

The De-Institutionalization Debate and Global Priority for Children's Care

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Abstract

Millions of children experience inadequate care, a problem that receives insufficient global attention and resources. Drawing on social science scholarship, we investigate factors internal to a global policy community addressing children's care that have shaped global priority for that issue. We triangulated among several sources of information, including peer-reviewed literature, organizational documents and 31 semi-structured interviews with individuals central to children's care programming, research and advocacy.

Multiple factors stand behind low global priority for children's care, including the limited power of affected children and families, the issue's multi-sectoral nature and competition for attention with other social welfare issues. Divisive disagreements among children's care proponents about the acceptability of certain forms of care, on care reform strategy—particularly a strategy termed 'de-institutionalization' (DI), and on the very meaning of DI, also hamper priority generation. Some who self-identify as DI proponents advocate for the rapid closure of all or nearly all forms of residential facilities. Other DI proponents argue for a progressive realization approach, with children in families or family-based care as the end goal but the maintenance in the interim of some forms of residential care. Others, critical of DI, view the strategy as lacking nuance and see the need for ongoing care arrangements of multiple forms.

This analysis focuses on these disagreements and their effects, as they are factors internal to the community of proponents that they potentially can influence. We outline the dimensions of these disagreements, and identify the factors that have shaped these differences. Among these factors are a weak evidence base on the scope of the problem and solutions; divergent experiences between former Soviet bloc and other countries; challenges in introducing formal alternative care arrangements; commercial interests that perpetuate non-family based forms of care; and perspectives of certain voices within the disability community and those children and families directly affected by the issue.

Disagreements among proponents have led to weak governance mechanisms for collective action, and an inadequate positioning of the issue needed to attract the support of political leaders and civil society organizations. With respect to governance, internal disagreements have fragmented the community and complicated efforts to coordinate initiatives, precluded the emergence of leadership that proponents universally trust, and hampered the engagement of potential allies including advocates concerned with addressing violence against children. With respect to positioning, competing stances on children's care reform strategies among proponents have complicated efforts to secure funding and convince policymakers to act.

These difficulties notwithstanding, there are signs of progress in transcending differences, including agreement in 2019 among 256 care sector actors on elements of a United Nations General Assembly Resolution on the Rights of the Child. To become a more potent force in generating greater global priority for the issue, children's care proponents will need to find ways to manage their disagreements, even if these cannot fully be transcended. Doing so will enable proponents to become more powerful agents of change for garnering attention to children's care.

Introduction

Every day, families are disrupted across the world due to migration, armed conflict, epidemics, urbanization and famine. Add poverty, abuse, neglect, and parental death or incapacity due to HIV/AIDS and other conditions, substance abuse and mental health problems, and the result is millions of children without parental care. By one estimate, there are 140 million orphans (UNICEF 2017)—children under 18 years of age who have lost one or both parents to any cause of death—and millions more children across the world at risk of separation. In many countries, few or no mechanisms exist to ensure the most appropriate placements, to encourage guardianship and adoption arrangements, and to provide support and monitoring for foster families. The absence of quality care, which provides stability and security, has bleak long-term physical, psychological, and social implications (Parkinson 2003) and poses significant challenges for the realization of children’s other rights including healthcare and education (Maclean and Kurczewski 1994; Assim 2013). Furthermore, children separated from their families and communities are unable to develop kinship and other networks critical to their well-being and success later in life.

Especially over the last decade, national and international institutions and non-governmental organizations have increased efforts to address children’s care. These initiatives have sought to strengthen and improve the care of children within families, prevent unnecessary family separation, and ensure quality care alternatives when family reunification is not possible or appropriate. The provision of formal or informal care for children without parental care—termed ‘alternative care’ (UNGA 2009; Unicef 1989)—and reform of the existing care system—referred to as ‘child care reform’—have become dominant aspects of the children’s care agenda.

Nonetheless, child care reform—and the larger set of issues connected to addressing children’s care—remains very low on the global development agenda. There is no mention of these issues in major goals and resolutions, including the Sustainable Development Goals (SDGs); there are few government resource commitments to and inadequate implementation (Davidson 2015; Davidson et al. 2017) of the United Nations Guidelines for the Alternative Care of Children (UNGA 2009; Davidson 2015; Davidson et al. 2017); and where organizational documents concerning child care exist, they are typically subsumed in discussions of violence against

children or child protection. The lack of global priority is also reflected in insufficient donor funding for the issue. Spending by the largest organizations on “orphan support” interventions in the 17 most affected countries during 2003 was estimated in the order of only US\$200–300 million (Stover et al. 2007). This represents a fraction of the resources needed to respond to the complex care needs of millions of children, and most of this support was spent on health services to deal with HIV/AIDS rather than on children’s care (UNICEF, USAID and UNAIDS 2004).

We analyze the factors shaping global priority for child care reform. A clear understanding of these factors is essential for members of the children’s care policy community to be able to identify better strategies to augment priority for child care reform, as well as the broader children’s care agenda. After describing the theoretical literature that our analysis draws on and the methodology employed, we focus on one central challenge to advancing children’s care: internal problem definition difficulties, reflective of competing perspectives among proponents on child care reform. We focus on this challenge, outlining the dimensions of this disagreement, because it is an aspect that proponents potentially have considerable capacity to influence. We take no position on these policy debates: our aim rather is to explore how members of the children’s care policy community understand the issues, and the effects of their differences on global priority for children’s care. We then describe the factors that shape and are shaped by these tensions. The final section identifies strategic challenges proponents need to consider in order to transcend difficulties and advance priority for children’s care.

Theoretical background

We drew on scholarship from the fields of policy studies, sociology and international relations to examine factors shaping global priority for child care, and specifically child care reform.

Research from these fields on how issues come to receive global priority reveals the central influence of *problem definition*—a social process involving the identification of the causes, consequences of and solutions to a problem (Weiss 1989; Dery 2000; Rochefort and Cobb 1994).

Problem definition shapes how policy-makers think and talk about particular concerns, and affects the rise and decline of issues on policy agendas (Rochefort and Cobb 1993). Blumer (1971, 301) elucidates the link between problem definition and agenda-setting in the policy process: "Social problems lie in and are produced by a process of collective definition. The

process of collective definition is responsible for the definition of social problems, for the way in which they are seen, for the way in which they are approached and considered, for the kind of remedial plan that is laid out, and for the transformation of the remedial plan in its application."

International institutions and governments are more likely to act on a problem when proponents come to evidence-based agreements on what the problem is, how it should be addressed, and why it is important (Shiffman and Smith 2007; Shiffman 2017; Shawar and Shiffman 2017). Action may be hampered when proponents become embroiled in conflict on the nature of the problem, who or what is to blame, and the preferred courses of action in order to address the problem (Klandermans 1997; Snow et al 1988). Such disagreements can fragment the community of proponents, hampering their legitimacy, ability to engage in collective action and capacity to convince policy-makers to act. Effective management of differences is all the more crucial because political systems have only limited agenda capacity: multiple policy communities compete to attract scarce attention and resources from global and national leaders, who select only a handful of issues for concerted action.

Social science research demonstrates that several categories of factors shape the emergence of consensus on problem definition and consequent global attention and resources that an issue receives. These include *issue characteristics*—inherent features of the problem itself—and *the nature of proponents*—the characteristics and relational dynamics among individuals and organizations centrally concerned with the problem. With respect to issue characteristics, issues backed by clear evidence on severity and intervention effectiveness are less likely to spark problem definition disagreements and more likely to garner attention and resources (Cairney 2016; Kalfagianni and Pattberg 2011; Keck and Sikkink 1998; Walt and Gilson 2014; Shiffman and Smith 2007; Shiffman et al. 2016). Also, problem definition disagreements are less likely to emerge for issues that are politically uncontroversial; if the issue is highly charged such as abortion, people tend to romanticize their own position and demonize that of their opponents (Sabatier, Hunter, and McLaughlin 1987). With respect to the nature of proponents, problem definition difficulties are less likely when (1) effective leaders emerge, capable of articulating vision amidst complexity and engendering trust among various factions (Kingdon 1984; Schneider and Teske 1992; Goddard 2009; Mintrom and Vergari 1996); (2) proponents are

relatively homogeneous in experience and professional backgrounds (although homogeneity may hamper the quality of decisions); and (3) governing mechanisms are in place to bring groups together and facilitate collective action (Hendrikse et al. 2008).

Social science research demonstrates the influence of problem definition on two other strategic challenges that shape the capacity of policy communities to achieve their objectives: *governance*—the creation of institutions to bring about collective action and advance coalition-building, and *positioning*—the portrayal of the issue in ways that inspire external audiences to act (Shawar and Crane 2017; Shawar and Shiffman 2017; Shiffman 2017). With respect to governance, problem definition disagreements, when ineffectively managed, may lead to difficulties in identifying leaders and setting up institutions capable of guiding collective action, and in forging alliances with external actors whose support and resources may be necessary to advance the issue (Keck and Sikkink 2014). Challenges with problem definition may also lead to difficulties with framing the issue in ways that attract the support of political leaders, particularly if proponents are unable to develop a coherent ‘ask’ of these leaders and position the issue in ways that resonate with the values and interests of these leaders (Stone 1989; Hilgartner and Bosk 1988; Koon et al. 2016; McInnes and Lee 2012; Shawar and Shiffman 2017).

