices and interventions. On the other hand, some social norms and traditions may stand as barriers, for example, preventing girls from having access to care and education services provided by residential care centres. It is essential that gender themes be given special attention when providing competent care for all children, since any personal discrimination suffered by girls in Yemeni society is compounded by the fragility of their situation as young women across the region. In Yemen, residential care centres are considered the last placement of choice for children and young people. However, there are a few efforts to develop interventions that could assist in preventing the separation of children from their families.

After months of civil war between Houthi tribes and Saudi Arabian military forces, supported by the United Arab Emirates, life in Yemen has deteriorated beyond imagination. Plans and aspirations that may have existed prior to 2015 have been dashed through death, destruction of essential infrastructure, cholera outbreaks, and burgeoning numbers of orphans. Time will tell what the outcomes might be, while children by their thousands have died or been made orphans in the world's most impoverished country.

Questions for Small Group Discussion or Guided Reflection

1. *Located between the Horn of Africa and the Arabian Peninsula makes Yemen a first destination or key transit point from Africa for many people seeking refuge during the humanitarian crises brought about in the region through drought, famine and conflict.* From which countries are most asylum-seeking migrants likely to travel through Yemen to countries further north in the Middle East and Europe and what cross-cultural challenges might these young people encounter?

2. *On 26 March 2015, an international coalition led by Saudi Arabia launched airstrikes against the Houthi armed militia that had taken over the capital Sana'a and forced the Yemeni Government into exile. What was meant to be a short, sharp campaign to stop the advance of the Houthis and restore President Al-Hadi to power, these initial airstrikes escalated rapidly into full-blown armed conflict.* What do you know about the Houthi people of Northern Yemen and why they are in conflict with the Government of Yemen and their Saudi Arabian supporters?

3. *The Yemen Humanitarian Country Team estimated that the current crisis has left 21.2 million people in need of humanitarian assistance, including more than 9.9 million children – the most vulnerable of all impacted by the conflict. About 1.3 million of these children are acutely malnourished, and an additional 880,000 are at risk of malnutrition.* What residential care or foster care options might be considered when seeking to address these challenges?

4. *'Children living in difficult conditions and circumstances' refers to diverse profiles of children and young people in need of out-of-home care, including street children, working children, orphans, trafficked children, children with disabilities, children who joined armed groups, children who have been abused or violated by their family, children beggars, and unaccompanied migrant children and young people.* In what ways might this profile of Yemeni young people in out-of-home care compare with young people in alternative care placements where you live?

5. *Kafalah is similar to kinship care to the extent that both generally promote continuity in upbringing in relation to children's cultural and religious backgrounds. In the practice of kafalah, a child is usually placed in a family that is as closely related to his or her natural family as possible without the new parents totally displacing the original parents. Three features distinguish kafalah from adoption: non-severance of family ties; non-transference of inheritance rights; and no change in the child's family name.* Compare and contrast the Islamic kafalah system with traditional adoption practices?

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Acknowledgement

Residential Care for Children and Young People in Iraq's Kurdistan Region

Chro Mohammed Faraj[1]

Abstract

This chapter reviews care and protection policies and practices with children and young people in the semi-autonomous Kurdistan region of Northern Iraq, focusing on residential care provisions for juveniles. These policies include a range of activities and institutional practices which work to provide services for individuals, families and society. These services are supervised by the government with the assistance of humanitarian organisations, sometimes on a micro level and sometimes on a macro level.

Introduction

Institutional or residential care and protection policies were initiated by government in the Kurdistan region of Iraq with the assistance of charitable contributions from individuals, groups and organisations. The special needs categories – including children and young people (Juveniles) – have grown because

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of a society that has developed around the complexities of modern life, amid the ravages of war that have continued for more than two decades, disrupting life as Iraqi peoples knew it – everywhere. Several factors led to the government establishing laws and regulations for the provision of services and vital assistance for its citizens with special needs and as well as for all citizens (Law of Juvenile Houses – Year 1986, 2016; Law of Juvenile Houses in Kurdistan Regional Government of Iraq, Number 1, 2008). These factors included the availability of resources, a growing awareness and development of academic, scientific, and professional social services, and increased understanding of the importance of care and protection policies for children and young people. Social welfare became a government bureaucracy, evolving with the progress and development of society – still impacted on all fronts by histories of warfare. Institutional care and protection policies include programmes to improve the physical and mental health, psychological, economic, social, and educational circumstances for children and young people and to help them develop their abilities and skills, learn how to interact and adapt with other people around them, and subsequently, to live full, self-supporting, independent lives.

Historical Development of Institutional Care for Children and Young People in the Kurdistan Region of Iraq

Generally, the development of institutional care for children and young people throughout the Kurdistan region is comparatively recent, beginning in 1953, when social welfare programmes and policies were first established. Orphanages were opened in the 1950s within the social care system, organised by the government at that time. This initiative has evolved over the decades that followed and legislation was enacted to cover the care of juveniles. The historical development of social care institutions in the Kurdistan region can be grouped into four stages.

Stage One: The first social care house was established by the State in Sulaimani city in 1953 with the goal of taking care of juveniles boys (orphaned children). It was then called an 'orphanage' but changed its name to the 'School Success Charity'. In 1958, after the annexation of charities into the Ministry of Labour and Social Affairs, the name was again changed, this time to 'State House for the Care of Juvenile Boys'.

Stage Two: Social welfare projects were established in the three governorates of Arbil, Al-Suleiman and Dohuk, up until 1974. In Arbil there were two types of social welfare institutions – Juvenile Houses and Social Centres – and in Al-Sulaiman there were two types of institutions – Social Centres and Juvenile Care Centres – while in Dohuk there was one type of institution named Juvenile Welfare (Ghafur, 2003). Social centres provided only a very narrow range of services, through raising awareness, counselling services, teaching sewing and knitting, giving lessons in literacy, and vocational education in printing for female students aged 10

years and older. There was also a house for infants attached to the social centres. The Social Welfare administration provides its services to a large section of the community including all governorates and cities in the Kurdistan region. It serves different age groups in different institutions to its residents who are unable to meet their basic needs on their own, and includes those who suffer from poverty, deprivation, disability, deficit, and homelessness. Social Welfare institutions comprise the following categories:

- Juvenile Care Houses for Boys
- Juvenile Care Houses for Girls
- Homes for the Elderly and Aging
- Homes for Infants
- Institutes for the Deaf and Mute
- Institutes for the Mentally Retarded
- Vocational Rehabilitation Institutes for People with Disabilities
- Observation Houses for Children
- Institutes for the Blind.

Several centres also provide services, such as shelters for the protection of females who have been threatened. These shelters also provide a house for the children of these females as well as for the staff and their children. In addition, there is a family counselling centre that provides support and guidance following transfer from another institution or exposure to psychological and social challenges. There is also a centre for children and young people with autism, discussed in more detail below.

Stage Three: Social care developed further when the law on social care was passed in 1980, signalling an expansion in social welfare projects and the establishment of several social welfare institutions. The first was established in 1980 in Arbil, named The Light Institution for The Blind, caring for blind youths of both genders. Hope Institute for the Deaf and Dumb (Mute) was established in 1980 to care for children of kindergarten age or pre-school age and elementary-school age, suffering from complete loss of hearing and speech. In Duhok, the Hope Institute for the Deaf and Dumb was established in 1981. Then in Sulaimani, the Institute for the Deaf and Dumb was established in 1983, and the Institute for Mental Disorders in 1984. A few years later, social welfare institutions were established under the name of Vocational Rehabilitation Institutions, in Dohuk (1986), in Arbil (1987) and in Sulaimani (1988) (Ghafur, 2003).

Stage Four: In 1991 major political, economic and social changes occurred as the first government of the Kurdistan region was established, resulting in the further development of social care. Further advances were made to provide services for the families and relatives of martyrs and victims of the Anfal genocide carried out between 1986 and 1989 during the military campaign waged against the Kurdish

people during the final stages of the Iran-Iraq War, led by Ali Hassan Majid – Chemical Ali – cousin of Saddam Hussein. Important regional advances have also been seen in the development of services for the disabled, the blind, street children, those with special needs, orphans, the aging, widows' children, and those without a guardian or someone to take care of them. Previously, juvenile delinquents had been transferred to Baghdad or Mosul but in 1991, services for the rehabilitation of juvenile delinquents were also established in the Kurdistan Region (Ghafur, 2003).

In 1996, a non-residential centre for boys and girls was established in Martyred Halabja by the German Valley Organization. This centre cares for children and young people ranging in age from 6-18 years but the building lacks facilities for sleeping, reading, communication, transport or outdoor games so that the young people are not able to sleep there (Ghafur, 2003)

The start of the third millennium, 20 March 2003 precisely, saw the invasion of Iraq by the US-led 'Coalition of the Willing' that included the UK, Australia, Spain and Poland, that brought about significant political, social, and economic changes for the second time. An estimated half million Iraqis were killed in the first 3-4 years of that conflict. Accepting its responsibilities toward society and all the individuals who live within its borders, the Kurdistan Regional Government is continually trying to provide services to as many groups in society as required, always struggling to balance the services it provides with the availability of resources to which it has access.

The war along with the national, political, and economic crises in the world – the Middle East in general, and in Kurdistan-Iraq in particular – have created major challenges that affect the growing number of welfare needs. It is worth noting that social welfare and social care are responsibilities of the governorate and the general administration of social welfare at the Ministry of Labour and Social Affairs of the region. The Kurdistan Regional Government funds and supervises the social welfare institutions, and several organisations also aid these institutions, such as UNICEF and the World Food Program sponsored by World Vision. Other organisations provide limited assistance to these institutions at times, like Kurdistan Save the Children, Save the Children Fund, UK, Peace Wins Japan, Help Age International, etc. (Ghafur, 2003).

In summary, residential social welfare has gone through several different historical stages. Social welfare institutions were built for the first time in Kurdistan Iraq in the middle of the Twentieth century, primarily through the efforts of philanthropic individuals and charitable organisations. Then, several houses and institutions were opened in the early 1980s, supervised by the Ministry of Health and Social Affairs. After the great uprising in the Spring of 1991 and the establishment of the first Kurdistan regional government, the Ministry of Labour and Social Affairs was established to take on responsibility for supervising all community social welfare projects, services and institutions. Each of these institutions is specialised and deals with a clientele in need, for whom they provide

social welfare services according to individual needs and circumstances. It is worth mentioning that many of the social welfare institutions or social centres have changed their names according to the services that they provide to their clients, and some of the social centres have been closed due to the lack of qualified staff in these fields. Attempts are continuing to establish other institutions aimed at meeting the needs of people with special needs, in line with ongoing scientific and professional development, and according to the requirements of the social and economic changes and resource availability in the region of Kurdistan. Today there are social welfare institutions located in the cities and towns of Arbil, Sulaimani, Duhok, and Halabja governorates.

Residential Child and Youth Care in Kurdistan:

Existing residential child and youth care services include a number of governmental institutions administered by the governorate through the general administration of social welfare at the Ministry of Labour and Social Affairs of the region supervised by the Kurdistan Regional Government. These institutions include many services directed towards different clientele:

- Juvenile Houses for Boys
- Juvenile Houses for Girls
- Homes for Infants – from birth to four years of age, including children who have lost their parents for any reason. The numbers of children are constantly changing over time, but the current number is approximately 30 in each home.
- Institutes for the Deaf and Mute – for teaching students who are deaf and mute between the ages of 6-14 years.
- Institutes for the Blind – to teach the blind of both genders.
- Institutes for the Mentally Retarded – for the children with mental retardation who range in age from 6-13 years; they are grouped according to their degree of mental abilities, to facilitate their education, general skills and social adjustment
- Institutes of Vocational Rehabilitation for the Disabled – to teach students who range in age from 13-18 years, where there is a workshop that contains sections for learning subjects like ceramic, roses industry, crafts, and sewing.
- Observation Houses for Homeless Male Children – which accepts children who range in age from 6-18 years, who have been found on the streets because of the deteriorating economic and social conditions in the region; most cases are the result of family breakdown; the hope of the observation houses is that they will be sent back to their families after their social behaviour has improved.

- Health Units – to identify and improve the health status of children and adolescents in social welfare institutions, including the following services:

    i.   Medical treatment for children and adolescents.
    ii.   Protection from disease for children and adolescents.
    iii. Dissemination of health education to children and adolescents.
    iv.   Facilitate procedures of operations for children and adolescents.
    v.   Medical examination for institutions, infant and juvenile houses.
    vi.   Provide and raise awareness about the health of workers in social welfare departments.

- Autism Centres – to build a reciprocal relationship with the autistic child on the one hand and to build a relationship with the child's family on the other hand. They prepare courses and meetings for the child's family to raise their awareness and their ability to raise their child properly. They arrange visits to the homes of the families who have an autistic child to gather information and develop programmes to implement in the autism centre. They then work on the conditions, circumstances and challenges that families are experiencing to reduce pressures and problems as much as possible.
- Other Assistance Centres operate from the former institutions, for example the educational centre has organised courses for the blind, such as sessions using special software, print various books about educational and recreational subjects for the blind, organise and customise lectures about computer learning for the students of the blind institute from Grade 4 to Grade 9 in primary stage, and an exhibition of audio books on cassettes and CDs for the blind.
- Emergency Line Project for Children offers a free phone line and connects with nearly 80 government and non-government institutions and organisations in the field of children protection and service. Its role is to listen to the children who call when they have a problem and cannot talk about their problem with their family, peers or anyone else, or they are somehow neglected and need someone to listen to them talk about their problem. This line offers psychological, social, and educational counselling from academic staff in the social, psychological, and educational fields. This project sometimes sends children to the protection institutions if they are unable to help them through the phone. (Emergency Line For Children, 2017)
- In addition to the institutions above, the Kurdistan regional government, through the Ministry of Labour and Social Affairs, designs other permanent or temporary institutions.

- Other organisations or campaigns depending on need and availability of resources. For example, currently the Ministry of Labour and Social Affairs in Kurdistan – with the assistance of UNICEF – is working on developing an adoption unit. (Unit of Adoptive Family, 2017). Once they are properly trained, adoptive families are frequently the best option from a social, psychological, health, educational, and legal point of view for children who have lost their own family and have no place other than a juvenile house in which to live.

Juvenile Houses in Kurdistan

Residential child and youth care in Kurdistan is comparatively new, and ongoing attempts are being made to improve the level of services and to achieve increasingly positive results in the care of children and young people. This is an influential and active population in Iraq society who require on-going care, supervision and the support of families. The care of children and young people is one of many social welfare institutions in the Kurdistan Region that offers full-time social services. Children, adolescents and young people are called juveniles and are cared for in residential institutions called *Juvenile Houses*. The aim of these Houses is to socialise and educate juveniles who are placed there because they have special needs – usually because of the break-down of their natural family environment.

The government takes care and provides full social services for children and young people who have lost their families or who have been otherwise deprived of their normal social environment because of family breakdown, the loss of one or both parents, or because they are the victims of disasters or wars in the region. Kurdish society has suffered much throughout its history, because of continuing political and geographical challenges. These have generated many difficulties for successive governments, adversely affecting the level of care provided for children and young people in residential care and impacting on care standards in Kurdistan Iraq when compared with equivalent international child and youth care standards globally. The constant change and turbulence that affects all aspects of life in Iraq society has led to many social problems across the whole population, including poor social conditions, misunderstandings and family breakdowns, separations and divorce. As a result, there has been an increase in the number of children who have no family or relatives to look after them.

These young people have lost their natural families and an environment that may have offered opportunities for a more normal growth and development. The juvenile houses were created to lift children and young people out of, and away from the effects of poverty, despair, deprivation, homelessness, abandonment, and other life-threatening experiences. All children and young people have a right to grow up in a suitable social environment, where he/she can develop his/her personality and become a useful, contributing member of society. In other words, a juvenile house represents a family alternative for children and young people by

providing them with socialisation and education opportunities, offering kindness and compassion, and by helping to meet their physical and spiritual needs by providing psychological, social, medical, economic, and entertainment support. In doing this, the juvenile houses seek to create a normal and suitable environment in which to raise children and young people in a protected setting away from deviant behaviour where young people can develop to their full potential and become useful citizens who can benefit their society.

The care and protection of children and young people includes any and every action taken with the juvenile to develop his/her resistance and reduce his/her power in responding to harmful stimuli surrounding him/her for protecting them from falling into delinquency. These services can be offered to young people who have been homeless, abandoned, maltreated, abused, deprived or maladjusted. After studying the case of each child and young person, the aim is to determine what appropriate care and treatment is required.

Life in the Juvenile Houses follows, as much as possible, that of a normal family home in Kurdistan. Other aspects of their lives are more organised and follow specific programmes. First, the juvenile house provides the basic essentials of food, air conditioning units, clothing, study and stationary needs, bedroom furnishings, washing machines, pocket money, sports equipment, videos and televisions. During the summer holidays, there are courses for learning English language, manual labour, ceramics and baking. A committee consisting of social specialists and teachers in the juvenile house visit the schools of these children and young people, to monitor their educational achievements. At the end of the year, they can identify the students who are not doing so well so that they can be supported, while awards are distributed to those who have been successful. Second, aspects of young peoples' lives are programmed and organised as, for example, meals are provided at set specified times three times a day, and a few hours are spent in the reading room with their teacher. After a break, the young people go to school in two groups, one in the morning and the other in the afternoon. Children can visit their parents' house if they want to after obtaining permission from the manager of their juvenile house.

Juvenile Houses are divided into two main sections: Juvenile Houses for Boys and Juvenile Houses for Girls. Both parts are separate and have separate management structures. Each part is divided into three groups based on age, generally as follows:

1. The Young Children's Section includes children between the ages of 4-10 years.
2. The Mid-Age Children's Section includes young people aged 11-14 years.
3. The Adult Children's Section includes youths between the ages of 15-18 years.

Each governorate with Juvenile Houses also has an Infants' House for both girls and boys together ages from birth to the age of four years. When children reach the age of four years, girls are sent to the Juvenile House for Girls while boys are sent to the Juvenile House for Boys. There are presently three juvenile houses in the Kurdistan region: one in the governorate of Arbil; one in the governorate of Sulaimani; and one in the governorate of Dohuk. The resident population of infants, children, and young people is always changing. In 2016, almost thirty infants were resident in each infant house and some fifty children and young people were living in each juvenile house (Data and Information, 2016).

The Juvenile Houses

All the Juvenile Houses are similar, having been built in accordance with guidelines for institutional-residential buildings for juveniles and are made up of two main wings:

a. An administration wing of the building that houses the service departments and administrative units for the manager and other staff.
b. The service wing includes several rooms along with halls, for sport, for functions and for reading, as well as a kitchen, bathrooms and a garden.

The administrative side of a Juvenile House consists of offices and meeting spaces for specific persons who work as a team within a set roster, with work roles and tasks identified according to specialisations, as follows:

1. The Director is primarily responsible for controlling, supervising and organising all the different activities inside and outside the juvenile house. He or she holds a certificate in sociology, with the manager of the juvenile house for girls being a female and the manager of the juvenile house for boys being a male.
2. Researchers are both male and female, hold a certificate in sociology or psychology, have a direct relationship with the manager, and organise relationships with the school, police, juvenile court and the juveniles' families or relatives.
3. Teachers follow the juveniles' education and study progress in an ongoing manner.
4. Care Workers supervise the cleaning and monitor juveniles' meals, change of clothes, and sleep in the evening and mornings. They oversee some of the different activities and alert medical staff if a juvenile becomes ill or needs to be taken to hospital.
5. Supervisor of an internal section deals with official correspondence, answers letters, deals with most official communications concerning staff

and juveniles, and prepares reports concerning the transfers of juveniles and staff.

6. Supervisor of the storage section supervises the warehouses where the main supplies are stored, like food, drink, stationary, clothes, and maintains appropriate records.

7. Cook prepares food daily for all meals, is an expert in healthy food, prepares meals, and takes responsibility for cleaning the dishes and the kitchen as well.

8. Child care workers supervise and care for the juveniles physically, look after them, and teach them the habits and traditions of the society. They are a second mother to the juveniles because they deal with the juveniles directly, helping children to wash and change their clothes, clean their closets and rooms, and also read them stories.

9. Health personnel examine the juveniles when they are sick, can provide first aid and offer medical treatment.

10. An accountant distributes salaries to the juvenile house's employees and pocket money to the juveniles as well.

11. Cleaners are responsible for cleaning throughout the juvenile house, including the halls, rooms, clothes, bathrooms.

12. Guards constantly monitor security at the juvenile house on a shift system day and night.

13. Drivers transfer juveniles to school and then return them to the juvenile house.

The Objectives of Juvenile Houses

The main objective of a juvenile house is to provide opportunities for the all-round development of young people as with any other young person who leads a normal life in society, including specific targets for the provision of services that meet primary and secondary needs. Budgets are managed by the government while charitable organisations provide material assistance for the Juvenile Houses annually whose goals can be summarised as follows:

1. Provide for the residential needs of those living in the Juvenile House – a place to sleep, a place to study and a place for recreational activities.

2. Provide for basic physical needs – food, sleep, cleanliness.

3. Provide for security needs by protecting the juveniles from risk of death, disease, hunger, and delinquency.

4. Provide for psychological needs that may require support to compensate for the love and compassion of absent parents.

5. Provide for social needs, by maintaining social atmosphere like that found in any other normal family in the community.

6. Provide for educational opportunities to study and prepare for their future, by sending them to school, providing care, as well as educational

stationery and office supplies, following up the juveniles' education throughout the year, and offering various educational courses inside the Juvenile House.

7. Provide health services – both preventive and therapeutic services.

8. Provide for recreational needs to develop juveniles' abilities and fill their leisure time – manual work, computer literacy, learning music, sports, English language, yoga, recreational activities at public events, weekly outings, camping and picnics in the summer holidays, etc.

9. Follow-up the juveniles on an ongoing basis to ensure their comprehensive development in all aspects.

Acceptance Criteria for Young People in the Juvenile Houses

Children and young people are accepted into a Juvenile House in line with specific conditions identified according to the court system, Number (4) for the Year (2008), Article (7) as follows:

1. Be a Kurd or Iraqi citizen and live in the Kurdistan region.
2. The death of mother.
3. The death of father.
4. The death of father and mother.
5. Family poverty.
6. Parental separation.
7. The imprisonment of father or mother.
8. The desperation of father or mother.
9. There is no one to supervise or care for the child.
10. There is a problem identifying the parentage or family of the child, so that the court decides to send the child or adolescent to a juvenile house for a short or long period of time. (Law of The System of Juvenile Houses in Kurdistan Regional Government of Iraq Number 1, 2008)

Conditions under which a Young Person can Leave a Juvenile House

Juveniles leave the Juvenile House in accordance with specific conditions that have been identified according to the court system, Number (10) in year (2008) and Article (11) as follows:

1. Be over 18 years of age.
2. One of the young person's family members returns the juvenile to their home.
3. The juvenile moves to an adoptive family and by law, the government pays 400,000 Dinar monthly to that family for bringing up the juvenile.
4. Leaves the school.

5. Juvenile is so deviant that it has become too difficult to treat that deviation.
6. Be employed in one of the government institution's departments.
7. Following an order from the court to the person responsible for supervising the juvenile while resident in the Juvenile House. (Law of The System of Juvenile Houses in Kurdistan Regional Government of Iraq Number 1, 2008)

The process of receiving children and young people into a Juvenile House involves approval by the juvenile court and a specific committee consisting of the manager of the Juvenile House, a social worker, and a psychologist. The youth is taken to the Juvenile House by the juvenile judge, the juvenile police or by the juvenile's parent or relatives. After the young person has stayed in the Juvenile House for the time specified by the court, she or he continues to be supervised through an after-care service operated by juvenile house staff who follow up with the young person.

Social Care Practices in the Juvenile House Programmes

The Juvenile House offers its own services to residents on a daily, weekly, monthly, seasonal and annual basis. These practices generally follow a particular programme, as suggested below:

1. Physical care practices offering three meals every day at set times and a menu that follows a weekly programme. Clothes are changed three times a year in line with the winter, spring and summer seasons.
2. Psychological and social care practices start as soon as the young person arrives at the house and is carried out by a social worker and psychologist who study all aspects of the young person's life, to identify and gain information about the juvenile's situation and problems. A programme is then developed to help the juvenile work to solve or mitigate personal problems and issues, aimed at restoring psychological reassurance to the juvenile and providing opportunities to trial new ways of adapting in their community through constructive, preventive, and remedy services.
3. Health care practices focus on structural, preventive, and treatment aspects. Periodic examinations are carried out and necessary vaccines are given. Medicines and medical supplies are provided by the government and the World Health Organisation, with health programmes supervised by workers in the health field.
4. Educational care practices form the core of work carried out by teachers. This includes sending the young people to school, delivering educational lectures in the juvenile house to increase awareness of specific subjects, following up the juveniles' progress, participating in committees when needed, providing monthly reports on the juveniles' learning level and

performance to the social research department in the juvenile house, supervising the library and library activities, organising educational courses to learn English language, computer, manual work, and other courses.

5. Economic care practices involve provision of daily pocket money and monthly allowances paid throughout the year to the young people. This comes in two forms. Firstly, young people are given a specific amount of money for their daily and monthly use. Secondly, another amount is placed in their bank accounts (every juvenile has his/her own bank account) for their future. Daily pocket money differs according to the juvenile's age. Monthly pensions or allowances are provided annually for juveniles who leave the juvenile house or now live with an adoptive family. Money that is provided by foreign charitable organisations on national and religious occasions, are also collected and put in the juvenile's bank account. When the juvenile is accepted into a college, the government makes financial payments until completion of the juvenile's studies.

6. Recreational care practices are provided by administration staff in collaboration with social researchers for the juvenile house. These programmes are prepared to help the young people have some recreation as well as seeking to reduce the suffering, deprivation, and misery that the juveniles have. These programmes include preparation of activities and entertainment during the weekend, events, and holidays. The summer vacation programme is put together for the juveniles who stay and spend their summer holidays in the juvenile house. The house management and researchers – in collaboration with the social welfare administration – develop an extensive summer programme where workers from the juvenile house are free to contribute according to their wishes and interests. The programme incorporates many kinds of activities to develop the juveniles' capabilities, such as theatre, sports, visits to specialised institutions, leisure trips, painting courses, calligraphy courses, music courses, ceramic courses, sewing courses, fitness, football, yoga, etc.), and summer camping in the Kurdistan coastal area. At the end of the summer holiday a festival is held to display the activities that the juveniles participated in.

Conclusion

Residential child and youth care has developed in Kurdistan out of necessity, to meet needs imposed by the geo-political, economic, and social realities of life in northern Iraq over the past two decades. Rapid changes have touched all aspects of life, the most prominent of which is arguably the progress and development of technology. Residential child and youth care developments are also a reflection of Kurdistan's people and their philanthropic nature which embraces people despite differences in their nationality, religion or culture. Recent events, wars, and crises

are living proof of assistance to migrants, refugees and foreign people from different regions. All this has been achieved through the prominent, important and continuous contributions made by international charitable organisations inside Kurdistan. The juvenile houses offer a family-style environment which seeks to create a normal life for each child and young person in care as might be found in any family in the community. While they try to guarantee the financial future of these children and young people, their capacity is limited, and more assistance is needed, both educationally and financially, from governmental and non-governmental bodies, as well as local and international NGOs.

Questions for Small Group Discussion or Guided Reflection

1. What do you know about Kurdistan Iraq and the relationships of its peoples with Kurds living in the adjoining regions of Turkey and Iran?
2. In what ways did the events of 20 March 2003 impact on residential child and youth care services in Kurdistan Iraq and social developments which have occurred there during the past fifteen years?
3. *Major political, economic and social changes occurred as the first government of the Kurdistan region was established in 1991, resulting in the further development of social care services for the families and relatives of martyrs and victims of the Anfal genocide carried out between 1986 and 1989 during the military campaign waged against the Kurdish people during the final stages of the Iran-Iraq War.* What do you know about the Anfal Genocide carried out against the Iraqi Kurds and how do you think this impacted on the further development of residential child and youth care services in Kurdistan Iraq?
4. *Young people living in Kurdistan Juvenile Houses are given pocket money for their daily and monthly use (the amount differs according to the juvenile's age) while a further amount is placed in their bank accounts (every juvenile has his/her own bank account) as a monthly allowance for their future.* How might such an arrangement with finances for each young person in care be managed where you live and work?
5. The conditions under which a young person might leave a Kurdistan Juvenile House may involve a determination that the *juvenile is so deviant that it has become too difficult to treat that deviation.* How might you explain such a determination and how do you think residential child and youth care centres in other places deal with claims that a young person may be '*too difficult to treat his or her deviation*?

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Children in Residential Care in Iran: A Capability Approach

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Abstract

An historical overview is provided about the development of institutional care for children in Iran and issues relating to the care and protection of children without protective family care. Adoption practices face many challenges within Islamic traditions and important restrictions are involved. A Capability Approach is briefly introduced and then used to analyse the results of key informant interviews about those capabilities that are considered important for all children, whether in receipt of institutional care or family and extended family care.

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Introduction

Children who are not living with a family are given various names in Farsi language, including orphan, children of The State Welfare Organization, children without a guardian, or children without competent guardians. For the purpose of this chapter and in accordance with other chapters in this volume, here we use the general term 'children in institutional care'. Discourses about children in institutional care in Iran are dominated by two main lines of analysis. The first paradigm focuses attention on disadvantages faced by children in institutional care as compared with other children (Zand, 1997; Poor-gonabadi *et al*, 2011). The second paradigm focuses on legislation that might address the unique dynamics and processes involved in adopting Iranian children who are without family care (Nazari, 2001; Mosavi Bojnordi, 2009; Tavasoli Naini, 2012). Attention is directed towards a core question about children's capabilities: What capabilities do these children demonstrate and what differences might be found between children living in institutional care and those who live with their own families and extended families in local communities?

This chapter examines the situation of children in institutional care using the Capability Approach developed by Amartya Sen (1985) and Martha Nussbaum (2000). It is a broad normative framework used to evaluate personal wellbeing and quality of life (Robeyns, 2006). The central focus in this approach is what children or young people can do, bearing in mind the availability of resources through endowments or through social and personal contributions (Robeyns, 2007; Chiappero-Martinetti & Venkatapuram, 2014). This approach is interested in unpacking those opportunities that children or young people need that help them achieve what they value in their lives. The Capability Approach is applied to two main sources of data, secondary data from scholarly literature as well as legislation and guidelines, and key informant interviews carried out in Tehran. This approach enables one to pay close attention to contextual factors that impact on the lives of children in institutional care, guiding our assessments and consequent judgments to achieve more helpful policy recommendations. Applying the Capability Approach to the examination of children in institutional care helps in evaluating relevant policies that could expand opportunities for children. In what follows, we briefly review the history of institutional care for children in Iran and reflect on related issues regarding children without protective family care in a more specific way. Then the Capability Approach will be introduced briefly and used to analyse key information about the status of children in institutional care.

Institutional Care in Iran: When and How Did It Begin?

Providing support and protection to children outside of family care in Iran started long before the creation of institutional care homes set up by the government. Broadly speaking, next to humanitarian reasons, culture and religion have been two other motivations for such supports by individuals in Iran:

motivations that are driven by power, as well as personal motivations (Kian-Thiebaut, 2002; Penziner, 2006; Pirzad, 2012; Redjali, 2013; Iravani, 2014). The oldest documented orphanage in Iran dates from 600 A.D (Jahanpoor, 2004). 'The Orphaned Children Madrassa[3]' was established in the days of the Safavid Empire and existed for more than five centuries. Historically speaking, elite families also played an important role in providing social support to orphans. Accounts of charitable activities among the elite, both female and male, have been prominent across many different Middle Eastern countries for centuries (Penziner, 2006; Jawad, Yakut-Cakar, 2010). One of those examples is Dar al-Aytam, one of the oldest orphanages in Tehran, currently known as Mozaffari's Residence for Boys (Khaneye Nobavegan Mozaffari). It was established in the late 1940s and is still run by the founder's great grandson and his wife (Iravani, 2014). The last major group that supported orphans in Iran are persons in position of power. One relatively recent example is the orphanage that was created by Farah Pahlavi, the Shah's wife, in 1968 (Penziner, 2006).

Government supported institutional care for children in Iran dates from 1919, when the first municipal legislation was passed to create a *Parvareshgah* (this was the word that was used for orphanages, which literally means nurturing house). Since the 1940s, *ad hoc* initiatives at the community level have been providing support to children without family care, among other marginalised groups. In the late 1950s, the government established Family Welfare Centres (*marakez-e refah-e khanevadeh*) around the country, whose mission was to rehabilitate poor households and support children without family care (*ibid*). During the 1960s all the *ad hoc* initiatives were brought together under the one social security umbrella. The name *parvareshgah* was changed to 24-hour centres (*shabaneh-roozi*) and the government's support to children outside of family care was legally endorsed through the fourth development plan (Mohseni-Tabrizi, 2001). Finally, the Act for Protecting Children without Guardians[4] (APCWG) was approved in 1974. Around the same time, other major changes were happening concerning family law in Iran, aimed at improving the legal rights of women.

The Islamic revolution in 1979 took over the process of improving welfare and the legal status of children without family care. Several important steps were taken following the revolution that benefited children in institutional care and other vulnerable groups. For a start, Articles 21 and 29 were written into the constitution referring specifically to children without a guardian[5] and thereby establishing the legal framework for State care and protection services. Second, the State Welfare Organization was established in 1980 with a mission to provide welfare and rehabilitation services to a range of groups, including children without family care. The State Welfare Organisation in turn helped to formalise policies, guidelines and

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[3] An Islamic religious school

[4] The literal translation for qanoon-e hemayat az koodakan-e bisarparast

[5] The literal translation for *koodakan-e bisarparast*

legislation concerning children in institutional care (Nazari, 2001; Mohseni-Tabrizi, 2001).

Who are the Children in Institutional Care?

Information about the current number of children without family care is scattered and often comes from different data sources. In 2013, about 23,000 children without parents were living under the support of the Social Welfare Organisation. About half of those children lived with foster families, while up to 12,000 lived in charity care houses (Tabnak, 2013). Mohseni-Tabrizi (2001) refers broadly to five main types of institutions for children without family care: protection centres; independent 24-hour centres; foster care; orphanages; and temporary houses for children and adolescents[6]. 24-hour centres are financially supported and run by donors. Children in institutions are placed according to their age (0-3; 3-7; 7-12) and service requirements (Maddah, 2015). While for many years, most institutions were large and hosted hundreds of children, in recent years, the Social Welfare Organisation has encouraged private sector and trusted individuals to establish smaller centres. These small residential centres (*khanh* or 'houses') are technically categorised under the "semi-family" group.

It is important to note that there is no uniformity in the background of children who live in institutions. Different legislation related to children without family care and children in institutional care before and after the 1979 revolution refers to a very heterogeneous group, broadly referred to as 'children with no guardians or unsuitable guardians' (*bisarparast and bad sarparast*). Children from fragile families where they are exposed to addictions and domestic violence, children of divorced parents, delinquent children, street children, Afghan migrants, disabled children, children born out of wedlock, along with children who have lost their parents are all included within the population of children in institutional care (Nazari, 2001; Mohseni-Tabrizi, 2001; Mollazadeh, 2003; State Welfare Organization, 2003). From a legal and welfare support perspective, these children with very different social characteristics and needs are grouped together under one broad cluster, share the same institutional residence and receive very similar services (Mollazadeh, 2003).

The Capability Approach

The Capability Approach offers a way of examining the situation of children in institutional care by helping to identify differences in their backgrounds, and the reasons which resulted in these children being deprived of family care. In what follows, a brief review of the Capability Approach is provided and then used to examine the data collected during this study. Broadly speaking, the Capability

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[6] Another type of residential care which is absent both in Mohseni-Tabrizi and in the current work is Youth Detention Centres, which are home to children under 18 who are termed as juvenile delinquents.

Approach claims that a person's quality of life cannot be evaluated merely by looking at their resources. It is important to evaluate what opportunities were available to achieve those qualities, as these are crucial in helping individuals to achieve and take ownership of those very qualities. This approach can be used as an analytic or normative framework to assess and evaluate aspects of wellbeing, including inequalities and poverty (Biggeri & Anich, 2009). Some important definitions used in capability approach discourses are worthy of note. 'Entitlements' are the full range of services that a person could access through exchanging his/her 'endowments' such as resources, assets, labour and land. 'Converting factors' influence one's freedom to convert endowments and entitlements into 'capabilities'. Chiappero-Martinetti & Venkatapuram (2014) refer to these converting factors as fundamental to the Capability Approach and that it is capable of embracing diversities amongst people associated with socio-cultural, physical, relational, biological differences throughout the course of one's life. Such conversion factors influence a person's agency or capacity to access resources and transform them into capabilities.

Capability and Challenges for Iranian Children in Institutional Care

To apply the Capability Approach to residential care in Iran, we carried out an analysis of the secondary data and literature before interviewing key informants in Tehran during the Spring of 2015 (Maddah, 2015). Our key informants had either worked directly for a long period with children in institutional care as caregivers or researchers or were in contact with children in institutional care through policy-related work with bodies like the Social Welfare Organisation. In the absence of earlier in-depth, qualitative research, official surveys and data sets about the population of Iran's children in institutional care, the methodological challenge to apply Capability Approach is very relevant. This obstacle became apparent when the researchers sought to reflect on various elements of the Capability Approach to analyse the data, its details and dynamics.

Chiappero-Martinetti and Venkatapuram (2014) introduced a multi-levelled variable matrix to facilitate the compilation and analysis of Capability Approach elements. Based on the review of secondary data and our own interviews, the matrix shown below (Table 1) focuses on those challenges facing children in institutional care to achieve the highest levels of well-being and happiness. Our three levels include: children in institutions, residential care institutes, and Iranian society and government. 'Agency' is used here to refer to a common ability and willingness between all the three levels of actors to facilitate children's wellbeing and rites of passage towards becoming happy and competent adults. The dimensions listed in Table 1 were derived from interviews and reports by local researchers and experts (Iravani, 2014).

Table 1
The Situation of Children in Institutional Care in Iran: A Capability Approach (Iravani, 2014; Maddah 2015)

Level of Analysis	Endowments (resources)	Conversion Factors (negative & positive)	Capability Set	Functioning (beings & doings)	Agency/ Personal-Capacity
Children in Institutional Care	Physical and mental features Existing family bonds	Sex Age Reasons for ending up in the institution Location of institution Attitude of care providers Sense of security Self confidence	To have education To enjoy physical and mental health To have safe and pleasant shelter To have leisure-time activities To find psycho-social and emotional support To feel loved and respected To live without shame To trust To have self-respect/a sense of identity To have a healthy relation inside/ outside the residential care system	To be educated To be healthy To have a shelter To have leisure and fun To have psycho-social health To have no shame about their status To have healthy relations with family, friends and supporters	The ability and will of a child to convert personal capabilities to function with the help of the endowments, to be a competent adult in future
Residential Care Institutes	- Finding - Skill and Experience of Employees - Physical Facilities and Infrastructure	Public support/ resistance Governmental support/resistance Violence Policies and guidelines (government. institutions) Attitudes of journalists, care providers, and policy makers Socio-economic and psychosocial status of the care providers Expertise and skills of caregivers Number of caregivers per child	To endure & continue working To provide a non-violent setting To be able to provide Children in Institutional Care with education To support psychosocial health of Children in Institutional Care To recruit skilful and devoted staff To attract the attention and trust of supporters.	To have prolonged activities To have a non-violent setting To provide Children in Institutional Care with education To support psychological health To have skilful and devoted staff with whom s/he can enjoy the supporter's trust.	The ability and will of the authorities of the institution to facilitate processes for children's education and psychological support
Iranian Government and Society	Public Goods and Services Cultural Practices Social norms and values Traditions and habits	Facilitating adoption laws Cultural factors Religion International conventions	Supervise residential care institutes Support residential care institutes Facilitate safe adoption Supervise foster families	To supervise the institutions To support the institutions To facilitate adoption process To supervise foster families	Ability and will to help Children in Institutional Care develop into competent adults

Mollazadeh (2003) has provided a detailed list of challenges faced by children without family care. He refers to the differences in experiences of children by virtue of their place of residence or the causes of their being placed in an institution. Lacking a sense of security is one of the important issues experienced by children without family care. The extent of this insecurity could be influenced by the location of the institution, moving from one centre to another, changing staff who provide services for children, changes in institutional policies by NGOs or government, and insufficiency of services (Mollazadeh, 2003). A fragile sense of personal security may lead to feelings of guilt and shame amongst those children.

Other issues that children in institutional care face include fragile self-confidence, difficulties with attachment to a primary caregiver or protector, lack of privacy or sense of ownership, anger, stereotyping and stigma, neurotic reactions with depression and anxiety, an absence of positive role models, sexual abuse, and education problems (Mollazadeh, 2003). The absence of a primary care provider has a deep impact on young children, influencing their long-term capacity to trust and share. This issue seems to be less influential among children who live with foster families (Mollazadeh, 2003).

Robeyns identified connections between physical space and a child's sense of identity in her gender analysis using the Capability Approach, suggesting that physical space affects a person's feelings towards him/herself, and a sense of personal identity (2003a, p. 81). Robeyns refers to shame and the capability to go about without shame as one of the "deeper, foundational, generic, fundamental and aggregated" elements of personal identity (2003b, p. 20). Our interviews also suggested that many children in institutional care experience identity crises and shame at a very young age. Trust issues and identity crises impact directly on children's relationships with others both inside, as well as outside residential care settings. Some children are ashamed of living in residential care and try to hide these circumstances from teachers and other children in school. They also experience difficulties in trusting their carers and supervisors inside residential care (Maddah, 2015).

At the institutional level, caregivers usually work on shifts of either 24 or 36 hours, depending on the number, age and status of the children in residence. One of the major challenges for House Directors involves the recruitment of caregivers. Poor salaries for working long shifts in emotionally-charged circumstances make recruitment and retention difficult at times, and in many cases, not very successful. Turnover of caregivers is another common problem, whether associated with personal problems, work challenges or problems with supervisors. Caregiver turnover has a prolonged effect on the development of trust in relationships between caregivers and children in institutional care. Using a Capability Approach, it is important to note how capabilities demonstrated by children in institutional care are mirrored in the capability sets amongst the caregivers. Trani, Bakhshi and colleagues (2011) refer to external or social capabilities for children in general and to vulnerable children. In so doing, they acknowledge that children's capabilities

depend on caregivers sharing some conversion factors in their relationships with children. Another important challenge at the institutional level concerns financial resources. As public funds are very limited, most of the institutions require private supporters and funds which are frequently difficult to locate and sustain. These funds are essential to the continuation of services, as well as to ensure that health and education standards are maintained for children living in institutional care.

At the level of government, resource scarcity creates difficulties for recruiting and retaining competent and skilfully qualified staff. This highlights the importance of effective supervision in the institutions. Without good supervision, an institutional environment and culture can turn unsafe very quickly and permitting increasingly prevalent violent acts, whether intentionally or unintentionally. Complexities associated with adoption laws are another issue that requires urgent attention by government to enact laws that have resulted from long discussions between religious scholars and policy makers. At present, the adoption process is very difficult, with financial expectations and other prerequisites for potential adopters, including a stable income, ownership of property and evidence of infertility. While the new regulations make it possible for single women to acquire official custody of a child, the adoption law is for the most part restricted to married couples in Iran.

Conclusion

A Capability Approach has been used to review the situation of children living in institutional care in Iran, with the aim of examining policy outcomes that shape children's capabilities. Such an approach helps in suggesting policies that could prevent further exclusion of children and improve their participation in community life. Our analysis suggests that shame, a sense of identity embroiled with uncertainties, and feelings of personal mistrust are amongst the most important challenges being experienced by Iranian children in institutional care. Those challenges, in turn, affect children's full participation and personal agency or capacity to assume greater control over their lives. Responses to challenges such as these may further reinforce social exclusion and it is important to adopt policies that will address those concerns. Knowledge and skill capabilities of the caregivers need to be nurtured, particularly as opportunities to obtain formal qualifications are very limited. Limited financial resources are needed for the recruitment and retention of skilled care workers through continuing professional education and training. Recruitment of well-trained, skilled care workers along with ensuring effective supervision are key factors if Iranian children in institutional care are to develop to their potential.

Questions for Small Group Discussion or Guided Reflection

1. *Broadly speaking, next to humanitarian reasons, culture and religion have been two important motivations for charitable giving by individuals in Iran.* In what ways might this approach to charitable giving for children in need be different from what happens where you live?

2. *Government supported institutional care for children dates back to 1919 in Iran, when the first municipal legislation was passed to create a Parvareshgah (the word used for orphanages, which literally means nurturing house).* What was happening in 1919 where you live and what orphanages or nurturing houses might have been operational there at that time?

3. *Iran's Islamic revolution in 1979 took over the process of improving welfare and the legal status of children without family care. Several important steps were taken that benefited children without a guardian, thereby establishing the legal framework for State care and protection services.* In what ways might children and young people in need of care and protection in Iran have benefitted from these changes?

4. *In 2013, about 23,000 children without parents were living under the support of the Social Welfare Organisation. About half of those children lived with foster families while up to 12,000 lived in charity care houses.* What observations might be made concerning the total number of Iranian children living under the support of the Social Welfare Organisation, and the proportion of that total living in charity care houses?

5. *Children from fragile families where they are exposed to addictions and domestic violence, children of divorced parents, delinquent children, street children, Afghan migrants, disabled children, children born out of wedlock, along with children who have lost their parents are all included together as children in institutional care.* How are '*children from fragile families*' identified in your country, and how might descriptions about the status of children in Iran be similar or different from where you live and work?

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Residential Care in Pakistan: Evolving Practices in Punjab

Sabahat Haqqani[1] and Arshad Mahmood[2]

Abstract

There is little documented information available on ground realities of what alternative care arrangements are made for children and young people in Pakistani society. Insights are offered into the nature of residential child and youth care in Pakistan, focusing on the province of Punjab. The current structure of alternative care arrangements, both at informal and formal levels is outlined, focusing on legislation as well as policy implementation. Existing practices, available evidence and outcomes for young people living in alternative care are also reviewed.

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Introduction

Alternative care arrangements are often needed for children and young people who are orphaned or need alternate care, vulnerable to exploitation and child labour. Article 20 of the Convention on the Rights of the Child (CRC) (Office of the United Nations High Commissioner, 2017) puts the onus on Pakistan to provide shelter and support to children who are temporarily or permanently deprived of their family environment. However, this does not require the Government to assume direct responsibility or control over the situation, believing that the main responsibility for caring for children lies with the society.

Pakistani society has a remarkable child protection capacity founded around strong family and community bonds. In addition to the community embedded care, the number of institutions offering care for orphaned or separated children is also rapidly increasing in Pakistan. This increase has come about because of demographic changes in the country, including rapid urbanisation leading to poor living conditions, and increased participation in the labour market by women (who had previously acted as the main carers for children, youths and older adults).

There is very little documented information available on how alternative care arrangements are made in Pakistani society. This chapter seeks to provide insight into the nature of residential child care in Pakistan, focusing on the province of Punjab in particular. The current structure of alternative care arrangements at both informal and formal levels is outlined, focusing on legislation as well as implementation. Existing practices, available evidence and outcomes for young people living in alternative care are also discussed. The authors conclude with recommendations for the future of residential child care in Pakistan.

Residential Child Care in Pakistan

Pakistan is an economically struggling Islamic country ranked as 113/142 on the global prosperity index. Regardless of its economic position, Pakistan has a rich community-based tradition of residential child care, indicating that cultural norms play a valuable and important role. Although an exact count of the children in need of alternative residential care arrangements – including orphans, destitute and children in street situations– cannot be discerned, NADRA (National Database and Registration Authority) started issuing smart ID cards to orphans in 2013. This has helped not only to provide a systematic estimate of children in need of alternative care arrangements but has also empowered the children with a sense of identity.

In Pakistan, services for children in need of alternative care are organised according to different administrative levels that include: the federal capital area, four provinces (Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan), the Federally Administered Tribal Areas (FATA), Azad Jammu and Kashmir, and Gilgit-Baltistan – formerly known as Federally Administered Northern Areas (FANA) (Government of Pakistan, 2013).

The country has diverse and unique socio-cultural values pertaining to each region that revolve primarily around Islamic principles. The administrative policies of each area, cultural diversity and socio-political scenarios have resulted in varying alternative residential care practices for children and young people in each region. Within each administrative region, both governmental and non-governmental organisations operate to provide residential child care.

In general, when a child needs residential care arrangements with people other than parents, extended family members or family-based care are considered as their first choice because family is the dominant influence on life in Pakistan. As families form the social and individual identity of a person in Pakistani society, they are primarily responsible for the care of abandoned children, widows, never-married adults, and relatives with different abilities. If residential arrangements are not possible within the extended family, wider community networks are explored. Approaching extended family and wider community networks (e.g. family-friends) is grounded in the Islamic tradition of showing great sympathy for orphans – "*You shall serve none but Allah and do good to parents, kinsmen, orphans and the needy*" (Al-Quran, 2:83). It is this religious background that provides the grounding for the rich community-based care of orphans.

While residential child care for orphaned children is widely recognised at formal and informal levels in Pakistan, less attention is paid to those children whose parents are alive but incapable of parenting due to mental or physical disability, or to children who have suffered from parental abuse and need alternative care arrangements. Poverty is another major but frequently unrecognised reason for the increased use of alternative care arrangements.

In Pakistan those who decide to care for children and young people in need of alternative care, mostly do so as 'foster parents'. It must also be pointed out here that these steps are taken at an informal level. At the legislative level, the care arrangements with extended family and wider community networks mostly operate under the umbrella of guardianship. Full adoption is hardly ever considered, and a regulated foster care system does not operate.

In cases where alternative residential care arrangements with extended family and wider community networks are not possible, welfare homes, centres for destitute children, orphanages and shelters serve as alternative choices for children in need of residential care. For such residential care arrangements, policy guidelines and standard operating procedures have been developed and are endorsed by the provincial governments at varying levels. Pakistan's child protection system is very much in its nascent stages in terms of implementation. No central database or child protection register exists that records or assesses the overall situation of children in need of residential care (Jabeen, 2014).

As for child welfare, the administrative structure is devolved from national to provincial level and then down to district level. After the 18th Amendment to the Constitution (introduced in 2010), power is distributed to the provinces which made it largely the responsibility of provincial governments to look after child

welfare (Khan, Syed, Haider & Kamran, 2013). The decentralisation of power to provincial governments is largely responsible for the differential approaches, variable sensitivity and care arrangements in different provinces.

In addition to the differences in administrative styles, the varying social and political situations have led to different needs for residential child care. For example, in Khyber Pakhtunkhwa there have been more disasters and terrorist attacks than in other provinces (Khan, Syed, Haider, & Kamran, 2013). In Punjab, the educational set-up is much stronger than other provinces, so there is more development in this province than in any other area. All these factors affect the provision of child care and are reflected in both the policy guidelines and the forms of alternative residential care for children and young people. It is this inter-regional variability which calls for a separate analysis of the situation in each region to understand the real situation.

The Province of Punjab

As compared with other provinces, the Punjab Province has a slightly more advanced system in terms of the formulation and documentation of rules and procedures for residential child care as well as other complementary structures. For example, the Punjab Home Department established a Child Protection and Welfare Bureau which introduced several projects such as a family support programme. This family support programme focuses on eradicating the social factors behind some child protection issues such as begging, drug addiction, and child labour.

The relatively advanced child protection and residential care system in Punjab can be used to teach important lessons. This is not to say that other provinces are lagging in their residential child care but that there is some value in sharing some unique aspects of practice that exist in Punjab. The Punjab Social Welfare Department and Bait-ul-Maal Department have outlined the minimum requirements for children in alternative residential care. However, specific and detailed guidelines are required to implement these standards. Although there is no legal system for the registration of children's institutions in the province, the Child Protection and Welfare Bureau is responsible for carrying out the child protection tasks through district Child Protection Units and Officers.

While laws, systems and operating procedures exist, and efforts are being made to implement these, there is very little information available about specific circumstances within specific residential care arrangements, making it difficult to identify whether the guidelines are being implemented. Earlier research on child abuse and child labour has already contributed to negative views of residential care. Where identifying shortcomings can provide pointers for improvement, looking at strengths provides an important foundation for building future systems of care. Hence, this chapter focuses on the province of Punjab as a way of identifying support structures that could provide positive foundations for the future.

Extent of Residential Child Care in Punjab

Bearing in mind the necessity of providing residential care for children in need that is genuinely effective, different systems and mechanisms have been established by both the public and private sectors across the country. However, as stated earlier, the situation is comparatively better in Punjab because of its stable economic conditions and the comparatively better response of those in power when formalising different laws and legislation. A summary is provided of the legal and practical steps taken to ensure quality alternative care for children and young people in the province of Punjab.

The Punjab Destitute and Neglected Children (First Amendment) Act

The Punjab Destitute and Neglected Children Act2F[3] was passed by the Government of Punjab in 2004 and amended in 2007. The Act was endorsed by legislators for the protection, care and rehabilitation of destitute and neglected children in the province. To implement the Act, Child Protection and Welfare Bureau offices were established in 2005 initially in Lahore district. Later services were expanded to other districts namely Gujranwala, Multan, Faisalabad, Rawalpindi, Sialkot and Dera Ghazi Khan.

The Child Protection and Welfare Bureau also ensures implementation of the principle of 'best interests of the child' in all its judicial and administrative decisions and in programmes, projects and services having an impact on children residing in the Child Protection Institutions (CPIs). Through 29th February 2012, the Child Protection and Welfare Bureau assisted 47,500 children with protection, health, education, vocational skills and reunification facilities.

Under the Act, for the protection of vulnerable children in the province of Punjab, the following initiatives have been taken:

- In accordance with the Punjab Destitute and Neglected Children Act (2004), Child Protection Courts were established to provide legal cover for the protection and care of destitute and neglected children. The Child Protection Court ensures children's participation by hearing their wishes regarding the decisions to be made concerning his/her rehabilitation measures and reunification.
- The Child Protection and Welfare Bureau also formed a Child Assessment Committee (CAC) comprised of teachers, caregivers, and professional psychologists. In the Child Assessment Committee, every child residing in a Child Protection Institution (CPI) is given the chance to be heard and

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[3] *Destitute and Neglected Children Act* 2004. (Online) Available from: http://punjablaws.gov.pk/laws/472.html (Accessed: 10 October 2017).

given the opportunity to contribute to decisions about his/her own career planning.

- The Child Protection and Welfare Bureau through its Child Protection Institutions can provide temporary custody and long or short-term rehabilitation for children and youth in need of residential care. In Child Protection Institutions children and youth are offered non-formal education, main-streaming in formal schools, vocational training and literacy courses. The Child Protection and Welfare Bureau has also instructed a committee to draft standard guidelines for Child Protection Institutions to regulate children's homes run by other organisations.
- A Child Helpline 1121 was also established in the Child Protection and Welfare Bureau, through which adults and children can report any incident of cruel or inhumane treatment. The helpline is operational 24 hours a day and 7 days a week. According to the official records available on the Bureau's website, the helpline provides prompt assistance and support to children subjected to violence, exploitation, abuse and neglect. Since its inception, 6,736 information calls and 2,264 service calls have been received at the Child Helpline and 2,213 rescue operations have been conducted because of calls received.
- The Child Protection and Welfare Bureau has set up an effective monitoring system to ensure that abuse of power by teachers in Child Protection Schools or other care givers at Child Protection Institutions, working with and for children may not take place.
- In compliance with the United Nations Convention on the Rights of the Child (UNCRC) article 21 and sub sections 1 and 2 of section 28 of the "Destitute and Neglected Children (First Amendment) Act, 2007", the Child Protection Court is authorised to entrust custody of the child to any suitable person in the best interest of the child. The Court can also take proceedings against child abusers in cases of cruelty to the child, employing a child for begging, giving intoxicating liquor or narcotics to a child, permitting a child to enter a place where liquor or narcotics are sold, inciting a child to bet or borrow, and exposure to seduction.

Implementation

Initiatives taken under the Act have enhanced the protection of children in need of alternative residential care. However, no rules have been formulated under the Punjab Destitute and Neglected Children Act (Amendment) 2007. Further, no minimum care standards have yet been established for operating Child Protection Institutions. Hence, despite the presence of clear guidelines, the situation remains complicated. Recently, under the Act of Destitute and Neglected Children First Amendment (2007), the Social Welfare Department tried to develop Minimum Care Standards for Child Care Institutions to improve the situation. One noteworthy

aspect of these rules3F[4] (that may be called the Punjab Control of Child Protection Institution Rules) requires that every application for a licence to establish or continue a Child Protection Institution must be accompanied by further documentation:

- a certificate from the District Health Officer that confirms that satisfactory arrangements exist for medical examinations of children;
- a certificate from the Child and Welfare Department of the district ensuring that the building is suitable for the accommodation of a specific maximum number of destitute and neglected children;
- an agreement by established Child Protection Institutions that they will admit all children who have been the victims of any kind of abuse and have been rescued by a legally established Child Protection Unit;
- and assurance that internal supervision must be developed that guarantees protection of every child from abuse or exploitation by the staff or other children.

Child Care Institutions in Punjab

The Punjab makes up half of Pakistan's total population which totals 110 million people (Government of Punjab, 2017). Out of this massive population, there are approximately 4.8 million orphans aged between 0-17, only 6-7 % of whom are registered with social organisations. Different child care institutions/foster care centres operate in Punjab to cater for the needs of neglected and vulnerable children. These include both Government-funded and private institutions. Madrassas are also commonly recognised as places where children in need of alternative care (usually orphans) are enrolled as residential students. However, these are not officially recognised as Child Protection Institutions and many of the madrassas are un-registered. There is a common perception in Pakistan that children are maltreated in the name of religious knowledge, but no official statistics are reported. The map and profile below provide an overview of official placements in Pakistan.

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[4] The Punjab Control of Child Protection Institutional Rules 2011-2012. (Online) Available from: http://tinyurl.com/podyno8 (Accessed: 3rd March 2015).

Map of Pakistan

Division Wise Percentage of Orphans In Punjab

Lahore	17.3
Gujranwala	14.7
Faisalabad	12.0
Multan	11.6
D.G.Khan	11.3
Bahawalpur	11.1
Rawalpindi	7.7
Sargodha	7.4
Sahiwal	7.0

Per 1000

It is also important to note that – among orphans – female orphans are the most vulnerable to violent abuse. The Punjab Government has established two orphanages for female orphans. According to the Punjab Social Welfare Department (SWD), however, currently there are only two female Model Children's Homes located in Bahawalpur and Dera Ghazi Khan, which have a resident capacity of 100. These female orphanages lack common household activities and basic necessities when compared with other homes. The orphanages are poorly resourced and offer poor nutrition, with untrained staff as well as insufficient numbers of female staff. Women and young girls are crammed into single rooms. There is also

a lack of psychological therapy, an absence of character-building measures, few activities during their upbringing, and no recreational facilities.[5]

Despite all the legal measures taken, there is considerable room for improvement. In institutional care, the caregivers are merely contracted, like nurses in a hospital, without their assuming any immediate obligations towards the children. This lack of accountability and relationship is often reflected in the care that children receive. It is therefore important to stress the need for relationships to be established between the child and the staff in the residential care centres, which should grow out of a sense of obligation and respect. A basic monitoring system should also be established to ensure that the children are taken care of properly.

There are several other Child Protection Institutions in Punjab. A brief introduction to two prominent organisations that have relatively better facilities are presented as follows:

Pakistan Sweet Homes [6]

Pakistan Sweet Homes is a project of Bait-ul-Mal that aims to provide shelter, education and medical facilities to orphan children. Currently, centres have been established in Sargodha, Multan, Gujrat, Gujranwala, Bahawalpur, Attock, Rawalpindi, Faisalabad and Okara. Orphans as young as 4-6 years can be admitted to these homes and are provided with education from the nursery level.

SOS Children's Villages of Pakistan [7]

SOS Children's Villages care for children who have lost their biological parents. SOS claims that these children are placed in an environment which is as close as possible to a natural home by providing them with care, security, higher education and job-training. The organisation is working towards the goal of one day being able to provide shelter to every deserving child in the country.

Where these two organisations provide the necessary care for children in need of alternative residential care, different incidents of mistreatment and exploitation have also occurred and been reported in the recent past. One possible reason for this could be the less strict implementation of standards set up by Child Protection and Welfare Bureau which in turn could be the result of no registration of Child Protection Institutions under the Punjab Destitute and Neglected Children (First Amendment) Act 2007, registration that would ensure closer monitoring.

