

Institutionalised Children Explorations and Beyond

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Focused on the South Asian Region



Institutionalised Children Explorations and Beyond

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EDITORIAL

Institutionalised Children: Explorations and Beyond **Vol.1, No.1, March 2014**

Introducing the New Journal: Note from the Editor-in-Chief *Monisha C. Nayar-Akhtar*

In January 2012, a small group consisting of mental health professionals and others connected with the care of children in institutions in some capacity (later constituting the core Editorial Board of the Journal) convened via Skype and later in person to brainstorm and explore the launching of a new journal. They had a singular purpose in mind: to publish a journal that would provide regional (SAARC) representation to papers related to children displaced out of family network and the management of services to this population. It was overwhelmingly recognised that there was a serious absence of any such journal or forum for presentation of ideas. The alarming increase in children requiring services from institutions and other organisations could not be ignored. And, NGOs, alternative care models, growing recognition of policies and much needed governmental regulatory bodies were becoming increasingly prevalent. Questions regarding universal standards of care with regional and cultural implications and interferences were being raised in many different venues of service delivery. One could say that the idea for such a journal had been percolating in the larger community and certainly in the minds of this group, for quite some time. And quite rightly so, as no such journal existed in the region. The time was right and with the dedicated efforts of our group, the idea flourished and began to take shape in more concrete ways in our minds. The dedication of my core editorial board, the collegial exchange of ideas, the weathering of internet highs and lows and finally, the contributions from our colleagues from the region and from around the world has indeed paid off.

It is with great pride and humility, that I as its Editor-in-Chief, now introduce this journal to the region. The scope and depth of “Institutionalised Children: Explorations and Beyond” (ICEB), is best captured by our mission and vision statements. They are as follows:

Mission

To conscientiously and with responsibility, appraise, evaluate, and commission research and studies that impact and have bearing on the lives of children, who are in institutions – orphanages, observation homes and others, in SAARC countries; and to develop a dialogue on existing systems, and possible adaptations, which will lead to an improvement in their quality

of life, thus influencing their becoming responsible young adults.

Vision

To make available a platform for consistent sharing of information, knowledge enhancement and the development of a dialogue and debate amongst professionals, policy makers, and volunteers working for institutionalised children, about best practices, research findings and studies, legislation, jurisprudence and case law, in relation to such children's mental health, social development, care and upbringing in alternative modes of institutional care in SAARC countries.

(SAARC countries are: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Sri Lanka and Pakistan)

The journal consists of a core Editorial Board and an International Advisory Board. For the first issue, the Editorial Board met weekly to discuss thematic issues and structural layout for the journal. The solicitation of articles was a major task, as it required contacting individuals working in the different SAARC countries, who were involved in working with orphaned or underprivileged children. This required significant effort and I know that the Editorial Board is deeply grateful to those individuals who gave selflessly of their time and energy to facilitate contact and establish a dialogue. Our International Advisory Board was established with a core group of mental health professionals and others involved in the care and management of vulnerable children from all around the world. These individuals were invited to become part of the board for their expertise in child development, for their well-established reputations in working with this population and for their demonstrated dedication to enhancing the understanding of issues related to the care and management of children, adolescents and families. Our International Advisory Board is an integral part of our identity and will become a core element of our group, as we move forward.

The ICEB is a bi-annual non-peer reviewed journal, March and September publications. We will solicit articles with a wide and diverse focus. These will range from policy development at both national and international levels, reviews of legal protection and the establishment of child sensitive laws and regulations, to effective and innovative standards of care implemented in different regional institutions and models, to ongoing research and longitudinal studies that examine various aspects of care related to by not limited by, physical and mental health, social development, impact of life altering situations such as sexual abuse and HIV/AIDS and the support and development of programmes to caregivers in their role as primary service providers. In addition, we encourage explorations of alternative and innovative care models as well as papers examining the

developing field of social work in the region. Our scope and vision will ensure a rich and wide array of papers that will inform and educate us and provide us with an ongoing dialogue on care and management of orphans and abandoned children. These are a few of the topics being covered in the journal and in this first issue.

Each journal issue will have the following structural format. It will begin with an in-depth interview of an individual whose work with institutionalised and abandoned children government is well-known. We will identify individuals from any of the eight SAARC countries to share their thoughts and ideas on children who have been displaced out of commonly recognised family networks and live in institutions. The interview will be conducted by an Editorial Board member and will follow a standard interview format asking questions relevant to the area of expertise. For the first issue we are proud to publish an interview of Mr. Ron Pouwels who is Regional Adviser of Child Protection for the UNICEF Regional Office for South Asia. Mr. Pouwels' responses on several open-ended questions regarding policies for children living in institutions and displaced out of family networks is cogent, informative and highly instructive for the region. This interview was conducted by Mr Luis Aguilar, a member of our Editorial Board.

For the main body of the journal, we will publish about eight to ten original articles solicited from individuals who conduct research with orphaned and abandoned children and those in need of protective care. The section will provide for scholarly literary input on various topics related to the population under consideration. Presentation of noteworthy articles on standards of care and assessment of effective exchange of ideas within the region will be of prime concern. For the first issue we have two articles from Bangladesh. The first by Sabrina Mahmood and Dr. Shamim Ferdous, examine the effects of psychosocial support on sexual abuse of children with disability while the second paper by Tuhin highlights the role of building ego-resiliency with this group. The mental health implications are quite evident and we hope to continue with this trend in future issues as well.

A paper on the assessment and establishment of effective standards of care by Jeganathan Thatparan, a child activist whose humanitarian efforts with this population is well-known, provides an interesting and comprehensive perspective on how this can be promoted in the region. This is complemented by a paper exploring the child care institutions in Sri Lanka. Mrs. Varathagowry Vasudevan's paper on alternative care services that provide 'family equivalent' care expands on this exploratory direction offered by Thatparan and contextualises it within the socio-cultural milieu of another country and region.

From our own Editorial Board we have a paper by Dr. Deepak Gupta and his colleague, Ms. Neha Gupta, on the prevalence of Post-Traumatic Stress Disorder in children who have been institutionalised. By drawing attention to mental health concerns that possibly emerge and are a result of institutional care or lack of it, suggests the imperative need for establishing standards of care for each organisation with regulatory agencies in place that monitor and implement the delivery of best care practices.

To give breadth and depth to our journal, a paper with a significant international perspective will also be published in each issue. These papers will be solicited from authors outside the SAARC region, whose research focus, literary investigation and the exploration of innovative and alternative care models contributes significantly to the field in general. These papers will draw attention to international models of care and policies in practice. For this issue we have selected a paper by Whettan et al, which provides a comparison of the well-being of orphans and abandoned children in institutional and communication based care settings. Drawing from less wealthy nations, this paper provides a much-needed cultural and regional focus, which is coloured by the dynamics of poverty and impoverishment in the field of childcare.

Finally, an article presenting ‘good practice’ will be selected to provide a comprehensive review of how institutional care is provided in different settings. For this issue, we have a rich and compelling presentation by Dr. Kiran Modi (along with other members of the board and her organisation) on Udayan Care; an NGO providing care for vulnerable children (identified as those displaced out of family networks for a variety of reasons) for children ages 5 through 18 and also aftercare services. Dr. Modi’s paper highlights the multilayered understanding of orphan care and children in need of care and protection, including the critical need to examine and explore how support and care is provided to caregivers who constitute an integral part of our service delivery team. This has also been highlighted in other papers as well.

The Editorial Board also voted to include a movie and book review in each issue. For the movie review we will solicit a review of movies from different countries in the SAARC region that focus on the portrayal of orphans in that region. This can include but is not limited to, social attitudes and perceptions of orphans, their depictions by social media and the stories that have evolved over the years regarding their participation in the political and social fabric of our times. For this issue, Dr. Namarta Joshi has a fine paper on how orphans are portrayed in mainstream Hindi films. Her introductory review of several movies is nostalgic, heartwarming and descriptive of how perceptions and attitudes

develop and are maintained by the social media and how they influence human behavior and socio-cultural institutions.

Similarly, a review of a book addressing issues related to orphan care and orphan hood will also be published. While we will primarily solicit non-fictional accounts of children who fall in this category, we will also not rule out fictional accounts that have achieved national and international status. For this issue, I review “Orphan Care: A Comparative Review,” by Jo Daugherty Bailey, whose selection of papers from six low to middle income nations, provides an exemplary account of compare and contrast in governmental policies, dovetailing with socio-cultural attitudes and the social work structures in place that provide responsible and effective care of orphans and abandoned children.

Finally, the journal will end with a Brief Communications section that will provide a sample of brief papers on various topics of interest. These papers will inform the reader of initiatives in the region as well as potential projects under consideration. Some of these papers will have a ‘country focus’ whereas others will provide a platform to announce significant new directions in the field. In this issue we have a selection of papers from Afghanistan, Pakistan and Maldives, all providing a bird’s eye view of prevailing programmes, socio-political concerns and contributions to the growing orphan population and speculations about future. The remaining papers focus on coverage of child friendly guidelines and innovative strategies for moving forward.

It is our wish and desire that people reading this first issue will become energised and enthusiastic and seriously consider contributing their ideas and articles to us for publication. We invite your participation in any form as we provide a diverse venue within which your paper can be placed. We are looking for innovative strategies that are being implemented in the region, for policies that are being developed, reviewed and regulated, for legal protection that is being considered and in general any endeavour that enhances the delivery of services to vulnerable children in need of care and protection in any of the SAARC countries.

Encouraged by growing international perspectives on children who are in need of care and protection and require a variety of services and dismayed by the silence in our own region, our objective was to simply provide a forum where scholars, researchers, practitioners, service providers and others in the SAARC region can come together, to publish and promote their areas of expertise. This issue is the first step and I hope, a promising one, in that direction. We will continue to work on improving this journal and welcome your ideas for consideration. Some ideas for future issues have already been generated. These include articles on child protection rights; policies, regulations, and preventive

practices and the monitoring and assessment of ineffective practices. Developing guidelines for minimal standards of care for the children is a primary concern as is the concern for children participation and the growing importance of accountability in the region.

ICEB also hopes to become a positive force in helping to attract others who are not currently conducting research and/or publishing in this area to initiate and develop their ideas of care and management of orphans and share it with the larger audience. The scope of this journal is vast as has already been described and certainly we invite creative and innovative scholarly directions from others as well.

It is therefore with great pleasure that I invite the readers, institutions and contributions to peruse this journal, to think of contributing to it and eventually to build it to become a leading journal in the field of institutionalised children and those in need of care and protection in our region. Finally, no journal can be put together without the efforts of many individuals and sponsors and I am grateful to all who have contributed in one form or the other. I am extremely grateful to all members of my Editorial Board and extend a heartfelt thanks to Mr. Luis Aguilar for keeping us on track with his role as secretary of our meetings and his diligent attention to details while taking down the minutes, drawing our attention to initiatives in other countries and overall carrying our vision and mission statements with vigor and integrity. The dedication of my board, their wisdom and insight, their ability to think ‘outside the box,’ and most of all their perseverance during difficult times with much needed humor made my job as the chief editor easy and enjoyable. I would also like to thank WHO SEARO for their generous contribution without which we could not have printed this issue. Finally, I would like to thank two individuals who gave time and effort in editing and finalising the format of this journal. From the United States, Ksera Dyette, my research assistant for this past year gave endless hours to edit and format the individual articles. Her counterpart in New Delhi, Avijit Chakravarti complemented her and my efforts, to print this journal in the form that we see it today. I am deeply grateful to both of them.

I am proud and privileged to have had this opportunity to facilitate the birth of this journal. It is the culmination of all our efforts for the past fifteen months. I am confident that with the ongoing support of my boards, and with the gracious sponsorship of others and your intellectual contributions in the future, the ICEB will indeed become a leading journal in the field.

Monisha Nayar-Akhtar
Editor-in-Chief

INTERVIEW

Ron Pouwels, Regional Adviser on Child Protection **UNICEF Regional Office for South Asia**

*Luis Aguilar Esponda**

INTRODUCTION

For the first issue of the journal “Institutionalised Children: Explorations and Beyond” (ICEB), Mr. Ron Pouwels, currently the Regional Adviser on Child Protection at the UNICEF Regional Office for South Asia was interviewed. Mr. Pouwels’ expertise in child protection is well-known and it is the hope of the ICEB Editorial Board that his interview will further our understanding of the debate surrounding this topic, particularly as it relates to all other structures dealing with children in need of care and protection, and also those in conflict with the law. The Editorial Board wishes to express their gratitude to Mr. Ron Pouwels and UNICEF for their collaboration on this effort.

In the light of your area of work in child protection, please briefly describe the current situation of children in South Asia?

While progress has been made, especially following the ratification of the Convention on the Rights of the Child (CRC) by all countries in the region, many children in South Asia continue to suffer from discrimination, violence, abuse, and sexual and economic exploitation. Many more children face protection risks. Violations of the child’s right to protection take place in every South Asian country and are often invisible, under-recognised and underreported. Such violations may occur by acts of omission or commission and occur across all sectors of society regardless of wealth quintile or other determinants. From the evidence available, it is clear that the consequences of child maltreatment can result in lifelong inequities for those children who experience any form of maltreatment and, sometimes, even in their death.

The 2006 UN Study on Violence against Children estimated that in South Asia every year between 41 and 88 million children witness violence at home – the highest regional total in the world. Evidence also indicates that half of the world’s child brides live in South Asia, where 46 per cent of women aged 20-24 are first married or in union before they reach the age of 18, and that around 44 million children are engaged in child labour across the region. Also 61% of

This interview was conducted on 15 December 2013 in Kathmandu / Delhi by Luis Aguilar Esponda, LL.M.,

**Associate Editor, ‘Institutionalised Children: Explorations and Beyond (ICEB)’ LL.M. in International Law and the Law of International Organizations, Mexico; laguilaresponda@yahoo.com.*

children under age five do not have their births registered in South Asia. Sexual abuse and exploitation, as well as child trafficking and corporal punishment raise additional concerns in the region.

The situation of children outside parental care and the provision of suitable alternatives for them is another concern in South Asia. An estimated 43 million girls and boys in South Asia are growing up without one or both of their parents due to the impact of poverty, disability, HIV/AIDS, armed conflict, natural disasters and migration. While some children without parental care live with their extended families in kinship care arrangements, others no longer have their families, have been separated from them, or their families represent a serious danger to their development and/or protection. For these children, States have the responsibility to provide special protection and assistance.

Global and regional evidence indicates that institutional care is very rarely the best option for a child's development; it is not cost-effective and has detrimental effects on children and society. However, institutional care is the most common type of alternative care provided by the State as well as by non-governmental organisations in the region. In some countries, it is the only option formally supported and recognised by the government. Regulatory frameworks and technical capacity within governments to ensure and monitor the quality of the care provided are still weak and it is common to see placements that are not supported by systematic assessments, gate-keeping policies, or individual care plans.

Relatively few children are in such care because they have no parents, with most being in care because of disability, family disintegration, violence in the home, and social and economic conditions, including poverty. This fact is an important reminder that many children living in institutional care can potentially be reunited with their parents.

Juvenile justice systems in South Asia do not aim sufficiently to ensure the dignity of children and reintegrate them into the community, which was also recognised by the Committee on the Rights of the Child. These systems are not always distinct from those applied to adults, and they resort too swiftly to institutionalisation. Sound data on children detained through justice systems in South Asia are lacking, but evidence shows that juvenile justice systems remain weak across the whole region and that often children in detention have not committed serious offenses.

The region is also subject to emergencies deriving from insurgency and instability, and natural disasters in the form of floods and earthquakes, which create new protection risks for children and worsen existing ones. Armed conflicts leave

children and populations vulnerable to rape, abduction, amputation, mutilation, forced displacement, sexual exploitation and killing. The breakdown of protection systems and mechanisms leave girls vulnerable to sexual violence (although boys in the region are also at risk) and unwanted pregnancy and threatens children with separation from their families, orphaning, increased risk of sexually transmitted infections, disability and serious, long-term psychosocial consequences. The wide availability of light, inexpensive small arms can contribute to the recruitment and use of children as soldiers, as well as to high levels of violence once conflicts have ended. Children can be enrolled as combatants, cooks, porters, and messengers; girls can also be recruited for sexual purposes and for forced marriage.

Let me conclude on a more positive note. There is a genuine recognition and commitment on the part of many governments in the region to address the situation of children's rights, including rights to protection. Although government, civil society and community strategies are not necessarily located within a national 'vision' or commitment to a national child protection system, substantial developments have been realised. As mentioned earlier, countries have particularly progressed in legislative, policy and institutional reforms on a broad range of issues, such as child marriage, child labour, and discrimination. A number of countries in the region have established specialist police units and courts for juveniles and there is a wide range of capacity development activities of professionals such as the police, magistrates, health care workers, and teachers. A number of countries are also working to build a cadre of professionally skilled staff through social work education and accreditation and to build or strengthen social work services for children and families within a child protection system. Several information sharing and public-awareness campaigns on child rights and, particularly, the right to protection, have also been implemented, while there are also several examples of the active participation of children in behaviour-change programmes, such as through child rights clubs in communities and schools.

What are the main concerns in the South Asian region in relation to children?

As child protection is a relatively new area of work in the region, there is a limited understanding and prioritisation. Moreover, many child protection issues are being regarded as sensitive, as "private troubles" that have to remain within the family and/or are deeply engrained in traditional and social norms that particularly affect girls. Systemic constraints are a common feature in the region. Regarding legislation, this ranges from gaps and weaknesses in legislation, to a slow enactment process with a number of bills pending in Parliament and a lack

of enforcement. There continues to be a lack of human resources both qualitative and quantitative compounded by a high turnover of staff, including those that had been trained in the past. Further constraints are inadequate budget allocations, a lack of coordination and sometimes a lack of clarity of mandates, responsibilities and functions within the system.

What are the major issues related to UNICEF-SAARC partnership?

UNICEF has a Memorandum of Understanding with SAARC, which dates back to 1993 and is currently under review so as to reflect the expanded areas of cooperation. The initial focus of the partnership included work on children's rights in general as well as HIV and AIDS. This has included, for example, a report on the Assessment of Progress in the SAARC Decade of the Rights of the Child (2001-2010) and the adoption and implementation of a SAARC Regional Strategic Framework for Protection, Care and Support of Children Affected by HIV/AIDS (CABA), 2007. Over the past few years, UNICEF's work with SAARC has expanded to include other sectors of work that are relevant to UNICEF and SAARC, such as nutrition, sanitation, education and social policy. With regard to child protection, UNICEF collaborates closely with the South Asia Initiative to End Violence against Children (SAIEVAC), which was established in 2010 and became a SAARC Apex Body at the end of 2011.

Does UNICEF consider the current lack of valid and comparable data on childcare in SAARC countries a major issue? What can be done to improve the compilation of data and its use to improve child protection in this region?

For a good analysis of the situation, valid data is crucial. It could help us, for example, to identify the extent of an issue/problem and who are the children most affected or most marginalised. With regard to children in alternative care, it may provide us with a picture of how many children (girls and boys, orphans, children with disabilities) are in care and what type of care and potentially could help us to assess why children are in care and who they are. This will subsequently assist us in better designing our interventions and programmes. As the Manual for the measurement of indicators for children in formal care (2009) states, the lack of comparable data "makes it difficult for local child welfare authorities and national governments to monitor progress in preventing separation, promoting re-unification and ensuring the provision of appropriate alternative care. The lack of such data also makes it impossible to compare the situation of children in formal care across countries and regions." To use another example from the UN Guidelines for the Alternative Care of Children (2009):

“It is a responsibility of the State or appropriate level of government to ensure the development and implementation of coordinated policies regarding formal and informal care for all children who are without parental care. **Such policies should be based on sound information and statistical data**” [emphasis added] (Para 68, p. 18).

For a start one could begin advocating for the use of the Manual for the measurement of indicators for children in formal care, which contains both qualitative and quantitative indicators. Formal care has been defined in the manual as including ‘all residential care, including where the placement arrangements were made privately, as well as all other care arrangements ordered or authorised by an administrative or judicial authority or a duly accredited body, which includes all foster care and residential care arranged by a third party, whether government or a private agency’.

INFORMATION RELATED TO CHILD CARE AND INSTITUTIONALISATION IN THE SOUTH ASIAN REGION

What about the general distribution of resources destined for the care and protection of children?

As far as I know, no specific budget analysis has been done to assess whether adequate resources are being provided for the care and protection of children. However, what we do know is that in the area of child protection there is a continued lack of human resources both qualitative and quantitative compounded by a high turnover of staff, including those that had been trained in the past. Further constraints are inadequate budget allocations. What is worthwhile noting is that although a national child protection system will incur substantial costs, they will be a minor fraction of the direct and indirect costs currently expended on the repercussions of child maltreatment and the subsequent drain on human capacity, societal cohesion and the future generations of children who continue to experience violence, abuse, neglect and exploitation.

To what kind of intervention is UNICEF giving priority in the South Asian region?

That depends on the country context, which is very different in the various South Asian countries. UNICEF’s Child Protection actions are centred on:

- Strengthening national child protection systems, including the set of laws, policies, regulations and services needed across all social sectors — especially social welfare, education, health, security and justice — to support prevention and response to protection related risks;
- Supporting social change;

- Strengthening child protection in armed conflict and natural disasters;
- Building evidence, managing knowledge and convening and catalysing agents of change as priority crosscutting areas.

If we are looking at the area of alternative care of children, UNICEF's priorities are to work with governments and other partners on prevention of separation of children from their parents; ensuring that the two main thrusts of the UN Guidelines for the alternative care of children, i.e. the necessity principle and the suitability or appropriateness principle, are adequately implemented; and that for those children for whom residential care is the preferred option minimum standards are in place and monitored. The CRC and the UN Guidelines for the alternative care of children guide UNICEF.

In the perspective of a future involvement, how UNICEF could cooperate to improve the situation in institutions?

In a number of countries in the region UNICEF is working with the government to develop minimum standards for institutions, such as in Bangladesh and Sri Lanka. Of course, once these standards are in place, it is crucial that they are also implemented and monitored and that corrective actions are put in place when minimum standards are not adhered to. Another area of work is to assess whether those children who are currently in institutions actually need to be there and whether institutions are the most suitable option for those children. It is particularly important to keep in mind that alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings, which should therefore be an age group to focus on first.

Are there any specific mechanisms in place to evaluate and monitor and give follow up to regional standards for children in need of care and protection, in conflict with the law and children in institutions?

There are no specific mechanisms at regional level, although one could say that SAIEVAC tries to follow up on the recommendations made in its technical consultations, such as the second technical consultation on care standards and child-friendly services.

At the global level, there is of course the Committee on the Rights of the Child, which examines the progress made in the implementation of the CRC through the review of reports from States. The latter have, in principle, to report to the Committee every five years. This gives the government, NGOs, children and the UN the opportunity to do a review of the measures taken. Within its concluding observations, the Committee has a chapter on Family environment and alternative care (covering articles 5; 18 (1-2); 9-11; 19-21; 25; 27 (4); and

39 of the CRC) and one on Special protection measures (covering articles 22; 30; 38; 39; 40; 37 (b)-(d); 32-36 of the Convention), which also includes a component on Administration of juvenile justice.

Finally, a more regular monitoring and evaluation mechanism should be in place at the country level. As the UN Guidelines state: 'States should ensure that all entities and individuals engaged in the provision of alternative care for children receive due authorisation to do so from a competent authority and be subject to the latter's regular monitoring and review in keeping with the present Guidelines. To this end, these authorities should develop appropriate criteria for assessing the professional and ethical fitness of care providers and for their accreditation, monitoring and supervision' (Para 54). It further mentions that in Para 129 that 'States should be encouraged to ensure that an independent monitoring mechanism is in place, with due consideration for the Principles relating to the Status of National Institutions for the Promotion and Protection of Human Rights (Paris Principles). The monitoring mechanism should be easily accessible to children, parents and those responsible for children without parental care' and subsequently spells out the required functions of such mechanism.

IMPROVEMENTS, CHALLENGES AND GOOD PRACTICES

What are the main improvements in the South Asian region for the protection of children?

First of all, one has to say that there is commitment to children's rights, including the right to protection, since all countries have ratified the CRC, all countries have ratified the Optional Protocol on the sale of children, child prostitution and child pornography (OPSC) and seven out of eight countries have ratified the Optional Protocol on the involvement of children in armed conflict (OPAC). Moreover, all countries in the region have ratified the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). And finally, countries have also ratified relevant SAARC Conventions such as the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia (2002) and the SAARC Convention on Combating and Prevention of Trafficking in Women and Children for Prostitution (2002).

Over the past years, we have clearly seen an improvement in the policy and legal frameworks. For example, adoption of the amendment of the Birth and Death Registration Act establishing a permanent Register General Office responsible for overseeing and monitoring birth and death registration in Bangladesh; the coming into force of The Protection of Children from Sexual Offences Act in India, the passing of the Child Adoption Act and the Child Care and Protection Act in Bhutan, the adoption of the Domestic Violence Act in

Maldives, and amendments to the Mediation Board Act to divert minor child offences from criminalisation to mediation in Sri Lanka. A challenge of implementation and enforcement remains.

As mentioned previously, we have seen some progress in the establishment of specialist police units and courts for juveniles, capacity development activities of professionals such as the police, magistrates, health care workers, and teachers, in building a cadre of professionally skilled staff through social work education and accreditation and build or strengthening social work services for children and families within a child protection system. We have seen information sharing and public-awareness campaigns on child rights and, particularly, the right to protection, and the active participation of children in behaviour-change programmes, such as through child rights clubs in communities and schools.

Finally, the establishment of the South Asia Initiative to End Violence against Children (SAIEVAC) in 2010 has been an improvement in bringing countries together to discuss the challenges, good practices, opportunities and way forward in addressing violence against children. SAIEVAC is providing a platform for open discussions and information sharing. It has also assisted in bringing together governments, civil society, children and international organisations (NGOs and UN agencies) and setting up national coalitions of CSOs, INGOs and UN agencies to end violence against children.

Institutionalisation of children has to be a measure of last resort. However, it does not mean that we do not have to work on improving the quality of care provided by such institutions whenever they are the last resort for children?

Our starting point should be the CRC, which emphasises the importance of growing up in a family environment and the role of parents and the UN Guidelines for the alternative care of children, which build on the CRC, and the principles it includes. There are two main thrusts of the Guidelines: **the necessity principle and the suitability or appropriateness principle.**

The first principle seeks to ensure that alternative care is used only when necessary and therefore places emphasis on preventative measures. It discourages recourse to alternative care by improving family support and reintegration services; tackling avoidable relinquishment; consulting with the family and the child; stopping unwarranted removal; addressing negative societal factors; ensuring effective gate-keeping; prohibiting “recruitment” by facilities/ individuals; regulating private care providers; and eliminating forms of financing that encourage unnecessary placements and/or retention in care (paragraphs 32-56). The second principle is about the conditions of care provision. It revolves

around two key questions: 1. Does the care option meet certain general standards taking into account the human resources (qualified, assessed, motivated), access to basic services, contact with parents/family, protection from violence/exploitation and no primary political, religious or economic goals; 2. Does the care option meet the specific needs of the child concerned taking into account the need for a case-by-case basis approach, catering to the child's characteristics and situation and promoting an appropriate long-term stable solution. Although family-based or –type care is usually preferred, application of this principle may indicate that **in some cases a form of residential care is the preferred option.**

With regard to residential care, the Guidelines specify that the ‘use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests’ (paragraph 21). ‘In accordance with the predominant opinion of experts, **alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings.** Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome’ (paragraph 22). In an emergency situation, the ‘... residential care [can] only [be used] as temporary measure until family-based care can be developed’ (paragraph 154c). The goal of alternative care is the child's eventual return to the family under appropriate conditions, or finding another long-term, stable solution if that is impossible. Central to the approach throughout the Guidelines is the systematic involvement of children and their families in decision-making.

In these contexts, what kind of organisational structure should be assumed by the institution to perform well in terms of “best interest of the child”?

The UN Guidelines provide also some rules and standards for the protection and care of children who are already in formal care. To mention a few:

- Children should have access to a complaints mechanism that is known, effective and impartial and should be offered access to a person they can trust (paragraphs 99 and 98 respectively);
- All agencies and facilities responsible for formal care must be registered and authorised to operate by social welfare services or another competent authority, which should be stipulated by legislation. These agencies and facilities should have a code of conduct for their staff and written policies

and practice statements in line with the Guidelines which clearly spell out their aims, policies, methods and standards for the recruitment, monitoring, supervision and evaluation of their carers (paragraphs 106-107). Special attention should be paid to the professional skills, selection, training and supervision of carers (paragraph 71) and training should include a focus on the rights of children without parental care and on the specific vulnerability of children (paragraph 115);

- The agencies and facilities should maintain comprehensive and up-to-date records, including detailed files on all children in their care (paragraph 109). The content of these records is spelled out in paragraph 110;
- Rules have to be set for the protection of all rights of children in alternative care ranging from the right to health care, education, play and leisure to being protected from all forms of violence and exploitation. Disciplinary measures and behaviour management must be in conformity with international human rights law.

Did UNICEF come across any good practice of institutionalisation in Asia, or any other part of the world?

Let me focus on good practices in relation to implementation of the UN Guidelines.

- Namibia: The Ministry of Gender Equality and Child Welfare, referenced the (draft) Guidelines during the drafting process of the 2009 “Minimum Standards for Residential Care Facilities in Namibia”;
- Chile: The nationally implemented SENAMA programme, which is committed to deinstitutionalisation and family-based care, is modelled after the (draft) Guidelines;
- Mauritania: A draft law on alternative care for separated children (Kafala) was developed and validated in 2010 based on the UN Guidelines. This draft of law is in its first step of adoption;
- Haiti Earthquake Response: The Guidelines were used for advocacy and policy positions during the immediate aftermath of the Haiti earthquake;
- Sri Lanka: Through support to reunification and deinstitutionalisation programmes, children living in institutions are reunified with their families and children are prevented from family separation through various family support interventions;
- Nepal: In 4 remote rural districts in Nepal, child separation from family is prevented through provision of counselling to families. Additionally, support

to biological, kinship or foster families for children are provided, including some reintegration with their own families following de-institutionalisation or temporary foster placement;

- Georgia: There is a stronger emphasis on foster care and small group homes over large institutions (see: http://www.unicef.org/infobycountry/georgia_69653.html)

Would you please describe any good practice on the work with or among South Asian countries, dealing with the protection of children and adolescents?