Research on advocacy coalitions and conflict resolution suggest that generating consensus within policy communities can be difficult, but that disagreements may be managed productively without fragmenting a community. One means is through policy-oriented learning, a gradual accumulation of information through scientific studies and new stakeholder experiences (Bennett and Howlett 1992; Sabatier 1987). Another mechanism is via a hurting stalemate (Zartman 1991): contending parties come to view a continuation of the status quo as unacceptable, run out of alternative venues to achieve their objectives and become more willing to compromise (Sabatier, Focht, et al. 2005; Sabatier, Leach, et al. 2005). Consensus may also emerge through processes external to policy communities such as external shocks—for instance economic recessions, epidemics and wars—that force communities to reconsider strategy and take immediate action (Zafonte and Sabatier 2004).

Methods

We triangulated among several sources of data. These included documents in the form of published, peer-reviewed literature, organizational reports and media. We searched Google Scholar, databases, and websites of organizations concerned with children’s care. The search was restricted to literature in English, between the years 1960 and 2019. The search terms used were: “children”, “child”, and/or “orphan”, in combination with “care”, “care reform”, “alternative care”, “orphanage”, “institutions”, “informal care”, “community-based care”, “family-based care” “foster care”, “adoption”, “kinship care”, and/or “deinstitutionalization”.

In addition, we conducted 31 semi-structured interviews with actors central to child care advocacy, research, and/or programming, as well as observers of global child care efforts (see Table 1 for organizational affiliations). 35 individuals were contacted for an interview (88% response rate). The interviews took place between November 2018 and December 2019. These lasted on average one hour and twenty minutes and were conducted over Skype or telephone. We continued to interview key informants until we reached theoretical saturation—the point at which we obtained no new critical information from additional interviews (Morse 2004). Employing a purposive rather than representative sampling strategy, we identified these individuals through our literature review and by asking interviewees whom they considered to be most centrally involved in child care programming, research and/or advocacy. The interview questions were open-ended and tailored to each individual’s background, although some questions posed were consistent across all those interviewed.

Table 1: Organizational affiliations of key informants

ACC International
Better Care Network
Better Volunteering, Better Care
Catholic Relief Services
Changing the Way We Care
Child Frontiers
Children and Youth Economic Strengthening Network

Defence for Children International
Disability Rights International
Doris Duke Foundation
Duke University
Elevate Children Funders Group (includes among other organizations: GHR Foundation, Oak Foundation, World Childhood Foundation)
Faith to Action
Family for Every Child
GHR Foundation
Hope and Homes for Children
International Social Service (ISS)
Lumos Foundation
Maestral International
Migration Policy Institute
Miracle Foundation
New York State Department of Social Services
Oak Foundation
Rethink Orphanages
Save the Children
SOS Children's Villages International
UNICEF
University of Central Lancashire
University of Chicago
USAID
Washington Network for Children and Armed Conflict
Whole Child International
World Childhood Foundation

We undertook a thematic analysis of the collected documents and interview transcripts, using these to create a historical narrative on efforts to address children's care, and specifically child care reform. We used an iterative process in developing the codes (Weston et al. 2001). We

originally coded data by two broad categories derived from policy frameworks that examine the determinants of political priority for global health and social development issues (Shiffman 2017; Shiffman and Smith 2007; Shiffman et al. 2016; Shawar and Shiffman 2017). These categories are 1) the characteristics of the issue and 2) the internal dynamics of the involved actors, including those pertaining to problem definition, positioning and governance. The coding evolved as additional data were collected.

The study protocol underwent ethics review and received exemption by the Institutional Review Board of American University (Washington, DC, USA). All interviews were recorded and transcribed with consent from participants. In reporting the interview data, we assigned each key informant a number, and listed his or her most prominent institutional affiliation type and country classification (see Table 2). Also, to ensure historical accuracy, we incorporated feedback on a draft of this paper from several interviewees, representing different institutions and perspectives.

Table 2: Key informant number/organizational type

1	International Organization
2	Network/Coalition/Alliance
3	International NGO
4	International NGO
5	International NGO
6	Network/Coalition/Alliance
7	Consulting Company
8	Network/Coalition/Alliance
9	International NGO
10	International NGO
11	Foundation

12	International Organization
13	International NGO
14	Consulting Company
15	International NGO
16	Academia
17	Network/Coalition/Alliance
18	Foundation
19	International NGO
20	Academia
21	Foundation
22	Academia
23	International NGO
24	Foundation
25	Foundation
26	Foundation
27	International NGO
28	International NGO
29	Network/Coalition/Alliance
30	Consulting Company
31	Network/Coalition/Alliance

Results

The children’s care agenda includes at least three components: strengthening the ability of families to care for their children, preventing family separation in groups most at risk, and providing suitable and appropriate alternative care for the millions of children separated from

their biological parents (Pinheiro 2006; UNICEF et al. 2014). Many respondents express concern that the latter component, child care reform, receives an unusual level of attention, inordinately shaping prospects for the children's care agenda as a whole (I2, I5, I6, I10, I13, I29).

There is a wide spectrum of beliefs among care proponents about the best approach to child care reform. Differences exist on the appropriateness of various forms of non-family based care; which forms ought to be labeled 'institutional' in nature, a term with negative connotations; the legitimacy of an approach termed 'de-institutionalization' (hereafter referred to as DI); and what exactly DI entails.

DI proponents view most non-family based forms of care to be unacceptable, consider many of these forms to be institutional in nature, and strongly promote a strategy that goes beyond a limited focus on closing large-scale facilities and orphanages. Among those individuals and organizations that self-identify as in favor of DI, a number view the approach as necessitating the rapid closure of all or nearly all forms of residential facilities. Respondents identify Disability Rights International as the organization that is most aligned with this perspective (I1, I10, I13, I14, I24, I25, I29, I30). Others who self-identify as supporting DI call for a progressive realization approach—with children in families and family-based care as the end goal, but recognizing the need for some forms of residential care in the interim and/or at the margins of the continuum of care. Among those supporting progress realization, some view quality, small group congregate care as part of the long-term solution. Respondents identify the Better Care Network, Lumos Foundation, Hope and Homes, USAID and the European Union as embracing this perspective (I1, I10, I14, I29, I30).

Those who self-identify as DI critics (themselves holding varying views concerning what 'DI' refers to), view the strategy as lacking nuance and therefore inappropriate, and perceive the need for continuing care arrangements of multiple forms. They see the need for ongoing non-family-based care arrangements when other alternatives are not available, and do not designate all these arrangements as institutional in nature. Respondents identify SOS Children's Villages International, Whole Child International, Family for Every Child and a small group of academics as embracing this perspective (I1, I7, I8, I10, I14, I18, I20, I25, I27). Disagreements also exist

about whether some of the actors—including certain disability rights activists and a number of individuals within academia—are even part of the care sector or community (I25, I27, I30).

Despite differences, nearly all care proponents agree that family-based care is ideal and that very large residential facilities are poor care arrangements and should be closed. As one respondent puts it:

Everybody agrees that we want to close down large-scale institutions, but I think there's a lot more ambivalence about whether one has no sort of residential care whatsoever in the continuum of care (I8).

These disagreements notwithstanding, over the past year momentum to address these differences has accelerated. Such momentum is evident especially in proponent efforts around a 2019 United Nations General Assembly Resolution on the Rights of the Child, which contained provisions on children without parental care (I3, I14, I29, I30; UNGA 2019). The Resolution reflected key recommendations (Better Care Network 2019) developed and endorsed by a broad coalition of 256 organizations, networks and agencies working at national, regional and international levels on children's care. Proponents agreed on the need to strengthen children's care in families, prevent unnecessary separation by addressing its root causes, tackle orphanage volunteering, and put an end to institutionalization by progressively replacing it with family and community-based care.

Yet proponents note this agreement did not bridge all differences:

Many of us 'in the middle' were very frustrated that the United Nations General Assembly discussions focused intently on the Disability Rights International position versus residential care advocates. We wanted the discussion to be on the Key Recommendations, which are quite extensive and which have the endorsement of 256 organizations. There is a coming together of minds, but you are not hearing it in these debates. Even those 'in the middle' sometimes are compelled to dive into these debates, if only to try to nuance the discussion (I30).

They disagree, even, on whether a middle position exists:

In all honesty, there doesn't seem to be much of a middle. The challenge has been that it's a very dogmatic community and polarized on either end. If there was a middle or

flexibility to compromise and find common ground we wouldn't be in the bad state that we are in (I31).