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[5] Female abuse rampant as government official shushes accusations. (Online) Available from: http://www.pakistantoday.com.pk/2012/02/12/city/lahore/female-abuse-rampant-as-govt-official-shush-accusations/ (Accessed: 3rd March 2015).

[6] Pakistan Sweet Homes. (Online) Available from: http://www.sweethomes.com.pk/intro.php (Accessed: 3rd March 2015).

[7] SOS Children's Villages Pakistan. (Online) Available from: http://www.sos.org.pk/Person/Objectives/ (Accessed: 3rd March 2015).

Long-term institutional care has been shown to be detrimental to both the psycho-social and the physical development of young children. This can occur because children are uprooted from their own communities and placed in an institutional environment where they sometimes fail to learn the necessary life skills or establish functional social networks that enable them to safely manage the transition from institutional care to successful independence in adult life.

Mental Health and Attachment Perspectives about Alternative Care

Whenever alternative care arrangements are made for children and young people, they are made with the intention of offering better opportunities. This perspective includes not only meeting their physical needs but also their psychological needs. To cater for this, an emergent practice comes from understanding the importance of children being able to develop attachments to caring adults. One aspect of attachment research has concluded that placement closer to the child's home is less likely to cause disruptions in attachment and mental health (Jones *et al*, 2011).

Because extended families tend to live much more closely together than in many other parts of the world, Pakistani culture inherits practices whereby children not only form primary attachments with their parents but are also encouraged to form secondary attachments with their other relatives such as grandparents, uncles, aunts, teachers and significant others. Such attachments recognise a cousin as a sibling, a mother's sister as another mother or auntie in support of grandparents, and teachers are recognised as spiritual parents. Whenever parents are not around, children and young people are encouraged to approach and consult their secondary attachment figures who are expected to provide a haven and a secure base upon which to nurture adjustment and development. This further highlights the importance of training caregivers and other significant adults for care work with children in alternative care.

Staff in Alternative Care Institutions

Although alternative care is widespread in Pakistani communities, very few formal efforts are made to train the staff working in those institutions. Some institutions like SOS Children's Villages conduct in-house training sessions for their workers. Apart from the dire need for training, there is also a need to develop screening procedures for hiring teachers and other carers. In many instances, carers make judgments based on their own ideas and beliefs and then act based on these personal judgements. For example, when a child exhibits shyness or disruptive behaviour, it becomes the carer's responsibility to take an appropriate course of action to deal with the behaviour rather than following a set of rules. Appropriate human resources screening and training for carers in residential child and youth care are recommended.

Daily Life in Alternative Care Institutions

To explain the daily activities of a child in alternative care, examples are taken from various child care institutions. The daily routine in alternative care institutions like SOS Children Villages is designed to be as close as possible to the routines that a child might experience in their own home. All children residing in their care homes are encouraged to study and receive vocational training until they can support themselves. SOS care homes are especially sensitive to the gender-based needs of children and to changing economic practices in Punjab and the federal area. High value is placed on obtaining basic education. While there is not much recognition of mental health or the need for vocational guidance within the wider society, counselling facilities are provided to the care home residents. Girls are especially encouraged to obtain training and support themselves.

Despite these efforts to provide a better quality of life for children and young people in alternative care homes, individual differences do exist in the quality of care and management. This is especially true for madrassas, where there is an undeveloped monitoring system and the focus is only on rote learning of the Quran. Some alternative care institutions provide protection and opportunities to develop although they can also sometimes hamper growth by providing a low standard of care in terms of meals served, education provided, beatings and sexual abuse.

Outcomes for Children and Young People

While research outcomes for young people residing in Pakistani institutions are scarce, research on youths rehabilitated in community settings is non-existent. This makes it difficult for social workers, policy makers and other stakeholders to draw evidence-based conclusions. Such evidence as is available indicates that settings more closely associated with family set-ups result in children with less behavioural problems. A study conducted by Lassi, Mahmud, Syed and Janjua (2011) in Karachi used strength and difficulty questionnaires and indicated that children residing in SOS Children's Villages showed less peer-related problems than those residing in conventional institutions. Although there were instances of behavioural problems in alternative care centres, there were also success stories. In the case of SOS Children's Villages, for example, several hundreds of children have successfully entered banking, teaching, the armed forces, industry, computer, electronics, and private sector businesses. Around 100 girls have been married.

There is an inherent bias in the evidence presented by researchers on the one hand and by institutions on the other. As a vast generalisation, researchers have tended to focus more on documenting negative outcomes, while institutions try to draw attention to their successful children and young people and may be inclined to brush problems under the carpet. Both approaches are important with the intention of informing learning.

Recommendations and Conclusions

Based on the foregoing discussion, we conclude that placement decisions for children in need of alternative care should be based on the history, economics, and cultural values of the country. Based on the available evidence (although scarce) and the author's field experience, our position is that – where possible – in Pakistan (specifically in Punjab) the best place for children and young people is at home with their families. However, in cases where it is in the best interests of a child or young person in need of alternative residential care, s/he should be provided with the safest and least restrictive environment. The necessary services should be "wrapped-around" each child's needs to ensure more intensive home or community-based services. The following are our recommendations.

1. Within an ever-changing demographic structure, Government needs to ensure that the principle of the best interests of the child is formally incorporated into the legislative, executive and judicial branches of Government by, *inter alia*, including reference to the best interests of the child in legislation and other actions in such areas as child custody in cases of divorce, kafalah of Islamic law, child protection, guardianship and juvenile justice.

2. Documenting the number and characteristics of children in need of residential care with relatives and family friends through Government would be useful. A hierarchy of care must be established formally. In this system, preference needs to be given to members of the extended family, followed by friends, other community volunteers and then institutions. However, families volunteering to support a child in need of alternative residential care must be provided with additional support and guidance. Regular monitoring must also be carried out.

3. Special measures need to be taken to strengthen families and to monitor the wellbeing of fostered children. The emphasis, however, must be on supporting families, and giving the family-based system the benefit of the doubt, rather than controlling families and threatening to withdraw fostered children on the first occasion of a failure to provide appropriate care, particularly if the only alternative available would be an institution.

4. Where children have been placed in institutional care, this placement needs to be registered and periodically reviewed by competent authorities, as prescribed by the Convention on the Rights of the Child. The review needs to determine if the continued stay in the institution is in the best interests of the child, or if there are alternative placement options that are more suitable for the child. To live up to Pakistan's commitments under the Convention on the Rights of the Child, competent authorities need to monitor institutional care to ensure that appropriate standards of care and protection are maintained. This also needs to include monitoring of foster care arrangements.

5. Teams of qualified staff should be hired in institutional care centres who can provide appropriate, supportive supervision for children and handle directly those cases which require their direct intervention.

6. With the support of NGOs, awareness raising should be carried out so that society at large understands that family care is the best for children's development and that no large-scale institution will ever provide the care a family environment can. Awareness must also be raised about the sources of help available to students. Furthermore, it should reinforce an awareness amongst communities of their responsibilities for these children.

7. Most important of all, children and young people in need of alternative care must become aware of their rights and the services available to them – educated about the sources, routes and hierarchy of help available.

The history of residential care for children in Pakistan shows a gradual improvement towards developing a systematic and sustainable system of residential child care. One of the major reasons for the delay in developing a more formal system could be the natural cultural set-up of the country. While this set-up was strong in the past, due to strong familial bonds and strong extended family networks, that might not hold so true today. Despite being a socially cohesive society, Pakistan has experienced a decline in extended family systems and an increase in the nuclear family system (Itrat *et al*, 2007). This has resulted in an increase in the number of alternative care arrangements required to meet this growing need. We conclude that the impressive community-based alternative care system should be revitalised, and the use of institutional care be discouraged as much as possible. If institutional care cannot be avoided, smaller family units should be provided for children and young people. For more comprehensive, well-integrated and systematic residential child care arrangements that enhance child and youth well-being, more research and practical efforts in Pakistan are encouraged.

Questions for Small Group Discussion or Guided Reflection

1. *The organisational structure of caring services for children in need of alternative care is organised according to different administrative levels in Pakistan that include: the federal capital area, four provinces (Punjab, Sindh, Khyber Pakhtunkhwa (KPK) and Baluchistan), and the Federally Administered Tribal Areas.* Examine Pakistan on the map at the start of this chapter, and then consider: How does geography and diversity amongst this sixth largest population in the world make for very complicated administrative arrangements with residential child and youth care services?

2. *If residential arrangements are not possible within the extended family, wider community networks are explored. Approaching extended family and wider community networks of family and friends is grounded in the Islamic tradition of showing great sympathy for orphans – "You shall serve none but Allah and do good to parents, kinsmen, orphans and the needy"*

(Al-Quran, 2:83). It is this religious background that provides the grounding for the rich community-based care of orphans. What philosophy or ideological principles operate around the care of children in need of protection where you live and how do these principles compare with those highlighted here for Pakistan?

3. *The Punjab makes up 56% of Pakistan's total population, and the population of Punjab totalling 106,585 million people. Out of this massive population, there are approximately 4.8 million orphans aged between 0-17, only 6-7 % of whom are registered with social organizations.* The population of Pakistan's Punjab province alone – one of four provinces and tribal areas in that country – is roughly the same size as one third of the total population of the United States of America. What priorities would you highlight in developing policy and service plans for 4.8 million orphans?

4. *Different child care institutions/foster care centres operate in Punjab to cater for the needs of neglected and vulnerable children. These include both Government funded and private institutions. It must also be pointed out that Madrassas are also commonly recognised as places where children in need of alternative care (usually orphans) are enrolled. However, they are not officially recognized as Child Protection Institutions and many of these madrassas are not registered.* What comparisons if any might you make between Pakistan's madrassa and any religious schools that may operate near where you live?

5. *Some alternative care institutions provide protection and opportunities to develop although other institutions sometimes hamper growth by providing a low standard of care in terms of meals served, education provided, beatings and sexual abuse.* What would you do if appointed to a Volunteer Service Abroad placement in an alternative care institution where low standards of care were observed*?*

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Residential Care of Orphans in Indian Kashmir

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Abstract

Emerging issues and concerns about the residential care of orphans in Kashmir are examined, based on field experiences, non-participant observation and informal interactions with orphans during orphanage visits. Kashmir has become a tragically sad place, full of mass graves, half-widows and a minefield 'playground' for orphans and 'half orphans'. Since 1947, the State of Jammu and Kashmir has been the focal point of tension between India and Pakistan, on the one hand, and a local separatist movement in the State on the other. Years of unrest have caused immense damage to the lives of children affecting their survival and protection, development and participation opportunities as well as their parents' abilities to care for them. Orphanages have become a growth industry using children and young people in an unregulated network of residential care and education business activities.

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Introduction

A place once described as Paradise, contemporary Kashmir has left its picturesque history far behind and has now become a tragically sad place, full of mass graves, half-widows and a minefield 'playground' of orphans and 'half orphans'. In Kashmir, 'half orphan' refers to those children one of whose parents (mostly fathers) have disappeared during the saga of political struggle leaving half widows to live their lives in a twilight zone. These children cannot be declared orphans since they are still unaware of whether their parent is alive or not (Mirani, 2007). Since 1947, the State of Jammu and Kashmir has been the focal point of tension between India and Pakistan on the one hand and a local separatist movement in the State on the other. Years of unrest have caused immense damage to the lives of children affecting their survival, protection, development and participation opportunities as well as their parents' abilities to care for them (Save the Children, 2010: p. 27). The impact of armed conflict on children is largely invisible though it has had long-lasting effects on their growth and development (Save the Children, 2010: p. 13). The intensity and enduring impact of the conflict on children is yet to be examined. Every child in Kashmir has a heart-rending story to tell, but until now, the problems related to children have been restricted to being an orphan and/or living in an orphanage. The problems related to psycho-social, political, economic, educational and emotional challenges experienced by children remained largely unexplored. The death of a parent or parents deprives children of the love and care of their birth family, leaving them as orphans. No one can really take the place of a mother or father and every society develops social responses that involve caring for orphans.

The practice of placing deprived children with little or no emotional or material resources in large residential institutions like orphanages, destitute homes and charitable educational institutions has continued for many years in socio-economically poor Asian countries. Such institutions were also quite prevalent historically in Western societies. An upsurge in such institutions in Kashmir was observed during the mid-1700's, mid-1800's and immediately after World War I (Rotar, 2005: p. 1). Historically, in Kashmir, caring for and bringing up orphans has been carried out by the community itself. Orphanages did not exist prior to the beginning of armed conflict in 1989 which resulted in an increased number of orphans finding shelter in a mushrooming of orphanages throughout Jammu and Kashmir.

Although orphanages are not considered to be the ultimate answer to the increasing numbers of special children in the Kashmir Valley, the number of orphanages continues to grow. Experts emphasise the importance of community-based care, which they argue would provide the best support for these children. However, the number of residential institutions continues to expand, and they then create issues that exacerbate instead of healing the problems of orphaned children. In what follows, emerging issues and concerns about these residential orphanages

in Kashmir are examined, based on field experiences, observations from orphanages visited, and informal interactions with orphans themselves.

The Status of Orphanages in Kashmir

The care of orphan children in Kashmir can be approached in two ways: a relief-based approach and a rights-based approach. The followers of the relief-based approach see the advantages of caring for children mostly in orphanages and are supporters of residential care of children. The followers of a rights-based approach are more concerned about the rights of the children. They raise awareness of their rights among the different stakeholders involved in child care and services in the State. They also criticise the institutional care of orphans and encourage the use of alternative care approaches, particularly community-based care. Interestingly, many of the heads of orphanages also believe that residential care of orphans needs to be replaced by community-based approaches. To quote A R Hanjura, who runs the *Darul Ehsan Orphanage*,

> "There are 80,000 special children in the Valley; how to nourish them is a question. Special homes are no solution but, in terms of catering for and nourishing some of them, residential homes play a vital role. There must be community-based relief. The community must be aware and Imams (clerics) who are influential should come forward to increase community awareness. The community should give real support to families headed by widows" (Rashid, 2008).

Unfortunately, the followers of both these approaches have failed to come up with any alternative working care system for these orphans, with the result that there is a mushrooming growth amongst orphanages in the State. The orphanages that have provided services for over two decades continue to expand their network of orphanages. For example, Jammu and Kashmir Yateem Trust managed just one orphanage in the Valley until 1995 but now the number of orphanages in this trust has increased to twelve. It should have been easy for those orphanages that have existed for two decades to come up with alternative care options. They might be expected to have gained enough valuable experience to present a new plan of action for other organisations interested in the care and development of orphans. They should also have gained an understanding of both the positives and the negatives of institutional care and might have offered valuable recommendations for Kashmir society.

However, these organisations have continued to use an institutional approach in their interventions with children. It seems that they believe that caring for orphans in orphanages is in the best interests of the children, so have continued to establish more orphanages in the Valley, especially since there are economic drivers that keep orphanages expanding. Meanwhile, society in general – including scholars, researchers, and children's rights activists – have not taken the problem of orphans

in Kashmir seriously enough. That may explain why there is no children's rights perspective, few comparative analyses, or any real child-centred action plans regarding the issues and concerns of orphans. In the meantime, society has just accepted orphanages in a quiet and calm mood as the best way of caring for orphans. People donate huge amounts of money to the orphanages without thinking about whether this is the best way of assisting these young people. Because of this attitude, orphanages are more accepted day by day and are becoming a permanent part of the social structure.

During the last few years, the caretakers of these orphanages now drive around in the orphanage vehicles to collect cash and goods from people in the community. Large banners are tied onto the vehicles depicting the name of the orphanage, and loud speakers are used to attract public attention for donations. During such fund-raising activities, members of the public are shown group photographs of the orphans with motivational orations sharing emotional and religious claims. Such activity has now become a normal activity in both urban and rural areas of Kashmir, particularly during the month of *Ramadhan* (the holy fasting month for Muslims). The mosques are other attractive places for the collection of donations for these orphanages. The worst part of this activity is that some people put up laminated posters on cars and buses advertising their orphanage and showing photographs of orphans. They also speak to the passengers for 5-7 minutes to collect the money for their orphanage. These kinds of activities market the desperately sad and heart-rending stories of the orphans as a commodity. On the other hand, there was a time when orphanages really did play a very important role in society and when they were greatly needed. In contemporary times, however, there is severe criticism of the emergence of unnecessary orphanages with no set rules or regulations.

Admission of Children to Orphanages

The absence of orphanages in society may be considered in different ways. Firstly, some places have no alternatives, so the community itself takes care of their orphans. Secondly, some people dismiss institutional care as a caring option for orphans, preferring community-based care. Where orphanages are available in society, admitting a child is considered the last option as there are negative issues related to this kind of residential care. Firstly, it separates that child from the community where his/her neighbours, relatives, peer group and friends live. Secondly, his/her upbringing or socialisation takes place within a limited space surrounded by children of similar backgrounds all living under strict rules and regulations. Then, when the child finally leaves the institution, s/he frequently feels alienation and stigmatisation, as though they are looked down on by society. Lastly, without a child-centred approach, orphanages inhibit the psycho-social development of children who live there.

When it comes to the admission of orphans in Kashmir, the orphanages may be more interested in admitting as many children as possible than in providing a

child-centred environment. Some orphanages invite applications for the admission of orphans through advertisements in local papers. Most of the orphanages use personal contacts to locate orphans. Sometimes people come from different areas of the Valley to admit their children to the orphanages, having learned about these orphanages through various sources. Orphanage staff determine whether the children are eligible for admission. If an application meets the admission criteria – being an orphan or poverty being the main reasons – then further action is taken. When admitting a child to an institution, the guardian is given a set of forms which must be completed and signed as a contractual agreement between the parties.

The admission process is completed by receiving the consent of the child's guardians. In some cases, the guardian may be one person – the father or more usually mother, or any other relative of the child. This admission process may not always be carried out in the best interests of the child, not least because the child is not consulted at any time throughout the admission process. The admission process involves only staff and the guardians of the child. This fact is quite evident when the age of these children is taken into consideration. They are very young and unable to give their opinion about the fate of being removed from their family and society. In many cases, the existence and survival of some orphanages is totally dependent on there being children in them, so children are admitted to the orphanages without considering whether this is in their best interests. This is a major issue that needs to be addressed. Child welfare committees need to review and recommend which children should be admitted to residential institutions. The institutions themselves need to have proper mechanisms to ensure that correct decisions are made after proper professional consultations.

Separation of Orphans from their Family and Community

The family is one of the main socialising institutions in society. Within the family, the child adopts society's social norms and values, and learns to develop relationships with other members of society. Psychologists agree that children with secure attachments to their parents have a much better chance of developing into happy, successful, and well-adjusted adults. Parents encourage their children to investigate the world, manipulate objects, and explore physical relationships. This helps children to develop physically and emotionally (Nashbandi *et al*, 2012). Psychiatrists also believe that raising an orphaned child in a family environment is 'safer' and often ensures better emotional health.

There may be different reasons for sending a child to an orphanage for care and development, but various studies have shown that poverty is the primary reason. In a family with a sound economic background, a fatherless child is rarely sent to an orphanage. On the other hand, in a poor family, fatherless children are more likely to be sent to an orphanage, as the family has lost the primary bread winner and it is very difficult for a woman to sustain the care and education of the children on her own. However, there are other options, and they need to be

explored more fully, so that the best interests of the children become the reason for deciding on a particular course of action.

At the same time, it would be wrong to discard the role of residential institutions, totally, especially in times of emergencies like war, armed conflict or natural disasters when there is justification for the role played by these institutions. Unfortunately, it is generally accepted that orphans who remain in institutions for a long time, excluded from their family and community, may not do well psycho-socially. On the other hand, these institutions can cater for the immediate needs of an orphan at the time of death of his/her parents or in emergencies. A child's right to survival and protection comes before the right to development and participation. In the meantime, questions need to be asked about whether residential institutions should become a permanent feature of Kashmir society and whether children gain or lose because of living there. Further research is also needed to analyse the outcomes for children and society, comparing those from the orphanages with those who remained in the community.

Existing studies conducted in different parts of the world on the institutional care of orphans show many reasons for replacing institutional care with community-based care. Field experiences and observations of Kashmir society reaffirm such a view. A child is physically, psychologically and socially linked with its family members that may include father, mother, brothers, and sisters and, in the case of extended families, the child's network of relationships is even wider. When a child loses his/her father – as thousands of children have because of the armed struggle in Kashmir – s/he is often placed in an institution a short time later. Poverty in the family is frequently what motivates the family members – especially the mother – to send a child away from home, away from her and away from the whole community. Placing children in institutions can limit their socialisation. If death deprives the child of parental love and care, orphanages also deprive the child of the love and care of the other remaining family members. Another issue of concern regarding the admission of orphans to an orphanage is the age of the child. In one of the orphanages that was visited – namely Mohammadia Yateem Trust – some of the children were under 5 years of age and were not yet able to talk but were looking very angry.

The absence of any laws on behalf of the Government for regulating orphanages in Kashmir has had a very adverse impact on the children who live there. Most of the orphanages run in central Kashmir are in the districts of Srinagar and Budgam. Such locations serve the interests of the orphanage and its administrative staff. If anybody from outside the Valley is interested in knowing about the condition of orphans in orphanages, they mostly prefer to visit those districts closest to them. However, most of the children residing in the orphanages are from far flung areas. Because of this, children rarely meet or visit their families. According to the staff of various orphanages, children can go to their families just three or four times a year but can also talk any time with their family members on the office telephone. Family members can visit their children any time throughout

the year. Most of the children wish to go to their families during holidays or festivals, but frequently the staff find this a problem because after visiting their families, children do not wish to return to the institution. As a result, some orphanages have limited children's visits to their family and prefer that family members or relatives should travel to meet their children in the institutions.

Some orphanages do not even allow the orphans to go to their families during the Eid festivals. Every child naturally wishes to celebrate these two occasions with their family and community but orphanage staff who lack a child-centred approach restrict them to celebrating these days within the four walls of the orphanages. The children miss their families very much on these days and even weep on what should be such joyful occasions. When analysing further the reasons for such restrictions on children, it became evident that some people only come to visit orphanages during these holidays to give donations and – for such donations to be made – orphans need to be visible centres of attraction. The absence of orphans on such occasions might well decrease the amount of donations given by people. This begs the question of whether the administrators of these residential institutions are more concerned about material gain than the needs or wishes of the children. The happiness of children may be sacrificed for the cause of the institution. The question is posed about whether institutions are there for helping the orphans, or whether the orphans are there as in income stream for the institutions. Such patently self-interested restrictions on the children offer further insights into the aims and objectives of these institutions.

Government and Residential Institutions

The gap between the Government and institutions for orphans is another major issue and concern. Firstly, Government has shown little interest in amending and implementing the Juvenile Justice Act – the act that is directly concerned with welfare provisions for children in need of care and protection. Secondly, the Government has failed to govern and monitor the existing orphanages under set rules and regulations. Caring for orphans was mostly carried by the community itself in the past and an orphan before the 1990s would mostly get adopted by one of his/her relatives or neighbours in accordance with religious and social practices. Thus, there was no need for orphanages, as is confirmed by the fact that only one orphanage existed in Srinagar city before 1986. It was not until 1996-97, that several NGOs started operating in the State, especially in the domain of orphan care (Suri, 2003: pp. 2-4). The absence of a social support network for special children in Indian administered Kashmir for the last 18 years of conflict has seen the emergence of many special homes, but with no rules to govern them (Rashid, 2008).

Establishing an orphanage in the Valley is not difficult as there is negligible intervention from Government in this matter. Anybody can open an orphanage with a simple trust deed in the judicial court and almost all the orphanages in the Valley were established through such deeds of trust. No policies and procedures

for registration are required by the Government, arguably the most pressing issue facing the residential care of orphans. The seemingly indifferent attitude of Government towards these institutions puts the basic rights of destitute children at stake, by allowing these institutions to care for them without any set rules or regulations. Only a few orphanages are registered with the Department of Social Welfare, although such registration is in name only and is not focused on creating a healthy child-centred environment in these institutions. Of the twelve orphanages that were visited, not one had been visited by the appropriate Department in the last five years.

At the same time, any private educational institution in Kashmir that takes on responsibilities for educating children must follow a long procedure for its establishment and operations. The owner of the institute must produce No Objection Certificates from various departments for the Director of School Education when seeking registration of the institute and, after it is established, the Education Department supervises the institutes periodically. So, there is very good reason to question why orphanages that take on far greater responsibilities concerning the welfare and development of children can be established by a few individuals and trusts without any oversight from Government.

After Care Support

These orphanages do not have policies concerning the age of children admitted to orphanages. Children of different ages at different times are admitted to the orphanages and at times such a procedure leads to exploitation of little children by the older ones. Similarly, there are no policies concerning the length of time to be spent by the child in the orphanage. There are orphanages that keep children until the 5th Standard; some keep them up to 8th Standard; and very few up to 12th Standard. Furthermore, children can be expelled at any time if they do not follow the strict rules of the institution. Decisions are taken by the institution and communicated to the child's guardian, leaving the guardian submissive to decisions taken by the institution authorities.

After completing several years in the institution, the orphan is re-integrated into the family, existing relatives and to the community. However, these orphanages did not have any post institutional care to follow up on the progress of the children in terms of their adjustment and integration into society. Orphanages have failed to track the post-care re-integration process of the children. Sadly, many of those children who have left the orphanages are in considerable need of psycho-social care and economic support. Many may face challenges in adjusting properly and lack educational qualifications, having received no career guidance and then have difficulties in finding employment.

One of the post-institutional issues for children leaving care is their sense of identity in society. Nunokawa (2007) noted that those living in institutions raised questions about being labelled and the extent to which their sense of identity was dependent on the institution which differs from his or her culture of upbringing.

Kaiser (name changed) now a graduate student, who spent 7 years in an orphanage reported that he never raised his voice against the staff of the institution, as he always felt subjugated by the institution. Such a submissive attitude has developed in him a strong sense of inferiority. When he was re-integrated into society, he considered himself inferior to those young people raised in the community. On many occasions, he has faced problems by being labelled as someone brought up in an orphanage. A similar viewpoint was reinforced by the famous State Psychiatrist, Dr Mohammad Maqbool Margoob, who said: "The over-used word *orphan* is a label that is put on a child's forehead that tells him he is different than other children all his life. The label is a reminder that life can never be *normal*" (Nissa, 2015). Children who spend many years in an orphanage face further problems if the residential institutions fail to develop programmes to help their young people prepare for a return to the community. There is a need to follow up regularly those children who have left, to observe and support his/her post institutional care as s/he re-integrates into the community.

Child Participation and Decision Making

Every child has a right to participate in long-term plans for their lives as well as in many day-to-day life decisions. Providing opportunities for children to participate in different activities not only provides socialisation experiences but also provides him/her with a sense of respect and belonging in society. In most Kashmir orphanages everything is decided by the administration, including the food and its preparation, schooling, recreation, family visits, and educational subjects to be taken by the children. Children in orphanages are mostly young and are obliged to do whatever the administration requires. Children in all these orphanages participate in the games which are played within the premises of these orphanages because most lack playgrounds, so many are restricted from playing outdoor games on a regular basis. Their playground is inside the institution premises. While going outside the premises, the children are again subjected to many restrictions and regulations.

The subjects studied by the children are also decided by the administration. In one of the orphanages, the administration forced five girls who had passed 10th class to opt for Medical subjects when they had wished to study Humanities. These girls were warned that they would be expelled from the institution if they did not accept the administration's decision. The girls' lack of interest in Medical subjects is very likely to impact their education and career in the long run. One of the teachers reported that these girls were good in studies till the 10th class, but the decision forced upon them had lowered their overall performance. Some teachers asked the administration to allow these girls to opt for Humanities, but the administration refused. The decision demonstrates an approach to working with children that is clearly more administration-centred than child-centred. For their own reasons, the administration had decided that their children would study only

medical subjects in their education institution and no one could make any other choice.

In the same orphanage, students who failed their 10th class examination in one or two subjects were forced to leave the institution and told that the orphanage is not for failures. If one were to view those girls' failure from a child-centred perspective, it would be clear that what they needed was more care, love, sympathy and attention to overcome their fear of failure. More effort should have been made and better alternatives should have been sought to help these young people overcome deficiencies in their studies. Instead of helping these children at a time of failure, stress and fear, they were ordered to leave the orphanage.

Institutional Caregivers

There are very few orphanages that have their own schools for educating the orphans, so most are sent either to private educational institutions or to government schools. In the former case, the caregivers include teachers, wardens, mothers (staff working in the institution as house mothers), cooks, watchmen and drivers, and in the latter case, caregivers include wardens, mothers, cooks, watchmen and drivers – both males and females. Apart from the recruitment of teachers, these orphanages have no procedures for selecting the staff involved in the residential care of the orphans. Nor do these caregivers receive any kind of training about child care. These children may have many psychological and physical concerns that only trained and professional caregivers can understand. In most of the orphanages, wardens, watchmen, cooks and mothers have little formal education of any kind, even though they carry major responsibilities for the overall care and development of the children. The teachers, on the other hand, must have both academic and professional qualifications.

Creating Child-Friendly Spaces for Children or Property Empires?

The orphanages in Kashmir are gender specific, meaning there are separate orphanages for boys and girls. Of the twelve orphanages operating under the supervision of the Jammu and Kashmir Yateem Trust, only two are for girls while the remainder are for boys. There is a serious lack of adequate infrastructure in most of the orphanages which, along with a lack of trained and qualified care workers, undermines the creation of child-friendly and family-friendly living environments. Serious questions are posed for those who really do want to work for orphans. Are the present conditions for orphans in Kashmir really a problem for society? Are there large numbers of orphans in Kashmir? Such questions require important scrutiny into the social and historical context of Kashmir. Yet, the exact number of orphans is still unclear. Estimates offered by *Save the Children* based on sampling in selected districts do not constitute a thorough survey or census. Government has also failed to conduct any census on orphans in Kashmir

and lacks information about the exact number of orphans in the Valley. In such a situation, organisations which operate orphanages in Kashmir may use this lack of clarity to their advantage and exaggerate the presence of orphans in the Valley. As the survival of orphanages depends upon the presence of orphans, exaggerating the number of orphans increases the importance of orphanages and their role in society. Somewhat alarmingly, visits to several orphanages showed that the number of staff exceeded the number of orphans and any thought about closing these orphanages strikes at the economic and employment interests of all those associated with these orphanages.

There are reasons that justify criticism of the huge number of orphans in Kashmir. Firstly, the prevalence of 4.4 percent orphans in the State is close to the 4.5 percent prevalence identified in the National Family Health Survey-3 (Tramboo, 2000). It is worth noting that these estimates are less than the national average, and less than the average in other states such as Arunachal Pradesh (9.4 percent), Meghalaya (8.3 percent), Assam (7.2 percent), Jharkhand (7.0 percent), Chhattisgarh (5.7 percent), Uttarakhand (5.6 percent) and Karnataka (5.3 percent). Secondly, most of the children in Kashmir who were orphaned because of the armed conflict would no longer be children, having reached the age of 14 years and many would now have become adults, since most of the people were killed or disappeared between 1995 and 2000. Children who were orphaned during that period would now be more than 14 years of age. Why then is there still a need for orphanages, as the Government of Jammu and Kashmir itself considers a person to be a child only up to age of 14 years? Thirdly, exaggerating the issue may sometimes be a deliberate effort on the part of various agencies to divert peoples' attention away from other issues. Increasing the number of orphans is a direct result of the freedom struggle amongst the people of the Kashmir.

Finally, in every society there are people who exploit the public in the name of social service and social welfare who use various means to enhance selfish interests by exploiting destitute people. Amongst the orphans' families that we met, their major problem was a need for economic support. However, some orphanages take the children away from their families and place them in institutions. Given that the Government provides all children with free education, it would seem to make more sense to finance the families instead of financing the institutions. Given the existence of free education and a range of other scholarships, some orphanages appear to focus more on their own existence than on the real needs of the children. Instead of building these properties, those resources might have been much better spent on keeping orphans within their families and maintaining them at home. More than 70 percent of children in Jammu and Kashmir seek education from Government institutions and the education provided in those Government institutions is free to all children up to the 8th class. Orphans also have access to free education.

Conclusion

To conclude, orphanages emerged following the start of armed conflict in the Kashmir Valley in 1989 as an alternative to family care. While the emergence of orphanages was an immediate response to the sudden increase in the number of children with no parents, over time, these institutions have become a permanent feature of community life. While there are problems associated with the residential care of children in Kashmir, there is considerable scope for improvement in their functions. There is also consensus within society that community-based care is better than institutional care. Society in general and the orphanage officials need to develop more community-based approaches to caring for orphans.

One important effort would involve strengthening Islamic charity at grass roots level in rural areas and urban centres. In Muslim majority Kashmir, people give to charity as a religious obligation and the largest part of this charity goes to religious organisations as well as to orphanages where religious grants are spent on organisational and orphanage activities. Were these grants to be spent in the areas close to where the grants were collected, then orphan children need not be separated from their community by admitting them to an orphanage located 45 kilometres or further away from their home village. Steps such as these would greatly assist the community rehabilitation of orphans. At the same time, those orphanages that are already well established should take steps to improve the quality of care and protection practices they offer to children. Government has also to take a more active part in overseeing the general functioning of these residential institutions, from registration of orphanages all the way through to the after care of orphans. The rapid expansion of orphanages requires further scrutiny and any orphanages that fail to comply with minimum quality standards should be closed. The challenges associated with orphans in Kashmir need to be investigated more fully. The real number of orphans and the quality of their care – both inside and outside residential institutions – needs to be examined and the results compared with children reared in the community.

Questions for Small Group Discussion or Guided Reflection

1. *Since 1947, the State of Jammu and Kashmir has been the focal point of tension between India and Pakistan on the one hand and a local separatist movement in the State on the other.* Locate the Northern Border of India on a map and the Kashmir Valley where the border with Pakistan is situated. How would you explain the drawing up of formal borders between India and Pakistan and why borders drawn up years ago still influence the numbers of orphans living in the Border State of Jammu and Kashmir?
2. *Beginning in 1989, armed conflict in Kashmir has resulted in increasing numbers of orphans and a mushrooming of orphanages throughout Jammu and Kashmir.* What factors

appear to have been influential in determining the number of orphanages that now exist in the Kashmir Valley but were not there thirty years ago?

3. *When it comes to the admission of orphans in Kashmir, orphanages seem more interested in admitting as many children as possible, with some orphanages even inviting applications for the admission of orphans through advertisements in local papers.* What factors contribute towards the expanding number of orphanages in State of Jammu and Kashmir and why do you think these factors are important?

4. *According to the staff of various orphanages, children can go to their families just three or four times a year but can also talk any time with family members on the office telephone. Family members can visit any time throughout the year. Most of the children wish to go to their families during holidays or festivals but having children visit their family is frequently a problem for staff because, after visiting their families, children do not wish to return to the institution. As a result, the orphanages have limited children's visits to their family and prefer that family members or relatives should travel to and meet their children in the institutions.* How does this approach to maintaining contact between children in care and family members compare with how family contact is managed where you live and work?

5. *In one of the orphanages, the administration forced the five girls who had passed 10th class to opt for Medical subjects when they had wanted to study Humanities. These girls were warned that they would be expelled from the institution if they did not accept the administration's decision.* How might you go about explaining this residential child and youth care administrative practice and what potential remedies might be offered for such practices?

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Institutional Child and Youth Care in Delhi

Kiran Modi[1] and Anil Kumar Das[2]

There can be no keener revelation of a society's soul than
the way in which it treats its children. – *Nelson Mandela*

Abstract

This chapter reviews the use of institutional care for children and young people living in the mega-city of Delhi. The situation in Delhi is located within a national overview of India and then provision of institutional care services for children and young people by government and non-government organisations. While efforts are being made to introduce de-institutionalisation and expand family-based care and support for children, demand for services far exceeds capacity to respond. Given the large number of homeless and destitute children, constraints on non-institutional child care and challenges associated with institutional child care, the future is seen to lie in promoting innovative child care practices that blend the rationale of family-based child care with the positive elements of institutional child care.

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Introduction

Children occupy a special place in society as they embody innocence, virtue and the future. They are also a vulnerable population group, as their ability to defend their rights, protect themselves against violence and counter critical situations in life is much less or non-existent, unlike the adults. While it is difficult to identify all children in vulnerable circumstances, whether street children, abused children, destitute and trafficked children, victims of warfare and disasters, working children, mentally ill, physically and mentally disabled, these children can also be put into three broad categories – namely children in need of care and protection, children in conflict with the law and children in contact with the law. These children need to be provided with *opportunities for mental, physical and emotional development, and means for realisation of their full potential as human beings*. In this context, the issue of child care in general and the mechanisms of institutional and non-institutional child care assume great significance. The focus of this chapter on dynamics, challenges and prospects of institutional child and youth care necessitates analysis, *inter alia*, of contextual issues, the nature of institutional care, challenges and good practices. For the present purpose, the terminology '*children in need of care and protection* (CNCP)' has been used as an all-encompassing category covering different types of vulnerable children.

A Brief History of Institutional Child Care in India

The history of child care in India is synonymous with institutional child care, with a focus on the care of orphans. Although children without parents were traditionally looked after by joint or extended families, there have always been children without any kind of support during times of crisis. In the past, orphanages provided shelter and care to these critically needy children. Some of the oldest orphanages like San Thome Orphanage in Tamil Nadu – established between 1820 and 1830 – Bachchon Ka Ghar – the oldest Delhi orphanage built in 1891 – and Arya Orphanage – started in Delhi in 1918 – remain operational even today. With Indian independence in 1947 and adoption of the Constitution on 26 November 1949, care of children received increasing legislative attention. The National Policy for Children of 1974, and the enactment of a uniform Juvenile Justice Act in 1986 replacing the Children's Acts of various States, along with India's ratification of the United Nations Convention on the Rights of the Child in 1992 all speeded up the country's movement towards welfare-centric child care. A turning point in the history of institutional child care, however, was the enactment of the Juvenile Justice (Care and Protection of Children) Act of 2000, which replaced the 1986 Juvenile Justice Act and brought about fundamental changes in institutional child care structures and functions in India. This Act was repealed in 2015 by the Juvenile Justice (Care and Protection of Children) Act, 2015 (JJ Act) that came into force on 15 January 2016, influencing further changes in the existing institutional and non-institutional child care systems.

Situational Analysis of Children Needing Care and Protection

Children under 18 years of age are an important population category in India, not only because they make up 39 percent of the country's population of 1.2 billion according to the 2011 Census but also because of their vulnerability to abuse, deprivation and abandonment. While the country's Constitution and legal system treat every child equally and the Governments of States and the Union intervene at multiple levels to protect and promote the rights of children, thousands of children and young people continue to live in sub-human conditions and are deprived of welfare, education, health care and entertainment. Children's vulnerability gets accentuated in mega cities where exploitation is high. The conditions for children in India's capital Delhi are no different as the sections below demonstrate having a significant contextual bearing on institutional child and youth care in the city.

One important category of Children in Need of Care and Protection is the **homeless and street children** whose number has been on the rise in Delhi in recent years due to migration from rural areas. Children migrate to the city either alone or with their families, as Delhi is known to offer huge employment opportunities for labourers and unskilled workers. The city has over 100,000 street children who are vulnerable to abuse, drugs, criminal and other anti-social activities, often under the control of organised gangs of criminals (Michalkiewicz, 2014). According to a study reported in August 2014, 80 percent of street children in Delhi are involved in **substance abuse** (Sharma, 2014). While these children are mostly engaged in rag picking, begging, street vending and daily wage labour, they are often abused emotionally, physically and/or sexually because of their contact with anti-social elements, indulgence in and exposure to deviant behaviour and practices, with little or no access to education and their sub-human living conditions on the streets without the most basic amenities or security.

Delhi is known for its high incidence of crime in general and **crime against children**. With a 10.5 percent share in the total incidence of crime committed against children in the country, this city occupied the third position amongst the States and Union Territories (UT) (National Crime Records Bureau, 2014). Such a high incidence of crime is also reflected in the very high rate of crimes committed against children at 166.9 per 100,000 children in 2014 – the highest rate across all the States and Union Territories reported. The extent of danger to which children are exposed can be gauged from Delhi's reputation as the most unsafe city of all the 53 mega cities in India, with an average of 16 crimes against children reported every day (Mid-Day.com, 2014). **Child victims of crime**, especially victims of violent crimes like rape, trafficking and physical abuse frequently occur when children are deprived of family and kinship support.

Children in Need of Care and Protection also include **child labour** which, despite the enactment of Child Labour (Prohibition and Regulation) Act, 1986, continues to exist in both industrial and commercial establishments as well as in households in the form of domestic help. The problem is more acute in Delhi

which is seen as a city with ever-expanding commercial activities with a burgeoning middle and upper-middle class. The Labour Department of the Government of National Capital Territory of Delhi recently stated that 99 percent of the 4310 child labourers rescued between 2009 and May 2014 were from other States (Singh, 2014). According to the Census of India, 2011, the number of working children in Delhi in the age group of 5-14 years was 26,473.

Children living in the slums of Delhi constitute another vulnerable category. The city has 1.7 million people living in slums (Rukmini, 2013), enduring highly unhygienic conditions devoid of proper civic amenities, housing, road connectivity, healthcare or education. As these people are engaged in daily wage labour, rickshaw pulling, rag picking and other petty jobs, their capacity to afford quality life conditions is extremely limited. The situation adversely impacts the process of children's primary and secondary socialisation, as the absence of a proper learning environment at home or in the community, inadequate parental emphasis on education, exposure to domestic violence and deviant practices, peer pressure and non-existent or inadequate coping mechanisms, financial hardship and emotional stress are all palpable phenomena in slums. With an infant mortality rate of 35.6 per 1000, an under-five-year old mortality rate of 73.6 per 1000, 67 percent of children suffering from anaemia and 45.9 percent of children underweight, children in Delhi's slums are also highly prone to diseases (National Health Survey, 2006).

Children with disabilities also suffer, especially when they belong to poor families with inadequate means to take care of their disability-specific needs. These children have limited or no access to disabled-friendly infrastructure or support. According to the Census of India 2011, the number of disabled children in Delhi in the age group of 0-19 years was 60,663. Of the total, five important categories are 'in movement' disabled (17%), hearing disabled (15%), multiply disabled (13%), visually disabled (11%) and mentally retarded (11%).

Children in conflict with the law are another vulnerable group amongst the city's children. According to data made public by the Delhi Police, a daily average of six crimes committed by children below 18 years were reported during the 10-month period beginning on 1 January 2014. The cases included snatching, robbery, membership in gangs or dacoity (armed banditry), attempted murder, murder and rape. Children in the age group of 16 to 18 years were involved in more than 60 percent of these cases (Bansal, 2015)**.**

It is evident from the foregoing sections that Delhi has millions of children in difficult and vulnerable conditions – whether living alone or with families – who need care and protection for the sake of their physical, mental and emotional development. The disempowered and exploitative social contexts in which most of these children live further reinforce the need for child-centric intervention. As we witness the gradual weakening of family ties in India, especially the system of joint/extended families that traditionally used to act as caregivers for vulnerable children, institutionalised child care has emerged as an alternative caring

mechanism. This is especially true for children who experience disruptive family conditions and inadequate access to or availability of non-institutional services.

Types and Nature of Institutional Child and Youth Care

The National Capital Territory of Delhi has different types of child care institutions as prescribed by the Juvenile Justice Act, 2015 and the Integrated Child Protection Scheme (ICPS) whose revised version came into effect in 2014, as shown in the table below.

Table 1
Type and Nature of Child Care Institutions

Type	Nature
Children's Home	For Children in Need of Care and Protection during initial investigations and for their subsequent care, treatment, education, training and rehabilitation
Observation Home	For the temporary reception of any juvenile in conflict with law pending outcome of any inquiry
Special Home	For reception and rehabilitation of juveniles in conflict with the law
Place of Safety	Any place or institution, other than a police lock-up or jail, that can temporarily receive and take care of juveniles
Home for Special Needs Children	For children with special needs (infected/affected by HIV/AIDS, drug addicts and mentally/physically challenged), either in the form of a specialised unit within an existing home or a specially designed shelter home
Open Shelter	For vulnerable children (homeless, street children, drug addicts, beggars etc.) in urban/semi-urban areas. These are 'community-based safe spaces', not permanent residential facilities.
Fit Facility	For temporarily taking responsibility of a child for a specific purpose
Specialised Adoption Agency	For housing orphans, abandoned and surrendered children, placed there by order of the Child Welfare Committee for the purpose of adoption

While some Child Care Institutions are managed by the Government of National Capital Territory of Delhi, there are many which are managed by non-governmental organisations (NGOs). The tables below show the number of institutions in each category.

Table 2
Number of Child Care Institutions Managed by Government

Type of institution	Number
Children's Home	16
Observation Home	7
Special Homes for Boys	1
Places of Safety	2
Homes for Children with Special Needs	5
Open Shelter	15

Table 3
Number of Child Care Institutions Managed by NGOs

Type of institution	Number
Shelter Home	7
Adoption Agency	13
Children's Home	86

Source: Compiled from data available with Ministry of Women and Child Development, GNCTD

The institutions managed by NGOs are licensed in line with the relevant provisions of the Juvenile Justice Act. These institutions are required to conform to standards of care prescribed in the Rules of the Act also prescribed in the revised Integrated Care and Protection Scheme which covers the following key areas:

- Physical infrastructure
- Clothing and bedding
- Sanitation and hygiene
- Daily routine
- Nutrition and diet scale
- Medical care
- Mental health
- Education
- Vocational training
- Recreation facilities
- Children's committee
- Child suffering from dangerous diseases or mental health problems
- Inspection

- Social audit
- Restoration and follow up

Despite these standards of care, Child Care Institutions in the city, especially those managed by NGOs, follow different approaches and practices regarding their functioning, thereby displaying dynamism and uniqueness in action. While some Child Care Institutions are known for their services to specific categories of vulnerable children, the differences in their approaches and practices pertain principally to two key elements – nature of service delivery and community outreach. Community outreach has been excluded from this analysis to focus exclusively on institutional child care in Delhi. Distinctive features about the operations of Child Care Institutions in Delhi and other related aspects are highlighted in what follows.

Targeted Children

While Child Care Institutions managed by the government fall into one of the categories noted in Table 1, those managed by some NGOs serve specific categories of children. For example, the care home managed by Naz Foundation (India) Trust specifically supports orphaned children living with HIV. The New Generation, another NGO, targets girls under 18 years of age who are victims of trafficking and prostitution, and boys who are HIV positive. Salaam Baalak Trust runs full care residential centres and shelter homes for street children. While St Anthony's Children's Home houses orphan and destitute girls from the slums, Prayas Observation Home for Boys is a short stay home for juveniles in conflict with law. The city also has a home called Mukti Ashram which provides shelter, food, clothing, education, health and other services to children rescued from child labour and trafficking.

Children with physical and mental disabilities are another targeted category in institutional care. While the government has six homes for children with special needs, which include physically and mentally challenged, there are NGOs in the city which also provide institutional care for such children. Some prominent NGOs in this domain are Cheshire Homes and Bal Chetna – a respite home and day care facility for mentally challenged children managed by the Delhi Council for Child Welfare. These Child Care Institutions provide facilities like physiotherapy, special education, speech therapy and vocational training. While the above examples of Child Care Institutions serve specific categories of children, others serve Children in Need of Care and Protection which focus, *inter alia*, on destitute, street children and orphans.

Nature of Service Delivery

At the core of institutional child care remains the delivery of services guided by standards prescribed by the laws of the country. Child Care Institutions run by

government are similar with respect to their methods of service delivery as they act according to the prescriptions of law, restricting scope for innovation. Those managed by NGOs, however, demonstrate innovation in approach as well as actions. Since it is impossible to account for approaches and the nature of services in all Child Care Institutions here, some that are considered innovative and unique, with the potential for maximising physical, mental and emotional development of children, are highlighted below.

SOS Children's Village – A Unique Child Care Model

SOS Children's Villages of India has one children's village in Delhi. Its model of child care ensures a home-like environment that is based on four fundamental principles namely the mother, brothers and sisters, the house and the village. According to their model, each children's village has a certain number of houses that the children call their home. Each SOS family houses an average of 10 boys and girls of up to 14 years age along with the SOS mother, who is responsible for providing care, security and emotional support to the children. The mother manages the house independently as is done in any other household. When they reach 14 years of age, boys move to youth houses. Each SOS Children's Village creates a village-like community which in turn allows children to mingle with their peers and families to share their experiences. The SOS Children's Village in Delhi has facilities like kindergarten, dispensary, community centre, provisions store, residences for co-workers etc. so that all the children's immediate needs are fulfilled. The Village provides support for children's education, health care, psychological development, career, marriage and other developmental needs until they are fully settled in their lives.

Other Child Care Institutions have also adopted the SOS-like child care model, in places like Sweet Home Children's Village which takes care of orphaned and missing girls as well as Minda Bal Gram which has facilities for both girls and boys. However, the scale of SOS Children's Village interventions is far more extensive when compared with the interventions of others.

Group Foster Care – A Pioneering Model of Udayan Care

Distinctive Features of the Model of Child Care Operating at Udayan Care

- Small size homes that resemble a family
- Individualised child care
- Best interests of children guarded and promoted
- Mentoring parents as lifetime volunteers
- Care under guidance of professional caregivers
- Effective and efficient compliance with standards of child care

- Child feels attached and cared for at homes and integrated with community
- An effective and guided after care programme that ensures proper settlement
- Unique community outreach that allows children's social integration and community's involvement in child care with a sense of ownership
- Emphasis on programmatic innovation and capacity building of staff.

The network of Group Foster Care (GFC) is an innovative child care model developed by Udayan Care – a leading Indian charity in the domain of child care – that manages 13 homes called Udayan Ghars in Delhi and elsewhere in North India. At a time when institutional child care is being considered problematic for children because of their disconnection from society combined with more of a focus on welfare than on development, Group Foster Care is an innovative alternative model that creates the warmth of a family with strong community interface having the potential for neutralising the stresses of institutional child care.

Group Foster Care is based on a strategy called LIFE (Living in Family Environment) that focuses on the long-term residential care of orphaned and abandoned children of 6 years and older in **'LIFE Udayan Ghars'** or **'Sunshine Homes'**. Each LIFE Udayan Ghar is in a community setting in a middle-class neighbourhood, houses not more than 12 children of the same gender, and that creates a home-like environment for the children under the overall guidance of Mentor Parents and socially-oriented staff and volunteers. In other words, it is a foster family that takes care of a group of targeted children. This approach creates opportunities for parental attachment, interaction with community, good in-house relationships, responsible primary socialisation and children's emotional enrichment.

Entry into a Sunshine Home gives the feeling of entry into a normal middle-class household with warmth and hospitality experienced from both children and caregivers. The uniqueness of Sunshine Homes is visible at two levels. At one level, children are provided with opportunities for and access to education, skill development, physical and mental health care, career counselling and overall guidance that instils confidence and raises hopes for a better future. On another level, these young people feel emotionally enriched in a family-like environment under the guidance of Mentor parents who act as long-term volunteers, and together promote children's value-based socialisation. Group Foster Care blends the multiple needs of children, offering personalised care in a family-like environment, helping to negate some of the adverse aspects of institutional child care.

Care Home of Naz India – A Home for Multiply-Deprived Children

The Care Home managed by Naz India in Delhi offers targeted intervention for orphans between the ages 5 and 19 years who are HIV-positive. These children come from different Indian States, indicative of interventions with a pan-India

reach. This Child Care Institution provides holistic care covering health, education, nutrition, recreation and psychosocial development. The services result in improved physical, psychosocial and personality development of those children who are considered in the most vulnerable category.

Palna: A Novel Intervention by the Delhi Council for Child Welfare (DCCW)

Palna (or 'cradle' in English) is an old and novel intervention by the Delhi Council for Child Welfare that combines care with a unique method of receiving children. At Palna, a cradle is placed outside the gate of the compound in order to allow parents to leave their children without having to identify themselves. While the Child Care Institution receives most of its children through this method, children also come through police and hospitals. As Delhi Council for Child Welfare attaches importance to family, it first tries to restore children to their biological parents. If this fails, they are placed for adoption. Palna provides health care, non-formal education, recreation, nutrition and other essential services for children.

Some Other Prominent Child Care Institutions in Delhi

The city has many other prominent Child Care Institutions known for their high-quality services like Don Bosco Ashalayam, Jamghat and Tara. While Don Bosco Ashalayam houses 125 street children, Jamghat manages small sized homes for street and destitute children – in a home for up to 15 boys called Aman and a home for 11 girls called Anchal. Tara, on the other hand, manages Tara Boys – a home for 20 boys in the age group of 6 to 18 years, Tara Tots – a home for 20 boys and girls aged up to 10 years, and Tara Girls – a home for girls in the 6 to 18 years age group. The city also has some faith-based organisations like Shri Digambar Jain Mahila Ashram for Jain and Hindu girls, Bethlehem Children's Home and St. Anthony's Children's Home promoted by Christian leaders, and Bachchon Ka Ghar which houses over 200 Muslim children (both boys and girls) in the age group of 4-18 years and Muslim Boys Hostel meant for Muslim orphans.

The above examples illustrate the diverse nature of Child Care Institutions operating in Delhi in terms of types of children served, nature of services and management structures.

After Care Services

After care services are meant for young adults who leave Child Care Institutions on attaining 18 years of age in accordance with provisions of the Juvenile Justice Act, where section 46 deals with after care. For rehabilitating children, Rule 55(6)(a)(x) of the Rules under the Act prescribes planning and follow up actions by Child Care Institutions for a period of two years in collaboration with organisations working for after care. The maximum time that a child should remain in a programme of after care is three years according to the prescription of the Integrated Child Protection Scheme.

After care services are especially important for established organisations like SOS Children's Village and Udayan Care which have children in the category noted above. The SOS Children's Village has an effective after care programme during which career counselling, vocational training, higher education, placement assistance etc. are provided for young people leading to their proper rehabilitation. According to the SOS approach, once boys reach 14 years of age, they are moved to youth houses, but girls remain with their SOS families. Support for young people is provided until they are fully settled in life.

Udayan Care has an elaborate after care programme for young adults who are provided 'hand-holding support' under the guidance of their Mentor parents and the organisation's overall support. While there is an after-care residential facility for older girls, the boys stay in flats or hostels associated with their educational institutions. These youths are supported for higher education, professional training and career development. Significantly, the after-care support offered by Udayan Care is not limited to three years as prescribed by the law, but it continues until each young person is finally settled. A somewhat similar system is in place in Tara, which manages Tara Big Birds for 20 girls and boys over the age of 18 years.

The government operates one after care home for boys and another for girls which provide vocational training, non-formal education, career counselling, and placement assistance for the rehabilitation of young adults. However, after care services – especially those provided by government – suffer from challenges, as indicated below.

Challenges to Institutional Child and Youth Care

Child care institutions are meant to care, protect, reintegrate and rehabilitate children who are victims of critical circumstances like abandonment, poverty, violence and disability. Although the Child Care Institutions of Delhi are governed by the provisions of the Juvenile Justice Act and are covered by the Integrated Child Protection Scheme, it is not uncommon to find institutions that do not always operate in accordance with the prescribed standards. A case in point in this context is the government-run Observation Home for Boys II which was inspected by the National Human Rights Commission (NHRC) in December 2013 following reports of drugs and child abuse. The inspection team found several problems, including drug abuse, physical harassment by recidivist juveniles, attacks on staff and sexual abuse (National Human Rights Commission, 2013). During 2013, three cases of rioting by juveniles were reported by different Delhi juvenile homes. These and many other cases of a similar nature indicate the extent of children's vulnerability in child care institutions.

Child care institutions also face challenges like inadequate infrastructure, non-availability of competent child care professionals, inadequate emphasis on vocational training or life skills training, and non-adherence to prescribed standards, all of which impact on their capacity and quality of services provided. While some of the challenges are circumstantial in nature, like inadequate resources affecting

the development of the physical infrastructure and recruitment of staff, and the non-availability of trained child care professionals, others, like non-compliance with standards of child care and poor documentation, are a result of deficiencies in management. While inspecting children/shelter homes in Delhi in May-June 2015, the Delhi Commission for the Protection of Child Rights (DCPCR) – a statutory body of the Government of National Capital Territory of Delhi – came across many such challenges and deficiencies in Child Care Institutions managed by government and NGOs.

Although rehabilitation is a key component of institutional child care, these services do not always focus on actions that strengthen the measure. Vocational training, for example, is a neglected area not only in Delhi but throughout the country. According to a study of Indian Child Care Institutions conducted by the National Institute of Public Cooperation and Child Development, New Delhi (NIPCCD, 2011), data for which were collected until June 2011, 44% of 185 Child Care Institutions were providing vocational training on tailoring, beauty care, computer applications, etc. During inspection of an observation home in Delhi in 2013, the NHRC found that only two courses on cooking and tailoring were offered as part of the vocational training programme, with the result that only a few children attended them. Training programmes were also not conducted regularly. After care services also face many challenges like inadequate infrastructure, insufficient access to services and non-compliance with international standards and best practices.

One significant challenge that institutional care faces in the present context is the focus on a child's right to family access and the resultant emphasis on fulfilling children's needs in a secure and nurturing family environment. However, it has limited contextual relevance in a place like Delhi whose population of Children in Need of Care and Protection is in the millions. The fact is that most of Delhi's homeless, abandoned and trafficked children belong to families which have little or no productive assets, are poverty stricken, socially subjugated, and incapable of managing their own developmental needs. There are also highly disruptive and divided families with little or no emotional bonding among family members, often resulting in constant physical, mental and emotional abuse of their children. For children of such families, re-integration makes little sense, as even after re-integration, the likelihood of children returning to the city is high. In view of the limited reach of non-institutional family-based child care, institutional child care assumes contextual relevance. An example of the limited reach of family-based care is child adoption in Delhi. The city had only 400 children available for adoption in 2013 with most of these children either mentally or physically challenged. With over 1000 families waiting to adopt a healthy, normal and fair child, there is a three-to-four year waiting list of parents wishing to adopt (Spucys-Tahar, 2013).

Future Prospects

The prospects for the institutional care of children in Delhi are closely linked to the city's unique situation regarding Children in Need of Care and Protection, the dynamics of institutional child care, and both existing and emergent legal provisions in India. While Integrated Child Protection Schemes accord primacy to family-based child care, the newly implemented Juvenile Justice Act, 2015 emphasises a preference for care by the biological family or by adoptive or foster parents, with placement of children in an institution as an intervention of last resort. As a result, long-term institutional care receives increasingly secondary status. However, bearing in mind the large number of homeless and destitute children in Delhi, the constraints on non-institutional child care and the challenges with institutional child care, the future lies in promoting innovative and effective child care models that blend the rationale of family-based child care with the positive components of institutional child care. With only about 6000–6800 children supported annually by the Delhi Government's Integrated Child Protection Scheme (2014[3]), more efficient and effective interventions are required to ensure children's rights in both institutional and non-institutional services. In this context, the models promoted by SOS Children's Village, Udayan Care and others hold promise.

To conclude, Delhi offers some of the finest models of institutional child and youth care that blend the needs of children with their rights, their welfare with personal development and custodial care. The dynamics of holistic development in the care of children will ultimately ensure their journey from circumstantial isolation to gradual inclusion and mainstreaming within society. The need for efficient and effective child care interventions far outstrips the capacity of Delhi to respond to the burgeoning population of children living rough and vulnerable to trafficking in India's capital territory. There is a continuing need for dialogue between the government and NGOs to address challenges facing institutional child and youth care, as highlighted earlier. Such dialogue needs to include key issues like physical and mental health concerns, plans for transition from care into semi-independent living as an adult, guidelines for emotional, psychological and financial support for children transitioning to independent life, and the importance of a continuum of care for young adults supported by legislation and support networking for care-leavers.

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[3] Delhi government wants to ensure protection of child rights (2014, August 2). Retrieved from http://articles.economictimes.indiatimes.com/2014-08-02/news/52356535_1_child-rights-child-abuse-child-development. Accessed on 28 October 2015.

Questions for Small Group Discussion or Guided Reflection

1. *In a country like India where 39 percent of the country's population of 1.2 billion people are under the age of 18, the vulnerability of children gets accentuated in mega cities where the degree of exposure to exploitative circumstances is particularly high.* How does this compare with challenges facing children and young people where you live and what do you think it would be like working in Delhi?
2. *In a city like Delhi, tagged as the most unsafe city of the 53 mega cities throughout India – with an average of 16 crimes against children reported every day –* what emergency youth services might be required?
3. How does the author compare the government operated residential care institutions with some of those operated by NGOs in Delhi?
4. *The SOS Children's Villages in India move boys from the family houses to youth houses when they reach 14 years of age, while girls continue to stay with their SOS families. Support to these youths is provided until young people are finally settled in life, with funding support for up to 3 years after the age of 18.* How does this after care service compare with what is available for young care leavers where you live?
5. *The authors conclude: "the future lies in promoting innovative and effective child care models that blend the rationale of family-based child care with positive components of institutional child care".* What might such a 'blend' look like where you live and work?

