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Charitable Children Institutions in Kenya: Factors Influencing Institutionalization of Children

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Background

Kenya has approximately 2.4 million orphans and vulnerable children and it is estimated that 30-45% of these children end up in institutions (Government of Kenya 2014: 4). According to the alternative care guidelines (ibid 2014), children who are most likely to end up in these institutions include: children living with HIV/AIDS, children living with disabilities, orphans and vulnerable children, and children abused, neglected, and exploited. These children live in conditions that would generally be considered difficile. Locally, news and reports have cast doubt on whether this spaces are caring or despairing spaces for children due to rampant neglect, abuse, and exploitation. For example, between April-June 2014, Mathew Durham a missionary from Oklahoma was found guilty of defiling around 10 children in a residential care center, (Rawstone and Allen 2014), another American, John Ott who had established an orphanage in Kenya was also sentenced for 20 years for having sexually abused 14 children (Karanja 2014). Similarly, a British Airways pilot Simon wood was found guilty of molesting girls in institutions during stopovers in Kenya (Press Association 2014). Furthermore, research globally has detailed the long term socio-emotional and psychological damage associated with this model of care. For example, Browne (2009:1), referring to a wide body of research shows that children in institutional care 'have reduced intellectual, social and behavioral abilities compared to those growing up in a family home'.

Introduction: A Long View and 3-D Wellbeing Approach

Despite institutionalization being widely condemned due to malpractices and the deleterious effects aforementioned, proliferation has persisted, and hence this essay tries to unwrap the basis of this proliferation. This is an area that has received less attention, and more likely, it is as a result of this inattention that many actors have continued to respond to the 'orphan' crisis through narrowly defined approaches that seem to tackle symptoms; for example, poverty, disability, HIV/AIDS, neglect, abuse and exploitation rather than the underlying factors causing the proliferation of institutions. That said, I will use two approaches to understand this phenomenon of proliferation. First, a 'long view approach', this approach looks beyond symptoms aforementioned. By using the approach I will endeavor to show not only the factors perpetuating the practice, but also how the neglect of the approach can perpetuate institutionalization, and probably using it might de-escalate institutionalization. This approach according to Sebates-Wheeler (2009: 115) can be realized through 'Transformative Social Protection (TSP)' which she argues 'looks beyond the manifestations of vulnerability to the underlying structural causes of vulnerability with a view to identifying a complementary set of interventions that aim to transform the initial condition that generated vulnerability and deprivation'.

The second approach I will use is the 3-D well-being approach; this is an approach that looks both at the child and the community as a unit of inquiry. This approach according to Sumner (2010:1066) 'takes account of material well-being, subjective well-being and relational well-being and their dynamic and evolving interaction'. For

a long time, many actors have had a tendency to define child protection as a 'discrete policy area' (Myers and Bourdillon 2012: 613). Interventions related to institutionalization have narrowly focussed on food, shelter and clothing and medical care which in this case is narrow and incomprehensive. With a 3-D wellbeing approach I will look at how this narrow approaches seem to influence institutionalization and how negating a 3-D well-being approach seems to perpetuate and socially reproduce institutionalization. Against this backdrop, this essay will first look at how de-institutionalization efforts in the north are not reflected in the south. Second, how the existing institutional frameworks are just a rhetoric from government, and due to lack of oversite and implementation the government has allowed institutions to flourish. Third, how child poverty and narrowly targeted programs perpetuate institutionalization. Fourth and finally, factors contributing to institutionalization of children living with HIV/AIDS and disabilities.

De-institutionalization in the North- Institutionalization in the South

Globally as alluded to earlier, institutional care which is historically a western model has faced well-meaning criticism due to abuse, neglect, and exploitation of children. Although significant and positive strides have been made against proliferation of the model in the north, the opposite has been experienced in the south. Unfortunately and ironically de-institutionalization efforts in the south have significantly been hampered by the same north, and Kenya like majority of other African countries has continued to experience proliferation (Williams and Njoka 2008: 21). Majority of the institutions are privately funded (Stuckenbruck 2013:4) by the north where the practice is significantly being effaced.

The idea of existence of institutions in the north elicits negative undertones of the inhuman deprivation and cruel treatment of children in the former Soviet Union in the 1990's. Equally, subsequent Eurocentric research on the practice which has continuously revealed the deleterious effects of the model has fervidly discouraged the practice in the north. Consequently, some countries in the north have even gone ahead to investigate and litigate key historical actors that perpetuated a practice that is abusive, exploitative and neglectful. This includes Irelands 9 year period enquiry which uncovered how some nuns and catholic priests sexually assaulted and physically abused children under their care and the government's failure to address the issue (McDonald 2009). Similarly, the 2004 Australian, senate enquiry on "forgotten Australians" which revealed rampant "endemic humiliation and sexual violation" in the care institutions. That said, although the north plays a fundamental role in influencing the proliferation of the practice; there is a need to understand the underlying forces within that influence. The following section will start by analyzing the Kenyan government's frameworks and the status of their implementation.