One respondent points to the effects of ongoing divisions:

We are bogged down on these technical issues and as a result we're unable to actually think strategically about...the fundamental issue of how we ensure care for children (I29).

Differences on the definition of 'institution'

Differences concerning what constitutes institutional care shape child care reform debates (I3, I9, I11, I25, I27, I29). The UN Guidelines for the Alternative Care of Children (UNGA 2009) distinguish between 'institutions'—a term that appears only once in the document—and residential facilities. The latter term encompasses all alternative care settings that are not family-based (including those that are categorized as 'family-like'—another term that provokes disagreement) from emergency shelters and small group homes to the biggest residential facilities. The former term is often reserved only for large residential facilities. However, there is no universally agreed understanding—in the Guidelines or among care proponents—of what constitutes an 'institution' as opposed to other kinds of residential care settings (Working Group on Children without Parental Care in Geneva 2013), and the terms are used inconsistently among care sector proponents. Among the dimensions care proponents consider for categorizing an arrangement as an 'institution' are number of residents, the size of the facility, a child's length of stay, the quality of care provided, and the care arrangement's structure or capacity to safeguard and promote a child's rights (I3, I9, I25, I27; CELCIS 2012). As one respondent puts it:

There's a big discussion about what...kinds of characteristics are considered institutional, and what kinds of characteristics are considered family-like, or less bad (I9).

Some stress depersonalization, rigidity of routine, block treatment, and social distance as constituting 'institutional culture' (Ad Hoc Expert Group on the Transition from Institutional to Community-based Care 2009, page 9). Others identify institutions by the number of children housed in the facility, taking the minimum threshold to be anywhere from ten to 25 (Law Commission of Canada 2000). Still others classify institutions based on the length of stay (for instance, a facility where a child stays for longer than three months) (Browne et al. 2007). And

others still argue too much attention is given to the structure and services provided by a facility, rather than the quality of care, isolation from society and culture, and impact it has on the child:

Bricks and mortar don't institutionalize children, people do. It is a question of restrictive regimes and a lack of quality care and attention which inhibits a child's development that leads to institutionalization. My concern is not the building; it's the institutionalization of a child in terms of disempowerment and poor developmental outcomes (I27).

Moreover, proponents disagree on what quality of care entails. Care proponents agree that institutions can be places of deprivation, neglecting the child's health, nutrition, stimulation, and/or relationship needs, "isolating children from the broader social world and failing to offer personalized caregiver attention" (Berens and Nelson 2015). However they disagree on whether a lack of a regular family life, even if the facility can provide individualized and consistent caregiving (Dozier et al. 2012; van Ijzendoorn et al. 2011), automatically constitutes inadequate quality of care, and therefore institutionalization.

These definitional differences have shaped proponent disagreements surrounding which residential care arrangements are institutional in nature and therefore an unacceptable option for children's care (I2, I5, I7, I8, I9, I10, I12, I13, I15, I18, I21, I27). These include emergency shelters, children's homes, small group homes, and children's villages. Some view these as institutional, while others consider some to constitute residential or family-like care approaches (Biemba et al. 2010; Petrowski, Cappa, and Gross 2017). One respondent noted:

Residential care does not by definition have to be institutional. You're in smaller groups, in smaller spaces with constant relationships and primary care givers can be more family-like. So most people when they think of residential care they think of the Romanian orphanages. And that of course is terrible...And there is no reason for that. The same structure can be restructured to feel like a home, where you've got little apartments (I15).

Others find any care arrangements that are not family-based to be institutional in nature, regardless of their particular form (I1, I12, I23, I24):

They are just mini-institutions and no child should be in a small group home, every child should be in a family (I1).

Differences on the legitimacy and definition of the DI approach

These disagreements about what constitutes an institution underpin the most divisive debate: whether DI is an appropriate entry point for care reforms, and what DI actually encompasses. Called for in the UN Guidelines for the Alternative Care of Children and the Convention on the Rights of Persons with Disabilities (CRPD), DI has been referred to as the process of reforming child care systems, closing down orphanages and institutions, preventing the opening of new ones, and, “replacing institutional care for children with care in a family or family-like environment in the community” (Terziev and Arabska 2016, 287; Groza, Bunkers, and Gamer 2011; Robert B. McCall, Groark, and Rygaard 2014). The UN Guidelines for the Alternative Care of Children state that the approach targets ‘institutions’ and not other ‘residential facilities’. Most recently, the December 2019 UN General Assembly Resolution calls for ending child institutionalization by progressively replacing it with family and community-based care.

Below we outline the arguments made by children’s care proponents who self-identify as being in favor of and critical of the DI approach. We do so noting that the very definition of ‘DI’ is one of the core points of difference, which means that on some issues—such as the harm large residential facilities may cause and the importance of family care—proponents and opponents of DI may be advancing the same, similar or at the very least not incompatible arguments. Furthermore, those holding a progressive realization approach to DI draw on arguments and evidence advanced both by those in favor of and critical of the DI approach—for instance on the costs and harm of institutionalization and the need for more nuanced approaches.

Arguments by those who self-identify as supporting ‘DI’

Advocates who self-identify as supporting ‘DI’ believe that facilities that institutionalize children are unable to guarantee the well-being of children and deprive children of their right to a family. As one respondent noted about those questioning the existing DI approach:

What they don’t do is look at the long-term consequences of [their] approaches. Yes [some facilities] can provide more adequate food than some kids were getting in their homes. No doubt about it. But in terms of being able to help children and young people get on a life course trajectory that’s going to be a positive one, I just don’t see it (I1).

Proponents cite several reasons for advancing a DI approach: facilities that institutionalize children have long-term harmful effects on child well-being; they are costly and divert resources

from preventing family separation and strengthening families; and most children residing in these facilities are not orphans.

Institutionalization harms child well-being

There is a wide body of evidence on institutional care and its impact, and many child care reform advocates draw from it regardless of their strategy and approach. Groups that promote complete DI draw most heavily on it, and often apply the findings to all forms of care that is not family-based. One of the primary arguments advanced in support of DI concerns the negative impact of institutionalization on children (I1, I3, I4, I12, I23, I21). The literature that supports this claim is sizeable and dates back to the mid-20th century. Researchers including Rene Spitz (1945), William Goldfarb (1945) and John Bowlby (1953) were the first to document the damage inflicted by institutional care on children's mental and physical development (McCall and Groark 2015). Spitz (1946) described institutionalized children to be extremely "delayed" and "lethargic", given their lack of "mothering." In a report to the World Health Organization, Bowlby (1952) observed that most institutionalized children were extremely delayed in development because of the lack of stable and continuous attachment relationships with caregivers, even when their physical needs were being met.

Since then, a number of studies have examined a variety of care arrangements and compared institutionalized children to noninstitutionalized children (Smyke et al. 2007; van Ijzendoorn, Maartje, and Juffer 2008; Judge 2004; Johnson, Browne, and Hamilton-Giachritsis 2006). These studies have reported similar findings: institutionalized children have significant developmental deficits across almost every domain, including physical, socio-emotional, and cognitive development (Dozier et al. 2012). Berens and Nelson (2015, 388) note that the "effects seem most pronounced when children have least access to individualized caregiving, and when deprivation coincides with early developmental sensitive periods". In terms of physical development, institutionalized children, as compared to others, are found to be atypically of short height, low weight, and small head circumference (Dobrova-Krol et al. 2008; Smyke et al. 2007; Sonuga-Barke, Schlotz, and Rutter 2010). In terms of psychological outcome, institutionalized children as compared to children raised in families have more attention deficit and social problems (Hawk and McCall 2010), increased rates of insecure attachment (The St. Petersburg-

USA Orphanage Research Team 2009), lower IQ (van Ijzendoorn, Maartje, and Juffer 2008), and higher rates of emotional and behavioral difficulties. Institutionalized children are also consistently more vulnerable to developing psychopathological symptoms (Cheung et al. 2011) and low self-esteem (Farooqi and Intezar 2009).

Many DI proponents point to the Bucharest Early Intervention Project (BEIP) (Nelson 2014). This study provided the first randomized-controlled trial data comparing longitudinal outcomes among young institutionalized children, and has offered the strongest evidence to date that institutional care has a causal effect on developmental deficits and delays (Berens and Nelson 2015). This is substantiated by a review of findings from research on the cognitive and social-emotional development of children exposed to various natural experiments, concluding that the lack of stable and continuous parenting appears to have significant negative effects on child development and well-being (Schoenmaker et al 2014). One respondent pointed to the strength of the scientific evidence:

The evidence that has emerged shows really dramatic differences [between children that are institutionalized and those that are not]. The science is...pretty clear that you know, a child needs a family (I1).

Others expressed concerns about the lack of scientific rigor in research supporting claims that residential care is comparable to the care received in family-based arrangements (I23, I29):

[There is] dangerous research [conducted by a] minority that is academically questionable saying that the clean institutions and residential care and group homes are just as good as foster care.... There is a very serious misunderstanding of science out there. There's an enormous amount of bad science in the children's community. They are not paying attention to the greater amount of science that shows that residential care and group homes are dangerous, and the children need to be with families (I23).