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Residential Child and Youth Care Practices Rajasthan Residential Child and Youth Care: Opportunity for a Fresh Start

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Abstract

The history, policies and laws are outlined concerning recent trends and the status of residential child and youth care in the northwest Indian State of Rajasthan. Attention focuses here on the defined model of institutional care in India and care and protection of children's in residential homes and the use of such services for children and young people. The chapter concludes with suggestions and recommendations about the needs and future development of residential child and youth care based on research visits to children homes, discussions with children and caregivers, and a collection of local case studies.

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Introduction – Pooja's Story (name changed)

Meeting with children in homes who come from different ethnicities, backgrounds and culture is truly a learning experience. Each child has his/her own unique story to tell. When Pooja (name changed) told her story flawlessly, everybody was surprised to see no sign of fear, anxiety or hesitation on her face – instead there was a glow of confidence connecting with everyone. After she had been rescued from child labour, Child Welfare Committee (CWC) members took her to a children's home after she found herself beset by many difficulties in her own home. Because she cherished an unseen dream to study, that is where she devoted all her efforts. She is now seventeen and in 8th standard, having never previously had any formal education and is probably the first person from her family and community to get this opportunity. All credit goes to the imaginative residential care and education links she formed while in the NGO run institution that took on her care. There, all the children are emotionally attached to caregivers and called them Maa (mother), Papa (Father) or Mausi (Aunt).

Key legislations for the protection of children includes Juvenile Justice (Care and Protection of Children) Act, 2015, Child Labour (Prohibition and Regulation) Act, 1986 (Amended in 2016), Prohibition of Child Marriage Act, 2006, Right to Education Act, 2009 (Amended in 2012), and Prevention of Children from Sexual Offences Act, 2012, The Aadhaar (Targeted Delivery of Financial and other Subsidies, Benefits and Services) Act, 2016 etc. The National Plan of Action for Children 2016 flowing from National Policy for Children 2013 therefore stands as the country's practical expression of commitment to a safe, dignified and fruitful life for all children.

India has the second largest population in the world with almost 39 percent of the total population of India involving children and young people under the age of 18 years. According to Alok Kumar "almost 50 per cent of these children need care and protection" (2012). Once children in need of care and protection such as these, meet institutional care through whatever means, it changes life in all aspects. Good institutions not only nourish and protect the child but also give opportunities to explore potentials.

According to Gopalakrishnan (2016) the home provides integrated, community-based institutional services for the care, protection and development of such children. Its focus is on improving the well-being of children and reducing their vulnerabilities to situations and actions that lead to neglect, abuse and exploitation. Institutionalization of children is the last resort and there are various categories of children in need of care and protection where family integration is not possible and residential care is the only option. According to India legislation, the child is restored to parents/guardian/family or is sent to a child care institution for the time being until parents/guardians are traced. If the parents are not traced, the child is either placed in a Children's Home/Fit Facility/SAA/Fit Person or is declared legally free for adoption or placed in foster care. Children's homes look after children with many different needs from care and immediate shelter, to places

for children to develop and grow, as well as provide food, shelter, a space for play and leisure activities longer term in a caring environment.

In the current chapter, we describe the history, policies and laws relating to residential child care institutions, recent trends and the status of residential care in the northwest Indian State of Rajasthan. Although there are many different types of residential care offering short and long-term care, our focus here is on residential children's homes that provide long-term care. We conclude with suggestions and recommendations on the needs and future development of residential care through visits to children homes, discussions with children and caregivers and a collection of case studies.

The history of India reveals that the care, protection and overall development of children was not only the duty of the family but also the collective responsibility of the whole society. A child was treated as God's finest creation and all members of society were fully concerned with their care and development. During the era of Ramayan and Mahabharat, children were sent to Gurukul for study and personal development; in these residential schools, children were educated and then returned to their society once their education was complete. The traditional Indian view of welfare is based on *daya* (mercy), *dana* (charity), *dakshina* (offering), *bhiksha* (giving), *ahimsa* (non-violence), *samya-bhava* (equality-observed), *swadharma* (own beliefs) and *tyaga* (sacrifice), the essence of which were self-discipline, self-sacrifice and consideration for others. Children were recipients of such welfare practices and became participants in such community learning activities with others.

During the 20th Century the concept of children's rights began to emerge. This rights approach is primarily concerned with issues of social justice, non-discrimination, equity and empowerment, and is embodied in the United Nations Convention on the Rights of the Child (CRC), 1989. India has made some significant commitments towards ensuring the basic rights of children and ratified the Convention on the Rights of the Child in December 1992. All children under the age of 18 years are entitled to the standards and rights guaranteed by the laws that govern our country and the international legal instruments we have accepted by ratifying them. India has also adopted several laws and formulated a range of policies to ensure children's protection and improvement in their situation. The age of a 'child' is defined differently for different laws in India.

Defining Institutions for Care and Protection of Children in India

The Central Government of India enacted the Juvenile Justice (Care and Protection of Children) Act ,2015 (JJ Act, 2015) which has come into effect from 15th January 2016, repealing the Juvenile Justice (Care and Protection of Children) Act, 2000, amended in 2006 and 2011. Some of the key provisions include: change in nomenclature from "juvenile" to "child", inclusion of several new definitions such as orphaned, abandoned and surrendered children; clarity in powers, function

and responsibilities of Juvenile Justice Board (JJB) and Child Welfare Committee (CWC); clear timelines for inquiry by Juvenile Justice Board (JJB); separate new chapter on Adoption to streamline adoption of orphaned, abandoned and surrendered children; inclusion of new offences committed against children; penalties for cruelty against a child, offering a narcotic substance to a child, and abduction or selling a child being prescribed. These are now mandatory in the registration of Child Care Institutions.

The Juvenile Justice (Care and Protection of Children) Model Rules, 2016 (JJ Model Rules, 2016) was notified on 21 September 2016, repealing the Juvenile Justice (Care and Protection of Children) Rules, 2007. The JJ Model Rules, 2016, are based on the philosophy that children need to be reformed and re-integrated into society. The best interests of the child along with child-friendly procedures are incorporated across the provisions and remain the primary consideration. The age of the juvenile was fixed as 18 years for both sexes, however, for heinous crimes; the ages are fixed as 16 years for juveniles. Juvenile Justice Act regulations outline the standards of care for children in a Child Care institution with mandatory registration and guiding principles. The Juvenile Justice Act has also made provisions for establishment of State Child Protection Society, District Child Protection Unit, Special Juvenile Police Unit, and Commission for Protection of Child Rights (CPCR). To facilitate setting up of these Institutions, the Integrated Protection Scheme (ICPS) 2009 was established. The Commission for Protection of Child Rights has been assigned the additional responsibility of monitoring the Implementation of the Juvenile Justice Act. The first time, 'General Principles of Care and Protection of Children have been inserted in Section 3 of chapter-II of the Act, 2015. There are 16 General Principles which are based on the UN CRC, 1989 – fundamental principles of care and protection of children.

According to the Act, the children in need of care and protection who are not placed in families for any reason may be placed in an institution registered for such children under this Act. Or these children may be placed with a fit person or a fit facility, on a temporary or long-term basis. The process of rehabilitation and social integration shall be undertaken wherever the child is so placed, based on the individual care plan.

Family-based care such as by restoration with family or guardian, with or without supervision or sponsorship has become the recommended option. Adoption or foster care are other options, provided that all efforts shall be made to keep siblings placed in institutional or non-institutional care, together, unless it is in their best interest not to be kept together. The restoration and protection of a child shall be the prime objective of any Children's Home, Specialised Adoption Agency or open shelter. Child care can be categorized as Institutional and Non-Institutional Care, as follows:

Types of Care	Institutional	Juvenile in conflict with law	Observation Home Special Home
		Children in need of care and protection	Fit Institution Children's Home Open Shelter
	Non-Institutional	Foster care Adoption Sponsorship After Care	

Types of Institutional Rehabilitation:

'Child care institution' includes observation home, special home, open shelter, place of safety for child in conflict with the law and children home, fit institution, SAA wherever, "a child in need of care and protection is housed for providing care and protection of children who are in need of services." 'observation home', 'special home', 'open shelter', 'foster care' and 'after care' are defined in the Act for child in conflict with the law. Juvenile delinquents who are kept in an observation home under trial, wherever a convicted child who is kept in the special home. A child who has committed a heinous offence in the age of 16-18 years is kept in open shelter. The Neglected child, Orphans and Abandoned children are housed in a children's home. "Aftercare means making provision of support, financial or otherwise, to persons, who have completed the age of eighteen years but have not completed the age of twenty-one years and have left any institutional care to join the mainstream of the society". All Child Care Institutions must be mandatorily registered within six months from the date of commencement of the Act and failure to do so is a punishable offence. Registration applications of Child Care Institutions are to be disposed of within six months otherwise it would be considered as dereliction of duty and will invite departmental proceedings.

The services that shall be provided by the institutions registered under this Act in the process of rehabilitation and re-integration of children, shall include:

(i) basic requirements such as food, shelter, clothing and medical attention as per the prescribed standards;

(ii) equipment such as wheel-chairs, prosthetic devices, hearing aids, braille kits, or any other suitable aids and appliances as required, for children with special needs;

(iii) appropriate education, including supplementary education, special education, and appropriate education for children with special needs: Provided that for children between the age of six to fourteen years, the provisions of the Right of Children to Free and Compulsory Education Act, 2009 shall apply;

(iv) skill development;

(v)   occupational therapy and life skill education;

(vi)   mental health interventions, including counselling specific to the need of the child;

(vii)   recreational activities including sports and cultural activities;

(viii) legal aid where required;

(ix)   referral services for education, vocational training, de-addiction, treatment of diseases where required;

(x)   case management including preparation and follow up of individual care plan;

(xi)   birth registration;

(xii)   assistance for obtaining the proof of identity, where required; and

(xiii) any other service that may reasonably be provided to ensure the well-being of the child, either directly by the State Government, registered or fit individuals or institutions or through referral services.

There are two types of institutional rehabilitation: (a) Short Term and (b) Long Term.

Short Term Care includes**:**

1. A Fit Facility recognized by JJB or the CWC, being run by a Government organization or a voluntary or non-governmental organization registered under any law for the time being in force to be fit to temporarily take the responsibility of a child for a specific purpose after due inquiry regarding the suitability of the facility and the organization to take care of the child.

2. The Open Shelter shall function as a community-based facility for children in need of residential support, on a short-term basis, with the objective of protecting them from abuse or weaning them, or keeping them, away from a life on the streets.

Long Term Care

1. Children's Homes may be established and maintained in every district or group of districts by Government itself or through voluntary or NGOs, which shall be registered as such, for the placement of children in need of care and protection for their care, treatment, education, training, development and rehabilitation.

Rajasthan State and Child Care Practices

Situated in the northern part of India, Rajasthan is the largest State in India by area and accounts for 43.6% of the child population. The total population of

Rajasthan is 6.86 crore[2] (approximately 70 million), roughly three-quarters (75.13%) of whom live in villages, thus making Rajasthan predominantly a village society. It has a multi-cultural, multi-ethnic and multi-religious population.

Rajasthan is a pioneering State which has taken positive action to ensure child protection. The **State Child Policy** was formulated in 2008 with a view to ensuring the comprehensive development of children, protection of their rights and mainstreaming children's rights into all development agenda through convergence with various state departments. **Rajasthan State Commission for Protection of Child Rights** (RSCPCR) was established by 2010 as an independent statutory mechanism for reviewing and monitoring the implementation of laws and policies relating to children. Action plans, guidelines and protocols have been issued from time to time to implement child-specific legislation, such as the Right of Children to Free and Compulsory Education Act, 2009, the Prohibition of Child Marriage Act, 2006, the Juvenile Justice (Care and Protection of Children) Act, 2000, and the Child Labour (Prohibition and Regulation) Act, 1986. In 2013, a **State Policy for the Girl Child** came into existence to address their vulnerabilities and a State level Task Force on Care and Protection of the Girl Child was set up to augment State action. The **Directorate for Child Rights** was established with the vision of having society respect child rights, free from all forms of discrimination towards children and playing the role of an advocate for children.

Rajasthan was the first State to promote as system of economic support to the family along with Kinship Care through the **Palanhar Yojana**, which was established in 2004-2005. The aim of the Palanhar scheme is to provide NIAC services in the form of financial assistance for orphaned children, children of a widow/abandoned/divorced/re-married mother, HIV-AIDS affected families, families affected by leprosy, disabled parents, parents sentenced to death or life imprisonment. **After care** aims to take care of juveniles or children after they leave special homes and children's homes, after reaching 18 years of age, to enable them to lead honest, industrious and useful lives. The After care system is operated by the State under the **Mukhya Mantri Hunar Vikas Yojana (MMHVY)**. This scheme provides financial assistance, vocational training, lodging and counselling to young people (between the ages of 17 and 21 years) who receive Palanhar financial aid and children residing in Children Homes. It aims to prepare children for independent living, sustaining themselves and improving their capacity to contribute to society.

Safety and Wellbeing of Children in Residential Institutions

The Government of Rajasthan developed Guidelines for eliminating corporal punishment in educational institutions and institutional care. The onus of safeguarding children from punishment lies with the head of the institution, as well as with management and administration at all levels. The Juvenile Justice Board or

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[2] Indian Numbering System

Child Welfare Committee shall direct the local police station or Special Juvenile Police Unit to register a case, take due cognizance of any such occurrence and/or conduct the necessary investigation. Another guideline also defines offences and punishments. A children's committee/parliament should be established in all institutions so that children's voices can be included and listened to. Minimum standards of care and protection should also be followed.

To make residential institutions safe for children, Rajasthan's guidelines for the prevention of child abuse were developed in 2013. They define abuse and provide directions and strategies for improved institutional design, careful monitoring of visitors, rules for the use of institutional premises by outsiders, participatory management of institutions, empowering children through their active participation in the full life of the home, listening to their suggestions, developing rules together and providing information. It also details appropriate standards of behaviour for staff and employees, volunteers and other visitors and behaviour protocols for children.

District Child Protection Committees, Child Welfare Committees and Juvenile Justice Boards play important roles in monitoring these homes to ensure compliance with the Juvenile Justice Act and ICPS guidelines. Inspection committees and social auditing are also provided for monitoring the homes. Inspection of the institutions must also include the quality of care and involve civil society representatives. There are different structures for child protection services including block child protection committees and panchayat-level child protection committees. Both work to support the identification of vulnerable children and to ensure the protection and promotion of their rights.

Care, Support and Rehabilitation Services in the State

Government-run Homes: 41 Homes (6 Children's Homes, 7 Observation Homes, 1 Special Home, and 27 Observation and Children's Homes), out of which 39 Homes (5 Children's Home, 7 Observation Homes and 27 Observation and Children's Homes) were supported under ICPS during 2012-13 with a further additional 2 Homes (1 Special Home and 1 Children's Home).

NGOs-run Homes: 39 Homes (33 Children's Homes and 6 Children's Homes for Special Needs Children) out of which 30 Homes (25 Children's Homes and 5 Children's Home for Special Needs Children) were supported during the last financial year and 9 Homes (8 Children's Homes and 1 Children's Home for Special Needs Children) are additional.

The **Childline – 1098 service** is functioning in 14 districts of Rajasthan. 37 specialised adoption agencies (33 Government run and 4 NGO Run SAAs) promote adoption in the State. A Child Welfare committee (CWC) exists in every district.

In rural Rajasthan, unemployment is a major problem, and those communities associated with caste-specific art and work, face the most urgent economic survival challenges. Many of these families are forced to migrate to urban

areas in search of employment, with children left behind and some are lost in this transition. Others run away from homes in search of a better life, many of whom are found in railway stations and the streets. During our travel in a train, a child was watched playing tricks and begging. When we enquired about his background, the child was very reluctant to respond. As these children are prone to many harrowing situations, this has forced them into forming homogenous groups based on shared religion, caste, education and birthplace. These groups may develop anti-social habits and criminal tendencies. Some of the children in these groups are victims; and some are offenders, but immediate counselling is needed for both groups.

When these children come to an institution, they try to re-form into such groups again. Expectations about the new home depend largely on peers, previous history, family, culture and previous caring practices. These expectations affect the child's acceptance of their new environment. Children's homes cater to all children in need of care and protection, particularly beggars, street and working children, rag pickers, street performers, orphaned, deserted, trafficked and run-away children, children of migrant populations and any other vulnerable group. These homes ensure protection of their rights and mainstreaming of them in the society by creating easy access to developmental services. In our interactions with caregivers, they clearly state that children come from all socio-economic strata of society.

Some children have lost their families and others have run away. They shared their experience of handling these children from different backgrounds, age and area. Each child is an individual and unique, and each must be treated differently. Home is the first place and family is the first teacher to help children in growing. But currently in the child's life, institutional care is the need of the hour. A long way must be travelled by caregivers to build a relationship with these children and encourage them to be able to communicate freely.

After visiting many institutions, we found many best practices are being followed. To avoid the negative and painful experiences associated with large-scale, impersonal institutions, where children frequently experienced long-term emotional, psychological and personality problems, we discovered that Government schemes have now introduced a focus on child development, education and skills enhancement to the old-style institutions.

On one visit to a children's home, we spent two hours just observing the 50 children in the home. They were a collage of different religions, castes, educational levels, cultures, ages, family backgrounds, and areas of country to which they originally belonged. The first and foremost feeling that came to me was a sense of contentment at how finely these children had developed a network of sharing things, communicating and assigning duties, and planning for the day-to-day tasks. They have a children's club where they gather and decide about their whole day's programme and assign daily duties on a rotational basis. Here they decide who will help in cooking, washing, cleaning, and helping the younger ones in school projects and other work as well as trying to resolve disagreements amongst themselves. It was delightful to watch how some were leading and others were comfortable in

accepting their decisions. Here a natural leader comes out to lead a group and develop his skills. After the meeting, they all raced off to complete their assigned tasks. This clearly reflects well on the home, the emotional bonding with each other, the sense of maturity, duty, responsibility and a sense of belonging that was developing over the course of time.

Another story relates to Gita (name changed). Before joining the home, she was living at Jaipur Railway Station and was involved in rag picking and selling water bottles. The group based at the Railway Station reported that she was frequently harassed and exploited by a group of fake 'Sadhu monks' living at the railway station. The sources also reported and confirmed that she has been repeatedly raped by someone and, due only to this cruel incident, had lost her mental balance and had suffered a major uterus infection. Eventually she was traced and brought by Childline staff to the shelter home. When she first arrived, she didn't understand anything, and behaved as if she was completely senseless. Furthermore, she had severe infections and wounds on her body. The doctors advised she would need some long-term treatment – which eventually took around 2-3 years. During this crucial and challenging period, other girls provided great care, love and affection towards her. The staff healed her pain with immense love and concern.

Now Gita is very much more settled and has overcome her mental distress. She has learned how to wash clothes, develop good eating habits, can hold things properly and even cook. She uses and can understand some symbolic language. Sometimes she laughs, greets people with folded hands, touches cheeks and expresses love, tries to dance with a few steps and appreciates new dresses and kind actions. She is regularly attending the vocational training centre where she makes decorative birds from cloth material. It is always nice to receive letters with her name from our international volunteers and visitors; they all love her and cherish memories of meeting her. Overall, Gita now understands her responsibilities and shows growing social and cultural development.

Sometimes, children are too young to understand what is happening to them and what the circumstances were that forced them to enter this circle of endless misery. Proper care in institutions change their life. This was true of Pintu (name changed) and his sister. He was merely five years old when he was left by his mother at Jaipur Railway Station along with his sister. Now, he is 15 years old and could recall only his mother's face and his father's name. He is not sure what happened to his family. He and his sister were admitted to the home by staff from Childline. The homely environment along with the opportunities for doing whatever he wants for his personality development are the main reasons for his happiness at living in this home. He is studying in 8th standard, is ambitious and wants to do something larger in his life. He wants to be a policeman and make home for himself and his sister.

The story of Devkinandan (name changed) is not dissimilar to other children at the home. His father was a drunkard and used to beat his mother. One day, his mother left his home and eloped with another man. His father left him at his in-laws' house but his maternal grandmother was also not interested in raising him.

She said he should go to the railway station where his father was waiting to take him to Jaipur. He went to the railway station but was unable to find his father, so he boarded the train and travelled to Jaipur. There he met with a team member from Childline and was taken to the home. The pleasant environment and opportunities for cherishing dreams opened a world of opportunities for him. He is very good athlete and has competed at national level. He is now in 10th standard and he wants to win a gold medal for his country in international competitions.

These stories show how some facilities follow the standard of care as described and directed by state, national and international polices and make efforts to improve and introduce innovative new practices that support the overall development and wellbeing of children. State statutory bodies and inspection committees also play visible roles to ensure good management of residential care.

In recent years, many interventions, programmes and activities have been added to both types of institutions to help capacity-building among the children and young people. Activities like theatre, special art and craft classes, vocational training, meditation and yoga have been introduced. Counselling, Festival celebration and Day celebrations have become part of the daily routine schedule, with Yoga, prayer, and value education added, to create a more child-friendly and homely environment. The environment at these homes helps develop a sense of generosity, caring and sharing habits, the ability to learn and communicate thoughts, improve self-care and autonomy, and foster happiness, faith, a sense of purpose and a need for others. Also, timely training of staff is mandatory. Children are now more focused on their future and on identifying personal competencies and skills. A friendly environment between staff and children is taking shape. As a result, children are not only doing exceptionally well in their studies but also competing in State and national games and other activities in such institutions.

In her study of homes, Gopalakrishnan (2016) found that providing girls with a family environment, re-directing cultural and social norms to be supportive of girls' equality, and aiming to get girls to see that they are of no less value than boys, remain huge challenges. Interventions that challenge cultural and social norms supportive of gender bias need to be integrated with daily practices and interventions. She also highlighted HAQ's (a child rights organization) role in the monitoring of institutions. HAQ realises that all accountability exercises must be backed and supported by strengthening capacities within institutions to help caregivers overcome their challenges. It is important to stay clear of these misconceptions. She highlighted a small incidence of misconceptions when children are involved in cooking and cleaning at the home to give them a sense of pride and ownership over it, some inspecting authorities misconstrue this to mean that these children are being used as unpaid labour.

Conclusion and the Way Forward

The need for a thorough appraisal of residential care in Rajasthan is critical. Regardless of whether these residential institutions are run by government agencies, private organisations or by individuals, whether the facility has an excellent infra-structure or sensible and sensitive caregivers, few people consider that these homes provide the best option for the children living there. After a century of large scale institutions, new ideas, thoughts, policies, government laws, interventions and programmes have been introduced into these institutions and new insights have been gained. Promoting non-institutional care may have one dimension but encouraging these residential institutions will help these children in out-of-home care to benefit from mainstream development opportunities that equip them to manage future hurdles and challenges of citizenship in India's rapidly changing economy.

After visiting many residential care institutions, the new environments that were found worthy of recognition embraced a rights-based approach that focused on the overall development of children, their education and vocational skill development, career training, individual care plans, health and medical support, learning activities that involved indoor and outdoor play, and so on. However, some institutes fail to even meet children's basic needs.

There is a serious need to ensure proper implementation and effective monitoring of schemes, programmes and policies involving child care. Juvenile Justice (Care and Protection of Children) Act, 2015 makes it mandatory to register all existing agencies as well as new voluntary organisations, working for the care and protection of children. Standards of maintaining an institution and the quality of care provided to children are prescribed in the Act, so there is a continuing need for all these institutions to be monitored to ensure that they meet not only these minimum standards of care, as well as striving to reach higher national and international standards. Further consideration should be given to the following:

- Empowering households to be able to better educate and protect their children
- Child-friendly learning tools, audio-video IEC should be developed and made easily accessible.
- Recognition of child care professionals, regular training and capacity-building programmes should be required.
- Convergence between skill development, educational residential institutions and homes for children in need of care and protection should be established.
- Organize community-based interventions and programmes for guidance and counselling for children and their care takers.

- The diverse needs of children should be acknowledged, and appropriate learning opportunities and rehabilitation should be provided to foster their overall development.
- Life Skills should be an integral part for these institutions.
- Attention should be taken to respond to the strong need for use of research in practices.
- Institutional transparency and accountability policies require improvement.
- Sharing of best practices on different platforms and encouragement.
- Mapping tools to access data on children in Need of Care and Protection and Children in conflict with law and proper strategic action plan to improve conditions of these children/juveniles.

Questions for Small Group Discussion or Guided Reflection

1. *The traditional Indian view of welfare is based on daya (Mercy), dana (charity), dakshina (offering), bhiksha (giving), ahimsa (non-violence), samya-bhava (equality-observed), swadharma (own beliefs) and tyaga (sacrifice), the essence of which were self-discipline, self-sacrifice and consideration for others.* How might this traditional Indian view of welfare apply when considering a residential child and youth care team of workmates with whom you are familiar?

2. *The age of a 'child' is defined differently for different laws in India.* Given India's policy orientation toward definitions of 'youth', and given that the United Nations identifies youth continuing through to age 25, how do these policy orientations and definitions of youth compare with what operates where you live and why?

3. *When a child is found to be in danger or at risk, there is a provision in the rules for a social worker or a public-spirited citizen to bring the child before a Child Welfare Committee within 24 hours (excluding the time necessary for the journey). Restoration of the child to his/her parents – including adopted and foster parents, guardians, fit persons and fit institutions – and the child's protection are the primary objectives of the Child Welfare Committees.* How does this decision-making procedure for the care and protection of Rajasthan children and young people compare with parallel decision-making processes where you live?

4. *In rural Rajasthan, unemployment is a major problem, and those communities associated with caste-specific works and arts, face the foremost economic survival challenges. Many of these families are forced to migrate to urban areas in search of employment leaving children behind and some are lost in this transition. Others run away from homes in search of a better life, many of whom to railway stations and the streets.* What comparisons might be drawn between the circumstances facing '*caste-specific*' Rajasthan youths and the racially and social class challenged youths around whom you live and work?

5. *Rajasthan children's homes cater for all children in need of care and protection, particularly beggars, street and working children, rag pickers, small vendors, street performers, orphaned, deserted, trafficked and run-away children, children of migrant populations and any other*

vulnerable group. After considering a particular child or young person that you know, how do you think that child might engage with you, were she or he to have been rescued from living on the streets in Rajasthan?

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Residential Child and Youth Care Practices in Mumbai and Maharashtra

Mohua Nigudkar[1]

Abstract

Of India's 2016 population of roughly 1.326 billion people, more than one third of the country's population or 440 million young people are below 18 years of age. India has a combination of facilities for children managed by State, NGO, and/or faith-based organizations. Each institution provides residential care facilities in accordance with their policies and available resources. In the context of this chapter, residential child care institutions provide shelter, food, clothing, education/vocational training, health care, recreation and other child specific services free of cost for boys and girls up to the age of 18 years. Some of these services are partially- or fully-funded by the State while some organizations raise their own resources.

### Introduction

All children are born into a family and need a nurturing home and family environment. From the child rights perspective, the right to a family is recognized

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as one of the most crucial rights for children. However, for various reasons, when children are deprived of a home and supportive family life, alternative or substitute forms of care may become necessary. This care can be provided through institutional or residential facilities or non-institutional, alternative care or a combination of both. Non-institutional alternative care
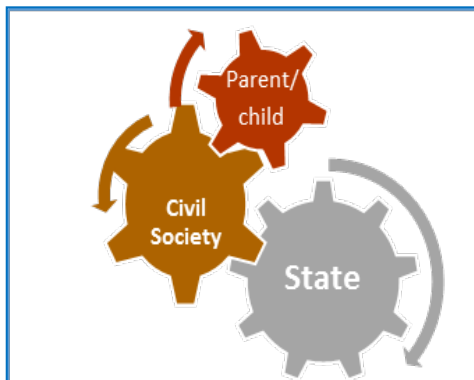
measures such as adoption, foster care, and sponsorship are considered some of the ideal forms of substitute or supplementary care. However, given the large numbers of children in India needing care and protection vis-à-vis the quantum of alternative care services available, residential care institutions continue to provide a substitute home for many vulnerable children bereft of family or family support.

The State has the primary responsibility to ensure that every child has optimal resources to grow well. Especially in the context of children without family or family care, the State must make necessary provisions. According to the Annual Report 2015-16 of the Ministry of Women and Child Development, Government of India, more than one third of the country's population, around 440 million, is below 18 years of age. It is further estimated that around "40 per cent of India's children (170 million) are vulnerable or experiencing difficult circumstances arising from their specific social, economic and geo-political circumstances. All these children need special attention" (pp. 43).

Residential child care institutions in the context of this chapter are those institutions that provide all young persons, less than 18 years, and in need of residential care, the following services:

- shelter (long term/short term stay),
- food,
- clothing,
- education/vocational training,
- health care,
- recreation, and
- other miscellaneous rehabilitative services specific to the child and based on the policy of the institution.

In India a combination of State institutions, Non-Governmental Organizations (NGO), and/or faith-based organizations provide residential care

facilities in accordance with the overall legal mandate of the country, specific policies and objectives of the organization, as well as available resources.

Residential Care: Policy and Legal Framework in India
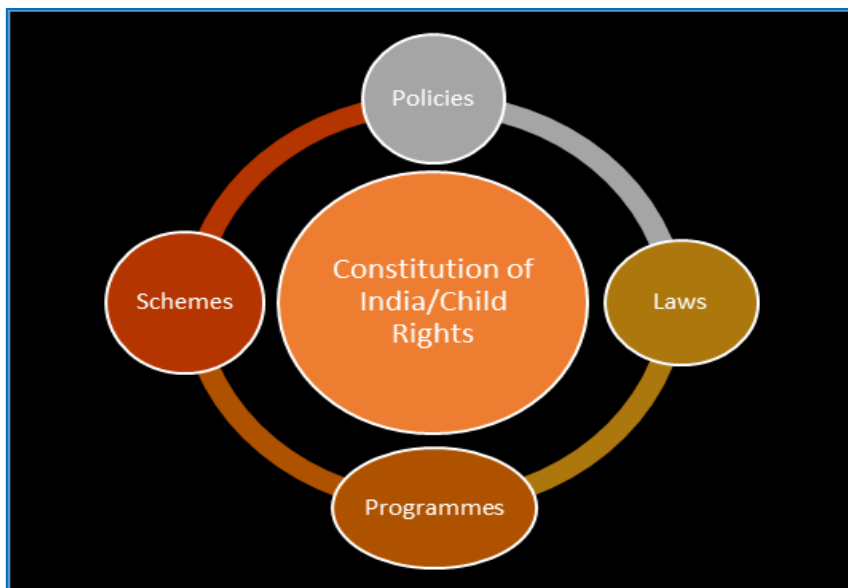
The overarching framework which governs all child and youth care practices is the Constitution of India. Further, the United Nations Instruments pertaining to human rights and child rights have been largely incorporated within the significant child-related policy and laws in India. Through a range of policy, laws, programmes, and schemes there is an endeavour to address the needs of all vulnerable children including children in residential or institutional care. Given below is a brief overview of the policy and legal framework especially within the context of vulnerable children.

The Constitution of India

The Constitution of India (adopted in 1949) is the overarching document that governs laws, rights, rules and regulations for the government and fundamental rights and duties of the citizens. The Directive Principles of State Policy, included within the Constitution, outline the duties and responsibilities of the State towards provision of social welfare and justice to its people. Much before child rights became an integral part of national and international documents and discourses,

the Indian Constitution had specifically outlined provisions for children in areas pertaining to education, child labour, child development and right to protection[2]

National Policy for Children

India has an overall national policy for children as well as specific policies in health, nutrition, education, and early childhood care. The first National Policy for Children, 1974 recognized the need for prominent programmes for children as part of the national plans. The priority areas included child health, nutrition, education, child labour, children with disability and children from "weaker sections of society". It had outlined the scope for State and NGO participation towards working on issues pertaining to children. Subsequently the national policy was revised and reformulated. The new National Policy for Children, 2013 sets 'Survival, Health, Nutrition, Development, Education, Protection, and Participation' as the key priority areas of the Policy. The scope of child-related work has been expanded along with integration of a rights-based approach.

To operationalize the abovementioned key areas, the National Plan of Action for Children, 2016 formulated by the Ministry of Women and Child Development, emphasizes "*safe children-happy childhood*". The National Plan of Action, based on the principles of National Policy for Children, 2013 commits to addressing four key areas: survival, health and nutrition, education and development, protection and participation. Additionally, the Plan intends to mainstream child protection. (National Plan of Action for Children, 2016)

United Nations Conventions and Instruments

India has ratified the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities, as well as two significant Optional Protocols pertaining to the sale of children, child prostitution, child pornography and involvement of children in armed conflict. Some of the other UN Guidelines, Protocols, and Rules pertaining to juvenile justice, organized crime and trafficking, and alternative care of children, too, have been endorsed. This has led to greater awareness, advocacy, and efforts towards influencing national policy and laws to strengthen child rights and child protection in all aspects of work.

The Integrated Child Protection Scheme: Comprehensive Scheme on Child Protection

Child protection is understood as addressing or preventing situations of violence, abuse, exploitation, and neglect in the lives of children. The Integrated Child Protection Scheme (ICPS) 2009, a central Government Scheme initiated provision of financial and technical support provided to State Governments/

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[2]Articles 14, 15, 15(3), 19(1) (a), 21, 21(A), 23, 24, 39(e) 39(f), and Article 45 of the Indian Constitution are especially significant for children as they highlight equality, non-discrimination, special provisions for women and children, and other safeguards

Union Territory Administrations in areas such as quality care of children in residential institutions within the juvenile justice system, other Homes, and family and community based preventive work. This Scheme has introduced a larger discourse on child protection in India and the critical need for preventive work. The overall philosophy of the Scheme is aimed towards convergence and greater coordination of child protection services, effective functioning of statutory bodies, and a thrust on alternative care facilities such as adoption, and foster care. Most significantly, the ICPS envisages setting up 'child protection society' at the level of every village, city and district, involving local *Panchayats* or local governance systems, family, and civil society. Monitoring is through the State Child Protection Society, District Child Protection Unit and State Government departments.

Childline: Emergency Helpline for Children

Childline, launched in 1996, is the country's first 24-hour, toll-free tele-helpline for children in distress. Any child requiring assistance, or adults on their behalf, can call the service[3] for help. Childline personnel/social workers reach out to the child and provide necessary assistance. The Childline service is available to children in 396 cities/districts across 30 States/Union Territories in India, through a network of 755 partner organizations. The Childline India Foundation Annual Report for 2015-2016 shows that Childline received a total of 9,215,338 calls from children and concerned adults. Childline has intervened in a wide range of cases of children including physical abuse, sexual abuse, missing child, trafficking, child labour, medical support, shelter, and emotional guidance and care. Childline has the legal mandate to admit children in residential Homes through the juvenile justice system. Childline has been brought under the ambit of ICPS for greater coordination and convergence of services.

National Commission for Protection of Child Rights: An Apex Monitoring Authority

The National Commission for Protection of Child Rights (NCPCR)[4], an autonomous Body of the Ministry of Women and Child Development, Government of India, examines, reviews, monitors the implementation of child rights across policy and programmes and conducts inquiry into child rights violations. Further, every State is required to set up a State Commission for the Protection of Child Rights (SCPCR).

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[3] Any child in need or an adult representing the child can dial 1098 and ask for the required emergency help or any kind of support

[4] The National Commission for Protection of Child Rights (NCPCR), has been set up under the Commission for Protection of Child Rights Act, 2005

Legislation Pertaining to Children: Key Developments

Several pieces of legislation have been formulated in critical areas such as education, child labour, adoption, persons with disabilities, trafficking, child marriage, child rights, and juvenile justice. The Juvenile Justice (Care and Protection of Children) Act, 2015 governs the entire juvenile justice system in India. The Juvenile Justice Act, 2015 covers two categories of children: a) "Child in Need of Care and Protection" – children who are found without shelter, family or family support, abandoned, destitute, neglected, orphaned, or abused/exploited children, and b) "Child in Conflict with Law" – children who come within the juvenile justice system on alleged offence charges. The law demarcates between these two categories of children and has mandated separate and independent mechanisms and procedure to address their issues. The Title and the introduction to the Juvenile Justice Act, 2015 affirms that for all children coming within its purview, (whether in need of care and protection or those allegedly committing offences) the State is responsible for "proper care, protection, development, treatment, social re-integration, by adopting a child-friendly approach". Further, this Act has reinforced the need for non-institutional or alternative care.

Special Child-Related Laws in India

- The Protection of Children from Sexual Offences Act, 2012
- The Right of Children to Free and Compulsory Education Act,2009
- The Prohibition of Child Marriage Act, 2006
- The Commissions for Protection of Child Rights Act, 2005
- The Juvenile Justice (Care and Protection of Children) Act, 2015
- Child Labour (Prohibition and Regulation) Act, 1986 (amended in 2016; The Child Labour (Prohibition and Regulation) Amendment Act, 2016).

Judicial Intervention: Impacting Policy and Legal Changes

The Supreme Court and High Court have passed several landmark child related judgements, notably in areas related to child custody, sexual abuse, juvenile justice, strengthening quality care in child care institutions, child trafficking, and missing children. The Supreme Court of India, the highest judicial body in the country, has initiated several measures towards effective implementation of the juvenile justice system. The Supreme Court Committee on Juvenile Justice and the different State High Court Committees on Juvenile Justice, headed by senior judges, in co-ordination with the State Government and other stakeholders, monitor issues of juvenile justice, child rights, and child protection, including quality of residential care.

Child Advocacy and Action: NGO and Civil Society Engagement

Many voluntary/Non-Governmental Organizations (NGOs), networks and civil society advocacy groups are actively engaged with child and youth care. They manage shelter homes, residential care facilities, vocational guidance centres, and mental health care facilities. Networks, coalitions, and advocacy groups working with children raise issues related to improving quality of care in institutions, better implementation of laws, child labour, missing children, child sexual abuse, child trafficking, and realization of child rights. Some of the networks and alliances also work with the State on policy revision.

Other Key Developments

Within the context of children in residential care, the central government has introduced an online national portal on tracking and monitoring missing children, expediting family tracing of children in residential care, and effective networking among different stakeholders (police, residential institutions, government departments, NGOs, Statutory Bodies, Commissions, legal authority, parents and family).

What do Welfare Policies Mean to India's Children and Youth?

While all of the above developments are in existence, the majority of the children themselves are yet to be fully aware of their rights and entitlements. Culturally there continues to be tacit acceptance that children are largely the 'property' of adults. Patriarchy, too, has its own impact on the socialization of boy children and girl children. Therefore, until a child actually enters State protective care or in contact with NGOs, their 'world' comprises the family, school, neighbourhood, the community and relationships therein. They are dependent on the adults in their lives to make the decisions. Thus, it is for the State, community, and family to make the necessary provisions so that every child is within a safety net as well as aware of his/her entitlements.

Residential Care: Historical Background

Around 1920, Bombay*, Calcutta*, and Madras* were the first three cities in India to introduce juvenile justice legislation.

* Cities now re-named as Mumbai, Kolkata, and Chennai respectively.

Institutional care arrangements primarily started in the United Kingdom and the United States of America. Children who for different reasons could not stay with their parent or guardian were admitted to substitute care facilities, given education, training and "rehabilitated" back into society. Thus, the terms "rehabilitation", "re-integration", "reformation" evolved around institutional care. Moreover, the two World Wars also resulted in the establishment of institutions for children who had become destitute or orphaned. However, in many of these institutions, children were abused and exploited. Over time, demands for reform increased and changes were introduced.

The Indian juvenile justice system is primarily based on British laws as India was under British colonial rule until independence in 1947. In India, residential care primarily started around the 19th Century with two kinds of developments. The British in colonial India introduced different kinds of reformatory schools and institutions under juvenile justice. Other Homes for needy children and women were started by individual social workers, philanthropists, small charities, registered trusts, and religious groups. Some residential care facilities were started with the objective of providing education and boarding facilities to underprivileged children residing in urban, rural, or tribal areas.

In 1924, the *Childrens Aid Society* (currently administering the Observation Home in Mumbai), was among the first voluntary organizations to be established in India for setting up children's institutions. The Bombay Children Act, 1924 was the first Act in India to become operational. The Juvenile Court in Mumbai was the first Court in India established specifically for juvenile offenders.

The Juvenile Justice System in India: An Evolving System

The juvenile justice system in India has evolved over several years. Prior to British rule, India was governed largely by customary laws. During the colonial period a more uniform system of law was introduced. The Reformatory Schools Act, 1897 began the system of "closed Institutions". Prior to "Reformatory Schools", the Apprentice Act of 1850 was the first legislation pertaining to child offenders in British India, with a focus on rehabilitation. Despite such "Schools", most juvenile offenders continued to remain in jails under harsh conditions. The Indian Jail Committee (1919-20), appointed by the then Government, observing the plight of children in jails, recommended that juvenile offenders should be treated differently than adults. The Committee's recommendations led to the enactment of the first Children's Acts in different cities. The Act included two categories of children: youthful offenders, and destitute and neglected children. Through the welfare approach, the 'Juvenile Court' would address cases of both these categories of children and ensure provisions and services for both the groups of children. (Nigudkar, 2013)

In Independent India, the first central legislation, the Children Act, 1960 also provided for two categories of children: "neglected" and "delinquent" with a separate adjudicating body for each of the categories. This Act was eventually changed, primarily due to changes in the arena of juvenile justice at the International level. Several UN instruments-initiated policy changes for the protection and promotion of human rights of children and juvenile justice. The Juvenile Justice Act 1986 initiated uniform legal provisions in the country for the first time[5]. A review of the lacunae within the Act and endorsement of India's commitment to integrate Convention on the Rights of the Child and other International Instruments culminated in a new Juvenile Justice (Care and Protection of Children) Act, 2000 replacing the earlier Act of 1986 (Nigudkar, 2013). The Juvenile Justice Act, 2000, (further amended in 2006, 2011) was a significant legislation. Many changes were introduced especially for children in need of care and protection, juvenile offence, and non-institutional services. The Act of 2000 has now been repealed and replaced with the Juvenile Justice (Care and Protection of Children) Act, 2015. This Act, the current overarching framework for India's juvenile justice system, has incorporated UN guidelines, Convention on the Rights of the Child principles, and child welfare/social provisions from the Indian Constitution[6].

The juvenile justice system which implements the Juvenile Justice Act, 2015 is not a single entity. It has different components or sub-parts: police, residential care institutions (Children's Home, Observation Home, Special Home, Shelter Home, and Aftercare), the Probation Officers, and lawyers, NGOs, voluntary organizations, individual experts, Child Welfare Committee (CWC), the Juvenile Justice Board (JJB) and the concerned Government Department. Each part has specific roles and responsibilities.

In Maharashtra, organizations have largely started as local responses to need and vulnerability of children in local communities. Statutory Homes within the juvenile justice system are now mandated in every city and district of Maharashtra including Mumbai. In a large urban city like Mumbai, there is a significant population of 'street children'[7]. Over the years, several shelter homes and residential care facilities have been started for children living on the streets.

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[5] Until the Act of 1986, each State had its own laws with varying levels and quality of justice delivery

[6] The Juvenile Justice (Care and Protection of Children) Act, 2015 has also been critiqued especially for some of the newer provisions pertaining to children in conflict with law

[7] As per a census study of street children in Mumbai, 2013, a total of 36,154 children were found in different areas during the time of the enumeration. Additionally, 905 children were found on the railway trains and platforms of Mumbai. Thus, all together 37,059 street children were enumerated in the census (TISS, 2013)

Causes of Institutional Care

Migration, poverty, low socio-economic condition of families, urbanization, changes in family structures, relationships, violence, natural calamities, death of parent, and sudden crises are some of the factors responsible for many vulnerable children requiring substitute and alternative care in Mumbai and Maharashtra. Placement in residential care could result from a single cause or from a combination of factors. Residential care facilities may include children who are:

- Orphaned,
- Missing, abandoned or destitute,
- Children living on the streets or 'runaway' children,
- Rescued from trafficking, including prostitution and child labour,
- Children admitted when parents are found unable to take care of their child,
- Undergoing detoxification and addiction treatment and rehabilitation,
- Child survivors of abuse and exploitation,
- Traced and family not willing to take child home,
- Traced and child not willing to go home,
- Child in conflict with law,
- Admitted to residential schools for educational purposes,
- Children with disability without family or family support, and
- Children awaiting adoption.

Models of Residential Care Practice

Residential care in India is largely characterized by:

- Children living in heterogeneous groups under the supervision of un-related adults.
- Institutions are usually Government/Trust/privately managed. Funding could be through State, Grant-in-Aid or voluntary donations or both.
- Institutions are of two types: "child care institution"[8] mandated by the law i.e. the Juvenile Justice Act, 2015 and those managed by voluntary bodies but are nevertheless licensed/registered institutions.
- Most of the institutions cater for either boys or girls. Some have both boys and girls but by and large in such cases their living arrangements are totally separate. A few institutions keep very young boys along with the girls. In

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[8] "Child care institution" means children home, open shelter, observation home, special home, place of safety, Specialised Adoption Agency and a fit facility recognised under this Act for providing care and protection to children, who are in need of such services [Section 2(21) of the JJ Act, 2015]

SOS Children's Villages of India, young siblings (brothers/sisters) are not separated and grow up together.

- Different institutions have their own admission criteria. Generally, each caters to a specific category of children, like infants, orphans, street connected, child in conflict with law, destitute children, children with disability, and special categories of vulnerable children. Children are admitted to institutions for short-term or long-term stay.

- There are two kinds of institution: closed and open. Most of the closed institutions come under the purview of the juvenile justice system. In institutions like the Observation Home and Special Home, children are kept under strict supervision. They are allowed outside the Home only under special circumstances. All their activities are within the institution itself. The children can leave only after the competent authority has passed the necessary orders. In Children's Homes and Special Homes, though many children do go outside the institution for learning purposes, they do not have the option to leave the institution at their will, barring exceptional reasons. Some of the detoxification centres are also closed institutions especially during the period of treatment.

In Open institutions children can go outside the institution for education and training. They can also decide to leave with or without informing the authorities. Closed institutions have their own challenges in terms of the routine. It is more structured and uniform for every child. Individual options for each child are limited. A typical day can include eating meals, attending training classes, if any, recreational activities, waiting for some information/development about their *case* proceeding, and preparing for the next day. Open institutions have greater flexibility as they do not have to necessarily provide for everything within the premises itself. Individual needs of children can be better catered for. Moreover, the juvenile justice system too has recognized the need for more open institutions, such as shelter homes or drop-in centres.

- Admission to the institutions is through an Order of the Child Welfare Committee, and the Juvenile Justice Board. Children/parent can seek direct admission too as per certain procedures

- Children requiring special care, because of disability, addiction, and children in conflict with the law, are usually admitted to specialized institutions

- Organizations catering for children living on the streets usually have open shelters or open institutions. In the past there have also been night shelters for street living children.

The following are the different kinds of child and youth care practices that can be largely found in Mumbai and Maharashtra:

Dormitory Style: Under this system there are large dormitories or multi-purpose halls for children. Each dormitory could have up to 50 children or more. Attendants/caregiving staff look after the needs of the children. All children follow the same daily routine. There is one large common kitchen and decisions regarding the children are centralized. There is usually one housemaster/matron to supervise all the children. The staff-child ratio is very high. The older girls/boys often become *monitors*. They assist the staff to a large extent in taking care of the children. Some of the Homes within the juvenile justice system have the dormitory system.

House System: In addition to having multi-purpose rooms or dormitories, some institutions have introduced more personalized group care through what they call a *house* system. Each dormitory becomes a separate *house* or *unit*, and each dormitory or *house* has 25-30 children under its own housemother or caregiver. The housemother lives alongside the children and has an adjoining room of her own. Children are divided into smaller groups. The kitchen is common to all the houses. All children follow the same daily routine though there could be some variations among the different *houses*. The housemother monitors and supervises the children. All major decisions regarding the overall schedule of the institution and its programme are centralized. Under the *house* system, though children are taken care of in large groups, they feel a sense of belonging to their *house*. Feelings of isolation and anonymity are reduced to some extent. Individual needs also have a better scope of receiving attention. Some Homes within the juvenile justice system operate with the *House* system.

Cottage System: Smaller groups of children live in a self-contained cottage or *Bal Sadan* in a 'family atmosphere' with a caregiver in each cottage to look after them. In this system, smaller groups of children stay in independent houses or cottages and are looked after by a housemother/caregiver who stays in a separate room but in the same unit along with the children. All the cottages are within the same campus. Each cottage has some flexibility to decide on their daily schedule and maintains its own identity and functions independent of each other. The housemother or caregiver is responsible for all the children in her care. In such a system, greater individualized care is possible. Children too have more living space. Some of the Children's Homes within the juvenile justice system have the cottage system too.

SOS Children's Villages: SOS Children's Villages come closest to a family-based alternative. In the SOS structure a group of nine to twelve children (boys and girls) of varying ages are provided a family home under a *house mother*. The house mother has total responsibility for the care and management of her home and children. Each home is an independent unit and clusters of ten to twenty units make a children's *village* or *Balgram*. The village Director stays in the *Balgram* along with his own family and is the 'father' figure for all the children. Girls and boys live

together and grow up as siblings. This is one of the few places where orphaned siblings need not be separated and can stay together in one home. The SOS model is akin to 'Group Foster Care' as per the Juvenile Justice Act, 2015.

House-parenting System: An innovative model of an organization working with street children in Mumbai is the *House Parent* system. A married couple with or without children of their own takes care of around 25-30 children in independent cottages or units. Another unique feature of this system is that the houses or cottages are not within the same campus. Rather they are situated in different neighbourhoods. The houses are either independent bungalows, parts of tenements or even flats in private buildings/cooperative housing societies. There are separate houses for boys and girls. Each house has an independent kitchen and follows its own routine. The housefather addressed as "uncle" by the children holds a regular job outside the organization and is like the father figure for the children. The housemother addressed as "aunty" stays in the house and looks after all the various needs of the children. The house parents manage each house autonomously. The central office provides each house with basic rations and groceries and all children-related goods.

Integrated Care System: An organization in Mumbai caters for infants, children, women, as well as the elderly all under the same roof through diverse services and programmes.

Ashram Shalas: *Ashram Shalas* or residential schools located in rural/tribal Maharashtra are residential care facilities primarily for education of tribal children. These facilities are within the purview of the Ministry of Tribal affairs; Government of Maharashtra and do not directly come under the purview of the juvenile justice system. It is estimated that there are around 500 state-run tribal schools in Maharashtra. There are also government hostels for assisting children and youths to further their education.

Night Shelters: A unique night shelter programme in Mumbai provides residential care and protection to children whose mothers are in prostitution. This shelter offers night care facilities, a safe space, and other rehabilitative programmes.

Residential Care for Drug-Using, Street-Connected Children: An innovative facility by an organization in Mumbai offers a residential care addiction-recovery programme for drug-using street children and homeless youth. This is among the few such child addiction-recovery initiatives in India. The programme includes a detoxification programme with residential care, education, family tracing, and vocational training.

Group Homes: Group Homes have been introduced by organizations for older children who come out of residential care (after reaching eighteen years of age) and require additional support or after care. Under this concept a small group of boys or girls stay together. The group must take responsibility for independently managing their home and expenses. The organization continues to support them by helping them find a house, and by providing guidance and direction, as and when

required. Group Homes are a transition for young people from residential care to mainstream society.

After Care Hostels: Within the juvenile justice system there is a provision for After Care for children who have reached 18 years of age and have yet to become fully independent. Such children can receive financial help for rehabilitation. Voluntary organizations have started After Care hostels in Mumbai. After Care is often neglected as it is meant for children who have completed eighteen years of age. Nonetheless it is a critical component for effective rehabilitation and social reintegration.

Foster Care Schemes: In Maharashtra the foster care scheme (*Bal Sangopan Yojana*) provides foster care facilities for children who require temporary substitute care until problems in their own family are sorted out. The children stay with foster families. Young infants awaiting adoption can also stay in foster care families. The scheme has a component of financial aid to foster families. The uniqueness of this scheme is that even single parents/relations can avail of the benefits of the scheme for their own children. The scheme has been designed to prevent long-term institutionalization of children. Social workers administer and monitor the entire process from placement to final rehabilitation. In Mumbai there are three such organizations who have foster care programmes. The new Juvenile Justice Act, 2015 had integrated foster care within the legislation and foster care guidelines have been formulated by the central government.

Life in Residential Care

Children growing up in residential care come from different backgrounds, with differing needs and life skills. Prior to being placed in an institution, many of these children have been victims of some form of neglect, abuse, exploitation or suffering. Apart from their physical needs, these children have unmet emotional needs too. Many children experience feelings of isolation, lack of belonging, yearning for a normal family life, low self-confidence and memories of their traumatic past. All of this creates a complex situation that manifests itself in behavioural challenges that are not always easy to fathom while working with these children. Many children may express defiance, lack of interest or motivation, hostility or unhappiness while some may demonstrate resilience and an ability to cope.

Crucial Requirements for Quality Care

For a child to feel happy and fulfilled, quality residential care needs to have the following basic components:

- adequate financial and other support from the government for children's institutions,
- the physical amenities and infrastructure for comfortable living arrangements,
- a humane environment created by sensitive and child-friendly management and staff, and
- programmes to provide opportunities for leaving the institution, social re-integration and for enabling the child to lead an independent adult life.

The success of any residential care depends on many factors such as infrastructure and available resources, and particularly the commitment and attitude of the management and staff towards the needs of the children who come to these residential care centres. Research has shown that long term institutionalization of children can have adverse effects. Children can experience an *institutionalised child syndrome* which is often characterized by feelings of isolation, insecurity, alienation, labelled as an institutional child and subsequent behavioural difficulties. All institutions are different in their quality of care. Children fare well if their rehabilitation is well planned and the child grows up as a skilled, confident, happy, and emotionally secure person. They bond with the caregiving staff and the 'institution' becomes their 'home'. Such children leave care facilities with hope and the promise of a better future. Unfortunately, not all children receive the desired facilities or individual attention. Such children grow up with a low self-image, insecurity about the future and leave care with anxiety and even bitterness. Alongside resources, it is thus the caregivers and other institutional staff who play a critical role towards building a trusting relationship with the child and increasing positive self-image and confidence of the child.

Despite inherent limitations, many children do benefit from residential care. Regular meals, medical services, learning to live together, education and vocational opportunities provide a sense of stability and structure. Children who have previously experienced abuse, hunger, exploitation, neglect, or loneliness, or a feeling of being unwanted, get attention and care from staff. The institution gives them hope and an opportunity to turn their lives around.

Conclusion

We have come a long way in our understanding of the need for institutionalization. Globally, including India, there has been an increasing shift towards de-institutionalization or alternative care. Nonetheless, some children will continue to require residential care, especially those without family or family supports. Institutions can support rehabilitation and social re-integration of these children. If we value young lives and believe in the potential of children and young people, then we must reach out to all children, especially children who are dependent on the State and other forms of care. An institution can never fully substitute for a child's home and family. Nevertheless, with a little effort and sensitivity, residential child and youth care facilities can make the child's stay happier and more meaningful.

Questions for Small Group Discussion or Guided Reflection

1. *In India more than one third of the country's population, around 440 million, is below 18 years of age. It is estimated that around 40 per cent of India's children are vulnerable or experiencing difficult circumstances arising from their specific social, economic and geo-political circumstances.* If 2 out of 5 of India's children are vulnerable or experiencing difficult circumstances, what comparisons might you draw with the state of children where you live, and what is special about their vulnerabilities?
2. *India's National Policy for Children, 2013 sets 'Survival, Health, Nutrition, Development, Education, Protection, and Participation' as the key priority areas of the Policy.* How do the seven core principles in India's National Policy for Children compare with the core principles which underpin residential child and youth care services where you live?
3. *The Integrated Child Protection Scheme (ICPS) 2009, a central Government Scheme initiated provision of financial and technical support provided to State Governments/Union Territory Administrations in areas such as quality care of children in residential institutions within the juvenile justice system, other Homes, and family and community-based preventive work. The overall philosophy of the Scheme is aimed towards convergence and greater coordination of child protection services, effective functioning of statutory bodies, and a thrust on alternative care facilities such as adoption, and foster care.* What comparisons might be drawn from this policy initiative in India when looking at how residential child and youth care services are planned and funded where you live?
4. *Most children in India are yet to be fully aware of their rights and entitlements. Culturally there continues to be a tacit acceptance that children are largely the 'property' of adults. Patriarchy, too, has its own impact on the socialization of boy children and girl children.* To what extent might it be said that this statement about children in India compares with awareness of rights and entitlements amongst children and young people where you live?

5. *For a child to feel happy and fulfilled, quality residential care needs to have the following basic components: adequate financial and other support from the Government for children's institutions; the physical amenities and infrastructure for comfortable living arrangements; a humane environment created by sensitive and child-friendly management and staff; and programmes to provide opportunities for leaving the institution, social re-integration and for enabling the child to lead an independent adult life.* How do you think India's statement about quality outcomes might apply for residential child and youth care services where you live?

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Residential Care of Children and Young People at Risk in Telangana and Andhra Pradesh, India

Fr. John Thakaran[1]

Abstract

While residential care for children in urgent need of care and protection is demanding our attention, there is an equally strong campaign against it based on the general developmental needs of children. This chapter sifts through the complexity of these demands and pushes for a changed perspective in the family as well as the residential homes. Based on real experiences, the need for attitudinal changes towards our children and the manner of child care and protection are emphasised. This chapter also examines practices in the care of children at risk, seeking ways of helping institutional centres evolve into homes away from home.

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Introduction

Any discussion about the residential care of children is generally in the context of children needing special care and protection. In a world where the place of the family is threatened, residential care for children is bound to get more attention. For those children perceived to be at risk, residential care that is carefully considered and pedagogically sound could pave the way for a meaningful future. For many children – particularly in developing countries – millions require alternative places of care, and residential homes may be the only places available.

After exploring the general approach to the residential care of children, this chapter looks at practices in the care of children at risk, seeking to find ways of helping institutional centres evolve into becoming homes away from home. Examples are also provided to indicate how the deprivation of a family upbringing, interrupted early development and childhood trauma can be sensitively addressed. The intention is not to promote residential care uncritically, as such, but to validate that it is essential for certain children in certain situations. Children at risk include the following vulnerable groups: children on the streets, child labourers, abandoned orphans, children in conflict with the law, children with disabilities, runaway children, children from dysfunctional families, institutionalised children, young substance abusers, children in war-torn and conflict zones, refugee children, children of displaced ethnic groups or minorities, children of sex workers, children affected by HIV/AIDS, school dropouts, children who are trafficked or in danger of being trafficked, and all children in other vulnerable situations[2]. Examples are drawn from regular contacts with children through counselling, individual care plans, and home or social reintegration. The greatest challenge today – more than activities and programmes – is developing a change in attitude towards children by all adults in general, and by those who take the place of parents who need to see children as people who are to be empowered.

The Principle of 'Last Resort' or Addressing Real Needs

Care workers and administrators who must take crucial decisions about children at risk are in a dilemma because this well-meaning principle "institutionalisation" is described as "a principle of last resort" but many give their all to see that children are cared for and ensure that their basic needs are met. The Indian law states the "*Principle of institutionalisation as a measure of last resort: A child shall be placed in institutional care as a step of last resort after making a reasonable inquiry[3].*" Many callous officials and poorly informed social workers who question care workers and administrators fail to understand that many children in dire need are

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[2] This list is taken from *YaR Child Policy and Essential Protocols (2013)*, YaR Forum India, The Don Bosco National Forum for the Young at Risk, Palam Gaon, New Delhi – 110045, India, Ph. 011 25081014, Email: yarindiaforum@gmail.com

[3] Section 3 (xii) of *The Juvenile Justice (Care and Protection of Children) Act 2015,* Chapter II, General Principles of Care and Protection of Children.

at immense risk because timely care is not provided and where residential care is the only available option!

The Telugu speaking States of Andhra Pradesh and Telangana have a long history of providing residential care for children. As in the rest of the country, education and other opportunities were and are limited in rural settings. Poor, uneducated and illiterate parents often took their children along with them to work in the fields or to take care of their younger siblings. Sometimes they sent their children as attached labourers to work in the fields or in the homes of the well-to-do. In other words, many children grew up as child labourers or as bonded labourers. One option for these parents was to send their children to boarding schools. Furthermore, there is an ever-increasing number of children who leave their homes in search of better opportunities elsewhere. Residential homes for children have been an excellent means of coping with the problems of illiteracy, poverty, child labour, bonded labour or homelessness. This reality makes the principle of "*institutionalisation as a last resort*" stand on its head and points to the actual needs of children, especially those who come from vulnerable situations.