The Government and the Rhetoric's of Institutional Frameworks

Since gaining independence, the Kenyan government has indeed developed particular progressive laws, policies and guidelines meant to protect institutionalized children.

These includes:The Children Act 2001, Guidelines for the Alternative Family Care for Children in Kenya launched in 2015, and The Best Practice Standards for Best Practices in Charitable Children Institutions, launched in 2015. However, these laws and policies have dominantly targeted institutional care and unintentionally and subtly reinforced institutional care as a default model at the expense of other alternatives (kinship-care, foster-care and guardianship) which seek to preserve, strengthen and support families. The government acknowledged this gap, and accepted its failure of a lack of policies to reinforce the alternatives (Government of Kenya 2014: 13) and subsequently developed the progressive Guidelines for the Alternative Family Care of Children in Kenya which were launched in March, 2015. Ultimately, the functional failure of the government previously not acknowledging and supporting these alternatives in the frameworks could have greatly contributed to proliferation of institutions. In addition, most of the existing policies and guidelines have remained largely rhetoric, the government has not done enough to strengthen and support the aforementioned alternatives. For example, very few orphaned and vulnerable children within kinship care, guardianship access the needed support. And due to poor investment in children issues, in 2013 Kenya dropped 15 places down on child well-being after having been ranked 6th in 2008 (African Child Policy Forum 2013: 81).

Related to governments poor investment in children's issues is that the government of Kenya has continued to largely rely on charity. The government relies on meagre private donors support in provision of social protection services to orphans and vulnerable children (UNAIDS 2010). A similar study by USAID (2009), country analysis affirms this by showing that private donors provide approximately 91 % of services to orphans and vulnerable children as opposed to 9 % by the government. Furthermore, through the Ministry of labour Social Security and Services (Department of Children Services) the above frameworks identify the government as the primary duty-bearer in protecting children. Unfortunately, according to Cooper (2012: 495), 'the existence of laws and protocols cannot be trusted as indicators of success in protecting vulnerable children'. Despite these frameworks proliferation of unregistered and unscrupulous institutions has been witnessed due to lack of monitoring and oversite by the government (Williams and Njoka 2008: 21). As a result of this laxity and apparent lack of accountability to the children; unscrupulous organizations have flourished where children are exploited, abused and neglected, a charity approach has flourished that allows malpractices such as voluntourism and inter-country adoptions to thrive.

According to Cheney (2014: 247), Africa has become the newest frontier of the lucrative inter-country adoption industry and consequently experienced rampant commodification of children. Inter-country adoption has not only led to commoditization of children, but also rampant institutionalization of children. However, locally in Kenya, the government banned inter-country adoptions after the pervasive illegitimate inter-country adoption practices in institutions were exposed (Nation 2014: 1) Figures from a government commissioned study reflected abnormal high statistics of inter-country adoption, the local adoptions between 2003-2008 were approximately at 62 % against 38% in inter-country adoption (Williams and Njoka

2008:4). These statistics were unduly high because Kenya is a signatory to the Hague inter-country adoption which accentuates the subsidiarity principle (International Social Service 2007: 1), meaning it unequivocally gives priority to local adoption as opposed to Inter-country adoptions and hence the number of children being placed in inter-country adoptions should have been significantly lower.

After these malpractices in inter-country adoption were exposed, banning Inter-country adoption was indeed welcome; but this ban should be seen as a stop gap measure and not a solution because it does not address the underlying issues. Having said that, there is a need to understand first 'why and how children are first separated from their parents' (Stuckenbruck, 2013: 11). In other words, there is a need to understand the social dimensions of vulnerabilities that lead to abandonment, and/or factors that lead to parent(s) relinquishing children to institutions where they get adopted. Despite scanty research, structural forces are still considered influential in the relinquishment, and Stuckenbruck (ibid 78) alludes to this by saying, 'just as impoverished parent(s) often believe that placing their child in a residential care institution may be a way of securing their wellbeing; they (parents) may also be induced to provide consent or persuaded to make ruthless decisions for their children's adoption' through these institutions.

Beyond inter-country adoption, Africa has also become a frontier of a growing trend called voluntourism. This praxis according to Tomazos and Butler (2009: 196) involves groups and individuals combining their vacations with charity work for worthwhile causes. However, not all this causes are worthwhile. 'Orphanage tourism' is an increasing trend which has significantly expanded since the early 2000's. Developing countries have experienced voluntourists flocking into orphanages (Better Care Network 2014). This practice although scarcely documented in Kenya it is rampant and more research needs to be conducted to understand what drives it and its extent. A fundamental component of this practice is that voluntourists, especially from the west pay to work in the institution (Tomazos and Butler 2009: 196). However, sometimes they fund them without engaging in work.