Some point to methodological flaws of such studies, which do not correctly compare outcomes for children in families with those in residential care facilities. For example, in the analysis conducted by Embleton et al. (2014b), the authors note that the former group received less support than the latter, who were more likely to live in permanent structures and have access to electricity and water.

DI proponents also point to evidence on the heightened risk to institutionalized children of neglect and abuse from caregivers and peers (Sherr, Roberts, and Gandhi 2017; Carr, Duff, and Craddock 2018; Mazzone, Nocentini, and Menesini 2018; Colton 2002; Mathews et al. 2015). For example, a Romanian study found that 38% of 7 to 18-year-olds in residential care reported severe punishments or beatings (Popescu 2016).

DI proponents also note that orphanage voluntourism—a growing phenomenon where travelers give back to the destination they are visiting by spending time in orphanages—unintentionally exacerbates the harmful effects that care that is not family-based has on children. For example, children are used to beg for donations, forced to entertain to get donations from volunteers, kept out of school to amuse foreigners, and purposely kept in destitute conditions in order to gain more sympathy from donors (Havens 2017). Another effect is social and psychological harm, especially in terms of attachment, given the constant overturn of volunteers in these facilities (Richter and Norman 2010).

Institutionalization is costly

Another DI argument is that institutionalization is not cost-effective (I1, I12, I14). Research from the United States indicates that group placements cost seven to ten times the cost of placing a child with a family (Barth 2002). In South Africa, residential models of care were found to be more expensive than kinship and community-based models (Desmond and Gow 2001). And one DI proponent makes the additional point that:

The more we continue to pour resources into improving institutions, the less resources [there are] for helping families take care of their children (I7).

Most institutionalized children are not orphans

Finally, DI proponents and many others in the sector advance that most kids in care that is that family-based are not orphans. Approximately 80% of the millions of children living in orphanages have at least one living parent (Lumos 2015; Richter and Norman 2010; Williamson and Greenberg 2010; Richter and Norman 2010; Williamson and Greenberg 2010). Accordingly, proponents argue that DI is critical to reintegrating these children that are unnecessarily placed in care that is not family-based back into their biological families, with the necessary financial and

social support services needed to strengthen a family's capacity to care for their children (McCall and Groark 2015).

Arguments by those who self-identify as critical of 'DI'

Those who self-identify as critical of the DI approach question the quality of the evidence that purports to show that all forms of care that are not family-based have more pronounced adverse effects on children than those that are family-based. They argue also that current DI discourse, which goes beyond targeting large-scale facilities and orphanages, is insufficiently nuanced as an approach to children's care: a variety of options are needed, with alternatives tailored to context (I10, I11, I14, I19, I25). They contend that particular types of care that are not family-based are an acceptable form of care (Rossiter 2014; Biemba et al. 2010; Petrowski, Cappa, and Gross 2017).

A questionable evidence base against non-family based care

Critics contend that research indicates the effects of care arrangements that are not family-based vary by circumstance (I11, I14, I16, I19, I21, I25; van Ijzendoorn et al. 2011). They express concern (I10, I16, I18; Whetten et al. 2014) that analyses examining the effects of care arrangements that are not family-based on child well-being have focused largely on one type of setting: large hospital-style facilities caring for infants with shift workers (van Ijzendoorn, Maartje, and Juffer 2008; Merz, McCall, and Groza 2013; Robert B. McCall et al. 2013; Zeanah et al. 2003; Nelson et al. 2007). Also, they note that studies providing evidence on the harmful consequences of care arrangements that are not family-based are based predominantly on the experiences of states in the former Soviet bloc (Ghera et al. 2009; Humphreys et al. 2015; Smyke et al. 2007; Berens and Nelson 2015).

Critics also express concern about design and methodological problems in studies of care arrangements that are not family-based (Huynh 2014). For example, many analyses focus on facilities with pre-existing high levels of malnutrition. Few studies explicitly compare the well-being of children in residential care with those in families (Gayapersad et al. 2019). Also, existing studies rarely disentangle the causal mechanisms tying residential care to alleged

adverse effects on child wellbeing. One respondent noted his frustration with the body of literature that claims any care arrangement that is not family-based is universally detrimental:

Nobody seems ever to take account of the trauma [children have] been through before placement in care. We just assume they were perfectly healthy when they went into care and come out of care damaged. But of course the very fact they're in care indicates that some degree of pre-care trauma has taken place (I27).

Critics also note evidence that family-based care can have adverse effects, challenging DI proponents on the absolute superiority of their approach. Studies examining orphans and non-orphans in the same household in sub-Saharan African countries show that the former had lower school attendance rates than the latter (Case et al. 2004; Mishra and Bignami-Van Assche 2008; McCall, Groark, and Rygaard 2014). A number of studies highlight that vulnerable and orphaned children are often exposed to significant levels of violence and abuse within extended-family care settings (Shibuya and Taylor 2013; Brodie and Pearce 2017; Kuyini et al. 2009).

Critics note also that in some instances outcomes for children in care arrangements that are not family-based may be equal or better than those for their counterparts living in kinship care arrangements (Atwoli et al. 2014; Braitstein et al. 2013; Embleton et al. 2014b). Outcomes include those pertaining to child rights (Embleton et al. 2014b), nutritional status (Braitstein et al. 2013), mental health (Atwoli et al. 2014) and sexual health (Embleton et al. 2017). For instance, a study conducted in Kenya provides evidence that the prevalence of posttraumatic stress disorder and sexual abuse was significantly higher among orphaned children in households than those in care arrangements that are not family-based (Atwoli et al. 2014, 6). Many proponents of DI question the methodologies behind these studies (I29, I30).

The need for more nuanced approaches

Drawing on this evidence, DI critics argue that more nuanced approaches tailored to context are needed and that particular forms of care that are not family-based in certain circumstances may be part of the mix. They are concerned that the current DI approach is too narrow a goal, one that overlooks a contextualized approach needed to improve care. Several respondents expressed their concerns with the existing practice of DI:

I really don't think we can do black and white, especially when it comes to children. And if we do black and white that all children have to be in a family...then we're not doing what the [UN Guidelines for the Alternative Care of Children] say and the guidelines really ask us for an individualized approach for every child (I19).

I found [DI-supporters] to be really dedicated, really super passionate, but I also found them to be slightly dogmatic...The goal is just to shut down institutions...That's not reforming care and it's not working in the best interest of the child (I11).

Specifically, they object to DI's universal approach:

I think some [DI proponents think]: 'This is how you do the deinstitutionalization. Here are the ten steps. Let's do the training program; we'll make it a global program and we'll just do it that way.' And I don't think that it works that way. I think you need to have a really good understanding about what's happening in the country and the reasons for who's funding the institutions, why are the children going in there (I9).

The profile of child in care worldwide is very different than that reality [in Eastern Europe]; those were, I mean, significantly younger children than are in care today worldwide and the evidence we're seeing out of, for example, in Sub-Saharan Africa is: kids are not 0 to 8 or 7 or 6; they're actually you know 7 to 18. They come into care to...access education (I18).

Critics worry also about consequences for children in various care facilities when these are shut down and no good alternatives are available (I9, I10, I11, I14, I15, I18, I25). There is particular concern that donor-led strategies have imposed unrealistic goals for DI implementation which have perpetuated poor practices:

Institutions are starting to close, but the alternative services aren't necessarily in place. And a lot of them have closed and just sent the kids home...and now the community's going 'oh, wait a minute listen, this is...how horrible, sending all these kids home and they're unsupervised' (I18).

[There] has been a pressure on the countries to close institutions without having a clear roadmap for what should be there instead, and sometimes it's done too hastily and without good, proper assessment for each individual child (I25).

I'm just going to tell you that a loving family is not going to pop up in the soil in front of the orphanage because there is no funded child protection system in places like Latin America... Like would you take this approach [DI] to refugee camps? I know, let's choke off the funding. Like who does that? There are actual children living in the orphanages...That's the only system we have at the moment (I15).

Those concerned with the current DI approach also point to the fact that not all biological parents or extended families are capable of or have a desire to care for their children:

So this made up fantasy number that gets cited everywhere, which is these families could all take the children if they were properly supported...is actually completely not factual.... Because on planet earth, from the best that we know, there are still always a certain number of children out of home care because the parents can't cope, even with all the support possible (I10).

So you get other bold statements like: 'A large majority of children living in institutions have one living parent or existing family.' So what? That says nothing about the willingness ability or capability of those people to be the caregiver. If they're not willing, it doesn't matter if they're alive (I27).

Critics contend that more attention should be given to the “quality of care provided within a setting, whether that setting be family-based or institution-based,” rather than eliminating all forms of care that is not family-based (Whetten et al. 2014, e104872).