Popular Understanding of Residential Education in India

In India there has been a long-standing tradition that children are sent at a very young age to study with a well-known *Guru* or Teacher. This has been particularly true among the Telugu speaking people, and *Gurukula* or *Ashram* schools are still common today. In British India, English education was valued and promoted. Children were sent to distant towns, requiring them to remain in boarding schools. There is also a modern version where children are sent for special coaching to well-known subject specialists, but these have now evolved into commercialised tuition centres.

A combination of these factors has led to the evolution of a new type of residential school that a speaker in a recent seminar referred to as 'poultry schools' because these are schools where extensive feeding takes place, similar to what Paulo Freire would call a "banking" concept of education where teachers mostly make deposits of information. In such educational systems, the mind is fed or crammed with the subject matter for long hours of class and study, and where games, community service or cultural activities are considered as distractions. There may be considerable brain development but no holistic development of the young.

Savitri Bai Phule[4] is credited with having pioneered the education of girls and *dalits* which was considered against religious traditions in India in those days. She started a school with 9 girls in January 1848. Soon she started other schools, including one exclusively for *dalit* girls when no one could even think of educating girls. The government honoured her in 1852 for her service in the field of education. In 1854 she opened an orphanage for unfortunate widows and orphaned children, probably the first such orphanage started by an individual in India.

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[4] http://www.dailyexcelsior.com/savitribai-phule-the-pioneer-of-women-education-in-india/

Largely because of the influence of missionaries, the field of education was thrown open to all, including girls and the *dalits* (members of the lowest castes) who had been denied education in the past. While some took the lead in establishing high quality education as well as higher education opportunities, others opened their doors to the most disadvantaged. As many of these disadvantaged children were not able to meet even their basic needs, these centres of primary and secondary education became residential centres where all their needs were taken care of. The parents contributed mostly in kind, according to their ability. Orphan children were also admitted to these homes, hence the various names by which these residential homes were called: ashrams, orphanages, boarding or hostels.

After Independence, the Government also entered education in a big way and provided residential educational facilities to disadvantaged children. These were sometimes called Gurukul or Ashrams and were often meant for Scheduled Caste or Scheduled Tribe children. The Andhra Pradesh/Telangana Residential Social Welfare Schools were set up to provide quality education with the best available facilities to help these students face competition. There is no limit to the opportunities available to these children, with, for example, one of these students, thirteen-year-old Malavath Poorna, becoming the youngest girl ever to climb Mount Everest[5].

Residential Homes for Children, as Centres for Cultural Transformation

From Vedic times, the Gurukul has been the universal hub of learning. Rabindranath Tagore, the famed Indian poet, writer and artist, and winner of the 1913 Nobel Prize for literature, was a product of a Gurukul. Tagore and Shanti Niketan, an experimental residential school started by him, have influenced and continue to influence education, culture and an ethical way of life in this country and the world at large[6]. The most interesting opportunities for the development of residential education in India can be found in the potential of Government schools and the hostels attached to them. Because authoritarian discipline is less prevalent in these settings, there is instead an overall spirit of freedom and camaraderie. Along with an absence of strong formal authority, hierarchical structures – including the caste system – break down in many of these settings. Such an environment is seen as the source of inspiration and support for movements for justice. In the face of neglect, it is often resilience that stands out. Today 656 Government schools in Andhra Pradesh and Telangana are part of a human rights education programme that is training teachers and students to run child rights clubs. They have already formed 1076 clubs with a total membership of 44,507[7].

[5] https://en.wikipedia.org/wiki/Telangana_Social_Welfare_Residential_Educational_Institutions_Society

[6] http://www.nobelprize.org/nobel_prizes/literature/laureates/1913/tagore-bio.html.

[7] http://www.paraindia.org/hrms/hrclub/.

Homes for Children at Risk

Children have many problems of their own. Even without wanting to, or for reasons they themselves cannot grasp, children get into trouble. They have been tried by special juvenile courts and imprisoned, with many placed in what have come to be known as correction homes, juvenile homes, observation homes or special homes. Experience the world over has been that these children frequently end up as criminals, unless some kind-hearted adults take an interest in them and provide them with better opportunities. Children who show aggression or commit petty offences were put in these homes after some perfunctory legal procedures. Other children found in their company or travelling without a rail ticket, as well as children in genuinely dire circumstances or without a home, were also brought to these juvenile homes.

The value of a more child-friendly approach to children was eventually accepted and formally acknowledged with the Juvenile Justice (Care and Protection of Children) Act, 2000. This Act for the first time outlined the distinction between Children in Conflict with Law and Children in need of Care and Protection. Unfortunately, fifteen years later, the same Government changed the law to reduce the universally accepted age of a 'child' from eighteen to sixteen with respect to more heinous crimes, so these children will be tried as adults[8]. Unfortunately, the Government has acted at the behest of the Supreme Court that had on different occasions asked it to take more stringent action against older children who commit crimes. There is little, or no consideration taken of the circumstances surrounding the offence or the steps taken to prevent such offences. Sadly, the Government does not acknowledge its responsibility for children in difficult circumstances, or the remedial measures it needs to take. The Government seems to be just passing the burden on to the children themselves, ignoring the findings of the Parliament Standing Committee that studied this issue[9].

Why Homes for Children?

Object Relations Theory, Self-Psychology or Attachment Theory – all tend to focus on the need for infants and children to be with 'good enough' parents who will help children to grow up into healthy, happy and productive adults. The question always remains, "What if the parents aren't good enough or there are no parents at all?" What resort do these children have other than the last resort? What of children who choose to leave home for various reasons and do not want to go back, at least not immediately? Children's Homes are essential for children who have no other option. They could become a home away from home for children who are

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[8] See Section 15 of the Juvenile Justice (Care and Protection of Children) Act 2015.

[9] The government cited National Crime Records Bureau (NCRB) data to say that there has been an increase in crimes committed by juveniles, especially by those in the 16-18 years age group. http://www.prsindia.org/theprsblog/?p=3610.

forced to leave home for a variety of reasons, including children leaving their parental homes because they have lost trust in the people significant to them.

These children need child-friendly homes with people they can trust in the place of those who should have been the significant persons in their lives. How could they trust total strangers in the residential homes, especially in the Government homes where they are going to be locked up? With such an environment, these homes would surely be the last resort. But then, where will all the other homeless children at risk go? Without a welcoming and friendly atmosphere, no child will be motivated to come to a residential home. These children need to be offered acceptance, affection and esteem. They must once again have reason to trust!

Children Leaving Home: Seekers not Runaways

Some children leave home because of situations of extreme deprivation; others come from families that have become dysfunctional because of addiction to alcohol, family conflict, abuse, or other reasons beyond the comprehension of the children. Children are sensitive and even feel guilty for the sufferings unjustly or unwittingly imposed on them. Sometimes problems come from the school or the neighbourhood. Some children leave home or school, often in the company of other children, for the sheer pleasure of adventure. However, despite tremendous hardships, the vast majority of children stay at home, are afraid to leave and try to manage somehow, perhaps because they may have become co-dependent.

In spite of dire circumstances, only the strong or truly desperate children dare to leave home seeking better opportunities. They may have to face greater hardships, but the hope of reaching a better future drives them on. The fortunate among them find sages or mentors who support, guide, inspire and challenge them. Others fall into bad company or are trafficked or exploited by unscrupulous people. We could choose to see most of these children as SEEKERS, young people on a quest, and not as runaways. However, their number is too big for comfort and is significant enough to affect the future of the nation. The attitude of civil society towards these children betrays the culture and the conscience of the nation. It is in this context that adults need to look at children leaving home as a challenge to their human and civic consciousness. This is also the challenge facing the residential care of children at risk. Here too, every child needs to be accompanied by a mentor or guide. The atmosphere in these homes should be such that every child would feel wanted and cared for. Only then will they trust adults again.

Discipline versus Difficulties

During a staff meeting at the beginning of the year, we discussed discipline in the home while reviewing children who were problems for us. There was Babu Rao, a 9 year-old boy whose name has been changed, a sweet looking child but very mischievous. "He needs to be disciplined", all the staff said in a chorus. One by

one they admitted to scolding him, punishing him, and even hurting him. Then they were told that he had been abandoned when he was small. Someone had picked him up and cared for him. Rather than discipline him, we needed to understand him and discipline ourselves.

Kumar was 11 years-old when he was brought to us. His own mother had saved him from the violence of his drunken father. In the melee at the railway station the boy had lost track of her and his younger siblings and had been picked up by an activist and brought to the home. This child would get into quarrels so easily that the staff members were extremely vexed. For the counsellor, working with this boy was an adventure. It was no exaggeration that he was a very loving boy, but he confided that he was angry about everything and everyone. He could not understand how people could be so cruel. When angry, he used to say that he would kill his father. When calm, he said that he would not hurt anyone, but he was finding it difficult to control his anger. Once he was so angry that we could not even get him to sit down. Finally, we got hold of him and made him sit in a quiet place. He was in a rage and calmed down only after he had voiced all his anger towards a staff member he considered responsible for his misery. "I went to school for 10 days. On the 11th day I went to a movie. Why don't they understand me? They can't understand how hard I struggled for 10 days!" Work with Kumar continued. Earlier when he was angry, he would hurt someone. Now he felt sad about his behaviour. Another time he said, "I have stopped fighting with people or hurting them. I have changed. But people think I am still the same. When I complained that someone hurt me, and that I did not hurt back, they still blamed me and said that I deserved this. They do not give me a chance to improve!" Then one fine day he declared, "I want to go home". He did go home and now lives with his relations. He keeps away from his father and is searching for his mother and siblings.

Care of Children with Behaviour Difficulties

We worked with children who found it difficult to take control of their anger; and others who got into temper tantrums and turned violent. There were those who could never sit quietly and would never pay attention in class or anywhere else. Others had addictions to substances such as cigarettes, tobacco, solvent or alcohol. Some were addicted to video games, movies or even internet pornography. There were those who would steal expensive things and sell them for a pittance because they needed money to maintain their addictions. Occasionally, some who were destructive were even setting fires. The earlier approach to these situations had been one of discipline and punishment. This would not solve the problem, however, because those responsible were often not caught or they would run away when they chose to move to a different setting or found an opportunity to earn easy money. Regular counselling helped many; others needed something more.

Discussions with colleagues working for the welfare of out-of-home children led to exploring alternative approaches. We started supplementing counselling with

psychiatric care. Over the years we had children showing symptoms of, or suffering from ADHD, ODD, impulse or mood control problems, child bi-polar, suicidal ideation, severe addiction, schizophrenia, paranoia, psychosis, conduct disorder or a combination of these. While we need to avoid labelling these children, we also have to ensure that they visit the psychiatrist regularly and take the prescribed medications on time. The doctors always appreciated our interventions because they help reduce the incidence of anti-social behaviour and contributed to transforming these children into people who would be acceptable to society.

We were alarmed at the thought that such young children had to suffer through no fault of their own and were labelled as undisciplined, problematic or even hopeless. It was also not easy to convince the care workers and administrators because they generally blamed the children for their behaviour. What else can we expect from a society where adults always consider themselves right? We felt the need to communicate to the care workers and administrators that, as adults, we ourselves need to deal with the annoyance, impatience or frustration that we experience while taking care of children. We must stop projecting our feelings on to these hapless children, even when they are seen to be out of control. Sooner or later, the adults need to understand and accept that these children with behavioural difficulties are suffering from the psychological consequences of a difficult past or from biological factors beyond their control.

Participatory Action Research on the Care of Children with Behavioural Difficulties

Whenever we had the opportunity, we talked about our attempts to understand children with behavioural difficulties. We sought the responses of people working in the field, and they shared their experiences of addiction centres, counselling services, special education, and so on. They had their success stories as well as their times of discouragement. The more we shared, the more convinced we were of the immensity of the problem. We noticed that the vast majority of people in families, schools or children's homes dealt with these situations as disciplinary problems. The children were blamed. Very few tried to understand the problem from the children's side. With this change in perspective, the very language was changed from 'problem children' to 'children with behavioural difficulties'.

Being part of the network for Human Rights Education in schools and with the experience of running child rights clubs, our thoughts turned to the four basic rights of Survival, Protection, Development and Participation. When working with children with behavioural difficulties, we were challenged on all four fronts. Then it struck us that the right to participation could ensure and maintain all the other rights. We realised that, with the participation of children, we could solve almost any problem. Without their participation, no real answers were available. We decided to initiate a Participatory Action Research approach to the behavioural difficulties of children. Under the guidance of an expert, we initiated a pilot project

on the theme of "Aggression" among children. The Participatory Action Research was a six-month study guided by Prof. Dr. Dev Manti[10] which took place between September 2013 and February 2014, involving 8 Researchers, 17 Care Administrators, 72 Children and 5 Organisations.

Our intention was to involve the children in looking for more meaningful ways for them to express themselves, also involving the staff as partners in this dialogue. Our plan was to evolve a self-sustaining and participatory methodology to solve the daily problems of aggression among children. At the end of six months, we were able to notice significant growth amongst all the participants – in self-understanding, insightfulness and reciprocity. There was also growth in respect for one another's rights as well as growth in personal responsibility. Behavioural difficulties were addressed differently, and discipline had improved. We saw this as a meaningful way to train care workers and administrators. The counsellors among us could step out of our offices and be actively involved with the children while retaining appropriate roles and boundaries.

In 2014 the results of the six-month study on aggression among children were presented at a National Workshop. As a result, an overwhelming majority of participants at the National workshop wanted to be taught the Participatory Action Research process. This led to PAR being accepted as a common project by the group. 30 researchers from 10 children's homes in South India are now participants in a 3-year Participatory Action Research programme.

Child Policy in Homes for Children at Risk

From 1970 to 2015 the work of the Salesians of Don Bosco for the Young at Risk has grown immensely. A significant feature of this work was their unique style that always promoted creativity in the way they approached the young. The most significant factor was that admissions to these centres or homes were decided by the children themselves, and not by the management, be they schools or residential centres. The children came willingly and were never forced to stay. In fact, they could leave whenever they wanted. To that extent, these residential centres began with the first principle of the renaissance pedagogy, that of making education child-centric and not adult-centric.

Work with child rag pickers – and children on the streets in general– was very challenging and needed a particularly creative approach. The Navajeevan centres in Andhra Pradesh and Telangana addressed each challenge creatively. This resulted in a variety of initiatives such as night shelters, day shelters, contact points, street education, vocational education, rehabilitation centres, homes, de-addiction centres, foster homes, and so on. As this work progressed, many other groups also pitched in to start centres and homes for children at risk. The first law in India on children

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[10] Prof. Dr. Dev Manti is currently associated with the Department of Conflict and Development Studies, Ghent University, Ghent, Belgium and is the Director of the Institute for Rural Studies and Administration, Guntur, Andhra Pradesh, India.

was the Juvenile Justice Act 1986 which was completely transformed by the Juvenile Justice (Care and Protection of Children) Act 2000. A truly child-friendly law was now in place. Rules for licensing and certifying residential homes as Fit Institutions came soon after. The Act of 2000 was significantly modified in 2006 and finally repealed and replaced by the Act of 2015, integrating many provisions of other acts such as adoption and licensing.

The Navajeevan Centres, along with their counterparts elsewhere in the country, came together to form the Don Bosco National Forum for the Young at Risk. Among the activities that the Forum spearheaded were the "Don Bosco Child Policy and Essential Protocols" in 2011. This Policy follows the norms of the UN Child Rights Convention 1989. Committees are formed to implement the policy, and all the adults in the centres sign the policy after a study of its contents. The policy has been re-written in the language and from the perspective of the children, so that the adults understand its implications better. A suggestion box for all in the campus makes it possible for children as well as adults to participate in the implementation of the Child Policy.

A Home Away from Home

Kiran was a young boy who got lost in the city in 1998 when he was only 8 years old. He was picked up by the police and sent to a children's home, then was moved from home to home and finally settled at Navajeevan in 2004. He had made many attempts to trace his relatives. He had also been to the railway station close to his village, but in 2009, after watching the movie Antwone Fisher – the story of a young man searching for his lost family – Kiran wanted to begin his own search afresh. He set off on the night train to his place along with a staff member. Early in the morning, the first person they approached at the station said that he knew his father and took him home. From then on, it was a series of celebrations wherever he went, just like in a movie. By now Kiran had grown up to be a master baker and was in charge of the bakery in the home. Earlier, during holidays he had not known how to spend his free time. Now, after discovering his family, he did not have enough time to spend with all his doting relatives!

A link with the family is all important. Yet, since they have often run away from their family, many children are hesitant to return until they have learned a trade or have an academic achievement to show. Others are willing to make contact provided they can return to the children's home. One 14 year-old boy had run away from home because he had been falsely accused of writing a love letter. After a year at the home he went back to his parents, continued with his studies, and is now happily settled. Another boy's family was traced with the help of an auto-rickshaw driver. When his father came, the boy hid himself. Later he agreed to go meet his family, provided he could return to the children's home. He had discontinued his English Medium education, but he seems to be happier with his peer group here than at home.

One principle that helps in the care of children in these homes is the principle of "the best interests of the child." No education is possible unless the children trust us and know that we are interested in them. These homes are open, and welcoming compared to the Government run homes where there are guards everywhere and the movement of children is restricted. Here there are playgrounds and plenty of open space. Visitors are surprised that this place is meant for vulnerable children from the streets and elsewhere. Once they visit such homes, they like to come again and spend time with the children. The district officials have finally realised the futility of insisting on needing guards in these homes.

On 24th January 2015 the police raided some child labour dens in the city and brought 216 children for safe custody to our premises. They kept the children under lock and key. We got the police to take off all their uniforms and all other symbols of police authority. The children from the home took responsibility for helping these new children. They accompanied them to the dining hall and or stayed with them throughout the day. Slowly the locks were removed, and games were organised. During the time of their stay, no child ran away. Finally, after two weeks, the children were happy to be restored to their parents in their respective states in North India.

A web application www.childmiss.net initiated by the Don Bosco National Forum for the Young at Risk helps to document relevant information about children and assists in the tracking of missing children. It is being put to good use for monitoring and generating reports on the progress of children. Here again, data helps to track the children and help them to connect with their families or with their former homes. The data helps to follow up each child to develop and implement individual care plans for each child, while they are with us, and even after they leave.

Conclusion

The masters in the East insist that we should live in awareness of the "Present." We can lose endless time and energy talking about the pros and cons of having residential facilities for children and young people. What are lost in such discussions are the best interests of the children and their present needs. We need to spend our energy giving the best care to these children and get everyone around on board with us with this enterprise. Because our facilities are open houses, children feel happy to come. We are aware that they may just as easily leave us, especially if they are not provided with their basic needs. In fact, meeting basic needs is the key to winning back the trust of children and young people. They have faced neglect, been abandoned or even been abused. Once trust is restored, their futures can also be rebuilt.

Counselling services have also played a significant role in restoring trust. Therapeutic sessions help children to come out of old trauma and address developmental backlogs. If we are prepared to listen to children, they become more willing to share their needs and pains, including those they feel about their families. Once we show our willingness to understand, the children become more willing to

open up and share with us. They also become more open to their parents. In fact, it is at these moments that many children express their desire to go home, and they begin to cooperate in locating their families. Some go home and come back spontaneously. This makes the residential setting much more wholesome. Some children consider the expression, "home placement" as hugely threatening – for them this may be a threat of expulsion!

Adults think they have power over children. They forget that dependency brings more responsibilities. The primary task of adults is to help children to grow in responsibility and gradually shed dependency. This is the developmental task in the family setting. This task has also to become the central focus of the Residential curriculum. The residential homes cited are following or evolving models for such developmental practices. Care of children requires aptitude as well as ability leading to commitment. As Scott Peck (1978) would say, unless the parent or the care administrator is willing to suffer alongside the child, no learning will take place. It is not enough for carers to be good people, as good people who are unskilled only maintain problems or aggravate them unwittingly. Training in child care is something that is essential to making child care just, meaningful and rewarding. Child and youth care training is a truly urgent need as the growing number of children needing special care is absolutely mind-boggling. We cannot address urgent issues by simply closing our eyes!

Questions for Small Group Discussion or Guided Reflection

1. *The Telugu-speaking States of Andhra Pradesh and Telangana have a long history of providing residential care for children.* What does Dr Google tell you about the more than 75 million Telugu-speaking peoples of India, the third largest language group in the country?

2. *Many years ago, in Andhra Pradesh, at the initiative of missionaries, the field of education was thrown open to all, including the dalits (members of the lowest caste) who had been denied education in the past. While some took the lead in establishing high quality education as well as higher education opportunities, others opened their doors to the most disadvantaged.* What can you learn about India's *dalits*, and what comparisons might be drawn between India's *dalits* and lower-class peoples where you live?

3. *In a society where adults think they have power over children. They forget that dependency brings more responsibilities and the primary task of adults is to help children to grow in responsibility and gradually shed dependency.* How do you think that an approach where children participate as equals, including in families, might contribute to the changing situation of children in general, and go some way towards preventing their running away from homes and becoming victimised?

4. *The attitude of civil society towards these children betrays the culture and the conscience of the nation. It is in this context that adults need to look at children running away or leaving*

home as a challenge to their human and civic consciousness. What does this statement mean to you?

5. *St. John Bosco was an educationalist engaged in residential child and youth care who operated according to the follow principles: Love what the children love, and they will love what you love. Let the children know that you love them. And finally, strive to make yourself loved.* How do these principles find expression in residential child and youth care practices where you work?

Glossary

- *Ashram*: A usually secluded residence of a sage or guru with a group of disciples.
- *Guru:* A personal religious teacher and spiritual guide.
- *Gurukula or Gurukul*: A type of residential school system in ancient India
- *Nirbhaya*: Meaning "fearless" is the name given to the 23 year-old victim of the December 16, 2012 Delhi gang rape case. The consequent change in law is also called the Nirbhaya Act 2013.
- *Sishya*: A student or disciple
- *Vinayaka*: A popular deity with an elephant head that is widely revered as the remover of obstacles.

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Institutional Care for Children in India: A Case of West Bengal

Satarupa Dutta[1]

Abstract

Family is the most fundamental and natural unit of Indian society for the care, protection and development of children. In earlier times, when the primary caregivers (parents) were absent, the close kin, caste and community members often performed the basic function of providing care and protection for the children. Adoption and foster care of children by close kin was a common phenomenon. However, with increasing incidences of child vulnerability, the state has established different alternatives for the care and protection of children. This chapter explores different aspects of the juvenile justice system in India focusing on the case of West Bengal.

Introduction

Family is the most fundamental and natural unit of Indian society for the care, protection and development of children. From the moment a child is born, the family takes care of her basic physical needs. As she grows up, the family and parents especially become the first and primary educators of the child. It is the

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family which teaches the child the values of right and wrong and how to make good choices in life. Throughout life, loving and nurturing family relationships help the child to trust others and make valuable and satisfying relationships of their own. Thus, the family provides the most conducive environment for the physical, social, emotional and intellectual development of the child.

Alternative Care

Years ago, when the primary caregivers were absent, close kin, caste and community members often performed the basic function of providing care and protection to the children (Naidu, 1986; Rane *et al*, 1986; Ravi, 2011). Adoption and foster care of children by close kin was a common phenomenon. However, under the influence of different social and political factors and with changing perspectives on child development, these informal alternative care mechanisms became no longer sufficient.

In recent times, the disintegration of the family system has become a common phenomenon. Illness, death, separation, desertion, economic, psychological and other stresses or emergencies outside the family's control are some of the major factors responsible for the increasing disintegration of the family. Poverty and impoverishment have heightened the vulnerability of children. Besides this, there are various local factors triggering increased incidence of child vulnerability. For example, West Bengal – due to its geographical location – faces a serious issue of child trafficking. It shares its borders with Bhutan, Bangladesh and Nepal and is an active transit and destination point for child trafficking. In fact, Kolkata, the capital of West Bengal, has the largest red-light district in Asia. Thus, there is a significant emerging population of underprivileged children in distress, unprotected and vulnerable, seeking the protection of the State. As a response, the State has stepped in to offer alternative care to these children in need of care and protection.

In India, the Juvenile Justice (Care and Protection of Children) Act 2015 (JJ Act, 2015) is the primary legislation upholding non-institutional and institutional alternative care options for children in need of care and protection (CNCP) as well as for children in conflict with the law (CCL). The Juvenile Justice Act, 2015 primarily focuses on adoption, foster care, sponsorship, after-care and institutional care as different types of alternative care for the rehabilitation and social re-integration of Children in Need of Care and Protection and Children in Conflict with the Law. This national legislation is applicable to all states of India except the state of Jammu and Kashmir, and states can formulate their own rules for the implementation of the provisions of the Act. West Bengal is still in the process of drafting its juvenile justice rules.

Institutional Care: A Glimpse of History

In India, it was the advent of British rule and the disintegration of the extended family that heralded the start of the alternative care and protection provisions for needy children. The first institutions for orphan children were established in 1850 in Hyderabad and then in 1855 in Madras by Roman Catholic missionaries. Between 1865 and 1905, 48 institutions for destitute and needy adults and children were established in India (Gore, 1955). The Hindus named these orphanages 'anathalayas' and the Muslims called them 'yatimkhanas'.

The formalisation of residential and rehabilitation services for children began in the early Twentieth century when different states in British India passed Children's Acts such as the Madras Children Act (1920), the Bengal Children Act (1922) and the Bombay Children Act (1924). Later, these provisions were expanded to the other states. However, execution of the law remained unsatisfactory due to a lack of infrastructure, facilities and other administrative issues.

In the formative years post-independence, it was primarily the Five-Year Plans which set out schemes regarding the care and protection of children. In the First, Five Year Plan (1951-56), primary responsibility for the care of neglected children was given to voluntary organisations. In 1953, a Social Welfare Board was established to strengthen the services provided for needy women and children. The Second, Five Year Plan (1956-61) recognised the supplementary role of the Government in child welfare and development. In 1960, the Central Government of India passed the Children Act (1960), a central legislation for the welfare of children in need of care and protection. This Act established separate Child Welfare Boards to handle cases relating to neglected children. It also created the position of Probation Officers who could "advise and assist neglected or delinquent children (Article 53(2), Children Act, No. 60 of 1960). In addition, it established separate Children's Courts for cases related to juvenile delinquents, thus separating the judicial process for delinquent and neglected children.

The Third, Five Year Plan (1961-66) focused on the problem of child beggars and children in conflict with the law. The Fourth, Five Year Plan (1969-74) stressed the importance of structuring institutional and non-institutional services for destitute children, allocating special funds for these services. The Fifth, Five Year Plan (1974-79) emphasised the integration and expansion of all development and welfare programmes related to children. The Fifth, Five Year Plan laid down highest priority to children in the social welfare section. It was in 1974 that the National Policy for Children came into force – a centrally sponsored scheme for the welfare and development of needy children. It set out programmes for the maintenance, education and training of orphan and destitute children. The policy also gave direction to the states on how to plan and develop welfare schemes for the rehabilitation of deprived children (Goel, 1989).

The Central Government followed this up in 1986 by passing the Juvenile Justice Act (1986). Like the Children Act (1960), the Juvenile Justice Act (1986) authorised the establishment of separate Juvenile Welfare Boards for neglected

children. After ratifying the Convention on the Rights of Child, the Central Government passed a new Act, known as the Juvenile Justice (Care and Protection) Act (2000), with a view to incorporating Convention principles and further streamlining the judicial system for children. This Act repealed the Juvenile Justice Act (1986). The Juvenile Justice (Care and Protection of Children) Act, 2015 is the latest national legislation guiding all state level policies, programmes and schemes. This Act has introduced new changes in different areas pertaining to children in need of care and protection, adoption, child protection and interlinkages with the Integrated Child Protection Scheme, 2009 among others. In addition to the Juvenile Justice Act, 2015, various religious personal laws also govern children's rights in India.

Child Care Institutions

Legally, there are many different types of institutional care for vulnerable children in India. Within the Juvenile Justice Act 2015, a 'child care institution' includes "children's homes, open shelters, observation homes, special homes, places of safety, specialised adoption agencies and fit facilities recognised under this Act for providing care and protection to children, who are in need of such services" (Section 2, 21), Juvenile Justice Act, 2015).

Observation Homes: These are temporary reception centres set up by the state governments – by themselves or in cooperation with NGO's – to house children who are in conflict with the law while enquiries are pending.

Special Homes: These are established for the long-term rehabilitation and protection of children in conflict with the law committed by the Juvenile Justice Boards (JJB).

Places of Safety: These are residential facilities for children in conflict with the law, who are between the ages of sixteen to eighteen years and are accused of or convicted for committing a heinous offence.

Children's Homes: These homes house children in need of care and protection for their care, treatment, education, training, development and rehabilitation.

Open Shelters: These are community-based facilities for children in need of residential support, on a short-term basis, with the objective of protecting them from abuse and violence and keeping them away from the street.

Specialised Adoption Agencies: These are organisations or institutions set up in every district for the rehabilitation of orphan, abandoned or surrendered children, through adoption and non-institutional care.

Fit Facilities: These are facilities which are deemed fit by the Juvenile Justice Board or the Child Welfare Committee to temporarily take responsibility for a child for a specific purpose.

Children in Need of Care and Protection

According to the Juvenile Justice Act 2015, children in need of care and protection (CNCP) includes different categories of vulnerable children who enter the juvenile justice system seeking support and safety. These children are considered more vulnerable than others because one or more of their rights and needs are either at risk or not being met by the family, government and wider society. The CNCP primarily encompasses the following groups of children:

- orphan, destitute and abandoned children
- working children
- trafficked children
- children in prostitution
- children in conflict with law
- children with a disability
- child beggars
- children living on the street
- children engaging in substance abuse and/or trafficking
- mentally ill children
- children affected and/or infected with HIV/AIDS
- children in families 'at risk'
- children who are victims of violence, abuse and exploitation
- child marriages
- children in conflict areas
- physically disabled children
- missing and runaway children
- children affected by armed conflict, civil unrest and/or natural calamity.

Children's homes are viewed as temporary shelters and recommended as a last resort, if all other means to restore the child with the parents/guardian or family based non-institutional alternative care fails. Unfortunately, due to various socio-economic factors, child care institutions continue to play a primary role in the rehabilitation and social reintegration of vulnerable children entering the juvenile justice system. Often issues of caste, identity and poverty deter expansion of non-institutional alternative care programs. Consequently, a large segment of Children in Need of Care and Protection end up in institutional care. A study by Dabir *et al* (2011) cite poverty as one of the most dominant factors in single-parent families for placing their child in an institution. Lack of access to quality schools in many

rural and semi-rural areas is also identified as one of the major reasons why parents seek institutional care for their children (Raman, 2006).

Socio-economic strife, brought about by the breakdown of employment opportunities in rural areas, migration to the cities in search of employment, family circumstances like abuse, abandonment, etc., are some of the other causal factors leading to children being placed in institutions. The shift from the traditional extended family pattern of living has also led to more and more children seeking admission to institutions organised either by the State or by voluntary agencies. In the case of girls, lack of safety in their home environments, especially those residing in urban slums and on the streets, make institutional care seem a viable alternative (Vasudevan, 2014).

The sub-group report on Child Protection in the Eleventh, Five Year Plan (2007-12) in India (ND: 57) reports that, out of a population of 427 million children in India, 44 million are destitute. Among them, 12.44 million are orphans with most of them in institutional care. Around 40,000 children are in institutions for children in conflict with the law. The report states that it is a major concern to have so many children in institutional care, as these children are not technically orphans and still have a family somewhere. It stresses that, once these children are brought to an institution, the chances of family re-unification become limited. Parents and families of children in need also look at institutional facilities as their first choice. Therefore, despite emerging global debate on the negative impact of institutional placements, institutional care today is the easiest and most feasible way of caring for deprived and vulnerable children in India.

Standards of Care

Institutions providing care to children exist in all sizes with the number of children in each ranging from 50 to 300. The characteristics of these institutions vary considerably. Earlier institutions could be set up under diverse legal provisions, but the Juvenile Justice Act, 2015 has laid down regulations for the mandatory registration of all child care institutions under the Act (Section 41, JJ Act, 2015). It is now mandatory to develop and maintain an individual child care plan for each child entering the juvenile justice system.

However, the processes for regulation and policy control are in the nascent stage and there are still areas of concern regarding the quality of institutional care being provided for children. At the micro-level, over-crowding, unavailability of adequate resources and other basic amenities, weak individual child care plans, insufficient monitoring and assessment tools are some of the problems faced by many child care institutions (Indian Council for Child Welfare, 1994; National Institute of Public Cooperation and Child Development, 1991; 2012). At the macro-level, a lack of consistent and reliable information and data on the number of children in child-care institutions, poor law enforcement, inadequate parliamentary budget allocations, lack of coordination among the various governmental departments and occasional ambiguity of mandates, responsibilities

and functions within the system are some of the lingering constraints (Esponda, 2014).

Children's Daily Routine in Children's Homes

In most institutions, a daily routine is followed to maintain discipline among the children. A schedule is prepared regulating the timing of morning chores, household duties, study hours, play time and extra-curricular activities. All children are expected to complete certain allocated household duties, including work in the kitchen, dusting and cleaning. Failure to complete the given task without a good reason is viewed as a breach of discipline. On the other hand, the children enjoy flexible schedules on Sundays and during vacations, and they are permitted to meet their family members once a week/fortnight and visit them during vacations.

Besides access to free education, most children's homes provide children with opportunities to learn and participate in different extra-curricular activities and vocational training programmes, which include dancing, drawing, singing, sports, tailoring, handicraft making, computer courses, catering and baking classes and embroidery. Cultural programmes and competitions are often part of festival celebrations. Life skill education is also part of the curriculum. However, most homes have strict guidelines regarding children's movement outside its premises. Children are generally not allowed to venture out on their own, so they are accompanied by houseparents while going to school, to the market or other places. Their contact with the outside world is limited and strictly supervised.

Rehabilitation and Social Reintegration

The objective of all child care institutions is to rehabilitate and socially reintegrate the children in need of care and protection into mainstream society through restoration with their biological family, or transition to family-based care like adoption, foster care and sponsorship and/or provision of after-care.

Family Restoration: This is the first and foremost means for rehabilitation of children entering the juvenile justice system. It involves intervention at different levels: Family tracing in cases of missing children; Crisis intervention and supplementary assistance to help families cope with emergency situations; and (Section 37 – 39, JJ Act, 2015).

Adoption: This ensures a child's right to family. It is a process by which a child permanently separated (orphaned, abandoned or surrendered) from her/his biological parents becomes the lawful child of adoptive parents (Section 56 – 73, JJ Act, 2015).

Foster Care: Foster care is the temporary placement of a child in an unrelated family which does not include the child's biological or adoptive parents for

short/long term care. The family is responsible for ensuring the overall well-being of the child. The biological parents can visit the child at regular intervals (Section 44, JJ Act, 2015).

Sponsorship: The aim of the sponsorship programme is providing supplementary support to families, Children's Homes and Special Homes to meet medical, nutritional, educational and other needs of the children, with a view to improving their quality of life. The Juvenile Justice Act, 2015, highlights three types of sponsorship programmes: individual to individual sponsorship, group sponsorship or community sponsorship (Section 45, JJ Act, 2015).

After-care: After-care is provided for three years to any youth leaving a child care institution on reaching eighteen years of age in order to facilitate the child's re-integration into the mainstream society (Section 46, JJ Act, 2015). It includes various services:

- Community group housing/transition hostels/facilities for accommodation within the same institutional home
- Counselling and health care
- Gaining employment
- Acquiring vocational training
- Pursuing higher education
- Appropriate life skill training
- Financial support through stipend or arrangement of loans for entrepreneurial activities
- Encouragement for gradual independent living.

There is very limited literature available on the rehabilitation and social reintegration of children in need of care and protection in India. Kochuthresia (1990) in her study on children's homes in Kerala has highlighted the lack of systematic programmes for family restoration, after-care and follow-up post rehabilitation and social reintegration. Ahuja (2013) has portrayed a similar picture of another institution in Mumbai where there was hardly any functioning after care programmes. Ravi (2011) has discussed the lack of adequate information among adolescent girls residing in institutions on sex education and marriage. Azavedo (2005) and Nagrath (2005), on the other hand, have reported on after care facilities for young adults to help in their rehabilitation and social reintegration. There is little scholarly research on the situation in West Bengal.

The Situation in West Bengal

Since studies in rehabilitation and social reintegration of children in need of care and protection are rare in West Bengal, a study was conducted to profile the

rehabilitation and social reintegration strategies of six children's homes operating in Kolkata, West Bengal. The data showcased the following findings. *Meaning of Rehabilitation and Social Reintegration:* The goal of the children's homes was to ensure an independent and self-sufficient future for every child. However, the perceived value and meaning of the words had an impact on children's home policies, activities and arrangements for rehabilitation and social reintegration of the children.

Strategies for Rehabilitation and Social Reintegration

Adoption: Adoption was viewed as a means of re-integration primarily for young children in the age-group of 0 to 6 years. Since none of the organisations studied housed children in this age-group, not much focus or emphasis was given to adoption.

Family Restoration: In situations where children had a biological family, foremost efforts were made to restore the child to their family. For children who had run away from home, the process of family tracing was undertaken on the basis of clues given by children regarding their hometown. For the dysfunctional and at-risk families, efforts were made to strengthen the families by providing them with counselling facilities, linking them to income generation schemes, and providing them with supplementary support like sponsorship. Children's homes even encouraged parents to save a token amount every month with the organisation for securing the child's future. Fortnightly or monthly meetings between the child and the family members were organised by the children's homes to facilitate regular family contacts. The visits were monitored to ensure their regularity. Annual reviews were undertaken by the Child Welfare Committee to facilitate quick and effective re-integration.

One of the interviewees commented on their unique strategy for rehabilitation of children:

All 130 girls residing with us have a legal guardian or parent. Therefore, our support is restricted until the children complete their 10th board examination or 18 years, whichever is earlier. Thereafter, they are expected to leave, as we do not support them any further. In rare cases, we try to arrange financial help for needy girls for their further education, but it is very limited.

Another interviewee, in charge of an institution run by a religious sect shared:

We admit girls at the age of 5 through interviews and these girls are provided education, vocational training and moral values to help them develop into a human being. Thereafter, once they complete their eighth standard they are required to take a call whether they would like to continue staying with the

ashram. We provide them further education till graduation if they show a willingness to become a celibate religious nun after they turn 30 years. The choice of course is given to them. If the girls are reluctant, they are expected to leave.

Individual Child Development: All children's homes provided formal education to the children free of charge. Some institutions had in-house library facilities to encourage good reading habits among children. Older children, brought into care with minimal educational background, were encouraged to complete their high school education through the National Institute of Open Schooling (NIOS). There were also various vocational courses offered by the homes on a regular basis. Some of these courses included tailoring, embroidery, weaving, knitting, candle making, soft toys, paper bags and other handicrafts, block printing, cooking and canteen management, hospitality courses, computer education, web and graphic designing, beautician courses and home nursing. Upon completion of junior college, nursing and teaching were common professions offered to the youth. However, not all options were offered by all organisations. In fact, one organisation hardly offered any choices to the children.

Emotional support: This was another aspect which played a crucial role in ensuring the children's psychological stability and their ability to socially reintegrate successfully into community life. With one exception, all the children's homes had provisions for professional counselling for the children. In one of the homes, intensive psychological programmes including psychometric tests, group sessions and therapy through music and dance were offered. In addition, all homes had a wide range of extra-curricular activities like dance, music, drawing and self-defense classes. For recreation, celebration of festivals, national holidays, sports days and annual day functions, picnics, study tours and excursions and weekend movies were organised.

Life skills education: In this part of the curriculum, children were taught cooking, budgeting, cleaning, shopping among other daily chores. Sex education sessions were also organised, except in those institutions run by religious groups. Subsequently, job placement opportunities were offered to youths by networking with the government, companies and corporate bodies to ensure financial independence for their young people.

Marriage: Marriage as a means of social re-integration for girls (over eighteen years of age) was highlighted by two of the homes. Both invited proposals from boys for those girls willing to get married. Investigations were made about the prospective groom's background and history. The girls were sent for marriage counselling. Thereafter, if the proposal matured, the institution subsequently sponsored the

marriage. Two other homes provided financial assistance to the girls for marriage but placed more emphasis on employment and fiscal independence.

The children's homes studied had varied social re-integration policies: while some were well-defined, others were loosely framed and ambiguous. There was no standardised framework for formulating policies. The organisational vision, goals and objectives, financial situation, specialised expertise and special interests of the NGO directors affected policy decisions.

Conclusion

The Juvenile Justice Act, 2015 and the Integrated Child Protection Scheme, 2009 are significant steps taken by the State which emphasise child rights and child protection. However, the rights-based ideologies adopted at the national level have not yet transformed the situation at the grassroots level. The organisational structures, processes, mechanisms and behaviours have been slow to change. A sector-specific, isolated, piece-meal outlook continues to undermine the functionality of child and youth care services. Each children's home has its own way of functioning. Overall, the focus on preventive action through family empowerment is minimal and sporadic. Due to inadequate state monitoring, the standardisation of processes is still a distant reality. However, despite obstacles, many children's homes continue to provide credible services for children's well-being and the protection of their rights. In summary, children's homes in India continue to be a very important avenue for providing timely protection to children who are victims of gross violation of their rights due to neglect, abuse and exploitation within the family set-up (Dabir et al, 2011). Institutional care is in reality the only option for this group of children who are not taken up for adoption, foster care or sponsorship, so it is not viable to do away with institutional care facilities anytime soon.

Questions for Small Group Discussion or Guided Reflection

1. *In India, the advent of British rule and the disintegration of the extended family heralded the start of the provision of alternate care and protection of needy children. The first institutions for orphan children were established in 1850 in Hyderabad and then in 1855 in Madras, both built by Roman Catholic missionaries. Between 1865 and 1905, 48 institutions for destitute and needy adults and children were established in India.* What was happening between 1865 and 1905 where you live, and how many residential child and youth care facilities were established there during that time?

2. *Institutions providing residential care to children exist in all sizes in India with the number of children ranging from 50 to 300. The characteristics of these institutions catering to the needs of these children vary. While some institutions are set up under the Juvenile Justice (Care and Protection of Children) Act 2000 (amended in 2006), others function under other Acts relating to children's institutions like the Women's and Children's Institutions*

Licensing Act of 1956. Institutions in India fall into four categories. What are these categories and how would these be identified amongst the services available to children and young people where you live?

3. *There are large numbers of school hostels in India run by the State and the educational institutions. There is no adequate information on the number of children in any of the states except for those in statutory institutions. Since voluntary organisations take a leading role in running the residential child care institutions, this makes it extremely difficult to determine the exact number of children in residential care.* In the world's second most populous country in the world, what explanations might you offer to explain India's incapacity to monitor the number of children and young people in residential care of one kind or another?

4. *Systematic assessments, gate-keeping policies, and individual care plans for children are weak and hardly monitored. Poor law enforcement, inadequate parliamentary budget allocations, lack of coordination among the various government departments and occasional ambiguity of mandates, responsibilities and functions within the system create further constraints.* How might you explain these circumstances facing Indian children, young people and family members who may require residential care and education, and what solutions might you consider possible?

5. *In summary, residential child care in India continues to be a very important avenue for providing timely protection for children who are victims of gross violation of their rights due to neglect, abuse and exploitation within the family set-up. Institutional care is, in reality, the only option for this group of children who were not taken up for adoption, foster care or sponsorship, so it would not be viable to do away with residential care facilities.* How might you argue in support of de-instutionalisation in India when faced with realities such as these on the ground?

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Child Welfare Management and Residential Child and Youth Care in Sri Lanka

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Abstract

Sri Lanka is an island separated by a narrow strip of sea lying off the southern tip of peninsular India, where in 2014 the population was estimated at just over 20 million people. The main objective of this chapter is to describe the existing management of residential child care and youth services in Sri Lanka, focusing particularly on the Northern Province – the region of the country recently steeped in conflict. In 2009, 14,842 children were in residential care: 2,234 in State-run residential institutions and 12,608 in certified children's homes run by voluntary agencies. In 2009, more than 21,100 children were living in 488 residential care institutions run by voluntary groups in Sri Lanka and managed by well-wishers, religious leaders and community groups.

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Introduction

Sri Lanka is an island measuring 65,610 square miles lying off the south-eastern tip of peninsular India, separated by a narrow strip of sea approximately 40 km wide at its narrowest point. In 2014, Sri Lanka's population was estimated to be 20,675,000 with a growth rate of around 0.9 % per year (Statistical Pocket Book, 2015*)*. The population is multi-ethnic, and consists of the Sinhalese (73.9%), Tamils (12.7%), Indian Tamils (5.5%), Moors (7.1%), Burghers (0.3%), Malays (0.3%) and others (0.2%) (Population Census, 2012*)*. Sri Lanka is predominantly an agricultural country. In the latter half of the 20th Century the industrial sector – particularly the manufacturing sector – began to develop and move forward rapidly with more foreign investments taking the lead. The composition of the economy, based on the number of people employed, indicates that the agriculture sector employs 28.5% of economically active persons, while the industrial sector engages 26.5% and the service sector 45% (Labour Force Survey Annual Report, 2014).

Since independence from the British in 1948, Sri Lanka has consistently achieved remarkable improvements in literacy levels (93.3%), of which the male literacy rate was 94.2% and the female literacy rate 92.6% (Labour Force Survey Annual Report, 2014). This is attributed to free education provided for all children, aged 5 to 18 years. Both textbooks and uniforms are provided free. Tertiary education is also available free for all students, island wide, who can achieve the required educational qualifications. Both preventive and curative health services are also provided free to the population with a special emphasis on children. This includes access to qualified medical services during childbirth, services for infants and pre-school children as well as school health services. The public has access to free inpatient and outpatient care in government institutions. This has led to consistent declines in infant, maternal and child mortality, and an increased expectation of life at birth for all persons.

The Child Welfare System

The child welfare system was planned and developed to promote the well-being of children by ensuring their safety, achieving stability, and strengthening families to successfully care for their children. There are, however, vulnerable families which need support, particularly in relation to the protection of children. Thus, a system of welfare and protection for such children is essential. While the primary responsibility for a child's welfare lies with the family, the support of relevant State authorities, such as the provincial councils, INGO's and NGO's, faith-based and private organisations also play a major role in supporting child care activities, by supplementing State services.

The Department of Probation and Child Care (DPCS) Services and more recently the National Child Protection Authority (NCPA) have for several decades provided protection and support for those children in need of protection from abuse, exploitation and neglect. There are also women and children's police units

for such support. Thus, there is a collective responsibility by many relevant stakeholders to deliver a comprehensive package of services, designed to serve the best interests of children and young people. Probation and Child Care services are devolved to the provinces, although policy formulation and coordination are undertaken at the central level, including resource allocations. The National Child Protection Authority functions at a national level in relation to coordinating, monitoring and advocating legislative initiatives related to child protection. Agencies involved in child care include the Department of Probation and Child Care Services, provincial councils, district and divisional secretariats, MOH, Schools, Zone Education offices, local hospitals, child rights monitoring committees, school child protection committees, women and children's units of the Police. There are ongoing efforts to improve the quality and coverage of such services. The primary responsibility for implementing child and family legislative mandates lies with the district and divisional level officers of both probation and child care. Youth Services and the National Child Protection Authority work with available agencies to develop programmes that focus on prevention, rehabilitation and developmental aspect of vulnerable children in Sri Lanka.

However, the stakeholders mentioned above have constraints placed on their abilities to serve children and families, partly due to limited budgetary allocations. The lack of a rights-based or a comprehensive child and family welfare policy are also constraints on government stakeholders' ability to deliver effective services. Furthermore, residential care and youth services need more resources, along with access to technical and logistical support, in order to ensure that young people in residential centres are re-integrated back into society to find work at the community level and access gainful employment. The national youth policy offers guidelines for on-going work programmes in the residential care sector, using a strengths-based approach to empower young people, helping them to become independent and gainfully employed so that they can live in greater dignity. It is important that child welfare services do not embrace a deficit approach, as a form of charitable service, based on laws which are unfortunately weak and inadequately implemented. The existing legislation is focused on welfare rather than empowering children, young people and families. Changes are necessary to take greater account of more rights- and strengths-based approaches to working with children and young people.

Methodology

This chapter seeks to describe how existing residential child and youth care services are managed in Sri Lanka, focusing particularly on the Northern Province – a region that was steeped in conflict until recently. It attempts to define residential care and to distinguish between 'professional' and faith-based child welfare practices. Current residential care management systems are identified, and the quality of service delivery assessed. It is hoped this will guide future thinking about new directions for residential care management in Sri Lanka. A largely reflective account of social work education, training and practices is offered by the author.

Use is made of interviews combined with a consultative process, undertaken during training programmes for care managers, probation officers and administrators of child welfare services. Visits to residential care centres were used to obtain additional information on the activities of organisations. Emergent themes were based on information shared by care managers and administrators, and reflections obtained from the Diploma in Child Protection courses conducted in Northern Province during 2011 and 2015, with probation officers and other Child Welfare supervisors of residential care institutions.

Residential Care in Sri Lanka

Commentaries about residential child care, and what happens in institutions, commonly focus on the negative aspects of institutional life, especially when compared with family life. Residential care is often considered stigmatising because of its development from the European Poor Law workhouses of the Nineteenth Century (Encyclopaedia of Social Work, 2000: p. 296). Residential care for children has often been charged with promoting an "institutional personality syndrome" among children. However, it is important to recognise that residential care is a diverse pattern of services, and each centre cares for groups of people, whether children, differently-abled young persons, old people, and others. Goffman (1961) explored the process of institutionalisation as experienced by 'inmates', focusing on the routines and structures of *total institutions,* arguing that the removal of normal activities and the nurturing of identities in a cultural and social context amongst individuals makes the process depersonalised. Goffman's concept of 'institutionalisation' involves the following four key features:

- all aspects of life occur in the same place, controlled by one authority;
- each aspect of a daily activity is carried out by either one or others who are all treated the same;
- all aspects are rigidly programmed;
- separation is maintained between staff and inmates.

Aspects of institutionalisation continues to occur despite changes to the various services and the provision of much more home-like environments for children (Vasudevan, 2014). Residential care for children is mostly a Western concept and residential care for children while prevalent in Sri Lanka as an alternative care arrangement, is a comparatively recent phenomenon inherited from Sri Lanka's colonial past. Residential care involves the integration of accommodation with personal care and unless relationships are acknowledged between carers and residents, it is all too easy to find highly regimented living arrangements and authority maintained though hierarchical relationships between carers and residents.

Residential care for children – especially in the urban areas and in the North East Province of Sri Lanka[2] – is receiving increased attention as a form of alternative care for children as compared with the family. The need for residential care is mostly for those children who do not have homes because their primary care givers have abandoned them or are economically or socially challenged. This includes single parents, marital strife and poverty issues. But contemporary society now perceives residential child and youth care institutions as centres offering access to education, or residential hostels to facilitate children receiving education. This is a growing trend with services such as these being accessed directly by families without access to proper housing, for what they perceive as "good" schools, or safety. It is also becoming popular among single parents or those who seek employment in foreign countries. It is they who choose to avail themselves of residential care for their children, in the belief that it provides suitable facilities which cater to the basic needs of their children.

There are also increasing numbers of children who have had trouble in living with their parents or other adults, and who choose to live alone in child-headed families. In these circumstances, residential homes for children seem the preferred choice of children, parents and child welfare officers in Sri Lanka, although compared with village life the hardships of urban life are far more complex. It needs to be recognised that families, and therefore children, face increasing difficulties due to the high cost of living, a shortage of housing, limited access to a regular income, as well as a range of other difficulties common in families. Urbanisation, rural-urban and international migration, industrialisation and the growing development of a nuclear family system all contribute to children seeking residential homes in urban areas.

In 2009, 14,842 children were living in residential care, 2,234 of whom were in State-run residential institutions and 12,608 children were admitted to certified children's homes run by voluntary agencies. There were more than 21,100 children in 488 residential care institutions run by voluntary groups in Sri Lanka and managed by well-wishers, religious leaders and community groups (Nirekha & Asitha, 2011). The statistical report of the Department of Probation and Child Care Services states that in 2010, 15,874 children were placed in 368 children's homes. The Table below shows the numbers of homes and children in residential care in 2010.

According to an un-published Survey (National Institute of Social Development, 2014), there are currently 14,179 children in 414 institutions spread across all nine Sri Lanka provinces. Of the total number of children residing in such institutions at the time of the survey, 8,538 were females (60.2%) and 5,641 were males (39.8%). Among all the provinces and districts in Sri Lanka, including

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[2] The North Eastern Province was one of the provinces of Sri Lanka created in September 1988 by merging the Northern and Eastern provinces, a merger that was declared illegal by the Supreme Court of Sri Lanka in 2006. The province was formally demerged into the Northern and Eastern Provinces on 1 January 2007.

the Northern and Eastern Provinces, the number of institutions has increased considerably during the past decade. There appears to be significant interest in establishing voluntary children's homes by faith-based organisations, non-governmental organisations and even individual philanthropists or entrepreneurs (Vasudevan, 2014).

Table 1.1
Number of Homes and Children in Residential Care in 2010

Type of Institution / Home	Homes	Children
Remand Homes	7	1156
Certified Schools	5	263
Receiving Homes	8	434
Detention Home	1	84
Approved School	1	10
National Training and Counselling Centres	2	112
Sub Total	24	2,059
Voluntary Children Homes	341	13,214
Voluntary Remand Homes	3	601
Total	368	15,874

Source: Statistical Report 2010, Department of Probation and Child Care Services

A survey of children in institutions in the North-East of Sri Lanka showed that 40% of children had been placed in institutions due to poverty (Nirekha & Asitha, 2011). The major reasons cited for placing children in institutions included poverty and difficulties in accessing education in rural areas, although free education is a universal service. Evidence available from a "Save the Children" project confirmed this finding. Many families said they were compelled to place their children in institutions because of an inability to provide them with the necessary food, health care and education. Another attraction for many was the provision of free educational facilities, school uniforms, shoes, exercise books and other material benefits that included extra tuition.

In the Northern Province, especially in the aftermath of the prolonged internal conflicts, the emergency prevailing during that time created a growing demand for residential care for children, particularly for children who had lost one or both parents. Others found it difficult to raise their children due to lack of housing and availability of school hostels. Residential care is regulated by the law and a court order is required to accommodate children in a residential care centre.

The admission of children to a voluntary home is the responsibility of the Department of Probation and placement committees in Sri Lanka.

Table 1.2
Registered Voluntary Children's Homes in Sri Lanka – 2010

Province	Registered Voluntary Children's Homes	Children
Western	94	3,797
Southern	29	962
Central	23	947
North Western	34	1,025
Sabaragamuwa	15	540
Uva	11	564
North Central	11	429
Northern	48	2,481
Eastern	76	2,469
Total	**341**	**13,214**

Source: Statistical Report 2010, Department of Probation and Child Care Services

Focusing on the management of residential care and in the Northern Province of Sri Lanka, the pie chart shows the number of residential care arrangements run by the government and those run by voluntary organisations. In 2013, the Northern Province had 55 voluntary children's homes caring for 2,603 children, most of whom required care in the aftermath of local conflicts. By 2015, numbers had increased to 2,686 children, although the number of children's homes had decreased to 45 voluntary homes over those same two years (Department of Probation and Child Care Service, Northern Province, 2013 and 2015).

Number of Residential Care Arrangements in Northern Province in 2015

Government Residential home — 4%
Registered Voluntary home — 66%
Unregistered Voluntary home — 30%
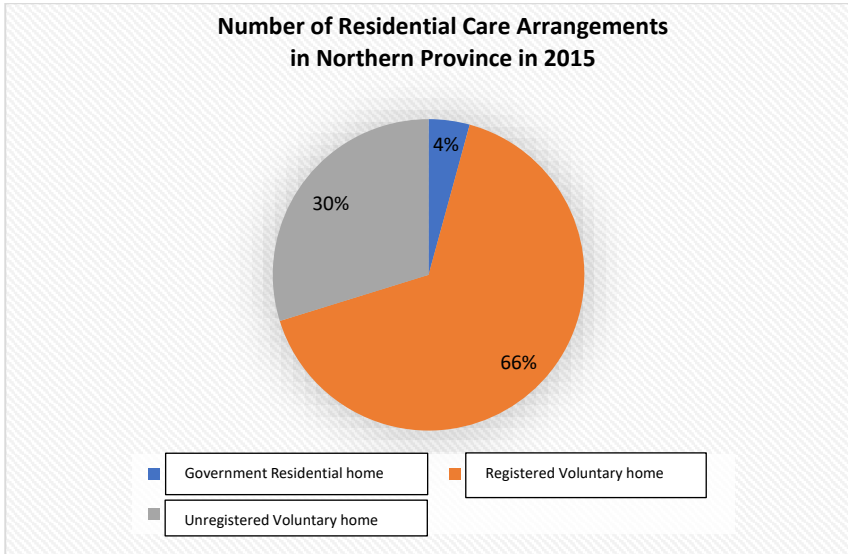
Family Care Compared with Residential Care

Although residential care is considered by some to be an option of last resort for child care, for several reasons it has become a growing reality in the Northern Province. Although the care of children is the responsibility of the family, nowadays families consider residential care homes to be a blessing. One mother stated, "I live in a hut and my daughter is safe, having three regular meals a day with educational and residential facilities in the hostel". This comment is typical of many families. The reality is that, in the present situation, new factors have emerged that have weakened family systems. Social, economic and political changes are causing stresses and problems that weaken family structures and relationships. These have made prospects for the quality of child and youth care more concerning in terms of children having access to experiences of love and affection from caring adults.

Some of the root causes of the challenging family dynamics identified were discussed in 2014 and 2015 during the Diploma in Child Protection and Training programme for residential home managers. This highlighted the increasing demand for residential care in the Northern Province because of a lack of infra-structure in the re-settled and re-located areas, a lack of housing, unemployment, increased cost of living, poverty, and hopelessness amongst parents due to the prolonged civil war. In addition, parents seemed to lack a sense of responsibility for the safety and education of their children, preferring to transfer this responsibility to the residential care centres. Other issues included the migration of parents, and the perception that sending their children to residential care centres would help access schooling and prevent early marriages. The fact that most residential care homes are urban and town-based is an issue facing those seeking to create better quality

facilities, and a prime concern for boards of management established to oversee residential homes for the voluntary organisations. These members are generally honorary volunteers who may also be educators or well-wishers, and those having a good social standing in the community.

Changes in the Lives of Children and the Need for Professional Child Welfare Management

Residential care is managed by boards of management with the advice of a placement committee and the Department of Probation and Child Care Services. The management teams of these organisations are critical components with the capacity to change the lives of children living in residential care. It is essential that the system of residential care management be developed into a more professional child welfare management system which can better address the developmental needs of children. No other agency at present can replace the current system.

Any large-scale system, be it economic, administrative, cultural or religious, needs to be managed by a well-developed organisation that can respond to the needs and demands of the modern world. The purpose of residential care organisations should be to enable children from vulnerable and at-risk families to be protected and have access to health and education services including other forms of social support usually accessible to a well-functioning family. Child welfare organisations should be professionally managed whether they are faith-based, or not. A systematic analysis of organisational management strengths and weaknesses, as well as its capacity to provide appropriate services that meet the developmental needs children must be undertaken, and gaps filled. Since meeting the developmental needs of children to the highest possible level is a non-negotiable obligation, all children's welfare organisations must accept the responsibility to act accordingly.

The following key issues have been identified in residential care management in the Northern Province of Sri Lanka, highlighting a real need to:

1) remove the current "deficit approach", to undertake an effective and complete review of the child care management systems, and ensure regular monitoring and closer supervision;
2) find ways to remove stigmatisation of children in institutions, and foster child development to its fullest, undertaking an assessment of such issues, and carrying out more research;
3) replace inadequately trained staff with more well-trained professionals who are "child friendly";
4) understand the need to develop better age-appropriate care plans and child-friendly activities in all matters related to child care and protection;
5) address the issue of the absence of after care plans with the collaboration of parents/guardians in most instances;

6) address the lack of programmes to help empower parents and guardians, so that they will adopt greater child care responsibilities; and

7) ensure transparency in all aspects of financial management.