Some documented examples:

- Gender sensitisation police training (Karnataka) - http://www.unicef.org/infobycountry/georgia_69653.html
- Community-based interventions to address child marriage (Assam) - http://www.unicef.org/india/9. __Child_Marriage_Community-based_Intervention.pdf
- Data Management for Effective Implementation of the Juvenile Justice Act (Odisha) - http://www.unicef.org/india/8._Data_Management_for_Juvenile_Justice_Act.pdf
- Increase in birth registration in Bangladesh captured in: UNICEF Good practices in integrating birth registration into health systems (2000-2009). Case studies: Bangladesh, Brazil, The Gambia and Delhi, India (2010) - [http://www.unicef.org/protection/Birth_Registration_Working_Paper\(2\).pdf](http://www.unicef.org/protection/Birth_Registration_Working_Paper(2).pdf)
- In Pakistan, the PLaCES (Protective Learning and Community Emergency Services) model introduced in response to lessons learned from the 2010 floods is proving successful in reaching a larger and less accessible target population, in a more cost-effective manner. It is also successful in helping displaced children recover from Post-Traumatic Stress Disorder - http://www.unicef.org/pakistan/reallives_8536.htm
- In Nepal, new guidelines have been approved to harmonise the case management process to address child protection issues. The new guidelines harmonise case management procedures and define the roles of government and non-government agencies in the different steps of the process, including detection/identification, reporting, rescue, verification, placement, follow-up, review, closure, referral and provision of economic, educational, legal, and medical and social services. The case management process seeks to ensure continuous care for children and coordination among the key actors.

THE EFFECT OF PSYCHOSOCIAL SUPPORT ON SEXUALLY ABUSED CHILDREN WITH DISABILITY

Sabrina Mahmood and Shamim Ferdous,PhD.***

Abstract

Child sexual abuse has been addressed in Bangladesh since the early 1990s. Sexual abuse of children with disabilities, today, is an under-reported phenomenon due to the inability of victims to report, lack of awareness of direct service providers to recognise and understand the meaning of signs of sexual abuse, and due to their reluctance to comply with mandated laws and responsibilities. In a 2012 study the World Health Organization (WHO) found that worldwide children with disabilities are almost three times more likely to be sexually abused than non-disabled peers. The study also found that children with cognitive or mental health disabilities are nearly five times more likely to suffer such abuse. Another study was conducted jointly by the Bangladesh Protibondhi Foundation (BPF) and Save the Children Sweden-Denmark in 2010. The results of this study showed that half of all the disabled children in Bangladesh are sexually abused, mostly by close relatives. Psychological approaches to helping children in Bangladesh recover from sexual abuse have emerged in the last few years. However, Bangladesh Protibondhi Foundation has set up counseling units as psychosocial support and have tried to provide full recognition of the holistic approach required to address child sexual abuse with adequate training, standards and protocols necessary to produce healing environments and effective interventions in support of the child. Child sexual abuse has been addressed in Bangladesh since the early 1990s. Sexual abuse of children with disabilities, today, is an under reported phenomenon due to the inability of victims to report, lack of awareness of direct service providers to recognise and understand the meaning of signs of sexual abuse, and due to their reluctance to comply with mandated reporter laws and responsibilities.

KEY WORDS: *Institutionalised, Behavioural disorders, Representations, Mainstream*

BACKGROUND

Child sexual abuse is the exploitation of a child or adolescent for the sexual gratification of another person. Child sexual abuse is a horrific crime against children, boys and

*Counselor, Bangladesh Protibondhi Foundation, Mirpur Dhaka, Bangladesh; sbrnmahmood@yahoo.com.

**Executive Director; Bangladesh Protibondhi Foundation, Mirpur Dhaka, Bangladesh

girls. It is a situation whereby a child is used by an adult or adolescent for their sexual means and stimulation. This, not surprisingly, can cause severe problems in the children's future lives. It can be soul destroying for any individual, as it's such a violation of trust that a lot of people find it very hard to overcome, and can cause many problems at later stages of life.

Children living in adverse conditions are more likely to be in abusive situations which may include physical or sexual abuse, and exploitation characterised by street child, child labor, child domestic workers, or youth offender. It may take the form of violation of rights such as family violence and neglect, conflict with arms and war, law enforcement; acid violence, sexual exploitation, child trafficking etc.

CAUSES OF CHILDREN LIVING IN ADVERSE CONDITIONS

- Poverty, ignorance and low level of education
- Adult's attitude toward children, social taboo e.g. blaming the children
- Inappropriate laws and ineffective implementation
- Power structure of the society
- Parenting; low participation of children in families
- Lack of children's participation in family and society
- Patriarchal nature of the society
- Unequal power structure and relations such as gender, age, class, disability, cast, religion etc.
- Existing violence in the society, including violence against children
- Stereotyped gender discrimination

RESEARCH FINDING

A 2012 study of the World Health Organization (WHO) found that worldwide children with disabilities are almost three times more likely to be sexually abused than non-disabled peers. The study also found that children with cognitive or mental health disabilities are nearly five times more likely to suffer such abuse. Child sexual abuse has been addressed in Bangladesh since the early 1990s. Breaking the Silence (BTS) was one of the first organisations in South Asia to address CSA. They began raising awareness on the issue in 1993. The Centre for Training and Rehabilitation of Destitute Women (CTRDW) provides shelter and day care for pregnant unmarried young girls and women, many of whom have been sexually abused and/or trafficked, and alienated from their families and communities. A study was conducted jointly by the Bangladesh Protibondhi Foundation (BPF) and Save the Children Sweden-Denmark (2010). The result of the study revealed that half of all the disabled children in Bangladesh are sexually abused, mostly by close relatives.

APPROACHES TAKEN BY BPF

1. Psychological:

Helping children in Bangladesh recover from sexual abuse has emerged in the last few years. The Bangladesh Protibondhi Foundation has set up counseling units for psychosocial support and have tried full recognition of the holistic approach required to address child sexual abuse with adequate training, standards and protocols necessary to produce healing environments and effective interventions in support of the child .

Depending on the age and sometimes gender of the child, different experiential techniques and approaches were applied .The activities of BPF fell into several major categories as follows:

- Individual Counseling
- Group Counseling
- Family Counseling
- Home Visit
- Community Awareness Raising
- Sexuality or Life Skills Workshop

2. Client-centered:

The basic belief of client-centered therapy is that people are essentially good having the tendency to guide, regulate, and control them towards self-actualisation. Person-centered theorists believe that a person is capable of finding a personal meaning and purpose to live. For a healthy self to emerge, a person needs positive regard -- love, warmth, care, respect, and acceptance. However throughout the life from childhood a person receives conditional regard from parents and others, thus learning to behave in certain ways to feel valued only through confirming to other's wishes. Incongruity between self-perception and experiences creates a gap between the ideal self and real self, which further leads to alienation and maladjustment. The basic premise is that once the proper conditions for growth are established, the client will be able to gain insight and take positive steps towards solving personal difficulties.

3. Family Counseling:

Conceptualise the System Theory

1. Families are system-having properties with more than the sum of the properties of their parts.

2. The operation of such a system is governed by certain general rules.
3. Every system has a boundary, the properties of which are important in understanding how the system works.
4. The boundaries are semi-permeable, that is to say some things can pass through them while others cannot.
5. Family systems tend to reach relatively, but not totally, steady states. Growth and evaluation are possible, indeed usual. Change can occur, or be stimulated, in various ways.
6. Communication and feedback mechanism between the parts of a system are important in the functioning of the system.
7. Events such as the behaviour of individuals in a family are better understood as examples of circular causality, rather than as being based on linear causality.
8. Family systems, like other open systems, appear to be purposeful.
9. Systems are made up of sub-system and themselves are parts of larger subsystem.

4. Cognitive Behavior Therapy:

Cognitive behavioral therapy (CBT) is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviours and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. The name refers to behaviour therapy, cognitive therapy, and to therapy based upon a combination of basic behavioural and cognitive principles and research. Most therapists working with patients dealing with anxiety and depression use a blend of cognitive and behavioural therapy. This technique acknowledges that there may be behaviours that cannot be controlled through rational thought. CBT is “problem-focused” (undertaken for specific problems) and “action-oriented” (therapist tries to assist the client in selecting specific strategies to help address those problems)

Cognitive Behavioural Therapy for Child Sexual Abuse (CBT-CSA) is a treatment approach designed to help children and adolescents who have suffered sexual abuse overcome post-traumatic stress disorder (PTSD), depression, and other behavioural and emotional difficulties. The programme helps children to: learn about child sexual abuse as well as healthy sexuality; therapeutically process traumatic memories; overcome problematic thoughts, feelings, and behaviors; and develop effective coping and body safety skill.

Play, art and drama were used to release emotions and expression. As for adapting methods appropriate to age or gender, several groups reported using play therapy

with very young children, and art and drama with older children. Drama therapy with the children as a method to reverse roles and explore abuse as an issue of power, relaxation and meditation as part of the healing process and direct and immediate crisis intervention.

OBJECTIVES

To show the effect of psychosocial support on sexually abused children with disability.

METHOD

Study Design

Mixed method (QUAN-qual)

Mixed methods research refers to all procedures collecting and analysing both quantitative and qualitative data in the context of a single study (*sensu lato* Tashakkori and Teddlie 2003).

Study Location

The study was carried out in three project areas of Bangladesh Protibondhi Foundation—Mirpur, Dhamrai, Kishorgonj.

Study Population

The present study was conducted with those children with disability who are already identified as sexually abused. The study was conducted jointly by the Bangladesh Protibondhi Foundation (BPF) and Save the Children Sweden-Denmark (2010).

Sample

The survey was conducted on 30 sexually abused children with disability. Among them 20 (66.67%) were females and 10 (33.33%) were males in the age range between 7 to 18 years.

All participants were selected from the project area of Bangladesh Protibondhi Foundation. 10 (33.33%) children from Mirpur, 10(33.33%) from Dhamrai and 10(33.33%) from Kishoregonj .

SCALES AND INSTRUMENTS

Quantitative data collection Instruments

1. The Wechsler Intelligence Scale for Children (WISC-R): developed by Wechsler, is an individually administered intelligence test for children between the ages of 6 and 16 inclusive that can be completed without reading or writing. The WISC takes 65–80 minutes to administer and generates an IQ score which represents a child's general cognitive ability.

The original WISC (Wechsler, 1949) was an adaptation of several of the subtests which made up the Wechsler–Bellevue Intelligence Scale (Wechsler, 1939) but also featured several subtests designed specifically for it. The subtests were organized into Verbal and Performance scales, and provided scores for Verbal IQ (VIQ), Performance IQ (PIQ), and Full Scale IQ (FSIQ). A revised edition was published in 1974 as the WISC-R

(Wechsler, 1974), featuring the same subtests however the age range was changed from 5-15 to 6-16. The third edition was published in 1991 (WISC-III; Wechsler, 1991) and brought with it a new subtest as a measure of processing speed. In addition to the traditional VIQ, PIQ, and FSIQ scores, four new index scores were introduced to represent more narrow domains of cognitive function: the Verbal Comprehension Index (VCI), the Perceptual Organization Index (POI), the Freedom from Distractibility Index (FDI), and the Processing Speed Index (PSI).

2. The Bengali version children’s Loneliness Scale: was developed by Asher Hymel and Renshaw (1984) and translated into Bangla by Sultana (2006).

There are 20 items in the Bangla version of Children’s Loneliness Scale.

- a) Loneliness item (16 items) and
- b) Filter items (4 items)

Test-retest reliability of the Bangla version was highly significant ($r=0.779, p<0.0005$). The alpha coefficient was as high as 0.99, indicating a high internal consistency of the scale.

Each item of the Loneliness scale has five alternative responses ; “always true”, “true “confused”, “not true”, and “not at all true” . From these alternative answers the respondent put a tick mark on one that would be most suitable for him/her. Scores of respondents are calculated as “always true “ =1,” “true =2,” “confused =3,” not true “=4,” and not at all true =5. For non-lonely item and for lonely item follows the reverse pattern of scoring and filter item is scored zero.

Lonely items are 2, 5, 7, 10, 11, 14, 15, 16, 17 and 20.

Non-lonely item are 1, 3, 6, 8, 13, and 18.

Filter items are 4, 9, 12, and 19.

The total score is completed by adding the obtained scores of each individual item. The maximum possible score is 80 and the minimum is 16. High score indicates greater loneliness or social dissatisfactions of the child and vice-versa.

3. The Bengali version children's Self-Esteem Scale: constructed by Rosenberg (1965) is considered one of the best scales specially designed to measure self-esteem. The items of the Self -Esteem Scale were translated and adapted into the Bengali version Monzur Ahmed, Dr mir R. Islam and Sanzida Zohra Habib(1995), Department of Psychology, University of Rajshahi. The scale consist of 10 items and has a 4 point response format ranging from strongly agree to strongly disagree, with the agree and disagree response of the middle.

Scores of respondent are calculated as “strongly agree” =1, ”agree” =2, ”disagree” =3 and “strongly disagree” =4. For or negative items and for positive item follows the reverse pattern of scoring. Negative items are 3,5,8,9 and 10. The total score is computed by adding the obtained scores of each individual item. The maximum possible score is 40 and the minimum is 10. High score indicates high self-esteem of the respondent and vice versa.

The test – retest reliability coefficient measured for the total score was found to be 0.60 (1-tailed sig. at -0.001 level) the reliability coefficient found between the two parallel versions of the Self-esteem Scale was 0.81 (1-tailed sig. at - 0.001 level). In order to test the internal reliability, internal consistency of the items self – esteem scale was measured by computing Cronbach alphas. The alphas were .88 and .71 found from the paralleled from reliability data (N=28 and the test –retest reliability data (N=57) respectively.

QUALITATIVE DATA COLLECTION INSTRUMENT

To collect data for case study, interviews were taken through structured and also unstructured open-ended questionnaires.

- 1 Observation Schedule: Sociometry was used to record the interaction of the sexually abused children with disability.
- 2 Case History Form: Case History Form was used to collected data from the case from different areas like personal history, family history, birth history, social and behavioural checklist, speech and language checklist, and educational checklist. This Case History Form is adapted from the Sample Background Questionnaire from the Book on ‘Assessment of Children, Behavioral and Clinical Application’ by Jerome M. Sattler, Fourth Edition.
- 3 Interview schedule for Teacher, Parents and the Case: unstructured open ended schedule was followed for teacher, parents and the sexually abused children with disability.

PROCEDURE

To show the effect of psychosocial support on sexually abused disabled children pretest and post test was conducted. Approval from the organisation was sought and obtained for the researcher to conduct the study prior to data collection. Data

for the present study was collected by personal interview techniques. Necessary rapport was established before administering the questionnaire as the research process was conducted over the year. The researcher was required to explain the purpose of the study, and to explicitly seek the consent of the children and their parents as they are disabled regarding participation, as well as to ensure that their responses were kept either anonymous or confidential.

The questionnaires were distributed to the children. Most of the time, they had to respond with the help of their parents and researcher as they are disabled children. Although there was a written instruction on the front page, the Ss were also given a brief verbal instruction as stated below:

This questionnaire has been developed to know some information about yourself. Read or actively listen to the questionnaire and choose your answer to each of the statements from among the categories of responses marked by putting a tick. These categories of responses actually indicate different degrees of agreement and disagreement as mentioned in the example in the example given on the front page of the booklet. There is no right or wrong answer for the statements; just select the one which you think to be appropriate in your case.

To collect data for the case, the researcher went to the home of the case as well as observed at school. The researcher went to home with proper permission from the school authority and also the parents of the case. After providing psychosocial support, including individual counseling, group counseling, family counseling, Person centered approach, psychotherapy and home-based psychological services over the year along with the same questionnaires were provided to the same participants.

DATA ANALYSIS PLAN

All the data collected from participants were transferred into numerical code. Then all the data was processed and analysed on the computer using the SPSS 12.0.

The loneliness scale was scored by summing all the 10 items. These item raw scores and subscale scores were used for correlational analysis.

RESULTS

The obtained data was first analysed by computing Mean(x), standard Deviation (SD) and Pearson Correlation.

Table-1:
Mean (X) and standard Deviation (SD) of Self-esteem and Loneliness Scale (N=30)

Variables	Mean	SD
Self-esteem	3.78	2.867
Loneliness	30.61	13.194

All obtained scores were significantly higher than the average that indicated sexually abused disabled children have low self-esteem and are lonely in their life.

Table-2:
Correlation of Self-esteem, loneliness (N=30)

	Self-esteem	Loneliness
Self-esteem Pearson Correlation Sig.(2-tailed)	1	.874(**)
Loneliness Pearson Correlation Sig.(2-tailed)		

**Correlation is significant at the 0.05 level (2-tailed).

Correlation of the 2nd table indicates that there is significant positive correlation between self-esteem and loneliness. That means a disable child who is sexually abused with low self-esteem influences his or her loneliness.

Table-3:
Pre and post test of IQ were done before and after the Psycho-social Support

ID no.	Gender	Age(years)	IQ Score Obtained in pre test	Age (years)	IQ Score Obtained in post test
1	Female	8	WISC-R, Full scale=40, verbal=49, performance=41	9	42
2	Female	9 years	WISC-R, Full scale=40, verbal=49, performance=41	10	41
3	Male	8 years	DDST, DA= 4	9	5
4	Female	11 years	WISC-R, Full Scale=49	12 yrs	50
5	Female	14	WISC-R, Full scale=40, verbal=47, performance= 41	15 years	40.3
6	Male	13	WISC-R, Full scale=41, verbal=47, performance= 42	14	43

ID no.	Gender	Age(years)	IQ Score Obtained in pre test	Age (years)	IQ Score Obtained in post test
7	Female	14	WISC-R, Full scale=49, verbal=49, performance= 47	15	49
8	Female	17	WISC-R, Full scale=51, verbal=49, performance= 47	18	52
9	Male	15	WISC-R, Full scale=49, verbal=49, performance= 47	16	49
10	Female	17	WISC-R, Full scale=52, verbal=49, performance= 42	18	52
11	Male	18	WISC-R, Full scale=49, verbal=49, performance= 47	19	49
12	Female	18	WISC-R, Full scale=52, verbal=50, performance= 49	19	54
13	Female	17	WISC-R, Full scale=50, verbal=49, performance= 47	18	51
14	Male	13	WISC-R, Full scale=49, verbal=49, performance= 47	14	49
15	Female	13	WISC-R, Full scale=43, verbal=40, performance= 49	14	45
16	Female	13	WISC-R, Full scale=44, verbal=40, performance= 45	14	45
17	Male	14	WISC-R, Full scale=51, verbal=50, performance= 49	15	52
18	Female	13	WISC-R, Full scale=51, verbal=50, performance= 49	14	52
19	Female	14	WISC-R, Full scale=52, verbal=50, performance= 49	15	53
20	Female	13	WISC-R, Full scale=50, verbal=49, performance= 48	14	53
21	Male	14	WISC-R, Full scale=48, verbal=45, performance= 42	15	49
22	Female	13	WISC-R, Full scale=52, verbal=50, performance= 49	14	54
23	Male	13	WISC-R, Full scale=42, verbal=40, performance= 45	14	45
24	Female	15	WISC-R, Full scale=49, verbal=50, performance= 49	16	49
25	Male	14	WISC-R, Full scale=52, verbal=50, performance= 49	15	53

26	Female	15	WISC-R, Full scale=50, verbal=50, performance= 49	16	50
27	Male	16	WISC-R, Full scale=52, verbal=50, performance= 49	17	52
28	Female	17	WISC-R, Full scale=51, verbal=50, performance = 49	18	51
29	Female	16	WISC-R, Full scale=50, verbal=50, performance= 49	17	52
30	Female	15	WISC-R, Full scale=49, verbal=51, performance= 49	16	49

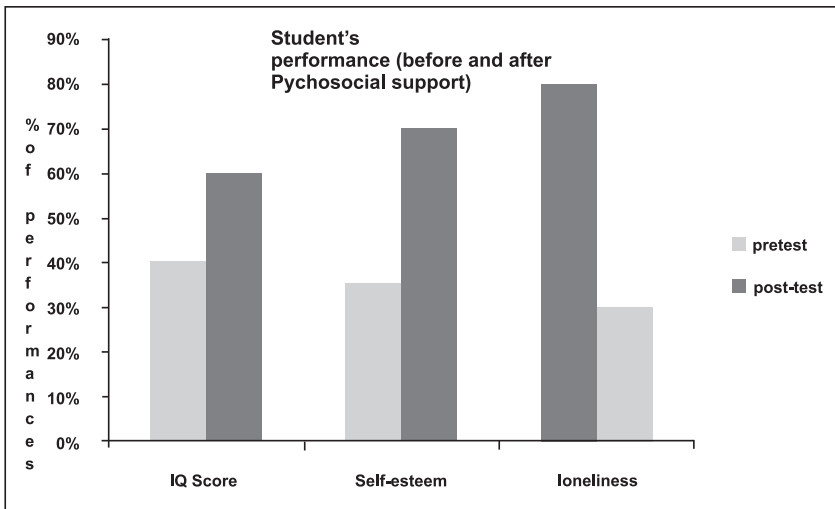
Table-4:
Pre and post test of Self-Esteem Scale were done before and after the Psycho-Social Support

Id	Gender	Age	Self-esteem Score(pretest)	Age	Self-esteem Score(pos-test)
1	Female	8	15	9	23
2	Female	9	17	10	20
3	Male	8	15	9	20
4	Female	11	16	12	21
5	Female	14	17	15	23
6	Male	13	12	14	17
7	Female	14	14	15	20
8	Female	17	20	18	25
9	Male	15	19	16	23
10	Female	17	17	18	24
11	Male	16	13	17	20
12	Female	17	14	18	20
13	Female	17	17	18	26
14	Male	13	15	14	20
15	Female	13	16	14	20
16	Female	13	15	14	19
17	Male	14	17	15	19
18	Female	13	18	14	17
19	Female	14	20	15	18
20	Female	13	25	14	20
21	Male	14	20	15	19
22	Female	13	20	14	18
23	Male	13	18	14	19
24	Female	15	17	16	20
25	Male	14	17	15	20
26	Female	15	18	16	26
27	Male	16	15	17	19
28	Female	17	14	18	24
29	Female	16	17	17	26
30	Female	15	16	16	23

Table-5:
Pre and post test of loneliness scale were done before and after the Psycho-social Support

Id	Gender	Age	Score of loneliness Scale (pos-test)	Age	Score of loneliness Scale(pos-test)
1	Female	8	71	9	32
2	Female	9	67	10	30
3	Male	8	65	9	30
4	Female	11	66	12	32
5	Female	14	60	15	35
6	Male	13	62	14	37
7	Female	14	74	15	35
8	Female	17	79	18	40
9	Male	15	61	16	31
10	Female	17	62	18	35
11	Male	16	69	17	38
12	Female	17	74	18	37
13	Female	27	77	18	36
14	Male	33	65	14	30
15	Female	13	66	14	39
16	Female	13	65	14	39
17	Male	14	57	15	32
18	Female	13	78	14	37
19	Female	14	75	15	38
20	Female	13	79	14	30
21	Male	14	67	15	33
22	Female	13	72	14	37
23	Male	13	79	14	34
24	Female	15	78	16	39
25	Male	14	69	15	35
26	Female	15	68	16	36
27	Male	16	75	17	39
28	Female	17	74	18	34
29	Female	16	77	17	26
30	Female	15	66	16	33

Table-6



From comparing pre-evaluation and post-evaluation assessment of their IQ, Self-esteem and loneliness it is found that 80% children showed significant improvement, which in turn, indicated that psychosocial support with medical treatment and Special Intervention could bring back children's overall progress.

DISCUSSION

The main purpose of the proposed study was to investigate the effect of psychosocial support on sexually abused children with disability. For this purpose Wechsler Intelligence Scale for Children (WISC-R), The Bengali version Children's Loneliness and Self-Esteem Scales were administered to 30 children before and after the psycho social support. Among them 20 (66.67%) were females and 10 (33.33%) were males. The age range of the participant was 7 to 18 years old and average was 13.

All participants were selected from the project area of Bangladesh Protibondhi Foundation. 10 (33.33%) children from Mirpur, 10(33.33%) from Dhamrai and 10(33.33%) from Kishoreganj.

The obtained data was first analysed by computing Mean(x), standard Deviation (SD) and Pearson Correlation. All obtained scores were significantly higher than the average that indicated sexually abused disable children has low self-esteem and lonely in their life . Correlation of the 2nd table indicates that there is significant positive correlation between self-esteem and loneliness. That means a disabled child who is sexually abused with low self-esteem influences his or her loneliness.

From the comparing of pre-evaluation and post-evaluation assessments it is found that 80% children showed significant improvement, which in turn, indicated that psychosocial support with Special Intervention could bring children's overall progress which supports the previous research.

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PROMOTING RESILIENCE IN ‘SEX WORKER’ CHILDREN: THE ROLE OF RESIDENTIAL CHILDCARE INSTITUTIONS IN BANGLADESH

*Tuhinul Islam, PhD.**

Abstract

Brothel children are the most marginalised within society. They are shunned by mainstream society and thus denied opportunities to mix with other groups of children. They carry a sense of shame regarding their origin, whether as a result of their direct involvement in the world of prostitution or merely by association — often, they are seen as ‘dirty’, ‘uncouth’, ‘unwanted’, ‘jaroj’ (bastards), ‘harami’ (whore kids). They suffer greatly from social stigma and discrimination. Sex worker mothers, on the other hand, due to the nature of their work, have little time to devote to their children. Residential childcare research is a relatively new area in the social work field in Bangladesh. Unfortunately, much negative publicity has been heaped on residential childcare institutions—their operational systems, practices and outcomes have often been found to be at fault. Although in large part this may be true, my study, interestingly, found institutional care in some part, to be rather more positive, and thus potentially useful to childcare social work practitioners in Bangladesh and elsewhere. This paper, broadly descriptive, explores the experiences of care, leaving care and after care from the perspective of a group of sex workers’ children and young people who lived in NGO-run residential homes in Bangladesh. It tries to understand the preparation process that enabled them to adjust better into wider society. The findings show that along with food, shelter and education, residential care staff actively created opportunities for them to develop safe relationships that fostered friendship and commitment with others, including the wider communities in which they lived.. The findings show that crucial lessons for the minority world could be learned from this study, namely the notion that the whole community needs to take responsibility for these vulnerable children if resilience is to become entrenched in them; and that attention needs to be paid to building relationships with adults, peer groups, parents, and the community at large.

KEY WORDS: *Residential Childcare Research, Brothel Children, Stigmatisation*

*Bangladeshi Social Work practitioner, researcher and academic with Senior Research Fellow at Northern University Bangladesh, and Director, Education and Child Development of a national NGO in Bangladesh; mmuhin@yahoo.com.

INTRODUCTION

Residential childcare has had an image which, at the very least, is not a positive one. It has often been blamed for weakening family ties, increasing stigmatisation, abuse and isolation of those in care, leading to poor educational (Dixon and Stein, 2005; Martin and Jackson, 2002) and health outcomes (Monaghan and Broad, 2003). There have been examples of children with many care leavers leaving care with low self-esteem and poor social skills (Bamford and Wolkind, 1998; Biehal *et al.*, 1995; Cleaver, 1997; Frost *et al.*, 1999; Kahan, 1999; Mather *et al.*, 1997; Mendes and Moslehuddin, 2004; Stein, 2002) leading them towards anti-social activities such as drug abuse and prostitution (Bonnerjea, 1990; Stein, 1999). Such children face greater challenges in life.

This paper, broadly descriptive, has been drawn from my doctoral research project. It explores the experiences of care, leaving care and after care from the perspective of a group of sex workers' children and young people who lived in NGO-run residential homes in Bangladesh. It tries to understand the preparation process that enabled them to adjust better into wider society.

THE STUDY: RESEARCH CONTEXT AND METHODS

There are broadly five types of residential childcare institutions in Bangladesh: government; faith-based; NGO run; private boarding school and cadet college. This paper focuses on the NGO-run Homes. Unlike government and faith-based institutions, NGOs cater for the most disadvantaged: rescuing them from unhealthy and risky environments. Their purpose – to integrate these 'unwanted' into mainstream society by providing them their basic needs, creating job opportunities and providing legal support to ensure their rights are met.

It is difficult to know exactly the size, numbers of childcare institutions, and numbers of children living in them, as no census of childcare institutions has ever been undertaken in Bangladesh. However, estimates suggest that between 100-200 children live in each NGO, 100-200 in the government institutions and between 100-7000 in the faith-based establishments. 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 millions of children living in faith-based orphanages.

Brothel children are often shunned by mainstream society, so do not get opportunities to mix with other groups of children. They carry a sense of shame regarding their origin, whether as a result of their direct involvement in the world of prostitution or merely by association -- considered to be the most

‘tainted’ or ‘rotten’ by society (Uddin *et. al.*, 2001). They suffer greatly from social stigma and discrimination. Sex worker mothers, on the other hand, due to the nature of their work, have little time to devote to these often ‘unwanted’ children.

Knowing the identity of one’s biological father is crucial in Bangladeshi culture to avoid the shame of ‘non-identity’. Thus there is the widespread practice in brothel communities of giving children the name of their mother’s ‘regular’ client as their ‘father’. However, this person is not necessarily a permanent feature in their lives. Their departure can cause an identity crisis, since they then do not know to whom they ‘belong’. The lack of opportunities for boys often leaves them disorientated and more likely to become drawn into antisocial and life-risking activities including thieving, pimping, running illicit drinking bars and gambling dens, or becoming extortionists. Girls are compelled into following their mother’s profession and join the sex trade. (BSAF and AB, 2001; Uddin *et al.*, 2001; own experience). Unfortunately the routine exposure to commercial sex and other illicit activities leads to the development of an unorthodox morality in these children, as well as increased health risks – STIs, lung cancer, alcoholism, drug addiction.

Qualitative research methods were employed for data collection. Adopting an ethnographic approach, the fieldwork took place over a period of one year. In-depth semi-structured interviews were used on 33 young people aged between 12 and 22, who had left the care system within a five-year period from the date of interview and who had resided in their care home for at least one year. Observation of the institution where they had lived also took place.

FINDINGS

Views about Guidance and Support by Staff

Young people expressed positive views about the guidance and mentoring offered to them while in care. They acknowledged that staff from the home ensured that they attended school regularly and staff arranged that all children attended homework classes after school to aid learning. In addition, staff had regular contact with schoolteachers, enquiring about their progress, achievements and difficulties. Shamim (M18) stated: “Mohsin sir used to go to my school and meet my schoolteachers to learn about my progress. He always talked to me about every visit. He would congratulate me if my schoolteachers gave positive feedback. If I was not doing well in school he would ask me to explain the reason why. He gave me advice on how to overcome difficulties.”