Factors shaping disagreements on De-Institutionalization as a strategy

Aside from differences on what DI actually entails, several additional factors have shaped care proponent disagreements on the legitimacy of DI as a strategy and global priority for the issue of children's care more broadly. These include data inadequacies on the problem's scope and nature, insufficient evidence on solutions, divergent experiences between former Soviet bloc and other countries, challenges in introducing formal alternative care arrangements, commercial interests that perpetuate institutions, and perspectives of the disability community and those children and families directly affected by the issue.

Data inadequacies on nature of the problem

Insufficient and unreliable data on the scope and nature of the problem—including the number of children in various care arrangements, the reasons for separation from their families, and the number of institutions that exist—have intensified proponent differences about the acceptability of care arrangements that are not family-based. Many proponents point to the scarcity of data as a problem (I2, I3, I4, I6, I8, I12, I13, I14, I21, I26, I27):

We all are saying, and the literature says, the data is very weak. It's a big issue for us (I2).

How many [orphanages] are unlicensed? We don't know. Number in children care? We don't know. Number of economic orphans versus orphans? We don't know (I11).

There are efforts to improve data collection: for instance the Tracking Progress tool for the Guidelines for the Alternative Care of Children (I14, I27), a forthcoming series of articles in the *Lancet* dedicated to the care sector, and publications that emerged out of discussions in a 2014 symposium co-hosted by the Better Care Network and the CPC Network (I29; BCN and MERG 2014; Canavera and Martin 2016; Martin and Zulaika 2016; Scott and Karberg 2016). However, difficulties persist in detecting the number of vulnerable and orphaned children. Divergent perspectives on the definition of 'orphan' and its usefulness as a designation shape these difficulties (Rotabi and Gibbons 2012), as does the dearth of accessible data from household surveys on children living outside of family care. With the exception of a few scattered estimates from a handful of countries and emergent efforts to better mine and use household survey data (Canavera and Martin 2016; Martin and Zulaika 2016; Scott and Karberg 2016), vulnerable children are "largely falling off the statistical map" (Clay et al. 2012). Calculating the number of children in residential care has also proven difficult (Biemba et al. 2010) as has identifying the drivers of institutionalization (I30): most are in private-funded facilities; national governments—particularly those in low-income countries—have weak monitoring capacity; and, as noted above, disagreements persist on what constitutes an institution (Browne 2009; Pinheiro 2006; Walakira et al. 2014; Rotabi, Roby, and McCreery Bunkers 2016; Frimpong-Manso 2014). Information on the number and circumstances of children living in family-based arrangements, such as foster care, is even scarcer than that on children in residential facilities—especially in LMICs where foster care arrangements tend to be informal in nature (Petrowski, Cappa, and Gross 2017).

Insufficient evidence on effective solutions

A weak evidence base on solutions also underpins proponent differences on how care reform should be conducted. There are limited and conflicting data on the impact of various care arrangements on child well-being. Robust impact measures for a number of areas of child

wellbeing are not available, and ‘quality of care’ is a difficult concept to measure. Few longitudinal studies follow cohorts of children, especially in LMICs, and measure the impact of interventions over time (Biamba et al. 2010)_(an exception is Bick et al. 2015). Those studies that do exist present contradictory results on the effects on children of small group homes versus other care arrangements (Wolff et al. 1995; Wolff and Fesseha 1998; Wolff and Fesseha 1999; Wolff and Fesseha 2005). Another information gap is insufficient data on what happens to children after DI. Yet another problem is that many of the studies examining care arrangements and interventions are based on experiences of former Soviet bloc countries (Ghera et al. 2009; Humphreys et al. 2015; Smyke et al. 2007). Several proponents also express concern about the lack of methodological rigor in impact research (I10, I6). One comments:

Let’s talk a little bit about the data that has supported this policy movement. None of it will hold up in proper science. I know there are peer review channels...but I’m telling you if this was the health sector it would’ve been laughed at (I10).

These information deficiencies—both on the scope of and solutions to the problem—decrease donor and policymaker willingness to support the issue. Without a clear understanding of how many children are in various care arrangements or what works to address the problems, proponents are unable to convey its severity and present policy alternatives backed by strong evidence. As one respondent noted:

You can’t prove the points to policymakers without the data (I27).

Divergent experiences between former Soviet bloc and other countries

Divergent experiences between former Soviet bloc and other countries have also fueled DI disagreements. Many with experience in the former tend to favor a strong DI approach given the history of child maltreatment in large-scale institutions in these countries.

Europe has a long history of residential care. Foundling homes were first established in Italy in the 14th century in response to the growing number of abandoned babies, a practice that then spread to other parts of Europe and Russia (Dozier et al. 2012). Orphanages also appeared across the region (Gabriel et al. 2013). In the 1990s, horrifying images surfaced of thousands of neglected children housed in overcrowded, state-run orphanages in Romania and other Eastern

European countries. These images sparked public outrage and brought attention to the developmental delays and abnormal behavior resulting from institutionalization. A number of organizations, donors, and advocates within the children's care sector—many of whom now strongly support DI—were moved to action (I9, I11, I18). One respondent notes that Lumos and Hope and Homes, for instance, both arose out of the Romanian experience (I18). By contrast, it was not until the 1990s, fueled in part by economic, political, natural, and/or health (especially HIV/AIDS) crises, that orphanages—largely introduced by colonial authorities—proliferated in a number of low-income countries (Nsabimana 2016; Csáky 2009).

These historical differences have partly influenced the number of children in residential care. Countries in Eastern Europe and the former Soviet Union account for 42% of all children living in institutional care— an estimated 1.3 million (Unicef, Unicef, and Others 2010; Carter 2005)— compared to 22% in OECD countries, 22% in South and East Asian countries, 10% in Latin America and 7% in Eastern and Southern Africa (although the numbers for many countries in Africa, Asia, the Middle East and Latin America may be underestimated given poor registration of residential care facilities and weak data systems) (UNICEF et al 2010). The majority of children living in alternative care across Sub-Saharan Africa are in family-based arrangements— living with a surviving parent, grandparent, or other family member (UNICEF 2017; United Nations 2013; Monasch and Boerma 2004; Petrowski, Cappa, and Gross 2017). Even double orphans—those who have lost both parents to AIDS—in Sub-Saharan Africa in 90% of cases receive care from extended family (Monasch and Boerma 2004).

In addition, there are differences between former Soviet bloc and other countries in why children are placed in care that is not family-based. In former Soviet bloc countries, most children placed in care that is not family-based are 'social orphans', meaning that they have living parents, but are institutionalized largely for socio-economic reasons, primarily poverty (Rockhill 2004; UNICEF 2005). The severe economic crisis of the 1990s in combination with the region's traditional reliance on public care resulted in and continues to drive the institutionalization of children (Bilson and Cox 2007; Bilson and Markova 2012; UNICEF et al. 2007; Ismayilova, Ssewamala, and Huseynli 2014). The primary driver of residential care in Sub-Saharan Africa is poverty, alongside the loss of parents or caregivers through disease (especially AIDS) and

disruption of kin networks through economic migration, war and conflict (Milligan et al. 2017). It predominately occurs when a child's relatives—often the only alternative in the absence of any social safety net—are unable to cope. Another difference is that most of the children coming into care in low-income countries are considerably older than those of former Soviet bloc countries given that access to basic services and particularly education drives children home placement. Furthermore, there are fundamental differences in the way that existing care systems are organized. Highly centralized and government-regulated systems are common among post-Soviet countries, while decentralized and poorly regulated systems often characterize other low-income countries, where private and often faith-based organizations dominate the landscape (I29, I30).

Respondents express frustration about the lack of recognition of the different realities:

The evidence that isn't necessarily being absorbed by the DI community is that really this whole DI movement started out as the former Soviet Union with large state-run institutions in Eastern Central Europe, Russia, Ukraine, Bulgaria, Romania. But you know the profile of the child in care worldwide is very different than that reality (I18).

There is a lack of evidence from multiple contexts about the solutions ...I don't feel you can say this works in the Ukraine, therefore, it will work in the rest of the world. We don't have or we're only just beginning to get information [on what] works in Rwanda and Cambodia and Zambia (I8).

You cannot adopt the same strategy to transform a care system in a country where you have a social welfare system which [has a]...weak or nonexistent legal system, no formalized workforce, virtually no control by the state or regulation of the funding that support services and no formal workforce or mechanism for coordinating or managing the delivery of the services at the local level.. *in the same way* that you transform it in a post-Soviet system where the States regulate every aspect of life, where the system is highly centralized and where you have massive injection of funds and regulation among others as a major carrot to enable entry into the European Union. You simply cannot (I29).