The above issues emerged because there has been a deficit approach to residential child care, frequently arising out of a faith-based management orientation based on religion and a philosophy of being charitable. This needs to be replaced by a system of professional child welfare management which can be promoted at all levels, particularly in child welfare policies and programmes. The diagram below illustrates the inter-relationships between professional child care and faith-based child care, and the unique interconnectedness that distinguishes them in terms of the knowledge, skills and attitudes of professional child welfare. Care managers with compassion also need more professional knowledge and care skills, including a greater understanding of rights-based approaches to the current system of care management. During the care plan workshop for residential care managers, those who expressed their views were many. This was the first workshop of its type given by the Department of Probation and Child Care Service of the Northern Province. Hitherto, care managers had only been given a few training programmes that imparted rules and regulations.

The absence of any system to strengthen residential care and move it towards a more family-type care system or family-strengthening programme has been a major problem. Those who have been responsible for children in need and those funding organisations have neglected the need to change institutions and work towards re-unification of families. The reality is that better quality residential care management has never been taught nor professional support received in the Northern Province. The need for an alternative care policy and the introduction of current technical know-how on child welfare management is becoming more visible as probation officers now try to educate care managers. It is also worth noting that the cost of providing family care is less than residential care.

The reality of quality residential care can only be achieved if active steps are taken to promote smaller institutions, living in family-style homes. A smaller number of better trained professionals must be encouraged to work in these units, rather than untrained or inadequately trained staff, who are largely unsupervised and poorly paid. Regular supervision is essential to maintain standards of quality of care (Hiranthi, 2014).

Gear Diagram Illustrating Existing Child Welfare Management

The gear diagram above reflects that spirit of volunteerism, faith-based service delivery and attitudes very much appreciated among the residential care management and child welfare administration. Administrative rules and regulations are also more related to charity-based beliefs than professionalism. One care manager proudly announced that residential care was a charitable service which enabled the service providers to get blessings from God and that the children should consider themselves very fortunate to receive such assistance. This reflects the plight of children who are accorded few rights and are caught in dilemmas between charity and professionalism. These ideological dilemmas prevent the child welfare managers from adopting a stronger leadership role in planning, organising, directly monitoring and supervising the whole residential care management in the Northern Province.

55 percent of the institutions reported that residential care homes conducted administrative committee meetings once a month in Sri Lanka to decide on administrative, financial and management matters (NISD, 2015). Only 44% of the staff working in the whole country are professionally qualified, and these are mostly social workers or psychologists. This reflects the greater need for professional training throughout the social welfare field to fulfil the best interests of children.

The loss of a family can greatly jeopardise the physical and emotional development of children. Children's physical and emotional development can be further damaged in poorly regulated and monitored institutions that are unfortunately widely prevalent due to poor supervision and monitoring (Hiranthi, 2014).

The mental health needs of these children also must be addressed, bearing in mind the interactions with physical and social needs as well as the impact of deprivation of their family and social interaction outside the institutions (Hiranthi, 2014). She also suggested that rigid systems of rules and regulations need to change to create a more family-type environment which is genuinely child-friendly, encourages leisure, play and recreation, and is one in which each child receives personalised attention to promote rights-based care, guaranteeing the best interests of children. Although the care managers accepted the value of family-type residential care, they also expressed their inability to set up this kind of environment or any other alternative care environments, because the policies that guide their activities only allow for the most basic minimum standards for their residents.

The overall health needs of children are another prime concern. The World Health Organisation (WHO) definition of physical and mental health is greatly affected by socio-economic and environmental factors and can be considerably enhanced by the adoption of a primary health care approach. There is more development mentally, socially and physically during a person's early years of life than at any other period of their life. A healthy start to life greatly enhances how children will function in school, with peers, in intimate relationships and with broader societye (Hiranthi, 2014). This is of significance for children in residential care in the Northern Province.

The mental health needs of Northern Province children have to be addressed, bearing in mind the interactions with physical and social needs as well as the impact of family deprivation and loss of social interaction outside the residential care homes as a 'collective traumas' which affect several generations. The concept of collective trauma has been introduced for the first time in a modern mental health diagnostic classification in the draft of the World Health Organisation's International Classification of Diseases Guidelines for Post-Traumatic Stress Disorder under cultural considerations: There is now recognition that large-scale traumatic events and disasters have a destructive impact on families and society. In collectivistic or socio-centric cultures, this impact can be profound. Far-reaching changes in family and community relationships, institutions, practices and social resources can result in consequences such as loss of communality, tearing apart the social fabric, cultural bereavement and collective trauma. For example, in indigenous and other communities that have been persecuted over long periods, there is preliminary evidence of trans-generational effects of historic trauma. (Daya, 2014).

The Way Forward

In summary, residential child and youth care services in Sri Lanka are delicately balanced between those who view professional child welfare management for residential care homes as essential alongside those voluntary and charitable entities where ideology and religious beliefs shape the development of children in care. Slow progress has been made towards actively promoting the dignity and rights of children which are generally considered foundational for the development of social relationships and for the re-integration of children into society after they leave residential care.

Child welfare management needs strengthening while appreciating that compassion needs to remain the guiding principle that starts to revitalise professional care management. De-stigmatising residential care and the promotion of family-strengthening programmes will be essential to encourage parental responsibility to consider residential care as only a temporary measure. There are further issues such as availability of funds, negative perceptions and 'child unfriendly' behaviour by some members of management. Other concerns include the quality and extent of supervision, training of staff and monitoring measures. These should be re-addressed with comprehensive alternative care options and adequate budgetary allocations for child welfare management.

This chapter recommends the development of well-considered strategies and programmes to resolve their child welfare management issues, which are widely prevalent, and the adoption of appropriate multi-disciplinary professional interventions. These should include indigenous faith-based knowledge and strategies. It is essential that the residential care management system is changed, with the aim of adopting a more holistic approach to child development. Consideration is also needed for the examination of alternative indigenous care strategies with greater involvement of families and communities. This will help generate more opportunities to enhance and promote a sense of ownership among families and communities for their children.

This analysis of institutional care for children, with reference to the Northern Province, indicates that most children in institutions are those who do have families, but who have been placed in institutions because of the perception by their families that this will improve their education, and support the child's future through enabling regular schooling. However, the data also reveals certain gaps in services which need to be addressed, including a lack of adequately trained caregivers, insufficient monitoring of the quality of care and significant resource deficiencies which affect access to basic services. The institutions also include some children who are without a family or have lost contact with their family. When these young people must leave the institution, for the most part they have no plans in place at a community level to help them function, neither vocational training opportunities nor placement in an income-generating occupation. Above all, it is vitally important that the problems that lead families to place their children in institutions need to be addressed with urgency.

Questions for Small Group Discussion or Guided Reflection

1. After conducting a short internet search about Sri Lanka and the Northern Province of Sri Lanka in particular, what would you say are the most important reasons for children and young people entering residential care in that country during the past decade and what practice issues might one face there as a prospective VSO Volunteer (Voluntary Service Abroad)?

2. *In 2009, more than 21,100 Sri Lankan children were living in 488 residential care institutions run by voluntary groups managed by well-wishers, religious leaders and community groups.* To what extent do you think *well-wishers, religious leaders and community groups* provide residential child and youth care where you live and how do children or young people get placed there?

3. Many in Sri Lanka now view residential child and youth care *institutions offering access to education, or residential hostels facilitating children receiving education – a choice becoming popular among single parents or those who seek employment in foreign countries who avail themselves of residential care with education for their children.* Compare and contrast this approach used by Sri Lankan families to ensure the care and education of their children with practices used in the USA, Canada or the UK where families may place their children and young people in boarding schools while on overseas work assignments or military postings?

4. *Large-scale traumatic events and disasters affect families and society. In collectivst or socio-centric cultures, this impact can be profound. Far-reaching changes in family and community relationships, institutions, practices, and social resources can result in consequences such as loss of communality, tearing of the social fabric, cultural bereavement and collective trauma.* What challenges might residential child and youth care services face in Sri Lanka as Northern communities move towards developing more family-based services that enable children to live with family or extended family members?

5. *Residential child and youth care services in Sri Lanka are delicately balanced between those who view professional child welfare management for residential care homes as essential alongside voluntary and charity entities where ideology and religious beliefs shape the development of children in care.* To what extent have you had to face potential conflicts between personal beliefs and professional ethics or values where you live and work?

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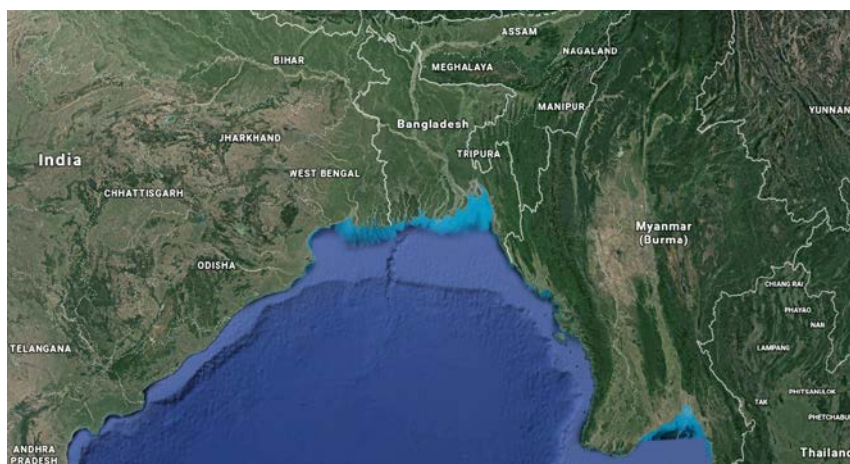
Residential Child and Youth Care in Bangladesh

Tuhinul Islam[1]

Abstract

A brief introduction is provided about the history of this South Asian country – once known as East Pakistan – before offering an overview of child welfare policies in Bangladesh that are shaped by religious and cultural traditions. Such traditions have shaped at least five different types of residential child and youth care services, including Homes run by Non-Government Organisations; Government; Faith-Based Community, Local elites and Armed Forces. Involvement in these care services is examined in terms of comparative systems, policies, practices and outcomes achieved by care leavers.

Introduction

It is unclear exactly when and where residential child care first began in Bangladesh and, like other part of the world, residential child and youth care homes

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have evolved over time. Within the Indian sub-continent, it began with philanthropic and religious institutions influenced by religious, social and political factors aiming to rescue, protect and support 'abandoned', 'neglected' and 'destitute' children (Abdallah *et al,* 2004; Islam, 2012; Kabir, 2011). This chapter draws from an exploration of experiences in care, leaving care and after care from the perspective of young people who have lived in residential child care institutions in Bangladesh. It begins with an introductory overview of Bangladesh, its welfare system, family structures, cultures and social changes, followed by a discussion of child welfare, child protection policies, and the history of residential child and youth care, highlighting why children might find themselves living in such institutions. The chapter concludes with a summary of young people's leaving care experiences and looks ahead to the future of Bangladeshi child and youth care provisions.

General Overview

Bangladesh, formerly known as East Pakistan, is a young country, born on 16 December 1971, when the two parts of Pakistan divided after a bitter conflict. It is located on the northern edge of the Bay of Bengal, bordered on three sides by India. Bangladesh is the seventh most populous nation in the world with 152.5 million people inhabiting 55,598 square miles. The influx of over half a million Rohingya refugees fleeing from Myanmar genocide has put additional pressure on the country, where now the largest refugee camp has been established on land barely habitable. Sixty-six million Bangladeshi are children under 18 years, constituting 45 percent of the total population. Almost 90% of its inhabitant's practise Islam, with other residents having equal rights and freedom to practise their own beliefs (BBS, 2011).

Bangladesh is possibly the richest country in the world as far as inland fishery resources and fertile soil are concerned. However, poverty prevails throughout the country (Hartmann & Boyce, 1979), with almost 40% of the population living below the poverty line (UNDP, 2011; World Bank, 2011). With one of the fastest rates of urbanisation in Asia, the disparity between the urban rich and poor is growing rapidly, with estimates now claiming that of the seven million people living in urban slums, 3.3 million of these are children (UNICEF, 2008).

With democracy never being fully achieved (Quddusi, 2008), Bangladesh has suffered from a range of problems, including endemic corruption, political criminalisation, lack of transparency and accountability across all sectors including the judiciary system, and obstructing the country's growth, development and public welfare (UNICEF, 2009; World Bank, 2011). Along with these 'man-made' problems, Bangladesh has experienced repeated natural disasters, during which many children become homeless, along with their families. Children may also lose their parents and relatives, making them vulnerable and increasing their chances of abuse, neglect and exploitation.

Child Welfare and Social Policy

Traditionally, family ties and social bonds have been strong in Bangladesh, while the social welfare system is weak and very different from that found in Western democracies (Aziz, 1979). As formal social safety nets are weak, individuals rely heavily on their families. The relationships between extended families and neighbours are very strong and interdependent in nature. Bangladeshi culture does not encourage living in a nuclear family, largely because it is not practical for survival. Religion stipulates that parents look after their children, prepare them for adult life, and children, in their turn, looking after their parents during old age. Nevertheless, accepting its constitutional obligation to look after its people living in poverty, the Bangladeshi government has formulated policies and allocated resources to pursue several Safety Net Programmes (SNPs). NGO support also covers almost all aspects of development and skills, but NGOs cannot provide blanket support, and what they do provide is often temporary. NGOs are also dependent on funding and are faced with frequent accusations of being donor driven.

Cultural Traditions and Religious Beliefs

Parents tend to take primary responsibility for securing a positive future for their children by providing quality education, care and support. Based on cultural and religious beliefs, the provision of care to orphans, abandoned and vulnerable children has been the duty of the extended family and community. Islam teaches that guardians must protect orphans' identities, by allowing them to keep their birth parents' names, thus preserving their heritage and establishing their connection with other living family members.

Government Legislation

As one of the first signatories to the UN Convention on the Rights of the Child (1989), Bangladesh agreed to reinforce and ensure the rights of children to survival, development, protection and participation. The Children Act 2013 provides the principal law for children in need of care and protection. Its focus is to provide custody, care and treatment of those children who are neglected, destitute, victims of violence and accused children. Bangladeshi law emphasises that institutional care should be the last resort and used only for short-term rehabilitation. This law encourages family-based care and protection, considering the best interests of the child with meaningful child participation. However, the Children Act 2013 aggressively focuses on children in contact with the law for their safety, security and rehabilitation.

Under the Children Act 2013, the Government approves child care institutions established for the reception, protection and prevention of cruelty to children. The Act defines an 'orphan' as any child under 18 years of age who has lost his/her father, or who has been abandoned by his/her parents or guardians. In

addition to government-run facilities, Bangladesh has faith-based communities that run orphanages to house and educate orphans, and private or NGO-run orphanages and shelter homes to protect vulnerable children. Encouraged by the promise of international aid, the Government has signed up to a raft of child welfare and protection policies and has introduced wide-ranging laws in this area. However, policies and legislation are not always 'put into practice' and some conflict with international law and policies, culture and religious beliefs.

A Brief History of Residential Child and Youth Care in Bangladesh

Residential child and youth care homes have evolved over time with philanthropic and religious institutions aiming to rescue, protect and support 'abandoned', 'neglected' and 'destitute' children. As well as faith-based institutions, residential education institutions such as boarding schools were set up in the belief that they provided better academic education, thus ensuring that children of the moneyed classes eventually gained jobs with status. Broadly, five types of residential child and youth care operate in Bangladesh: NGO run homes; government Shishu Sadan (State-run children's homes); faith-based community run orphanages; boarding schools; and cadet colleges. A short summary for each type of service is given below.

NGO Run Homes

NGOs are a comparatively recent arrival on the residential child and youth care scene in Bangladesh. NGO-run homes are either partially or fully-funded by international donor agencies and all must be government registered. NGO-run homes tend to cater for the children of sex workers, child sex workers, street and disabled children, children involved in drugs, human trafficking and other criminal activity. There were 13 such children's homes in Bangladesh in 2005 (Alam, 2005).

Government Shishu Paribars

The Social Welfare Services of the government of Bengal began before India and Bangladesh partitioned in 1943, with four government-run orphanages established for orphaned and abandoned children. Following the devastating cyclone and the war of liberation in 1971, a great number of children were orphaned or abandoned. The government established 60 further shelters to care for the 'victims of independence', especially war widows and their children, to provide the essentials of food, accommodation, health care and education for the children.

In 1976, the Department of Social Welfare separated children in care from adults by converting these centres into regular 'orphanages', hoping to ensure a better quality of care and support. During the 1980s, these orphanages were renamed Shishu Sadan (Children's Home). In 1988, the government re-structured

these institutions, adopting the SOS Children's Village International model and renamed them Sarkari Shishu Paribar (Government Children's Family). Under this structure, children in these new institutions live in 'family' groups of 25 children of different ages. Each 'family' is further divided into sub-groups of three to five children who take turns to cook for the whole family on a weekly basis. Families in the boys' institution are looked after by a 'Bhaiya' (elder brother) while a 'Khala Amma' (auntie) looks after girls' families.

In addition to government-run orphanages, there are many privately managed orphanages in Bangladesh, registered and managed by the Voluntary Organisations (Registration and Control) Act 1961. At present, the number of registered private orphanages in the country is about 3,023 (DSS, 2016), with most receiving a nominal capitation grant for only some of the orphans in their care.

Faith-Based Community Orphanages

The development of faith-based community orphanages is closely associated with the development of faith-based educational institutions, such as madrasahs and Church-based schools (Abdallah *et al,* 2004; Islam, 2012; Kabir, 2011). Faith-based community orphanages, mostly Muslims, take in the majority of children and young people requiring residential care. They offer children free accommodation, board, health care, safety and security, community engagement as well as an education. Muslims believe that it is their religious duty, as well as social responsibility, to establish madrasahs cum orphanages for community use (Raisuddin, 1997). During the Mughal rule of India, madrasahs and orphanages were funded through taxation under the patronage of these Muslim rulers (Riaz, 2011). However, things began to change with the advent of European colonisation. The number of madrasahs and orphanages declined sharply during the British period. The source of public funding was lost, and orphanages became increasingly reliant on the goodwill of individuals and the community. However, after the departure of the British, the new Pakistani government (with a desire to promote a secular 'Western'-style education system) continued the British policy of neglecting madrasah education and no public funds were allocated. After the war of liberation in 1971, orphanages took responsibility for the care of most children orphaned during the war of liberation (Ayoub Ali, 1983). There are no government restrictions on establishing orphanages. Rather, orphanages are essential to meeting the challenges of caring for the huge numbers of orphaned and abandoned children in Bangladesh. The Government today recognises this but offers no material support to them. A small number of Buddhist, Christian and Hindu residential homes also exist, catering for the needs of minority religious communities, but funding for these comes from the community rather than from Government.

Other Institutions – Boarding Schools and Cadet Colleges

These were set up to cater for the children of middle and upper-class Bangladeshi families. Their function is to provide bed and board, as well as extra

tuition, in a residential setting for students wishing to improve their grades in preparation for university entry. These boarding schools operate primarily on a commercial basis. The Bangladeshi Army runs seven residential 'cadet' colleges for children who pass a rigorous entrance exam at Grade Seven. The Government provides large subsidies for cadet colleges, but guardians are still expected to pay an annual fee. After passing Grade XII exams, cadets are invited to join a branch of the Armed Forces, almost guaranteeing employment for life.

Size of the Child Care Institutions and Numbers of Children

As no census of child care institutions has ever been carried out in Bangladesh, it is difficult to know the exact number of child care institutions, nor the number of children living in them. Such data that does exist is highly unreliable. The sizes of the institutions vary enormously and the numbers of children and young people resident in each institution range from between 100-200 in the NGOs and government institutions to between 100-20,000 in the madrasahs and orphanages. UNICEF estimates that there are more than 49,000 children in residential care in Bangladesh (UNICEF, 2008) but this figure fails to include the many thousands of children living in madrasahs and orphanages. It is estimated that 1200-1500 children from brothels live in 13 NGO-run homes (Alam, 2005); 3000 children live in 84 Government Shishu Paribars, 6 baby homes, 3 homes for destitute children, 6 Adolescent Development Centre (children and youths who came in contact with law/court order/court punishment) and 1 home for intellectually disabled children (DSS, 2016). Community faith-based orphanages care for more than 6 million children (Islam, 2012).

The Study

This chapter is based on an ethnography compiled over a 12-month period in 2007, with follow-ups between 2013 and 2016. Semi-structured, in-depth interviews were carried out with 45 young people aged between 12 and 26 from 3 types of institution – 15 NGOs, 13 Government Shishu Paribars and 17 faith-based orphanages. The interviewees had left care within a five- to ten-year period before the date of interview and had resided in their care home for at least one year. Observations took place at the six institutions where interviewees had lived: two run by a non-governmental organisation (NGO) for sex workers' children; two run by the Government for orphans; and two faith-based orphanages run by the local community. Of the 45 young people interviewed, 27 were male and 18 female.

Why were Children Placed in Bangladeshi Care Institutions?

While children live in care homes for many reasons, in Bangladesh, most children enter institutions for material benefits: free education, food, accommodation and health care, due to parental poverty. Giving their children to institutional care may seem to some parents to be the best and only option available

to them. Some children are placed in institutional care as a way of rescuing them from a detrimental environment, such as a brothel. Other children are sent to residential care institutions for education or for strong religious reasons.

NGO Run Homes

Poverty, safety and security, and a lack of alternatives provide a strong driver for sex workers in sending their children to NGO institutions. Sex workers' children are often unwelcome in local schools and prevented from mixing with the local community due to their birth mother's profession. Many mothers see institutions as an escape route for their child, giving their child access to a possible better life.

Government Shishu Paribars

Family poverty is the primary reason for sending children to government institutions, as parents hope to gain material benefits and protection through the provision of education, shelter, food and, possibly, better marriage and employment prospects (Doná & Islam, 2003; DSS, 2016). Another study identified that parents were concerned about their children's safety and protection from deviant activity (BEI, 2011), particularly the case for girls. According to the law, only orphaned and abandoned children should be admitted into government institutions. However, disadvantaged and poor parents sometimes enrol their children by hiding their identity. It is worth noting, however, that because of bribery, patronage and the need for adult support, many orphans cannot access these institutions. Doná and Islam (2003) found that most children in government institutions had a mother but their fathers were absent.

Faith-Based Community Orphanages

There is a perception that children from relatively poor backgrounds get ready admission into faith-based orphanages. That is because these orphanages do not usually charge poor or orphaned children for education, board and lodging. Ahmad (2005) found that most children were indeed from poor families, from rural and small-town areas. Children in Aliya Madrasahs and its orphanages, on the other hand, came from a more diverse background: better off; lower-middle class families; secularly educated; and expatriate families (BEI, 2011). Kabir (2011) states that many parents send their children to the madrasah to preserve their Muslim cultural identity which, they fear, is increasingly threatened by the rise of secular culture in Bangladesh. Many Bangladeshi families enrol at least one male child in the madrasah because they believe that this is necessary to bring Allah's blessings onto the family.

Overall, the social backgrounds of children living in residential care institutions in Bangladesh is changing. By and large, the notion that poorer parents send their children to institutions remains valid, like what can be found in other Asian countries such as Mizoram (Lalzallana, 2008), Indonesia (Martin & Sudrajat, 2007) and Sri Lanka (Jayathilake & Harini, 2005). These changes are taking place,

largely because of the number of 'well-to-do families' paying to send their children to madrasahs.

The Physical Environments of Child Care Institutions

When considering the physical environment of Bangladeshi residential child care institutions, the picture that comes to mind is often one of a tall, walled or fenced building, covering a large plot of land, with a semi-pukka (low cost mud-covered floor) building made with corrugated iron sheets, containing a sleeping area, kitchen, toilet facilities, playing field, pond and school. Of course, not all residential child care institutions in Bangladesh look the same. Their buildings, grounds, facilities, structures and enclosing fences are very different. Such differences are heavily influenced by the availability of funds and the values, religious beliefs and cultural practices of the people who manage these facilities.

NGO Run Homes

Children's homes located in rural areas are usually made of corrugated iron sheets or brick with the main entrance monitored by a security guard. The office building would have a visitors' room, available to mothers whenever they come to visit their children. The main building complex would house children and staff and incorporate a large multi-purpose auditorium. The building complex would include: a mosque, primary school, playground, farming land, poultry, dairy and fish farm. Bedrooms would generally contain 4 beds, private reading tables and chairs, a small wardrobe and trunks in which to store personal belongings.

Government Shishu Paribars

Government children's homes are usually situated in a town centre, surrounded by high protective walls. The main gate is kept locked with a guard checking all those entering and leaving, like the NGOs. The sizes of these homes vary but most are at least ten times bigger than NGOs and some faith-based orphanages. Mostly, the properties are old and badly in need of refurbishment. Four to seven children would share each bedroom, with the younger children often sharing a bed. Children cook for themselves in 'family' groups.

Faith-Based Community Orphanages

Faith-based community-run child care institutions are the biggest service provider for children who need care, education, health care, safety and security. These orphanages can be found everywhere in Bangladesh. They vary considerably in size, construction and quality, often related to the financial health of each institution. Rooms are used for sleeping, study, eating and playing. Sometimes even 100 children sleep in rows on the floor in one big hall. The kitchen would be smaller and very different from the NGO and government institutions. There is no furniture there so children sit on the floor to eat.

Routines and Rhythms in a Typical Day at a Children's Institution

Each institution has its own activities, rules and rituals, but with several similarities and the same aims: to support children in care to prepare for an independent adult life after leaving care. The NGO and government institutions have a series of structured activities to keep children occupied. The faith-based orphanages, on the other hand, were flexible in everything except education. All institutions were residential for the children, but not necessarily for the staff. The residential staff worked a 24-hour day with no shift changes as in 'Western' institutions.

Children's Contact with Families

NGO Run Homes

The NGO homes generally welcomed mothers to visit their children at any time except during lessons. Accommodation was available for those who came from a distance, and mothers were encouraged to join in home functions, for example, religious and cultural festivals, meetings, training, sports events or cultural programmes. Children could keep in touch with their mothers via the home's mobile phone.

Government Shishu Paribars

Parents preferred to phone their children directly on their own or friends' mobile phones, even when this was forbidden by the institutions. According to Shishu Paribar Management guidelines, only those named on admission forms can visit children in the Government institutions making them much more restrictive around maintaining family contacts. When parents did visit, there was no private place to sit and talk so they had to go into the open playing field. Children could visit their families during festival breaks or in emergencies.

Faith-Based Community Orphanages

Children living in faith-based orphanages had the greatest opportunities to visit their parental homes on a regular basis. Depending on the distance, children could visit every day if they wished. Due to the flexibility in visiting, children maintained strong bonds with their biological families. Although the orphanages were flexible with allowing visits, they did discourage too frequent visits if they distracted from the main function of Qur'anic memorisation. So long as the children did their class work, they could come and go as they pleased.

Care Leavers' Experiences

The young people in this study had mixed feelings about their lives in care, preparation for leaving care, and after care support. While their experiences were diverse, their time spent in residential child care in Bangladesh was overall, a positive experience for these young people. It gave them opportunities for education, health care, relationships and social networks that would not have been available otherwise. After leaving care, these young people had better chances for finding a job, higher education, marriage and family life. Those young people who did best were those who had developed positive attachments with at least one trusted adult who acted as a mentor and strengthened their commitment and self-motivation. For some young people, material benefits (such as good food and clothing) were less significant than spiritual guidance to their developing a sense of self-value and well-being. Those who had a spiritual upbringing did especially well in terms of education and future careers. The young people who fared least well were those who had been evicted from their institutions. The findings highlighted the need for consistent residential child and youth care policies and formal after care support for all Bangladeshi children in care as guaranteed under the UNCRC. Key findings are presented below.

Experiences of Education

Overall, young people in the study valued education and acknowledged how their institutions had played a positive role in their education. The young people who achieved most educationally were those who remained in care for several years. This is in marked contrast to research carried out in the developed world (Chakrabarti & Hill, 2000; Sinclair & Gibbs, 1998) where poor educational outcomes were associated with longer periods of stay in care institutions. As well as young people's own attitude, a sense of determination, confidence and commitment were found to be important factors for educational success. However, those whose care was disrupted (critically, through eviction) fared worst and a poor education impacted negatively on life chances. The education system embraced in the faith-based orphanages, although narrowly focused, was found to result in good outcomes for most young people in terms of jobs as well as social acceptance.

Experiences of Health Care

Young people from the faith-based orphanages were happier and appeared healthier than counterparts in the other institutions, even in the absence of medical facilities. The quality and quantity of food mattered less to the young people than might have been anticipated. 'Spiritual food' was significant for some young people, especially those living in the faith-based orphanages. Relationships with staff and other peers were critically important, as was contact with birth families to keep children well, both physically and mentally. Finally, the study suggested that a number of inter-related factors promote personal wellness in emotional health,

mental health, healthy social relationships, safety and security, encouragement and interdependency, and most importantly, spirituality and religious beliefs.

Experiences of Personal Relationship, Identity and Social Networks

Young people who made friendships while in care often continued those relationships after leaving care. This was also the case for relationships with adults. They welcomed continuing contact with family members and the wider community. It should be remembered that most children in all the institutions were not orphans or without families in the strictest sense. Regular family contact contributed to young people's positive outcomes, thus supporting the Fulcher and Garfat argument (2015) that young people who retain good family links are better able to create and maintain social networks in the longer term. For them, the certainty of having family contacts provided self-esteem, confidence and assertiveness, thus promoting personal resilience. This study showed that resilient young people did better educationally, had the ability to ignore past discriminatory experiences, were able to develop social networks outside the care institutions and could easily overcome life's setbacks. They were better able to cope with the world outside of the institution and could do so much more easily than their counterparts. Interestingly, there was no evidence from this study that a smaller unit produced better outcomes for children, or that a smaller unit was more likely to lead to better quality attachments for young people. This study showed that even in larger institutions, where more residents were able to get to know more people, having multiple attachments was even more beneficial. Children and young people turned to each other for support, and in so doing, were able to build stronger relationships and enhanced social skills. They learned to become more independent and were thus better prepared for life beyond the institution. Staff continuity, at the same time, seemed less important to these young people than staff attitudes. Hence, a relatively new staff member might become a 'special person', because young people were able to build relationships quickly. Stigma around birth identity, care histories, and social discrimination, were on the other hand, barriers to success.

Experiences of Transition, Leaving Care and After Care Support

The study found that support for young care leavers is important in Bangladesh. Those who were evicted early from the NGO and government-run homes were highly vulnerable to abuse and exploitation (through gangsterism and prostitution); their educational and health care outcomes were reduced, and their life chances diminished. Supporting young people beyond care was not easy for some institutions, not least because young people may not wish to identify as care leavers because of the stigma attached to birth identity and being in care itself. Young people from faith-based orphanages who received no formal preparation

for leaving care (as it is understood in the developed world) and no formal support after care, nevertheless did best in the world beyond the institution. This reminds us that having formal procedures in place may be less important than informal supports from family and social networks; also, that the impact of stigma (of birth and care identity) may be difficult to overcome, no matter how much willingness there is on the part of institutions to support young people who leave care. The study also confirms that young people's social integration is much more effective if society understands the problems faced by young people such as these after leaving care, and thus share some responsibility for supporting them in integrating and being included. Nevertheless, the study has shown that institutions have a role to play in supporting young people after care, especially when there are few or no family supports available.

The Future of Bangladeshi Residential Child and Youth Care

With such huge numbers of children in care, it is imperative that the Bangladeshi Government and civil society develop a long-term sustainable plan to cope. Since Government does not have the financial capacity to support most faith-based orphanages, they thus lack overall control. The Shishu Paribars find themselves in a similar situation, with outcomes that are not particularly encouraging. Support for NGOs depends upon available funds and INGO agendas. INGOs are not particularly supportive of religious establishments, including faith-based orphanages, even though this contradicts UNCRC policies. The eviction of children and young people from government and NGO homes due to serious misdemeanours is also a concern. There is no national child care policy nor any formal after care provisions in Bangladesh. Instead, Government, NGO and faith-based orphanages have their own approaches in dealing with child and youth care.

No apparent reduction is anticipated in the number of residential child and youth care institutions needed in Bangladesh soon. Rather, there is likely to be greater need. Natural disasters, unstable political situations, Rohingya refugees, international political conflicts, and above all, the needs of child and youth care institutions will keep the need for residential care alive. As a majority world country with aspirations of becoming 'modern', Bangladesh has 'bought into' the idea that education brings progress, development and wealth to its citizens. Still an agriculturally-based economy, Bangladesh has become increasingly industrialised with more people aspiring to enter factory and office environments instead of back-breaking work in the fields. Those with an education enter a world of easier work and better pay. The upper-middle classes have always managed to educate their children to enter this materially comfortable world. Working class families now share similar aspirations, viewing education as important and seeking opportunities for their children. If families cannot afford to pay for their children to go to school themselves, they use opportunities provided by faith-based orphanages, NGOs and government residential homes.

In conclusion, considering the Bangladeshi Government's current political climate, priorities for development and funding, this study found that the State needs to work on 'reducing, re-shaping and improving' residential child and youth care to ensure that the UNCRC rights of these children are being met:

- State recognition is needed around the importance of residential child and youth care for those who need it, reframing and amending existing policies around education, health and well-being (including spiritual health), extra-curricular activities, and building relationships with staff, peers, families of origin and the wider community to improve facilities and services impacting the lives of young people.
- Given the marked differences across residential care institutions in Bangladesh, reframing existing Government child care policies and new guidelines are needed to support all types of residential child care organisations, respecting religious and cultural beliefs, and ensuring good enough standards are maintained across all institutions.
- Looking after children and providing substitute parenting are complex tasks that require training and staff development if care roles are to be performed more effectively. Adequate resources are required to provide skill development training for all staff to do their jobs effectively.
- Giving a 'voice' to young people is a significant issue that requires careful consideration. Care staff and other professionals should be encouraged to listen to young people with sincere and open hearts, ready to accept constructive criticisms about the care system as they have experienced it.
- Residential settings need qualified management with good systems of governance in place to oversee management and administration procedures. Management needs to encourage care staff to take decisions independently with confidence. Staff should also be accorded with greater respect and be better remunerated commensurate with the importance of their role in preparing young citizens of the nation.
- It is essential that staff from all Bangladeshi institutions be given opportunities for reciprocal visits and to learn about how other institutions operate. This could lead to shared interests around learning about and supporting the formulation and maintenance of enhanced care standards for looked after Bangladeshi children and young people.

Questions for Small Group Discussion or Guided Reflection

1. *Bangladesh is the seventh most populous nation in the world with 152.5 million people, sixty-six million (45%) of whom are children under the age of 18 years, and where over 40 percent of the population live in poverty.* What might be implications arising for the use of residential child and youth care in Bangladesh?
2. *As formal social safety nets are weak in Bangladesh, individuals rely heavily on their families.* What do you think happens to children who do not have families or who are disconnected from their families?
3. *Muslims believe it is their religious duty, as well as social responsibility, to establish madrasahs cum orphanages for community use.* What comparisons might you make with other types of religious education using boarding schools where you live?
4. In a majority Muslim populated country like Bangladesh, each day begins and ends with the call to prayer, with prayers offered five times a day at set times around a lunar calendar, and with a Holy Month of Ramadan Fasting each year. What daily, weekly and seasonal times of cultural celebration feature where you live?
5. *There seems no apparent prospect of any dramatic reduction in the number of residential child and youth care institutions needed in Bangladesh during the near future. Rather, there will be greater need.* How does one advocate for the de-institutionalisation of children in a country like Bangladesh with extensive poverty, Rohingya refugees, child trafficking and sexual exploitation of children?

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Thailand Residential Care: From Temples to Today's Better Alternatives

Kimberly Quinley[1]

Abstract

Thai children from impoverished families once received shelter, food, clothing and education from Buddhist monks in local temples. Thailand's child welfare system began when families, struggling to provide for their children, sent their sons to live in temples to become disciples of Buddhist monks, where orphan boys were also cared for in these sacred spaces. The first private home for orphan girls was established in 1890 and remains open to this day. Residential care in Thailand has grown exponentially since the 1950's with nearly 50,000 registered children living in various alternative care settings in 2014. Most of the children reside in the 51 government boarding schools throughout Thailand, followed by 35 government residential care facilities, 127 private registered residential care facilities, 77 provincial Shelters for Children and Families, registered kinship care, and registered foster care.

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[1] **Kimberly Quinley**, Director, Families at Risk Programs, Step Ahead Integrated Community Development

Selfless Acts

Many moons ago under glistening spires and gilded stupas (dome-shaped shrines), Thai children from impoverished families received shelter, food, clothing and education from Buddhist monks in local temples. Thailand's child welfare system began when families, struggling to provide for their children, sent their sons to live in temples to become disciples of Buddhist monks. Orphan boys were also cared for in these sacred spaces (Baily, 2012). In 1890, Her Royal Highness, Pravimadather Kromra Suddhasininart, recognized that orphan and vulnerable girls also needed a safe place to grow up and established the first private home for orphan girls. Nineteen years later, and in memory of King Rama V, Lady Talub, the wife of a nobleman, took over the management of the home. It was later transferred to the Department of Public Welfare and re-named Chartsongkraw School in 1948. The school provided food, clothing, lodging, and medical care for orphans and poor infants. The name later changed to Rajavithee Home for Girls and remains open to this day. In 1941 the Department of Public Welfare set up the first Home for Boys, later called the Pak Kred Home for Boys. A Nursery Home was set up in 1952 to care for and protect babies less than three years of age (Baily, 2012).

Since the 1950's, residential care in Thailand has grown exponentially with nearly 50,000 *registered* children living in various alternative care settings, as of 2014. Most of these children reside in the 51 government boarding schools located throughout Thailand, followed by 35 government residential care facilities, 127 private registered residential care facilities, 77 provincial Shelters for Children and Families, registered kinship care, and registered foster care.

Education and Poverty

However, these numbers do not reflect the hundreds of *non-registered* private residential care homes and dormitories in Thailand. Rossukon Tariya, Head of the Social Welfare and Protection Division Office of Social Development and Human Security in Chiangmai Province, estimates there are more than five hundred residential children's homes in Chiangmai Province alone[2]. Thailand has 77 provinces and many more thousands of children are living in residential care settings. One Sky Foundation in collaboration with the Thai government studied 17 orphanages in Sangkhlaburi District in Kanchanburi Province. Prior to entering the orphanages, 467 children of the 605 interviewed were living with a mother, father or both, and 106 children were living in a kinship care setting. Education was the main reason for entry into residential care for 382 of the children (Thailand convention on the Rights of the Child, Alternative Care Working Group, 2016).

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[2] (R. Tariya, personal communication, May 20, 2015).

In 1984, I said goodbye to family and friends to start an adventure volunteering at a private orphanage in Northern Thailand that cared for nearly one hundred children. Prior to my arrival, I assumed all the children at the orphanage were double orphans, meaning both parents were deceased, and the orphans had absolutely no relative to care for them. As I began to learn the Thai language and observe most of the children going home during school breaks, I understood that poverty and lack of education access were the driving factors for children entering residential care.

One girl with whom I have kept in touch all these years vividly described to me the day she entered residential care: "When I was eight years old, my parents sat me down with two of my sisters and explained that we would all be going away to an orphanage. It was a heart-wrenching decision for my parents. They explained to us as best they could that they had no money to support our education costs. I'll never forget riding for what seemed like hours in a bumpy songteow down the steep curvy mountain roads to Mesai. I was car-sick and scared. Loneliness best describes my existence those first couple of years. We spent two years in Mesai and then we were moved to another orphanage, where we stayed till I completed university. The evening before I left the orphanage for good, I was asked to speak at our devotional meeting and say goodbye. Many of the children started crying, which made me cry too. The next day, a new foreign volunteer drove me to my village. As I rode in the truck back home, I had a flashback memory of that day fourteen years earlier and realized how little had changed. I was still that lonely, scared, car-sick girl." (Kimberly Quinley, Jeera)

Sarah Chhin, country advisor at Mlup Russey, interviewed over 500 residential care-leavers and found, "When people start an orphanage, they tend to focus on the needs of the most vulnerable children. What we've found through our research was that vulnerability was not taken away as the children grew up. It was actually just delayed until the children left the orphanage." (Little & Monkolransey, 2015)

Southern Thai Conflict

Indeed, poverty and lack of education access are the greatest motivating factors for children entering residential care (estimates over 80 percent). However, just as alarming is the number of orphans created by the Southern Thailand conflict, an ongoing insurgency in the four most southern provinces. Over 6000 people have been killed and 10,000 injured in the decade between 2004 and 2014[3]. The number of orphans in the region is a growing concern, with a study by local non-governmental organisation, the Pattani Juvenile Observation and Protection Center, putting the number at more than 5,000. Other child welfare groups estimate the figure is two or even three times higher (Agence France Presse, 2015). Save the Children estimates the number of orphans is closer to 22,000 in the conflict area.

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[3] *South Thailand Insurgency.* (2008). From Wikipedia, the free encyclopedia. Retrieved 23 May 2015, from http://en.wikipedia.org/wiki/South_Thailand_insurgency.

Many of these children are living in kinship care arrangements although residential care options are also widely used.

Orphanage Recruitment in Natural Disasters

In December 2004 a giant tsunami wave swept across the Andaman Coastline in Southern Thailand leaving 1200 children orphaned (Few, 2005).

I was part of a coalition called, We Love Thailand, which set up child-safe zones in the displaced person camps hoping to protect children from potential traffickers and provide a secure place for children to play while their family members tried to make sense of the disaster, find employment and wait for new homes to be built. One morning, I arrived at a safe zone to find a young mother with tears streaming down her face, hopelessness in her eyes, and the burning sting of defeat that grew with each tear falling onto the toddler she clutched close. The weary widow listened to a foreign woman explain, "It takes courage to make the right decision to give your child away." The Christian missionary children's home director spoke confidently, assuring the weeping widow her precious daughter would never know hunger again.

Carrying a clipboard with paperwork and photos of a beautiful cement home, the director came prepared for this young mother to sign her child over. Every three months she could visit her daughter, and the daughter would have the opportunity to complete high school and possibly attend university. Arriving with the ink still wet on the orphanage registration form, I realised what was happening, and spoke to the young mother asking her, "Do you really want to give your child away?" The young mother felt she had no choice because she was unemployed and had no money to care for her daughter. I explained that her organisation believed no mother should have to make that choice and would find support for her family.

Turning to the orphanage director, in anger, I explained that orphanage recruitment is wrong and institutional care is far more expensive than other forms of alternative care. Residential care facilities require staffing and upkeep: salaries must be paid, buildings maintained, food prepared, and services provided. Comparisons consistently demonstrate that many more children can be supported in family care for the cost of keeping one child in an institution (Williamson & Greenberg, 2010).

The question must to be asked, "When will we learn to spend our money keeping orphans in their communities rather than spending it to take them out (Greenfield, 2007)?" Sarah Chhin argued that there are not orphanages because there are orphans; there are orphans because there are orphanages. Most of the children living in orphanages have parents, have family, and being in the orphanage separates them from their families, and alienates them from their communities to such an extent that when they leave the orphanages they have broken relationships with those families (Little & Monkolransey, 2015).

HIV/AIDS

Natural disasters rarely happen in Thailand, although the 2004 earthquake in the Indian Ocean resulted in a tsunami hitting Thailand's western coast with devastating consequences. A different kind of life crisis is faced daily by children living with HIV/AIDS and children affected by AIDS (CABA) because their parents are infected. These children and families often feel a flood of stress, stigmatisation and discrimination and a great sense of isolation when separated from their families. Being placed in an institution has a negative impact on these children. A UNICEF study reports, "Children whose mothers are living with HIV are approximately three times more likely to die by age 5 than children whose mothers are not, regardless of the child's own HIV status" (2011). In the Thai context, a recent Situational Analysis submitted by ICF International with the Central Statistical Agency of Ethiopia (2012) reported that Children Affected by AIDS might be the most at-risk children and "appear to be exposed to cumulative vulnerability factors as they often belong to poor families as well" (ICF International, 2012). In 2010, 16,000 children were living with HIV while 250,000 children aged 0-17 became orphans due to AIDS. Current estimates place Thailand's Children Affected by AIDS population at 385,582 children under the age of 18 (ICF International, 2012).

In many cases, parents or caregivers may not have the personal resources or access to social protection to provide adequate care for children affected by AIDS. In such situations, parents or caregivers may feel compelled to seek alternative ways of caring for their children. When this happens, children affected by AIDS may be deprived of their main context for love, protection, care, and socialisation ~ the family. In addition, they also face multiple uncertainties in terms of survival, health, education, access to opportunities as human beings and citizens, and all too often, they experience spiralling disadvantage. Relatives left to look after children affected by AIDS know all too well the stigma and discrimination that comes with caring for a dying AIDS patient. Struggling to tell the story, one woman whispers,

> *My daughter was a good girl. She loved her children. Her husband brought home a gift from the brothel and gave it to my daughter. He died first. My daughter hung on a while longer. We didn't know her breast milk carried the dragon in her blood. Little Chompoo is also ill. I am getting too old to care for the grandchildren. Sometimes I forget to give Chompoo her medicine on time. The children are better off at the orphanage.[4]* (Grandma Daeng, Bangkok)

Parents on the Move

More than 3.4 million children in Thailand do not live with either of their biological parents (UNICEF, 2014) and many are living in alternative care facilities. When considering those who may need financial assistance defined as those who

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[4] D. Chalrenpuch, personal communication, April 21, 2015.

live below the poverty line, there are potentially over 400,000 children who may need government assistance but are outside the formal system. For these children, kinship care is the most common form of alternative care; however, long-term residential care is increasing. Inter-generational families have been a traditional form of family support in Thailand, with children caring for their ageing parents, who in turn care for their grandchildren. In 2011, 13.7% of all households among persons 60 years and older were "skip generation" households in which the grandparent takes virtually all responsibility for raising their grandchildren during their developmental years. (Knodel, Prachuabmoh & Chayovan, 2013). In the rural Northeast of Thailand 30% of children do not live with either parent due to internal migration and abandonment.

Forty minutes outside the town of Buriram, down a dusty lane lined with sticky rice fields on one side and sugar cane on the other, young Gop and Gan play games on a Samsung tablet that their mother had sent from Bangkok while their Auntie describes their reality:

> *Their mom has been gone a long time. She works in Bangkok serving drinks at a restaurant. Their dad has a new wife now and lives far away. We haven't heard from him in years. Like many young girls in Isaan, Gop and Gan's mother got pregnant at fourteen. She quit school before Gop was born and it wasn't too long after she found herself pregnant again. She went to Bangkok to find work to help support her small struggling family.*
> *Gan listening chirps in, "We see mom every year at Songkran and she brings us presents. She bought a new refrigerator for Auntie and fixed the leak in the roof just in time before rainy season."*
>
> *Sometimes I am so tired, I threaten to send them away to live in a children's home. Just the other day Gop and Gan overheard me talking to a neighbour about a new orphanage opening down the road. I found Gop crying that night because she was worried I would really send them away. If I tell the truth, I really think about it. Life is hard. Gop heard a neighbour say their mother is looking for a foreign husband in Bangkok. She proudly told the neighbour, "Mom meets lots of foreigners." I think she thinks that if her mom marries a foreigner, she and her sister would never have to live in an orphanage.* (Auntie Beng)

Children like Gop and Gan are high risk for orphanage recruitment. According to Save the Children, Thailand's teenage pregnancy rate is the highest in Southeast Asia after neighbouring Laos, and also the second highest rate of mid-late (15-19 year olds) teenage pregnancy in the world.

Special Needs and Disability

Special needs and disabilities often separate children from family because, without proper skills and personal resources to care for their child, families find it nearly impossible to cope and have no other choice but to send their child to

residential care. Based on the questionnaire sent by UNICEF to alternative care settings in Thailand, most of the children with special needs in residential care settings are living in government facilities. To illustrate, one private home is the Christian Care Foundation for Children with Disabilities receives children with special needs mostly from government facilities. The Foundation cares for small numbers of children and emphasises that this is a short-term solution with the long-term aim being to re-integrate the children back into their families or to provide them with long-term solutions such as adoption. Christian Care Foundation places a strong emphasis on maintaining and building relationships between the child and his/her family during the child's stay in the facility.[5]

> *Weechai's mother and father died when he was a baby, leaving him a disabled orphan with no family. He entered a government orphanage and spent three years there before moving to Hope Home. Weechai could not sit or talk and feeding him was difficult. He never kept his head still, and it was a three-person job – one to hold his head, one to hold his arms and one to feed him. He spent seven years at Hope Home receiving one-to-one care and learned to sit independently, stand in a walker, play football and ride a bike with support. In 2014, the Thai government laws changed so that any child who has special needs and is not in direct family care must be moved to the large Government orphanage in Bangkok on their tenth birthday. Sadly, on Weechai's tenth birthday he had to leave his high-quality care and move back to the Government orphanage.[6]* (Judy Cook, Hope Home Founder)

Border Children

Thousands of migrant children live in residential homes and dormitories dotted along the porous border with Myanmar. Well-meaning foreigners founded many of these homes, founders with little knowledge, if any, of child protection or the legal formalities of running residential homes in Thailand. In just one sub-district of Sangkhlaburi District in Kanchanaburi Province, seventeen homes were studied: not one home was legally registered as a residential centre, only two had records of why the children were living there, needed protection or welfare, and only two centres kept a record of the children's physical and mental health upon arrival. Four homes did have a child protection policy; however, only two of those four homes had heard of the UN Convention on the Rights of the Child, and none of the seventeen homes had read the Thailand Child Protection Act 2003.

Compasio Foundation runs several registered best-practice small group homes in Maesot on the Burmese border. Grace Home provides a haven for children born in prison or brought into that environment with their mothers. Temporarily separated from their mothers, the children receive education support

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[5] Ccdthailandorg. (2015). *Ccdthailandorg*. Retrieved 28 May 2015, from http://www.ccdthailand.org/

[6] Wordpresscom (2015). Hope home Chiang Mai. Retrieved 28 May 2015 from https://hopehomecm.wordpress.com/

and health access. Upon release from incarceration, Grace offers a place of restoration for mothers to reconnect with their children. Mentoring, counselling and life skills training empower the mothers to have a healthy and stable future with their children.[7]

> *I remember being so confused and asking a kind-looking lady, "What's going to happen to us?" My little brother, Myint, was so small and weak the day we arrived at Grace Home. He was barely 3 years-old. I felt so responsible for him. I think I was seven. Birthdays weren't celebrated in my family, so I wasn't quite sure. I had to be strong. I still couldn't believe my Dad was gone too. "Why did he have to die? How long will mamma be in jail?" I was the girl with so many questions and so many worries. There was a special lady at Grace I could talk to and she always made me feel like I could tell her all my secrets, all my fears. Every month we got to visit my mamma in jail. I wish our visits were more often. But rules are rules and we needed to follow them. Mamma always looked so happy when we visited. We would take her Let Thnk Sohn, her favourite salad. The two years went by slowly with mamma away, but I had school to keep me busy and the staff became like our new extended family. Whenever we were sick, the staff took us to the doctor and made sure we were comfortable. I grew to love the staff and trust them. Finally, the best day arrived! Mamma came to live with us at Grace! We spent a few months living together at Grace getting to know each other again. The staff at Grace helped mamma find work and process all our legal documents! We then were able to move to our own place. I am so grateful to Grace Home.* (Mya, 12 year-old girl from Myanmar)

Children at Risk of Sexual Exploitation and Human Trafficking

The Alternative Care sub-committee of the Convention on the Rights of the Child Coalition Thailand feels concerned and alarmed by the newest growing trend in residential care: rescuing children at risk of sexual exploitation and human trafficking. Hundreds of well-meaning foreign volunteers move to Thailand to work with this vulnerable group and serve in children's residential homes. The Alternative Care sub-committee recognizes that the issues are complex; however, building children's homes only acts as a Band-Aid. Most of the directors running these homes do not understand the adverse effects of institutionalization, gate-keeping practices, family strengthening and the importance of building community resilience, which plays a vital role in prevention and intervention. The Alternative Care sub-committee understands that shelters for children victims of human trafficking should be temporary and permanency plans to place each child in a loving family in communities should be priority.

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7 Compasioorg. (2015). Compasioorg. Retrieved 29 May 2015, from
http://compasio.org/projects/shelters/

Boarding Schools and Dormitories

Education access for all is a commitment that Thailand has made under various laws and regulations. The 1999 Education Act guarantees the right of all children, without discrimination, to a quality education. A Thai Cabinet declaration in 2005 re-affirmed the right of all children, including non-Thai children living in Thailand, to receive an education. Furthermore, in 2009 the Government announced the extension of mandatory free education from 12 years to 15 years. Thailand's Ministry of Education has designated 51 schools throughout Thailand to accommodate children needing somewhere to stay because their home is too far from school, or they live below the poverty line. Nearly 40,000 children reside in these Government boarding schools.[8] It is estimated that many more thousands of children across Thailand live in dormitories run by private NGOs. It is much easier to register as a dormitory or boarding school than an orphanage or children's home.

I was 11 years old when I moved into the Christian dorm. My parents were separated because my dad was addicted to opium. I lived there because my family was too poor, and our Akha village did not have a school. When I arrived, I couldn't believe I was sleeping in a real bed, and I got new clothes, and I always ate three meals a day there. But, I missed my traditional village life so much and I especially missed my family. I was able to go home at Christmas and for evangelist meetings. One thing that was difficult is that we had to do a lot of construction work to build a new building and it was hard for me. One night a boy broke into our room. It was scary. I was never abused, but other girls were. (Apoe, Akha girl spent 5 years in a dormitory to complete senior high school)

Abuse and Neglect

Childline Thailand – a hotline (1387) for children or concerned adults to call reporting abuse, neglect and exploitation – receives about 150,000 calls each year along with the Thai Government hotline (1330). Children experiencing abuse, neglect or exploitation are first taken to a local One-Stop Crisis Centre (OSCC), which uses a multi-disciplinary approach to provide physical and mental treatment, legal assistance, as well as recovery and rehabilitation support. After release from the One-Stop Crisis Centre, the child is taken to The Centre for the Protection of Children, Youth and Women within the Royal Thai Police or one of the Government Shelters for Children and Families established by the Department of Social Development and Welfare (DSDW) under the Ministry of Social Development and Human Security which serves as an emergency home for children and women victims of violence.

Social workers at these shelters have seven days to perform an assessment to verify if returning the child to his or her family is in the best interests of the child. If after seven days, the child cannot return to his or her family, then an additional 3 months is given for the social worker and/or child protection officer to plan for

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[8] School of Global Studies (SGS), Thammasat University. (2015).

a permanent long-term placement for the child. During these three months, the social worker must work on ways to improve the family situation first. If it is determined that home is not safe for the child to return, then kinship care is the next best alternative, followed by foster care. If no such alternative family is found, then the child is placed in long-term residential care. Sadly, these procedures are rarely followed. There is a lack of clearly defined roles and responsibilities with coordinated communications across agencies. At the end of three months, many times the child ends up in long-term residential care with no plans for a permanent placement with a substitute family.

> *I was barely 4 years old when my father killed my mother. Abuse was normal in my family. I remember staying a few nights with my pre-school teacher before the social worker arranged for me to stay with my 16 year-old brother and his new wife. I spent a few years with them. When they had more children, they sent me away to live at an orphanage in Phuket. "For my own good," they said. The orphanage promised I would go to university for free, but I knew the real reason: I would be less a burden for them. I was miserable. I missed my family and my village. I missed seeing the sea every day.* (A young sea gypsy girl from Phangnga Province)

According to the Ministry of Public Health, which collected data from 631 hospitals in 2013, more than 19,000 children (or about 52 children per day) were treated in hospitals due to physical and sexual abuse (Uniceforg, 2015). Bijaya Rajbhandari, UNICEF Thailand Representative claimed that violence against children persists because it is often accepted by adults and the children themselves as part of life. Violence against children is a serious problem in our society. It doesn't only harm the well-being of children, but it also undermines the productivity and prosperity of the country (Uniceforg, 2015).

Foster Care and Adoption

Foster care and adoption have been slow to catch on in Thailand, even though adoption became legal in 1935 (Baily, 2012). There are many cultural stigmas to taking in a child not from one's family of origin, with several negative Thai proverbs that refer to foster care and adoption. One says, "*Don't raise someone else's children; don't eat someone else's food.*" Some concerned Buddhists feel that bringing in a child that was abandoned or troubled might bring bad luck into their home. Superstition plays a big part in adoption. Often a Thai family will check with the spirits to make sure the date and year of the child's birth will benefit their family.

Holt Sahathai Foundation is partnering with Viengping Children's Home, and Care for Children Foundation is partnering with Chiangmai Home for Boys to model best practice in terms of re-integrating children into family-based care. Emphasis is placed on the re-integration of children into their original families as well as linking children in residential care into foster homes.

Children are not Tourist Attractions

A quick Google search on visiting an orphanage in Thailand while on holiday or volunteering at an orphanage or children's home generates hundreds of opportunities. However, according to the UNCRC, children have the right to privacy. A revolving door of volunteers and tourists is not healthy for children already suffering from attachment disorder and abandonment issues. Visitors who have not been properly vetted create more vulnerability. Most orphanages and children's homes in Thailand operate unregistered and have no child protection policies. Indeed, some homes actively solicit volunteers and tourists to help fund their home. The Convention on the Rights of the Child Coalition Thailand, Sub-committee on Alternative Care, hopes to see laws strengthened, so that children living in residential care are not tourist attractions and are safe from exploitation.

Legal Framework

Over the past 15 years, Thailand has made significant progress towards placing alternative care for children within the broader legal and policy context of child protection. The principles and language used in the legal and policy framework resonate with international guidance towards realising a systemic approach to child protection: guided by the Convention on the Rights of the Child (CRC). It promotes a holistic view of children and child protection through the coordinated engagement of different sectors and actors responsible for protecting and realising children's rights and well-being. However, limitations in the current legal and policy framework make it very difficult to implement the alternative care of children, prioritising family-based care and preventing institutionalization. Gate-keeping is very weak and there has never been data collected on how many residential care homes exist or the exact number of children who are resident in them. These issues are compounded by social perceptions about institutions, as a suitable option to meet the care needs of children when families feel unable or unwilling to provide care.

Hope

This chapter has focused on the complex vulnerabilities and drivers of separation causing children to live outside of family care in residential centres in Thailand. Margaret Mead once said, "Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has" (1982). The good news is that there is a small, but growing group of organisations and practitioners – both private sector and Government – that are working together to develop programmes to strengthen families so that children can stay together with them in communities. The Thai Government is improving its infrastructure so that children can more easily access education on better roads and more schools built in rural areas. The existing legal framework supporting alternative care will have policies and procedures, which will increase oversight and accountability and

ensure adherence of standards and processes to the essential principles laid out in the UN Guidelines on Alternative Care. Cultural attitudes will change as awareness grows and Thai families will enjoy the good blessings from fostering and adoption.

Questions for Small Group Discussion or Guided Reflection

1. *Since the 1950's, residential care in Thailand has grown exponentially with nearly 50,000 registered children living in various alternative care settings, as of 2014, the majority in 51 government boarding schools throughout Thailand.* Government and private boarding schools have a well-established tradition in Thailand. How does this compare with where you live and work?

2. *These numbers do not reflect the hundreds of non-registered private residential care homes and dormitories in Thailand. Rossukon Tariya, Head of the Social Welfare and Protection Division Office of Social Development and Human Security in Chiangmai Province, estimates there are more than five hundred residential children's homes in Chiangmai Province alone.* In light of these estimates, what might you say about the way residential child and youth care is organized in Thailand?

3. *One Sky Foundation in collaboration with the Thai government studied 17 orphanages in Sangkhlaburi District in Kanchanburi Province. Prior to entering the orphanages, 467 children of the 605 interviewed were living with a mother, father or both, and 106 children were living in a kinship care setting. Education was the main reason for entry into residential care for 382, or almost two-thirds of the children?* What do you think this means about the placement of Thai children and young people in residential child and youth care settings?

4. *Intergenerational families have been a traditional form of family kinship care support in Thailand, with children caring for their ageing parents, who in turn care for their grandchildren. In 2011, 13.7% of all households among persons 60 years and older were "skip generation" households in which the grandparent takes virtually all responsibility for raising their grandchildren during their developmental years. In the rural Northeast of Thailand 30% of children do not live with either parent due to internal migration and abandonment.* How does this changing pattern of extended family care compare with the way inter-generational care might be found operating where you live and work?

5. *Thailand's Ministry of Education has designated 51 schools throughout Thailand to accommodate children needing somewhere to stay because their home is too far from school or they live below the poverty line. Nearly 40,000 children reside in these Government boarding schools. It is estimated that many more thousands of children across Thailand live in dormitories run by private NGOs. It is much easier to register as a dormitory or boarding school than an orphanage or children's home.* To what extent are boarding schools acknowledged as residential child and youth care services where you live, and why do you think the split between care and education is so common in some parts of the world?