Views about the Effects of Care on Education

Nearly all acknowledged the positive effect being in care had had on their education. They said that education developed their sense of rights and responsibilities, increased their tolerance and morale, and gave them a chance to be better respected and valued by the wider community. Nahid (M22) said: “There were lots of negative rumours and fear in society about our lifestyle, culture and beliefs because of our mothers’ profession. I won’t deny that brothel culture is different. I can’t change that; neither can I change what people think. If we couldn’t get out and didn’t have opportunities, we wouldn’t have been able to change and we couldn’t mix with others, we wouldn’t see drugs and illicit sex as bad. This understanding has developed through education and by being in the home. We are now seen as ‘decent’ because of our education and etiquette.”

Accounts of Friendship, Companionship and Comfort

Young people stated that the Home’s activities helped them to develop interpersonal skills, enhanced their self-confidence and provided them with a positive identity.

Rubel (M17) and Aslam (M17) met in the Home. They both stated that their happiest memories were of ‘going to school as a group, walking and playing together with friends from the Home sharing our highs and lows together’. These two remained close even after leaving the home. They hoped to maintain their ‘friendship for the rest of our lives’. This suggests that being enabled to make trusted friendships while in care helped fulfil emotional needs, and had a positive impact on the children’s lives. It indicates that through the process of friendship-making, young people were able to develop their interpersonal and communication skills. Skills which later helped to build and maintain successful relationships outside of care.

Feelings about Being Cared for and Supported by Staff

In general, these young people were happy with staff’s sensitivity, attitude, care and the support. They commented that they received love, care and attention from staff. Some staff developed a ‘parent-child’ relationship with them, meeting their material and emotional needs, thus enabling them to develop a caring attitude themselves. This attention, openness and care by staff developed in young people a positive view of life in care. Herok (M16) called one staff ‘amma’. He felt she understood his needs and feelings just like his own mother. He said: “All my demands were to Kiran amma, I shared everything with her;

she was so patient and caring. She knew what I liked and what I didn't. You know, she even brought food to my room and fed me with her own hands, like her own son, when I was ill."

Young people reported that most staff offered advice, support, and encouragement during times of emotional turmoil helping them to overcome their difficulties. Nargis (F18) used to get many love proposals from young men. She did not know what to do about this. Like a sister, the staff's encouragement, advice, religious and spiritual guidance and support helped her to steer a different course for herself. She said "I might have fallen in love without thinking of future consequences if Nasreen apa hadn't helped me understand the situation."

Views about Personal Development, Self-confidence and Self-understanding – Promoting

Resilience

Young people mentioned not knowing much about the outside world when they were living in the brothels, because its culture and environment prevented this. They said, prior to coming to the home; they did not know what proper parent-child or brother-sister relationships were like, or how to get along with their neighbours. They related that some activities in the home allowed them to mix with invited community children and their families whom they also met outside school. This gave them a broader understanding of relationships between family, friends and the wider community. Runa (F19) related: "I didn't know what it felt like to be loved by one's father, or how a daughter hugs and respects her father. [...] I didn't know what an extended family was like, the importance of neighbours and community people before taking admission into the home. [...] The home put on different events to meet people and work together. We invited them into the home. Many of our school friends also invited us to their places and we observed family relationships – love, affection and care, we tried to feel it, we learnt to develop friendships and relationships."

Young people were pleased that most staff supported them to explore their potential, develop skills and confidence. Many extra-curricular activities were put on by the home. Nayan (M21), an international martial arts champion, three times running, recounted the guidance and encouragement given by staff to boost his confidence. He said cheerfully; "My martial arts teacher's training, guidance, support and encouragement boosted my confidence, made me believe that I could participate, fight and win competitions. I'll never forget my first win; it was quite emotional, and a turning point in my life."

Others said singing and dancing were powerful tools in overcoming their shyness and building up their self-esteem, confidence and morale. Mukta (F18) said: “I didn’t know I had any potential; I never believed I would sing and dance before thousands of people.... I won several national prizes. Honestly it was the teachers who helped spark my latent talent.... Once there was a fear I would follow in my mother’s footsteps; this doubt has gone. I have discovered myself; now I am studying at a good college in Dhaka. I believe a bright future is awaiting me.”

Some young people mentioned how the home ‘opened their eyes’ to differentiate between good and bad deeds, to understand social stigma and community attitudes towards them. Due to their birth identity, many were discriminated against. However, they said that over time they were able to change the attitude of people by performing good deeds, proving their talent in school and participating in community activities with the support of staff. Nuri (F17) explained that ‘life-skills training, and teachers’ guidance, helped me a lot to understand my strengths and weaknesses, accept reality, respect different opinions and to think positively about myself’.

Feelings about Aftercare Support

Those who left care in good grace obtained aftercare support and help from the institution to find employment and accommodation, accessing higher education, and getting financial aid. Robiul (M21) worked in the organization’s hospital as an ambulance driver. He explained how the home helped him:

“When I came out from the home, the authorities allowed me to undertake training in driving. They then offered me a job as an ambulance driver. After four years of working, I disclosed my relationship with Nepu to the Karate teacher. He informed the principal [of the home] who arranged our marriage. They [the NGO] paid for the wedding, Nepu’s jewellery and all household items, including a fridge and TV. They acted the way parents normally do.”

DISCUSSION

Young people interviewed were, on the whole, satisfied with the educational experience they received, appreciating that without institutional care, their education would have come to an end much earlier. The home recognised the importance of education as a vehicle for social improvement, reflecting the common conceptualisation of childhood as a time of education and training (Bourdillon, 2000). The findings suggest that with a little guidance, motivation and support from staff young people’s confidence and determination can be

boosted, enabling them to cope with the stigma and discrimination they faced because of their birth and care identity. Knowing that there was someone looking out for them was essential for these young people.

Education helped these young people join society and get support into employment, deterring them from a life of crime. This is consistent with other studies, e.g. Jayathilake and Harini (2005) in Sri Lanka, Martin and Sudrajat (2007) in Indonesia and Lalzallana (2008) in Mizoram, Emond (2009) in Cambodia, Freidus (2010) in Malawi, Harker *et al.* (2003) and Morgan (1999) in the UK. In fact, the most powerful message from this study is that education and staff's loving guidance boosted young people's morale, confidence and determination, as well as developing their sense of rights and responsibilities. These findings significantly challenge common perceptions about residential childcare (Tolfree, 1995) and the negative connotations that often accompany it.

Friendship and social companionship are essential for wellbeing. The study found that friendships and being in company boosted young people's morale, self-confidence and self-esteem. This resonates with several UK studies on friendship and social support (see Berndt, 1992; Borge, 1996; Emond, 2004; Gilligan, 2012, Hudson, 2000; Kosonen, 2000; Rutter, 1990; Sinclair and Gibbs, 1996; Sarason *et al.*, 1990). Friendships of course serve as a vital buffer against stress and help to develop self-esteem. The findings suggest that young people who spent time in care were able to develop strong and stable life-friendships precisely because they had gone through good and bad times together while in care.

The findings also show that young people talked about concepts of relationships and attachment, relating them to a sense of belonging, trust, safety and feelings of being nurtured. They managed to develop secure and sustained relationships with staff and friends. Such feelings helped their development by giving them a sense of confidence, self-worth, hope and ambition, with a positive effect on their attitude, behaviour and ways of thinking. Those who had a sustained, a long-term relationship with an adult-figure felt secure and safe. This reinforced their confidence, morale and belief in their abilities. In other words, they developed a positive self-image and image of the world and their part in it. This supports research by Dziech and Hawkins (1998), Fowler (1996) and Garmezy (1993).

Possibly one of the strongest indicators of attachment with staff is when children want to address staff by familial terms such as 'dad', 'mum' or 'brother'. These children addressed staff as 'baba' or 'amma', it seemed to mean a lot,

perhaps because none of them knew their biological fathers; the most important factor in identity and status within Bangladeshi culture. As well as this, their biological mothers were unable or unwilling to show them adequate care and affection (Uddin *et al.* 2001). The love and affection that these children received from staff compensated for the lack of love they got elsewhere.

Another important finding was the discovering of hidden talents and achievements, thus promoting resilience, developing self-confidence, boosting morale and promoting a sense of identity, pride and positivity about life in the young people who were able to succeed in this way. Young people talked about discovering and nurturing dormant talents and becoming successful. This success inspired them to take up challenges, gave them hope, aspirations and spirit. In addition, social activities in the institutions helped to develop their resilience (Borland *et al.*, 1998; Borge, 1996; Quinn, 1995; Rutter, 1990; Sinclair and Gibbs, 1996; Gilligan, 1999; 2012) and boosted their self-esteem. They also mentioned the impact that activities had on the expectations of others, in particular, staff. Staff's reactions provided powerful signals that helped to shape children's attitudes and beliefs about themselves. Low expectations from staff, as we know, can create real barriers to achievement for children (Francis, 2008; Jackson and Sachdev, 2001; Sinclair 1997).

Young people's achievements were found to have a positive impact on their well-being, identified by Rutter (1985) as one of the building blocks of resilience. In addition, the stories and experiences presented here support the fact that certain aspects of residential care can promote resilience (Newman and Blackburn, 2002) and increase young people's ability to cope with life's challenges. Stories from institution indicate that resilient children can turn negative experiences into positive ways of being, with the help of others. All these stories are anecdotes of how extra-curricular activities and staff's positive attitudes turned young people's lives around for the better.

Young people in this study had a great deal to say about the community, and specifically about the negative impact of being stigmatised by others as either 'home'-children, or, worse still, 'brothel'-children. Some were bullied not just by fellow students, but by teachers and other members of the community, reflecting an experience that Goffman (1963) has called 'courtesy stigma'. However, they had developed characteristics of resilience and confidence to help themselves overcome these to varying degrees. This was much easier when the community as a whole understood the problem and acted upon it. Young people acknowledged that to change societal prejudices would be difficult, and had thus taken advantage of the opportunities made available to them to

develop themselves educationally and in other ways. Such individuals showed capacities for success by adopting different strategies. This confirmed that institutional care had a positive impact on the lives of young people once they had left care, thus supporting Smith's (2005, 2009) study.

Reflecting on the life stories of these young people, it is understood that reliance is a two-way street. Society has a part to play and so does the individual. The children had no control over their birth identity and therefore the prejudice of the wider society, yet they did have control over their 'attitude towards life'. Those that succeeded were the ones that had a positive attitude and took advantage of the opportunities made available to them. They accepted the rules of the institution and knew their place within it. The Home did its utmost to help create a learning environment for the wider community to get to know the children and thus see them as just that – children, like their own.

STUDY LIMITATIONS AND RECOMMENDATION FOR POLICY AND PRACTICES

This is a relatively small number, participants were selected from only one NGO run children's home, in Bangladesh, so it would seem unwise to try to generalize the findings to a wider population. Nevertheless, I would be surprised if my findings were very different if the sample size and make-up were changed. Although, this NGO run home did not want to 'change the world', they probably do show that change is possible positively, and their counterparts in other parts of the world can learn from it. Therefore, this study offers some recommendations for policy and practices:

- The State must recognise the importance of residential childcare for those who need it, and accordingly, reframe and amend existing policies and develop further ones around the principles of: education; health (including spiritual health and well-being); extra-curricular activities; and most importantly building relationships both inside and outside the institutions (with staff, peers, families of origin and the wider community) to improve facilities and services impacting on the lives of young people.
- Government needs to reframe its existing childcare policies and develop guidelines to support all types of residential childcare organisations, respecting religious and cultural beliefs and ensuring good standards are maintained.
- Prejudice and discrimination towards the children of sex workers, and all children from residential care, is rife. New approaches are needed to

involve the community, both to develop their understanding about residential childcare practice, and to increase sympathy and respect for the children in care.

- Education, both formal and informal, is a principal tool for future success and independence for young people. For this reason, it must be encouraged and supported.
- Giving a 'voice' to young people is a significant issue and needs to be looked at carefully. Provision should be made to encourage staff and other professionals to listen to young people with sincere and open hearts, not fearing to accept constructive criticism of the care system put forward.

In conclusion, this study brings home the notion that the whole community needs to take responsibility for such groups of vulnerable children if resilience is to become entrenched in them. If attention is paid to building relationships with adults, peer groups, parents, and the community at large, this will offer the best chance of building resilience in children in care, thus producing tangible outcomes for the nation as a whole in the form of well-rounded and stable citizens.

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RISK OF POST TRAUMATIC STRESS DISORDER (PTSD) IN CHILDREN LIVING IN FOSTER CARE AND INSTITUTIONALISED SETTINGS

Deepak Gupta, M.D. and Neha Gupta, M.A.***

Abstract

There is a growing body of research on children living in foster care and other institutionalised settings. Impacted by early separation, neglect and abuse, these children often show symptoms of Post Traumatic Stress Disorder (PTSD). Early institutionalisation is known to alter brain development and disrupt patterns of attachment with subsequent decreases in ego-resilience and an inability to cope with trauma. This article aims to review papers on children living in institutionalised and foster care settings and its association of being at an increased risk of developing PTSD symptoms as compared to those who are raised in a family environment. The search was conducted on published literature between the years 1980 to 2013 (present). The databases searched ranged from Science Direct, Pub Med, ERIC, and the University of Edinburgh online library. All papers reviewed reflect a significant relationship between institutionalisation, abuse and neglect. Furthermore, some papers highlight a correlation between the above variables and risk of developing symptoms of PTSD in children. Results in most studies indicated that children raised in institutions were more likely to develop mental disorders as compared to those who were raised at home. However, at the same time most studies did not touch upon the direct association of PTSD and institutionalisation. Post-Traumatic Stress Disorder (PTSD) is associated with functional abnormalities of the hypothalamic-pituitary-adrenocortical (HPA) axis which plays a role in normal stress reactions. Evidence suggests that early abusive and neglectful care may disrupt the HPA axis in children, increasing stress responses and making them more susceptible to processing situations as threatening. This review highlights the need for future research to examine relationship between institutionalisation and symptoms of PTSD in such children.

KEYWORDS: *Institutionalisation, Foster Care, Institutionalised Child Care, PTSD, Trauma, Neglect, Abuse, Attachment.*

**Child & Adolescent Psychiatrist, Founder, Centre for Child & Adolescent Wellbeing (CCAW), Consultant, Sir Ganga Ram Hospital (SGRH), In-charge, Mental Health Programme, Udayan Care, New Delhi, India; deegupta_2000@yahoo.com.*

***Psychologist, Centre for Child & Adolescent Wellbeing (CCAW) New Delhi, India*

INTRODUCTION

Institutionalisation is the placement of children in institutions, such as orphanages and residential child care. On the other hand, foster care is the term that is used for a system where a child is placed into a ward, group home or a private home. Placing children in either one of these systems during early critical development periods for long durations is very often associated with developmental delays due to environmental deprivation, lack of early childhood stimulation and poor staff to child ratios. The detrimental effects of institutionalisation were first highlighted in the 1990s when Romanian orphanages attracted the attention of the media and researchers because of the devastating and impoverished conditions in which the children were placed (Johnson, 2000 as cited by Johnson, Browne and Hamilton, 2006). The effects of this deprivation acted as a natural experiment and provided researchers with an opportunity to investigate whether the effects of such institutionalisation could be reversed if these children were put under family based care. Ever since, the research on the impact that foster care and institutionalisation has on young children has been on the forefront. A systematic review conducted by Johnson et al. (2006) highlights how young children placed in institutions are at risk of harm. A review of 27 studies, this systematic review provided conclusive evidence underlining how exposure to institutional care in the absence of a primary caregiver puts these young children at risk of poor attachment patterns and poor social, behavioural and cognitive development when compared to children under family based care. The review presented a clear and detailed account of the impact of institutional child care on the development of children. However, vulnerability of these children to developing mental disorders like Post Traumatic Stress Disorder (PTSD) wasn't explored in detail. PTSD as described by the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (APA, DSM IV, 1994) is a constellation of symptoms that stem from exposure to threatening or frightening experiences leading to re-experiencing of those traumatic memories, lowering their resilience to cope against future stressors and causing clinical impairment in significant areas of functioning. The association between childhood maltreatment, abuse and neglect and risk of developing PTSD or symptoms of the same has been under significant scrutiny in the recent years. PTSD is known to develop due to functional abnormalities of the Hypothalamic-Pituitary-Adrenocortical (HPA) axis (Gunnar and Vazquez, 2006, cited in Gunnar and Tarullo, 2006). This system is known to play a role in normal stress reactions that may get disrupted during early years of neglect and abuse. Therefore the goal of this article is to provide a review of the literature on the association

between institutionalisation and the risk of developing PTSD and its related symptoms in these children.

REVIEW OF THE PAST LITERATURE ON PTSD AND INSTITUTIONALISED CHILDREN

The current review was conducted on published literature between the years 1980 to 2013. The databases searched ranged from Science Direct, Pub Med, ERIC, and the University of Edinburgh online library. The key search terms included: institutionalisation, children, foster care, institutionalised child care, Post Traumatic Stress Disorder (PTSD), trauma, neglect, abuse and attachment. This review studies the difference between institutionalised children and children brought up in a family environment with regard to the development of PTSD symptoms either as children still living in institutions or as adults (post-institutionalised). The purpose of this review is to encourage future research to develop interventions and strategies that can focus more on the emotional needs rather than only fulfilling physical needs of a young child to reduce the potential for trauma that arises from this early separation and deprivation (Browne, 2002 as cited by Johnson et al., 2006).

Most children in institutions or children homes are not orphans. They either have one or both parents alive. These children with a history of maltreatment such as neglect, who also endure the trauma of being separated by their caregivers at an early age, are susceptible to mental disorders like PTSD (Racusin, Maerlender, Sengupta, Isquith and Straus, 2005). A few studies have indicated that at least half the children in foster care have a tendency to experience one or more mental disorders and about 63% are victims of neglect (U.S. DHHS, 2007 as cited by Bruskas, 2008). Substantiating the above statistics, a cross sectional study conducted by Leenarts, Verneiren, Van de ven, Lodevijks, Doreliejers and Lindauer (2013), examined (using structural equation modelling) the relationship between exposure to early-onset interpersonal trauma, symptoms of PTSD, symptoms of complex PTSD and other mental health problems. The sample was a population of 92 girls recruited from 3 residential treatment facilities. Twenty-nine percent of the girls reported that they had experienced at least one interpersonal traumatic event before the age of 5, and all girls except one reported an experience of interpersonal trauma after the age of five. To assess the symptoms of PTSD, the posttraumatic test subscale of the Trauma Symptom Checklist for Children (Briere, 1996) was used. The results of Pearson's correlations between the variables modelled in the structural equation model indicated that exposure to early-onset interpersonal trauma was directly related to mental health problems and symptoms of PTSD mediated the relationship

between the two. These findings are consistent with current insights on girls in compulsory care, which posits that when these institutionalised girls suffer from symptoms of PTSD, this also involves other substantial mental health problems that may go on to affecting them in the long term (Ford, Chapman, Connor and Cruise, 2012, as cited by Leenarts et al., 2013). However, the study does have a few limitations that should be kept in mind while interpreting the results. Being cross sectional in nature, this study does not allow any inferences to be made. Along with that, the small sample size for interpersonal trauma prior to age of 5 years (29%) may limit the interpretations as well. Finally, all reports on trauma were self-reports by the participants, making room for social desirability bias (Leenarts et al., 2013).

Effects of institutionalisation spill over to later years as well, as seen in post-institutionalised adults. Documenting the adult adjustment of survivors of childhood institutional abuse in Ireland, a study conducted by Carr, Dooley, Fitzpatrick, Flanagan, Howard, Tierney, White, Daly and Egan (2010), interviewed 247 adult survivors of institutional abuse with a mean age of 60 years. The protocol included the Childhood Trauma Questionnaire, modules from the Structured Clinical Interview for Axis I Disorders of DSM IV and the Trauma Symptom Inventory (TSI-I). Results indicated an 80% prevalence of psychological disorders amongst the adult survivors of institutional abuse as compared to another study (Wolfe, Francis and Straatman, 2006) of a group of 76 Canadian adult survivors of institutional abuse, where the prevalence of a DSM IV psychological disorder was 88% (sometime in their lives) and 59% (current disorder). In both the studies, PTSD, Alcohol and Mood Disorders were the most common. These adults also had higher rates of trauma symptoms and disordered patterns of attachment. Child maltreatment i.e. abuse (physical, sexual, emotional) and neglect has been known to have significant long-term effects as validated by the above study. In the systematic narrative reviews by Springer, Sheridan, Kuo and Carnes (2003), the paper has substantiated the same by providing evidence that child abuse and neglect have a profound negative impact on adult physical and mental health and their psychosocial adjustment. Focusing on the study by Carr et al. (2010), its principal limitations mainly related to the non-representativeness of the population, the retrospective nature of the childhood data and the reliance on interviews for interpretation of results that increased the scope of bias in the study.

One of the endeavours of the present article was to review studies investigating the difference in the prevalence of Post Traumatic Stress (PTS) symptoms in children living in institutions/ foster care as compared to those living at home. A

study conducted (Kolko, Hulburt, Zhang, Barth, Leslie and Burns, 2010), aimed to examine the extent and correlates of PTS symptoms in a nationally representative sample of 1,848 American children and adolescents, aged 8 to 14 years. These children were referred to the child welfare for investigation of neglect and abuse based on the National Survey of Child and Adolescent Well-Being. The scale used to measure the severity of the PTS symptoms was the subscale of the Trauma Symptom Checklist for Children. Results highlighted an overall prevalence rate of 11.7%. After comparing the two variables (out of home care and in home care), the prevalence of PTS symptoms was higher in children who were placed in out-of-home care (19.2%) as compared to those maintained at home (10.7%). In the full sample, the four main contributors to the heightened PTS symptoms were younger aged, abused by a non-biological perpetrator, and levels of victimisation and childhood depression. The study underlined how younger children were more susceptible to heightened PTS symptoms as compared to adolescents. One such reason that can be attributed to this difference is the Cognitive-Developmental Models of PTSD (Salmon and Byrant, 2002, Kolko et al., 2007) that highlights how younger children have fewer and weaker protective mechanisms to manage and interpret their traumatic experiences, and cognitive-affective regulation and peer support groups do not develop fully well till adolescence. The findings of another study (Stone, 1999) also present reasoning to the above difference by identifying a strong association between exposure to violence and internalising symptoms in younger children (6th graders) as compared to older children. However, the study (Kolko et al., 2010) is not devoid of limitations and therefore merits consideration. To begin with, the type of maltreatment that resulted in investigation was based on an allegation and was not necessarily confirmed. Also the cross sectional nature of this study precludes any definitive conclusions about the prediction of the heightened post-traumatic symptoms.

The studies reviewed have mostly examined the implications of institutional and foster care maltreatment, abuse and neglect on children and adolescents placed there. Indeed, there are institutions that increase resilience in children by providing them a more secure environment and therefore, prevent the development of mental health problems. However, whether or not these children experience maltreatment in the institution, the children come with undesirable pasts (Racusin et al., 2005 as cited by Bruskas, 2008). To begin with, they are placed in such institutions after separation or neglect, which in itself is a traumatic experience. Early parental separation and neglect and then institutionalization does have a negative impact on these young children. Thus, even witnessing abuse affects

them greatly as their resilience (towards stressors) is low from birth. Supporting the above, studies have shown that the rate of maltreatment (physical, emotional, sexual or even witnessing the same) is as high as 49% in institutions and that exposure to such abuse and violence even if it is being witnessed can contribute to heightened PTS symptoms (Stein, Zima, Elliot, Burnam, Shahinfar and Fox, 2001).

The preceding paragraphs in this article reviewed papers that discussed the interplay of institutionalisation and mental health outcomes, primarily PTSD. However, it is also important to investigate how PTSD and its related symptoms develop in these young children, adolescents and adults (who were once institutionalised) so that accurate associations can be formed for future research. The age of the child is a highly deterministic factor in observing the effects of institutionalisation. As seen above from the results of various studies, the effects of institutionalisation are measurable. Reverting to the study on the Romanian Orphanages, the English and Romanian Adoptees (ERA) Study Team compared children adopted from Romania before the age of two years with children adopted before 6 months of age. The researchers found severe developmental impairments in half the sample of children placed into permanent families before the age of 2 years. However children adopted before the age of 6 months were physically and cognitively similar to a sample of children in the United Kingdom living under family based care (Rutter and The English and Romanian Adoptees Study Team, 1998, cited in Johnson et al., 2006).

Post Traumatic Stress Disorder (PTSD) is associated with the dysregulation of the Hypothalamic- Pituitary- Adrenal (HPA) axis. This dysregulation is known to be an important etiological link between child maltreatment and subsequent psychiatric disorders like PTSD; however, the research available on outcome and exposure is not robust. This may be due to the fact that in PTSD, the timing of the stressful experience and the type of the trauma influences the outcome to a great deal (Shea, Walsh, MacMillan and Steiner, 2004). The HPA axis is one of the three major systems activated as a part of the stress response (Bremner, Vythilingam, Vermetten, Adil, Khan, Nazeer, Afzal, McGlashan, Elzinga, Anderson, Heninger, Sothwick, and Charney, 2003). During acute stress, biochemical responses occur, increasing secretion of hormones, primarily cortisol (Chrousos and Gold, 1992). This helps an individual to cope with stress but can be extremely detrimental during times of extreme stress that occur during early periods in life (child sexual abuse, child physical abuse, emotional abuse and neglect). A number of researchers (Kessler, Davis and Kendler, 1997; Kendler, Bulik, Silberg, Hettema, Myers and Prescott, 2000; Heim, Newport, Bonsall, Miller and

Nemeroff, 2001 as cited by Shea et al., 2004) have associated the above traumatic experiences with PTSD. This is one primary reason why institutionalisation during the early years of a child is more detrimental as compared to later years. There are a number of animal models that have showed the harmful effect of early separation and prolonged maternal separation in rats and mice (Plotsky and Meaney, 1993). Findings suggested that when these species were separated from their mothers for a period of two to three weeks, it produced increased HPA axis responses to stress in adulthood. Another study in Russia and Eastern Europe found that institutionalised toddlers have high cortisol levels during the morning indicating elevated stress levels (Carlson and Earls, 1995 as cited by Tarullo and Gunnar, 2006). Despite the fact that alterations in HPA function associated with child maltreatment are likely to be detrimental in the long run, they were initially adaptive responses. Therefore for a maltreated child, the elevated cortisol levels may be adaptive in terms of coping with a chronically stressful situation of having a maltreating caregiver or disruptive environment but at birth the same HPA axis is extremely immature and the developing brain circuits are only shaped by early experiences (Gunnar and Vazquez, 2006). This is the reason why infants and toddlers when institutionalised have more long terms negative effects due to stressful and traumatic events, invariably reducing their resilience towards developing mental health problems, like PTSD.

EFFECTS OF INSTITUTIONALISATION ON CHILDREN IN THE INDIAN SETTING

Children and adolescents in child care institutions in India are just as much at risk if not more for developing mental health problems like other institutionalised children are across the world. A study by Suman (1986) examined the mental health status of 300 institutionalised children because of lack of parental care in India. These children were then compared to 150 children from low-income families. Their mental health was evaluated using the scale developed for the assessment of 16 indicators of mental health. Results indicated poor mental health seen more in institutional settings, with 33% of them having behavioural problems and these mainly related to parental deprivation and early life institutionalisation. Similarly other studies from India have shown the need for early stimulation of children and infants in institutions in India (Suman, 1986; Sharma, 1989 as cited by Taneja, Sriram, Beri, Sreenivas, Aggarwal, Kaur and Puliyeel, 2002). Despite being aware of the concept, little efforts are being made to stimulate children in orphanages. One such reason is that caregivers of these orphans in institutions are under great pressure to cater to their physical needs that all other social and emotional needs are sidelined.

A study by Taneja et al. (2002) was the first of its kind to develop an intervention programme of structured play, hypothesizing that such an intervention would accelerate psychosocial development. The results of the study did prove the hypothesis. Therefore, the above studies have serious implications for future research and practice. Once established, these interventions can be incorporated into the regime of caregivers, social workers and children. Apart from this, future research specifically in India needs to carry out more studies on mental health outcomes of institutionalisation with respect to PTSD and symptoms of PTS, so that interventions can be developed accordingly and are culture specific at the same time.

IMPLICATIONS FOR FUTURE RESEARCH

A paper synthesised by Delilah Bruskas (2008) reveals foster care outcomes by reviewing past literature on the same and specifically explored notions of oppression and domination (as defined by Young, 1990). The paper finds that most children in foster care, if not all experience feelings of confusion, fear, apprehension of the unknown, loss, sadness, anxiety and stress. Whether an infant, child or adolescent is placed in foster care through the child welfare system or through a relative, he or she shares many similarities. These may be; absence of parents (biological or primary caregiver), experiencing of pain and confusion, having a social worker, living away from home and so forth. According to Young (1990), these shared characteristics are qualifications for what defines a collective group of people and these children face domination or oppression if they face one of the five conditions; exploitation, marginalisation, powerlessness, cultural imperialism and violence. As per Bruskas (2008), children living in foster care and institutions meet not only one, but all five criteria. “The powerlessness of children in foster care is dramatically increased when information and knowledge about their future is withheld.” (Young, 1990). The above statement calls out for the need for systemic foster care orientation. Interventions that address children’s experiences and feelings associated with institutionalization and foster care are needed (Leslie, Gordon, Lambros, Premji, Peoples and Gist, 2005, as cited by Bruskas, 2008). Research has gone a long way in focussing and identifying socio-demographic factors linked with institutionalisation, but at the same time basic known factors associated with the effects of institutionalisation are ignored. This refers to orientations for children placed in such institutions. They should be educated about foster care and their relationship to the foster care and institution they are placed in. Such orientation or anticipatory guidance helps children with their questions, legitimises their traumatic experiences and lets them know what they could expect while they are under this particular

care. In the absence of such interventions, some children struggle alone to make sense of their surroundings. Bronfenbrenner (1979) defines development as an evolution of change that involves how one interprets their environment. He emphasises on the fact that human development relies more on how the environment is perceived rather than how it exists in reality. Education that helps a child interpret their 'world' and adjust to their new environment can decrease factors such as confusion, helplessness, stress, anxiety and fear; associated with institutionalisation. Therefore research must promote the need for systemic interventions that propagate the above (Bruskas, 2008).