The funding of these institutions seems to contribute to the sustenance and proliferation of orphanages (Better Care Network 2015). These funding seems to lead to 'manufacturing' of orphans by unscrupulous individuals and organizations in the sense that children who are not supposed to be in orphanages are exploited by being removed from families and communities into these institutions and used as baits for funding. Although most of the criticism is directed to the voluntourists, the government is equally responsible. It is the government's failure to regulate, and monitor such practices to ensure that only particular children who fit a certain criteria get into institutions and that it is a last resort. In addition, It if its poverty pushing families to relinquish children to care facilities then indeed by just banning voluntourism and removing children from institutions and leaving them as impoverished as they came in does not address the core issues.

Children and Poverty

As alluded to earlier, poverty seems to be the leading cause of institutionalization in Kenya (Stuckenbruck 2013:31) Consecutively, O'Neill and Zinga's (2008:40) have hence argued that the term orphan is a misnomer when used in reference to the vast majority of children in institutions as nearly all have living parent(s) or contactable relative(s). According to the Word Bank (2008:2), almost 47 percent i.e. nearly half of the Kenyan population lives below the poverty line. Furthermore, 60% of children aged between 0-17 are said to be living in child poverty (de Milliano and Plavgo 2014:20). From a 3-D wellbeing approach, children are multi-dimensionally and disproportionately affected by poverty compared to adults. They experience complex socio-emotional, cognitive, physical processes and are vulnerable to abuse, neglect and exploitation from adults (Sebates-Wheeler 2009: 109). Poverty is indeed a threat to not just the progenies of Kenya but also the society as a whole. But the issue of proliferation of institutions is more nuanced than assumed in institutionalization discourses, it encompasses intricacies of structural violence, child protection, private actor's attitudes and practices, and governments (in)actions. Actors, through massive aid from the west continue to forage the slums and villages to 'rescue' and 'save' children. The mushrooming of Institutional care could be attributed to the fact that actors have dominantly been narrowly responding to symptoms of childhood poverty, for example, malnutrition, poor health, orphanhood, lack of education, hunger, abuse, neglect, and exploitation. This is not to say there is no need to intervene in some circumstances, but as Sebates-Wheeler (2009: 115) puts it, there is need to 'take the long view'; to identify, examine and analyze the underlying factors in order to intervene appropriately.

First, removing a child from a community or a family to an institution due to poverty is not only narrow but also a gross misdiagnosis that reinforces their social exclusion. These children are forced to identify as poor and kept in spaces for the 'poor, orphan and vulnerable', in this case institutions. Montgomery (2013:63) quoting a research, points out that despite these children's deprived/ impoverished situations, 'few wish to identify themselves as poor or want to claim membership to such a highly stigmatized group and strive to portray themselves as normal'. Also important to reckon is that ad hoc removal children from a family or community disrupts local systems of community care; that is care and protection in the family and in the community.

Most organization that remove children from communities have decontextualized children and focussed mainly on their material well-being. This neglects alignment of interventions to fit the socio-economic circumstances and involving families and communities' (Myers and Bourdillon 2012: 615). A 3-D well-being approach embraces not only the material needs, but also the community as unit of inquiry. It emphasizes the need to look at children as relational beings embedded within the wider community (Sumner 2010: 1066). The essence of a community cannot be ignored, it is an important space of socio-emotional support, belonging and identity. Simplistic interventions that focus just on material aspects seem to also criminalize poor parent(s), kin networks, and community members because they cannot

adequately meet these needs. A TSP approach suggests a broader frame of reference by looking at the need to change the conditions of the caregivers and also of communities that generate the structural vulnerabilities/ violence (Sebates-Wheeler 2009: 116). In this case, conditions that might lead or predispose them to relinquish children to institutions.

Second, institutional care may also be thriving because of its pre-packaged and imposed nature. This practice tends to isolate and subordinate children; children are viewed only as perceive recipients of services, consequently ignoring their agency. In a conference report (KESCA and KOBWA 2014: 8) some participants said they were removed from their families against their wishes. Not to romanticize agency, but the ad hoc removal of children from families clearly is a cause of concern. Agency is a key component of both TSP and 3-D wellbeing approach. TSP suggests the need for actors to regulate behavior towards vulnerable groups by acknowledging the power differences in terms of voice (ibid 116). Similarly, a 3-D wellbeing approach emphasizes children participation in all decisions that affect their lives (Sumner 2010:1069). And not just participation, but also integrating their views in decision making (Myers and Bourdillon 2012: 617).