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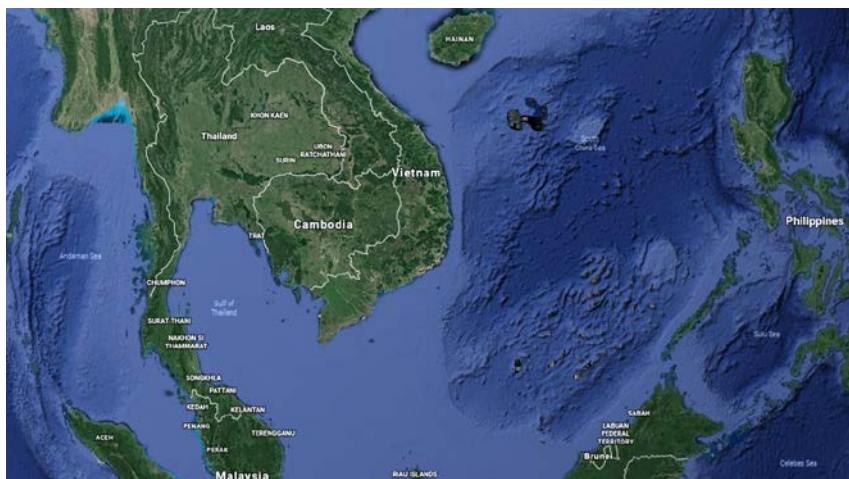
Residential Care for Children and Young People in Cambodia

Mia Jordanwood[1]

Abstract

Residential care for children and young people in Cambodia is examined against the backdrop of a long war for independence from France, a genocide endured for decades, invasion by Vietnam and a long-running civil war. Cambodia has no national programme of social services. Poverty is the leading reason for out-of-home care. There has been a rapid expansion in the number of residential care places during the past decade, despite national policies to the contrary, with services provided almost entirely by NGOs and private groups heavily reliant on international donors and donor volunteers. Residential care for children in Cambodia is in a period of dynamic change.

[1] **Mia Jordanwood** has been involved in issues related to residential care and reintegration in Cambodia for over fifteen years. She is the author of *With the Best Intentions*, a research study into attitudes towards residential care (MoSVY/UNICEF), which was credited by the Cambodian government with precipitating changes in government management of residential care. She has also published numerous studies focused on child protection, residential care and reintegration.

Introduction

In the past decade, Cambodia has experienced a surge in the number of residential care centres. This increase is contrary to government policy, which mandates that residential care should be a last resort and undermines traditional cultural practices. The increase is not driven by demographics, as it has occurred during a time when the number of orphaned children is decreasing. Most children now living in residential care in Cambodia have at least one living parent. Most children enter residential care to alleviate poverty and to access education. However, it is unclear whether residential care centres offer services that adequately address children's needs. Recently, the Cambodian government has begun to address the increasing number of residential care centres, partnering with civil society to start closing some abusive or extremely sub-standard residential care centres. However, as children from residential care centres are reintegrated into their families, it is important that implementing partners offer adequate long-term support and oversight to ensure that children are not placed again in harm's way.

Residential Care for Children in Cambodia

Cambodia is emerging from a long period of political upheaval. Since gaining independence from France in 1953, Cambodia has endured a genocide in which over one million people died, an invasion by Vietnam, and a long running civil war (Chandler, 2007). In 1992, power was transferred to the United Nations Transitional Authority (UNTAC), which engaged in a period of nation-building (Chandler, 2007). For the past 18 years, Cambodia has been ruled by the same leader Hun Sen, and during the last decade, the country has experienced rapid development and growth. However, one fifth of Cambodians still live below the poverty line, and the World Bank estimates that a 'small shock' could double this number (World Bank, 2013). Cambodians are increasingly migrating to cities, and to neighbouring countries in search of work, thereby contributing to the separation of children from parents (Jordanwood, 2011).

How Many Children are in Out-of-Home Care in Cambodia?

There is very little data available regarding the number of Cambodia's children who do not live with their families. The national census enumerates by household, so that children who are not living in households are not included. Research conducted in limited target areas has suggested that significant populations of children out-of-home can be found sleeping in pagodas (Andrews, 2008; Hosea, 2004), working as child domestic workers (Brown, 2007; Nou *et al*, 2015), and working as child labourers in the construction industry, factories and agriculture (NIS, 2013). There is also a significant population of street-living children predominantly centred in Phnom Penh (Friends International, 2013). Traditionally, kinship care has been the preferred option for children not living with their parents and research suggests that most children not living with their birth

families live with relatives (Andrews, 2008). These informal arrangements are seldom registered with local authorities, in part because the laws that cover domestic adoption are complex.

There is no national programme of social services within Cambodia. Most programmes that offer support services to children who are living out-of-home are operated by NGOs. These include several residential programmes, including short-term shelters for street-living children and children who have been victims of crime (for example, trafficking). There is also a small but growing number of foster care programmes (Vuthy & Sophanna, 2006; Jordanwood, 2013). However, by far the largest formal support service for children living outside of home is long-term residential care.

Over the past decade, Cambodia has experienced a surge in the number of children placed in registered residential care centres. The Ministry of Social Affairs, Veterans and Youth (MoSVY) is the Ministry tasked with overseeing the welfare of children and maintains records of registered residential care centres. According to the Ministry's Alternative Care Database, in 2005 there were 153 registered residential care centres. A decade later, despite recent efforts by the Ministry to curb the expansion of residential care, there were 254 registered residential care centres, an increase of 66 percent in ten years (UNICEF, 2011).

However, this number is not believed to accurately represent the total number of residential care centres in Cambodia. Government policy calls for all residential care centres to be registered with the Ministry of Social Affairs, Veterans and Youth (MoSVY, 2006; MoSVY, 2008) but, according to preliminary results of mapping being conducted by the Ministry and UNICEF, most residential care centres fail to do so (MoSVY/UNICEF 2016). This research is ongoing, but early results identified 401 residential care facilities in five provinces alone, 267 of which were not registered with MoSVY (MoSVY/UNICEF 2016).

Increases in the number of residential care centres is occurring during a time in which the number of orphan children is decreasing (Holt, 2005; NOVCTF, 2008). The increase is due in part to a declining HIV infection rate and increased access to health care (NOVCTF, 2008). Holt (2005) surveyed 7,697 children in residential care and found only 2,869 were double orphans. Because most of these children have one living parent, these institutions are not referred to as "orphanages" in this chapter but are instead referred to as "residential care centres," a term more accurately describing their function.

What does Welfare Policy and Protection Mean for Cambodian Children and Young People in Care?

Until 2006, Cambodia lacked comprehensive policies to oversee the formal care provided to children by organisations. In 2006 the Ministry of Social Affairs, Veterans and Youth issued the Policy on Alternative Care for Children, followed by the Minimum Standards on Alternative Care for Children in 2008. These

documents stressed the necessity for residential care organisations to register with the Ministry and provided minimum standards of care that these organisations provided. However, the Ministry was understaffed, only conducted one Minimum Standards on Alternative Care for Children monitoring visit a year and did little more than advise on improvements to failing residential care centres (Consiglio & Pisey, 2014). This began to change in 2012 when the Ministry began closing residential care centres that failed to meet the Minimum Standards on Alternative Care for Children. Closure numbers are currently not published, but staff from organisations working closely with the Ministry, have explained that there have been 10-20 closures of residential care centres since 2012. The Ministry has only received the mandate to monitor unregistered residential care centres in the last year (Consiglio & Pisey, 2014, RGC, 2015). As a result, sub-standard and unregistered residential care centres continue to operate. At the same time, new residential care centres continue to open under the oversight of other ministries (Consiglio & Pisey, 2014).

Expansion of Residential Care in Cambodia

In 1997 the last remaining rebel groups joined the government, and shortly thereafter, the first study in decades of residential care was conducted (Daigle & Dybdal, 2001). This survey identified 130 registered and unregistered residential care centres in Cambodia. In 2005, the Ministry of Social Affairs, Veterans and Youth established the first government mechanism for enumerating and monitoring residential care centres – the Alternative Care Database – which is intended to record the total number of registered residential care centres in Cambodia. In 2005, the Alternative Care Database recorded 153 residential care centres (UNICEF 2011). By 2015 that number had risen to 269 (UNICEF 2011), and it became clear that Cambodia was experiencing a rapid expansion in residential care. Concerned about this increase, the Ministry and UNICEF commissioned the study referred to earlier, to identify what factors were fuelling this expansion, given that it was contrary to government policy articulated in the Policy on Alternative Care for Children and the Minimum Standards on Alternative Care for Children (Csaky, 2009).

This study (Jordanwood, 2011) identified a number of factors that were driving this sharp increase and argued that it is partially donor-driven. While many residential care centres are founded or operated by Cambodian nationals, few could continue to operate without international donations. The government operates 22 residential care centres, but these are predominantly funded by an international NGO. Funding comes largely from small groups such as overseas churches, service clubs and individual donors. For many donors, residential care is the first and only option they considered when deciding where to donate money to support children.

That study further explored the reasons why donors choose to fund residential care centres, finding that donors are motivated by altruism, the search for a new experience, and the assumption that local communities will not help

children. Many donors expressed the belief that the families of children are untrustworthy, and that if families are given funds they will not spend the money on children. An additional motivation noted by donors and funders in this report is the intent to convert children to Christianity. An estimated 39 percent (Jordanwood, 2011) of all registered residential care centres in Cambodia are operated by a single Christian organisation with a proselytising mission that is clearly articulated (FCOP, 2015). That organisation has repeatedly refused to take part in research studies. However, in interviews published online, the founder explains these residential care centres are part of a model for planting churches, and converting children to Christianity (Berkley Center, 2010).

Jordanwood (2011) notes that both the founding and the funding of residential care centres often occur with minimal assessment of needs, and usually occur prior to the identification of children. As a result, residential care centres are faced with the need to fill empty beds, and many have taken to recruiting poor children to their centres. In some cases, local authorities are first asked to identify poor families. Then residential care centre recruiters will visit these families, developing relationships to persuade them to place their children into residential care and education. Some recruiters offer families goods or services in return for placing their children in care.

Almost all residential care centres in Cambodia rely to some extent on overseas donors for funding. Jordanwood (2011) found that, as a result, residential care centres have begun to solicit funds through 'orphanage tourism', and this has been linked to several negative outcomes described below. When overseas visitors provide core funding, some residential care centres have intentionally maintained sub-standard conditions to encourage visitors to make donations. Other centres have required children to solicit funds through performing traditional dances for visitors, or by collecting money for the residential care centre in tourist areas.

Few questions are ever posed about how children in care suffer because of life disruptions through the high turnover of volunteer caregivers. Volunteers often visit residential care centres for several months, and by their own reports, develop strong bonds with children. They then leave, and the process is repeated, and few question whether the children suffer emotional loss. Few consider the extent to which children are placed at increased risk of abuse from visitors. Very few residential care centres in Cambodia hold child protection policies and volunteers are commonly given unrestricted access to children, without being subject to a background check (Hosea, 2001). As will be discussed later, there have been reports about the abuse of children by volunteers in these centres.

Why Do Cambodia's Children End Up in Residential Care?

A second factor driving the increase in numbers of residential care centres is the willingness of parents to place children in care. Within Cambodia, decision-making power usually lies with adults (Jordanwood, 2005; Gourley, 2010). Parents are often the family members who decide whether to place children in a residential

care centre (Emond, 2009; Jordanwood, 2011). As noted earlier, many children in residential care have one living parent, and many more have extended family (Holt, 2005), who would traditionally have been expected to care for orphans (Andrews, 2008). However, some choose instead to place them in residential care.

The most common reason families give for placing children into care is poverty (Daigle & Dybdal, 2001; Holt, 2005). Circumstances leading to poverty can include one parent leaving the family unit (often due to migration or divorce), a high level of debt, a catastrophic event (such as an illness), alcohol abuse or mental illness within the family (Jordanwood, 2011). In these cases, residential care centres act as a form of social service with education provision. Residential care also fulfils this role when it accepts children who have been raped or abused. Since Cambodia lacks a comprehensive, government social services network, local authorities often view residential care as the best option for helping struggling families.

Another commonly cited reason for placing children into residential care was to access education (Daigle & Dybdal, 2001; Emond, 2009; Holt, 2005; Jordanwood, 2011). Children are most likely to enter care at age 6, in time for primary school or at age 12 before the start of secondary school (Holt, 2005; Jordanwood, 2011). While primary education is free in principle in Cambodia, children are expected in practice to pay a variety of informal school fees. The Ministry of Education does not have sufficient funds to provide a living wage to teachers, and teachers cannot subsist without informal school fees (Bray, 2009). These fees are so central to the operation of the school, that the Cambodian education system has been dubbed a hybrid education system (Brehm *et al*, 2012). Faced with their inability to provide for these informal school fees, which may take up 26.5 percent of non-food spending among poorest households (World Bank, 2005), families choose to send their children to residential care to better access education.

Families also believe that residential care will offer their children opportunities they would not receive at home. Residential care is believed to provide an escape from a life of manual labour, to a career as a professional (Jordanwood, 2011) and is viewed as a path out of chronic poverty. Emond (2009) found that children in residential care described the centres as offering them education that would allow them to change future identities and to access a higher social status. It is important to note that families who place children in residential care often do so in the belief that it is in the best interests of the child. When describing the thought processes that lead to placement in residential care, many families expressed their love for their children, and explained that it was an extremely difficult decision to make (Jordanwood, 2011). Most families expressed the belief that they are placing the welfare of the child above their own need to live with the child (Jordanwood, 2011).

Conditions in Residential Care Centres

Qualitative studies suggest that conditions in residential care centres vary considerably throughout Cambodia. Outliers at one end of the scale provide a high level of material provision (one centre has a swimming pool), and at the other end of the scale provide an extremely inadequate level of material provision (one centre housed children in a chicken coop) (Jordanwood, 2011; CNN, 2013). However, it is not possible to quantify the number of residential care centres that provide for children's basic needs since there has been little quantitative research in this area, and the research that has been conducted has been limited in scope.

In 2001, a survey of alternative care service providers found that 97 percent of residential care centres provided food, 92 provided medical care and 94 percent provided education (Daigle & Dybdal, 2001). In 2005, a second survey found that 88 percent of children were described as developing within expected norms and most centres provided education (Holt, 2005). These results were obtained through surveys conducted with the staff of residential care centres, focusing on what staff said was provided, not what children reported receiving. Neither survey spoke with children living in residential care nor made attempts to validate information given by the staff through other means. It is possible, therefore, that the staff may have overestimated conditions within the centres. None of the above surveys measured the quantity or quality of services given. As a result, a residential care centre may have reported providing food, even though this food may have been insufficient to meet the needs of a child.

However, in 2012 a study was conducted in five countries including Cambodia, which assessed the physical and emotional growth and functioning of children in residential care (Whetten *et al*, 2009). This study compared orphaned or abandoned children living in residential care with similar children living with relatives receiving no external support. This study found that health, cognitive functioning and growth were no worse among children living in residential care. This study argues that residential care is not necessarily damaging to children. However, its findings compare children in residential care with children in the community receiving no external support, instead of children receiving support in family-based care with relatives. Furthermore, this study has limited applicability within Cambodia since most of the children in residential care in Cambodia are not abandoned or orphaned.

Several qualitative studies have presented findings that suggest that some children in residential care may not be receiving adequate food and nutrition (Hosea, 2001; Jordanwood, 2015) or adequate medical care (Boyle, 2009; Hosea, 2001). In addition, a recent study (Jordanwood, 2015) found that most children in residential care attend local government schools, and experience significant barriers accessing education because they do not receive additional funds to cover informal school fees. Taken together, the research presents a muddy picture of service provision in residential care. The existing research suggests that some children experience problems in accessing adequate food, medical care and education, but it

is unclear how widespread these problems are. MoSVY monitoring of registered residential care centres could provide outcome-based data on children's welfare if this data were to be published. It is an area that warrants further research.

A large body of international research suggests that placement of children and young people in residential care impacts children's cognitive and emotional development (Carter, 2005; Parker *et al,* 2005; Zeanah *et al*, 2005). While there are no studies dedicated to the emotional impact of placement in residential care within Cambodia, it has been briefly addressed in several studies (Emond, 2009; Hosea, 2001; Jordanwood, 2011; Project Sky, 2007). Many children and youths in these studies said that they suffered emotionally because of living separately from their families. Many explained that they missed their homes greatly when they first entered the centre and described crying frequently at night during their first months in residential care. Several children described how their connections to families decreased over time, since most children in residential care centres visit their parents only once or twice a year (Emond, 2009; Jordanwood, 2011; Project Sky, 2007). Children and youths also have trouble forming relationships with staff. The child-to-adult ratio in residential care centres is low during the day, but even lower at night. Staff members describe themselves as overworked and are aware that they are not able to meet the emotional needs of so many children (Hosea, 2001). Children note that staff members have favourites among children and that this is very difficult for those not included. Children also explained that they experienced difficulty when they form bonds with volunteers and staff who then leave (Jordanwood, 2011). Older children suffer from lack of personal freedom, regarding their ability to make choices about when they go out (Emond, 2009), clothing, friends and romantic relationships (Project Sky, 2007).

One area in which there is urgent need for research involves physical and sexual abuse in residential care. In the past decade there have been several high-profile cases of abuse in residential care reported in the press, documenting physical and sexual abuse of children in care by both local and international staff (Henderson & Soenthrith, 2013; Hunt, 2010; Henderson & Sokhean, 2015). Research has noted that few residential care centres have child protection policies in place (Hosea, 2001). Staff working in residential care and re-integration have also repeatedly noted that there is a high level of physical and sexual abuse of children by older youths in residential care. M'lup Russey, an organisation that responds to abuse in residential care, reported receiving 53 allegations of abuse in 2014. Further research is justified to ascertain how widespread this problem is.

Children and young people in residential care also describe themselves as lacking the life-skills necessary to live independently as adults and feeling afraid of people from outside the centre (Project Sky, 2007). Emond (2009) argued that chores completed by children *inside* the residential care centre, such as washing clothes, prevented skills-loss. However, in other studies, youths have described their inability to do simple daily tasks *outside* the centre with confidence (Jordanwood,

2011; Project Sky, 2007), to the point that some youths describe themselves as unable to talk to neighbours or to shop at a market (Project Sky, 2007).

At the same time, some children and young people are also aware of the benefits offered by residential care centres. While acknowledging the emotional cost, youths may go on to describe themselves as lucky because their placement in residential care allowed them to leave a life of rural poverty to be educated (Emond, 2009). Many children who have come to residential care from abusive families, explain that they prefer the peace and safety of residential care. In describing their experiences, children and young people often follow a complaint with a *caveat*, noting that without placement in care they would not have been able to attend school (Jordanwood, 2015; Project Sky, 2007).

Areas of Success

While some donors and funders of residential care centres argue that Cambodian families cannot be trusted to raise children because of the high levels of domestic violence and corruption, programmes supporting family-based care have demonstrated otherwise (Jordanwood, 2015). In many ways, the traditional social norms that promote the inclusion and acceptance of extended family, provide a good basis for inclusion of foster children (Gourley, 2010). Programmes supporting emergency short-term and longer-term foster care, while not without challenges, have had a relatively high rate of success (Vuthy & Sophannara, 2006; Project Sky, 2007). Programmes re-integrating children into families of origin have also shown mostly positive outcomes (Jordanwood, 2015). In the case of re-integration, three factors have been shown to promote positive outcomes: income generation programmes for family members; interventions to address domestic violence; and family follow-up for at least two years, depending on the circumstances of the family (Jordanwood, 2015).

What is the Future for Residential Care in Cambodia?

Residential care in Cambodia is in a period of dynamic change. The past decade has seen a rapid increase in the number of residential care centres, largely funded by overseas nationals who are coming to Cambodia in greater numbers every year (Ministry of Tourism, 2014). At the same time, Cambodia's economic gains are continuing to leave many poor families behind (World Bank, 2013). These two circumstances may combine in the future to create a funding stream for residential care centres as well as more children to fill these residential places. However, other factors may come into play. In the Policy on Alternative Care for Children (MoSVY, 2006) and the Minimum Standards on Alternative Care for Children (MoSVY, 2008), MoSVY has taken a strong stance supporting family-based care as the best option for vulnerable children. Until recently, MoSVY's monitoring efforts had lacked adequate enforcement mechanisms. In the future, if MoSVY is given both the funding to hire sufficient staff to monitor more regularly

and comprehensively, and a robust mandate that permits the closure of both registered and unregistered residential care centres that do not meet the Minimum Standards on Alternative Care for Children, then the number of residential care centres may begin to decrease. If Cambodia moves away from residential care centres as the dominant model of care for vulnerable children, it will face challenges in both prevention and reintegration. Prevention will require the government to ensure MoSVY is the sole Ministry tasked with overseeing the registration and monitoring of residential care centres. MoSVY in turn will need to expand programmes offering support, including educational support, to children living with families.

Re-integration will also present challenges. Recent programmes to re-integrate children from residential care centres have varied greatly in process, quality and time commitment (Rosas, 2012; Jordanwood, 2015; Zhou, 2014). Re-integration programmes must win the support of residential care staff and donors, trace and serve families in remote areas, and secure funding for long-term support of children in families (Jordanwood, 2015). Children who enter residential care centres often come from families that are chronically poor and/or dysfunctional. As a result, both children and families may require external support to ensure that the problems of the past do not re-emerge (Jordanwood, 2015). Within Cambodia there are successfully monitored and supported foster care models, which have provided family-based care options for children unable to return to their birth families. It is important that re-integration is seen as a process that continues well beyond the moment that a child is re-united with their family, and that both implementing agencies and donors commit to long-term support of re-integrated children and their families. There is the risk that, if large-scale poorly-planned re-integration of children from residential care centres occurs, children will be placed at further risk.

Questions for Small Group Discussion or Guided Reflection

1. Cambodia gained "*independence from France in 1953, endured a genocide in which over one million people died, an invasion by Vietnam and a long running civil war* … [and] *no national programme of social services*". What might this mean to Cambodian children today in need of shelter, care and protection?
2. "*The most common reason Cambodian families gave for placing children into care is poverty.*" To what extent does poverty shape out-of-home care placements where you live?
3. The author quoted research saying that "*significant populations of children out-of-home can be found sleeping in pagodas, working as child domestic workers and as child labourers in the construction industry, factories and agriculture* [and] *there is also a significant population of street-living children* [in the city]". What care do you think children like these deserve and why?

4. "*Cambodian families believe that residential care will offer their children opportunities* [and education] *they would not receive at home ... an escape from a life of manual labour, …* [and] *as a path out of chronic poverty".* How might such family views be addressed by advocates for de-institutionalization?

5. "*An estimated 39 percent of all registered residential care centres in Cambodia are operated by a single Christian organisation with a proselytizing mission that is clearly articulated*". How do you feel about missionary work such as this by Western Christians and what comparisons might be made with what happens in madrasa, across Islam?

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Institutional Care of Children and Young People in Malaysia: Searching for Direction

Faizah Haji Mas'ud[1]

Abstract

This chapter focuses on the institutional care of children and young people deemed 'at risk' according to current Malaysian law on child welfare: Malaysian Child Act (2001). Institutionalisation of children and young people in Malaysia dates from the social welfare development of the country during the British colonisation of the Malay States. With the development of universal social policies such as the United Nation Convention on the Rights of a Child (UNCRC), Malaysia observes and supports this policy and implements them according to local needs. Institutionalisation of children and young people remains the 'last preferred option' but, this option frequently offers the best solution for high-risk children. Challenges and issues of institutionalisation continue to confront Malaysian social services.

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Introduction

Children around the world are dependent on adults and how they wield their power and authority to influence the social and physical environments in which they live. Children are also subject to the impact of various economic, political, and social factors within influence of adults as parents, guardians or policy makers. The constructs of childhood and youth are defined according to the development of knowledge about 'them' within various fields of academic study (Aries, 1962). In Malaysia, to 'make sense' of the residential child care system, looked-after or substitute care for children – more commonly known as institutional child care in Malaysia – one needs to understand something of the history of the formal welfare system presently in place.

Like other Commonwealth countries around the world, British ideologies in the Malaya States provided a backdrop to the current Malaysian social welfare policy and contemporary Malaysian laws (Swettenham, 1984). British colonial policy was similar in all Commonwealth countries, which developed their colonies in line with British customary traditions (Vasil, 1980). The Malay States were not considered to have sufficiently advanced socio-economic and political structures, so that intervention was deemed necessary to fully benefit from the availability of local resources and trading activities (Roff, 1967).

The new state of the *Persekutuan Tanah Melayu* (Federated Malays) of Peninsular Malaya was an arbitrary amalgamation of states with little internal cohesion (Nah, 2006). The task of the new government was to develop, and address ongoing issues left behind by the British administration (McKie, 1963). The proclamation of Independence of Federation of the Malay States was on August 31, 1957 by the first Prime Minister, Tunku Abdul Rahman Putra Al Haj in Kuala Lumpur. The country of Malaysia as we now know it was formed in September 16, 1963, consisting of Federation of Malaya States (Peninsular Malaysia), Singapore, Sarawak and British North Borneo or Sabah from the Borneo Island (Purcell 1965; Ongkili 1985).

Malaysia and Child Welfare Policy

Laws relating to children and young people in Malaysia were inherited and further developed from the British Colonial Administration (Shaffie, 2006). Official intervention through the Juvenile Court (1947) and Children and Young Persons Act (1947), for example, were introduced to solve problems and maintain peace after the Japanese occupation of the Malay States (Ahmad, 1987; Fong, 1984; Bakar, Kaur & Ghazali, 1984; Purcell, 1948; Vasil, 1980; Zakaria, 1995). The Malay States under British administration imported substantial welfare models and systems from Great Britain. Given the local situation and the aftermath of World War II, the Malay States needed to develop policies to attend to the new social issues that had been recognised as problems for the British Empire. From this juncture, institutionalisation of children and young people were considered appropriate to

address various social issues during the British colonial administration in the Malay States and to safeguard the power of the British colonists.

Children are subject to multiple legal documents, either directly for them, or for those adults who would influence their lives. In Malaysia, two systems of laws govern the country. Under the Malaysia federal constitution, both civil law and *Syariah* law existed in West Malaysia, and customary laws in the States of Sabah and Sarawak. The history of a multi-layered jurisdiction and systems created significant factors influencing the welfare of children, including shaping contemporary residential child care policy and practices.

Changes in family and child welfare policy reflect the continuous influence of global and local forces on the formulation of Malaysian social policy. These drivers are manifested in the changing emphasis in the Malaysian national plans (Malaysia's Five Yearly National Plan). The focus of Malaysian national policy has moved from residual and social development approaches to economic driven approaches, with families and children becoming less visible in the country's development agenda.

Table 1
Malaysia Population Age Group 0 to 19 Years ('000)

Age Group	2000		Total	2006		Total	2013		Total	2014		Total
	M	F		M	F		M	F		M	F	
0-4	1347.6	1265.1	2612.7	1589.9	1490.5	3080.4	1297.1	1226.7	2523.8	1316.8	1230.8	2547.6
5-9	1365	1281.5	2646.5	1480.3	1395	2875.3	1306.2	1242.1	2548.3	1297	1229.5	2526.5
10-14	1276.3	1215.4	2491.7	1380.7	1295.5	2676.2	1369.4	1299.9	2669.3	1367.3	1296.9	2664.2
15-19	1195.8	1171.2	2367	1305.6	1250.2	2555.8	1414.2	1344.6	2758.8	1452.4	1369.8	2822.4
Total	5184.7	4933.2	10117.9	5756.5	5431.2	11187.7	5386.9	5113.3	10500.2	5433.5	5127	10560.5

(Adapted from Malaysia Welfare Department Report 2012, 2013 and 2014)

The Malaysian Child Act (2001) (MCA 2001) (Act 611) highlights one of the changes in government policy that has directly supported the goals of Malaysia's nation-building.

Table 2
Percentage of Malaysian Population of Age Group 0-19 Years

Year	Population ('000)	Age Group 0-19 ('000)	Percentage (%)
2000	23274.8	10117.9	43.47
2006	26640.2	11187.7	42
2013	29715	10500.2	35.34
2014	30261.8	10560.5	34.90

(Adapted from Malaysia Welfare Department Report 2012, 2013 and 2014)

In the 8th National Plan (2001-2005) (8MP), MCA 2001 mirrors the State's aspirations to uphold the best interests of the child and the significant role of the family in its development.

18.50 Efforts to ensure the survival, protection, rehabilitation and development of children were continued to ensure improvements in their quality of life. To provide better protection for the well being of children, the Juvenile Courts Act, 1947, the Women and Girls Protection Act, 1973 and the Child Protection Act, 1991, were reviewed and streamlined into the Child Act, 2000, which covers all children under the age of 18 years. This Act, while ensuring the best interests of the child, recognizes the role and responsibility of the family as the source (The 8MP, p. 516).

Malaysian social policy changed course in the early 1990s (Wan Ramli, 1993). As the State increased its engagement with international social policy, especially the Declaration of Universal Human Rights and the Convention on the Rights of the Child (CRC), the nation slowly began to pursue contemporary approaches to addressing social issues, especially involving children. In the late 1990s, there was growing awareness of the overwhelming social problems among children and youth groups throughout Malaysia. The ongoing reports of child abuse, neglect and delinquency (Muhamed Jawhar, 1995; Wan Ramli, 1993) without effective intervention frameworks or measures to overcome these problems required the government of Mahathir Mohammad to formulate a policy capable of controlling the rate and minimising the consequences of these occurrences (Muhammad Jawhar, 1995). This move also aligned with a long-standing international child welfare policy promoting the role of the State in protecting and securing the rights of children (Country Report Malaysia, 2003). Advocacy for this policy was driven by international bodies like UNICEF and the UNCRC.

We wish to move beyond comparative accounts of national care systems that concentrate on institutional description, available data on expenditure and numbers provided for. Rather, we seek to capture something normative and moral qualities of care systems: the degree to which citizens find them desirable, accessible, reliable and fair and trustworthy (Sipilia, Anttonen & Baldock, 2003, p.1).

Under MCA 2001, various training programmes and media campaigns were introduced with the central aim of strengthening the family unit (The 8MP, p. 50). The proposed legislation also shifted the focus from problem-solving to preventive interventions with the intention of maintaining family institutions and promoting a caring and loving community. However, this has not yet been identified as either fulfilling the needs of multi-cultural Malaysian society or as being merely a continuous reflection of international trends from a Western-dominated child welfare orientation. Institutionalisation of children continues to be the option that caters for children at risk for care, protection and rehabilitation.

RECOGNIZING the role and responsibility of the family in society, that they be afforded the necessary assistance to enable them to fully assume their responsibilities as the source of care, support, rehabilitation and development of children in society (Preliminary of MCA 2001).

During the Ninth Plan period, the thrust of youth development will emphasize empowering youths to enhance their role in society, fostering national unity and nation building (Government of Malaysia, 2006, p. 295)

According to Dr Nungsari in support of the MCA 2001 formulation (Bin Radhi, 1999),

"We think that the country has accomplished economic growth and fantastic development within the last 42 years. But when we sit back and think, before these 42 years, Malaysian, Malayans then, Federation of Malaya at that time were very simple people. Within these 42 years, if we consider a generation of 20 years, has such a huge change, its transformation is very rapid. Not many countries in this world and in the history of human development have undergone such a fast change in a short time period. Although it is a blessing and reflects our achievement, but we have to observe our support system to ensure the wellbeing of the people"

Understanding the history of colonialism and the melding of structural and personal influences of colonisation by the British is essential when looking at current Malaysia social policy (Rau & Sampathkumar, 2006).

Residential Child Care in Malaysia

Residential care in Malaysia remains an important and relevant option for accommodating children and young people in need of care, protection and rehabilitation if other options fail. Despite the global movement to abolish institutions for children, substitute care continues to be relevant in this current environment and 21st Century challenges. Malaysia's Children's Act of 2001 was amended in 2016 by strengthening support for UNCRC to protect children and attended to changes in the family dynamics of Malaysian families. These amendments addressed three issues, including de-institutionalisation, establishment of a database for child offenders, and a new community services order for offenders (children or parents) (Child (Amendment) Act, 2016). The amended Act redefines substitute care and re-interpreted the concept of children in need, at-risk, and 'offender' within the law. In January, the Sexual Offences Against Children Act (2017) was gazetted to address the new wave of sexual violence against children – whether physically, emotionally or virtually. Residential care remains a significant option as families face new challenges – economically, socially and politically. To support these recent legal changes for children, residential care will require further reinterpretation and re-structuring to ensure the enhanced welfare of children and families in Malaysia.

The 2016 amendment also included relatives and individuals as fit to care and protect children in need within the overall framework of place of safety centres. The role of NGOs and small centres are strengthened with a view to providing additional placement options for children in need. These changes are an addition to residential child care provided by established international and local NGOs, for example the Salvation Army, Rumah Bakti and other small home providers, whether ethnic or religious-based (Chong, 2013; Fulcher & Masud, 2001). In MCA 2001, children or young people – assessed as moderate to high risk, according to the Court for Children – will be relocated to a place of safety or refuge either temporarily or permanently (MCA, 2001). Due to the position of children as vulnerable citizens of Malaysia, they should be cared for and protected against any harm that may jeopardise their wellbeing and future. Currently, residential care comes in many forms and under various organisations. According to a study by Abd Rahman et al, (2013, p. 1) residential child care is arranged by the Malaysian Welfare Department under the provision of MCA 2001

> that a child, by reason of his physical, mental and emotional immaturity, needs special safeguards, care and assistance, after birth, to enable him to participate in and contribute positively towards attaining the ideals of a civil Malaysian society (Preamble of MCA, 2001)

Malaysian children are protected by various laws, but the delivery is yet to be proven effective and innovative for the contemporary environment (Raj & Raval, 2013). The most recent law for children was enacted in 2001. MCA 2001 was

constructed with the objective of focusing more on prevention than on problem-solving. With the enactment of UNCRC in 1981, Malaysia – as one signatory of this policy – moved in 1985 to incorporate the UNCRC principles into the country's welfare policy.

> The major role of a child welfare system in the 21st Century is to ensure the safety, permanency, care for children and youth whose families are not meeting these needs or protecting them (Mallon & Hess, 2005, p. 1).

Residential child care in Malaysia has played a significant role within a child welfare policy of the country since the beginning of colonisation (Fulcher & Masud, 2001). It has been the first option for the placement of children if parent(s) fail to deliver their duties of care according to the law. Even though Malaysia regained its independence nearly 60 years ago, the influence of residential care introduced by the British as the main replacement for parents and family is still applicable, with the limited development of 'stranger' foster care now common in the UK.

In MCA (2001), children and youth are placed in institutions from between 1 to 3 years or until they reach adulthood. Nonetheless, the children who are institutionalised are not usually 'normal' children but are children who are 'at risk', as in PART IX, Chapter 1 of MCA 2001:

> *54. Places of Safety*
> The Minister may, by notification in the *Gazette*, establish or appoint any place, institution or centre to be a place of safety for the care and protection of children. The Minister may at any time direct the closing of any place of safety established or appointed under subsection (1).

> *55. Places of Refuge*
> The Minister may, by notification in the Gazette, establish or appoint any place, institution or centre to be a place of refuge for the care and rehabilitation of children. The Minister may at any time direct the closing of any place of refuge established or appointed under subsection (1).

With MCA 2001 in place, and the new Sexual Offence Against Children Act (2017), the State sets a standard of protection and regulation of children. The rights of parents and guardians are explicitly reflected in the court procedure, unless they jeopardise the welfare of a child. The right to make decisions in a child's life are taken over by the MCA 2001 or the State only if a child is at risk and finally children and young people will be moved to an institution accordingly.

No or Low Risk: Parents will have their child returned to them and retain their rights as parents. However, a court may order parents or guardians to be supervised by a protector,

> (a) order his parent or guardian to execute a bond to exercise proper care and guardianship for a period specified by the Court For Children; (Sect. 30 [1](a) of MCA 2001)

Low to Moderate Risk: Each case will be placed under the supervision of welfare officers. A child is returned to the family, but the Court for Children will ensure the family is accountable to avoid another incident of abuse or neglect in the child's life. Interactive Workshops were established, and the execution of a bond was designed to assign more responsibility to parents and families regarding a child's wellbeing. In both orders of the Court, parents are liable for the child's wellbeing and responsible for a child's 'good behaviour' in the case of juvenile delinquency. Family is still considered the medium in which to regulate and control children's behaviour and to ensure peace and harmony.

> Section 40 [3](c) makes an order requiring the parent or guardian of the child to execute a bond, with or without sureties, as the court for children may determine, for such period not exceeding three years from the date of the order subject to such conditions as the court thinks fit for the proper care and guardianship of the child;

Moderate to High Risk: The Court for children will make a definite decision in the best interest of the child within the jurisdiction assigned under MCA 2001 to care and protect a child in at-risk circumstances. This may result in children being taken away from families and placed in institutional care. For example, as stated in Section 37(4)(b), 'the child may:

> be placed in a place of safety or in the custody of a relative or other fit and proper person on such terms and conditions as the Protector may require until the child attains the age of eighteen years or for any shorter period.

> Section 42[7] and [8]

> (7) If after considering the report submitted under subsection (6) the Court For Children is satisfied that a child brought before it is in need of protection and rehabilitation, the Court may –

> (a) order the child to be detained in a place of refuge for such period not exceeding three years from the date of the order as the court may in the best interests of the child deem fit; or

(b) make an order placing the child under the supervision of a Social Welfare Officer appointment by the Court for such period not exceeding three years from the date of the order as he Court may in the interest of such child deem fit.

(8) The order made under subsection (7) may have the effect of extending the period of such detention or supervision, as the case may be, beyond the date on which the child attains the age of eighteen years.

With enactment of MCA 2001, the admission of children and young people to residential institutions slowly began to decrease according to different provisions of the MCA (2001). Most children come into residential institutions under care and protection provisions. For the State as "parents", this is still considered the best option for child care, protection, and rehabilitation. Currently with the changes or age of a child in MCA 2001, the residential child care centres have received a different intake of children. In MCA (2001), substitute care is 'commonly' referred to institutions under PART IX of MCA (2001, p. 62-73). These institutions follow the order by the Court for Children. Places of Safety Centre and Places of Refuge are:

a.　Places of Detention;
b.　Probation Hostels;
c.　Approved Schools;
d.　Henry Gurney Schools – catering for juvenile criminals.

To deliver the above MCA (2001) provisions, the Welfare Department of Malaysia, currently operates three general categories of residential care. The Welfare Department, under Malaysia's Ministry of Women and Community Development, oversees the provision of Places of Safety Regulations (2004) to complement the enactment of MCA 2001. The place of safety and refuge to support the Act will be different according to the types of services: care and protection or rehabilitation.

Types of Children's Services[2]

Types of institutions and out of home care have changed considerably with the enactment of MCA 2001 and reducing the age for maintaining a child in care from 21 years to 18 years, in parallel with UN Convention on the Rights of a Child. Most institutions are located in every Malaysian State throughout Peninsular Malaysia, as well as Sabah and Sarawak in the east.

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[2] Retrieved from http://www.jkm.gov.my/content.php? pagename=jenis-jenis_perkhidmatan_kanak-kanak&lang=en

1. Protection

Institutional Services
- Rumah Kanak Kanak (Children's Home – 13 homes)
- *Taman Sinar Harapan* (Home for Disabled Children – 7 homes)
- Special Protection Centre (Children)
- Rumah Perlindungan Ehsan (Shelter for Street Children) Kota Kinabalu (1)

External Services
- Foster Care
- Child Protection Team (PPKK) and Children Activities Centre (PAKK)
- Witness Service Programme

2. Rehabilitation

Institutional Services
- Sekolah Tunas Bakti (Approved School – 9 schools)
- Taman Seri Puteri (Rehabilitation Centre for Young Girls – 4 institutions)
- Probation Hostel (Temporary place for children at-risk of beyond control, delinquent and crime related behaviour)
- Henry Gurney Schools (catering for juvenile criminals – 5 institutions)

External Services
- Children Welfare Committee
- Service for Abandoned Children

3. Development
- Children's Institutions – Sports Championship
- Children's Institutions – Band Competition
- Vocational Skills Training
- Children's Education
- Human Capital Development
- TASKA 1Malaysia

Table 3
Number of Children

Institution	2012			2013			2014		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Children's Home	580	713	**1293**	534	617	**1151**	535	644	**1179**
Taman Seri Puteri	0	175	**175**	0	194	**194**	0	158	**158**
Taman Sinar Harapan	325	351	**676**	294	332	**626**	284	323	**607**
Asrama Akhlak	126	80	**206**	119	64	**183**	117	60	**177**
Sekolah Tunas Bakti	926	289	**1218**	806	304	**1110**	788	314	**1102**

According to the Malaysia Welfare Department annual reports from 2012 to 2014, there are no specific trends in the number of children placed in these four important types of institutional care or the place of safety. However, there was a reduced number of placements for young girls in Taman Seri Puteri, consistent with the age of children in State care being reduced to 18 years. The data also shows that there was a slight increase in the number of older girls placed in approved schools during this same period.

Challenges and Issues

In recent years, child welfare policy in Malaysia has shifted from an earlier focus on child care and the protection of family rights, to a focus on child rights (Axford, 2009). Traditional concepts previously used in the policy and programme of the State were replaced with a universal language that is acceptable in the new, contemporary discourses in child welfare policy. A range of approaches to childhood and family protection in social policy and practice globally is included to support the State's agenda (Fortin, 2003). These approaches evolved around individualistic, remedial, and discriminatory strategies which concentrate on the realm of family-centred, child-centred and community-based practices and policies (Bowes, 2004). However, institutionalisation of vulnerable and at-risk children is still relevant to support the objective of nation-building and continues to be considered very pertinent for socio-cultural and political stability.

Advantages and disadvantages associated with institutionalisation of children and young people remain an ongoing discourse in Malaysia, as with elsewhere. Since the beginning of de-institutionalisation in the 1960s and 1970s in America and Britain, the notions of confinement and isolation have been critically questioned,

especially around the benefits and long-term impact on the wellbeing of children and young people, along with the effects on the country's development. The question now is whether institutions are a good option or whether there are other alternatives that will better ensure that the well-being of children and young people is fully restored.

A review of research outcomes on residential child and youth care published by Science Direct from 1990 to 2005 shows a "promising" result with institutional care of children if behaviour-therapeutic methods and focus include family involvement and are applied in residential programmes (Knorth *et al*, 2008, p. 1). Nonetheless, there is little research showing the positive effects on children after long-term institutionalisation. However, several studies in Malaysia have shown the long-term 'negative' effects of institutionalisation on children, in terms of behavioural, psychological, social and mental development (Abd Rahman *et al,* 2013; Chong, 2013; Raj & Raval, 2013).

The outcomes of institutionalisation vary according to various factors that influence the individual and his or her environment. Children and young people who are placed in these facilities come from environments deemed at-risk and need a receiving environment that will provide for their needs accordingly (Knorth *et al*, 2008). Receiving institutions will have to better cater for and attend to the individual's needs and create individual plans for every child that enters these facilities. Positive environments relating to infrastructure, staff skills and effective programming must be in place to ensure that children can develop and achieve their full potential. Failing to address these issues and attend to the living environment according to the child's needs are likely to result in further issues and challenges for the child and their future undertakings. Given the development of social services across Malaysia, these factors may not be fully implemented in residential child and youth care (Abd Rahman *et al*, 2013; Chong, 2013; Raj & Raval, 2013).

With the global focus on de-institutionalisation and the universal policy on the rights of children, ensuring the effectiveness of services for children and youth is still a challenging task. Malaysia is still working to shape and construct its own way of working with children and young people in need of care, or the 1 Malaysia's way. Nonetheless, places of safety for these two vulnerable groups (children and young people) will continue to be part of a necessary safety net to provide short and long-term refuge for children and young people in need. Ongoing social and physical challenges in Malaysia will continue to influence the lives of children in Malaysia despite the national aspiration to be a developed nation by 2020.

Questions for Small Group Discussion or Guided Reflection

1. What do you think it means for daily practice with Malaysian children and young people that, "*laws providing for the care and protection of children and young people in Malaysia were developed and inherited from the British Colonial Administration*"?

2. *Civil Law, Shariah Law and Customary Law all feature in the care and protection of children and young people in Malaysia.* How do you think this might impact on daily practices in residential child and youth care centres?

3. Despite the global movement to abolish institutionalisation of children, what explanations might be offered for why substitute care remains relevant and continues to be relevant in Malaysia and the challenges children, young people and families face there in the 21st Century?

4. When a Malaysian child or young person is assessed to be "moderate to high risk" of abuse, the law says that young person can "*be placed in a place of safety or in the custody of a relative or other fit and proper person on such terms and conditions as the Protector may require until the child attains the age of eighteen years or for any shorter period*". How does this compare with child welfare laws where you live and work, and how might you 'use' this legal clause to support a young person living rough?

5. *The institutionalisation of vulnerable and at-risk children is still relevant to support the objective of nation-building in Malaysia, very pertinent for socio-cultural and political stability.* To what extent are *nation-building* or *socio-cultural and political stability* offered as justifications for the institutional care of children and young people where you live?

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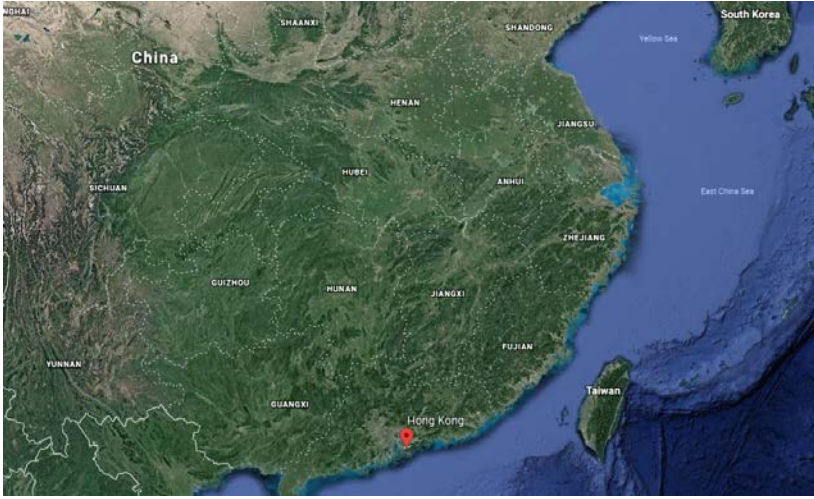
Residential Child Care Services in Hong Kong: Review and Reflection

Mooly Wong Mei-Ching[1]

Abstract

Residential child care is one of the longest-running social services in Hong Kong, first launched in the mid-1800s and in receipt of government subsidies since the mid-1960s. An overview of these services is offered, including the historical development, nature and operation of the services, a users' profile as well as service utilization. At the end of the chapter, the effectiveness of the services will be discussed, and will conclude with the author's thoughts on future directions.

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Introduction – Historical Background

Services were launched in Hong Kong with the purposes of ensuring the safety of, and shelter for homeless or abandoned children and babies, and for young women who would otherwise have been sold as prostitutes or "mui ja" maid servants (Ting, 1997). Social conditions changed in the post-war years, as there were an increasing number of destitute people arriving in Hong Kong. It followed that the number of children's homes increased from 15 in 1950 to 29 in 1954, caring for about 2000 under-privileged children (Working Group on Development of Residential Child Care Services, 1987). From that time onwards, the profile of children in care was different from that of previous times. In the 1950s, one-third of these children had a home of their own and the children had been sent to the residential homes by their parents, partly due to poverty and poor family planning that prevented parents from raising them properly, and partly due to the educational opportunities provided by the residential homes (Hailuete, 1966). However, the involvement of families was low, and contact between children and their families outside the homes was rare (Ting, 1997). The proportion of orphans dropped gradually in the 1960s, with improved social conditions and welfare provisions, together with wider knowledge of family planning (Tam & Ho, 1993).

Currently, most children placed in these services in Hong Kong do have families. Research findings (Hong Kong Family Welfare Society & Lam, 1992; Tam & Ho, 1993) and official statistics (Social Welfare Department, n.d.a) provide this evidence. For example, from 2009 to 2010, the three most common reasons for parents/caregivers requesting placement were inadequate parenting (28.92%), child abuse (12.81%) and parent's mental health problems (10.8%), implying that those children admitted to care had experienced negative family issues (Social Welfare Department, n.d.a). Furthermore, most children living in care facilities maintained close connections with their family members through visitations and home leave.

Local government places strong emphasis on the family's responsibility for child care, as reflected in various social welfare policy papers (Hong Kong Government, 1965; 1973; 1979; 1991; Working Group on Development of Residential Child Care Services, 1987). For instance, in a White Paper in 1965, the purpose of the child care service was "to help families to remain intact as strong natural units and to care for (and not to abandon) their children and handicapped or aged members … The constant endeavour should be relied on to the maximum extent on the natural family unit to strengthen and help the family to cope with its members rather than removing them to institutional care (Hong Kong Government, 1965: p. 10). In another White Paper in 1991, the government re-affirmed the role of family in child care and stated that its role was "to support and strengthen families so that they may provide a suitable environment for the physical, emotional and social development of their children, and to provide assistance to those disadvantaged and vulnerable children who are not adequately looked after by the families" (Hong Kong Government, 1991: p. 22). Hence, placing children in institutions was the last resort.

At present, the purpose of the services is "… for children and young persons under the age of 21 who cannot be adequately cared for by their families because of various reasons such as behavioural, emotional or relationship problems, or family crisis arising from illness, death and desertion" (Social Welfare Department, 2015a, para.1). The goal of these services is to provide alternative care for children so that "they [children] can continue to enjoy family life until they can re-unite with their families, join an adoptive family or live independently" (Social Welfare Department, 2015b, para.1). Thus, residential child care services are only temporary shelters for children whose families are in crisis.

Nature of the Services

Since the late 1980s, local government has advocated the adoption of family-like settings, including foster care and small group homes, as alternatives to institutional care. A policy paper stated clearly that "a family setting meets the needs of a child in care better than in an institutional setting and particularly so for younger children" and "in an institutional setting, smaller residential units are preferable to larger ones" (Working Group on Development of Residential Child Care Services, 1987: pp. 14-15). Since then, the number of placements in foster care homes and small group homes has increased, out-numbering placements in conventional institutional settings like children's homes, boys'/girls' hostels, and boys'/girls' homes with or without a school on site (Table 1). The rationale for this change is to improve the quality of care to children by reducing the ratio of children or young people to care staff, making it possible for more of a relational approach to care working. Unlike the institutions that are often located in remote areas, foster care homes and small group homes are in city areas where it is possible to minimise the social isolation of children. Hence, the shift from institutional care to community-based care preferences since the late 1980s (Shek & Lam, 2004).

Foster care services were started in 1972 and provide family care for children under age 18 (Social Welfare Department, 2015a; Ting, 1997). Foster parents should preferably be 25 years-old or older and have at least a primary level of education (Social Welfare Department, 2015a). There were 1020 placements in foster care in 2012-2013, or roughly a third of all placements (Table 1) and the Social Welfare Department is the largest residential child care service in Hong Kong.

Table 1
Summary of Type, Number and Enrolment Rate of Placements in Residential Child Care Services in Hong Kong (2012-13)

Type of Service	Age	Gender	Mode of Services	School Placement	No. of Centres	No. of Places	Average Enrolment
Foster Care	0-18	Both	Substitute family care	In the community	Not applicable	**1070**	87.8%
Small Group Home	4-18	Both	Substitute care in family-like environment	In the community	108	**864**	93.4%
Children's Home	6 – under 21	Both	Small group living units with structured home routines	In the community	5	**407**	90.4%
Boys'/ Girls' Home with School for Social Development on Site	7 – 18	Boys	Small group living to enhance individual treatment	School for Social Development on site	4	**457**	88.7%
		Girls			2	**200**	84.3%
Boys'/ Girls' Home without School on site	11 – under 21	Boys	Small group living	In the community	3	**201**	76%
	12 – under 21	Girls			1	**30**	83.1%
Girls' Hostel	14 – under 21	Girls	Small group living with minimal structured routine	In the community	3	**77**	83%
Boys' Hostel	15 – under 21	Boys	Small group living with minimal structured routine	In the community	1	**18**	79.5%
Total Number of Places						**3,324**	

Sources: Social Welfare Department, n.d.b

The first two small group home units started operating in 1975 and served children from age 4 to 18 years. Nowadays, up to eight children are placed in a group home and cared for by one member of the couple employed as houseparents, usually the female member (Social Welfare Department, 2015b; Ting, 1997). Houseparents are expected to have at least a secondary level of education and a social worker supervises 3 homes, with a total of 24 children. By 2012-13 this number had grown to 864 placements, representing 26% of all residential child care placements (Table 1). Currently, it is the second largest residential child care service in Hong Kong.

Other types of placements represent around 42% of all residential child care placements in 2012-13 (Table 1). These are institutional settings and have more structured routines and programmes than the smaller group homes. Although the total number of residents is more than those in small group homes, the residents are divided into small group living units so that individual contact, attention and treatment can be increased, and children can develop closer relationships with staff. Apart from those boys' and girls' homes that have a school on site – in which schools are subsidised by the Education Bureau – all children who live in other types of placement attend schools in the community.

Operation of the Services

Since 2003, all residential child care services have been operated by non-government organisations (NGOs) in Hong Kong, but financially supported by the local government. Indeed, the importance of non-government organisations as the key service providers of child welfare services for disadvantaged groups had already been confirmed by the local government as early as in the first White Paper in 1965 (Shek & Lam, 2004; Ting, 1997). In the second White Paper in 1973 (Hong Kong Government, 1973), the government improved service standards by increasing its financial support to NGOs and providing increased staff training opportunities (Ting, 1997). The role of the NGOs became even more significant when entering the 21st century. For example, foster care services that used to be operated by the government have now been transferred to the NGOs; the last residential child care unit that was originally run by the government was closed in 2003 and its resources were transferred to NGOs (Ip, 1997).

The arrangement of the services is either formal or informal. Formal services happen following a child protection intervention, either by voluntary agreement or by a care-and-protection court order, e.g. the Protection of Children and Juvenile Ordinances (Chow, 2011; Irving & Hewitt, 2011). Informal services are arranged without the intervention of statutory authorities or the court. The operation of the services is based on the procedures in the Central Referral System of Residential Child Care Service (CRSRCCS) [2] manual, which has been used in Hong Kong since 1995 (Social Welfare Department, 1998). When a child is in need of a residential child care placement, a referring worker, which may include social workers from various social services settings such as the family social service, the youth outreach service, school social work services and children and youth services; psychologists; counsellors; student guidance officers and student guidance teachers; and social workers from the unmarried pregnant girls' service, will make a referral to the Central Referral System of Residential Child Care Service. The referring worker, on behalf of the child's primary caregiver or guidance, will indicate the choices of placement in the referral. If a suitable placement is found, the Central Referral System of Residential Child Care Service will send the referral to the residential unit directly. A social worker of a residential child care unit will arrange an intake interview for the child and the primary caregiver, and then report to Central Referral System of Residential Child Care Service whether the child has been admitted or not after intake. If a suitable placement cannot be found for a child due to a lack of availability of the choices of the placement, the child's name will be put on a waiting list. The child's situation will be reviewed after 3 months.

When a child is placed in a residential child care unit, the case is shared between a referring unit and a residential child care unit. There is a clear division

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[2] Central Referral System of Residential Child Care Service was established in 1995 and was operated by the local government. Its functions included streamlining referral procedures, maximizing the use of available placement resources, identifying and establishing service demand, and providing systematic information on planning and development in Hong Kong (Social Welfare Department, 1998).

of labour between workers of these two units. One of the responsibilities of the referring workers is "to continue working with the child and the child's family while the child is in placement, remaining in close touch with the child and providing necessary resources to the child and the family" (Social Welfare Department, 1998: p. 17) and the social workers in the residential units are "to provide opportunities for the child to establish positive relationships, to develop potential and to meet developmental needs" (Social Welfare Department, 1998: p. 19). In other words, the role of the referring workers is to focus on the family, and the responsibility of the residential child care social workers is to facilitate the children's development when children are staying in the care facility.

A residential child care social worker, together with a referring worker and the child's primary caregiver, will formulate a permanency plan for the child after the admission. "Permanency planning refers to the systematic process of carrying out, within a specific time-frame, a set of goal-directed activities designed to maintain children in their own homes or live in a stable and home-like environment that offers continuity of relationships with nurturing parents or carers as well as providing the opportunity to meet developmental needs and establish life-time relationships" (Social Welfare Department, 1998: p.2). The goal of the plan serves "the child's best interests and long-term needs, including the needs for belonging, stability and continuity of care" (Social Welfare Department, 1998: p. 2). The plan will be reviewed once in six months in a case review meeting with the purpose of monitoring the case development, reviewing the child's placement needs as well as aiding the child and the child's family towards the achievement of the welfare plan.

Children and Families' Profile

Most children's admissions to the services are due to family issues. A local study in 1993 found that 97.8% of the cases had been admitted to the services due to a lack of parental supervision (65.2%), family breakdown due to death, separation and divorce (53.8%), lack of economic resources (40.3%), lack of parental control (37.6%) and marital conflict (36.4%) (Tam & Ho, 1993). Similar reasons for admission were still found recently. As mentioned earlier, the official statistics from 2009 to 2010 revealed that the top three circumstances for children's parents/ caregivers requesting placement related to parents' parenting abilities or mental health (Social Welfare Department, n.d.c).

Many families faced multiple problems before the placement. Tam and Ho's (1993) study showed that of 833 cases (full population at that time) in the residential child care services, almost half (47.5%) of the children were from single-parent households, resulting from divorce (13.7%), desertion (12.0%), death (11.4%) or separation (10.4%). Less than one-third (31.3%) had parents who were married, and a sizeable proportion (21.1%) had parents who had never been married. Apart from those issues, the majority of the families are financially disadvantaged in society. A study by the Hong Kong Family Welfare Society and Lam (1992) showed that 62.2% of the families had monthly incomes ranging from $3000 to $3999,

which was barely one-third of the median monthly domestic household income at the time[3]. Other studies also found that 35.7% of the families were living on welfare. Over half (59.1%) of the children and 18.3% of the parents were living in public housing and partitioned flats respectively (Hong Kong Family Welfare Society, Hui & Wong, 2002).

Some children in care have additional special problems. A study revealed that 21.4% of fostered children had borderline intelligence (Hong Kong Family Welfare Society & Lam, 1992). There was also a prevalence of behavioral problems (e.g. bed-wetting, nervous habits, stealing), physical problems (e.g. physical handicap), school-related problems (e.g. mental retardation, poor attention, antagonism to teachers), and peer-related problems (e.g. violent/ aggressive behaviour, withdrawn behaviour) among children in care (Tam & Ho, 1992). A recent study also showed that nearly 40% of children had special needs, including physical, psychological and learning problems. Meanwhile, between 15% to 32% of children experienced different types of maltreatment before placement in care facilities (Hong Kong Council of Social Services, 2017). Together with the multiple problems in families, many parents are so overburdened that they are unable to offer sufficient support to their children.

Service Utilization

As of December 2016, there were 575 children who were on the waiting list for placements (Hong Kong Council of Social Services, 2017). The average waiting time ranged from 1.4 to 5.4 months in 2015-16, depending on the types of placement (Legislative Council House Committee and Subcommittee – The Subcommittee of Children's Right, 2017). Furthermore, the average length of stay for children ranged from 2.2 months to 47.8 months. Among these children, adolescents had a longer residency period than younger children (Labour and Welfare Bureau, n.d.). Local studies have shown that some children resided in care facilities for 5 years or more (Hong Kong Family Welfare Society et al, 2002; Wong 2014), contrary to the temporary nature of the service.

Children were discharged from care facilities through being reunited with family, admitted to other types of residential care services, because they were adopted or were living independently (Labour and Welfare Bureau, n.d). From 2011 to 2014, just over half of children placed in care (55 %) were reunited with their families. Thirty-four percent were admitted to other residential care placements, 10% were adopted and 0.3% were living independently (Labour and Welfare Bureau, n.d.). Little is known about long-term outcomes for care leavers in Hong Kong. One longitudinal and qualitative study indicated that most children had a stable family life after family reunification (Wong, 2014) but this study only followed

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[3] The median monthly domestic household income was $9,964 in 1991 (Census and Statistics Department, 2002).

up the children for 5 months which might not be long enough to examine the situation fully. Questions such as: "How many children re-entered the care system and what did long-term psychosocial development look like for these children?" remains unclear.