Over the years there have been interventions have significantly altered the early care experienced by children who would have otherwise received standard institutional rearing. The St. Petersburg Orphanage Intervention Project (Tottenham, 2011) and The Bucharest Early Intervention Project (BEIP, 2000) have been successful in accelerating the development of institutionalised children in various domains. The former aimed at improving the physical environment, employment practices, and daily procedures for the staff that would care for infants and children. Improvement that took place post intervention included warm, sensitive care giving. Children showed remarkable improvement in their social and personal domains along with improvement in fine and gross motor skills. This intervention aimed at transforming institutional culture into a more *family-like* culture. The latter intervention randomly removed some children from institutional care and placed them into foster families. When compared to the children who continued to be in the institutional setting, children in foster families showed better cognitive development, attachment relationships, and greater resilience to psychiatric symptoms. This research had beneficial implications for various reasons. Firstly, it shows the plasticity of the developing brain, raising hope for better outcomes in younger children. Secondly, it reduces scientific doubt that the institution itself rather than genetic or prenatal factors cause poor outcomes, suggesting that many of the effects of institutionalisation are likely to put these children at a higher risk of PTSD and other mental disorders rather than pre-existing conditions of the child. Thus, more interventions need to be developed for optimal development of children living in out of home care. In cultures where it is possible, research must identify good practices for the de-institutionalisation of children in residential care that considers the needs of the child and reduces the potential for trauma. Alternate forms of family based care should be evaluated after identifying advantages and disadvantages for the child as well as factors related to successful and unsuccessful placements (Tottenham, 2011).

Critically reviewing all the implications of institutionalisation on the development of children and adolescents, it is deemed necessary to develop interventions that focus on systemic orientations and emotional needs thereby creating a more family-like environment for children placed into foster care and institutions so that young children become more resilient to past trauma and future traumatic experiences that might occur, as well as reduce the long term effects of PTSD and symptoms of PTS in post-institutionalised adults.

CONCLUSION

Institutionalisation represents an atypical rearing environment for infants and children that also increases the risk for atypical development. Thus, interventions and future research must continue to provide significant opportunities for optimal development in these children. Where adoption into stable homes is the most ideal situation, it may not be always possible. Therefore different cultures and countries must develop robust and scientifically backed interventions that work best with the particular environment (Tottenham, 2011). Interventions like the Bucharest Early Intervention Project should be developed in countries where there is a high rate of institutionalisation and to implement the same, there is a need for ground breaking research on the effects of institutionalisation in specific domains like PTSD. Till now, research has focused only on the developmental impact of institutionalisation and foster care in broad domains. The more the specificity in research, there will be greater reliability and efficiency of interventions that will be developed to prevent mental disorders in institutionalised children. Therefore, along with systemic foster care orientations and development of culture specific and efficient interventions, future research should identify specific correlates and factors that lead to the development of Post Traumatic Stress Disorder (PTSD) and PTS symptoms in institutionalised children, adolescents and adults post institutionalised.

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CHILD CARE INSTITUTIONS AS QUALITY FAMILY, SURROGATE (ALTERNATIVE) CARE SERVICES IN SRI LANKA

*Varathagowry Vasudevan, M.A.**

Abstract

Institutional care for children can be regarded as a form of alternative care that is provided in an organised manner, while keeping in mind the best interests and protection of the child. It is therefore imperative that this alternative care should respond to the physical, psychological, emotional, social, moral, ethical and spiritual needs of children in an age appropriate manner. Furthermore, these institutions should be managed and supervised by trained and motivated staff. But institutionalisation by its very nature leads to a more professional relationship between adults and the children rather than one that occurs in the more natural setting of parental care or a family. Given this, what emerges as most important is the quality of the care component. Quality care in such circumstances is defined as a form of developmentally appropriate care given by adult caregivers to children. This study aims to ascertain how best the children in such institutions can receive quality care, in accordance with their rights and needs and based on their age and particular vulnerabilities. Furthermore, it aims to highlight the gaps in the current system and makes suggestions moving forward. This study is mainly based on reflective accounts and information gathered to in-service training programmes conducted for welfare officers, field visits and supervision of probation officers, child protection officers and other child welfare officers operating in the Northern Province of Sri Lanka. In addition, case studies of children as well as key informant interviews and reflections of the diploma programme on child protection were used. The results of this study indicated that institutional childcare is highly contextual to the cultural background of the area studied. They also demonstrated clearly the necessity to provide regular and improved professional support to enhance the quality of care through specified monitoring, regular supervision, and improved quality of training for caregivers.

KEY WORDS: *Alternative Care Services, Quality Care, Child Care Institutions*

*Senior Lecturer in Social Work, Sri Lanka School of Social Work National Institute of Social Development, Ministry of Social Services, Sri Lanka; gowrynisd@yahoo.com.

INTRODUCTION

Institutionalisation tends to have general connotations that are largely negative compared to institutional living, not comparing at all favourably with living in a family and community. Institutional care is also very often stigmatised. This is because of its development from the poor Law Workhouse of the nineteenth century (Encyclopaedia of Social Work, 2000:296). Institutionalised care for the children is often charged with creating an institutional personality syndrome among the children. However, residential care can be diverse. It could have aims, which are based on different needy groups. These include children, old people, differently abled and others. Tolfree (1995) defined institutional care for children as “a group living arrangement in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society.” This definition implies that it is a professional relationship between the adults and the children which is very different to the one that is parental. The organised and deliberate structure for the living arrangements of children is also criticised (Dunn, Jareg, Webb as cited by Nirekha, and Asitha, 2011). Goffman (1961) explored the process of institutionalisation as experienced by inmates; he focused on the total institution, which has regular routines and a structure. He argued that the removal of normal patterns of activities and identities provided a cultural and social context within which individuals became depersonalised. He developed the concept of institutionalisation as a model of the total institution with four key features:

- All aspects of life occur in the same place, controlled by one authority.
- Each aspect of daily activity is carried out by others who are all treated the same.
- All aspects are rigidly programmed.
- The separation of staff and inmates is often maintained.

The concept of institutionalisation still remains with shifts and changes of various service deliveries and the provision of a homely environment for children. What is lacking, is the homely and emotional bonds of love and affection as occurring in families. It is a result of more formal and distant relationships between adult carers and children.

Institutional support for the children is mostly a western concept. Although institutional care for the children has been prevalent in Sri Lanka as an alternative care, it is still a relatively recent concept, beginning in the colonial period. Institutional care involves the integration of accommodation and personal care. It appears to be mostly a mechanical living arrangement, which creates a weakening of social relationships. However, certain rapid social changes have created stress and problems

in traditional family structures and relationships, which have made the position of children, especially among girls, of concern in terms of their safety in existing family environment situations in which their protection is at jeopardy.

The majority of institutionalised children stay in voluntary homes as an alternative care option in Sri Lanka. These children homes are monitored by the department of probation and child care services. These voluntary homes cannot provide for ad hoc admission to children, but have to follow government-approved procedures to accommodate children. This paper focuses only on the children who are being cared by voluntary homes.

CONTEXTUAL BACKGROUND

In Sri Lanka, the number of residential care has been increasing mainly due to disasters and internal displacements. These have created the need for more institutional care as an alternative living arrangement, often for considerable periods of time, although it is a western model of care. In 2009, 14,842 children were Institutionalised 2,234 of them were institutionalised in state-run residential institutions and 12,608 were admitted to certified voluntary children’s homes. Currently there are more than 21,100 children in 488 voluntary residential care institutions in Sri Lanka managed by well wishers, religious leaders and community groups (Nirekha, Sand, and Asitha, 2011). Through the introduction of quality care measures and the improved monitoring of child care institutions, the statistical report of the department of probation and child care services states that 15,874 children have been institutionalised in 368 children’s homes in 2010. The Table below gives the number of homes and children in institutionalised care.

Table 2.1:
Number of homes and number of children under institutionalised care

Type of Institution / Home	# of homes	# of Children
Remand Homes	7	1156
Certified Schools	5	263
Receiving Homes	8	434
Detention Homes	1	84
Approved School	1	10
National Training and Counseling Centre	2	112
Sub Total	24	2059
Voluntary Children Homes	341	13214
Voluntary Remand Homes	3	601
Total	368	15874

Source: Statistical Report 2010, Department of Probation and Child Care Services

Between all the provinces and districts in Sri Lanka, the Northern and Eastern Provinces, the numbers of institutions have increased by several fold during the past decade. There appears to be a significant interest in establishing voluntary children’s homes by various faith-based organisations, nongovernmental organisations and individuals. A survey of children in institutions in the North-East of Sri Lanka showed that 40% of them had been placed in institutions due to poverty (Nirekha, Sand, and Asitha, 2011). The major reasons cited for institutionalisation include poverty and difficulties of access to education in rural areas, although education is free for all in Sri Lanka. Evidence obtained from a “Save the Children” project confirmed this finding. Many families said that they were compelled to institutionalise their children due to their inability to provide the required food, healthcare and education. Another major factor that appears to have attracted many of those who placed children in the said institutions was the provision of free educational facilities, uniforms, shoes, exercise books, other materials and extra tuition.

In Northern Province, specially in the aftermath of 3 decades of internal conflicts, the emergency situation also created the seeking of greater institutional care for children, particularly those who had lost both parents or those having a single parent, and those who found it difficult to raise their children due to lack of housing. Service providers using referral procedures assess these safety concerns of children. Institutionalisation is regulated by the law, and requires a court order to accommodate children in an institution. The admission of children for a voluntary home is the responsibility of the department of probation and placement committees in Sri Lanka.

Table 2.2:
Registered Voluntary Children’s Homes – 2010

Province	Number of Registered	Number of Children
voluntary children’s homes		
Western	94	3797
Southern	29	962
Central	23	947
North Western	34	1025
Sabaragamuwa	15	540
Uva	11	564
North Central	11	429
Northern	48	2481
Eastern	76	2469
Total	341	13,214

Source: Statistical Report 2010, Department of Probation and Child Care Services

The Table 2.2 shows that the number of Voluntary Children's homes and number of children in the nine provinces of Sri Lanka in 2010. It is noted that western province, northern and eastern have more children's homes than the other provinces. Northern Province has 55 voluntary children's homes and 2603 children in 2013 (Department of Probation and Child care service, Northern Province, 2013) especially aftermath of local conflicts.

FAMILY AND ALTERNATIVE CARE

Working more closely with families is a professional practice. However, in the Northern provincial context, in the aftermath of the conflict, services were extended during the emergency situations beyond that of a professionally assessed service delivery system. Thus the department of probation and childcare services has taken measures to enhance quality care for children. They have identified children who are in need of institutional care and those who could be taken care of at home without being institutionalised. Still, due to certain reasons, a small number of families remain who are unable to uphold a family system and values, and who therefore use institutionalised services for their children. Childcare institutions are observed as alternative care service providers, extending their services on a charity basis rather than adopting a more professional approach towards children. Institutions hardly make any effort to help families to enhance capacity to take up their own parental responsibilities and care for their children, which is an essential part of child development. For children to become competent adults, they need to learn family life skills within their own family and community environment. Childcare has by tradition been the concern and responsibility of the family. In fact, children are considered to be the centre of a family system. But in the present scenario, there is a divergence, and new factors have emerged which have weakened the traditional family system. These could be the result of disasters such as the Tsunami and the prolonged conflict.

METHODOLOGY

The main objective of this study was to ascertain how children in voluntary homes could receive quality care, in accordance with their rights, based on their age, and on particular vulnerabilities. It further aimed to highlight the gaps in the current system and point towards a way forward. This study is based on reflective accounts and information gathered during in-service training conducted for welfare officers, field visits, and supervision of probation officers, child protection officers, and other child welfare officers functioning in the Northern Province of Sri Lanka. The study also used three case studies of children, meeting with parents, key informant interviews with administrators, and reflections of trainees in a diploma

programme on child protection conducted in the Northern Province of Sri Lanka.

The case study method was mainly used to examine quality of care as an alternative to family system. Three children were identified from three different children homes and interviewed by one of the authors of the paper. The collected data was written and analysed using thematic order. Major findings of the study are summarised below:

FINDINGS

Socio Economic Status

The general profile of children indicated that they were from families in rural areas where infrastructure facilities were not adequate to provide quality care for their children and particularly, gain access to education. The majority of institutionalised children and their families were economically challenged, and had imbalanced family systems with various social issues such as poverty, weak implementation of parental responsibilities, family separation, loss of both or one parent due to the conflict, migrant mothers, lack of housing facilities, and infrastructure facilities in their own communities.

REASONS FOR INSTITUTIONALISED CARE

Some of the root causes identified for the increasing institutionalised care in Northern Province were as follows:

- **The need to educate children** which was considered as a prime responsibility of family in the modern competitive world of today, as a preparation of the children's future careers and gainful occupations.
- Children's homes have taken up the role of being school hostels due to **lack of school hostel** facilities during and in the aftermath of the conflict which lasted for over three decades.
- **The high cost of living and problems of housing** in displaced areas, which contributed to separating children from parents. The root cause of this issue was the displacement of families for the past period of 30 years due to war and natural disaster such as the tsunami.
- The increased use of **technological developments** has caused tremendous changes in life styles and values in the aftermath of the conflict in Northern Province. Children appear to be unable to be kept alone even in rural areas due to the increasing numbers of instances of **child abuse**, inappropriate use of mobile telephones, the Internet and excessive leisure time activities.

- **The migration of the mothers** who leave children behind in search of jobs abroad (mainly the mid-east). This exacerbates the problem of facilities for care, and the need for better protection by fathers and grandparents.
- The general opinion among under privileged communities is to depend on **utilising state or voluntary welfare services** rather than improving and expanding the traditional family systems of extended family support.
- Institutional care is regarded as a means to **prevent early marriages** among girls.

Though institutional care is not really suitable for our culture and background, today there are increasing numbers of children who require such care, even on a short term to rebuild lives in the aftermath of the conflict particularly in the Northern Province. The majority of these children's homes are urban and town based.

The requirement for institutional care for children are for those who do not have a home and primary care givers, who have been abandoned or whose family is economically challenged. The lack of family care or caring parents is a problem. The family as a social institution has been idealised, but in reality, many children have experienced serious difficulties and problems in their own family environment. The major reasons are lack of safety, discipline and educational opportunities. The children's homes offer several educational and extracurricular opportunities. In such circumstances, childcare homes appear for families to be a better choice for children to grow up in.

The majority of the children live in rural villages of Sri Lanka. Although village life has many hardships, and usually has extended family systems, there is an erosion of protection for children, and a weakening of educational opportunities in their own community. This mainly stems from internal displacements, resettlement, and lack of school facilities. For instance, children's homes are situated in towns. There are 55 such registered Children's homes in the Northern Province. According to the Department of Probation and Child care in the Northern Province, 2603 children have been provided with residential care, with girls outnumbering the boys by more than 100 per cent. The statistics show that there are 1778 girls and 825 boys.

Government, non-governmental organisations and private organisations provide welfare services to children responding to developmental needs. It is argued that the effect of the institutionalisation of children is felt more related to care and protection. From the angle of services for children, with regard to institutions, it

provides a certain level of care which is regarded as being better than that possible in a family in these areas. This is particularly so for food, health-care, educational facilities, discipline and entertainment. These factors appear to be considered more important as compared with emotional attachments of parental love and affection. There is a perception that children are placed in homes for educational purposes. They do so up to their advanced level examination. One physically challenged girl expressed that “I have all facilities here” as they were provided with appropriate individual and healthcare facility along with well-arranged transport facility for her to attend school and tuition classes. The particular voluntary home has only 19 girls and all of them were very satisfied with the facilities in the institution. She also shared that everyone was “friendly” to her and helped her to cope with her disability. She did not feel a separation from her family.

according to the probation officer and other inmates. This particular children’s home had a well-managed administration, including a well-managed component for children’s participation in deciding their desires for food preferences, entertainment and a small allowance to purchase fancy items for their personal use.

The children were also being viewed as a social capital in thought; therefore educating children has become commercialised. As a result, their childhood and right to a family environment is ignored. On the other hand, children are also feeling that they have to study for a successful future, and that they are powerless, unable to separate being with their parents from the means to attain educational goals. One single mother expressed during the parents meeting held by one of the institutions, *“I have to educate my children for a future job for them, and I do not want them like me to become a daily labourer.”* Another uncle who is guardian of a child who lost both parents, emphasised that, *“I have to educate her to stand on her own in her life. Although others in the community may perceive this negatively even if I look after her well as my well as my sister’s daughter, it is better for her to stay at the children’s home where facilities specially educational and extracurricular activities are available in abundance and free of charge.”* This statement provides some evidence that informal foster care is being criticised and viewed as negative, and that there are rapid changes occurring in the no of family system. There is a lack of awareness of the fit person order. Informal foster care is perceived as quality care within a family environment. One single parent expressed with tears that his daughter was safe here, and having three meals a day and that if she was with him, she would not have a safe environment as he is staying in a

temporary tent and had inadequate food to give her. Another belief among parents of children on institutions was that these were safe places for girls to grow, and that, it prevented them from early marriages. Once children are institutionalised parental responsibility is transferred to children homes and parents felt relieved of taking up the challenge to look after their children. However they hardly provide any money while their children are in the institutions. A few parents out of fifty raised their hands as having the habit of saving for their children, especially as an after care plan. The post care plan should be the responsibility of children and their parents or guardian.

QUALITY CARE IN INSTITUTIONS

Quality care is a social construction within a society. Institutions should endeavor to promote child development and socialise them to become responsible citizens in a society. Quality care is seen as contextual and viewed within cultural factors. Age-related needs of children are essential for a caring and stable development. That raises the need for an individual care plan, which is a vital need for institutionalised children to measure themselves and for fulfilling developmental needs. The study revealed that parents and children are pleased with the existing institutional living arrangements. However, it is observed that when mothers visit to see their children, the children express their desire to go back with them, and live with their mothers. One of the girls quoted that *“I don’t like the warden. She used to scold us often and call us orphans and donkeys. She always wants us to do what she tells us otherwise she beats us up. She has a child who is also living with her in the home, and she takes good care of her child only. She always uses offensive language with us and this is why I don’t like her. When she scolds me I used to sit alone or go and talk to my other friends. I used to think and cry, and wonder why, god has given us so much sadness. This may be the fate of orphans like me.”*

All three case studies done among the children and key informant interviews reflected that these institutional wardens are not trained to properly care for children. There are homes, which employ unmarried/ widow and senior interns as wardens who lack proper training. One of the managers of the institution reported that their institution had no trained staff, and that they had hired these persons to look after the children. The wardens need to undergo training in taking care of the children in such a manner that the children are not denied care and affection. The institutionalisation mainly aims to provide a temporary/ alternative care for children who need care and protection but it is seen that long term care is the outcome, once they are institutionalised. The children stay till the age of 18 and some time more than 18. They may even receive employment in the same home.

The study found that there is a lack of preparation for parents/ guardian to provide for their children with an after care plan, while the children are still in the homes. Parents and / guardians meetings reflect that only very few parents save for their children during the institutionalisation of their children. A dependency attitude reflected during the discussion with parents. These findings on the whole have highlighted a number of issues, which need to be researched further in depth, before using the relevant data in the formulation of welfare policies pertinent to childcare services.

ISSUES IDENTIFIED

The issues identified were:

1. Inadequate infrastructure facilities and services for vulnerable and poor rural families
2. Lack of parental responsibility
3. Safety issues, especially for girls
4. Problems of unemployment
5. Poverty
6. Process of institutionalisation and stigmatising of child development
7. Appointment of inadequately trained and supervised caregivers, and lack of staff who are “child friendly”.
8. Failure to develop better age appropriate care plan and child friendly measures
9. Lack of an after care plan with the collaboration of parents/ guardian
10. Lack of empowerment of parents and guardians to take up their child care responsibility

CONCLUSION

The administration of childcare institutions and their influences on children differs on the basis of the number of children in such institutions, available funds, perception and behavior of the management, the quality and extent of supervision, training of staff and monitoring measures. In the analysis it was observed that certain common patterns regarding institutionalisation emerged on the basis of routine activities and the availability of free educational facilities. Children appeared to have collaborated willingly with their parents to join the institutions, in the prevailing notion, that this was the only way to pursue their education. As a result, they become passive recipients of institutionalised care services.

The study recommends the development of strategies and programs to resolve identified issues, with appropriate multi-disciplinary interventions, to attain the aim of a more holistic approach to child development. It also highlights the need to appoint and train case managers who can identify creative skills and abilities of children who can fulfill their potential to become productive citizens. It is important and interesting to point out that among the findings, the most striking outcomes that pervades all issues is, the impact of the process of institutionalisation, and the growth of an artificial style of living arrangements for children in institutions, away from their family and familiar surroundings. It is important to widen access to education in rural areas, and improve the accessibility to schools in such areas.

It is imperative to develop alternative strategies to solve identified issues covering wider samples, and search for a more multi-disciplinary child friendly practices, based on evidence from social work interventions and research, which will enhance the collective social responsibility of families and communities. This must include social protection systems for deprived families and communities with community based support mechanisms that will enable and empower children to remain in families and grow and develop to their full potential. This should include protection measures for children, particularly girls within such families.

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IMPROVING NATIONAL CARE STANDARDS IN SOUTH ASIA

*Thatparan Jeganathan, M.A.**

Abstract

The need for scrutinising and implementing childcare rights in the SAARC is imperative. It has become quite apparent in recent years, that for children living in non-family environments, this may indeed be a preferred care option as laws exist that protect their rights and secure their living situations. However, the institutions are overcrowded and a large number of children await the services. Within South Asia, only a few countries have been able to put in place new laws and guidelines that protect the placement of children in these institutions. However, the implementation of new laws and guidelines does not guarantee a better outcome. What remains to be conducted are sound studies examining the adjustment of children in these homes and the implementation of preventive measures with respect to the violations of children's rights. It is also imperative that the standards of care for caregivers be explored conscientiously to help in the delivery of services to insitutionalised children. Collaborative efforts between different agencies, policy makers and those in charge of such institutions can only ensure that the rights of children are protected and their care is maximised in ever way. This article focuses on one aspect of raising standards and building child protection systems by exploring the existence of best care practices, any existing evidence of replication of such care practices, the ability to monitor and standardise care practices in a facility and the provision of state accountability during these steps. A survey of the research literature and over ten years of experience in the field has informed this article. The process included focus groups discussions and extensive review of related material. The article concludes by identifying certain changes that when implemented in these homes will raise the standards of care.

KEYWORDS: *Child Care Standards, Child Protection Systems, South Asia Child Protection*

INTRODUCTION

Global data estimates that more than 8 million children¹ are without appropriate care around the world, and live in residential care as a result of poor economic conditions, conflict, abuse, family disputes, disability, and absence of parental care. South Asia is home for nearly 28% of the world's child population and this estimates that around 2,998,756² children live in child care centres in SAARC (South Asian Association for Regional Cooperation) classified countries. However, it should be noted that the actual figure should be much higher, due to the new forms of unregistered institutions and the lack of data on at risk or vulnerable children. It should be also noted that increasing number of children across SAARC countries are becoming institutionalised, not because of the death of parents or endemic poverty, but due to reasons such as fulfilment of educational needs, parental views towards institutions as necessary for discipline, the idea that the institutions is a safe and secure environment, situations of conflict and displacement, need for interim care and protection, and/or unavailability of appropriate services for children in the community . Not all children outside parental care are orphans. In fact, in South Asia, the majority of children outside parental care have living parents.

CONVENTION ON THE RIGHTS OF THE CHILD (CRC) AND INTERNATIONAL STANDARDS

CRC and alternative care guidelines emphasises that the family is the better place for children (Preamble) and parents have the primary responsibility for the care and protection of their children (articles 7.1, 18 & 27). International instruments and domestic laws (of all SAARC countries) also stipulate the importance of family and recognise the State as a better guardian in the absence of the primary care givers. Therefore, it is the duty of the State to ensure that parents and legal guardians receive the assistance they require to be able to care adequately for their child. The State is also obliged to provide special protection for a child deprived of his or her family, and to ensure that appropriate alternative care is preferable (article 20) and also to make sure that the removal from parental care should only be if it is in his or her best interest, and is subject to judicial review (Art 9.1).

REGIONAL CONTEXT - POPULATION

It has been estimated (2013) that in South Asia there are almost 651,903,547 children. Out of this, nearly 41 million are orphaned children (please refer to the table below).

¹ UNAIDS (2009) <http://www.childinfo>

² P S Pinheiro, *World Report on Violence against Children*, UNICEF: New York, 2006; up to 8 million children around the world are living in care institutions and 28% of the world's child population lives in South Asia

Country:	No of Children ³	Percentage in South Asia ⁴	No of Orphans Estimates	No of children living in Institutions ⁵	No of children who have one/ both parents (not orphans)-but live in children's homes ⁶
Afghanistan (AFG)	14,430,400	2.21	907,567	72,152	66,380
Bangladesh (BGD)	64,294,800	9.86	4,043,676	321,474	295,756
Bhutan (BTN)	249,503	0.04	15,692	1,248	1,148
India (IND)	484,920,000	74.39	30,497,947	2,424,600	2,230,632
Maldives (MDV)	128,444	0.02	8,078	642	591
Nepal (NPL)	11,004,800	1.69	692,122	55,024	50,622
Pakistan (PAK)	68,322,000	10.48	4,296,958	341,610	314,281
Sri Lanka (LKA)	8,553,600	1.31	537,959	42,768	39,347
Total:	651,903,547 ⁷	100	41,000,000 ⁸	3,259,518	2,998,756

In India, orphaned children number at 31 million. The situation is not encouraging in other South Asian countries either. The number of children orphaned was estimated as 4.2 million in Pakistan and 4 million in Bangladesh. As a result of nearly three decades of war in Afghanistan, there are more than 900,000 children who have inadequate parental care in the country. In Nepal and Sri Lanka the numbers are lower but still worrying, with 537,959 and 692,122 orphan children respectively. Due to a much smaller population, children who lost one or both parents in Bhutan were estimated to be below 20,000, while Maldives counted only 8,078.

INTERNATIONAL INSTRUMENTS

All eight SAARC countries have reaffirmed their determination and renewed their commitments towards the better implementation of children's rights; the following table describes the details of the international instruments that are

³ Based on the available stats on age wise population data, Government websites (formula used – (total population-population above 18)

⁴ Country representation (out of total estimated children)

⁵ <http://mojuproject.com/about/orphans/> [accessed 20 November 2013, 0455am] estimates of 0.5% of the total children

⁶ "Home Truths", Sri Lanka, (2005), Study findings; 90% of the children who live in institution have both/single parents

⁷ Total of all estimated figure

⁸ <http://mojuproject.com/about/orphans/>[accessed 20 November 2013, 0455am]

related to children without appropriate care, and the status of each SAARC country. The Convention on the Rights of the Child (CRC) and other related instruments were most widely ratified by all the SAARC countries.

Treaty / Country	AFG	BGD	BTN	IND	MDV	NPL	PAK	LKA
CRC ⁹	Signatory (S): 27 Sep1990	S: 26 Jan 1990	S: 4 Jun 1990	S: 20 Nov 1989	S: 21 Aug 1990	S: 26 Jan 1990	S: 20 Sep 1990	S: 26 Jan 1990
	Ratification (R): 28 Mar 1994	R: 3 Aug 1990	R: 1 Aug 1990	R: 11 Dec 1992	R: 11 Feb 1991	R: 14 Sep 1990	R: 12 Nov 1990	R: 12 Jul 1991
Optional Protocol	Ratification and accession by General Assembly resolution A/RES/54/263 of 25 May 2000							
(OPACCRIC) ¹⁰	Entry into force 12 February 2002							
Optional Protocol (OPSCCRC) ¹¹	S: 19 Sep 2002	S: 6 Sep 2000	S: 15 Sep 2005	S: 15 Nov 2004	S: 10 May 2002	S: 8 Sep 2000	S: 26 Sep 2001	S: 8 May 2002
	R: 19 Sep 2002	R: 6 Sep 2000	R: 26 Oct 2009	R: 16 Aug 2005	R: 10 May 2002	R: 20 Jan 2006	R: 5 Jul 2011	R: 22 Sep 2006
The Paris Principles ¹²	Accepted	Accepted	-	Accepted	-	Accepted	Accepted	Accepted
Jurisdiction, applicable law, recognition, enforcement and cooperation in respect of parental responsibility ^{13,14}	-	-	-	Member state (accepted the Statute)	-	-	Non member status (signed, ratified, or acce-	Non member status (signed, ratified, or acce-

⁹ http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-11&chapter=4&lang=en; accessed on Dec 11th 2013, at 1010pm

¹⁰ Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (OPACCRIC) <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPACCRIC.aspx> (accessed on Dec 12th 2013, at 1740pm)

¹¹ Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography of children in armed conflict (http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-11-c&chapter=4&lang=en; accessed on Dec 11th 2013, at 1040pm)

¹² Principles and Guidelines on children Associated with Armed Forces or Armed Groups - 2007; The Paris Principles, Principles and Guidelines on Children Associated With Armed Forces or Armed Groups, February 2007, <http://www.refworld.org/docid/465198442.html> [accessed 11 December 2013, 1850pm]

¹³ Convention on Jurisdiction, applicable law, recognition, enforcement and cooperation in respect of parental responsibility and measures for the protection of children (Concluded 19 October 1996); http://www.hcch.net/index_en.php?act=conventions.status&cid=69 accessed on Dec 11th 2013, at 1055pm UN Children's Fund (UNICEF)

¹⁴ Guidance on the protection of children as witnesses - UN Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime (ECOSOC Resolution No. 2005/20) [html](http://www.unhcr.org/refworld/docid/465198442.html) [accessed 12 December 2013, 2145pm]

Guidelines for Care of Children ¹⁵	Human Rights and the General Assembly, Council resolutions 7/29 of 28 March 2008, the Alternative 9/13 of 24 September 2008 and 10/8 of 26 March 2009 and Assembly resolution 63/241 of 23 December 2008
Hague Convention	International regulation that sets standards for how adoption should be carried out between countries (Inter Country Adoption -1993)

REGIONAL POLICY DOCUMENTS

In addition to the above, SAARC countries have adopted the following regional documents as their own policy documents in recent years;

1. SAARC Social Charter and Colombo Declaration to End Violence against Children
2. SAARC Framework for Care, Protection and Participation of Children in Disasters
3. SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia

Child Friendly Services and Care Standards

Subject matter:	AFG	BGD	BTN	IND	MDV	NPL	PAK	LKA
National law differentiate different type of institutions	No	No	No	No	No	No	No	No
Registration of voluntary children homes (any legal requirements)	Legal requirement but there are unregistered institutions	Legal requirement but there are unregistered institutions	No requirement	Legal requirement but there are unregistered institutions	No requirement	Legal requirement but there are unregistered institutions	Un known	Legal requirement but there are unregistered institutions
Registration process is governed by different state agencies	Yes	Yes	No	Yes	No	Yes	Yes	Yes
Child admission is systematised (followed through a process)	No	No	No	No	No	No	No	No
Whether child can be admitted directly to	No	No	No	Yes	No	Yes	Yes	Yes

¹⁵ http://www.unicef.org/aids/files/UN_Guidelines_for_alternative_care_of_children.pdf
html [accessed 12 December 2013, 2155pm]

Subject matter:	AFG	BGD	BTN	IND	MDV	NPL	PAK	LKA
compul- (rather highly depend on government officer)								sory but none of the instituti ons follow
Standards available	Unknown	No	Unknown	Guidelines	No	Only for adoption related issues		Guidelines
Monitoring committees established for process/ progress monitoring the child development	No	Only for adoption related issues	Unknown	Centrally managed monitor- ing systems established and well connected with the regional mechanisms	No	Only for adoption related issues	Only for adop tion related issues	Establi- shed at provincial level and attempt to make this as compre- hensive
School, community based structures are existing to monitor the child rights violations	Yes, but not active	Yes, but active in few local- tions	Yes, funcio- ning well (people know each other)	Yes, active and lots of NGOs and CBOs are pro- actively support for effective functions	Yes, but active in few local- tions	Yes, active and lots of NGOs and CBOs are pro- actively support for effective functions	Yes, but active in few local- tions	Yes, but active in few locations
Basic services for children and social services are available for the betterment of the children	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level	Avail- able at grass- roots level

It's now obvious that despite the progress made across the countries within South Asia to minimise the negative impacts on children; there is less focus upon needy children such as the disabled and handicapped. Children continue to

experience serious forms of violence, abuse, negligent and exploitation and double victimisation and many other challenges such as child labour, discrimination, trafficking, imprisonment, corporal punishment, sexual abuse, emotional abuse, migration and displacement, disability, and abandonment as well as various forms of traditional and harmful practices. The following country level examples further prove the above status. The attempts undertaken by a few countries within South Asia by introducing new laws, guidelines and systems in place to decide on the placement of children, and also to ensure that the institutions maintain a set of minimum standards have been small but encouraging.