Third, the targeted approach to orphans and vulnerable children in institutions seems to not only reinforce and accentuate their social exclusion and vulnerability but also seems to perpetuate institutionalization. More and more desperate biological parent(s) who are socially excluded from these 'orphan' targeting programs are often compelled to relinquish their care responsibility to these institutions. For example, some young people have reported that their care givers gave them up to institutions for a 'better life' (KESCA and KOBWA: 2014). Likewise, some children who are not orphaned but equally materially deprived have been forced to fashion survival tactics where they claim vulnerability by identifying themselves as 'orphans' and consequently end up in institutions. Having looked at the nexus between poverty and institutionalization of children, the following section examines and analyses the structural factors, and attitudes that lead to institutionalization of children living with HIV/ AIDS and disability.

Children living with HIV/AIDS and Disabilities and Institutionalization

The HIV/AIDS pandemic has indeed continued to cause havoc in Kenya despite significant interventions by the Government and non-governmental actors. According to the National AIDS Control Council, the number of infections rose from 1.4 to 1.6 million in 2013 (Government of Kenya 2014:7). The alliance between the pandemic and death has disintegrated and overstrained the extended family networks, and consequently created more orphans (van Blerk and Ansell 2007:866). However, responses and attention have been significantly on exploitation, abuse, neglect and violence (Pells 2012: 563).

These responses to interpersonal abuse and violence as Pells identifies them (Ibid 562) have somehow contributed to mushrooming of institutions that exclusively target children living with HIV/AIDS. The responses have not only detached these children from the broader political and structural forces, family and community context but also from the underlying attitudes towards them. Most poor families lack adequate

livelihoods to provide to themselves and their children; they lack adequate access to health care too and as a result of these oppressive impoverished conditions they are forced to make ruthless decisions of sending children to institutions. On the other hand, stigma and discrimination are still rife in Kenya (NEPHAK 2011: 8), and as a result some caregivers prefer sending children to institutions to negotiate ridicule, discrimination and stigma. From a long view perspective, if it's the discriminatory attitudes and perceptions towards children living with HIV/AIDS that are responsible for institutionalization, then intervening at the source of the problem by actors is advised.

Besides children living with HIV/AIDS, children living with disabilities have increasingly been subjects of institutionalization (Pinheiro 2006: 4). In Kenya, 4.6 % of the total population are people living with disability (Government of Kenya 2008: 9). In Africa, disability is associated with rampant levels of poverty and disease (Ansel 2005:215). Moreover, harmful traditional and historical attitudes towards people living with disability are still flagrant in some communities in Kenya. For example in Kenya National Survey of Persons with Disabilities report (Government of Kenya 2008: 18), 57 % of the disabled participants reported negative attitudes towards them was a major concern. Consequently, children with disabilities are also viewed as a burden and bad omen to their families and communities. As a result of these attitudinal issues, some parent(s) may decide to: hide their children in homes, abandon them, where most likely they will end up in institutions or blatantly relinquish them to institutions. On the other end, structural factors are dominant, and reports indeed suggest significant levels of livelihood deprivations amongst people with disabilities (ibid: 16). The government is not doing enough to support families willing to help support their disabled children within communities. There are hardly any community rehabilitation centers, the infrastructure are poor and inadequate in both urban and rural areas, few accessible schools exist and those present are normally very expensive. These structural problems leave but little option for many parents but to send their children to institutions.

Lastly, and worth noting, it is not just children living with HIV/AIDS and children living with disabilities who end up in institutions due these attitudinal factors and social behaviors. But also girls who are rescued from female genital cut, and early marriages.

Conclusion

In conclusion, the subject of institutionalization has been widely discussed and debated globally and locally. However most of the discourses are predominantly on the socio-emotional, and developmental ramifications of institutionalization and few studies have hardly sought to understand underlying factors that perpetuate the practice. In order to understand these underlying factors, the essay used a 'long view approach', and a 3-D well-being approach. First, from the findings it is clear that the government has significantly failed in the oversite and monitoring of the practice as provided in the existing legal frameworks and hence allowed proliferation and malpractices. Second, the government has significantly failed to support the alternatives to institutional care, for example kinship care and guardianship and this has somehow contributed to increased institutionalization of children. Third, most

intervention by non-state actors have significantly negated a long view approach and extensively chosen the easier path to address the symptoms and signs more than the underlying structural factors. This essay has also essentially looked at the nuances within poverty, HIV/AIDS, and disability that seem to contribute to institutionalization of children. The essay has acknowledged that it is not just the social-economic and political structures that play a significant role in perpetuating the practice, but also negative discriminatory and stigmatizing attitudes towards people living with disabilities and HIV/AIDS.

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