Challenges in introducing formal alternative care arrangements

The lack of social protection and legal systems and capacity to implement formal alternative care arrangements in many low-income settings lead some proponents to question the feasibility of DI as a strategy. While many countries have made efforts to establish legal and statutory

frameworks for child care reforms, the implementation of these laws and regulations has been challenging, given the lack of financial resources, inadequately qualified staff, and poor service provision (UNICEF 2013; Gale 2016). In Uruguay and Guatemala, as well as other countries in the region, police, rather than social workers, assess protection risks and make most referrals into care (UNICEF 2013; RELAF 2011).

Cultural, religious, and social resistance to certain alternative care arrangements also exist. In a number of countries alternatives such as domestic foster care or adoption are resisted because of unease with the idea of families raising another person's child (McCall, Groark, and Rygaard 2014). In most African countries, formal adoption is rare (Chiwaula, Dobson, and Elsley 2014; Gerrand and Nathane-Taulela 2015). In Namibia, for example, only about 80 adoptions are registered per year (Kangandjela and Mapaure 2009). Although legal processes are in place in most countries, they are often incompatible with traditional values and cultural practices (Milligan et al. 2017). One respondent describes the problem this way:

Foster care, development of small group homes, development of domestic adoption have all been proposed...we're asking other countries to develop a whole type of profession which is socially, politically, culturally, religiously not necessarily something that naturally comes out of their own country environment. So, it can feel like an imposed solution (I8).

Stigma may drive some hesitancy about adoption. Many individuals view HIV-positive children as unfit for adoption (Meintjes et al. 2007). In addition, costs associated with the adoption process are exorbitant (Chiwaula, Dobson, and Elsley 2014) and there are disincentives for kinship or foster carers who may lose financial support if they complete the adoption process (Gerrand and Nathane-Taulela 2015). Despite recent changes to legislation to promote adoption in some countries, such as Kenya and Sierra Leone (Republic of Kenya 2015), there remains uncertainty about the extent to which legal changes can overcome entrenched stigma and cultural barriers.

Commercial interests that sustain and perpetuate institutional care

The fact that individuals and organizations profit from institutional care and therefore have an interest in sustaining their existence also fuels disagreements on DI as a strategy. DI proponents argue that this phenomenon heightens the need for their closure:

If you don't close the institutions, the places will be filled with new children. So, without strong gatekeeping and without actually closing them, you will have new children coming in (I25).

Others, while acknowledging these interests, believe that DI proponents use these as an excuse to promote an uncompromising position on the unacceptability of all or most residential care arrangements.

Few in the children's care community deny that commercial and economic interests shape the persistence and growth of residential care (I4, I8, I25; Berens and Nelson 2015; Rotabi et al. 2017; Williamson and Greenberg 2010; Gayapersad et al. 2019). Employees of residential facilities fear losing their jobs (Tobis 2000; Dozier et al. 2012; Ismayilova, Ssewamala, and Huseynli 2014). Poor families, often seeking better education or health for their children, are pushed by orphanages engaged in intercountry adoption (Graff 2009) or residential facility managers driven by profit into giving up their children (Rai 2015). Many parents do not understand the legal implications of adoption, signing papers without understanding that the provision is permanent (Surtees 2005; Martin and Sudrajat 2007). Orphan tourism—fueled by foreigner desires during their travels to help local children—motivate operators to set up new residential facilities and to use illicit practices to recruit clients (Havens 2017; Rotabi, Roby, and McCreery Bunkers 2016; Guiney and Mostafanezhad 2015; Cheney and Ucembe 2019). Ghana, for instance, saw a rise from ten orphanages in 1996 to 148 in 2006 (UNICEF, Child Frontiers, Crescent and Government of Ghana 2012) and Cambodia a 75 percent increase in the number of orphanages between 2005 and 2010 (Ministry of Social Affairs, Veterans, Youth Rehabilitation and UNICEF 2011). In Cambodia, motorcycle rickshaw drivers scout tourists and are paid to bring them to orphanages (Guiney and Mostafanezhad 2015). Orphanage directors create an environment of deprivation to elicit sympathetic responses from visitors (Rotabi, Roby, and McCreery Bunkers 2016). Government officials often support these facilities. As one respondent comments:

Government officials often have significant investments in orphanage care because it's a lucrative business model for them, either financially or through their faith connections, and often it's both (I18).

Several proponents note how strong business interests make residential care facilities hard to close (Programme and Mulheir 2007):

You're talking about very powerful people. Some of the people who run these orphanages are well connected. And so it's not easy for you to put your foot on the ground and tell them this is what you should do (I4).

While acknowledging this reality, one respondent expressed frustration about how some DI proponents exaggerate the pernicious nature of profit-making in these facilities:

I'm not saying that never happens and that it has never happened, but you cannot generalize globally that ...the only reason why children are in child protection systems is because evil people who run orphanages want to make money (I15).

Perspectives of children, families, and the disability community

Tensions among proponents about the acceptability of residential care have also been shaped by the perspectives of two historically under-represented groups in child care reform debates: the children and families directly affected by care reform (I11, I19, I21, I27), and the disability community (I8, I9, I13, I30). Some of the former point to circumstances in which residential care is preferable, while particular disability rights organizations argue against its use in any form.

Children and young people themselves sometimes express a preference for residential over family-based care alternatives (I2, I11, I14, I19, I21, I28). This was found to be particularly true for teenagers who are at the stage where "the idea of having a family is not the most important thing" or for children who have already been through multiple foster placements that have failed (I2, I21). HIV positive children have also reported benefiting from important protective factors while living in residential care. These include a sense of belonging and appreciation for community, and gaining the resilience for coping with challenges such as stigma (Fournier et al. 2014). Practitioners working with young, unaccompanied migrants stress the need to maintain a

range of different care arrangements, accounting for children's particular needs and the specific legal, political, institutional and socio-economic context in which care is being provided (EPIM 2017). One respondent working with migrant and refugee children reflected on this:

It is really important to keep that menu of [care] options really open, be really conscious about what profiles may be more appropriate for certain types of care, really listening to the children themselves, re-evaluating, not having too much of a default mechanism to allocate children to particular types of care (I28).

Several other respondents noted the importance of accounting for children's voices and respecting their preferences:

The reality is there are some children, and it's recognized in the international framework, [that] would not actually do well in a family alternative.... They've experienced a lot of stuff in their lives and creating a family or trying to create a family at that stage sounds like a nice idea but some of these young people don't want that (I2).

If you start interviewing the children...in care in these institutions, some of them have grown up there all their lives. If you take them out of these institutions you're taking them away from their only brother, like it's a social brother, a social sister (I19).

A lot of kids are saying: 'I am able to study here [within a residential facility]. My house is chaotic. I have 17 brothers and sisters...I can't study. I have to be out in the field. This is really good for me to be here' (I11).

I have worked with a 14-year old. We were trying to put him into foster care and he said 'Just stop. I don't want an alternative family, thank you very much. I'm close to my school here, I've got my friends here, don't send me somewhere else' (I27).

Disability rights groups are another important actor in child care reform debates. Children with disabilities are more likely than other children to be taken away from their families and placed in long-term residential care (I8, I9, I13, I23). Most disability rights groups strongly support the DI agenda for both children and adults.

Disability rights advocates point to numerous declarations that advance the right of children with disabilities to live with their families, including the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, and the UN Guidelines for the

Alternative Care of Children. In 2017, the Committee on the Rights of Persons with Disabilities advanced the right of a child to grow up in a family, finding institutions—regardless of quality or size—to be unacceptable alternatives:

Policies of de-institutionalization therefore require implementation of structural reforms, which go beyond the closure of institutional settings. Large or small group homes are especially dangerous for children, for whom there is no substitute for the need to grow up with a family. “Family-like” institutions are still institutions and are no substitute for care by a family (CRPD 2017, general comment number 5, para. 16(c)).

Disability Rights International (DRI), which launched the ‘Worldwide Campaign to End the Institutionalization of Children’ in 2013 (DRI 2019a), and partner organizations subsequently called for the UN General Assembly to include in its Resolution on the Rights of Children a recognition that there are “no exceptions to the right to grow up in a family for any child, and the provision of care never justifies the denial of this right”. Further, they argued that States have “legal obligations” to “create the family-based support systems necessary to implement the right to family for all children”, and that failing to meet these obligations is “a human rights violation” (DRI 2019b, page 2).

Arguments advanced by some disability rights advocates—especially DRI and to some extent the European Network on Independent Living (ENIL)—have catalyzed debates within the child care reform community about the acceptability of residential care in any circumstance (I13, I29, I30). While some care reform proponents sympathize with the concerns expressed by disability rights advocates, they express frustration with claims that residential care is akin to encroaching on a child’s human rights:

Children with disabilities are effectively the last to benefit from preventive measures, family support measures and suitable alternative care measures. So, I absolutely understand where they’re coming from and I support that completely. The problem is that they are mixing up dogmatic rights and justified claims...They’re saying basically that putting a child in a residential care home is tantamount to violating that child’s rights. And it’s not (I13).