Effectiveness of the Services

Two local studies in 1993 and 2002 (Hong Kong Family Welfare Society *et al*, 2002; Tam & Ho 1993) revealed a high percentage of parents who felt satisfied with the services. The first 2002 study found that 92.9% of birth parents considered that the service was very much needed at that time. Some (78.6%) even commented that the quality of care offered by the foster families was even better than what they themselves could provide. They found that their children were well-treated and had progressive development. Tam and Ho (1993) further categorised the areas of satisfaction from parents in aspects of the child's daily care (e.g. child's diet and study); residential staff (e.g. staff were patient, kind and helpful); outcome of placement (e.g. the positive changes in the children's behaviour); and children's moral development (e.g. staff were more capable of teaching children and taking appropriate disciplinary actions for misbehaviour). 80.3% of parents were satisfied or very satisfied with the services.

Nevertheless, a recent longitudinal and qualitative study (Wong, 2014; 2016a) found that even though the caregivers considered that the services were helpful, they had a strong sense of inferiority when performing their roles as parent/caregiver. This perception was formed by their experiences with social services, their children's care experience, and the negotiations around their child's discharge. Many caregivers felt they had received much bias and discrimination from the helping professions due to their failure in parenting. As a result, parents were still struggling with parenting when their children returned home, which might well negatively impact the parent-child relationship in the long run.

Although children are the main service users, we have a lack of study to reveal their voices. A local mixed-methods study revealed that the outcomes of most of the children and adolescents who lived in small group homes were positive. Specifically, they reported that, when compared with local secondary students, the children who had been in care demonstrated the same self-esteem scores, lower peer problems scores and high pro-social behaviour scores (e.g. ability to observe rules and regulations, be friendly to the others, and be helpful) (Hong Kong Sheng Kung Hui St. Christopher's Home, & Center on Behavioral Health, the University of Hong Kong, 2005). The report concluded that there was evidence to support the existence of resilience among the children and adolescents even though they faced a variety of major adversities in life, and most of these adversities were in relation to family. The group care did have a positive impact on fostering resilience among the adolescents. As all the children in the group home had experienced similar adversities that could normalise their own difficulties and problems. Moreover, group life could foster pro-social behaviour under the close care and

supervision of houseparents and social workers. In return, they gained greater social support from these adults and other children – thereby enhancing their self-esteem.

Undeniably, many children have received good quality of care when they resided in these care facilities. Notwithstanding, children's experience in the process of care (from admission to discharge) is still relatively unknown. Wong (2014; 2016b) explored the children's subjective experiences in pre-placement, placement and post-placement period. The study indicated that many children had experienced a period of stabilisation, i.e. from chaos to organisation. Children had a strong sense of powerlessness in admission, their daily lives during care and the negotiations around their discharge. When they returned home, they regained a sense of autonomy even though they were still facing many challenges in family and personal growth. The study found that the residential child care services tended to be focused on behavioural management and lacked some developmental perspective. For instance, some rules were not age-appropriate. Moreover, many children had strong bonds with their families, but the services did not help much to re-establish the attachment between children and their parents.

Discussion

Residential child care services have been established for more than 100 years in Hong Kong. The government takes on the role of providing service direction and financial support. However, Hong Kong society has undergone tremendous changes in the past decades, leading to changing needs of these disadvantaged children and their families. Nowadays, the service implementation is still based on a policy paper issued before the early 1990s, on reports formulated in the late 1980s, and with a referral system operating since 1995. It is necessary to have further development and advancement of the services, specifically in developing service initiatives, enhancing family work and establishing a record-keeping system.

Development of Service Initiatives

Service development in past decades has focused mainly on resource allocation such as increasing the numbers of placements in small group homes and girls' homes with education (Legislative Council House Committee and Subcommittee – The Subcommittee of Children's Right, 2017). As revealed by some recent empirical studies, the issues faced by children and their families were getting more complicated. Together with the tendency towards decreasing numbers of foster care families, it is essential to develop new types of placement that are more directly relevant to the current situations presenting in Hong Kong society.

In countries such as the United Kingdom, the United States and Australia, out-of-home care services are seemingly more tailor-made and specialized, with treatment foster care for children suffering severe mental, behavioural and emotional issues. Treatment foster care programs provide intensive, foster family-

based, individualized services to children, adolescents, and their families as an alternative to more restrictive residential placement options. Research outcomes indicate that treatment foster care, when compared with residential treatment services, is less expensive, is able to place more children in less restrictive settings at discharge and produces greater behavioural improvements in the children served. This service has developed in response to the limitations in traditional foster care services and in a lack of family-based mental health services for children who are unable to live with their families (Meadowcroft, Thomlison & Chamberlain, 1994). In our case, the growing number of children with special needs inform us that the current services are insufficient to render relevant support to children and their families. Many foster parents lack sufficient training and support to cope with the challenging behaviours of high-demand fostered children.

Kinship care is another important development in residential child care services in many countries. In places such as Australia, kinship care placements out-number non-kinship foster care placements in recent decades. Research evidence supports the advantages of kinship care (Kang, 2007) since children in kinship care continue their relationships with kin networks and maintain their familial and cultural heritage. Kinship care also helps to ensure the commitment and the continuity of care from caregivers to children and can eventually contribute to improved children's well-being outcomes (Kang, 2007). The nature of kinship care is culturally relevant in Hong Kong as Chinese people place great emphasis on family ties and obligations. The current variety of placements available in Hong Kong have largely existed for many decades, even though they may not have responded adequately to the needs of Hong Kong children and their families. While it is too early to conclude that these two types of placements are applicable for the local context, it is important to learn of service experiences from other places and perhaps re-think the service model.

Enhancement of Family Work

As discussed, many children who reside in care facilities do have families, and the local government emphasises that the services are only a temporarily measure. Hence, family reunification is the top option for the children. Nevertheless, as mentioned above, children have resided in care facilities for quite long periods of time and family reunification rates are not high. Even though children return home, they still face multiple family problems (Wong, 2014; 2016a). This may be partly due to inadequate family work offered by the service.

Starting in 1995, Hong Kong's social welfare reform changed the social services to become management-oriented (Leung, 2002). The workload of the social services units has been increased to maximise their performance in the free market. For instance, one of the units collaborating with residential child care services is Integrated Family Services. The workload of the social workers has been increased to such a level that they are unable to provide intensive family counselling services to the families. Fortunately, some residential child care services agencies

have launched family-oriented projects to strength family work for children in care (Tsang, Chan, Ng & Luk, 2016; Wong, Ma & Chan, 2015; 2017). Although the outcomes of the projects were positive and encouraging, they are very often short-term and limited in scale. The increasing demands on the residential child care services due to the changing needs of society make it extremely difficult for the agencies to develop more wide-ranging services to accommodate the needs of families. Ultimately, priorities and choices are still given to conventional residential child care service responsibility that focus on children only. Without addressing family needs directly, the effectiveness of residential child care services is likely to be undermined.

Establishing an Information System Database

For the development of policies and services for children in care in Hong Kong, it is necessary to establish a reliable and a sustainable database to have better informed decisions, plan targeted interventions that address the special needs of these children, and sustain their development through to healthy and strong adulthood (Wong, 2017). In countries like the United Kingdom and the United States, strong, comprehensive and accessible systems for providing information regarding children in out-of-home care are already operational (Gov.UK, 2017; U.S. Department of Health and Human Services – Children's Bureau, 2017). Other places, such as Australia, have also reported relevant data on children in care regularly (Commonwealth of Australia, 2015). Such a database would enable the recording of general information such as the number of looked-after children, data on placements, and legal status, but also a more detailed analysis of out-of-home care services for different children and families. Although we have data collection mechanisms for residential child care services, it is criticized that the data is limited in scope, incomplete, unsustainable, inaccessible, and uncoordinated, and the data collection process is uninformative (Wong, 2017). For instance, there is missing data for children during their period of residency (e.g. number of sibling placements; number of different types of disabilities of children in care; number of children with special needs etc.) and post-care outcomes (e.g., number of care leavers that leave homes after family re-unification; number of care leavers that re-enter a care facility; number of care leavers who dropout from schools; frequency of truancy among care leavers/absences from school, school exclusions; and number of care leavers attempting or committing suicide/abusing substances/or externalizing behaviour problems). Such a database is an important source for carrying out research. Only 25 research studies have been carried out thus far and focused mainly on evaluation studies of service outcomes and effectiveness[4]. Although children are the main service users, there are only four studies that collected the views of

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[4] These studies are the Center for Social Policy Studies, the Department of Applied Social Science, the Hong Kong Polytechnic University, 2005; Hong Kong Children and Youth Services, 1990; Hong Kong Christian Services, 2007; Hong Kong Family Welfare Society & Cheung, 1994; and Hong Kong Family Welfare Society, 1996.

children[5]. Given the importance of data for ensuring quality planning for the development of services, as well as for advancing specialist knowledge about children in out-of-home care, there is an urgent need to review our current data collection and reporting systems and formulate a work plan with timelines to upgrade existing data information systems.

Conclusion

In conclusion, residential child care services have contributed much to Hong Kong society historically. In the beginnings of service development, residential child and youth care services played an important role in rescuing at-risk children and protecting young women. With tremendous changes taking place in society, the profiles of children in care and their families have changed. Most children in care do have families but their families are faced with many personal, familial and social challenges. In view of their diversified needs, there is urgent need for the Hong Kong government to re-think service directions and strategies for developing new service initiatives, enhancing family work and establishing a reliable information database system for children in care.

Questions for Small Group Discussion or Guided Reflection

1. *Residential child care services were launched in Hong Kong during the 1860s with the purpose of ensuring the safety of and shelter for homeless or abandoned children and babies, and for young women who would otherwise have been sold as prostitutes or maid servants.* In what ways might the origins of residential child and youth care be different where you live compared with Hong Kong?

2. *The number of children's homes in Hong Kong increased from 15 in 1950 to 29 in 1954, caring for about 2000 under-privileged children.* What factors may have contributed to this massive expansion of residential child care provisions in Hong Kong?

3. *The goal of residential child care services in Hong Kong is to provide alternative care to children so that "they [children] can continue to enjoy family life until they can re-unite with their families, join an adoptive family or live independently". Thus, residential child care services are only temporary shelters for children whose families are in crisis.* In what ways, if any, might this goal of Hong Kong's residential child care services compare with the goals operating for similar services where you live?

4. *Apart from those boys' and girls' homes that have a school on site – where schools are subsidised by the Education Bureau – all children who live in other types of placement attend schools in the community.* In what ways might this connection with education opportunities compare with practices that are common in your part of the world?

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[5] These studies are the Hong Kong Christian Service, 2014; Hong Kong Sheng Kung Hui St. Christopher's Home, & Center on Behavioral Health, the University of Hong Kong, 2005; Save the Children Fund, 1995; and Wong, 2014.

5.   *A residential child care social worker, together with a referring worker and the child's primary caregiver, will formulate a permanency plan for the child after the admission. Permanency planning refers to the systematic process of carrying out, within a specific time-frame, a set of goal-directed activities designed to maintain children in their own homes or live in a stable and home-like environment that offers continuity of relationships with nurturing parents or carers as well as providing the opportunity to meet developmental needs and establish life-time relationships.* How might this approach to permanency planning in Hong Kong compare with how permanency planning operates where you live?

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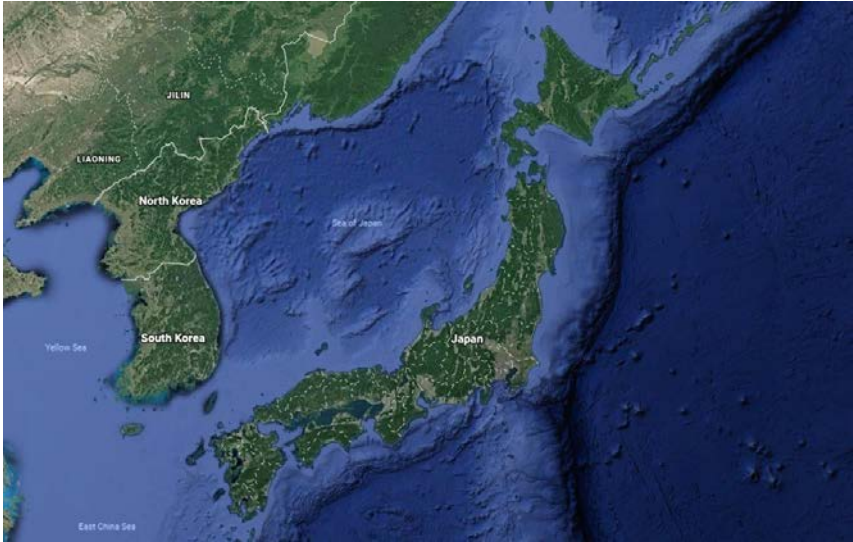
Japanese Residential Child Care in Transformation – Implications and Future Directions

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Abstract

In March 2014, a total of 39,047 children aged 0-18 years of age were living in out-of-home care in Japan, with roughly 85% living in 585 Child Welfare Institutions located throughout the country. Japan is one of the few developed nations that still relies heavily on

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residential care to look after children who have been separated from their biological parents. Peculiarities associated with residential care for children and young people are highlighted before focusing on an investigation of some psychological effects that residential care can have on children.

Introduction

In March 2014, 39,047 children (aged 0-18 years old) were living in out-of-home care in Japan (Ministry of Health, Law and Welfare, 2014), meaning that approximately two in every thousand Japanese children are placed in State care. Roughly 85% of these children live in one of 585 Child Welfare Institutions (CWI) located across the country (MHLW, 2014). This makes Japan one of the few developed nations that still relies heavily on residential care to look after children who have been separated from their biological parents. This chapter discusses residential care in Japan and its peculiarities. By focusing on a specific aspect of the Japanese system, it investigates some psychological effects that residential care can have on children. A brief description is given of the historical context within which Child Welfare Institutions in Japan were first introduced. Then, four unique features of contemporary Japanese Child Welfare Institutions are outlined. By considering these features, we argue that research on institutional care studies in other countries does not apply to Japan in any straightforward manner. Some new data is presented from the Japan *Jidō-yōgō-shisetsu* Study (JJS) on the nature of CWIs and their effects on children's internalising and externalising behaviours. In the conclusion, future research directions are outlined that can inform Japan's on-going transformation in its alternative care system.

A Brief History of Japanese Residential Care System

Jidō-yōgō-shisetsu, whose components literally mean Child (*jidō*) rearing/caring (*yōgō*) institution (*shisetsu*), is the Japanese term used for Child Welfare Institution (CWI). In 593 BC, the first Child Welfare Institution, called *Hide-In* was established to provide care not only for orphans, but also for the poor and the vulnerable (Ōga, 2001). Around that time, Japanese authorities founded many similar institutions across the country (Iwamoto, 2008). In the Japanese discourse about child welfare, the word "orphan" did not appear until the establishment of the first modern Child Welfare Institution in 1887 when child care institutions had to face the increasing needs of orphans, whose number raised significantly as a consequence of the economic and social changes following the *Meiji* Restoration (Goodman, 2000). Inspired by the ideas of English priest George Müller, *Ishi'i Jūji*, "the father of Japanese orphans", established the *Okayama Koji-In* ("Orphan-age") (Hosoi, 2006). *Ishi'i's* model was based on small-scale, family-like residential care connected with various educational programmes. His model had a significant impact on the modernisation of the child welfare system and CWI development. Most contemporary Japanese Child Welfare Institutions follow the example set by *Okayama Koji-In* (Hosoi, 2006).

The tragic events of World War II forced Japan to face again a dramatic increase in the number of orphans and homeless children. In 1947, according to the *Jidō Fukushi Hō* ("Child Welfare Act"), the term *Koji-In* was changed to *Yōgo-shisetsu* to emphasise the protective role that such institutions would play in child welfare. It is at this time that Child Welfare Institutions became the standard institutions of child care (Goodman, 2000). Since then, *Yōgo-shisetsu* have changed their primary function a few times. During the post-war economic miracle of the 1960s, they took in illegitimate children. In the 1980s, their focus shifted to providing shelter for delinquent youths. From the 1990s until now, their primary mission has been to care for maltreated children who are removed from their family and for those with mild developmental disorders. Gradually, the role of *Yōgo-shisetsu* changed from responding to a state of emergency to addressing a larger set of issues related to children and their development. In 1997, the New Child Welfare Act introduced the term *Jido-yōgo-shisetsu* in the Japanese welfare system. Adding Jido- (child) to the existing term showed a concern with children's welfare intended in a broader sense exceeding mere protection (King, 2012).

Background of Japanese Jidoyogoshisetsu Study

Despite many similarities, there is one difference between caring for children who have been removed from their biological parents in Japan and those in other developed countries. In most cases elsewhere, foster care and adoption have replaced residential care, which is still the default option in Japan. *Jidō-yōgō-shisetsu* provide care virtually every time a child is removed from his/her biological parents. Surprisingly enough, in contemporary Japan we see at the same time a lower birth rate and a rising number of children admitted into residential care.

Recently, conjoined efforts from both the World Health Organisation and UNICEF persuaded the Japanese Government to promote placements in family-like settings rather than in residential care (Pinheiro, 2006; United Nations, 2009). Since 2010, the Japanese Government has implemented a series of policies that are intended to improve the living conditions of children in care. However, there is a lack of knowledge about the current and long-term psychological outcomes of institutional care in the specific Japanese context. To facilitate evidence-based policy making, it is imperative that the effects of *Jidō-yōgō-shisetsu* on children's psychological outcomes are investigated so that alternative care packages can be assessed against these data.

Though other large-scale studies such as the Budapest Early Intervention Project (Zeanah *et al*, 2003) and the St. Petersburg-USA orphanage research project (Groark, Muhamedrahimov, Palmov, Nikiforova, & McCall, 2005) have documented the effects of residential care on children's academic and psychological outcomes, such findings are not easily applied to Japanese children and teenagers. Here we choose four distinctive features of Japanese Child Welfare Institutions. These features are discussed below to better understand the nature of institutional

care in the developing world. We focus on the fourth feature, and further elaborate research possibilities in the conclusion.

(1) Relatively High Quality of Care for Children's Basic Needs

Classic studies of institutional child care generally focused on contexts where children's basic needs were not met (Fox, Almas, Degnan, Nelson, & Zeanah, 2011; Goldfarb, 1945; Gunnar, Bruce, & Grotevant, 2000; Rutter, 2006). This is not the case for most of Japanese Child Welfare Institutions. Over the years, effective legislative actions have had a positive impact on the quality of Japanese residential care. By applying Gunner's (2000) three-level model of deprivation, the basic-need level in institutional provision is regulated by law (Ministry of Health Law and Welfare, 2012). For example, *each child is guaranteed 4.96 m² of physical space; full-time nutritionists overview meal plans to meet children's nutritional needs; all children have medical records and have access to medical and dental care.*

At the second and third level, complications arise. Legislation is not that effective and, in any case, regulations in these matters are more difficult to implement with any consistency. In considering the second level, defined by Gunner as "*stimulations and opportunities support motor, cognitive, language, and social development*" (Gunner, 2000: p. 678), most Child Welfare Institutions are equipped with relevant material such as books, sports equipment, and musical instruments. However, access to this material is regulated by the Child Welfare Institution, and regular use requires a high level of self-motivation from the child. Moreover, contextual variations may have a significant impact on children's access to enriching activities and experiences at all levels, such as concerts or baseball matches. The third level has to do with a need for "*stable interpersonal relationships and the opportunity to develop an attachment relationship with a consistent caregiver*" (Gunner, 2000: p. 679). This suffers from similar shortcomings. For instance, although it is mandatory for every 6 children to have 1 caregiver, caregivers work up to three rotating shifts per day with administrative duties, working 3,000 hours annually. Combined with their low salary and high stress levels, staff turnover and burnout are frequent (Nakagawa, 2010), making the creation of close relationships with children problematic.

(2) Shift in Reasons for Admission into Care

After World War II, many children were admitted into care because of poverty, parental death or homelessness. However, recent studies show that in developed countries, the primary reason for being placed in residential care is generally maltreatment (Browne, Hamilton-Giachritsis, Johnson, & Ostergren, 2006). In 2014, a third of Japanese children were placed in institutional care because of maltreatment (MHLW, 2014). Zhang *et al* reported that in 2013, in Hyogo and Tokyo, over half of the children were in care because of maltreatment, 1 in 5 because of poverty, and just over 1 in 10 because of parental divorce. This shift in reasons for admissions has had two relevant consequences. As Zhang *et al* (under

review) reported, children are likely (1) to have contact with their biological family, and (2) to be placed in care with their siblings.

*(3) Heterogeneous Age of Admission*

In a 2008 survey by the Ministry of Health, Law and Welfare (2014), over half of the children entered care before the age of 5, a third between the ages of 6 and 11, and roughly 1 in 8 entered care after the age of 12. This also means children stay in care for various lengths of time. The same survey reported that in 2008, more than half of the children in care had been there for less than 4 years, a quarter had been in care for 4 to 8 years, and roughly 1 in 7 had been in care for over 8 years (MHLW, 2014).

(4) Heterogeneous Types of Residential Care Arrangements

There are currently 6 different styles of residential care in Japan, defined by the size of the wards or living units that constitute the Child Welfare Institution. *Taisha* ("large-scale dorms"), the most common type in Japan (about 60%), house at least 20 children per living unit. As seen in Picture 1, all children live in a big building, and are divided by age and gender. Usually there are 4-8 children per room and children dine in a big hall, taking food that is cooked by a central kitchen. Children living on the same floor share all other facilities. Although this system makes it easy for caregivers to supervise, it is very hard for children to have their own privacy or experience an intimate atmosphere. *Chusha* ("middle-scale dorm") houses 13-19 children per living unit, and there is a smaller version of *Taisha*.

All children live in the same building. However, each living unit has its own facilities for, among other things, cooking and bathing. *Shosha* ("small-scale dorm") house 6-12 children per living unit, offering a much more family-like environment compared to *Taisha* and *Chusha*. If an institution has more than one living unit, children either live in independent houses within the same complex, or in apartments belonging to the same building. *Taisha*, *Chusha*, and *Shosha* are the most traditional types of care arrangements in Japan. From 2000, Group Care (GC), Group Homes (GH), and Family Homes (FH) have been introduced into the system. They are family-oriented Child Welfare Institutions accommodating no more than 6 children where children generally have their own rooms. Caregivers cook together with the children in the home kitchen and dine in the living room. Many *Taisha*, *Chusha*, and *Shosha* living arrangements are in the process of reforming into these family-like living units. One should note that this recent reform forcefully promotes scaling down the size of residential care. However, whether this is useful in terms of promoting children's well-being is still open to debate.

A typical Taisha ward arrangement

A typical Group Care arrangement
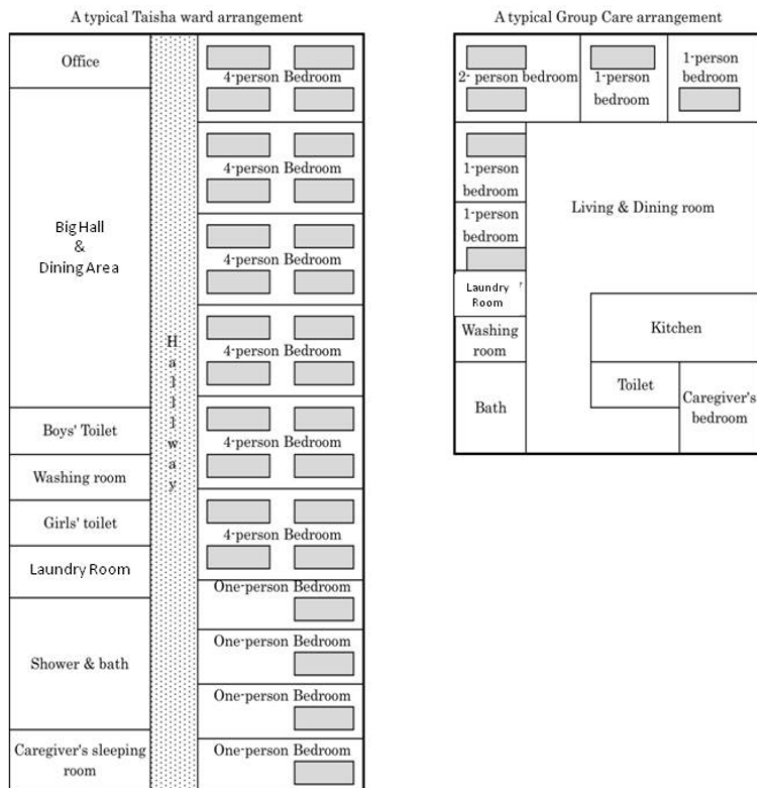
Within the context described above, in 2013 the *Japanese Jidoyogoshisetsu Study* was established to examine the quality of care provided by the Japanese child welfare system, as well as the mental health outcomes of children living in out-of-home care. This represents the first attempt to systematically measure the effects of an institutional up-bringing on a range of child psychological outcomes in that context. In another paper (Zhang, Mori, Tanaka, & Lau, under review), no significant difference was found in emotional and behavioural developmental outcomes for children across different types of living units. This may be due to two reasons. First, it might be the case that simply reducing the number of children per unit need not enhance the family functions of the living environment. Other factors, such as caregivers' parenting behaviour and stress also play an important role. Second, there might be a placement bias influencing results. In the following section, we present data from the Japanese Jidoyogoshisetsu Study to examine the following questions: (1) Are there placement biases in terms of a child's characteristics at the time of protection placement? (2) Are there differences in

children's psychological well-being due to the type of units they live in? (3) Are there interactions between children's characteristics and the type of units they in which children live?

Method

Recruitment and Study Sample: Sampling was very broad with 27 institutions selected from all regions of Japan (for more details, see Zhang *et al,* under review). Of those selected, 2 declined and a third was excluded since it is in Fukushima, which was devastated by the 2011 Tsunami. Across a total of 1,295 participants in the remaining 24 institutions, 592 met the inclusion criteria of: (i) being aged 8 to 15, (ii) having an absence of intellectual disabilities, (iii) having been in care for at least 2 weeks, and (iv) not undergoing legal proceedings about placement. 457 subjects were available to participate on the day of data collection.

Procedure: Ethical approval was granted from Konan University, Japan in 2011. Consent forms from the institution directors and caregivers, as well as assent forms from the children and young people were obtained prior to data collection following an explanation of the study. Children's self-report questionnaires were collected on the day of visitation, with each child assisted by a trainee clinical psychologist following the data collection protocol specifically designed for this study. Caregiver questionnaires were handed to children's key caregivers on the day of data collection and were collected by post no more than 1 week after the visit.

Measurement

Child Characteristics: Caregivers provided information on (1) child's date of birth and (2) child's gender.

Family Background and Placement Information: Caregivers provided information on (1) whether child had maltreatment history; (2) whether child had contact with biological parent(s) in the past year; and (3) Date of first placement.

Size of the Residence: Caregivers were asked to provide information about what style of living unit the child currently lived in (*Taisha, Chusha, Shosha*, GH, GC, FM).

Child's Psychological Functioning: Caregivers completed the Japanese version of the parent rating Strength and Difficulties Questionnaire (SDQ) that comprises 25 items across 4 difficulty sub-scales: Hyperactivity/Inattention (HI), Emotional Symptoms (ES), Conduct Problems (CP), Peer problems (PP); and 1 strength subscale: Pro-social behaviour (PB). Each subscale consists of 5 items. HI and CP are externalising behaviours, and ES and PP are internalising behaviours. Caregivers rated each of the children and youths in their care on each item using a 3-point scale (Moriwaki & Kamio, 2014).

Children self-reported on their depressive symptoms using Birleson's (1981) relatively brief and simple 18-item Depression Self-Rating Scale for Children (DSRS-C). Respondents indicate the degree of each item on a 3-point scale, with '1' = 'sometimes', and '0' or '2' = 'never' or 'most of the time' depending on positive or negative tone. Within a mixed sample of clinical children, those scoring at or above the cut-off of 15 points were 6 times more likely to have a diagnosis of depression than those scoring below 15, and no child from a 'non-psychiatric disorder' group scored above the cut-off (Birleson, Hudson, Buchanan, & Wolff, 1987).

Results

Child Characteristics: As shown in Table 1, just under half (44.9%,) of the sample was male. Participants were aged between 8 and 15 years, 3 months old, with a mean age of 11 years, 9 months. 43.8% were adolescents (12 years and older).

Background and placement characteristics: Half of the children lived in big living units (*Taisha*), the rest in smaller units. Children first entered care between the age of 0 and 13 years old (mean = 5 years 6 months, SD = 6 years 1 month) and two-thirds of the children were maltreated before coming into care. Over the past year, 67.2% of the children had contact with at least one of their biological parents.

Table 1

Information on Children's Characteristics, Background and Placement

Category	N (%)
Gender	
Boy	205 (44.9)
Girl	252 (55.1)
Age	Mean = 11.74 (SD = 1.93)
Non-adolescents (under 12 years old)	257 (56.2)
Adolescents (12 + years old)	200 (43.8)
Institution Size	
Taisha (Large-scale)	247 (54.0)
Other	200 (43.8)
Chusha (Middle-scale)	58 (12.7)
Shosha (small-scale)	73 (16.0)
GH, GC & FH (Family-like)	69 (15.1)
Missing	10 (2.2)
Age of Removal from Biological Family	Mean = 5.09 (SD = 3.79)
0 – 2.5 years old	124 (27.1)
2.5 – 7 years old	121 (26.5)
7 years old and older	126 (27.6)
Missing	86 (18.8)
Maltreatment History	
Yes	301 (65.9)
No	149 (32.6)
Missing	7 (1.5)
Contact with Biological Parents	
Yes	307 (67.2)
No	124 (27.1)
Missing	26 (5.7)

Next, a test was carried out to determine whether there was a bias in placement by children's own characteristics (gender and age) and their background information (maltreatment history, biological family contact, and age of removal from biological family). A chi-square test of independence was performed to determine the relationship between gender and living unit size. A significant relationship indicated that boys are more likely to be placed in big size living units. A significant relationship was also found between maltreatment history and unit size, where children without maltreatment history are more likely to be placed in smaller residences. The same significant relationship was found between unit size and biological parental contact: children with biological parental contact are more likely to be living in big size wards (Table 2, over the page). An independent sample t-test was performed to determine that there was no significant difference between the two groups of children in their age of removal from biological family.

Child's Psychological Functioning: Data from the Japanese SDQ and DSRS-C are reported in Table 3 over the page. An independent sample t-test was used to detect differences between children placed in large scale institutions and those who are not. Children placed in other types of units were found to have significantly elevated Emotional Symptoms as well as internalising problems than their peers placed in *Taisha*. No significant differences were detected in other subscales of SDQ and DSRS-C (Table 3). A series of factorial MANOVA – with DSRS-C score, SDQ's internalising and externalising behaviour score included in the models – were conducted to examine the interaction between unit size and child's characteristics and background.

The interaction between living unit size with child's characteristics and background included: (1) child gender, (2) child's age (adolescent or non-adolescent), (3) contact with biological parents in the past year, (4) maltreatment history, and (5) age of removal from biological family. The results are shown in Table 4. While no significant interaction effect was found between unit size and maltreatment history, and biological family contact, significant interactions were detected with child gender, child age, and child's age of removal from biological family.

Table 2
Size of Living Unit by Gender, Maltreatment History, Contact with Biological Family, Age of Removal from Biological Family, Length in Current Care and Length in Care Total

| | | | Size of unit | | |
			Taisha	Other	X²/t
Child's gender	Girl	N	98	102	5.28 *
		%	49.00%	51.00%	
		Std. Residual	-1.2	1.3	
	Boy	N	149	98	
		%	60.30%	39.70%	
		Std. Residual	1.1	-1.2	
Maltreatment history	No	N	93	54	5.77 *
		%	63.30%	36.70%	
		Std. Residual	1.3	-1.5	
	Yes	N	150	143	
		%	51.20%	48.80%	
		Std. Residual	-0.9	1	
Contact with biological parents	No	N	51	70	14.01 ***
		%	42.10%	57.90%	
		Std. Residual	-2.1	2.4	
	Yes	N	187	114	
		%	62.10%	37.90%	
		Std. Residual	1.3	-1.5	
Age at biological family removal		Mean	5.11	5.09	.07 ns
		SD	3.63	4.04	

Table 3
Differences in Psychological Functioning between
Children Living in Taisha & Other CWIs

		Total (N = 457)	Taisha (N = 247)	Other (N = 200)	
		Mean (SD)	Mean (SD)	Mean (SD)	t
SDQ	PB	4.28 (2.48)	4.15 (2.51)	4.44 (2.43)	-1.21
	Externalising problems	8.59 (4.56)	8.50 (4.58)	8.68 (4.60)	-0.41
	HI	5.05 (2.77)	4.89 (2.72)	5.25 (2.81)	-1.35
	CP	3.56 (2.49)	3.62 (2.52)	3.46 (2.46)	0.64
	Internalising problems	6.43 (3.57)	6.08 (3.62)	6.90 (3.53)	-2.36 *
	ES	2.83 (2.25)	2.61 (2.25)	3.16 (2.25)	-2.50 *
	PP	3.61 (2.23)	3.49 (2.13)	3.74 (2.36)	-1.19
DSRS-C	Total	11.24 (5.05)	11.34 (5.14)	11.06 (4.95)	0.58

SDQ: Strengths and Difficulties Questionnaire; PB: Prosocial behaviour; HI: Hyperactivity/Inattention; CP: Conduct problems; ES: Emotional symptoms; PP: Peer problems;

DSRS-C: Depression Self-Rating Scale-Child

* $p < .05$; ** $.05 < p < .01$; *** $p < .001$

Table 4

Factorial MANOVA Result for Children's Psychological Functioning

Level B variables	Dependent variables		Taisha Mean (SD)	Other Mean (SD)	Ward size	F Level B	Interaction
Gender	DSRS-C	Girl	12.28 (5.88)	10.28 (5.03)	0.87	0.01	**9.04 ****
		Boy	10.69 (4.51)	11.75 (4.85)			
	SDQ-Internalising	Girl	6.38 (3.36)	7.22 (3.60)	5.28 *	2.09	0.00
	Behaviour	Boy	5.86 (3.78)	6.68(3.48)			
	SDQ-Externalising	Girl	7.53 (4.36)	7.77 (4.39)	0.64	14.10 ***	0.07
	Behaviour	Boy	*9.11 (4.47)*	*9.60 (4.70)*			
Adolescent	DSRS-C	Yes	12.48 (5.03)	11.12 (4.86)	0.89	4.68 *	3.02 †
		No	10.50 (5.08)	10.91 (5.11)			
	SDQ-Internalising	Yes	6.48 (3.72)	6.36 (3.83)	5.10 *	0.37	6.83 **
	Behaviour	No	5.76 (3.54)	7.52 (3.16)			
	SDQ-Externalising	Yes	8.09 (4.88)	8.72 (4.27)	0.30	0.43	0.69
	Behaviour	No	8.77 (4.78)	8.64 (4.96)			
Age of Removal from Biological Family	DSRS-C	0-2.5	12.02 (5.65)	11.71 (5.02)	0.22	1.93	0.48
		2.5-8	10.26 (4.07)	10.71 (5.33)			
		8+	11.83 (5.71)	10.89 (5.14)			
	SDQ-Internalising	0-2.5	5.73 (3.22)	6.42 (3.39)	0.16	5.78 **	0.11
	Behaviour	2.5-8	5.62 (3.63)	8.02 (3.75)			
		8+	7.27 (3.94)	6.43 (3.49)			
	SDQ-Externalising	0-2.5	9.21 (4.73)	9.12 (4.58)	3.57 †	1.63	5.49 **
	Behaviour	2.5-8	9.31 (4.42)	8.78 (4.81)			
		8+	7.34 (3.94)	7.35 (4.31)			

† p < .10; * p < .05; ** .05 < p < .01; *** p < .001

Discussion

Nearly 7 decades of high quality research have impacted out-of-home care practices and policy making in Japan. On a global scale, alternative care and especially residential care have changed dramatically from that described in classic studies in terms of institutional provision and children's circumstances. Those changes pose new challenges that vary across different cultural, social, and economical contexts. The study presented in this chapter is the first attempt in Japan to systematically measure the developmental outcomes of children in care. At this time of rapid transformation in Japanese child welfare practices, this Government supported the Japanese Jidoyogoshisetsu Study, which is expected to contribute greatly to the understanding of the nature of out-of-home care in the Japanese socio-cultural context. By addressing some of the gaps in our knowledge about out-of-home care and its impact on children's development, we hope that such a study will inform the country's policy making and practice.

Data analysis presented in this chapter confirms one of the underlying principles guiding the on-going reform of the Japanese out-of-home care system: *Shokiboka* ("living unit downsizing") and its effect on children's psychological well-being. Results showed how 3 years into the reforms, most of our participants were still living in big living units. When considering the sample, the study found a possible complication associated with residence downsizing: being placed in smaller units seems to escalate the risk of developing internalising behaviours. As argued in Zhang *et al* (under review), this unexpected direction may be due to selective placement bias. One plausible explanation suggests that children with histories of more severe problem-behaviour are more likely to be placed in smaller units.

While limited by our research design for tracking children's psychological functioning from the time of first placement to test this hypothesis, we chose four variables:

1. child gender;
2. age;
3. age of removal from biological family;
4. maltreatment history and contact with biological family.

Those are more likely to be obtained at the time of placement and are less likely to change over time. On the one hand, we found that males and children who have family contact are more likely to be placed in big sized institutions, which provide a more restrictive environment that better handles externalising behaviour and complications introduced by parental visitations. On the other hand, children without maltreatment history are more likely to be placed in smaller units. In practice, placement bias is likely and the reasons behind placement bias are easy to understand. Matching categories of children with particular types of units is functional within the system. However, one must be careful when this placement

bias goes unnoticed. Placement processes need to be informed by scientific evidence to fully account for the children's needs.

We also found that children's psychological functioning is not primarily influenced by the structure of the units they live in: interactions of unit size and child characteristics are more important. Bigger living units function as a risk factor for developing depressive symptoms in girls and adolescents. Studies in the developmental trajectory of depression show that gender differences become obvious around the beginning of adolescence, when girls become at higher risk of developing depression (Hankin *et al*, 1998). According to Hankin and colleagues (2007), this is because girls experience more peer stressors and respond to those stressors with more depressive symptoms. In our case, it is not simply the size of the unit that is relevant. More likely, a higher risk of developing depression is a function of the type of interpersonal conflicts and stressors that big living units promote.

Being placed in residential care as a younger child leaves them at greater risk of developing both internalising and externalising patterns of behaviour. This finding is particularly interesting. However, one must hesitate to draw the conclusion that continuing placement in a deprived family environment is necessarily better than being placed in an institution at an early stage. To disentangle the mechanism behind this phenomenon, we must be able to compare the environment provided by disturbed families with that offered by Child Welfare Institutions.

Against all expectations, no significant interaction effects were found between contact with biological family and unit size, or between maltreatment history and unit size. However, this may result from two limitations with this study. First, the study was not authorised to access children's case records, relying instead on caregiver reports for information which may not be accurate. Second, earlier findings on contact with biological family while in care are rather controversial (Attar-Schwartz, 2009; Lee, Seol, Sung, Miller, & Minnesota International Adoption Project, 2010; Vorria, Rutter, Pickles, Wolkind, & Hobsbaum, 1998). Rather than the mere presence of contact, studies need to consider the quality of such interactions and further work through the Japanese Jidoyogoshisetsu Study will do just that. Finally, one cannot help but notice that this study is also limited by the relatively small sample size of children living in family-like residences. Hence, data analysis was limited to comparing big sized living units with other types of units. Each of the six forms of living unit structure has its own distinctive characteristics, so more detailed comparisons across all types of residences are needed.

Japan's own out-of-home care characteristics make it possible to answer many questions for which there are still no answers. The relatively high quality of basic care and the spectrum of environmental variations in children's intellectual stimulation and psychological development give opportunity to look closely at the heterogeneous nature of residential care. Moreover, different reasons for admission make it possible to examine how different types of early deprivation impact on

children in institutions. Finally, the wide spectrum of age groups in Japanese residential care will help us gain insights into the effects of institutional placement on young people over the course of time. These future studies may very well facilitate evidence-based interventions and inform policy making that benefit Japanese children and young people in residential care.

## Questions for Small Group Discussion or Guided Reflection

1. *In 593 BC, Prince Shōtoku Taishi established in Osaka the first Child Welfare Institution in Japan, called Hide-In.* How might historical traditions like these influence discussions around foster care and de-institutionalisation?
2. *In the Japanese discourse about child welfare, the word "orphan" did not appear until the establishment of the first modern Child Welfare Institution in 1887.* How do you think the word orphan came to be used and became such a dominant way of thinking about children placed in residential care?
3. *The tragic events of WW-II forced Japan to face a dramatic increase in the number of orphans and homeless children, so that from 1947 onwards, Child Welfare Institutions became the standard approach to child care.* In what ways do you think wars, famine and natural disasters have contributed to the creation of residential child and youth care centres everywhere?
4. These authors argue that "*placement processes* [in Japan] *should be informed by scientific evidence in order to fully account for the children's need*s". To what extent might you say that residential placement processes are informed by scientific evidence where you live and work?
5. This Japanese research showed that *being placed in residential care as a younger child leaves them at greater risk.* What risks might you identify as being important?

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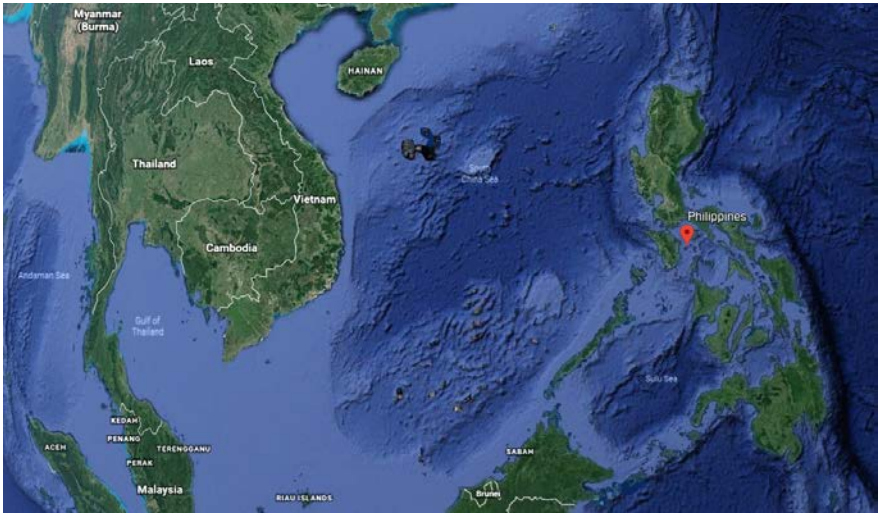
Residential Care of Children in the Philippines

Charity Graff[1]

Abstract

The United Nations Convention on the Rights of the Child (UNCRC) states in its preamble that a family is the natural environment for the growth and wellbeing of all its members, and particularly children. There are countless situations where children do not live with their families, and their natural parents do not hold the primary obligation for their upbringing. The need for care and protection of some of these children is fulfilled by members of their extended families or by other people within their community. Some children who live in countries where fostering of non-natural children is not practised, make residential child care institutions as their only alternative care.

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Introduction

In 1989, the United Nations (UN) General Assembly adopted the Convention on the Rights of the Child (CRC) and one year later in July 1990, the Philippines ratified this Convention making the Philippines the fifth country in Asia and the 31st country world-wide to do so. The roots of the country of the Philippines run deep in community, partially because of having to band together to survive years of occupation. The Philippines was ruled by the Spanish for 400 years and then by the Americans for 50 years. Much of the influence of social welfare development came from these cultures and governments that brought aid and education to the peoples of the Philippine Islands.

As a state party to the UN Convention on the Rights of a Child, the Philippines is obliged under Article 9 to uphold the rights of children, to ensure and promote the indivisibility of their rights, to protect children from rights violations and to ensure all Filipino children have access to services and venues where they can participate meaningfully (UNCRC, 1989). To date there are more than 50 pieces of National Legislation in place to do that. The Department of Social Welfare and Development (DSWD) is the social welfare arm of the national government and is widely recognised and known for its astute policies and standards in child and youth welfare. Their vision today is of a "society where the poor, vulnerable and disadvantaged individuals, families and communities are empowered for an improved quality of life" (Mendoza, 2008: p. 36). However, while there is protective legislation in place by the Philippine government and while there are protective services and intervention provided by the Department of Social Welfare and Development, manpower and availability of services are sadly lacking.

Children in the Philippines

According to the Council for the Welfare of Children (2006), in the Philippines there are 12.4 million children below the age of 5 years, 12.8 million between the ages of 5 and 9 years, and 12.8 million between the ages of 10 and 14. It is estimated that 23 out of 100 of these children will die before the age of one, while 28 out of 100 die before reaching the age of five. Seven out of ten deaths in the Philippines occur at childbirth with eleven women dying in childbirth every day. Malnourished pregnant women give birth to underweight infants. "Infant deaths, under-nutrition, poor immunization coverage, lack of micro-nutrient supplementation, inadequate attention to cognitive and psychosocial development, and low birth registration threaten children's survival and development, babies who survive will most likely be born deformed and mentally challenged" (Perry, 2010: p. 33).

According to the 2010 Population Census conducted by the National Statistics Office (NSO), the total population of the Philippines was 92.34 million, a figure that has increased to 104.9 million in 2017. Just under half (42.06%) of the 2010 population was below 18 years of age, with 1 million more males than females.

The poverty incidence among children was 35.2 percent (Council for the Welfare of Children, 2006). Now more than ever, these poverty-impacted Filipino children are in need of special protection. Many are victims of family violence and neglect, are often in hazardous and exploitative labour, are left to fend for themselves on the streets, or are victims of sexual abuse and commercial exploitation. Others are victims of trafficking, find themselves separated from or have lost their parents, are in conflict with the law, and in situations of armed conflict. Children with disabilities, girl children, children of Indigenous Peoples, and children affected with HIV/AIDS are also considered in need of special protection. The numbers are staggering, and the need is great.

According to a report by the Council for the Welfare of Children (2006), on average 367 children and youths were in conflict with the law (CICL) and were detained in city, municipal and district jails in 2012. Almost 19 per cent of male children between 5 and 17 years of age were working children. It is estimated that there are 372,154 persons with disabilities (0-19 age group), the majority of whom are between 10 and 14 years old. There are approximately 246,011 street children or roughly 3 percent of the child population. Only 44,435 of these street children are estimated to be visible. Of the total of 12 million population of Indigenous Peoples, approximately 5.1 million are 18 years old and below. Also reported by the Department of Social Welfare and Development – Policy and Planning Bureau – the highest causes of children needing care and intervention are neglect, child trafficking, sexual abuse, and abandonment (Council for the Welfare of Children, 2015). As with all countries, the Philippines has its own unique cultures that influence decisions and its abilities to deal with the current trends of child and youth welfare.

Towards a Child-Centred Perspective

In presenting a paper on Child Work in the Philippines, Camacho (1999) discusses the "new child-centred perspective" on child welfare work. Socialisation of children in the Philippine context is unique, and at a young age, children have roles and are taught and expected to do certain chores and responsibilities. As Medina points out, Filipino parents are generally protective, indulgent, affectionate and nurturing towards their children (1991).

The family has the responsibility of helping children to learn their roles and these roles are consistent within the Filipino family for the most part. While they are learning and growing then, children are often viewed as "immature, incompetent, passive beings and as such cannot as yet make significant contributions to society" (Camacho, 1999: p. 23). Believing "the youth are the hope of our nation", Philippine society continues to take pride in its children and young people. Rivera argued, "Children are a mirror of the level of development of a country. Children are also a mirror of the crisis in a country" (Camacho, 1999: p. 24).

According to UNICEF and the Philippine Institute for Development Studies (2010), almost half of all children in the Philippines live in poverty. Children suffer from lack of food, shelter, health care, education, water, sanitation facilities, electricity and even information. One in every three children lives below the poverty line and one in five suffers from serious nutritional needs, with most of these being extreme situations. Along with the economic burden of poverty, there are unseen stressors that traumatise and impact on the child emotionally, intellectually, physically, and even spiritually. Among the poorest of the poor, or "informal settlers" as they are known in the Philippines, there are unique factors that contribute to the neglect, abuse and abandonment of children. Many of the children born in these lower-class communities are born to young parents with minimal education. Statistics reported by the Council for the Welfare of Children in 2015 show teen pregnancies in the Philippines have increased by 65 percent in the past 10 years. Unwanted teen pregnancies often end in illegal and dangerous attempts at abortion. Often women cannot afford to give birth in a hospital so the local midwife (who may or may not be trained), or a grandmother or relative will help in the delivery of the child. This can result in many complications that may leave the baby with long-term physical or cognitive damage.

Because the cost of hospital care is so high, babies are frequently abandoned in hospitals because parents have no money. In one government hospital in Manila, out of 1,500 infants each month, as many as 9 will be surrendered for adoption, abandoned, or rescued from trafficking. The biggest reason for a mother not keeping her baby is poverty (Go, 2012). Unwanted babies are commonly thrown in garbage cans or left in a field. There is a lack of education about local legal adoption practices. Selling a child or unwanted baby is an easy way to make money and an easy fix for a couple that is childless. The current laws do not address exchanging a child for money after birth so there is no evidence of physical exploitation. A child who is sold or given away in exchange for an amount of money can be the victim of "simulated birth", now a crime in the Philippines. Despite laws and despite persistent attempts by many non-government organisations to advocate for legal adoption procedures to be respected, simulation of birth still happens regularly.

Children who are not legally adopted but given to a neighbour or a distant family relative to raise are often referred to as 'just adopted' and "considered to be less deserving of the same treatment, care and love that is given to biological children" (Clark, 2010: p. 33). They are often left out of the family will and often bear the brunt of workload, household chores, and hardships of life. They do not get the same educational opportunities and are often reminded when something goes wrong that they don't really belong. Because so many broken families and so many common law relationships fall apart, there are many children who are given to someone else to raise as their own. The Filipino man takes pride in his ability to procreate but is often unwilling to raise the child of another man. Such children are often abused by the 'step-father'. Because the mother is desperate to keep the man

who may be the breadwinner, she will find somewhere to leave the child, abandoning the child and breaking any bonds that might have already formed.

Birth control is not yet widely accepted in this culture nor by the Catholic Church, as seen in the recent Reproductive Health Bill debate, and so other methods must be used when unwanted pregnancies occur. If the baby is kept, a young mother (or a tired mother with 6 or more other children) is then faced with providing for the basic needs of this new baby. She is often the breadwinner and will need to leave the baby off to the side on a hard mat, while she washes clothes to feed her other children. The child lies unstimulated and alone, surrounded by chaos, dirt and the disease that is rampant in the urban poor communities.

Extended Family Systems

The family system is a distinctive feature of community life in the Philippines. "There is a common tradition in Filipino child-rearing of entrusting to older children the responsibility of attending to younger siblings" (Arellano-Carandang, 2001: p. 47). A young child will often take on the responsibility of the mother in order for the mother to make money for their daily expenses. This leaves babies in the hands of mere children, so that their physical, emotional and social needs cannot possibly be met appropriately. Another factor in the Philippine setting is the myth or misconception that babies cannot see nor hear until they are several months old. Children are often left in a room in the dark and left unfed, untouched or unwashed because of these beliefs, regardless of potential damage to neurotransmitters in their brain. Because of a lack of education and because of poverty, many families cannot afford to buy simple powdered milk formula. The mother's breast milk often dries up because she herself does not have enough to eat. The baby will be given rice broth, diluted coffee, sugar water, or a very cheap, watered down powdered milk.

Shame or "hiya" is a very strong, dominant value in the culture of the Philippines. It affects many decisions and behaviour in every age group, from the youngest to the eldest. Hiya is not merely "the actual emotion felt when one has violated social norms, but also, the sensitivity to rebuke and fear of exposure of one's insecure self" (Mendoza, 2008: p. 103). In describing the Philippine context of shame and doubt, Tappenier shows how many "Filipino parents respond to a young child's attempts at autonomy and expression of will with disapproval" (1996, p. 100). It is looked upon as rebellious and is viewed negatively. In the Filipino family, it is assumed that children know nothing, and the parents know everything. There is an unspoken expectation that the children will obey without question, and there is little opportunity to express one's own feelings, needs or wants. Even as a small child, there is a "wound inflicted – that of feeling like an insignificant part of the family. He feels invalidated as a person, who in fact does think, feel and behave in a unique and special way" (Tappenier, 1996: p. 101).

The concept of adoption is often viewed in the light of shame because it goes against social norms. The Filipino places strong value on the family and on

being together. "Sacrificing individual interest for the good of the family, parental striving to give their children an education even at great cost to themselves, older children sacrificing for the younger siblings, and mothers especially, making sacrifices for the family" all demonstrate the value to the Filipino of emotional closeness and security within the family (Mendoza, 2008: p. 104). Sick children or children with congenital diseases or chromosomal conditions, will often not get the medical intervention they need because the mother is afraid of what will be said about her. Children are left to die quietly, and help is not sought for an illness that could often be cured. Parents who are aware of the legal system of adoption would rather hide their decision to surrender a baby than admit their decision to their friends or other family. Young women will go to great lengths to hide a pregnancy, followed by an adoption. Out of necessity, most children needing rescue or respite care are placed in residential care facilities within the country.

Residential Care

Residential care, according to the definition in the Guidelines for the Alternative Care of Children (UN, 2009) is care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities, including group homes. In the following section, residential care is defined as care that occurs 24 hours a day, seven days a week outside of the children's own home with his biological family (Every Child, 2011).

In 2010, there were 64 facilities throughout the Philippines distributing social services for the Department of Social Welfare and Development. These facilities served 4,749 cases of child abuse, with more than half of these being children who were abandoned (1,433) or neglected (1,079) (Virola, 2011). Local Government Units – offices run by the Mayor of each city – handle most of the needs of the children and youths in conflict with the law (CYCL). This is often done at the expense of children who are the most in need of special protection. They are housed together, and much abuse happens in centres that are not designed, equipped, or staffed to handle the vast diversity of needs within the urban setting.

The bulk of care, however, is shouldered by non-government organisations (NGO) and the private sector, run by missionaries and organisations with funding and stakeholders from developed countries. As of 2013, there were unconfirmed estimates of more than 4,000 institutions, licensed and non-licensed, in the Philippines catering for marginalised children. The Department of Social Welfare and Development has strict licensing guidelines for those offering residential care to children and youths. However, monitoring of compliance and of the actual care being given is very difficult, to say the least. The need is tremendous, and manpower is very much lacking. A host of agencies accept children surrendered for adoption, children who are abandoned at a young age, and children who need temporary shelter. There is, however, a tremendous gap in the system for children with special needs, such as cerebral palsy, hearing and visual impairments, and other medical

needs. There are few agencies that are working with the huge number of children and youth in conflict with the law.

Institutional care is far from what it needs to be despite the efforts of the Government and foreign stakeholders to provide the physical structures and to advocate for the basic needs of those children and youth needing care. Few agencies are currently addressing the care of a child in a holistic manner. Often, agencies are overcrowded and understaffed. In 2002, there were 177 licensed social welfare agencies operating 197 residential institutions with 8,339 children under their care (Council for the Welfare of Children, 2005). By 2005 this had increased to 787 licensed social welfare agencies serving 11,130 children.

While the idea is to provide children with a place to go when home is not safe nor an option for them, residential care often referred to as an "orphanage" or "institution" is sadly far from what it was hoped it should be. Care that is provided to children and youths in residential centres is often not appropriately or adequately delivered. In many centres, the basic needs of children such as food, clothing, medical and health services are not even met. There is substantial evidence of the harmful effects of larger, dormitory-style residential care. Children's ability to form an attachment to a caregiver has been shown to have a crucial impact on self-esteem, confidence and ability to form relationships (Every Child, 2011). Nurseries are often too full and the ratio of children to caregiver is excessive, meaning that the children cannot possibly get the individual attention they need. Caregivers are often overtired and in danger of burn-out because of long hours and too many children for one person. This makes the carers short-tempered and unlikely to provide gentle or loving stimulation for the children in their care. There is often considerable turnover of staff due to the less than ideal working conditions. This is additional trauma and stress for the children in residential care. The large number of children, the use of shift systems, and the lack of consistent caregivers providing affection and individualised care for children, make it hard for children in such facilities to form bonds, even if efforts are made to improve the quality of care offered.

Attachment and Relationships

In many institutions, it is all too common to forget about emphasising the need for bonding and the emotional well-being of the children. Neglect, malnutrition, crib confinement, restraints, and lack of stimulation and modelling impede the normal development progress. "Developmental retardation has been found in children admitted to institutions in the first month of life when they have yet to develop any attachments and have a very limited ability to differentiate between the adults providing care" (Rutter, 1972: p. 35). This is referring to children who are behind when measuring developmental milestones. They are children who are slow and who cannot seem to catch up with the expected skill level of their age.

One institution has proved to be very successful at addressing the individual needs of the children in their care in a holistic manner. Based in Manila, they have

worked among informal settlers (those who own no land or homes) for more than twelve years, taking in children who are malnourished, neglected, ill, abandoned, abused or dying. This institution was licensed in 2003 under the Department of Social Welfare and Development of the Philippines (DSWD) as a residential and child-placing agency, and in 2009 was accredited by the same authority. This institution has been active in the rescue, rehabilitation, release and adoption of hundreds of children since 2004. Focusing on trauma and the competent care of such, the mission of this institution is to provide holistic residential home care rehabilitation services to children in physical danger. These are children who are severely ill, malnourished, abandoned or in other crisis situations because of poverty, an uncaring family environment and other related problems, who remain involved until they can be reunited with their family, placed in foster care, or adoption is facilitated.

Reasons for Placement

Of the children who come into the care of the institution, four out of ten have experienced serious neglect, three out of ten have been abused either sexually or physically, two out of ten have been abandoned, and only one out of ten was surrendered willingly by the biological parent for legal adoption. Not only have these children all experienced trauma on some level, but also a break in attachment has occurred with their primary caregiver. There are three stages that the children in this institution go through as healing takes place and attachment is formed with a primary caregiver. Beginning with the intake assessment, the initial engagement of the child, and the initial construction of the child's personal treatment plan are priority. Once attachment has begun, holistic rehabilitation of the child is the primary focus and includes the implementation of the treatment plan, evaluation of the behaviours of the child with intentional behaviour modification and intervention provided by the case management team. As paperwork is processed for legal adoption, the final focus involves the discharge of the child – generally to international adoptive parents – facilitated by the Inter-Country Adoption Board of the Philippines.

Time in Care

From the very moment the child arrives in the care of this institution, s/he is monitored and given individual attention. The primary caregiver begins the intentional stage of promoting bonding. This includes showing her/him the new environment, assigning her/him personal belongings and a bed, as well as a tour of the home. All this is done by the primary caregiver and involves laughter, expressiveness, gentleness, spontaneous affection, and eye contact. These actions are all done regardless of the response of the child. The caregiver remains consistently affectionate and cheerful even if met with anger, tears or unresponsiveness.

The child and primary caregiver eat together and engage in conversation. The primary caregiver is trained to be aware of body language and non-verbal behaviour of the child. There are words of encouragement, love and empathy, always assuring the child that s/he is safe and secure within the centre and with the caregiver. For infants, the same intake procedure occurs with much less emphasis on the environment. The child is held close and snuggled. The child is sung to and wrapped in a blanket. S/he is given a bottle if needed and held in a nursing position; the child is never left propped with the bottle to drink on her/his own. The primary caregiver will talk and sing so the child becomes accustomed to her voice. When caregivers change shift for the night or a day off, the secondary caregiver intentionally engages in the same behaviour that has been established with the primary caregiver. Intake can be frightening for a child, depending on the circumstances of admission. Being taken away from their mother or caregiver and placed with another is traumatic, even if it is necessary. Sometimes the children are very sick or wounded and the care required is extremely intense in the beginning phases.

The longest part of intervention – averaging around 18 months – is the rehabilitation of a child who has experienced trauma. The hurts and wounds of the past are addressed, and healing is slowly realised through the day to day activities and bonding with the primary caregiver. The family-centred atmosphere of the institution as well as the consistency of the staff and caregivers, allow the child to have a healthy "family-like" experience. The children are grouped together in ages and eat wholesome meals together in the kitchen. They have free time to play and have access to a variety of toys and stimulating games. They can bathe privately, and each child has her/his own bed with a cabinet of her/his own personal belongings. They have access to professional counselling and other interventions as needed. They attend school within the centre and some even attend public school. They are given opportunities to go to the mall, to eat out at fast food restaurants, they are taken on outings to museums and the beach and attend devotions in the evening with all the children in the centre. They interact freely with staff and other children, but each child has one caregiver that is considered primary. The ratio of children to caregiver is less than 10 to one for older children and often five to one for infants and small children. The behaviours that promote attachment are visible and observable throughout the duration of this stage, allowing the child to develop trust in a primary caregiver and experience the foundational relationship for all other relationships in his life.