India: The enactment of the Juvenile Justice Act aimed to provide a customised justice delivery mechanism for juveniles in conflict with law and children in need of care and protection through the Integrated Child Protection Scheme (ICPS), which is a Centrally-sponsored scheme of Government-Civil Society Partnership. Within the overall framework, regional government developed Standard Operating Procedures (SOP) and enforced through the child protection and social welfare systems, which already exist. Further acts advocate a child friendly approach in the settlement of matters keeping in view the developmental needs of the child. Centrally managed committees play a major role to ensure that the standards of care are maintained in all childcare institutions. Unfortunately, the children of Jammu and Kashmir (nearly 100,000 children) are not covered by the provisions of the JJ act.¹⁶

Sri Lanka: The draft of the “Guidelines and Standards for Childcare Institutions in Sri Lanka¹⁷” was developed by the National Child Protection Authority in 2013 and handed over to the Ministry for further comments and endorsement. This draft includes the guidelines and standards for child care institutions, which will be helpful in creating better surroundings and a healthier lifestyle for the children who live in all types of institutions. Once it is passed through the parliament, then this policy framework will substitute the existing ones. The National Institute for Social Development in Sri Lanka introduced a national diploma program in child protection for professional’s skills improvement in child protection, child welfare, standards and the other related fields in Sri Lanka (Targeting Government and nongovernmental officials who work with children, and also social workers). It is designed in keeping with the qualification framework advocated by the Quality Assurance and Accreditation Council of the University Grants Commission in Sri Lanka. The Open University of Sri Lanka too conducts

¹⁶ Chapter 1, section (1), sub section (2), Juvenile Justice (Care And Protection Of Children) Act, 2000

¹⁷[http://www.childprotection.gov.lk/documents_guidelines% 20and%20standards 20for%20childcare%20institutions20in% 20sri%20lanka.pdf](http://www.childprotection.gov.lk/documents_guidelines%20and%20standards%20for%20childcare%20institutions%20in%20sri%20lanka.pdf) [accessed 12 Dec 2013, 2214pm]

certificate courses for front line workers. Additionally, The Voluntary Home Monitoring Teams (VHMT) is a monitoring programme in Sri Lanka established by the Department of Probation and Child Care Services – DPCCs (Government) collaboratively with INGOs to ensure that institutions have reached the required minimum standards of care for children’s institutions/homes. The VHMT is led and guided by the Provincial Government called as Department of Probation and Child Care Services (DPCCS) and is comprised of a multi-agency team with members from government, and local and international non-governmental organisations (NGOs and INGOs).

Nepal: Standards for Operation and Management of Residential Child Care Homes were issued in 2012. It identified 78 standards to be complied by the Child Care Homes. Inter country adoption was legalized by amending the National Code of 1964 in 1976. Before it, only national adoptions were allowed. From 1976 to 2000, Nepal Children’s Organisation (*Bal Mandir*) was the only entity mandated to conduct adoption. The Terms and Conditions issued by the Government of Nepal opened up inter country adoption to child centres other than Bal Mandir. Now, more child centres are able to apply for adoption orders.

Pakistan: Established a Human Rights Commission for the following;

- to coordinate and monitor the child protection related issues at different level;
- to ensure the rights of the children in need of special protection measures;
- to support and establish institutional mechanisms for the child protection issues;
- to make necessary efforts to enhance and strengthen the existing services of different child welfare institutions;
- to set minimum standards for social, rehabilitative, reiterative and reformatory institution and services and ensure their implementation;
- to supervise in the light of minimum standards, the functions of all such institutions established by government or private sector for the special protection measures of the children;
- to set minimum standards for all other institutions relating to the children (like educational institutions, orphanages, shelter homes, remand homes, certified school, youthful offender work places, child parks and hospitals etc) and ensure their implementation;
- to review laws, propose amendments in the relevant law, wherever necessary, so as to bring those in conformity with the relevant international instruments ratified by Pakistan and to propose new laws;

- to recommend development of a Policy and Plan of Action for the children.

Other Countries: National level guidelines focus on national adoption (Kafala as referenced in CRC-Bangladesh, Pakistan, Bhutan, Afghanistan and Maldives); and a set of standards focusing on food and nutrition also exists in few countries like Bangladesh, Bhutan.

General Issue¹⁸: In all SAARC countries, religious organisations and political parties play a major role on institutionalised children. Little monks, Seminaries and Christian movements, and educational institutions run by Islamic societies function more independently than the other children's homes:

1. Faith-based children's homes are registered themselves as social service/ educational institutes under their respective religious body, not with the Department or Ministry of Social Affairs or Child Development.
2. In SAARC countries, governments rely on religious leaders and religious groups as they become more popular and place higher pressures.
3. Registration has been given to politicians and ex-terrorists to run child care institutions.
4. Caste based child care centres function in SAARC countries (admissions are limited to the particular caste)
5. Foreign-based and faith-based organisations receive support for the effective function of an institution and the same foreign country aid goes to the government for de-institutionalisation of those children.

CONCLUSION

Although the international and regional instruments establish a useful framework, they fail to consider the holistic approach at children's institutions; do not differentiate amongst institutions; do not establish standards for controlling admissions; as well as fail to provide guidance or set minimum standards for those registered institutions. Such guidelines should have a comprehensive framework which include policy and practice to deal with issues such as prevention, formal institution registration and categorisation, family and child-circumstances assessment, individual care plan elaboration, definition of terms and conditions for children to be removed from parental care, provision of a range of care options to meet individual children's needs, listening to child concerns, for determining out-of-home care options as well as the selection, training, monitoring and support for alternative care options.

¹⁸ Based on the consultation in different countries with identified key officials who work with Children

STRATEGIC FRAMEWORK ON WAY FORWARD

1. Immediate Interventions

- Data Collection
- Ensure the children who live in children homes have no other alternatives (Filtering the existing no of children)
- Mainstream deinstitutionalization process
- Registration of children homes and categorization
- Develop draft SoPs and standards for those homes
- Mandatory placement committee meetings in all children homes
- Research work on understanding the local knowledge on alternative care settings (existing) and promote
- Orient children on complaint mechanism

2. Policy framework

- Develop Guidelines for the placement of children to state, private homes
- Consultation with children home management and donors to divert the services which they offer
- Develop a community based approach based on the local context and alternative care guidelines
- Develop Standard operating procedures to determine the best interests of the child if institution as a last report option
- Regularise voluntary home monitoring systems
- Curriculam development on social work, child protection and raising standards

3. Prevention

- Diversion of children cases with community based correctional options
- Better implementation of the care plan and regular followup through the placement committess
- Recommend children for amnesty based on the progress
- Vulnerability index, interconnect services for most vulnerable population through better coordinated services
- Prevent children who have been institutionalised are not double victimised
- Capacity building of care givers through a recognised institution
- Promote good parenting and educate youngsters on parental responsibilities

A COMPARISON OF THE WELLBEING OF ORPHANS AND ABANDONED CHILDREN AGES 6–12 IN INSTITUTIONAL AND COMMUNITY-BASED CARE SETTINGS IN 5 LESS WEALTHY NATIONS

Kathryn Whetten^{1,2,5}, Jan Ostermann¹, Rachel A. Whetten¹, Brian W. Pence^{1,5}, Karen O'Donnell^{1,3,4}, Lynne C. Messer¹, Nathan M. Thielman^{1,6}, The Positive Outcomes for Orphans (POFO) Research Team”*

Abstract

Background: Leaders are struggling to care for the estimated 143,000,000 orphans and millions more abandoned children worldwide. Global policy makers are advocating that institution-living orphans and abandoned children (OAC) be moved as quickly as possible to a residential family setting and that institutional care be used as a last resort. This analysis tests the hypothesis that institutional care for OAC aged 6–12 is associated with worse health and wellbeing than community residential care using conservative two-tail tests.

Methodology: The Positive Outcomes for Orphans (POFO) study employed two-stage random sampling survey methodology in 6 sites across 5 countries to identify 1,357 institution-living and 1,480 community-living OAC ages 6–12, 658 of whom were double-orphans or abandoned by both biological parents. Survey analytic techniques were used to compare cognitive functioning, emotion, behavior, physical health, and growth. Linear mixed-effects models were used to estimate the proportion of variability in child outcomes attributable to the study site, care setting, and child levels and institutional versus community care settings. Conservative analyses limited the community living children to double-orphans or abandoned children.

¹Center for Health Policy, Duke Global Health Institute, Duke University, Durham, North Carolina, United States of America, ²Terry Sanford Institute of Public Policy, Duke University, Durham, North Carolina, United States of America, ³Departments of Psychiatry and Pediatrics, Duke University Medical Center, Durham, North Carolina, United States of America, ⁴Center for Child and Family Health, Duke University, Durham, North Carolina, United States of America, ⁵Department of Community and Family Medicine, Duke University, Durham, North Carolina, United States of America, ⁶Department of Medicine, Division of Infectious Diseases and International Health, Duke. **First Published, Open Access, December 19, 2009.**

Principal Findings: Health, emotional and cognitive functioning, and physical growth were no worse for institution-living than community-living OAC, and generally better than for community-living OAC cared for by persons other than a biological parent. Differences between study sites explained 2-23% of the total variability in child outcomes, while differences between care settings within sites explained 8-21%. Differences among children within care settings explained 64-87%. After adjusting for sites, age, and gender, institution vs. community-living explained only 0.3-7% of the variability in child outcomes.

Conclusion: This study does not support the hypothesis that institutional care is systematically associated with poorer wellbeing than community care for OAC aged 6-12 in those countries facing the greatest OAC burden. Much greater variability among children within care settings was observed than among care settings type. Methodologically rigorous studies must be conducted in those countries facing the new OAC epidemic in order to understand which characteristics of care promote child wellbeing. Such characteristics may transcend the structural definitions of institutions or family homes.

INTRODUCTION

Global, national and local leaders are struggling to find care solutions for the estimated 143,000,000 children worldwide who have had at least one parent die (hereafter defined as orphans) [1].

South and East Asia have the largest number of orphans (72,000,000) [2]; estimates for Africa indicate that 12% of all children on the continent will be orphaned by 2010. High mortality among young adults from conditions such as malaria, tuberculosis, pregnancy complications, HIV/AIDS and natural disasters are responsible for the large and increasing number of orphans [3]. A common demographic characteristic of orphans in the new epidemic across southern and eastern Africa is that rates of orphaning increase with age [4]. Millions more children are abandoned and in need of supportive living environments because their biological parents are not able to provide food, shelter and safety; are forced to leave their children to seek employment elsewhere; or are mentally or physically unable to care for children [2,3]. The majority of OAC live in Sub-Saharan Africa and Southern and Southeastern Asia, in countries with rankings of medium and low on the 2009 Human Development Index (HDI).

Studies have demonstrated ill-effects of being an orphaned or abandoned child (OAC) in resource poor countries, including traumatic grief, poverty, impaired cognitive and emotional development, less access to education and greater likelihood of being exploited as child labour [3,5–11]. Other reports describe the challenges faced by families and communities in providing food, shelter, health care, and education for increasing numbers of OAC while the number of potential caregivers is diminishing due to increasing age-adjusted mortality [10,12–15]. OAC are in need of living environments that promote their wellbeing.

Several influential studies have concluded that institutional care is damaging to the development of infants and small children relative to foster care [16–21]. One study of 65 children in the 1960s in London found that children placed in institutions who were then adopted or returned to their birth families (N = 39) did not suffer the negative emotional consequences that those left in institutions suffered [16,17]. The Bucharest Early Intervention Project (BEIP) found that children 12 to 31 months of age in institutions in Romania, a high HDI country, had significantly higher rates of Reactive Attachment Disorder (RAD) and that RAD significantly decreased with increased quality of caregiving within the institutions [18]. Other studies in Romania found that young children in institutions were more likely to have RAD, cognitive delays, poorer physical growth and competence and negative behaviour but that, within the same institution, when the ratio of children to caregivers was reduced over a 1 week period, the rates of RAD significantly decreased and that improving caregiving quality within an institution was associated with better outcomes [19,20]. A meta-analysis of 42 studies conducted in 19 countries using IQ as an outcome found significant differences between the IQ of institutional children and those raised in family settings and that children younger at assessment and at age of being placed in the institution had worse outcomes than those who were either older or placed in the institution at an older age [21]. Significantly, in 3 of 4 medium or low HDI countries included no differences were found between the IQs of children in institutions and families [21]. These studies indicated that, at least in high and very high HDI countries, living in institutions is associated with poor outcomes, particularly for children aged 4 and younger; however, improving care in institutions improves outcomes. A limiting factor is the small number of institutions involved in the studies resulting in limited generalisability to institutions with different characteristics.

Other studies, primarily of children over age 4, show positive outcomes for institutionalised OAC under good caregiving and structural conditions [22–27]. For example, a study of orphanages in Eritrea found that children aged 9 to 14

in institutions with participatory decision making and where children were encouraged to become self-reliant had significantly fewer emotional and behavioural difficulties than children in institutions that did not have such characteristics [24], while another study found that changing the organisational structure of institutions so that they provided the children with greater decision making and encouragement resulted in improvements in child emotional wellbeing [25]. A study of orphanage alumni in the US found that the alumni fared well compared to their non-orphanage counterparts in terms of economic and emotional wellbeing and that alumni credited the structure of the orphanage, including the work ethic and religious teaching, with their long term wellbeing [27]. While provocative, study design flaws limit the generalisability of the later studies.

As the need for OAC care options increases particularly in medium and low HDI countries, global policies now recommend that one option, institutional care, be used as a last resort and that children in such care be moved to residential care as quickly as possible [28,29]. These recommendations make explicit neither what constitutes an “institution” nor which characteristics of institutions are presumed to be responsible for poor OAC outcomes. They also do not recognise that in some cases, a family setting is either not an option or possibly a worse option than living in an institution that promotes child wellbeing. In the absence of such information, such policy movements limit care options without assurance that community environments will be more safe and supportive than the institutions from which children are moved.

This study uses cross-sectional data for children age 6 to 12 from the Positive Outcomes for Orphans (POFO) study to assess if the hypothesis that institutional care for children of this age group in countries facing the current OAC crisis is associated with poorer intellectual functioning, memory, emotion, behavior, and health than community care. The analyses describe the variation in child wellbeing of 1,357 children in 83 institutional care settings in 6 study sites across 5 medium HDI countries; these children are compared with 1,480 orphaned and abandoned community dwelling children from 311 community clusters (geographically bound sampling areas) in the same regions. All children included in the study had at least one parent who had died (83%) or had been left in the care of others (17%). Sensitivity analyses were conducted for subgroups of institution-based children and for 658 of the community dwelling children whose primary caregiver was not a biological parent. The variation in institutional care settings and child outcomes across and within community and institution-based care settings is examined.

This study adds to the body of evidence related to OAC caregiving in at least three ways. First, the study was conducted in six culturally, politically, religiously, historically and geographically distinct sites in 5 medium HDI nations facing rising OAC populations. Such a design reduces confounding between outcomes and culture. For example, in one culture extended families may traditionally care for the children of deceased siblings; in another culture such children may be shunned and treated harshly by extended families. Single country/culture studies could attribute differences related to cultural norms to the effects of the living structure. The structure of, and quality of caregiving in, the average institution in such places as Cambodia, Tanzania or Romania may be quite different from each other due to policy, religious, economic and cultural differences [30–35]. The same is true of family style care where, in addition, the quality of interaction is influenced by the cultural beliefs regarding acceptable treatment of OAC relative to biological children and the economic means of the family which may be less than those families caring for OAC in wealthier nations.

Second, this study attempted to draw a locally representative sample of institutions at each site resulting in one of the largest samples of institutions ever examined in any single study of OAC and perhaps the most representative of institutions at the sites. While studies comparing children living in one or two institutions to community-based children have explored a variety of community-based settings, they failed to consider the variability in institutional care.

Finally, this study focuses on children who are aged 6 to 12 and, while the results cannot be generalised to younger populations, this age group provides insight into the longer term effects of orphaning and the effects on children who were orphaned or abandoned at older ages; countries with emerging OAC epidemics have many children being orphaned at older ages. The magnitude of the OAC crisis demands that safe and sustainable care options be identified quickly and systematically.

MATERIALS AND METHODS

Positive Outcomes for Orphans (POFO) Sampling

We employed two-stage random sampling survey methodology in 6 geographically defined regions of 5 less wealthy nations to identify a sample of 1,357 institution-living and 1,480 community-living OAC ages 6–12 who were statistically representative of the population of institution- and community-living OAC in those regions. The data collection was conducted between May 2006 and February 2008 among community-based and institution-based OAC and

their caregivers. Four main instruments collected information from: 1) children reported to be aged 6 to 12 residing in communities who had a parent who had died or was missing; 2) children residing in institutions; 3) the children's primary caregivers; and 4) a person who could respond to administrative questions about the institution. Age inclusion criteria were based on survey instrument validity and pilot testing: The study sought to look at OAC aged 4 and older due to the findings of previous studies, but the pilot testing indicated that 4 and 5 year olds did not seem to understand many of the questions. Written informed consent was obtained from each participating caregiver and from the heads of participating institutions. Written assent was given by all participating children. Ethical approval was provided by the Duke University Institutional Review Board (IRB), the IRBs of Meahto Phum Ko'mah (Battambang, Cambodia), SaveLives Ethiopia (Addis Ababa, Ethiopia), Sharan (Delhi, India), ACE Africa (Bungoma, Kenya), and Kilimanjaro Christian Medical Centre (Moshi, Tanzania), and regulatory agencies in all participating countries: National Ethic Committee for Health Research (Cambodia), Ministry of Science and Technology (Ethiopia), Indian Council of Medical Research (India), Kenya Medical Research Institute (KEMRI), and the National Institute for Medical Research (Tanzania).

Country selection. From a group of 13 countries in which the research team had existing relationships with grassroots community organisations with an interest in the proposed research, five countries were selected that were culturally, historically, ethnically, religiously, politically, and geographically diverse from each other. Political boundaries were used to define six study areas (See Table 1).

Institution selection. For each of the six study areas, comprehensive lists of all institutions were created. To ensure broad representation, institutions were defined as structures with at least five orphaned children from at least two different families not biologically related to the caregiver(s). While this procedure could have resulted in the inclusion as "institutions" of family homes that are more like foster families, only 3 of the 83 institutions included were run out of caregivers' homes. Institutions specifically for street children, special needs children, and international adoption were excluded. The institutional sampling frame was generated through inquiries to local government officials, schools, and organisations working with orphans. Lists were randomised and institutions were approached sequentially until 250 children were enrolled into the study (see child selection below). If an institution refused participation, the next institution on the list was approached. To ensure that the sample was not dominated by large institutions, up to 20 children per institution were eligible to

participate; at three sites this threshold was later eliminated to allow for the enrollment target of 250 children to be met at each site (see below). In total, 83 institutions participated in the study: 9 in Battambang (1 refusal), 12 in Addis Ababa (2 refusals), 13 in Kilimanjaro Region (1 refusal), 14 in Hyderabad (5 refusals), 14 in Dimapur and Kohima Districts of Nagaland (2 refusals), and 21 in Bungoma (no refusals). Reasons for refusals ranged from fear of psychological damage to the children to wanting monetary compensation for project participation (Appendix S4).

Table 1:
Study enrollment and child characteristics

	Inst. Sample		Comm. Sample					
<i>Site (N, %)</i>	Institutions	Children	Sampling Areas	Children				
Cambodia	9(11%)	157(12%)	47(15%)	250(17%)				
Ethiopia	12(14%)	250(18%)	51(16%)	250(17%)				
Hyderabad	14(17%)	250(18%)	51(16%)	250(17%)				
Kenya	21(25%)	250(18%)	54(17%)	250(17%)				
Nagaland	14(17%)	202(15%)	58(19%)	229(15%)				
Tanzania	13(16%)	248(18%)	50(16%)	251(17%)				
Total	83	1,357	311	1,480				
CHILD CHARACTERISTICS								
Age (Mean, SD)	9.0 (1.8)		8.9 (1.8)					
Female (%)	42.8		47.1					
PARENTAL STATUS	◆ Alive	◆ Dead	◆ UK*	◆ Total	◆ Alive	◆ Dead	◆ UK*	◆ Total
● Alive (%)	11.2	28.8	3.0	43.0	8.8	52.9	2.8	64.6
● Dead (%)	7.4	35.4	4.8	47.6	11.9	17.4	3.4	32.7
● Unknown (%)	0.7	2.2	6.5	9.4	0.3	2.0	0.4	2.7
● Total (%)	19.2	66.6	14.2	100.0	21.1	72.2	6.7	100.0
◆ is father's status.								
● is mother's status.								
*UK is Unknown.								

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Selection of institution-based children. Each institution provided a list of all residential children under their care aged 6 to 12. Using a list of random numbers, up to 20 children per institution were randomly selected; the exception to this protocol was sites where the enrollment target of 250 children could not be met using this restriction: under this condition, all children in the age range became eligible to participate. Of the 5,243 children cared for by the institutions, 2,396 were reported to be age-eligible, and 1,357 were selected for enrollment. The number of participating children per institution ranged from 1 to 51. One quarter

of children had been residing in the study institution for less than one year; 38% between one and three years; 21% between three and five years; and 10% more than five years. Information was missing for 6% of children. Five percent of children entered the institution before age 2; 15% at ages 2 to 4; 45% between ages 5 and 7; and 30% at ages 8 or above. These percentages only apply to study children. No information was collected on reasons for institutionalization or whether a child previously had spent time in other institutions.

Selection of community sampling areas. In each study area, the community sampling strategy involved the selection of 50 sampling areas (“clusters”) and 5 children per cluster. Geographic or administrative boundaries were used to define sampling areas: by necessity, the specific definition varied across sites. The primary community sampling aim was to select an unbiased sample of community-based care settings while adhering to the overarching methods.

Selection of community-based children. The definition of community-based children was an orphan, as defined above, not living in an institution; abandoned children living without either of their two parents were also eligible to participate. In each sampling area up to five eligible children were selected, either randomly from available lists, or through a house-to-house census conducted until 5 households with age-eligible children were identified. In 13 villages in Cambodia, 12 in Nagaland, and 1 in each of the remaining sites, substitutions for insufficient sampling areas or areas with fewer than five eligible children raised the number of children per sampling area to between 6 and 10. In households with multiple age-eligible children, one child was selected as the child whose first name started with the earliest letter in the alphabet. In total, 1,480 community-based children were enrolled in the study; 658 of these children were cared for by a primary caregiver other than the biological parent.

Caregiver selection. The children’s (self-identified) primary caregivers were asked to respond to surveys about themselves and the children. In total, 193 institutional caregivers, ranging from 16 institutional caregivers in Nagaland to 52 in Cambodia, and 1,480 community-based caregivers participated in the assessments.

INTERVIEWER TRAINING

One local male and female interviewer and a lead investigator from each site were trained on study protocol and procedures. A week-long training took place at a central location with all interviewers and primary investigators present. Following the training, the interviewers continued practicing and were certified only after repeated direct observation or video taping of interviews

with local non-study children. The psychological testing was reviewed by the Duke child psychologist for fidelity to standard test procedures. Site visits, with interviewer observation, were conducted during the data collection to further ensure accuracy and consistency across interviewers and sites. Interviews were conducted in the child's residence and children were interviewed verbally in their native language.

MEASURES

Subjective health. Caregiver-reported health measures included symptoms of fever, cough, and diarrhea in the last 2 weeks; general health of the child (single item from the Medical Outcomes Study Short Form 36 [36], with response options of “very good,” “good,” “fair,” “poor,” “very poor”); and physical wellbeing on the day of the interview.

Objective health growth. Growth measures included height and weight. Body Mass Index (BMI) and child height were age and gender standardised according to WHO growth charts [37].

Behaviour and emotional health. The Strengths and Difficulties Questionnaire (SDQ) [38,39], asked of children aged 11 and 12 and of the caregivers for all children, is a brief behavioral screening tool applicable for children 3–16 years old, used to assess behavioral and emotional difficulties and pro-social behavior. The SDQ has versions for parent, teacher, and self report. The five scales (emotional symptoms, conduct problems, hyperactivity/inattention; peer relationship, and pro-social behavior) have 5 items each; items are scored from 0–2. The first four scales result in the summary score of Total Difficulties, ranging from 0 to 40, with higher values signifying more difficulties. The raw Total Difficulties scores are used for group comparisons only.

The SDQ was selected because of the dimensions of behavior assessed, its brevity, the high correlations with well accepted but much longer child behavior measures [40], and its wide use in both resource rich and poor countries [41,42]. One study reports SDQ differences between institutionalised and non-institutionalised children in the Netherlands, relating the findings to the low prevalence of secure attachment in the institutionalised group [43]. Although the SDQ has no published data regarding its psychometric properties or standardisation in the five countries reported herein, its validity is supported by translation and use in 67 languages and the care with which translations and back translations are conducted in each of our study sites with native language speakers. In wealthy nations, mean scores range from 7.1 to 8.4 with scores

indicating elevated (one standard deviation above the group mean) difficulties ranging from 12.8 to 14.3.

Cognitive development. Subtests from the Kaufman Assessment Battery for Children-II (KABC-II) [44] were used to evaluate the children's intellectual functioning. The KABC-II was chosen because it has been successfully utilised in low resource settings [45]; the visual attractiveness of the materials and tactile nature of the tests make them engaging for children around the world. Subtests appropriate for children ages 3 through 18 were used that can be administered with limited oral language, making them less dependent on language differences, and could be performed in less than 30 minutes. To assess sequential processing and short term memory through visual motor abilities, spatial relations and visual motor integration, sustained attention, and visual problem solving abilities, 3 of the 5 subtests were chosen: Hand Movements, Triangles, and Pattern Reasoning. The scores reported here are the mean subtest scaled scores using the test's normative data for child age with a test result range from 0–19 with higher being better. The use of U.S. norms was justified because the scores were used to test group differences in an age-standardised way and not to assess individual child abilities.

The child's attention, motivation, and memory were assessed using a "Market List", which is an adaptation of the California Verbal Learning Test (CVLT-Children's Version.) [46] The CVLT is used in a variety of settings to assess verbal learning and memory in children. The Market List was adapted to each site with the assistance of the local interviewers to reflect 15 items that would be seen in a local market, following the three semantic categories of the original CVLT. The child is read a list of items he/she might see in a market and asked to repeat the list. The items on the list were chosen to be common in everyday life in that area, even for a child who has not been to a local market. For this report, the score used for analysis was the mean of three administrations of the list.

ANALYSIS

Standard survey analytic techniques were used to estimate mean values of each outcome for institution-living OAC, community-living OAC, and community-living OAC not cared for by a biological parent, as well as 95% confidence intervals for the differences between means. Estimates accounted for unequal selection probabilities and the multilevel study design. Specifically, the survey estimation commands specified the stratified sampling by study site and the clustering of children within each institution or community cluster. For

institution-living children, selection weights were defined as the inverse of the product of the sampling probabilities at the institution and child levels, and a finite population correction was applied in the calculation of the mean. For community-living children, sampling probabilities were not available since the sampling frame was not always known. In the calculation of means, the outcomes of institution-living OAC from each site were directly standardised to the age and gender distribution of that site’s community-living OAC to reduce possible confounding by differences in the age or gender distributions between the community and institution-based samples.

To ensure robustness of the results, analyses were rerun on these subgroups: single orphans, double orphans, and single and double orphans only; ages 6–9 and 10–12; children in institutions with 25 children, 50 or more children, and 100 or more children; children residing in their current living situation for 1 year, 3 or more years and 5 or more years; and community children living with a biological parent.

In order to describe the proportion of total variation in outcomes that was attributable to each of the three levels of the survey design (study sites, care settings within sites, and individuals within care settings), we fit a linear mixed effects model (“model 1”) for each normally distributed outcome Y_{ijk} for child i in care setting j in study site k , adjusting for age and gender and including random intercepts for sites u_k and care settings nested within sites u_{jk} ; e_{ijk} denotes child specific errors. The assumption of normally distributed residuals was checked with quantile (probit) plots [50].

$$\text{Model 1 : } Y_{ijk} = \beta_0 + \beta_1 + \beta_1 \text{age}_{ijk} + \beta_2 \text{female}_{ijk} + u_k + u_{jk} + \varepsilon_{ijk}$$

The variances of u_k , u_{jk} and e_{ijk} , respectively, describe the variation in outcomes among study sites, variation among care settings within a site, and variation among individuals within a care setting.