Consequences of problem definition disagreement

Difficulties with problem definition have hindered the ability of the children's care community to address other strategic challenges: establishing effective governance arrangements to steer collective action; securing allies through strong coalition-building efforts; and identifying a powerful positioning of the issue that can attract the support of policy-makers and other actors whose resources are needed to make progress on the issue.

Weak governance

Proponents identify numerous fault lines that hamper the establishment of effective governance arrangements for the children's care community, ones that could enable actors in the sector to work in tandem. The primary fault line is grounded in the problem definition difficulties pertaining to DI strategy discussed above. As one respondent puts it:

There [are] differences of opinion about what it is we're arguing for and what the solutions are that we're putting forward, which preoccupy us as a community...[and] stops us from being very cohesive and coherent (I8).

Proponents identify additional fault lines based on organizational focus and type: for example, between organizations largely active in and drawing on experiences in Eastern Europe and those focused on care reform in Sub-Saharan Africa and Asia; as well as between advocacy and program-oriented organizations (I9).

Proponents note that fragmentation is driven not just by differences over ideas, but also by individual and organizational interests and the pursuit of turf. Respondents identify power struggles, with contention over control of the child care reform agenda and institutional desires to gain credit for their contributions (I4, I5, I6, I7, I9, I11, I18, I21, I27). Multiple respondents express concern over the uncomfortable environment in the children's care sector that has emerged as a result (I2, I5, I10, I11, I15, I25):

Organizations are trying to shut each other up rather than having a proper conversation (I2).

The ideology becomes a battering ram...If you're not on board, you are an outcast. If you're not singing from the hymnal, you're excommunicated from the community (I20).

Proponents perceive the sector's lack of resources to have contributed to competition (I2, I3, I5, I7, I12, I13, I27), resulting in organizations becoming "connected with their model" and unable to "step back and look at these issues free of their organizational needs" (I3). Some proponents expressed how hopeful they were when Catholic Relief Services (CRS), Maestral and Lumos were awarded 15 million dollars in 2018 as finalists in MacArthur Foundation's 100&change competition. Their "Changing the Way We Care" initiative was seen as a promising opportunity to bring the care sector together and advance the issue. However, respondents noted that the award stoked jealousy and competition. One respondent described the problem:

We're fighting for the same dwindling pile rather than fighting for the bigger pile overall and I think that's a huge problem because everyone's picked their niche and wants to opt for that niche ...we're not unified enough to fight for the bigger cake instead of [the] scraps from the table (I27).

Effective leaders—individual and institutional—might help in transcending these challenges, but respondents note a dearth of unifying champions for child care reform (I3, I6, I9, I13, I18).

Respondents describe there to be several consistent players, such as Lumos, Hope and Homes, Family for Every Child, SOS Children's Villages International, Save the Children, USAID, The Elevate Children Funders Group, Faith to Action, and International Social Services, but a limited capacity for these organizations to unify proponents, especially given organizational cleavages to particular care reform approaches. One respondent noted:

They may think they're a leader [but]...I don't think there is a leader in this sector. I think there's been consistent funders in this sector for a long time, but nobody has emerged as a leader that people are willing to follow (I18).

Some respondents, however, identified UNICEF (I3, I4, I5), given its ability to facilitate connections with national governments, and the Better Care Network (I7, I11, I21), given its efforts to foster collaboration and information sharing among the involved organizations, as possible sector leaders although neither is yet widely recognized as leaders. They also noted influential voices of individuals within organizations such as USAID, Hope and Homes, and Lumos (I3, I25) and the championing of the issue by JK Rowling and the positive impact she has had on bringing attention to the issue. However, some expressed caution about the extent to which she is able to represent the vision of all care proponents:

She is promoting one model. She is always speaking for one organization. So, it's a shame because I think she should extend her grace to speaking about the issue broadly. (I3)

Inadequate coalition-building

Proponents note that care reform and family strengthening strategies require engagement with a variety of sectors including education, early childhood development, social welfare, child protection, health and justice (I2, I5, I8 I14, I24), since many of the “drivers don’t even sit inside of [the care] sector for the most part” (I5). Despite this awareness, proponents note the care sector’s limited engagement with these sectors, as well as with those working with unaccompanied migrant or refugee children (I2, I5, I8, I9, I14, I19, I26, I28). One proponent expressed frustration with the inability to move forward given the lack of engagement with other critical sectors:

The very sectors and actors that need to be at the table to actually create the reforms we need aren’t there. Education’s not at the table. The social protection communities aren’t at the table. The linkages to cash transfer systems and all those kinds of things, often they’re not there. The actors aren’t there and they’re not part of the conversation which are absolutely flawed because if you look at the reasons children are coming into care, it’s typically those reasons. And so it’s like we’ve got our eyes on the symptoms, not on the root causes and we’re trying to reform the sector but from a symptomatic perspective. And I think that’s one of the strategic flaws in the way we’re approaching it at this point in time (I5).

Some note disinterest or active resistance by these sectors in connecting their issues to children’s care because of resource constraints, bureaucratic red tape, or lack of awareness of how their issue relates. Several respondents note the education sector as the “biggest offender” (I2, I8, I9, I14, I26):

They don’t work with anybody and they’re such a big player and supporting interventions which would really improve outcomes for these kids...[But] they don’t want to share data or information because they also struggle with their own resource challenges and teachers are overburdened and [there is] a high turnover. [In] child welfare there is really no incentive to coordinate around this issue (I26).

We see that there’s an incredible linkage between childcare and education. If education is really poor, children tend to drop out of school. If they drop out of school, they start

working on the streets, then they start breaking away from the family. Or, if there's no schooling around, they get pulled out of the family to be placed somewhere much further away to have access to education. So, education is incredibly important, but very few educationists will see the linkages with it [children's care] (I8).

Proponents also acknowledge their own missteps in making connections with other sectors (I2, I5):

None of the key organizations that are working on children's care have an education strategy. Have a poverty strategy. Yet, what is on the global agenda? Poverty. Education (I2).

The greatest lost opportunity proponents note has been the inability to capitalize on the recent surge in attention for addressing violence against children (VAC) (I2, I3, I5, I8, I9, I12, I14, I21, I25), whose policy community, in the last several years, managed to secure a dedicated SDG, World Health Assembly Resolution, and United Nations appointment of a Special Representative of the Secretary-General for the issue. Respondents noted the close linkages of the two issues since both require a strong child protection system that is able to respond to violence, abuse, exploitation, and neglect, as well as a strong family, since children are usually best protected and cared for in a family environment (I9). Donors within the Elevate Children Funders Group, traditionally concerned with care issues, are perceived now to be doing more joint advocacy and communications around VAC (I25).

Despite some efforts to advance linkages with the VAC sector (Better Care Network and The African Child Policy Forum 2017; New York Working Group on Children without Parental Care 2014), some child care proponents believed that they themselves were in part to blame:

I think it's also partially our fault for not linking them more closely...It seems like a quite a strong link, but it's not one we are collecting evidence on or doing more research about, and I think part of that is also when funding goes down, you do a lot less, you're trying to continue your programs, you're not necessarily thinking let's do a global study (I9).

Some blame VAC sector actors for this disconnect, perceiving them to have "elbowed care issues out of the way" in their attempts to bring their issue prominence in the SDG discussions (I2):

The violence sector felt like it was convenient to narrow down violence and to narrow down the context and the system in which violence takes place in order to make it

exciting and palatable at the global level... They felt ‘neglect’ was too complicated. It’s hard to explain. Bear in mind, in the US or any other country....80% to 90% of child protection cases are neglect. Those actors were saying to us: ‘Forget the 80%, it’s too complicated to explain. Let’s focus on child sexual violence and physical punishment’ (I2).

They [those concerned with VAC] actually took us back 20 years...More and more donors are moving back to an even more siloed, even more narrow [approach] and putting all their eggs into the violence basket. And that is...utterly foolish. What is violence, if not care? (I2).

Several proponents note frustration with the VAC sector taking attention and resources away from the care sector (I2, I12, I14, I25), with attention to child care often only —at best— subsumed within dedicated organizational strategies for VAC (I14):

The donors are also drifting away [from care] because they go where they feel the momentum and the political will is...Donors are going to go for the violence because it’s got profile, it’s in the SDGs.... We [child care] only have guidelines whereas these guys [concerned with VAC] managed to get an international framework that every government has to report on (I8).

Unconvincing positioning

Differences surrounding problem definition have made it difficult for care proponents to address the challenge of positioning: advancing a clear case that will motivate policy-makers and civil society groups to act. Divergent approaches to child care reform lead to unclear messaging (I9, I18, I21, I29), and to policy-maker confusion concerning what they are being asked to do. Respondents note that each organization has its own message, and care reform proponents lack a “collective elevator speech” (I18).

Respondents express concern that the terminology actors in the sector use is ambiguous and complex, making it difficult to communicate to those working outside of care reform (I3).

As long as we can’t define what an institution is and what it looks like, it makes it hard to then advocate for governments not to support it (I9).