Finally, 'release' of the child is facilitated through legal (local and) international adoption. Practising how to continue learned attachments is crucial as the experiences of bonding are put into context and the child is carefully guided in initiating the transfer of trust to adoptive parents. The child is monitored carefully by the social worker and the caregiver and given extra attention and affection during this potentially anxious time. For older children who have established clear and secure attachment to a primary caregiver and understand adoption, the discharge

process is done intentionally and monitored carefully with open discussions about grief, loss, the child's personal life story, and their fears and dreams. The child is given freedom to express her/his thoughts, feelings, and emotions in sessions both with the counsellor and with the adoptive parents when they arrive.

While many Filipino institutions do a same-day discharge out of the main office of the centre, this institution conducts adoptions differently. The adoptive parents are always met in the living space of the child and are required to spend a minimum of three days on site to observe their child in her/his environment and bond with her/him in a safe place for the child. The discharge can be a potentially emotional time, depending on the relationship of the child to the caregiver and the security that the child has experienced. Secure children do not fear strangers and easily transfer their trust to another, given time and opportunity. Behaviours that promote attachment are actively employed by the caregivers of the institution and receive favourable responses from the children. The consistency and congruency between caregivers is in place and the intentional behaviours that are practised are an integral part of the attachment and connecting process of each child to a caregiver, whom s/he has learned to trust and depend upon.

Conclusion

When the Philippines Department of Social Welfare and Development considers licensing an agency, its primary focus is placed on the standards of care that are outlined in the policies and manuals of the Department. This even includes details of the number of items of clothing a child should have, the space between beds, and the physical environment. It also details the staff-to-children ratio and the programmes and services that should be offered. The process is detailed and finely tuned. However, there is a lack of focus placed on the end result and on the level of healing that children should achieve while in care. In order to achieve greater awareness and practice sensitivity to the current needs of children and youth requiring residential care, greater acknowledgment of the importance of attachment-based care must occur. Caregivers who care for children within institutional settings should be taught attachment-promoting activities and behaviours. Basic attachment behaviours that need promotion include being spontaneously affectionate, having laughter and singing, being patient with the child, being more expressive in facial and verbal responses than is culturally common, being gentle in touch and speech, reading non-verbal communication, showing empathy, having clear boundaries with discipline, and being consistent in all responses to each child. Caregivers in institutions that cater particularly for children who have experienced trauma should be aware of these. It does not require special education to use these behaviours and make connections with a child as they can be practised by any caregiver who is trained to intentionally love and connect with a child.

Social workers should be trained in supervisory roles within the institution. The social worker's supportive role is to help caregivers do their job of promoting

attachment to children. A great deal more knowledge of attachment issues needs sharing, learned, assimilated and assumed by the social workers of institutions. Beginning from the intake interview, a social worker must be sensitive to and aware of the signs and symptoms of attachment issues between a child and her or his primary caregiver. This will enhance care, education and treatment planning. As Page and Norwood state, "a child's capacity to form an attachment after suffering severe deprivation is likely to be the single most important developmental event in the child's life, setting the stage for future social relatedness" (2007, p. 15). This would support the hypothesis that children in institutional care with traumatic and negative experiences in their background can absolutely experience significant healing of those traumas. Such children can witness a wonderfully positive outcome in adoption and ultimately life when provided with a family-centred environment, albeit institutional, and cared for by those who understand and actively promote the attachment of that child to a primary caregiver. While the continuing protection of the rights of every Filipino child remains a daunting task, there is hope as awareness increases. Providing holistic care, addressed to meet each child in care as an individual, is not only the hope for the Filipino child but for all children in need of alternative care.

Questions for Small Group Discussion or Guided Reflection

1. *According to the 2010 Census conducted by the National Statistics Office, the total population of the Philippines was 92.34 million, a figure that has increased to 104.9 million in 2017. Just under half (42.06%) of the 2010 population was below 18 years of age, with 1 million more males than females. The poverty incidence among children was 35.2 percent.* How does this profile of children and young people in the Philippines compare with what the same profile might look like where you live?

2. *There are approximately 246,011 street children or roughly 3 percent of the child population in the Philippines. Only 44,435 of these street children are estimated to be visible.* What do you think it means when it is said that of nearly a quarter million street children, less than 50,000 are visible?

3. *According to the Department of Social Welfare and Development – Policy and Planning Bureau, the highest causes of children needing care and intervention are neglect, child trafficking, sexual abuse, and abandonment.* In what ways can it be argued that all four causes listed here are closely interconnected, so that a child needing care and intervention from these causes requires multiple strategies and relational practices?

4. *Statistics reported by the Council for the Welfare of Children show teen pregnancies in the Philippines have increased by 65 percent in the past 10 years. Unwanted teen pregnancies often end in illegal and dangerous attempts at abortion.* What social and cultural traditions may be influential in these Philippines statistics and what do you think might be done to assist young girls there considering these findings?

5. *When Department of Social Welfare and Development considers licensing an agency in the Philippines, their primary focus is placed on the standards of care outlined in the policies and manuals of the Department that even includes details of the number of items of clothing a child should have, the space between beds, and the physical environment. It also details the staff-to-children ratio and the programmes and services that should be offered. The process is detailed and finely tuned. However, there is a lack of focus placed on the result and the level of healing that children should achieve while in care.* Why do you think organisational rules and procedures in residential child and youth care give such little recognition for relational practices that occur in the everyday moments of care?

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Residential Child Care in Indonesia: A Case Study of SOS Children's Village in Lembang

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Abstract

The United Nations Convention on the Rights of the Child (UNCRC) states in its preamble that a family is the natural environment for the growth and wellbeing of all its members and particularly children. There are countless situations where children do not live with their families, and their natural parents do not hold the primary obligation for their upbringing. The need for care and protection of some of these children are fulfilled by members of their extended families or by other people within their community. Some children who live in countries where foster care of children is not practiced where they are unknown to family members make residential child care institutions their only alternative care.

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Introduction

The United Nations Convention on the Rights of the Child (UNCRC) states in its preamble that a family is the natural environment for the growth and wellbeing of all its members and particularly children. However there are countless situations where children do not live with their families, and their natural parents do not hold the primary obligation for their upbringing. The need for care and protection of some of these children are fulfilled by members of their extended families or by other people within their community. Some children who live in countries where foster care of unrelated children is not practiced, have child care institutions as their only alternative care (Dunn, Jareg, & Webb, 2003). Many supporters of child care institutions argue that the absence of parental care does not necessarily put children in a damaging environment. The idea of alternative child care should be to provide a caring and nurturing environment similar to that found in the family so that children can access sufficient care and protection (Delap, Georgalakis, & Wansbrough-Jones, 2009). In cases where children cannot be raised within their family, a child care institution is seen as one alternative where children can find appropriate care as well as access to education and health services, which will eventually improve their growth in many aspects.

Overview of Child-Rearing Practices in Indonesia

As the 4th most populated country in the world, Indonesia is inhabited by 252 million people, with 85 million children[5] in 2014 equivalent to one-third of the national population. Around 3 million Indonesian children do not live with their biological mother, but this does not necessarily mean that these children are orphans (Statistics Indonesia, 2015). Migration contributes to the high number of children in Indonesia who live separately from their parents. Indonesia is one of the main exporters of migrant workers (especially women) in Asia, together with Philippines, Thailand, Vietnam, and Sri Lanka (Bryant, 2005; Reyes & Manila, 2008). Migration across provinces in Indonesia is also very common, and data from the 2007 Indonesia Family Life Survey shows that more than half the children whose parents migrate within Indonesia are not taken with their parent during migration (Rizky *et al*, 2017).

Other research carried out by Save the Children together with Ministry of Social Affairs and UNICEF in 2007 (Martin & Sudrajat, 2007) reveals that, while the total number of child care institutions in Indonesia is unknown, it is known that the number of institutions has increased dramatically over the past two decades, partly due to the lack of regulation, attention, and supervision from the Government of Indonesia. There are approximately 8000 organisations involved in running child care institutions (Martin & Sudrajat, 2007), but only a small portion

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[5] According to Law No. 23 Year 2002, Indonesia defines child as a person under the age of 18.

of these are owned and funded by the Government of Indonesia. It is estimated that more than half a million foster children live in foster homes across the country.

Non-formal alternative care in Indonesia is normally carried out through adoption of children by cousins or other extended family members. This is common practice in some cultures in Indonesia, especially for those in Java, Lombok, and some parts in Sulawesi. The tradition of adopting the child of extended family has its local names: in Lombok it is called *ngalak anak*, whereas in Java it is called *mupu*. Both terms mean 'to adopt a child'. This type of adoption does not involve formal documents or a legal process although agreements are made between the two families that arrange the adoption (Rofiq & Ganefo, 2014). Some families adopt a child from a cousin or an extended family member simply because they fail to conceive. There is also a belief that having a child at home will positively affect the efforts to conceive. Adopting a child is believed to send baby dust (good luck) to the couple who are trying to conceive (Rofiq & Ganefo, 2014). Lastly, the decision to adopt a child from an extended family member is also a way to help relatives who are economically unable to raise a child.

Child and Youth Protection Policy in Indonesia

National Standards of Care for Child Welfare Institutions adopted under Ministry of Social Affairs Regulation 30/HUK/2011, stipulate that 'alternative care' is defined as the care provided by parties other than the child's nuclear family, in cases where the child's natural parents are unable to provide appropriate care. Alternative care consists of fostering, guardianship, adoption, and residential child care. Together with the Law Number 23, Year 2002 on Child Protection which was already amended by Law Number 35, Year 2014, these two judicial commitments clearly stipulate the rights of children who receive care apart from their natural parents. It requires that all forms of alternative care must guarantee the rights of children to protection, provision, participation and best interests of the child respectively.

According to Ministry of Social Affairs Regulation 30/HUK/2011, 'fostering' is defined as a form of temporary care. Through this regulation, Government of Indonesia argues that in the future the child should live in more permanent family-based care, be it with his/her natural parents, extended family, or relatives. Some foster parents in Indonesia do not necessarily live together with the children. Foster parents can also refer to individuals or groups who donate money to help supply the material needs of unfortunate children, while the children still live with their natural parents or in child welfare institutions. Other foster parents do live together with their foster children, usually until the children finish their education.

Law Number 35, Year 2014 on Amendment of Law Number 23, Year 2002 regulates 'guardianship' as another form of temporary care. The court shall appoint an individual or an institution that meets the requirements to serve as a guardian to the child in cases where the child's parents are legally incompetent or their

whereabouts are unknown. On the other hand, Government Regulation Number 54, Year 2007 defines 'adoption' as a legal action that transfers the child's civil and legal rights from his/her natural parents to the authority of the adopting parents. Adoption implies legal consequences in the form of guardianship and inheritance. Unlike fostering and guardianship, child adoption is considered permanent care.

In October 2017, the Government Regulation Number 44, Year 2017 which regulates the foster care system for children whose parents are no longer capable of being responsible for their upbringing is finally issued. This law ensures that government will protect children, who by any situation is forced to be separated from their parents, to get the best nurturing environment by considering the children's best interest. It is indeed an essential regulation for establishing a more comprehensive fostering system as the newly issued regulation rules that foster parents must obtain approval from a social agency in their region and undergo a series of assessments before they are finally allowed to take in a child. Before this regulation was issued, foster children would automatically be brought to a child care institution or to a foster home without being registered or documented. Currently the Government of Indonesia, especially the Ministry of Social Affairs, is actively campaigning for the new policy to ensure a nurturing environment for foster children.

Types of Child Care Institutions in Indonesia

There are two major types of child welfare institutions in Indonesia: 1) residential care (non-family-based care), and 2) family-based care with a formed family. Residential care outnumbers the family-based care, and its growing numbers is very much greatly supported by diverse religious groups in the country, as some of the residential care institutions are faith-based. Since most Indonesians are Muslim, there are a great number of many Islamic residential child care institutions that operate based on Islamic principles and values. The Islamic boarding school is the most common type and it is impossible to say when Islamic boarding schools were first established in Indonesia. Some argue that these boarding schools began in the 14th Century, when Walisanga – a group of nine prominent people who spread Islam in Indonesia, especially in Java – was still actively spreading Islam in Indonesia (Bamz Aulia, n.d.). In those days, Islamic boarding schools were supposed to be centres of Islamic learning in Indonesia. To catch up with recent changes in society, contemporary Islamic boarding schools do not focus solely on Islamic teaching but include secular subjects in their curriculum. Historically, Islamic boarding schools traditionally charged very low fees for the students, but some modern boarding schools have started to increase their rates. During school holidays, students are sent back home to live with their parents and resume a normal family life.

Catholic-based residential child care is also very common in Indonesia. The oldest Catholic-based residential child care institution is administered by the Jakarta Vincentius Association, which was established in 1855. At first, its main objective

was to help those children of Dutch descent (Indo-European) who became a social problem in society and it started with a form of home care (Jakarta Vincentius Association, n.d.). In 1947, the Government of Indonesia requested that they build an orphanage to accommodate displaced children and children who had become victims of the independence war. To honour that request, an orphanage was built and given the name *Panti Asuhan Desa Putera,* which became the oldest Catholic-based residential child care institution in Indonesia.

Funding for residential care centres comes from government, private companies, and social organisations. This is used to cover food expenses, water and sanitary equipment, household equipment, and building(s) (Martin & Sudrajat, 2007). However, the report by Martin & Sudrajat (2007) depicts the poor quality of care in Indonesian child care institutions, highlighting the small role of care in these institutions, as staff focused more on providing access to education and health, such that the other aspects of child's emotional and psychological development were ignored.

SOS Children's Village is a family-based care organisation that has been working in Indonesia since 1972. Started in 1949, SOS Children's Village is an international non-governmental organisation that is committed to working towards ensuring children's rights and protection. In Indonesia, there are now 8 SOS Children's Villages that accommodate 1300 children through family-based care. In an SOS Children's Village, a family is comprised of 8-10 children with a foster mother who live together within their own house. These families live side by side like neighbours in the SOS Children's Village. The concept of SOS' family-based care is an alternative care that replicates as closely as possible a family in general, where children who are not raised by their natural parents can still have opportunities to develop their potential to the fullest.

Values and Aims of Child Care Institutions in Indonesia

Every child welfare institution holds its own values and beliefs as principles underpinning the caring services they give to the children. Both faith-based and non-faith-based institutions have one thing in common: their ultimate focus is to provide an opportunity for children to achieve their own potential and understand that they have purpose in life. Faith-based institutions operate based on the values rooted in each religion. To nourish children's faith, it is common for the institution to include a strict rule in its schedule for prayer or learning the Bible incorporating, for example, celebrating mass every Sunday for Catholic children and regular 5-times a day prayers for Muslim children.

Friendship among children living together in a child welfare institution is invaluable, as many become as close as siblings. One example of friendship at a residential child care institution is well portrayed in an Indonesian best-selling novel by Ahmad Fuadi (2009), based on a true story, entitled *"Negeri 5 Menara".* At the institutions, children also do chores like cleaning their room and washing dishes. Those values are taught to help build their character and prepare them for life after

leaving residential child care. Most of the institutions are responsible for taking care of their children until they turn 18. After that, the children are supposed to leave since it is assumed that they are then capable of being on their own. In some cases, children do not leave the child care institution as they become junior staff members and join the care management team.

According to the Ministry of Social Affairs Regulation Number 30/HUK/2011, the purpose of child welfare institutions is to support family-based care and provide caring services for children who are not able to access caring services from their natural family, extended family, relatives, or substitute family. Every child welfare institution must adopt four principles of child caring services:

1) **Non-discrimination**: children must be able to access their rights without any type of discrimination.
2) **Child's best interest**: every decision related to children should be based on the children's present and future consideration.
3) **Survival and development**: this principle implies the child's rights to fully develop their potential skills for their physical, psychosocial, and social development.
4) **Participation**: acknowledges children's rights to freely express their opinions and be involved in decisions affecting them.

Why Do Children Live in Child Welfare Institutions in Indonesia?

In some parts of Indonesia where cultural and religious values remain dominant, sending children to a residential institution is still considered the norm. This happens in Aceh, the only region in Indonesia that adheres to the law of *Syari'ah*. It is common for parents in Aceh to send their children to Islamic boarding schools as early as primary school. In fact, this tradition normally runs through generations where a child whose parents were educated in an Islamic boarding school are likely to enrol in the Islamic boarding school.

Some children living in residential child care institutions are not necessarily orphans. There are many cases where parents cannot look after their children and have no option other than sending their children to a residential child care establishment. There are several reasons for parents to send their children to residential child care including financial difficulties, illness (including mental illness), criminal acts, or unwanted children. Martin & Sudrajat (2007) found that one of the main reasons children are placed in a child welfare institution is because parents want them to have better living conditions than they can provide, and access to quality education.

Conflicts and natural disasters have also become reasons for children to live in child welfare institutions. The political turmoil in Indonesia in May 1998 led to a chaotic situation where many young girls were raped. As a result, many babies were

born without identities as their mother did not want to acknowledge them. The tsunami in Aceh in 2004 also sent a lot of children to child welfare institutions, as they lost their families during the disaster. Young marriage and unplanned pregnancy resulting from rape or an illegal affair also contribute to the high number of unwanted children who begin living in child welfare institutions from the time they were born.

Poverty is considered the most common reason for a child to live in a child welfare institution. For poor families and families who live just above the poverty line, their economic circumstances are so very fragile that any small shock may tip them further into poverty. Most of the time, education is the primary reason parents send their children to child welfare institutions. It is true that public schools in Indonesia are free of charge, but poor parents still may not be able to afford transportation costs or pocket money for their children. Greater access to education that most of the institutions provide has become the key reason for parents sending their children to a child welfare institution.

Bridging the Gap

Ministry of Social Affairs Regulation Number 30/HUK/2011 on National Standards of Care for Child Welfare Institutions has become the main reference for quality care at Indonesia's child welfare institutions. Supporters of this regulation argue that this law is very important as it sets the standard for quality care at child welfare institutions. Government of Indonesia regulations emphasise that child welfare institutions should be considered as the last option for a child who cannot live with their families. Consequently, child welfare institutions in Indonesia should not recruit children pro-actively and such children should first be referred to the Ministry of Social Affairs, well before any placement is considered. Placement of a child in a child welfare institution should only be considered as temporary care, while a more permanent family-based child-rearing plan is developed for the child.

At the same time, the law also creates fear as it emphasises that child welfare institutions should be a last resort for children who cannot be raised by their own families. There is some concern that child welfare institutions may no longer be needed as Government of Indonesia now prioritises family-based care and makes alternative child care a support service. The limited role of Government of Indonesia in supporting child welfare institutions also contributes to this miscommunication. The National Standards of Care for Child Welfare Institutions have not been widely known by all child welfare institutions due to poor communication between Government of Indonesia and the institutions. The Ministry of Social Affairs needs to ensure that all child welfare institutions are informed that a national standard now regulates the quality of care at Government of Indonesia child welfare institutions. At present, there is a substantial gap between the expectations of Government of Indonesia and the actual capability of many child welfare institutions. Limited staff at the child welfare institutions and

inadequate support from the Ministry of Social Affairs are believed to be some of the reasons behind the reluctance of child welfare institutions to fully implement the National Standards of Care for Child Welfare Institution. The Ministry of Social Affairs must also improve their work so that quality care can be implemented across all child welfare institutions.

Debates about Child Welfare Institutions among NGOs

It is necessary to improve the way children are cared for in many of Indonesia's child welfare institutions. The institutions need to fully understand the rights of children, child protection, and human rights, as comprehensive knowledge of these three elements are essential for improving the quality of care at child welfare institutions. As for now, most institutions operate using a needs-based approach to provide care for children. However, the rights-based approach is seen as a more appropriate legal framework to help analyse and justify the causes that prevent children from accessing their rights, serving as a conceptual framework that ensures children receive good quality of care that enables them to reach their potential.

Children in a child welfare institution find themselves placed in conditions that are totally different from life with their own family, living in the institution for quite a long time or until they finish senior high school. This implies that they spend a significant proportion of their childhood in the institution where they may be required to engage in harmonious or inharmonious relations with caregivers and peers (Tolfree, 2004). Some NGOs believe that child welfare institutions should only serve as a temporary place for children in times of hardship (e.g. poverty, conflicts, victim of natural disasters, etc.) and re-unification should always be a priority whenever the children are ready to be re-unified. Re-unification itself is, however, a dilemma for the children at child welfare institutions as they are sometimes found to be neglected after they return home, and there is lack of support from the Government of Indonesia for after care. On the other hand, some NGOs believe that family-based care in a formed family can be a permanent solution for children until they turn age 18.

Challenges for Child Welfare Institutions in Indonesia

The Ministry of Social Affairs Regulation Number 30/HUK/2011 is a national standard for the Government of Indonesia for the quality of caring services in child welfare institutions. This regulation needs to be circulated more widely among child welfare institutions because some institutions are still not aware of what it documents. The Ministry of Social Affairs needs also to upgrade the knowledge of its staff and officials regarding quality child care, children's rights, and human rights so that the monitoring process of quality care at child welfare institutions can be carried out thoroughly. Considering the large number of child welfare institutions in Indonesia, it is unlikely that monitoring can be managed

centrally by the Ministry of Social Affairs. The Ministry needs to establish a monitoring mechanism that allows its representatives at the local level to cooperate with social workers and local cadres. A de-centralized monitoring system means that monitoring would be performed by representatives of Ministry of Social Affairs at the local level, but the main reference is still the Ministry of Social Affairs Regulation Number 30/HUK/2011. Violators of the standard should be given strict sanctions so that reinforces the message with the other child welfare institutions.

The Government of Indonesia also must strengthen the quality of human resources available at the child welfare institutions. People who work for these institutions must be familiar with all the regulations concerning child rights and child welfare practices at the institutions. Knowledge about quality child care and child caring practices requires updating from time to time, as the world becomes more dynamic each day. Capacity-building for caregivers at child welfare institutions must be prioritized in order to raise the quality of care to national standards. Government of Indonesia should also consider facilitating knowledge-sharing among child welfare institutions so that best practices can be shared, and an exchange of information may help improve the overall quality of care.

The last but probably the biggest challenge for Government of Indonesia and child welfare institutions is the increasing number of children who do not live together with their natural parents or extended families, namely children who are out of care. Limited resources in the child welfare institutions – human resources, funds and facilities – restricting their capacity for providing quality child care for large numbers of children. It is imperative for the Government of Indonesia to build more child welfare institutions to avoid overcrowding or increasing numbers of homeless children.

SOS Children's Village in Lembang

The SOS Children's Village in Lembang, Bandung was established in 1972 – in West Java, it hosts approximately 100 children in 14 different houses (SOS Children's Villages Indonesia, n.d.). In 1972, it started with only 6 houses and 24 children. Supporting facilities for children are a library, activity rooms, medical and dental clinic, vocational training centre, and a dorm for teenagers. At the beginning, SOS built an elementary school named *Hermann Gmeiner Elementary School*, but now the school has been taken over by local government. Some programmes that are running in the SOS Children's Village in Lembang are Family-Based Care, a Family-Strengthening Program, Kinship Care and Foster Care.

Family-based care provides children with a family-like environment where children experience a sense of belonging. The family environment is expected to be a solid foundation that shapes the children's character in the future. The family concept of SOS Children's Village is based on four principles: each child needs a mother, should grow up most naturally with brothers and sisters, live in their own house, and enjoy a supportive village environment. An SOS family consists of 6-8

children and a foster mother. A foster mother is a professionally-trained caregiver responsible for all the children who live with her in the same house.

SOS Children's Villages admit children who have either lost one or both parents, or whose parents are unable to provide necessary care. Many of the SOS Children's Village in Lembang have been abandoned for various reasons:

- one/both parents are ill or already died;
- broken-home family;
- whereabouts of parents are unknown;
- unwanted children;
- parents are incompetent in providing adequate care for children.

The decision regarding a child's admission is made by a committee comprised of the village director, an SOS mother, social workers, and sometimes the national director in cooperation with national authorities. The committee decides whether a child can be admitted and whether the child needs a permanent home. Not all SOS children are referred by the Ministry of Social Affairs. Some children are referred to SOS by hospitals, by village leaders or respected figures from where the child came, or by the child's own family. A referral system by the Ministry of Social Affairs has not yet been fully executed even though this has been regulated by the law.

In SOS, children are brought up according to the religion of their natural parents. Houses are differentiated by religions and there are Muslim, Christian, and Catholic houses. This practice is intended to fulfil children's rights to express their faith and to assign them to a foster mother who shares similar values. SOS also has a commitment to keep biological siblings together. For Leaving Care, there is an SOS Youth Programme for young people who are ready to move out of SOS families, normally when they start to go on to higher education or start vocational training. Leaving care is designed to prepare young people to become more independent and lead mature lives. The SOS Children's Village in Lembang also has a Family-Strengthening Programme for vulnerable families around the village. Started in 2005, the programme is intended to provide capacity-building for parents from vulnerable families where living conditions are difficult. Through this programme, SOS offers support skills such as family-planning, financial planning, and job search. In a wider sense, the SOS Children's Village also has other services such as kindergartens, a mobile library, and support services for adolescents.

Life in SOS Children's Village: The Story of Amba and Bisma

Amba (age 13) and Bisma (age 15) are two children who live in the SOS Children's Village in Lembang. Their daily activities are no different from those of children who live together with their parents. Every day, they wake up as early as 5 a.m. and do chores around the house before going to school. After school, Amba

and Bisma have lunch at their home together with the other children. They usually take naps or just stay at home after lunch. SOS provides various activities for children in the village participating in afternoon activities each day. Amba takes a music class on Mondays, a dance class on Tuesdays, and a craft class on Fridays. Meanwhile, Bisma chooses karate, painting, and computer classes. There are also classes for reciting Al Quran and tutorial sessions every week in the village. During weekends, the children normally play with their friends, watch movies, help mother at home, and (for Christian and Catholic kids) go to church.

According to Amba and Bisma, they live a happy life in the SOS Children's Village. They can play with a lot of friends and have many siblings. Both Amba and Bisma have best friends in the village with whom they feel comfortable to share stories. Because she is a girl, Amba prefers to play with other girls and she doesn't really like playing with boys because they always end up fighting over toys. Bisma likes to play soccer with his friends during the weekend. At their young age, the only sadness they acknowledge is the fact that they have never met their parents. In the future, Amba says she wants to become a doctor so that she can help a lot of people. Bisma says he wants to become an architect because he likes drawing and painting, that's why he takes painting class as his afternoon activity.

Life after SOS Children's Village: The Story of Aruna

Aruna spent her childhood in the SOS Children's Village in Lembang, as her mother left her in the hospital where she was born 26 years ago. She was raised at the village by four different foster mothers until she turned 18. Aruna built a very strong emotional relationship with the foster mother who raised her until she turned 8 years-old, but the relationship is not so strong with the rest of her foster mothers. However, each foster mother contributed a lot to Aruna's development until she became the mature and independent woman she is today.

When Aruna was a child, she was ashamed of her background, especially in school, where she was a very introverted little girl. She was afraid people would judge her if she revealed that she lived at the SOS Children's Village. Most of the time she was jealous of the other children who were picked up by their parents after school, and of those children at the Village who were visited by their mothers on their birthdays. Aruna was never visited by her family during her time in the Village. When she grew up, she began to search for her biological mother, but her efforts came to a disappointing end as there was no emotional chemistry between them when they eventually met. She began to hate her mother and became rebellious. Aruna stopped going to school as a form of disappointment. During this crisis, her foster mother helped her a lot by continuing to provide the love, care, and motivation that Aruna desperately needed.

Aruna said SOS has had an important role in transforming her into an independent and confident young woman. She found her passion in athletics, and she was a sprinter for 10 years. SOS supported Aruna's hobby and guided her throughout all her stages of development. SOS encouraged Aruna to apply for a

scholarship so that she could go to college and study sports. During her college years, Aruna started to gain confidence as she met new friends from various backgrounds. She began to reveal her identity and was surprised to find that her friends were interested in the SOS Children's Village. Aruna found that her childhood experiences in SOS Children's Village helped her to survive.

Lessons Learned from Challenges at SOS Children's Village in Lembang

In the SOS Children's Village in Lembang, children can find their passion as there are various art and sporting activities. They are offered instruction and training on a weekly basis, in the hope that they can make use of the skills they acquired once they grow up. Children are nurtured with love and care, so they feel as if they are living within their own family. It would be wrong to claim that children in the SOS Children's Village never felt lonely and different at various times. However, the foster mother always gives her best to fulfil the children's needs by providing them with love, care, and motivation. The SOS Children's Village in Lembang also invests in the capacity-building of foster mothers. Even though they are professionally trained caregivers, a 24/7 job is not easy for anyone. Once a week, these foster mothers consult with a psychologist to share their problems and get feedback. Each foster mother is also in charge of their children's food, and she must make the best decisions on every penny she spends while consulting with their children. SOS collects all the food donations the Village receives and then sells them to the foster mothers at a reduced price. The income earned is allocated to buy items that the children needed. This practice ensures that all children enjoy the benefits from the donations fairly. One of the main challenges for the SOS Children's Village in Lembang is their dependence on funding from SOS International. In 2020, it is hoped that all SOS Children's Villages in Indonesia will be able to fund themselves and already, SOS Children's Villages Indonesia became one of the first self-sufficient countries. To do so, however, SOS will need considerable support from Government of Indonesia, especially to fund their operational costs.

Questions for Small Group Discussion or Guided Reflection

1. *Some children who live in countries like Indonesia where fostering of non-natural children is not practiced, have child care institutions as alternative care.* What do you know about why foster care is not practiced in Indonesia and what added pressures might this add to residential child and youth care practices in that country?
2. *As the 4th most populated country in the world, Indonesia was inhabited by 252 million people in 2014 and the number of children reached 85 million – equivalent to one-third of the national population. Around 3 million Indonesian children do not live with their biological mother, but this does not necessarily mean that their mothers have already passed*

away. In a large island archipelago in the Pacific, as seen in the map at the start of this chapter, what do you think would be the top priorities for addressing the residential child and youth care needs of more than 3 million Indonesian children who do not live with their birth mothers?

3. *Since most Indonesians are Muslim, there are a great number of Islamic residential child care institutions that operate based on Islamic principles and values. The most common type is the Islamic boarding school. It is impossible to say when Islamic boarding schools were first established in Indonesia, but some argue that they began in the 14th Century, when a group of nine prominent people called Walisanga helped to actively spread Islam in Indonesia, especially in Java.* What do you know of the history of religious residential boarding schools in the region where you live and how might you locate religious boarding schools on a wider continuum of residential child and youth care services?

4. *Catholic-based residential child care is also very common in Indonesia, the oldest administered by the Jakarta Vincentius Association established in 1855. Its main objective at first was to help children of Dutch descent (Indo-European). In 1947, the Government of Indonesia requested that they build an orphanage to accommodate displaced children and children who had become victims of the independence war.* What special challenges might someone working at a Catholic-based residential child and youth care centre face daily while living in a Muslim majority community and country?

5. *Family-based care provides children with a family-like environment where children experience a sense of belonging. The family environment is expected to be a solid foundation that shapes the children's character in the future. The family concept of SOS Children's Villages is based on four principles: each child needs a mother, should grow up most naturally with brothers and sisters, live in their own house, and enjoy a supportive village environment.* How do you think that the four principles upon which the SOS Children's Villages family concept in Indonesia is based might apply to residential child and youth care practices where you live?

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Conclusion: A Return to the Basics of Survival

Tuhinul Islam and Leon Fulcher

Introduction

Asia, including the Middle East, is home to the majority of the world's Muslim population, as well as the birthplace of all the world's major religions – including Buddhism, Hinduism, Judaism and Christianity. However, conflicts among and between certain Asian countries have carried on for decades and are said to be the result of religious animosity. Continued warfare, political instability, and 'natural' disasters have had a direct impact on the lives of many Asian and Middle Eastern peoples, and not surprisingly, women and children. Since the first Gulf War, initiated by the then US administration, the region has been in a state of major turmoil with countless acts of barbarism – the on-going civil unrest in Israel-Palestine; claims about weapons of mass destruction in Iraq; the Taliban cleansing of Afghanistan; the much documented fight against ISIS in Iraq and Syria; the recent failed military coup in Turkey; tensions between Qatar and Saudi Arabia; the on-going rivalry between India and Her neighbours (in particular the nuclear power, Pakistan); North and South Korean threats; and Myanmar's 'ethnic cleansing' of the Rohingya Communities, to name but a few. All these events have made the

whole region extremely unstable, adding more reasons for the significance of this volume.

In our *Global Perspectives* volume, contributors highlighted the tensions created when Western child and youth care systems, policies, and practices were 'imposed' onto non-westernised nations, via INGOs claiming to be 'experts' in child and youth care practice. Similarly, the impact of the aggressive de-institutionalisation movement was questioned, along with the campaigns led by selected West European and American NGOs in the economically poorer nations of Eastern Europe as noted in our *European Perspectives* volume.

This volume seeks to widen understanding of the impact that warfare, political instability and natural disaster have on settled communities, turning them into migrants and refugees. The problems faced by pregnant women, unaccompanied minors and child-orphans are extremely distressing. Focusing on the current case of 'ethnic cleansing' taking place in Myanmar, we share tales of woe emanating from Cox's Bazar, the land-mass bordering Myanmar and Bangladesh, now home to a million Rohingya refugees – the world's largest new refugee camp.

The plight of hundreds of thousands of Rohingya people is currently one of the world's fastest growing refugee crises. Since August 2017, more than a million individuals have fled from the Northern Rakhine Province of Myanmar into neighbouring Bangladesh's Cox's Bazaar region. Many have died making this journey. Survivors have shared harrowing accounts of the State violence they have either witnessed or endured, including hundreds of cases of rape by the Burmese Army. According to local sources, over 70,000 women are reported to be pregnant, many the result of rape by Army personnel. The United Nations has named the Rohingya peoples as, "currently the world's most persecuted minority group" and described the atrocities committed by the Myanmar State as a, 'textbook example of ethnic cleansing and genocide'. (UN News, 2017).

It is estimated that almost 60 percent of those fleeing Myanmar are children. Thousands of these children have been orphaned, while many others have become separated from their families while fleeing. With so many undocumented children living in the camp without guardians, aid workers are worried about cases of abuse, and even trafficking. Most refugees have experienced some form of trauma, having witnessed loved ones killed or tortured, and seeing their home destroyed. The UN and Amnesty International have termed the raped and abused Rohingya women and girls as 'psychologically disturbed'. The numbers of children arriving continue to increase daily. The camps are not ideal and conditions there can be described as 'dire'. Access to adequate health care, safe drinking water and sanitation is poor. There is no educational support in place for the children and young people. Those with enough strength can access whatever the aid agencies have to offer. Those too weak to carry aid back to their 'home-tent' must rely on the good will of others, and the weakest are slowly dying.

Through his work with Muntada Aid, Tuhinul visited Cox's Bazar at the beginning of 2018 to understand the scale of the crisis, assess needs and link up with potential local partners supporting the refugees. He witnessed first-hand the dire conditions in which the Rohingya were being forced to endure. He interviewed orphaned children, rape victims, young pregnant mothers, men who had undergone torture by the Myanmar Army, as well as aid workers and Bangladeshi civil servants charged with making policies on refugee issues. Stories heard were reminiscent of horror movies – details of how whole families were slaughtered by the Army; how women were raped and then killed; how pregnancies were becoming infanticides as the newly born 'products of rape' were drowned in wells. Stories of children being burnt alive in front of their parents were also commonplace. Around 1.2 million Rohingya have sought refuge in Bangladesh since August 2017 and the numbers show no sign of abating – giving further indication of the continuing violence taking place in the Rakhine Province. The media focus may now have turned again to Syria while the crisis in Cox's Bazar is dire. "It's hard to comprehend the magnitude of the crisis until you see it with your own eyes. The refugee settlements are incredibly precarious, made from mud and plastic sheeting fixed together with bamboo and scattered across the little hilltops of Cox's Bazar" (Tuhinul Islam, personal reflection).

Even though Bangladesh is one of the poorest and most populous countries in the world, its government remains committed to supporting those seeking refuge on its soil. National and international NGOs are working alongside the government to offer support. This chapter offers a first-hand account of Tuhinul's visit to his former homeland to see for himself the real situation confronting orphaned children wondering to what extent activists from the De-institutionalisation Movement might offer answers to the plight of these orphans, mothers and children fleeing these genocidal acts across a State Border. The themes of Survival, Water and Sanitation; Health and Nutrition; Trauma Scars; Education of Children; Pregnant Mothers with Infants and up to 10 Children are used to question what strategy or policy options are being developed to nurture hope for those orphans and young mothers fleeing genocide in this war zone.

Survival, Water and Sanitation

The main refugee settlement is that of Kutupalong. It was home to several thousands of Rohingya people prior to the recent wave of incomers in 2017. Hence, it looks fairly organised. Yet as one moves deeper into the camp, into the area covered by forest land and those areas with no proper roads, it is a different story. Government and NGO facilities are next to nothing making the vulnerability of the people's living condition shockingly dire. Family groups with up to 10 children are living under one small tarpaulin shelter on muddy and flood-prone terrain. People have few belongings. They are vulnerable to attack from wildlife. Access to clean drinking water, latrines, food or health care is minimal. It is a very fresh displacement situation with people in survival mode, an existence clearly

visible from their body language. People are taking each day as it comes, trying to secure the basics to get through the day. Aid is scattered, with tarpaulin, bamboo and ropes being distributed in one location, while bags of rice or water in another. Certain parts of the camp are densely populated, with around 90,000 people living on one square kilometre, resulting in a complete lack of privacy, a situation particularly intolerable for Muslim women who are required to maintain 'purdah'.

It is hard to imagine the impact of not having adequate sanitation facilities or safe drinking water. The outbreak of disease is rampant, and the situation will worsen once the monsoon season starts in June. Shelters were witnessed dripping rainwater causing muddy floors and waterlogged terrain. Walking on slippery muddy hill-paths presents real risks. Tube wells had become covered by water, and human excrement could be seen floating everywhere. Some women explained that they avoided eating because they could not find anywhere safe to defecate.

During the initial stages of the influx, many Bangladeshis came to volunteer in the camps, offering food and medicine, building temporary shelters, and installing hand-pumps for drinking water and latrines – work now being done by the aid agencies. Water and sanitation remains a priority due to the continuing influx and expansion of existing mega camps, and spontaneous settlements. This is compounded by the high proportion of non-functional hand-pumps (31%) and latrines (35%) that were rapidly built during the acute phase of the crisis. Poor sanitation and hygiene increases the likelihood of outbreaks of water borne diseases such as diarrhoea and cholera.

As an over-burdened nation itself, Bangladesh was ill-prepared to host the vast numbers that have arrived on its Border. For this reason, initial welcome of the Rohingya influx was not very well organised but gradually, with the support of the Bangladeshi Army, camps are becoming 'better organised', in terms of shelter and other basic facilities. For example, camps are being named in different blocks, those built on dangerous ground are being removed, proper pathways are being marked out, and other establishments are being created. Locals wishing to help are asked not to distribute items to the Rohingya themselves but rather to go through local State-run aid coordination committees. Food items such as rice, potatoes, pulses, oil, salt and in some cases baby food, are being distributed via Aid Distribution Centres, yet it is not enough to feed the large families. Fresh produce such as vegetables, meat and milk are extremely limited as well as wood for fuel. To make ends meet many refugees are having to resort to exchanging their daily rations for wood, blankets or other things they can get as relief. Those who have the strength to make it to the distribution centres benefit more than those too weak to trek to the centres located at great distances away. 'Survival of the fittest' is clearly visible in the relief distribution centres, hence tensions run high as individuals fear the products will finish before their turn comes.

Health and Nutrition

Fulfilling the health and nutritional needs of refugees is paramount. It is estimated that around 400,000 children under the age of 15 years require urgent medical treatment. The risk of communicable diseases – like cholera, measles, diarrhoea and respiratory infections – breaking out remains acute given the overcrowded nature of the refugee camps as well as the lack of adequate food so essential for growing children, and for pregnant and lactating women. It has been estimated that 70,000 pregnant Rohingya women are at a high risk of developing health problems due to malnutrition, unsuitable living conditions, poor health care, and psychological trauma. These women tend to be particularly weak due to incidences of multiple pregnancies. It is not uncommon to find women having given birth to between 7-14 children. Many are traumatised and have gone without food for days while fleeing Myanmar. As a result, miscarriages as well as other gynaecological health problems are commonplace. Local physicians working in the camps are limited in the support they can offer.

Prior to fleeing, the state of most Rohingya people's health was not good. Due to State discrimination, the Northern Rakine region of Myanmar was particularly badly served by government services. Myanmar's Demographic and Health Survey (2015-16) shows that only 29.7% of women in the Rakhine Province received any form of antenatal care, while only 54.2% of women were offered a post-natal check-up in the first two days after birth. The statistics are particularly worse in the Muslim-majority Northern Rakhine region, from where most of the Rohingya have fled. Discrimination in state-run health care services has been on-going for decades. Thus, the overall health of Rohingya women has never been good.

One pregnant woman explained how she had managed to escape with her children after soldiers shot dead her husband, saying, "We do have a place to live but have to survive on scraps of food my eldest son collects as aid every day". When asked about her diet, she replied they were being offered only biscuits and puffed rice. Clearly such a diet will not meet the daily nutritional requirements of anyone, let alone a pregnant woman. Such scenarios were not uncommon amongst pregnant and lactating women in the camps.

Aid agencies and government services are doing their best, but illness is rife, and services are over-stretched. The basic needs are not being met for cleanliness, good food, rest and peace of mind. Without these any medical remedy is futile. People are alive but not living. Adults and children with families have managed to find the wherewithal to live. But what about the 17,000 or so reported orphans who have no significant adult looking out for them?

Trauma Scars

Survivors have given harrowing accounts of the violence they have witnessed and endured, including the hundreds of cases of rape by army personnel. According to Rohingya community leaders and survivors now living in the camps, almost every individual is either a survivor of, or a witness to multiple incidences

of horrendous abuse. Women and girls arrive at the camps, often alone. Damaged and traumatised, having been sexually violated by the perpetrators of this genocide, the demand for abortion facilities in the camps is near epidemic proportions.

The survivors' accounts are heart-renching. The calamity, initially reported by the world media in 2015, heightened by 2107, and has remained in the public domain ever since. Media scenes showing children exposed to extreme trauma, as they gave accounts of loved ones being killed or tortured in front of them, and seeing their homes being destroyed brought tears to the eyes of viewers. One child interviewed, said, "my mum, dad, brother and sister, we all got separated by the river. Then my mother found me and grabbed on to me. She did not know how to swim. I found myself telling her "you're going to drown, and you'll take me down with you". Hearing these words, she let go of me … and drowned. I cannot sleep recalling these words. My mum could not swim and was afraid. She clung to me for safety but her love for me made her let go of me and now she is no more. "I have lost my mum".

The camps are filled with children who became separated from their families and their numbers are growing. These children are left traumatised by loss. One wonders how their trauma will manifest itself in their futures, and for the worlds they inhabit without adequate counselling and support?! A 19-year-old girl – recently married – explained how the Burmese Army had gunned down her husband and five members of her family. At the time she was out of the house but witnessed everything. Unable to do anything to save her family, she ran away. She wonders if their bodies have been buried and the thought that they were not given their last rites is eating her up. She arrived in Cox's Bazar after a 23-day arduous trek – going through forest, rivers and mud-slip paths. Along the way, she witnessed three women being raped by the Army, four men shot dead and one have his throat cut. These scenes return to her as nightmares. Now she lives alone in one of the camp's tents, disoriented and traumatised. She cries all the time, recalling the scenes she witnessed repeatedly. She accuses herself of not doing anything to save her family, explained that she felt deeply depressed and suicidal but to save herself from the violence within the camps, she acts out. She lacks the energy to go to the aid distribution centres for food items and because of her mental condition, other refugees try to ignore her. It seems she is unlikely to live for long.

Another woman explained how ten of her family members, including her husband, were slaughtered over a three-day period. She said soldiers picked up her crying 2-year-old daughter and threw her onto the body of her murdered husband, which was covered in blood to shut her up. She lives for the day when she can exact 'revenge' on those who took her family away from her. She says that she will never forget and will not let her children forget either. They will mete out justice on her behalf, once they reach adulthood. Hearing this one is reminded of the years of blood-shed that the world has seen in places like Northern Ireland and Israel-Palestine, where the next generation of adult's fight for the injustices inflicted upon their parents.

Another pretty-looking pregnant woman, in her early 20s was gang raped and bitten on the cheek leaving a scar. The rapists smoked methamphetamine to sustain the torture in front of her husband after 8 of her family were burnt by the Burmese Army. When her husband shouted at the rapists, they shot him in the head. "Child marriage is a strategy to prevent women from being raped by the Myanmar Army," said Lailufar Yasmin, a professor at the University of Dhaka who has studied Rohingya gender issues. "The community strategizes that if women are married in puberty and became pregnant immediately, they will be not be targeted by the army." However, pregnancy and early marriage is no defence against the Tatmadaw – the Burmese State Defence System (New York Times, 23 December 2017).

If the world wants to avoid on-going conflict, the victims of trauma need to be supported adequately. As an economically poor and hugely populous country, Bangladesh is not able to provide for its own citizens fully, let alone take on the integration of another 1.2 million refugees. Yet when refugees are told that eventually they will have to return to Myanmar, panic runs through them. They clearly unable to contemplate returning to a place where they lost so much and had to flee for their lives. One interviewee said 'you can kill us, but we will not go back there. If we die here (in the camp) at least we will be buried as Muslims. We were not able to bury our people who were killed by the Mog (the local allies of Burmese soldiers). Please don't send us back, we don't have anybody there". Unfortunately help for these traumatised people is significantly lacking if one goes by the food, accommodation and general health care facilities being offered. None of the NGOs present on the ground have the wherewithal to deal with the situation and government agencies are unable to coordinate the relief effort sufficiently. Yet if refugees are not treated for their trauma, especially the children and women, this generation will undoubtedly become a burden for Bangladesh and beyond.

Seeking the Light of Education for Rohingya Children and Young Refugees

The humanitarian effort is very challenging. As numbers grow, access to food, safe drinking water, and emergency shelter is becoming stretched but this is the priority. Yet several NGOs are coming in to offer educational facilities to the children and young people. Decades of prejudice, discrimination and persecution have rendered 80% of Rohingyas illiterate, with 60% of their children not attending school. A total of 473,000 Rohingya and affected Bangladeshi children aged between 4-18 years urgently need access to education. It is crucial that these children and young people, who have suffered so much in this crisis, should have access to education in a safe and nurturing environment. This is critical not just to provide them with a much-needed sense of normality now, but so that they can build a future to which they can look forward.

The Myanmar government announced on February 15, 2018 that it had ended its military operation against the Rohingya. But, despite the hardships in camps,

many parents are not planning to return home for fear of further discrimination and torture. "We will stay here and hope we will have the chance to educate our son", said one young parent, who continued, "we want our son to learn all different subjects, and not be limited". Parents understand the importance of education. Another parent said, "If they learn, they will be able to live their lives properly." Another parent said, "Wherever we go, the children need knowledge".

The Bangladeshi government has denied the establishment of any formal school system in the camp site because it wants the Rohingya to eventually return to Myanmar. It is negotiating with the UN and Myanmar government on repatriation as well as planning to relocate the Rohingya refugees to a remote island in the Bay of Bengal if return to Myanmar is not feasible. Although there are schools located nearby the camps, Rohingya children are denied access and cannot leave the camps, so they are unable to attend. Some NGOs have established Temporary Learning Centres for very young children inside the camps. Teachers are often unqualified, and resources are limited but it is better than nothing. During visits to some of these centres, they were found to cater for approximately 50 children at a time. Children study English, Maths and Burmese language. Interestingly, the Bangladeshi government has disallowed the teaching of Bangla in these Centres as they fear that once the Rohingya learn Bangla they will become indistinguishable from the local population. In a sense, the Rohingya Community has been stateless since the British left Burma in 1947 and this human right of statehood has been denied them.

No educational or recreational arrangements for older children were identified during the January 2018 visit. Such a lack of opportunities is dangerous and Aid workers worry that if older youths are not engaged in some meaningful activity the possibility of their becoming involved in criminal activity is highly likely. Awareness of the Temporary Learning Centres is sporadic. Children are enrolled by caring adults who have managed to learn about such facilities. But what about the orphans or unaccompanied minors who have no one to inform them of such Centres? Nobody is enrolling them. Unaccompanied minors are more likely to be guided by those involved in crime – human traffickers and drug dealers – to whom they are easy prey. Reports of 'missing' children are now rife.

On the up side, Local Authority Education coordination committees have recently reported that NGOs are swiftly moving to set up several Temporary Learning Centres (TLCs) around the refugee zone. Budgets are tight, yet teachers are being trained in working with refugee children between the ages of 4 and 14, and 'class places' are quickly being filled. One might think that such Centres are easily set up, but Aid agencies have reported major challenges in finding suitable ground to build such Centres, near to where the children live, as overcrowding is widespread. Teacher drop-out rates are high as the work is arduous. Attendance by learners is sporadic, due amongst other things, to the fact that children are often in charge of collecting relief items from distribution centres. There is limited availability of WASH facilities in learning centres and adequate learning resources.

Mindful of their limited budgets, the NGOs are developing short videos on effective teaching practices to support the learning centres in a cost-effective way, until a more permanent solution can be found. Without electricity to power video machines, this is often a failed enterprise.

Pregnant Mothers with Infants and Up to 8 Children and Orphans

There are several reasons for the high fertility rates among Rohingya communities. Firstly, pregnancy and early marriage is an age-long strategy employed to prevent Rohingya women from being raped by State oppressors. The Burmese Army has generally not targeted pregnant women. Secondly the fear of 'vanishing' as a community, due to the atrocities their menfolk have undergone has, psychologically made Rohingya want to increase their numbers. The community expects its womenfolk to produce large numbers of children. Thirdly, being a religiously conservative people, Rohingya people frown on the use of birth control, and lacking 'modern' education due to poverty, large family-size is seen as a way of survival.

This has meant that women who arrive at camp are often pregnant and arrive with numerous children. Currently the camps are housing over 70,000 pregnant women and around 7 per cent of the total influx are mothers. With husbands killed or missing, they are now the head of household, a role for which they have not been trained nor prepared. The United Nations High Commissioner for Refugees has reported that 53% of all Rohingya households are headed by single mothers. While Bangladesh has opened refugee camps to receive those fleeing from persecution, they have so far been ill equipped to meet the needs of pregnant and lactating women. Stories of fleeing women giving birth on route are commonplace. One Aid worker explained, "Just two days ago we found a woman who delivered on the roadside in the middle of night. She was brought to one of our health centres, where our midwives were able to take care of her and the baby, and such stories are shared daily."

The number of pregnant, traumatised women arriving at the camps is huge. Most arrive having travelled without food for days. Incidences of miscarriage as well as other health complications are common. Many of these women are arriving with their children, many of whom are mere infants. It is not unusual to see a pregnant woman supporting five or six, sometimes even up to fourteen children. Early marriage is encouraged by the Rohingya and so early pregnancy is common. Yet, due to the horrific circumstances in which these women now find themselves – without basic needs such as food, safe shelter, and sanitation facilities – their safety and security is greatly compromised. Rest and psychosocial support is crucial for their well-being. One young, pregnant woman explained how 'it is not easy to cope with the pain of losing everything, the suffering caused by having nothing, not even a warm bed. The fear of being sent back to Rakhine, and the

responsibilities towards our kids with no husband for support, and then on top of that, carrying another baby inside you that you must protect and bring into this world of suffering'.

The number of female-headed and elder-headed households displaying greater vulnerability than those households headed by men is not surprising. In a male-dominated world, households headed by females suffer greater discrimination. Having fled extreme circumstances, these vulnerable households are not only traumatized by the loss of their loved ones, but also the loss of their financial assets and means of obtaining a decent livelihood. There are incidences where women and their children having sold their remaining assets, now turn to negative coping mechanisms such as drug dealing and prostitution in order to survive. If support is not quickly forthcoming, not only will the numbers of those dying increase, but those that manage to survive will be deeply troubled for many years to come – likely contributors to increased levels of mental illness and criminality.

What makes this crisis heart wrenching is that almost 60% of those fleeing Myanmar are children, and there are more than 20,000 orphans with no one looking after them! One in five Rohingya children under the age of five is estimated to be acutely malnourished, requiring medical attention. The Rohingya crisis has been labelled a "children's crisis", the Director of one of the leading humanitarian networks saying, "never have I seen so many children in a crisis. Children who've seen things that a child should never witness". Médecins Sans Frontières has documented that dozens of Rohingya girls have been provided medical and psychological support at one of its sexual and reproductive health units. With so many undocumented children living without legal guardians, aid workers reportedly worry about cases of abuse and trafficking. Safeguarding children from criminal opportunists must be priority number one.

According to the Daily Star (an independent Bangladeshi newspaper), around 20,740 orphans have been identified since 20 September 2017. In most cases, they arrived at the camps with someone they knew, but not always. Due to the vastness of the camps and the lack of adequate registration facilities, when other family members did arrive and sought out their children, they were difficult to trace and hence reunite with their families. It was found that newly arrived youngsters were unable or unwilling to disclose their identity, perhaps because of trauma or discrimination. Hence it has been a challenge identifying unaccompanied minors.

Children and young people themselves can be at risk in a crisis environment such as a refugee camp. One can only imagine what can potentially happen when presented with 20,000 children now left alone to fend for themselves. The risk to younger children from human trafficking, sexual abuse or forced marriage, is potentially much greater, especially for girls. There is already anecdotal evidence in the camps that child trafficking is taking place. Safeguarding children from opportunists looking to make a 'quick buck' from such acts of viciousness must be prioritised. The focus on promoting psycho-social well-being is gaining

momentum, as demonstrated through work being done with adolescents by the Bangladesh Institute for Theatre Arts (BITA). Work is also underway to undertake a comprehensive verification and validation account of all vulnerable children, thus highlighting and remedying potential gaps and inadequacies. Initial work is on-going now to pilot social protection actions with foster families. It is not yet clear which modality will be the most appropriate (cash transfer or a voucher system) to provide this support, but at least it has begun.

Having refused the building of permanent shelters where children can stay for a prolonged period, the Bangladeshi Government now finds that individual citizens are beginning to do this themselves, as an act of religious duty. One retired official explained how he was personally supporting around 300 unaccompanied minors, providing them with a place to stay as well as access to educational facilities. This man believed he was meeting the children's health and safety needs as well as essentials. A large, secure, fenced-off area was their playground, thus serving their physical, mental and spiritual development. He was also providing a daily cooked meal to 3000 children and ensuring they have access to a safe playground for physical recreation that helps to combat the symptoms of trauma they have experienced. His rational for undertaking this 'service to the community' was, "if I don't do this, these children will certainly be trafficked or die. I have some money, so I am trying to use it for good. However, I don't know how long I can continue, because my resources are finite, and the needs of these children is on-going. Pray for me that I can continue my work. Inshallah it will be good". He said his army connections were enabling him to influence the local administration to do this work. If he was an ordinary person, even with much money, it would not easy. Thousands of unaccompanied minors arrive daily requiring immediate support and protection. Government bureaucracy is holding things up because they do not want the camps to become a permanent feature on Bangladeshi soil. Ultimately, the Bangladeshi government want the Rohingyas to be repatriated.

Conclusion

Denied citizenship by Myanmar's government and targeted by what the United States calls 'ethnic cleansing', the Rohingya are currently among the most mistreated people in the world. Within this traumatized population, women are uniquely vulnerable. The stateless Rohingya have been sequestered and preyed upon by Myanmar's Tatmadaw military for years. But the latest campaign of gang rape against Rohingya women has been so brutal and systematic that Pramila Patten, a United Nations special representative on sexual violence in conflicts, has deemed it "a calculated tool of terror aimed at the extermination and removal of the Rohingya as a group" (New York Times, 2017). Myanmar's government has denied any instance of sexual assault, even claiming that Rohingya women are 'too unattractive to merit attention from Tatmadaw soldiers'. Yet the fact remains, millions have been displaced from Myanmar to Bangladesh. People do not flee their

homes without good cause. They leave because their lives are in danger, and they find no other option.

Bangladesh has been forced to house over a million people within a very short time. Being a poor and over-populated country itself, it has not been easy. The International Community has urged the Government of Bangladesh to keep its borders open and has offered support to do this. How such support is used by the Bangladeshi government and the aid agencies on the ground is now a matter of urgent concern. Citizens of the world have shown their concern by giving hard-earned money. Now those who will use this money must ensure that the money is spent wisely and for the benefit of the victims, and particularly for the children who are the adults of tomorrow. Expressing concerns over the plight of the Rohingya children, Nobel Laureate, Kailash Satyarthi – India's foremost children's rights activist – stated, "If any child is being victimised during the current Rohingya crisis in Myanmar, then it is the moral responsibility of the world community to resolve this crisis". Those children with adult family members looking out for them are relatively okay, but what about the thousands of orphans?

Activists from the De-institutionalisation Movement seem uncharacteristically silent about the plight of these victims of genocide. What strategy or policies have these de-institutionalisation activists formulated to nurture hope amongst the Rohingya orphans and mothers fleeing Genocide due to an Imperial policy that denied citizenship to a group that was indentured from India to Burma in the 1800s?

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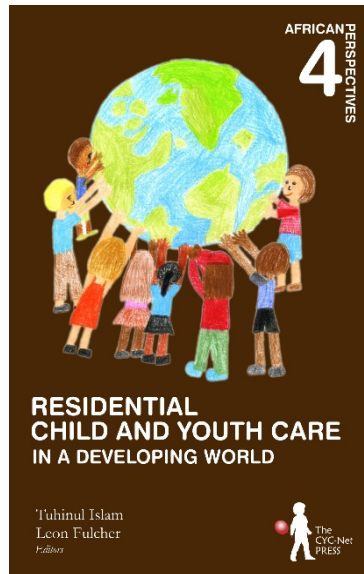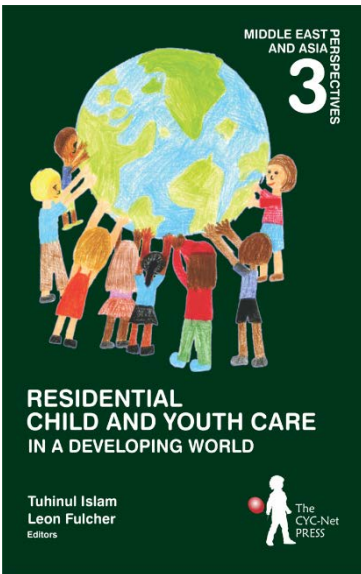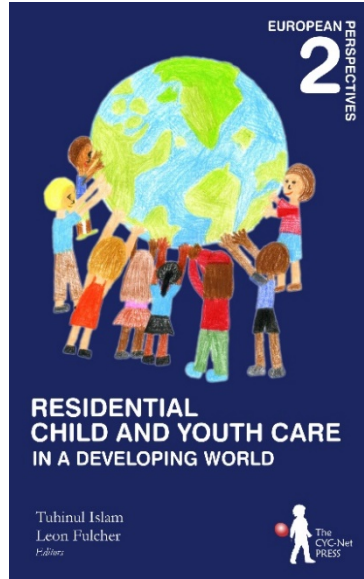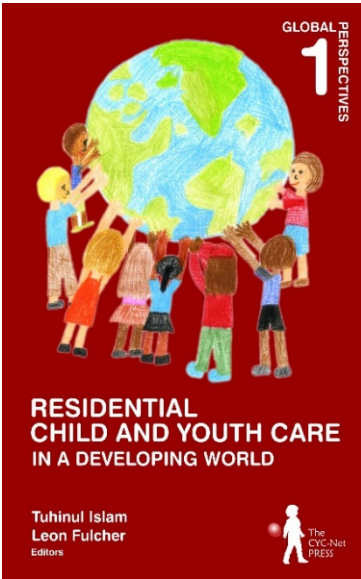
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This volume is the first of its kind in which contributors from across the Middle East and Asia Region discuss how residential child and youth care is provided in their localities. Practitioners, managers, scholars, policymakers and educators interested in international social work and residential child and youth care will find this volume an essential resource. Highly suitable for instructional purposes, every chapter of this eminently readable book includes insightful questions that foster reflection and deeper learning.

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