To further describe the proportion of variability in outcomes, after adjustment for study site, age, and gender, that was attributable to overall differences between institutional and community-based care settings, we fit a second set of models that added fixed and random effects, b_3 and u_{1k} , respectively, for a dichotomous variable indicating care setting type (“model 2”) [47].

$$\text{Model 2 : } Y_{ijk} = \beta_0 + \beta_1 + \beta_1 \text{age}_{ijk} + \beta_2 \text{female}_{ijk} + \beta_3 \text{type}_{ijk} + u_j + u_{ok} + u_{1k} \text{type}_{ijk} + e_{ijkM}$$

We estimated the proportion of variability attributable to care setting type V^2 as where t_1^2

$$\Omega 2 = 1 \frac{\tau_2^2 + \sigma_2^2}{\tau_1^2 + \sigma_1^2}$$

and s_1^2 correspond to the care setting level variance and the individual level variance, respectively, estimated from models 1 and 2, respectively; V^2 can be thought of as a partial R^2 (conditional on age, gender, and site) within the context of a hierarchical model [48–49]. Analyses were conducted using Stata v.10.1 [51].

RESULTS

Children

2,837 children participated in this study: 1,357 resided in institutional care settings and 1,480 in community-based care (Table 1). Females comprised 42.8% of institution-based children and 47.1% of community-based children; the average age was 9. The institutional sample is characterised by an age-related drop-off in the percentage of girls ($p = 0.02$; not shown): among 6-year olds, 47.4% of children were female, among children age 10 and older only 38.7% were female. This trend was the result of a site-specific drop in Hyderabad ($p = 0.007$) and was not observed in other sites or in community settings. More than one-third of children in institutions (35.4%) and one in six children in the community (17.4%) were double orphans. Fifty-one percent of institution-based children and 76.8% of community-based children had one parent who was known to be alive. Fifty-five percent of community caregivers were biological parents; 22% were grandparents and 13% were aunts or uncles (not shown). Almost half of the children in institutions (47.6%) and one-third of children in the community (32.7%) had mothers who had died. Across settings, approximately 70% had fathers who had died.

INSTITUTIONS

Table 2 describes the variation in selected characteristics of participating institutions; Figure 1 illustrates this variation graphically, both across institutions and weighted by the number of children residing in these institutions. The mean (median) number of children in the institution was 63 (42); the mean (median) number of caregivers was 6.5 (4) and the mean (median) number of children per caregiver was 13.7 (9). The largest child-to-caregiver ratio for institutions with any children under age 2 was 16.9 (not shown). One quarter of the institutions (28.9%) had 20 or fewer children; the largest (17%) had 100 or more children (not shown). The largest institutions were located primarily in Addis Ababa and Hyderabad. One-third of the institutions had been in existence fewer than 5 years prior to the time of the interview; 31% were 5–9 years old, and 31% had been operating 10 years or more. Six institutions were all female and 11 all male.

Table 2:
Characteristics of institutional care settings (N = 83) and caregivers in institutional and community settings (N = 1,672).

<i>Institutional Characteristics (N=83)</i>	Mean	SD	Median	Min	Max
Numberofchildren	63.2	69.3	42	5	376
Numberofcaregivers	6.5	7.7	4	1	50
Children per caregiver	13.9	14.0	9.2	1	75.2
Timeofinstitutional existence	%				
0–4 years	37.3				
5–9 years	31.3				
10+ years	31.3				

	<i>Caregiver Characteristics (Institutions:N=192; Community:N=1,480)</i>	
	Institutions (N=192)	Community (N=1,480)
Age (Mean, SD)	35.5 (11.1)	41.6 (13.5)
Female (%)	77.3	83.9
Educationinyears (Mean, SD)	10.9 (4.2)	5.5 (4.3)
Hoursofwork per week (Mean, SD)	111.0 (55.4)	29.2 (23.9)
Of those (%):		
,20 hours	5.0	37.6
20–39 hours	8.3	26.3
40+ hours	50.0	36.2
residential (168 hours per week)	36.7	
Earning an income (%):		
in institution only	49.1	n/a
outside institution only	7.4	70.1
both inside and outside institution	18.3	n/a
none	25.1	29.9

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CAREGIVERS

Three-quarters of institutional caregivers were female (77%), and the mean caregiver age was 35 (Table 2). On average, institutional caregivers had a 10th grade education and worked more than 100 hours per week. Full-time residential work (168 hours per week) was reported by 37% of caregivers. One-third of the interviewed institutional caregivers reported working in the institutions without a salary (32.5%). Institutions reported providing room and board and a living stipend for many of the latter. Community caregivers, on average, were 42 years old, had a 5th grade education, and worked less than full-time, on average, with 70% reporting earning an income.

CHILD CHARACTERISTICS

Caregivers subjectively rated the children's health on a five-point scale (higher = better); by these ratings, institutional-dwelling children had significantly better

health scores than the community dwelling children (institution-living OAC: mean 4.00; community-living OAC: mean 3.72; weighted difference 0.34, 95% confidence interval [0.28, 0.41]) (Table 3). By caregiver report, institution-living children were also less likely to have had a cough, diarrhea, or fever in the two weeks before the interview (19.9 vs. 41.2%, weighted difference 220.6%, 95% CI [-24%, -18%]) or to be sick on the day of the interview (5.9% vs. 12.2%), weighted difference 26.1%, 95% CI [-8%, -4%]). There were no differences between institution-living and community-living OAC in mean height for age or BMI for age. Total Difficulties scores on the Strengths and Difficulties questionnaire were lower (better) in institution-living than community-living OAC (weighted difference -0.78, 95% CI [-1.18, -0.38]). Institution-living OAC demonstrated greater intellectual functioning (weighted difference 0.38, 95% CI [0.25, 0.51]) and memory (weighted difference 0.59, 95% CI [0.40, 0.78]) than community-living OAC. In general, differences were more pronounced when comparing institution-based children with only community based children not cared for by their biological parents.

There was substantial variation in mean child outcomes among participating institutions, and even greater variation in outcomes across institution-based children (Figure 2). The distribution of child outcomes among institution-based children was similar to that of study children in residing in communities.

After adjustment for age and gender, differences between study sites accounted for 2.2% to 22.5% of the variation in child outcome measures, while differences between care settings within sites accounted for 7.9–13.9% of the total variation and differences between individuals within care settings accounted for 63.6%–86.8% (Table 4). Differences between care settings within sites accounted for similar proportions of total variation whether considering only institution-living OAC (5.9–21.2%) or community-living OAC (1.8–17.1%). In the models that conditioned on age, gender, and site, the dichotomous variable for care setting type (institution vs. community-based) explained 0.3–6.9% of the total variation in child outcomes.

Our sensitivity analyses of sub-groups (e.g., excluding non-orphaned children, including only single orphans, only double orphans, only children in their current setting less than 1 year and alternatively only 5 years and longer, and only children in small (25 or less) or large (100 or more) institutions) did not change the overall results of the analyses (Appendixes S1, S2, S3). The differences in cognition and memory remained significant in all analyses, the biometric health measures became significant in the direction of better health for children in

institutions and behaviour became insignificant while still trending toward better behaviour for children in institutions. In general, the results were consistent in direction and magnitude.

Figure 1:

Characteristics of study institutions and distribution of children ages 6-12 residing in these institutions (N = 2,396). Legend: Dark bars describe the distribution of institutions. Light bars describe the distribution of institution-based children. Caregivers per 100 children calculated using the total number of children in the participating institutions.
doi:10.1371/journal.pone.0008169.g001

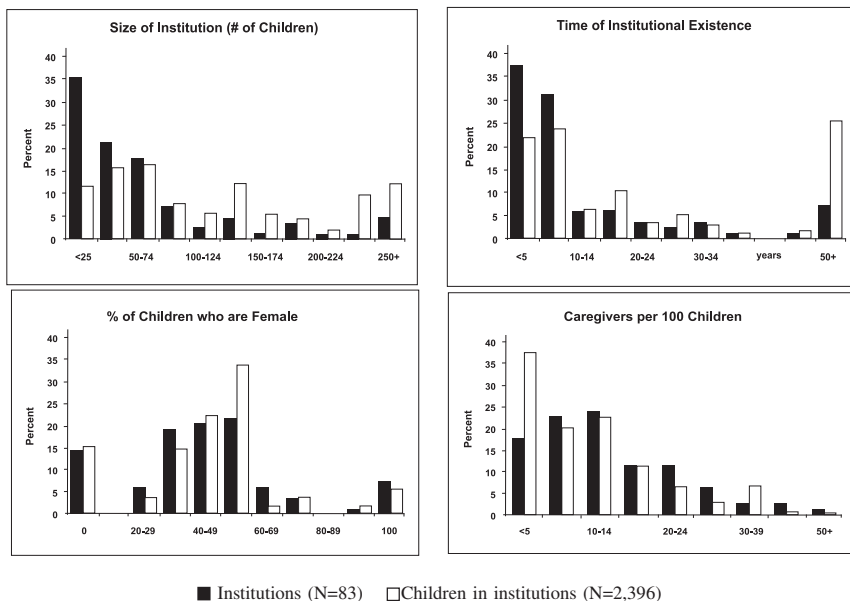


Table 3:
Comparison of child outcomes between institutional and community-based care settings.

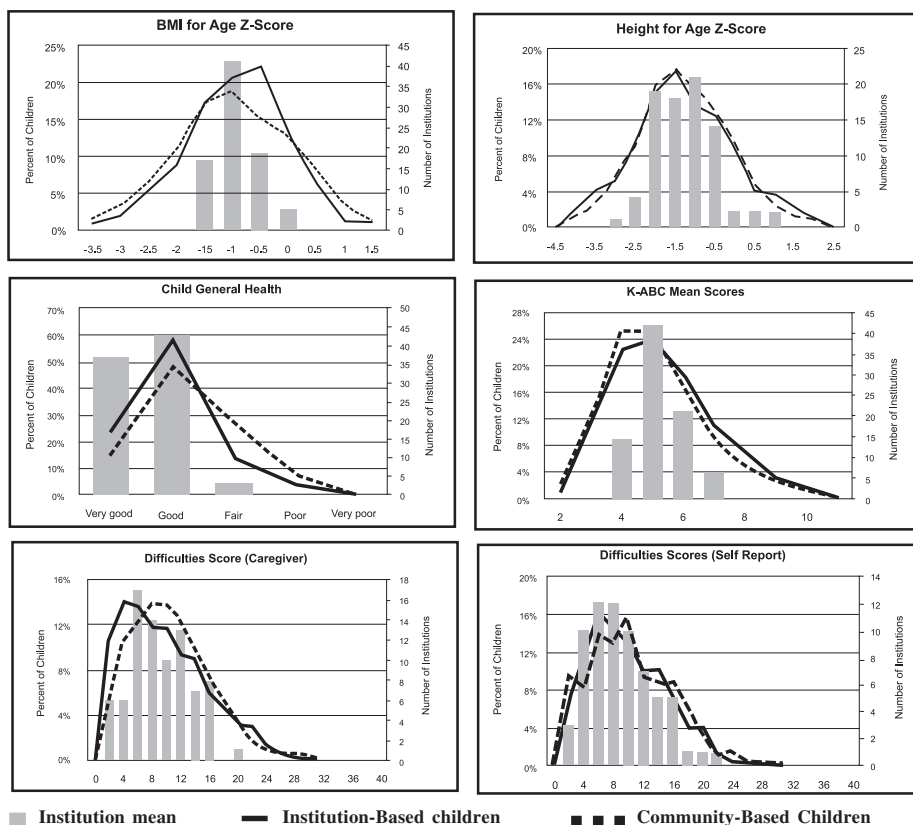
Unweighted	Weighted ¹ Institutional children	All community children	Community children w/out bio. parents	Institution vs. community children	Institution vs. no biological parents
Number of children	1,357	1,480	658		
Positive outcomes (higher is better)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (CI)	Mean (CI)
Caregiver-rated health	4.00 (0.76)	3.72 (0.83)	3.67 (0.83)	0.342 (0.28, 0.41)	0.367 (0.29, 0.44)
Height for age score (WHO)	-0.96 (1.46)	-1.03 (1.29)	-1.10 (1.36)	0.011 (-0.08, 0.10)	0.074 (-0.04, 0.19)

¹Weighted means and standard errors account for sampling weights and the complex survey design and are further adjusted for age and gender (standardized to the site-specific distribution of age and gender among community children).

BMI for agezscore (WHO)	-0.68 (0.97)	-0.73 (1.39)	-0.84 (1.27)	0.072 (-0.01, 0.16)	0.113 (0.02, 0.21)
Cognition (K-ABC II) ²	4.76 (1.89)	4.43 (1.71)	4.44 (1.83)	0.379 (0.25, 0.51)	0.429 (0.28, 0.58)
California Verbal Learning Test ³	7.77 (2.35)	7.22 (2.24)	7.29 (2.24)	0.590 (0.40, 0.78)	0.599 (0.38, 0.82)
S&D Total Difficulties score (0=worst, 40=best)	10.13 (6.07)	10.93 (5.66)	11.05 (5.84)	-0.778 (-1.18, -0.38)	-0.968 (-1.48,-0.46)
Negative outcomes (higherisworse)	N(%)	N(%)	N(%)	%(CI)	%(CI)
Diarhea/fever/cough in last2 weeks	269 (19.9)	603 (41.2)	273 (41.5)	-20.6 (20.24, 20.18)	-20.4 (-0.24, -0.16)
Child sick on day ofcaregiver interview	79 (5.9)	179 (12.2)	69 (10.4)	-6.1 (-0.08, -0.04)	-4.5 (-0.07, -0.02)

Figure 2:

Distribution of child outcomes for community-based (N=1,480) and institution-based (N=1,357) children residing in 83 institutions. Legend: Grey bars describe the distribution of institution means. Solid line describes the distribution of child outcomes among institution-based children. Dotted line describes the distribution of child outcomes among community-based children. doi:10.1371/journal.pone.0008169.g002



²Mean of three K-ABC-II subtests with responses converted to scaled scores using age-specific norms (range 0–19 with higher being better) distribution of age and gender among community children).

³CVLT score defined as the mean number of items recalled in three administrations (range 0–15). doi:10.1371/journal.pone.0008169.t003

DISCUSSION

These analyses were designed to test the hypothesis that institutional care for OAC aged 6–12 is associated with worse child health and wellbeing than community care, specifically in areas of the world most affected by the current orphan crisis and where many children are orphaned at a later age. The results do not support this hypothesis. While it is possible that respondent bias accounts for better subjective health scores for children in institutions, the lack of significant differences on the biometric scores and the lower prevalence of recent illness suggest that the growth and overall health of children in the institutions is no worse than that of children in communities. The institution-based children scored higher on intellectual functioning and memory and had fewer social and emotional difficulties. The differences were more pronounced when comparing these children only to community-based children not cared for by a biological parent. Results were robust in the sensitivity analyses. There were children in the study who scored poorly across all dimensions while others scored highly; this variation was equally true for children in institutions and

Table 4:
Percent of total variation in outcomes attributable to differences among sites, care settings and individuals, and explained by care setting type.

	Variation attributable to differences among ¹			
	Sites	Care settings within sites	Individuals within care settings	Variation explained by care setting type ³
Health	7.0	21.3	71.7	3.8
Height for age score (WHO)	5.4	7.9	86.8	0.9
BMI for age score (WHO)	14.3	13.4	72.3	6.9
SDQ Total Difficulties Score	22.5	13.9	63.6	0.3
Cognition (K-ABC-II scores) ⁴	4.0	10.1	85.9	1.8
California Verbal Learning Test ⁵	2.2	12.1	85.7	2.8

¹From a linear mixed model adjusted for age and gender and including random effects for sites and care settings.

²Institutions or community clusters sampled within sites.

³Percent reduction in overall variance upon introduction of dichotomous variable and random site-level slopes for setting type, conditional on site, age, and gender.

⁴Mean of three K-ABC-II subtests with responses converted to scaled scores using age-specific norms (range 0–19 with higher being better).

⁵CVLT score defined as the mean number of items recalled in three administrations (range 0–15).
 doi:10.1371/journal.pone.0008169.t004

communities. These findings challenge the policy recommendations to use institutions, for all children, only as a last resort and to get children who have to be placed in institutions back out to family-style homes as quickly as possible [52]. There is even a movement to evaluate the success of institutions by how quickly they get the children back out to family-style homes [53]. The evaluation measures would likely affect future funding of the institution and therefore provide an adverse incentive to send children out to family-style homes that may not be able to provide adequate care to promote the child's wellbeing.

The similarity of distributions in child wellbeing in community and institution-based children suggests that 'institutional care,' per se, should not be categorically described as damaging or inappropriate for all children. Relative to variations in child outcomes within communities and within institutions, and between care settings of each type, the overall differences between communities and institutions were small. There was significant variation in average child wellbeing across institutions and across community settings, explaining more of the variation in child outcomes than differences between institution and community-based care settings.

Institutions varied across many dimensions, including the number of children and the gender distribution of the children they housed, including all female, all male and mixed institutions. They varied by the length of time that they had been in operation, and by the characteristics of the caregivers. Such differences may be important determinants of child outcomes and should be further explored. There was also significant variation in child wellbeing in community settings. Advocating the moving of children from one care structure to another, such as from institutions to community settings, without understanding the causes of the differences in child outcomes may place children at risk of worse outcomes.

A potentially important finding of this study is that is that, on average, the institutions look quite different from institutions included in most of the previous studies that compared the outcomes of children in institutions and those in community settings. For example, simply the finding that many of the caregivers live at the institutions, work long hours and may be paid only in room and board is important. This supports a statement made by a medical student from Uganda who was orphaned, that "what people do not realise is that this [the institution] is our community response [54]." Many institutions grew out of the community to meet the need of caring for the new wave of orphans and are a part of the community in a way that institutions in other regions and perhaps of the past were not. These institutions are not family-style/community care and they are not foster care, but they also do not look like institutions as we have come to

think of them. If this represents a new kind of care structure that minimises some of the damage to children demonstrated in past studies and in different contexts, then researchers and policy makers need to: 1) gain a better understanding of these organic care structures and 2) ensure that they are not hindered by blanket policies about institutions.

Children entering institutions are likely to differ systematically from orphans cared for in their communities. Indicators of such bias in this study are the greater proportion of institution-based children that were double-orphans, and maternal death being a greater risk factor for being in an institution than paternal death. Systematic biases resulting from past life events will influence children's longer term outcomes and may be reflected in cross-sectional differences between institution-based and community-based children. For example, children in institutions may have experienced the orphaning or abandonment at a later age, when they are less vulnerable, relative to the children in the community. Many environmental influences on health and wellbeing are cumulative, the subject of substantial lag times, and will differ by the dimensions of wellbeing (e.g., growth, emotion, behaviour and cognition). Cross-sectional analyses, such as the one presented here, cannot account for these effects. Similarly, the study does not inform us as to why there are fewer older female children at one site; one might speculate that they were hired or forced into domestic work or prostitution, but only longitudinal studies will allow researchers to consider such speculations. Longitudinal studies will further advance our knowledge as to the particular care characteristics that best support children in their emotional, intellectual and physical development.

The results of this analysis cast doubt on the generalizability of past studies indicating that institutions are systematically associated with poor child outcomes to children of this age group, 6 to 12 years of age, in less wealthy nations. The differences in the study findings may be due to several causes. For example: This study is of older children and cannot be generalised to other age groups, particularly the very young where much of the strong evidence demonstrating the detrimental effects of institutions on child brain development has been found. It is possible that the negative effects of institutions that have been found in past studies either do not hold for older children, or that measurements need to be more precise to find differences.

Secondly, the countries included may have poorer community settings where caregivers are not able to provide as adequate care. It is possible that when communities are very poor, as indicated by the HDI scores for the sites included

in this study [55], that differences between institutional care and family-style care are minimised. In such places, positive institutions may provide a place where children can focus on education and their own needs rather than supporting their families. If the latter is true, then it may not be that institutional care is “good,” but that it is better than the community alternative. Further, the study results cannot be generalised to wealthier areas where orphaning and institutions are more rare.

Finally, cultures may differ so that institutional caregivers provide more parent-like support; and children living in the institutions may be more incorporated into the surrounding community. Because of their lack of visibility, intensive effort was required to create the sampling frames from which institutions were sampled at each site. Small locally run institutions were hardest to locate. The virtual invisibility of a majority of institutions in less wealthy nations may be one reason why the results of this study contradict those reported in previous studies. It may be that locally run institutions have characteristics that are more conducive to positive child outcomes than the more formal and visible institutions that have typically been assessed in OAC-related research.

As the number of OAC increases in medium and low HDI countries, it is vital not to discount an important care structure before conclusively assessing whether these structures have systematic negative impacts on the millions of children for which they care. This study indicates that in these culturally diverse medium HDI nations, OAC aged 6–12 cared for in institutionalised settings had outcomes that are as good and as poor as their community-based counterparts. While there was great variation in child wellbeing across outcome measures, this variation was not determined by residence in one physical structure over another. This study argues for a move beyond the dichotomized choice set of community vs. institution-based care towards an analysis of the specific characteristics of these care settings which are associated with improved child outcomes. Future studies that seek to assist medium and low HDI countries in finding feasible solutions for their OAC need to be conducted with rigorous methods in these countries.

SUPPORTING INFORMATION

Appendix S1 Differences in child outcomes between institutional and community-based care settings. Institutional sample stratified by children’s time spent in the current institutional care setting

Found at: [doi:10.1371/journal.pone.0008169.s001](https://doi.org/10.1371/journal.pone.0008169.s001) (0.12 MB DOC)

Appendix S2 Comparison of child outcomes between institutional and community-based care settings. Institutional sample stratified by children's age at entry into the current institutional care setting

Found at: doi:10.1371/journal.pone.0008169.s002 (0.04 MB DOC)

Appendix S3 Comparison of child outcomes between institutional and community-based care settings. Institutional sample stratified by size of institutional care setting.

Found at: doi:10.1371/journal.pone.0008169.s003 (0.04 MB DOC)

Appendix S4 Reasons for Institutional Study Refusals

Found at: doi:10.1371/journal.pone.0008169.s004 (0.03 MB DOC)

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AUTHOR CONTRIBUTIONS

Conceived and designed the experiments: KW JO RW KJO BWP NMT. Performed the experiments: KW JO RW KJO BWP NMT. Analyzed the data: KW JO BWPLCM. Contributed reagents/materials/analysis tools: KW. Wrote the paper: KW JO RW KJO BWP NMT.

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GOOD PRACTICES AND MODELS OF ALTERNATIVE CARE

“UDAYAN GHARS (SUNSHINE HOMES):” A COMPREHENSIVE PSYCHO-SOCIAL PROGRAMME FOR INSTITUTIONALISED CHILDREN IN THEIR JOURNEY TO RECOVERY

*Kiran Modi, Ph.D.**, *Monisha Nayar-Akhtar, Ph.D.***,
*Deepak Gupta, M.D.**** and *Sohini Karmakar, M.Phil.*****

Abstract

This paper explores the needs of children who find themselves in institutional care. They often have histories of being abandoned and severely neglected, sexually or physically abused, sustaining several losses, witnessing and experiencing significant trauma, and therefore, lack basic social skills and the capacity for healthy attachment to others. These children need intensive efforts directed toward helping them address their attachment challenges, histories of trauma, basic social skill needs, and opportunities to receive a better education. Udayan Care has set up 15 Children’s Homes and Aftercare facilities, in North India, that have over 200 children and young adults in the L.I.F.E. (Living In Family Environment) setting. This paper explores the various ways in which Udayan Care, basing its services on a bio-psycho-social perspective, utilises its team of Mentor Parents as lifetime volunteers, care staff, and Mental health professionals, who work to ensure the mental and physical well-being of the children placed in their care. Particular attention is paid to how the children function academically and to the development of age appropriate social skills. They work as a team, helping children in different social settings to move beyond their personal histories of tragedy and loss to learn to function more adaptively. This paper explores ways in which Udayan Care is improving its services to ensure the physical and mental wellbeing of the children in their care.

KEYWORDS: *Udayan Care, Bio-Psycho-Social, Trauma, Attachment, Living in Family Environment, Children, Child Care.*

**Founder Managing Trustee, Udayan Care, Associate Editor, ICEB; kiranmodi@udayancare.org.*

***Director, Indian Institute of Psychotherapy Training, New Delhi, India, Psychologist/Psychoanalyst, Philadelphia, Pennsylvania, USA.*

****Child & Adolescent Psychiatrist Founder, Centre for Child & Adolescent Wellbeing (CCAW) Consultant, Sir Ganga Ram Hospital (SGRH) In-charge, Mental Health Programme, Udayan Care, New Delhi, India*

*****Program Executive, Udayan Care, New Delhi, India*

FACT SHEET

An estimated 31 million children in India, aged 0-17 years, are orphaned and abandoned according to the most recent statistics from UNICEF.¹ Research proves that orphans who do not receive proper care turn to crime and are vulnerable to child labour, prostitution and other violations. Domestic adoption rates are abysmally low at 5964 children². A report by a leading newspaper daily (Hindustan Times) in 2011 suggested there are close to 30.35 lakh orphans in the north zone of the country consisting Delhi and other surrounding states.³ The same report suggested SOS children's village analysed of National Family Health survey for 2005-06 which cited 20 million (4% of population) are orphaned or abandoned in India. Very few of the orphanages and shelter homes in India offer adequate care. UNICEF's estimate of **11 million street children in India** is considered to be a conservative figure, added up by **100,000 in Delhi alone**.⁴ The crimes against children reported a 24% increase in 2011 than in 2010. The states of Uttar Pradesh and **Delhi** together accounted for 47.6% kidnapping and abduction of children reported in the country.⁵ According to National Crime Records Bureau in India, a child goes missing every eight minutes out of which almost 40% of those children haven't been found.⁶ According to National Commission for Protection of Child Rights (NCPCR) - an autonomous body under the Ministry of Women and Child Development, GOI - cases of child abuse in India have gone up by an unbelievable 117 per cent in the last four years.

This is what raises concern over the *vulnerability* of children in India; especially for those who **lack their first line of protection - their parents. This was the seed for starting up Udayan Ghars so that they would not remain nobody's children!**

WHO ARE 'CHILDREN IN NEED OF CARE AND PROTECTION'?

'Children in need of care and protection', as described by The Juvenile Justice Act 2000, are those who are either homeless, found begging/ working on streets, lost, orphaned, abandoned, neglected, abused, have an incapacitated parent, a victim of war/ social unrest or national calamity, under threat of life, displayed anti-social behaviour, suffering from terminal diseases, mentally/ physically challenged and with no support.

¹ http://www.unicef.org/infobycountry/india_statistics.html

² <http://adoptionindia.nic.in/Resources/Adoption-Statistics.html>

³ <http://www.hindustantimes.com/India-news/NewDelhi/About-20m-kids-in-India-orphans-Study/Article1-725905.aspx>

⁴ Railway Children, 'Our work in India', [online]. Available at <http://www.railwaychildren.org.uk/asia.asp>.

⁵ Crime in India 2011, National Crime Records Bureau, <http://ncrb.nic.in/CD-CII2011/Home.asp>

⁶ <http://ncrb.gov.in/>

HOW DO THEY COME TO UDAYAN CARE?

All vulnerable children (except for those ‘suffering from terminal diseases or are diagnosed with severe mental and physical challenges’) can be placed in licensed ‘Children’s Homes’, such as ‘Udayan Ghars (Sunshine Homes)’ run by **Udayan Care**, but only through the orders of the **Child Welfare Committees**.⁷ Children however may also in some cases come through other sources such as **relatives** or **parents**, who cannot care for the orphaned/ abandoned children, or by **Police/ Good Samaritans/ Other Institutions referrals, but only by permission of CWCs**.⁸

BACKGROUNDS OF THE CHILDREN

It is a fact that as many as 8 million of the world’s children are in residential care. Some major reasons as pointed out by the study by United Nations on Violence against Children are it is lesser in number where a child is in residential care as they have no parents whereas major cases are registered because of their disability, family disintegration, violence in home and social and economic conditions including poverty.⁹

In Udayan Ghars, most of the children come from a background of **extreme economic deprivation**. If not double orphans, children with single parents or biological relatives may be abandoned by their parents or extended family, because of poverty or domestic marital complexities. In many cases, parents have themselves declared their children orphans and have posed as relatives of children before us only for the sake of getting their children admitted at Udayan Care and for securing their future. The struggle to survive is such that some of the children living with us know the whereabouts of their parents but do not disclose as they do not wish to return to the world of deprivation. Many of the children are lost and their families are untraceable. Many of our children are also victims of physical and sexual abuse at the hands of their own family members or by society when they land up on streets.

⁷ The Procedure of any child coming to Udayan Ghars are in compliance with “**Article 20 of the Convention on the Rights of the Child**” which necessarily entails “A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

⁸ As per the provisions of the Juvenile Justice (Care and Protection of Children) Act 2000 (amended in 2006) State governments are required to establish a **CWC-Child Welfare Committees** or two in every district. The CWC usually sends the child to a children’s home while the inquiry into the case is conducted for the protection of the child. The CWC meets and interviews the child to learn his/her background information and also understand the problem the child is facing. The probation officer (P.O) in charge of the case must also submit regular reports of the child. The purpose of the CWC is to determine the best interest of the child and find the child a safe home and environment either with his/her original parents or adoptive parents, foster care or in an institution.

⁹ Report of the independent expert for the United Nations study on violence against children, 2006

These children do not belong to any particular religion, caste or creed but share common scars inflicted by poverty, social apathy and abuse, neglect, malnutrition, ill health, emotional trauma and lack of education. It is well-known that the children, who fall into the artifice of ‘Children in need of Care & Protection’ and get into institutional care, bring with them the experiences of being orphaned/abandoned/lost, a past full of utter deprivation and penury, street history and mixed experiences (mostly of child labour and even small time crimes), huge trauma issues emanating from physical, sexual and emotional abuse, lack of basic life skills, need for attachment, communication & behavioral modification, need to develop social skills and need to get educated. Needless to say they need utmost care and careful handling.