Many of us use ‘alternative care’. But it’s quite diffuse, it is not an English word. It’s kind of vague. Even within this sector it doesn’t seem to be super clear if ‘alternative care’ includes residential care because usually we talk about alternative care as non-

residential care or non-institutions...So, I think that is a problem for us, but also for ordinary people. You know, what does that mean? It's very vague (I25).

One of the difficulties with making the case for children's care are misperceptions individuals have about orphanhood being the problem (I29) and the best way to support orphans. These misperceptions encourage the institutionalization of children and orphanage volunteerism, and do little to strengthen communities and families. While coalitions of organizations, such as ReThink Orphanages (formerly Better Volunteering Better Care) and campaigns such as the 'The Love you Give', are trying to address this problem, it is difficult to redirect an individual's well-meaning support of orphanages via volunteering, donations, and faith-based mission work to support efforts to help strengthen and unify families. One respondent noted the difficulties in striking a balance in messaging that combats these public misperceptions, but that also does not deter the public from supporting children's care all together:

How do we nuance the message so that you can say: 'yes eager person wanting to volunteer overseas, we still want you to maintain your optimism and go and learn something but at the same time we don't want you to volunteer in an orphanage'...and the backlash of them thinking: 'oh well I thought I was doing something good and now I've been told I'm doing something bad, so I don't trust it at all and I don't want to do anything' (I9).

Another positioning concern, one even DI supporters acknowledge, is that they have placed too much emphasis on DI itself to the neglect of the role of family (I3, I6, I8, I18). The focus on institutions, the role of residential care, and DI in particular, are portrayed as the sector's end goal, rather than as a "stepping stone" (I19), or one among multiple goals. As a respondent notes:

The important unit here is family and preserving family wherever that is in the interest of the child and recognizing the reasons for families falling apart when they do, [and] how do you address those. This is very different from the focus of others which is kids are in institutions, you've got to get them out of institutions. To do that, you've got to strengthen the families (I8).

Respondents say that while DI is solutions-oriented, in demanding the closing of institutions proponents over-emphasize the problem and lack a positive messaging that might be attractive to decision-makers (I3, I11, I25). Several respondents described this difficulty:

You can't inspire somebody to undo something. You know? You can't inspire them to undo the smoking or the drinking or bad-mouthing women....You can only inspire them to be bigger and better and that's really I think what's really missing (I11).

[DI] is about what you don't want to have. It's negative rather than saying what you want to achieve and want to support (I25).

Some also note their concern about how the current DI messaging alienates and hinders meaningful engagement of the most important stakeholders on this issue—affected children and parents—instead giving prominence to the roles of government officials and orphanage personnel in the child care reform process:

Parents and children have been a real lacking group of people for me in this field, I haven't heard a lot about the parents; I haven't heard a lot about the children. I've heard a lot about the governments and a lot about the orphanage leaders, but I haven't heard a lot about the real agency in the room (I11).

Respondents noted how a focus on the family rather than discussions explicitly calling for DI were more likely to resonate with governments (I10, I11, I19):

[Care proponents were] having debates about small group homes and then you just have to give them a reality check and say: 'Listen guys, this is not going to fly politically. We can argue as much as we want, but if you go and talk to them about institutions as your first point of call, they're not going to listen to us.' Once you start talking about family, they're more open to that, it's less controversial...I mean because everybody agrees you should support the family, everybody agrees that the child should grow up with a family (I19).

Strategic considerations for advancing global priority for children's care

Given the scope and severity of the problem, global priority for children's care remains insufficient. While multiple factors hinder priority generation—many not directly under the control of the set of global actors concerned with the issue—one factor connected to this set of actors is influential: problem definition disagreements pertaining to the acceptability of care arrangements that are not family-based, and DI as a care reform strategy. Multiple factors have shaped these disagreements, including a weak evidence base on the scope of the problem and solutions, divergent experiences between former Soviet bloc and other countries, and commercial interests that perpetuate support for residential facilities. These problem definition

disagreements contribute to difficulties on governance—establishing global institutions to facilitate collective action—and positioning—framing the issue to attract the support of policy-makers and civil society organizations.

Despite these challenges, several developments portend well for priority generation. Multiple forums and networks aimed at bringing champions together are in place, including the Elevate Children Funders Children’s Care Working Group, the Better Care Network, the Geneva Working Group on Children Without Parental Care (now a thematic Working Group under Child Rights Connect), the Coalition on Children Without Parental Care (formerly the Children without Appropriate Parental Care Working Group), and an emergent ‘Better Collaboration’ group. Also, the year 2019 presented opportunities for mobilization, with the thirtieth anniversary of the UN Convention on the Rights of the Child and tenth anniversary of the UN Guidelines for the Alternative Care of Children. Perhaps most significantly, the United Nations General Assembly (UNGA) selected ‘Children without Parental Care’ as the theme for the ‘Rights of the Child’ resolution for 2019. This catalyzed unprecedented discussion and unification among care sector proponents, as reflected by the agreement of hundreds of care sector actors on a set of key recommendations for the UNGA resolution that address key challenges and opportunities in implementing the rights of children without parental care. Many organizations are collaborating to support the organization and content of a day of general discussion on the UN Resolution’s provisions on alternative care, to be held in September 2020. Furthermore, data are growing on which interventions are most effective to support children in families, prevent unnecessary separation, and provide quality alternative care when they cannot live with their parents or families.

Advancing global priority for children’s care will require that proponents address the impasses that exists within their community. Proponents are unified by a deep concern for the well-being of children who lack adequate care. But they are divided deeply by disagreements on how best to address this problem, resulting in a number of acrimonious relationships among policy community members. The situation inside the community has features of a hurting stalemate, with entrenchment of policy positions as one of the central problems the children’s care sector faces. Needed are venues to bring actors together that enable them to stand back from certain

beliefs and consider the policy positions of those with whom they disagree: for DI supporters to consider the limits of the current strategy and for DI critics to consider its merits. Immediate policy windows and crises may provide motivation to do so. The UNGA resolution presented a significant recent opportunity, where significant traction was made to overcome historical divides. Other opportunities include the possibility of building on the attention now being given to preventing violence against children, and the imperative to address present children's care crises, including those pertaining to Syrian refugees and Central American migrants to the United States.

Without transcending problem definition difficulties, it will be difficult for proponents to manage other strategic challenges, including developing a convincing positioning that motivates policy-makers and donors to act. In particular, proponents will need to consider how focus on the issue of child care reform may have crowded out attention to other critical components of the children's care agenda such as family strengthening, and the potential value of frames that better encompass the wider agenda. Also, proponents will need to consider how to surmount ambiguity surrounding terms such as institutional care, residential care, and alternative care, communicating in ways that key audiences understand. In addition, proponents will need to specify what exactly they are asking of policy-makers and of well-meaning individuals who want to support vulnerable and orphaned children, identifying simple, positive actions.

Better positioning strategies will also help with coalition-building—creating alliances with other sectors necessary for advancing the children's care agenda. Care proponents will need to strategize about how to gain seats at the table of entities that exercise leadership in other sectors—such as the Global Partnership to End Violence Against Children and the Global Partnership for Education—to ensure these and other forums actively consider concerns related to children's care. Finally, while some efforts of this kind are emergent (i.e., Better Care Network 2019b), care proponents should explore avenues to pursue more active engagement with the disability community, as well as families and children directly affected. Not only will such engagement increase the care sector's legitimacy and improve its visibility, it will also expand the set of grassroots allies that can advance children's care.

The experience of another global policy community is worth considering with respect to transcending differences (Shiffman and Smith 2007; Smith and Rodriguez 2016). From the mid-1980s through the early 2000s a global community of individuals and organizations concerned with reducing maternal mortality made little progress in generating priority for the issue, fractured by disagreements over how best to address the problem. Some advocated for the provision of emergency obstetric care; others called for a focus on skilled attendance in childbirth. All major meetings of this community were dominated by this debate. In the mid-2000s, recognizing that their policy disagreements were hampering their credibility and capacity to move policy-makers to action, leaders of these factions found ways to transcend their disagreements, deciding to advance a unified three-fold strategy to address maternal survival: provision of emergency obstetric care, ensuring skilled attendance at birth, and making available widespread access to reproductive health services including family planning. Since the mid-2000s maternal survival has become a prominent global development issue as evidenced by its central place in the MDGs and SDGs, donor provision of extensive resources and the priority the issue receives on national policy agendas. While not the only reason for the rise of attention and resources, the maternal survival policy community's management of disagreements was one factor, as it enabled that community to come together as a cohesive force, pushing international organizations, donors and national governments to act.

Within the children's care community, challenges surrounding problem definition are considerable; however, proponents have many advantages, not least of which is a shared concern over the well-being of children at risk. Given this and other advantages, there is no reason to believe that this community cannot replicate the experience of that of the maternal survival community, finding ways to transcend differences and become a powerful and cohesive agent of change to advance the children's care agenda.

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