EMERGENCE OF UDAYAN GHARS (SUNSHINE HOMES) MODEL

Udayan Ghars are based on an indigenously developed, carefully researched model of group foster care, called LIFE: *Living in Family Environment*. The essence of the model is to recreate the warmth and security of a home and family for children who do not have natural families. The model has evolved after a due deliberation of existing orphanage models in India and the foster family system in the West. The western family based care model did not seem viable culturally, as children with a past are viewed as a potentially bad influence to the other children in one’s family; additionally monitoring mechanisms for foster care in India is not as developed as in the West. Instead, group fostering with smaller numbers of children in community settings (just 12 children of same gender as one unit) was developed (as opposed to the large numbers in institutions). The small group, home-like settings based in communities overcome some of the primary challenges of traditional institutional settings, such as minimal to no interaction with the normal community life and the subsequent lack of integration into normal patterns of development. Small group homes try and provide all the elements of family based care – stability, secure attachment figures (Mentor Parents as Life-time Volunteers), fostering of good relationships, models of responsible behaviour, and emotional investment by both children and carers to generate a sense of belonging and responsibility in the children in a loving environment.¹⁰

¹⁰ World over there has been a debate regarding care at orphanages to that of given by families who take in orphaned or abandoned children in a community setting. It is also identified by a study by Dr. Kathryn Whetten, director of the Center for Health Policy at Duke University as reported by The New York Times, 2009. Institutions are still the last resort for those children when nothing works out for their refuge.

UDAYAN GHARS (SUNSHINE HOMES) ENSURE:

- Group Foster Care, where 12 orphaned, abandoned and abused children get a home, a foster family that ensures care and love for them.
- A group of Mentor Parents, life-time volunteers, who commit to nurture these children and bring stability and hope in their lives; and reinforce attachment in their lives.
- Reintegration of children into the community by placing the homes right in the midst of middle class neighborhoods; working on removal of ignorance and a change of attitude at the grassroots level to draw on local communities' support and strength.
- Opportunities to study at the best private schools, even universities, and get vocational training, based on individual talent and academic interest.
- Enjoyment of leisure, outings, hobbies, and fun, like any normal child, and insistence on sporting activities
- A comprehensive Healthcare programme with health promoting and preventive components
- A comprehensive Mental Health Programme to help the children to come to terms with their traumatised pasts and look towards shaping their own future.
- Building capacities of the Carer team, comprising of Mentor Parents, Social Workers, Caregivers and Volunteers, so that they can contribute positively to each child's development, on multiple levels.

All the components of care and protection of Udayan Ghar Programme are in compliance with the **Section-5** of the **Clause- 2** of the **Guidelines for the Alternative Care of Children by United Nations; the Resolution adopted by the General Assembly states:** whenever child's own family fails to provide appropriate support and care for the child, abandons or relinquishes the child, the state is responsible for protecting the rights of the child and ensuring alternative care with or through competent local authorities and duly authorised civil society organisation". It also mentions very clearly that it is also the role of the state to supervise the role of safety, development and well being of the Child placed with the alternative care through regular review of the arrangements provided for the child.¹¹ So much so that all the children in Udayan Care's residential programme-Udayan Ghar-Sunshine Homes for children are closely monitored

¹¹ United Nations General Assembly (2009). **Guidelines for the Alternative Care of Children**
http://www.unicef.org/aids/files/UN_Guidelines_for_alternative_care_of_children.pdf

by the Child Welfare Committee, with quarterly progress reports of individual child, regular visits to the Home and also to the Child.

BIO-PSYCHO-SOCIAL PERSPECTIVE TO UNDERSTAND THE CHILD'S WORLD

Keeping those parameters in mind, a **bio-psycho-social** perspective is used by Udayan Ghars to understand and explain the complexity of mental health of children in institutional care and a model is developed to address this. **The biological factors** include Genetic Contribution, Temperament, Disability, and Intelligence. **The psychological factors** deal with type of past, preoccupation with past and ongoing trauma, distressing life events and perceptions thereof, child abuse; lack of coping skills, behavioral and emotional problems; and above all the capacity of the child to relate to another human being in a secure versus insecure or trusting versus mistrusting way, in the placed home ethos/support/rejection/criticism. **The social factors** relate to reasons of institutionalisation, and its impact on the child, challenges in placement, parenting/multiple caretakers, role models, opportunities, social & communication skills, exit/transition and spiritual outlook.

We know that emotional, cognitive and behavioral development of the child is crucially dependent on the child's bio-psycho-social world. Since the biological information about the children (whether first generation learner; IQ, any other disability that was genetic) who are placed in care is rarely available when they come to us; nor the history of their past experiences - early traumas of parental separation, parental abuse, poverty, maltreatment, other distressing events on streets and other placements before coming to us - easily obtainable; we at Udayan Care work with our children with the belief that while genetic disposition and early life experiences do have an impact on one's lifetime functions; these cannot set the stage forever for the child from the perspective of developing personal competencies. If there are strategies that enhance the development of self in the child, once implemented consistently, positive results can occur.

Every attempt is made to understand the genetic contribution each child brings with oneself. The basic observation of the child - immediately after placement, in terms of intelligence, educational levels, social and communication skills, and then to validate IQ tests - enables us to understand the intelligence competencies; on interviewing the child, the details about parents, their occupation and level of education also brings home the biological and psychosocial disposition, that helps us in designing and planning development strategies for the child.

It is common knowledge that adverse early experiences of orphanhood, parental abandonment, dysfunctional parenting, child abuse, and other most undesirable life events, like experiences on the streets, change of placements etc., exert effects on child development (Sameroff, 1975; Felitti et al, 1998); and can result in mistrust, lack of coping skills, consequences with attachment, and difficulties in social behavior. It may even lead to anxiety, depression and even conduct disorders. Such children evince greater problems in understanding affective responses to interpersonal situations and show a lack of problem solving skills.

Yet, there have been evidences that improving the social environment of the abused child decreases the psychiatric risks. There is substantial evidence that children subjected to recurrent personal assaults and emotional and physical traumas are at significant risk for psychopathology in general and emotional disorders in particular (Saplosky, 1996; Taylor, Fisk and Glover, 2000) Early childhood trauma can lead to insecure attachment, chronic or generalised mistrust, increased interpersonal conflicts with carers and peer group, defiance based disorders, all of which can lead to chaining effects that create risks for externalising and internalising disorders throughout life. It is evidenced in Udayan Ghars that though the toxicity of the past cannot be totally alleviated; improving the psycho-social environment of the traumatised child through family settings, sustained relations with caring adults and peer groups, social integration with a neighborhood community, good schooling, opportunities to find one's voice and talents, physical healthcare and an ever evolving mental health programme, has strong and sustaining beneficial effects over time.

UDAYAN CARE STRATEGY: L.I.F.E (LIVING IN FAMILY ENVIRONMENT) TO COPE WITH SEVERAL CHALLENGES

Considering the aforementioned, Udayan Care bases its strategy on developing a foundation of relational experiences, a strategy based on **LIFE: Living In Family Environment**; where the child is provided a family like setting, with multiple Long-term Volunteers as caring Mentor Parents and role models, the other children of the Home (12 as a unit) as involved siblings; and care staff, accepting friends in the neighbourhood community and schools as positive peer influence, and teachers and other volunteers as other extensions of social life. This model enables erstwhile orphaned and abandoned children in Udayan Ghars to grow in a loving family environment. Children are nurtured by Mentor Parents - a group of socially committed, civil society members, who voluntarily commit themselves to groom the children like their own. Since the homes are placed in middle class neighbourhoods, these afford the community a sense of ownership for these children and ability to be inclusive in their approach. Similarly the

schools the children attend develop a greater affiliation and affinity with traumatised children and work with us on improving the educational milieu for the child. Even though it is hugely challenging to break the social stigma around a 'street child' with past, with consistent efforts towards sensitising the community, it is paying off. An outstanding testimony to Udayan Care's belief in collective action towards restoring Child Rights, these Ghars (Homes) enable great civil society participation.

Udayan Care's greatest effort is always to look for and appoint Mentor Parents - Life time Volunteers, who commit themselves to raise the children in our placement - to develop positive affiliative relations with the child, in the hope that the effects of absent parents and biological family, or the risk of parental dysfunction, and earlier abusive situations on the child's psychopathology, will be superseded by the positive, sustained relationship with them. This will help evolve self-development in the child, such as personal competence and self worth. Multiple parents gain the children an understanding of different adult temperaments and help in developing in them, capability to design strategies to deal with different types of temperaments, which are beneficial once they grow up.

Since the **Carer** team consists of many levels: Caregivers (who are semi-literate but stay with children 24x7 and help in all household chores and sometimes disciplining also); Social workers (who do legal work, and counsel the children and caregivers) and Mentor Parents (who work in a group and have functions of a parent, to manage finances, obtain opportunities for children for their education, talent, leisure and outings as well as soothe the children by nurturing them), the big challenge for Udayan Care is to work on their teamwork, which it does through a series of workshops to make them come together and understand each others' importance and work with each other in a structured, planned way. Sometimes the caregivers, due to their lack of education and traumatic upbringing are not able to appreciate the need for structure, and consistency of behavior with children. This may adversely impact therapeutic interventions. Mentor parents also, at times, have their own cultural understanding of situations, which may not coincide with a child's need at the time. Sometimes, Social Workers need more on the job training to be able to balance the different pulls and pushes amongst the carer group as well as the children! The regular meetings and discussions, in addition to capacity building workshops pave the way for a better understanding of each other and helps evolve strategies which are implemented in the carer's work.

The Carer group's consistent efforts are to make the children adjust to the entirely new environment at the Udayan Ghars by developing a sense of trust, bonding, and security in the children, thus ensuring a non-threatening, non-judgemental, non-violent, loving, caring, and sharing environment. Carers address issues like immediate medical care, teaching personal hygiene, food, physical and emotional security, and restoring their self-esteem/worth. This secure and stable environment helps reduce the impact of negative experiences and traumas in the children, of being orphaned, abandoned and abused, of utter deprivation, and malnutrition. The parental love and bonding, and security experienced in the homes help them to come out of their shells. Fulfillment of their emotional needs many times auto correct some of the psychosomatic and behavioural problems.

COMPREHENSIVE PHYSICAL HEALTH INTERVENTIONS

The initial health screening and comprehensive health assessment, as there is hardly any medical history available, and then regular medical checkups and interventions, and provision of nutritious, balanced, varied meals address the children's developmental health needs. In the Care plans for children, health is a very important aspect and includes all health care – primary, tertiary and speciality healthcare. Challenges of budgets are addressed by developing linkages with medical fraternity.

EDUCATION AND VOCATIONAL TRAINING

Choice of schools, good, consistent education, regular vocational training and hobbies and leisure activities are other strategies that lead to wholesome experience of a recreated childhood that many of the children had never experienced. It is sometimes challenging to develop children's interest in education in the face of their traumas and their first generation learner status and development of complacent attitudes, but this is constantly being addressed.

REGULATION OF DAILY ROUTINE IN A FAMILY ARRANGEMENT

All children in the homes are given a schedule that provides structure and regularity to their life as well as serves as a layer for therapeutic intervention. In addition to the daily routines, like attending school, doing homework, participating in household chores, children in the Ghars (homes) regularly attend educational - recreational workshops. Conscious efforts are made so that all the children in the Ghars come together to participate in seasonal camps that offer sports, games, and songs to create a sense of belonging through unity. The children enjoy celebrations of birthdays and holidays, which again brings a sense of normalcy in their lives.

ENHANCED MENTAL HEALTH ASSESSMENT AND SERVICES

The traumas faced by children in their early formative years sometimes lead to severe behavior or emotional problems, and require intensive, consistent and specialised mental health intervention to build onto the trust and sense of identity of the child. The initial mental health screening and assessment, referral to a specialist if need be, helps prepare the carer team to develop a proper mental health care plan for the child.¹²

Even in placement, there are many environmental changes: change in caretaking; court proceedings; reappearance of the lost, dysfunctional family; sometimes restoration of one child from the peer group, entry of another highly disturbed child; inability to cope with the pressures of studies or expectations from self and others, etc. Such circumstances require constant supervised mental health interventions. Even leaving care can be traumatic, whether for reunification with the family, or transition to adulthood and self sufficiency, they still require assistance related to mental health needs and thus the Carer team should be able to deal with such diverse issues.

Monthly Capacity Building Workshops organised with Mentor Mothers/ Fathers, Social Workers, Counselors, Supervisors, and Caregivers with the perspective of primary, secondary and tertiary prevention at all the homes with the ultimate goal to promote emotional and social well-being in each child. Mentors Parents (*though with proven track record of raising their own children successfully*) get regular training in trauma and abuse incidences so as to help them deal with such children in an appropriate manner. Similarly all the support staff receives training in dealing with such children appropriately. As children are growing into adolescents, issues regarding relationships, sexuality and career related issues, transition and settlement are emerging in forefront.

Some of the mental health training workshops conducted are as follows:

- Emotional Disorders
- Violent and Suicidal Disorders
- Disruptive Behaviour Disorders
- Case Presentation and Discussion of Cases from Various Ghars
- Communication with Traumatized Children

¹² A study by Whetten et al. from Duke University indicates that single orphan and abandoned children both boys and girls with traumatic past are at high risk for potentially traumatic events and associated difficulties demonstrating the need of similar protection, care and appropriate psychological services. Our strong Mental Health Care model addresses those indicators.

- Motivation and Academics
- Transitioning and Support

Typically Udayan Care organises about 30 workshops in a year, for its Mentors, professionals and care staff, separately. All the workshops are designed keeping in mind “**attachment and trauma challenges**”.

Professionals on various issues related to mental health, team building, tolerance, career choices, etc organise more than 24 workshops with children and adolescents. These workshops besides being very educative are highly participatory. Besides these, regular Life Skills and Leadership Workshops are held. Another source for introspection and developing greater communication with each other and with adult Carer group is “Monthly Family Meetings”, where children set the agenda and discuss all issues pertaining to themselves and their homes. The participatory processes are good tools to teach children decision-making and leadership skills.

The Mental Health team at Udayan Care comprises: Child & Adolescent Psychiatrist, Psychotherapist, Counselors, and Social workers, Parenting Coach, Administrative Staff and Volunteers.

THE MENTAL HEALTH PROGRAMME AT UDAYAN CARE CONSTITUTES¹³:

- Individual screening, interventions, counseling and medication
- Observation and Interaction with children
- Group therapy
- Life Skills Workshops & other skills building workshops for children
- Regular Care Plans for the child; continual assessment of children’s needs
- Dealing with children’s anxiety, and stress for their indefinite / insecure future
- Dealing with Sexuality and other teenage issues
- Regular Meetings within Homes and at the Head office of staff and mentors
- Capacity building workshops for Caregivers, Social Workers and Mentors
- Research & Development
- Advocacy

¹³ Going by Article 25 and Section 1 of the Article 27 of the Convention on the Rights of the Child which clearly states “*State Parties recognise the right 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*”, Udayan Ghar’s periodic Mental Health Assessment and Services to each child in closely in sync with it.

The MHP Team has grown over the years. Work on “Prevention” is now taking centre stage. Early identification and interventions are being emphasised upon and a holistic approach is being worked upon. Carer team is better equipped to deal with children’s ‘acting out’ issues. Training models and advocacy plans are growing and research work is getting enhanced. An outcome-based approach is being developed for which different questionnaires, dealing with perception of needs of institutional child and perceived fulfillment or lack thereof (client satisfaction), using multiple informants, like child, Mentor parents, social workers and care givers, etc. is being conducted and analysed. Difficulty being, the existing and established scales, are all western in origin and it is an accepted fact that socio-cultural perspectives are widely different in the west and east.

The future of mental health programme in Udayan homes entails now consolidating what exists, training the trainer’s model, preparing and disseminating modules for mental health care, manuals on induction and orientation, trainings, based on attachment model for intervention; national advocacy and Longitudinal Research work. Currently we are working on creation of Caregivers’ training manuals, based on attachment model.

While deeply appreciative of the fact that addition and emphasis on spiritual and philosophical dimensions to our childcare practice will aid in bringing greater resilience and creativity to our children, we still have to develop a comprehensive spiritual practice, which can suit the diverse religious sentiments of children in the homes.

Mentor Parents can be the single-most huge resource as they come with rich personal histories of parenting, economic security, with potential benefits in terms of providing linkages and resources and above all long-term commitment; this model needs more research into its efficacy and greater exploitability.

Various other challenges are encountered while developing the model. This comprises priority on physical health and education by the Mentor parents; sometimes reluctance on the part of the Carer team to accept mental health needs and learn evolving mental health concepts. Issues of labeling, bias against medication, lack of enough and trained human resources, constant attrition and change of professionals and involvement of Mental Health professionals in other admin work due to lack of adequate financial resources, etc. are other pertinent challenges that we have to deal with.

RESEARCH TO MAKE UDAYAN GHAR MODEL BETTER

It is an important goal of Udayan Care to consistently assess and re-examine our strategies in order to make our model more effective. To this end, we have started a variety of studies to examine the perceived and met mental and physical health needs of our resident children and caregivers. For example, the **research paper “Perception of Quality of parenting and mental health programme in Foster care Residential Homes: An Indian Experience”**, presented as a Poster as a part of Donald Cohen Fellowship at 13th International Congress of European Society for Child and Adolescent Psychiatry (ESCAP), Florence, Italy, August.2007 found that children and their mentors’ views of care and control were quite varied, highlighting the importance of better understanding differences in perception of care giving from both the adult and child perspectives. In most cases, the mentor rated the quality of their care mechanism in excess of what children perceived, while their own rating of control mechanism fell short of what children perceived about the same. Individual Programme Plan (IPP) revealed shortcomings in all the eight parameters in most of the children at the first assessment (0 month) with 58% of them showing improvement in at least 4 out of 8 parameters after 8 months of ongoing mental health programme. 17 children (21%) were identified with various multiple mental health problems with ADHD being the most common diagnosis (35.3%) with comorbid psychiatric diagnosis in 2 children (11.8%).

A symposium presentation at IACAPAP, Beijing, China, June 2010, was done on **“Developing a comprehensive Mental Health Services for children living in foster care homes, New Delhi, India.”** This paper discussed the MHP model and various challenges and evolution of MHP over the years.

A research paper **“Assessing the Needs of Children living in Foster Care Homes of Udayan Care,”** was presented at ASCAPAP conference in September 2013, New Delhi, and examined the perception of needs fulfillment in Udayan Care children from different Udayan Ghars. Around 30% - 60% of the children assessed felt that their needs were always met. On the other hand, about 8% - 17% of the children felt that their needs were never met. 15% - 60% children felt that Educational Needs were always met. 30%- 65% of the children feel that Interpersonal Needs were always met. 26%- 57% children felt that Emotional Needs were always met (i.e., they felt safe and secure, cared for, loved and have the perception of living in a family). This study has helped the organisation to better understand the needs of children living at Udayan Care and to improvise the facilities provided to enhance physical and mental health services for the children under care.

The qualitative observation of a pilot study done by Nayar-Akhtar, M., Carter, M., Nath, S., Dyette, K. (2013) of an ongoing longitudinal investigation of the children to assess **the issues of attachment, trauma and adjustment in the years following entry at our at Udayan Ghar** from four selected cases (based on ECR-RC and Piers-Harris 2 data) suggests **attachment** and **self concept** are both within one standard deviation from the normative mean except one child who demonstrated a better self-concept and more secure attachments. Results also show that attachment insecurity and self-concept tended to vary inversely. Generally, boys exhibited more secure attachment and better self-concept than did girls. The older children's attachment scores were more extreme than the younger children's scores. Measures included self-report, projective, and descriptive measures of attachment security, self-concept, ego resiliency, behavioral functioning, history of trauma, and post-traumatic symptomology. As a part of longitudinal study by using measures of attachment and adjustment with these individuals, who are between the ages of 5 and 22, a developmental perspective will be provided on how attachment and adjustment relate to each other and each of these will be examined with larger sub-group *N* to assess the influence of age, gender, cultural and developmental factors and the attachment-self-concept relationship. (Bowlby, J. 1969/82, Ainsworth, M.D.S., Blehar, M.C., Waters, E., and Wall, S., 1978)

REACH

In 18 years, we have impacted about 300 children. Currently 192 children are being nurtured at our 13 homes. Of these, 22 have moved to our three After Care facilities, as they have crossed the age of 18 years; while most of them are pursuing university education, many are in vocational training too. More than 25 young adults are already leading independent, productive lives, outside in the larger world, with whom we are in constant touch.

CONCLUSION

In conclusion, it can be said that issues of emotional and physical well being of such children is being addressed by our unique model of care, notwithstanding so many challenges and are found to be successful with different children in varying degrees. Both prevention and intervention is being integrated at all levels of delivery of services for children in care to make their journey to recovery possible. It is a huge task at hand as each child and adolescent's needs go beyond set conventional approaches. Only one requirement is universal and that is acceptance of the challenge and the will to work with each child as an individual.

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PORTRAYAL OF ORPHANS IN MAINSTREAM HINDI FILMS

*Namarta Joshi, Ph.D.**

Abstract

Art does not exist in a vacuum. Artistic expressions find their genesis in the social concerns of individuals and the community at large. The artist endeavors to establish an emphatic connection with his fellow human beings by giving expression to societal issues that disturb him. The condition of orphans is one such area. It requires the attention of the welfare state, society and art alike, not only because of the need for a humanistic approach but also because of its long term repercussions on society. The sense of abandonment makes these children more vulnerable, socially and psychologically. Institutions like orphanages provide succor to such children but their role and whether they are able to heal the wounds fully is a matter of debate. Many experts feel that institutionalized children develop behavioural disorders, which are not present if they get family care and support. Hindi films have also taken up cudgels on behalf of many peripheral groups, and orphans are one of them. In mainstream Hindi cinema like *Dosti*, *Bootpolish*, *Brahmchari*, *Mr. India* and many others have depicted the problems of institutionalized children and their emotional turmoil's in different ways. The fate of orphans in Hindi films, however, is generally quite predictable, representing themes of petty crime or helping other such deprived children. Rarely has a mainstream Hindi film delved deep into the general existence of this orphan group, nor have they endeavoured to find effective solutions towards making these children respected and responsible citizens. Since mainstream Hindi cinema has been a vehicle for the projection of many social causes, children should also be a centre of focus with an emphatic portrayal of their situation.

KEYWORDS: *Institutionalised, Behavioural Disorders, Representations, Mainstream Cinema, Social Responsibility*

INTRODUCTION

*“Jane walo zara mudh ke dekho mujhe
Ek Insaan hun main tumhari tarah”*

Remember these lines from the song in *Dosti* (1964), where a destitute boy bemoans the callousness of the society towards children like him. Reduced to penury and beggary through no fault of theirs, children are left at the mercy of fate through the death of one or both parents. Sometimes they are abandoned on the streets or garbage dumps by families who cannot take care of them any longer. They are left to face the harsh realities of life on their own. These words in the song are just a cinematic representation of situation in real life. Art mirrors life. Art does not exist in a vacuum. Artistic expressions find their genesis in the social concerns of the individuals. The artist attempts to connect with his fellow human beings by giving expression to social concerns that disturb him. As George Braque says, “The function of art is to disturb. Science reassures. “It is the aim of any art to sensitize the masses and awaken them about certain issues or particular marginalised groups. The condition of orphans is one such area that requires the attention of the welfare state, society and art alike. Humanistic reasons as well as the potential for long-term repercussions on society and its future warrant this attention.

It is the right of every child to have a decent, dignified existence with the fulfillment of their basic needs, including education, parental love and care, for they are vulnerable, sensitive and unable to take care of themselves. Their innocence must be preserved for it contains the essence of all the good and fine in the world. As Eugene Ionesco remarks:

*“Childhood is the world of miracle or of magic: it is as if creation rose
luminously out of the night, all new and fresh and astonishing.
Childhood is over the moment things are no longer astonishing. When
the world gives you a feeling of “déjà vu,” when you are used to
existence, you become an adult.”²*

Children are like delicate plants, which have to be taken care of until they take root and grow deep into the earth and above it. The responsibility for raising these future citizens rests with the families. However, some children do not have that support system. They are left bereft due to various reasons, some natural and some man made. Henry Ward Beecher quotes,

*“ Living is death; dying is life. We are not what we appear to be. On this
side of the grave we are exiles, on that citizens; on this side orphans, on
that children;”³*

It is estimated as per a 2010 survey, that out of a total 34011900 children in the age group of 0-14 years in India, 23246000 are orphans which is approximately 6.8% of total children.⁴ Here, society, State and their agencies like NGOs and institutions like Orphanages need to step in and take charge because if a child is deprived of his family and thrown out onto the streets with no means of survival, he/she is likely to develop certain psychological disorders which might prove detrimental to the child individually but also to the society and nation at large. For example, a section of juvenile delinquents are minors who have gone through some sense of abandonment and experienced physical and emotional torture at the hands of the elements in their environment. These institutions, indeed, provide some solace and succor to destitute children. However, they are not able to ameliorate the deficits in their personality left by tragic circumstances nor are they necessarily able to project the cause onto the society to make them more sensitive and aware. The task of taking up cudgels on behalf of such peripheral groups perhaps lies with media. Media, in all its forms, has the social responsibility of reflecting the problems of people who are unable to do it on their own. They can and have become the voice of voiceless. Cinema also does not lag behind in displaying a certain social consciousness and being responsive to the needs of the society. Portrayal of orphans in mainstream Hindi cinema has been multifaceted, in its long (more than 100 years) journey in India.

REPRESENTATION IN HINDI FILMS PRIOR TO 1990

Most of these representations do not portray the institutions in a positive light. The orphanage conditions are not seen as being conducive to the development of healthy personalities in these children. In B.R. Chopra's *Waqt* (1965), after Lala Kedarnath's family is lost in the aftermath of earthquake, his eldest son Raju is shown taking refuge in an orphanage run by a wily Manager played by veteran actor, Jiwan. In just a few shots, the Director establishes the pathetic conditions of the orphanage. The opening shot has the Manager getting his legs pressed by three boys, dressed shabbily. They are frequently scolded and thrashed by Jiwan for not ministering properly to his needs. When Kedarnath comes to enquire about his son, he is taken to a small room where children lie on the floor, packed like sardines. They look up expectantly at the distraught father, for some sort of recognition. On not finding Raju there, he is told that the boy has run away after getting beaten by the Manager. The boys then accuse the Manager of regularly beating the children. The Manager is furious. Lala Kedarnath loses his temper on hearing about his son and strangles the Manager.

As the police take him away, Raju is shown as fleeing. Later, he is shown as a sophisticated thief, working for Chinoy Seth.

Brahmchari (1968) and Mr. India (1987) have almost similar themes. In contrast, to the harsh environment depicted in many films, both these films have a messiah like protagonist, as a father figure to a number of orphans, loving and caring for them even in desperate economic conditions. Brahmchari differs though thematically from Mr. India, being a love triangle whereas the latter has a sci-fi action angle added to it. The main plot refers to the financial constraints faced by the hero in raising these children and the ties of love that bind them. In Brahmchari, when the Editor asks him to leave the kids, his response is that he is doing the work that should have been done by the society. There are philanthropists who have dedicated their lives to serve the deprived in our country also, who face obstacles and meager resources and after whom such films are patterned. These representations appeal to the more humane side of individuals and society.

REPRESENTATIONS IN FILMS AFTER 1990

*Rehne ko ghar nahin, sone ko bistar nahin,
Apna khuda hai rakhwala, humko usi ne hai pala.*

This song from Sadak (1991) reflects the happy go lucky attitude of many destitute children who grow up to become self-reliant in some way or the other—taxi drivers, garage mechanics etc. These are people who are cynical, worldly-wise but with a heart of gold. They are people who do gooders, giving back to the society what it had given them, living just on the brink of the dark alleys of life but refusing to get sucked in. Another thematic plot in these films revolves around an orphan being adopted by an extremely loving family who take him/her into their fold as a real son or daughter. There is, then, some sacrifice that has to be made by the adopted child in return as shown by Madhuri Dixit in *Dil To Pagal Hai* (1997), Sanjay Dutt in *Saajan* (1991), Preity Zinta in *Har Dil Jo Pyar Karega* (2000). Another film, *Baghban* (2003) is the story of an elderly couple (Amitabh Bachchan and Hema Malini) who while at first separated from their sons are later treated shabbily by them. It is their adopted son, Suraj, who provides them with happiness in their old age, idolising his adoptive parents who gave him a chance to have a good life, by giving him a good education and plenty of love and affection. Similarly, the orphan servant in *Swarag* (1999) teaches a lesson to the greedy brothers of his master. He eventually helps his master retrieve the fortune from his greedy brothers by revealing how Sahabji had taken him home from a temple and become his entire world. Another special

mention needs to be made of blockbuster Bollywood film *Kabhi Khushi Kabhi Gham* (2001) which shows Shahrukh Khan as Rahul, the adopted son of Yash and Nandini Raichand. He feels obligated to this family when he comes to know of their generosity and is even ready to sacrifice his love for the sake of his parents but circumstances force him to move away from them. But the bond between them is never broken.

An orphan child who finds misery in orphanages under cruel wardens and managers must seek love and protection outside. This is shown in *King Uncle* (1993). The film describes the bond between an orphan girl and a millionaire who has a tough exterior. She manages to break this eventually to reveal the original loving avatar inside. Through her, the family is reunited.

Many of the orphans in Hindi films are taken care of by close relatives as in *Parineeta* (2005). Hindi cinema have also explored both sides of the coin- good and evil- as the relatives are shown torturing and mistreating them as well as showering their love on them. In *Seeta aur Geeta* (1972), the ever scheming Kaushalya Chachi, leaves no stone unturned to harass the timid orphan girl. Films also showcase the problems faced by both, the guardian and the children, in adjusting to each other as in *Parichay*, *Hum Hain Rahi Pyar Ke*, *Thoda Pyar Thoda Magic*, *Raju Chacha*. External agencies, circumstances and disagreements over property and money serve as the triggers for contentious disputes that fuel action. The plot develops further thereby providing a fertile ground for fights the ensue to preserve the rights of the orphans in such films.

Bootpolish (1954) and *Dosti* (1964) at one end of the spectrum, treat orphans not as those destined to grovel in mud, cynical and frustrated individuals, who would most likely to be lost in the dark alleys of crime but as confident beings even in their misery, bent on finding a ray of hope that will take them to their goal through their own efforts, which they reach with aplomb. They need no sympathy. As the song in *Dosti* goes,

Rahi manva dukh ki chinta kyon stati hai
Dukh to apna saathi hai
Or Bhola and Belu sing in Bootpolish with Uncle John,
Nanhe munhe bacche teri muthi mein kya hai?
Muthi mein hai taqdeer hamari,
Humne kismet ko bas mein kiya hai.

These are the utterances of children believing in being self reliant even in adverse circumstances.

As is written in the article - “Virtue Ethics” of *Boot Polish* and *Dosti* , as Compared with *Slumdog Millionaire*,

*“Overall, both Boot Polish and Dosti portray a sector of society where people suffer from poverty, diseases, death and other difficulties, but the hardships turn out to be blessings in disguise. These troubles turn the protagonists into courageous heroes who dream big and, instead of becoming puppets in the hands of criminals or merciless destiny, transform their lives by their determination and perseverance until eventually the goodness of society also proffers a helping hand. It is this optimistic idealism of independent India in the 1950s and 1960s that these early films successfully combined with their social realism.”*⁵

These films do not dwell on the pessimistic notes of life but emphasise incessantly the optimism that can be gleaned from the darkness. John Chacha (in *Bootpolish*) continuously goads the two orphans to give up beggary and find employment like polishing shoes. In *Dosti*, the two disabled friends use their musical talent to earn their daily bread and finance education.

On the other end, from *Aawara* (1951) to *Besharam* (2013), the portrayal of destitute children has followed the stereotypical pattern of making them turn to crime, due to hunger. As the hero Raju in *Aawara*, who is amused that the reason he was put in jail was for stealing bread, something which he would automatically get there. Quite often, these children are taken into the fold by some underworld Don as Pasha in *Hero* (1983) who then become his loyal henchman only to be changed by someone’s love. In the end they turn against their mentor. Another stark and disturbing reality is portrayed in a bit off beat film by Madhur Bhandarkar’s, *Page 3* (2005), where young boys from a Children’s Home are sexually exploited by people belonging to the upper crust of society and by their friends from abroad. The searing pain of innocent children hits home in this depiction.

CONCLUSION

The depiction of orphans in Hindi cinema is therefore nuanced, with many shades of characters, circumstances and outcome. Films have, indeed, done a yeoman’s service in raising the issue of these destitute children and their condition in the society. They have also raised awareness of the malaise afflicting institutions like orphanages and the gaps in the policies of the government in taking care, educating and rehabilitating orphans. They have also taken on the task of changing the attitude of the society towards orphans. As Raghunath Raina remarks in his article , *Social Roots of Indian Cinema*,

“The social reality gets invariably reflected in the cracked mirror of Indian cinema, some times realistically and some times elliptically. But under the glamour of realism, the harsh facts of life invariably peep out. This is so because however, escapist or realistic cinema may be, it cannot remain unaffected by political and social milieu.”⁶

Mainstream Hindi cinema has all the elements, the *masala*, to captivate its audience but underlying this glamour, sheen and veneer is the social message for building a better life, a better nation.

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BOOK REVIEW

ORPHAN CARE: A COMPARATIVE VIEW

Edited by: Jo Daugherty Bailey

Sterling, VA: Stylus Publishing, LLC, Kumarian Press, 2012

I was introduced to ‘Oliver Twist’, (written by the English author, Charles Dickens and first published in 1838), the story of a young orphan boy, when I was in my teens, growing up in my native country, India. In his famous second novel, Charles Dickens dramatically outlines the trials and tribulations of orphans, as they become wards of state and dependent on governmental structures for their basic needs and emotional well being. Enthralled by Dickens’s portrayal of orphans in England during the 19th century, I found myself joining forces with Oliver Twist and his gang of young boys as they fought their way to social acceptance, encountering adversity and sometimes salacious and unsavory characters along the way and in the end winning the hearts of all who read their story of struggle and survival. Dickens’s epic story of Oliver Twist, as a young orphan boy, in England during the 19th century was a must read for my time. Similarly, I believe that ‘Orphan Care’ by Jo Daugherty Bailey, is a must read today for those interested in deepening their understanding of orphan care in a global context. Let me now tell you why.

In her edited book “Orphan care”, Bailey, introduces the reader to the care of orphans in six low to middle income nations, represented by: Brazil, Russia, Thailand, Zimbabwe, Botswana and China. The countries profiled are quite diverse in their socio-political and cultural milieus and the primary focus in each paper is on the sociopolitical context that impacts the care of orphaned children. Bailey identifies the social work profession as a primary source for service delivery, and for social and psychological management of orphans. This is reflected throughout the book as each country defines the development of the social work profession in their region and the role they play in the care and management of orphaned children. In doing so, Bailey, explicitly and implicitly recognises that the social work profession that has been defined and developed predominantly by Western nations and their philosophical perspectives on orphan care and management of social issues may or may not be applicable to the understanding of this special population in other countries. The alarming increase in numbers of orphans in low to middle income nations, the socio-political struggles

that plague these countries, and the significant absence of human and economic resources in their communities, often lead to different strategies and models for providing orphan care. By asking indigenous authors to write about the care of orphans in their respective countries, she reflects her wisdom and sensitivity to cultural and varying social milieus that have profound impact on both the care of orphaned children around the world as well as on the development of the social work profession itself in these countries. All authors expand on this notion and contribute to it in their respective reviews.

Elaborating further on some of the striking features of this book, one immediately notes the rich array of statistics, from the number of orphans all around the world, about 140 million with a vast majority living in Asia to those in need of special care due to disability, poverty, famine and other debilitating social and psychological conditions. The variance between individual country statistics and international reports is commented on with some speculation on causes for this distortion. One also becomes quickly aware of how the causes of orphan hood seem to vary widely between these six countries. From loss of one or both parents due to natural causes, economic circumstances and social and political situations (war) that alter family structures drastically, as well as famine and life threatening diseases that impact family and social milieus, each country has a particular profile which of course informs their institutions of care. Furthermore, political institutions also vary widely and their corresponding involvement with regulatory agencies provides another level of discourse. Regardless, Bailey emphasises four critical areas in the care of orphans: basic needs, protection, psychosocial effects and education. Nations vary in how they attend to these basic needs and the authors for each country highlight these primary areas of concern with detailed accounts of orphan care in their respective papers. By setting this initial benchmark however, Bailey provides us with an important conceptual grid that can then be applied to the evaluation of orphan care in other countries as well.

The introductory chapter by Bailey provides a summary of each paper and is informative and helpful. The six papers that follow expand on the basic notions set forth in her introductory chapter and in her literary and professional stance. They elaborate on how each country is engaged in the care of orphan children, identify factors leading to social inequality in their countries, such as poverty, domestic violence, drug and alcohol abuse, and child victimisation and the prevalence of institutions and alternative care structures in their respective societies, including kinship models, foster care and/or family placement. Insufficient funds and inadequate human resources plague many of the countries

while some are also influenced by political structures that favor one model of care versus another. Sometimes the sheer number of orphans and the lack of human and financial resources lead to inadequate and ineffective care. While it is difficult to compare and contrast these countries, as their social and political milieus are quite different, the grid provided by Bailey does make it easier to follow each author as they elaborate on the socio-political and cultural fabric of their respective nations, the development of social work within their communities and how orphan care has been shaped and managed by these evolving structures.

In addition, Bailey stresses the commitment that all six nations have made to the UN Convention on the Rights of the Child. By ratifying this Convention, they subscribe to a set of common standards for the rights and care of children. This Convention binds all countries that are interested in developing and adhering to a set of rules and regulations that ensure that the most vulnerable in our world are adequately cared for. The presence of the universal standards that are coloured by varying cultural factors and societal issues, ensures ongoing scrutiny and sensitivity to this growing concern in the world.

The concluding chapter by Tatek Abebe complements Bailey's introductory chapter by providing an interesting account of the etiology of orphan hood from a historical and global perspective. Abebe's chapter provides further insights into the social history of orphan hood and to the ways they are viewed in different societies. It then explores how orphan hood is associated with victimhood, innocence, vulnerability and dependence. It also explores various models of care including family care, institutional care, community based care and rights based care. A model of institutional care as reflected by the SOS children's villages is described along with the growing and encompassing challenges of poverty and marginalisation facing children in low resource countries.

The book is impressive in its diverse representation of countries, the clarity of thinking regarding the salient issues surrounding this topic and the provision of an outline defined by some core beliefs by the author. These are clearly reflected in each chapter and expanded upon by each author within their individual contexts. This makes for a socially and culturally informative book that is structured, well defined and with clear objectives. For those wishing to inform themselves about orphan care in less developed nations, this book is a valuable resource.

Despite the obvious strengths of this book, however, there is one glaring omission. The absence of any information on mental health concerns regarding orphans as well as any information regarding long term adjustment, in light of

overwhelming reports of early childhood trauma and other factors leading to orphan hood is striking. The significant impact of early childhood deprivation, social isolation and its impact on the developing mind has been well documented by many authors and the literature continues to expand on this topic (Spitz, 1945, 1951, Walker et.al. 2007). It would have been helpful if a section on psychological issues such as problems in attachment, mental health concerns related to post traumatic stress disorders and their management were also part of these reviews. An occasional reference to psychological problems alludes to likely problems, but there is very little written on how different societies manage and take care of mental health concerns. This, in light of the population that is described as being quite vulnerable and therefore quite susceptible to experiencing difficulties in long term adjustment, is surprising.

That being said, the book is well written and easy to read. The translations wherever applicable have portrayed the social context of orphan care in the six countries diligently and with clarity. The increase in orphans around the world whether due to war, poverty, illness or any other socio-political reasons cannot be ignored and this book is a first step towards consolidating global understanding and efforts in working with this vulnerable population.

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**THE 35-YEAR WAR: OUR LOST CHILDREN
A GLIMPSE BEYOND THE
INSTITUTIONALIZED SETTING IN
AFGHANISTAN**

Sima Samar, Ph.D., and Ed. Ksera Dyette***

After three and a half decades of war in Afghanistan, millions of people have lost their lives, property, and homeland. Millions were forced to leave the country, becoming internally displaced or refugees in neighboring countries or other parts of the world. Specifically, the military conflicts and wars have caused such great casualties whether by bombings, suicide attacks, targeted killings of people, or other terroristic activities. With such great conflict extending over decades, among the lost include our children, who are most vulnerable amidst the destruction of an already unstable world. This article focuses briefly on my experiences in my home country Afghanistan, and what effects I have seen on our youth.

Children are already vulnerable, and it is up to their families and communities to provide the basic structures and warmth needed for their survival. Afghanistan represents a situation beyond institutionalization. With the ongoing war, it has become nearly impossible to meet even our children's most commonplace needs, which has left the region with children who are now more defenseless than ever.

CONTRIBUTING FACTORS:

- 1. War and military conflict in the region:** As mentioned, Afghanistan has been at war for approximately 35 years. Although the warring factions, level of aggression, and type of violence implemented has changed during this time, the violation of human rights and the loss of lives continue to grow in number. Regardless of who is killed, in spite of whom they fight for or against, there are children who they leave behind. These children often have to press on, living without the primary breadwinner in their family or without protection. Often, it can become the job of the child to support their family, which can perpetuate the vicious cycle that leaves them vulnerable to following a bad path.

*Chairperson Commissioner of the Afghan Independent Human Rights Commission (AIHRC);
sima_samar@yahoo.com.

**Graduate Student, Clinical Psychology, Widener University 16', Chester PA, United States

- 2. Poverty and low standards of living:** As matter of circumstance, poverty is very common and well known in the region. Most of the countries in South Asia are underdeveloped and highly populated. Thus, home is overcrowded affording little privacy, and there is limited access to clean water, bathrooms, and proper food. Occasionally, poor families may have more children in order to increase productivity and the chances of survival, but this often adds to the hardship. As such, a family already bringing in very low income may work in hazardous situations where basic health insurance is not provided. Compounded with the poor working conditions, the providers in the family may become ill and die, leaving behind their family and young children who may have to soon find work. Children may turn to carpet weaving centres for work, whether they toil more than 12 hours per day without access to basic services with the imminent return to poor living conditions. They become victim to physical, emotional, and sexual abuse via exploitation that is prevalent in these conditions.
- 3. Lack of education:** Access to education is one of the most basic human rights, including access to health care services. However, the literacy rate in Afghanistan is very low, despite improvements observed in the last decade. Although the numbers of children going to school in different parts of the region have increased, quality of education is not something that can be greatly counted on. As such, fundamentalist religious schools become a place of hope for families to send their children. Unfortunately, here is where groups may exploit the children and turn them into fanatics, terrorists, or suicide attackers.
- 4. Lack of healthy play environments:** Lack of healthy play environments leave children roaming the streets. Any instance in which a child does not have a secure place to go is a breeding ground for those who would exploit them. They may be bullied, called derogatory names, and derided for the state of their family. Even at schoolteachers will bully can call the students names.
- 5. Lack of access to health services and reproductive health care:** Information and knowledge about family planning and access to contraception is largely non-existent, despite what is known about the difference it makes in people's lives. Families who already struggle from low literacy and poor access to health care services may be more vulnerable to exploitation via sexual abuse of children and/or sexually transmitted infections.

- 6. Lack of Social Security programming:** Currently, the region is devoid of initiatives that would establish Social Security and protection mechanisms for its citizens. Such a venture could greatly improve benefits for workers who become ill, unemployed, or homeless. Aside from the children, the region as a whole is lacking in a basic protection mechanism.
- 7. Negativistic culture and traditions:** The present culture persists in giving preference to sons over daughters in families. Even if there are 10 girls in a family, the family will continue to produce children in order to gain a son. This is a common tradition in South Asian countries that negatively impacts the family as a whole along with the lives of each individual child. Naturally, girls become most vulnerable to discrimination in these family units and the larger society. These traditions extend to the general welfare of the children. If a woman loses her husband, then she is treated as the property of the family. If she leaves the husband's family, her children will remain with the extended relatives, where they may be treated as cheap labour and are susceptible to being abused. Although the government has tried to establish orphanages and institutions to protect the children, they are usually in very poor condition and exist in violation to the rights of children. The money provided to the orphanages can barely sustain the most basic of the children's needs, and it is not unusual that a corrupt official would utilize the money.

WHAT SHOULD BE DONE?

It is easy to say what needs to be done as our country continues to be at war. However, that does not mean action cannot and should not be taken. As per international human rights instructions for children and citizens, action needs to be taken to protect their basic human rights. An assessment of possible programming that could aid our children and their futures would need to be examined. Although people have mixed opinions about the institutionalized setting, creating new settings and reforming old ones is a step to reigning in our lost children. In these settings, particular attention needs to be paid to their physical and emotional needs, and traumas. The care and love that every human requires, should be honoured for them. People working in these centres, must be trained to see it through and be fully committed to the task. It would be helpful overall for women who are outcast to be recruited and trained for jobs in these institutions to help the children cultivate a safe and stable environment. Access to education is also vital and important for the children and should be promoted and encouraged. Education in anti-discrimination interactions should be cultivated along with cautions about aggressive military teachings and acts. A zero-

tolerance policy for harassment should be the norm for staff and children. Furthermore, the government should consider making no exception in budget allocations as it concerns the operations of these facilities. To increase accountability, it could work with a neighbouring country for the distribution of resources. Finally, it is important to remember that our children will be the leaders of these states in the future. We must be invested in helping them to become looked after, helping them grow into dignified, responsible, and caring citizens who are invested in a future where war is not the norm.

CULTURE AND TRAUMA: WORKING IN A GLOBAL CONTEXT ON ISSUES FACING GIRLS AND WOMEN IN PAKISTAN

*Rukshana Chaudhry, Ph.D.**

This paper will focus on the creation of an ongoing mental health programme working with women and girls in a slum in Islamabad and in an orphanage in Rawalpindi, which was developed with a Pakistani Humanitarian organisation. The different types of gender-based violence issues in Pakistan, which occur in rural and urban areas, will be described. Utilising interpersonal groups in a self-esteem building and empowerment model of intervention, examples of the impact of trauma will be described. The intervention model was based on psychodynamic principles of healing trauma and adapting theoretical notions to be utilised in the programme including the establishment of safe spaces for girls and women to express and establish coherent narratives of traumatic experiences. This programme was delivered with the support of a psychologist, health workers, and caregivers who were trained to witness and listen to the trauma story. The challenges the women and girls faced within their communities and in their societal settings will be discussed such as forced marriages, lack of education, cultural norms of reduced opportunities for socialization, isolation, and notions regarding masculinity and femininity. Challenges of coming from a Westernized understanding and definition of mental health will be discussed. Recent outcomes of the programme intervention and training will also be highlighted.

**Assistant Professor of Clinical Psychology, George Washington University. United States; moonach@gmail.gwu.edu.*

The mental health programme has been in work for four months and participants have reported experiences of increased self-esteem, positive motivation and improved life skills. Participants have also reduced the number of high-risk behaviours they have engaged in over this four-month period. Caregivers, teachers, and health workers who were trained as part of this programme have investigated their own backgrounds and employed similar group models to process loss and trauma. Many of the girls and women have increased the amount of supportive relationships they have with each other as substitutes for outside support, which may not be available. This model is geared toward generating healing in individuals who otherwise may not address traumatic experiences or live in environments where trauma may go unacknowledged due to cultural norms. Through interpersonal relating and connection with each other and instilling the utilisation of their counterparts as their main sources of support, their sense of inner strength is increased and their ability to experience responsible decision-making increases. These newly inspired positive experiences occurring among each other leads to changing the narrative within their communities regarding gender-based issues of violence and opportunities for girls and women.

CARE AND MENTAL HEALTH OF CHILDREN IN INSTITUTIONALISED CARE REPUBLIC OF THE MALDIVES

*Mariyam Nisha**

The purpose of this piece is to give a brief overview on mental health of vulnerable children under institutional care in The Maldives and the current system for providing care of children living in the institution. Furthermore, it explores the current child protection system and main reasons behind placing children in institutions. Finally, it examines the challenges they face and overcome in order to understand the necessary changes that are needed to improve institutionalised care for the children.

**Counselor, Acting coordinator of Childcare section, Children's Home, Ministry of Health & Gender, Male', Republic*

There are two facilities that provide residential care for children who are taken under state care in the Maldives. One such facility is the Children's Home (Kudakudhinge Hiya) located in Villingili, which is the fifth ward of Male' the capital of Maldives. This residential care facility was officially opened on 11th May 2006, with a capacity to accommodate 45 children through a joint venture between a private company and the government, where the overall management is mandated to the Ministry of Health and Gender. The main aim of the institution was to provide a safe, secure and enabling environment for vulnerable children who have no other means of primary care. It is a concerning issue that the number of children brought to the institution has increased at an alarming rate over the past years to a total of 65 children at present. This facility was initially intended to accommodate children below the age of 9 years; however, there are children up to the age of 23 years currently residing in the institution. Children have been brought to institution for various reasons, namely because of neglect or abandonment and some of the children's parents being in the drug rehabilitation centres, while others have difficulties coping with their family breakdowns. As difficulties faced by our community have increased over the past years, these children have had to endure all forms of hardships and abuse.

It is needless to say that children brought to our institution have gone through severe abuse and trauma in their tiny life spans. Several children residing in our institution have been diagnosed with mental illnesses, learning disabilities and have behavioural issues. It is essential to provide a safe environment with the necessary psychosocial support required for children. There is one counsellor and one assistant counsellor at the institution who attend to psychological support for children, while children who require further treatment are seen by local psychiatrists.

Some of our main challenges include lack of trained professionals in different areas such as social workers, counsellors, care workers, lack of resources as the institution is run on government funding, lack of space to provide a friendly environment for children, lack of professionals who provide psychological support in the whole country (there are only 2 psychiatrists who attend mental health needs of the whole country), lack of a proper holistic child protection system, and local stigma attached to children living in institutions. These challenges need to be addressed immediately to improve the overall mental health status of children living in our institution.

SOUTH ASIAN REPORT ON THE CHILD-FRIENDLINESS OF GOVERNMENTS REGIONAL

Turid Heiberg, Gustav Månsson, Enakshi Ganguly Thukral, Maria Rosaria Centrone and Rajan Burlakoti*

A groundbreaking report on the Child-friendliness of the South Asian Governments (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka), it was published by Save the Children, HAQ: Centre for Child Rights, Plan International, CRY: Child Rights and You, and Terre des Hommes Germany, in collaboration with a large number of researchers and contributors from each country in South Asia and beyond. The full report is available at: <http://resourcecentre.savethechildren.se/library/south-asian-report-child-friendliness-governments-0>

It assesses the efforts of these governments in implementing the obligations made in the United Nation's Convention on Rights of the Child. Furthermore, objectively measures the extent to which the South Asian governments and non-state actors have contributed to the creation of child-friendly societies. Based upon quantitative data feeding into a composite index and complemented by detailed country-level information, the report provides key information for more focused government action and effective non-governmental advocacy to improve and change the lives of children in South Asia.

The Report highlighted that, in particular since 2000, governments have been putting in place a basic enabling framework of laws, policies and institutions for the implementation of the Convention on the Rights of the Child (CRC) and child rights in general. However, the countries that have done the most towards putting in place an enabling structural framework for children, have not always been able to ensure as good education, health and protection outcomes as may have been expected, nor have they necessarily promoted children's voices in decision-making at local and national levels. Additionally, inefficient use of financial and human resources and low priority for children's issues makes implementation difficult, even when funds are available. Therefore, much more remains to be done to ensure children's legally enforceable right to health, education and protection. Strong mechanisms are needed to make new laws, policies and institutions more meaningful entitlements for the children.

*Project Director and Co-editor, South Asian Report on the Child-friendliness of Governments

There are seven key recommendations which include: *The need for governments to continuously follow up on the Concluding Observations, Universal Periodic Review recommendations and the General Comments*, and embark on the high-level coordination across the ministries and all levels of government. Also, ensure adequate and effective utilisation of private and public resources.

Children's participation in decision-making affecting their lives is identified as a key requirement for realising children's human rights. As part of the general principles of the Convention on the Rights of the Child, child participation should therefore be promoted in all law and policy-formulation affecting children, as well as in practice.

SNAPSHOTS

- Sri Lanka has the highest score in the overall child-friendliness index.
- India has done the most towards establishing an enabling legal and policy framework for children, closely followed by Nepal, Bangladesh and Sri Lanka.
- Maldives, Bhutan and Sri Lanka have scored well on health, education and child protection outcomes (birth registration/ child marriage).
- Children and young people in South Asia have experienced rapid changes, including increased access to education and information, as well as rising affluence.
- The collaboration between governments and non-state actors has strengthened the legal and policy framework for children. Particularly, the efforts of India, Nepal and Bhutan have been most significant. The weakest aspect of this collaboration has been government engagement with other non-state actors such as religious institutions and the private sector.
- A chapter on the efforts at Child budgeting by governments and non-state actors describes the country-wise processes of identifying government expenditure on children and including it in national planning processes. It shows that the Child budgeting processes have been initiated in all countries in South Asia except for Bhutan and Maldives.

MOVING FORWARD: IMPLEMENTING THE 'GUIDELINES FOR THE ALTERNATIVE CARE OF CHILDREN' INTERNATIONAL

Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). UK: Centre for Excellence for Looked After Children in Scotland.

A very pertinent handbook published by CELCIS (Centre for Excellence for Looked After Children in Scotland) at the University of Strathclyde; and commissioned by International Social Service (ISS); Oak Foundation; SOS Children's Villages International; and United Nations Children's Fund (UNICEF). It was designed as a tool for informing and inspiring practitioners, organizations and governments across the globe who seek to provide the best possible rights-based care for children who are, or who may be, in need of alternative care. The 'Moving Forward' publication and its associated resources can be found in English, French, Russian and Spanish at: www.alternativecareguidelines.org/

The handbook provides support to the implementation of the *Guidelines for the Alternative Care of Children*. It highlights implications for policy-making, provides links to what is already being effectively done on the ground, and provides insight and encouragement to all professionals on what can feasibly be done in resource-constrained contexts. It describes 'promising' examples of efforts already made in diverse communities, countries, regions and cultures of the world. These examples were submitted by experts and NGOs or identified by the project's own research. It provides further resources, literature on alternative care, and websites of major children's rights organizations and networks.

Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). UK: Centre for Excellence for Looked After Children in Scotland.

GUIDELINES FOR CONTRIBUTORS

MANUSCRIPTS AND EDITORIAL COMMUNICATIONS may be submitted as an attached file, preferably in Microsoft Word (for Windows or Mac), and e-mailed to: Kiran Modi at **iceb-journal@udayancare.org** or Monisha Akhtar at **monisha_akhtar@hotmail.com**

Each author will be sent an acknowledgment, confirming receipt of submission.

Manuscript should be double-spaced and begin with the title of the paper followed by an abstract of no more than 500 words. A few key words identifying the main ideas contained in the paper should follow. Then the author's name, professional affiliation and e-mail contact should be provided. If the author prefers another address to be used for mailing correspondence please include that on a separate sheet of paper. The author's name and address should not appear on any subsequent pages. Manuscripts will not be returned. Manuscripts should not be more than 10-15 pages in length. References should conform to the standards APA format. All papers must be submitted in English. Direct initial inquiries prior to submitting a manuscript to the same email addresses as written above.

Authors may also consider just submitting an abstract with key words for a quick and initial review prior to begin working on their main paper.

Manuscripts can be submitted from any individual working with any of the following countries : Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Sri Lanka, and Pakistan. Manuscripts can address research issues, issues of child care and policy, legal concerns related to child care and management issues, home care strategies and care-giver solutions, developing home monitoring systems, children with special needs such as disabilities, juvenile delinquency, or children diagnosed with HIV/AIDS. Regional and local issues can be considered.

Manuscripts addressing issues related to 'best practice' are encouraged. The journal encourages articles aimed at regional collaborations.

Original Articles can be accepted for publication only on condition that they are contributed solely to the ICEB journal. Authors of articles already published in foreign-language journals should communicate with the Editor before sending manuscripts. An article already published in another journal may be considered for inclusion in a forthcoming journal. All permission rights, however, must be obtained prior to submission for consideration to the ICEB journal.

SUBMISSIONS OF NAMES FOR AN INTERVIEW of a prominent individual or organization involved actively in child management, policy and protection rights can be made directly to Kiran Modi or Monisha Akhtar. The e-mails addresses are as written above.

BRIEF COMMUNICATIONS do not require any abstract. Manuscripts submitted for inclusion in this section should not be more than three pages and can cover highlights of upcoming conferences addressing policy issues, alternative care strategies, working with vulnerable children, working with caregivers, working with children who have been sexually abuse, have HIV/AIDS, other disabilities or are otherwise in need of care and protection. Brief summaries of projects being conducted primarily in the SAARC region, but not limited to these countries alone, can be submitted for consideration in this section. These brief abstracts can later be developed by the author into a full manuscript and submitted for consideration in another forthcoming issue.

REPRINTS of original articles published elsewhere can be considered if the article is considered as contributing to the field. Not more than two papers will be considered for reprinting in any journal issue.

MANUSCRIPTS ON INTERNATIONAL PERSPECTIVES will be obtained from outside the SAARC region. These articles will examine issues of orphan care and children in need of protection. These articles may cover issues of policy, child care management, alternative methods of service delivery and legal issues. Furthermore, research initiatives regarding comparing and contrasting different model of care that constitute best practice will be encouraged.

COMMUNICATIONS ABOUT MOVIES to be reviewed should be sent to Monisha Akhtar at monisha_akhtar@hotmail.com. Movies in any language can be considered for a review.

COMMUNICATIONS ABOUT BOOKS to be reviewed should be addressed to Monisha Akhtar at monisha_akhtar@hotmail.com. Books on orphan care or vulnerable children can be considered for review. They do not have to be limited to authors within the SAARC region. Reviews should not exceed five pages.

JOURNAL THEMES will cover a wide range of topics. From time to time, an issue may be devoted to a particular theme as in addressing mental health concerns and treating trauma in this population. Authors are encouraged to

submit their ideas for particular themes and can work with the editor-in-chief to develop their ideas into a special issue. We hope to encourage creativity in thinking and promote a desire to develop new initiatives in research and care in this field. Authors who are interested in editing a special issue should contact Monisha Akhtar at monisha_akhtar@hotmail.com

All the manuscripts should be clearly typed in double space with 12 point font. The cover page/letter should contain the title of the paper, author's name, designation, official address, phone number, e-mail id and an abstract of not more than 150 words. The final decision on the acceptance or otherwise of the paper rests with the Editorial Board and it depends entirely on its standard and relevance. The final draft may be subjected to editorial amendment to suit the ICEB requirements. **The copyright of the contributions published in ICEB, unless otherwise stipulated, rests with Udayan Care.** We also reprint if worthy.

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The journal is now accepting abstracts for the second issue. If you wish to submit an abstract please do so by June 1, 2014. Next issue publication date is September 1, 2014.



Institutionalised Children Explorations and Beyond

Mission

To conscientiously and with responsibility, appraise, evaluate, and commission research and studies that impact and have bearing on the lives of children, who are in institutions – orphanages, observation homes and others, in SAARC countries; and to develop a dialogue on existing systems, and possible adaptations, which will lead to an improvement in their quality of life, thus influencing their becoming responsible young adults.

Vision

To make available a platform for consistent sharing of information, knowledge enhancement and the development of a dialogue and debate among professionals, policy-makers, and volunteers working for institutionalised children, about best practices, research findings and studies, legislation, jurisprudence and case laws, in relation to such children's mental health, social development, care and upbringing in alternative modes of institutional care in SAARC countries.

Purpose and Scope

To expand and enhance knowledge about children who have been institutionalised. Such children are often at risk with the law and often are subjected to leading marginalised existences. This journal will attempt to address limitations in the research, knowledge and counseling practices currently prevalent while working with institutionalised children.

There is scope for a lot more work to be done on the problems of children who are institutionalised like orphans, abandoned, abused or runaways. There are also children who are at risk with law. ICEB sees itself as a forum for studies, discussions, debates and research on issues that would lead to the integration of such children into the mainstream and thus to their inclusion in civil society.

The focus on inclusion is reflected in children with disabilities being included in all efforts of enabling and where necessary, restoring children to a fulfilled life. ICEB would open out debates and discussions on such children. This would significantly influence the quality of life of these children in SAARC countries.

The law in respect to the well-being of children is constantly evolving and older laws are being revised and superior newer laws are coming into force. There is very little scope for discussion among professionals and care-givers of the impact of such laws and amendments. ICEB would also seek to encourage debates and discussions as well as reviews of existing and forthcoming laws. It would also explore areas where laws could be necessary.

The scope would include encouraging studies on these issues by including universities and hospitals, together with clinics; young professionals and those in the field of care giving, especially in the non-governmental not-for-profit-sector.

At a later stage, ICEB would enable continuing education in dealing with institutionalised children and in re-establishing positive mental well-being practices. The belief is that such education and sharing of knowledge and experience would lead to more dynamic prevention models as well as rehabilitation models.

Periodicity

ICEB is a bi-annual journal that would be published once in six months. The publication months will be March and September every year.

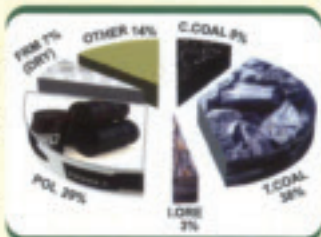


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