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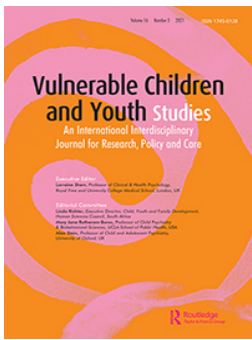
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Monitoring the situation of children living in residential care: data gaps and innovations

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ABSTRACT

Worldwide, an estimated 2.7 million children live in so-called orphanages or other residential care facilities. This figure is likely an underestimate, however, since many low and middle-income countries lack reliable data on this issue.

To address this gap, the United Nations Children's Fund (UNICEF) has developed a comprehensive tool to collect data on children living in residential care. It is comprised of a protocol that outlines the recommended steps for gathering data, 12 data collection tools, and an implementation package covering everything from sample design to the dissemination of the findings. The package is designed to generate information on the number and location of all residential care facilities in a country, the number and basic characteristics of children living in them, as well as selected measures of their well-being. The survey gathers data from children and their caregivers using existing measures of child well-being that can produce data for reporting on a number of key child-related indicators, including those that comprise global monitoring frameworks such as the Sustainable Development Goals.

The purpose of this article is to describe the process of testing and piloting the UNICEF protocol on children in residential care in three countries: India, Ghana, and Kazakhstan. The methodology employed in each country is briefly described along with some of the key challenges faced, and lessons learned, from implementing the protocol in these three diverse settings.

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Introduction

Worldwide, an estimated 2.7 million children live in so-called orphanages or other residential care facilities (Petrowski et al., 2017). This figure is likely an underestimate, however, since many low and middle-income countries lack reliable data on this issue.

The toll institutionalized care exacts on nearly all aspects of child development is astounding, and the costs are particularly high for children under the age of 3, who risk lifelong consequences: impaired social and interpersonal development, difficulties forming secure attachments to caregivers, delayed cognitive and language development, poor nutritional status, and a heightened risk of exposure to abuse, to name a few (DeLacey

et al., 2020; Berens & Nelson, 2015; Konstantopoulou & Mantziou, 2020; Strijbosch et al., 2015). These impacts stemming from early adversity can persist over time, and the losses in health and productivity are felt even at the societal level (Rutter, 1998).

As is well known, a nurturing home environment and stimulating social interaction are essentials for healthy development (Shonkoff et al., 2012). They lay the groundwork for children to realize their full potential in later years. It has also become clear that, in some countries, it is not the loss of parents, per se, that typically leads to the institutional care of children. Rather, poverty and its consequences, including family breakdown and poor or unequal access to services, are often to blame.

Persistent data gaps

Growing recognition of the potential dangers of institutionalization has prompted many countries to reduce the number of children living in residential care. However, before a country can close such establishments and move children into foster or adoptive families – or reunite them with their birth families – they must first understand the number of children this involves and how they got there in the first place.

This seemingly straightforward task has proved to be anything but, since many countries lack a functioning system for producing accurate figures on the number of children living in residential care (Petrowski et al., 2017). Traditional household surveys and censuses systematically exclude children who do not live in households, while administrative records maintained by ministries and service providers are often unreliable and inconsistent. In fact, in many countries, official records capture only a small fraction of the actual number of children living in residential care, and children in privately run centers are often not counted.

In the absence of systematic data collection, a number of studies have been conducted over the years across a wide variety of contexts and regions in an attempt to understand the scale, profile, and well-being of children living in residential care. These studies had several purposes: Some aimed to count the number of residential care facilities in a country or region as well as the number of children in these facilities (see, for example: Frimpong-Manso et al., 2018). Others took a sample of institutions and extrapolated to estimate the number of children in residential care nationwide (Stark et al., 2017). Still others surveyed institutionalized children themselves to find out more about who they are and how they are faring (see, for example: Rouski et al., 2020; Tatsiopoulou et al., 2020; United Nations Children’s Fund, 2006). So far, however, no study has combined these different aims to produce data on both the number and well-being of children in residential care. And, while these studies provide useful information, most are not comprehensive in their coverage of institutions nationwide. Furthermore, they are uneven in terms of their scope and methodological rigor. Nor are they comparable, because different researchers asked very different questions and used very different approaches to collect the data.

Drawing from lessons learned and building on these previous exercises, UNICEF, with support from the US Agency for International Development (USAID), has developed the first-ever comprehensive package to collect data on children living in residential care (United Nations Children’s Fund, 2020). It is comprised of a protocol that outlines the recommended steps for conducting two phases of data collection, 12 data collection tools,

and an implementation package covering everything from sample design to dissemination of the findings. It is designed to generate information on the number and location of all residential care facilities in a country, the number and basic characteristics of the children living in them, as well as selected measures of their well-being. The survey gathers data from children and their caregivers using existing measures of child well-being that are being used to produce data for reporting on a number of key child-related indicators, including those that comprise global monitoring frameworks such as the Sustainable Development Goals.

The purpose of this article is to describe the process of testing and piloting the UNICEF protocol on children in residential care in three countries: India, Ghana, and Kazakhstan. The methodology employed in each country is briefly described along with some of the key challenges faced, and lessons learned, from implementing the protocol in these three diverse settings. It should be noted that while different terminology is used across contexts, the term ‘residential care facilities’ (RCFs) is used in this paper to refer to non-family-based group settings (United Nations General Assembly, 2009).

Protocol and tools for a census and survey on children in residential care

The collection of data on children in residential care is achieved through two phases of data collection.

Phase One maps all facilities found in official government records and identified by key informants. Data are collected on some key characteristics of the residential care facility, and a roster is compiled to generate a complete listing of all residents living in it and record their basic characteristics (age and sex). An Observation Checklist is also completed to capture basic information about the facility’s infrastructure, availability of amenities, and any obvious signs of health or safety issues. Finally, a physical count and visual verification is conducted to confirm the presence of all the children listed as residents in the roster. The facility director or other designated official responds to questions during Phase One.

A two-stage stratified sampling approach is used to draw a sample of facilities and children for Phase Two, using the Phase One census as a sampling frame. Facilities are selected at the first sampling stage using probability proportional to size, based on the number of children in the facility. Stratification variables differ across countries. A fixed number of children for each age group (i.e. 0–4 years, 5–14 years, and 15–17 years) within each sampled facility is then selected at the second stage.

Phase Two questionnaires were developed and adapted from the standard questionnaires used in the sixth round of the Multiple Indicator Cluster Surveys (MICS6) as well as other validated tools on experiences of some forms of violence and resilience. Questionnaires are administered to caregivers on a representative sample of children living in the facilities between the ages of 0 and 14 years. In addition, direct interviews are conducted with a representative sample of adolescents between the ages of 15 and 17 years. There is also a questionnaire for social workers/caseworkers for each randomly selected child and adolescent aged 0 to 17 years. [Table 1](#) summarizes the content of all the questionnaires/tools across both phases of data collection. The surveys in India and Kazakhstan also included a breastfeeding and dietary intake module for the

Table 1. Questionnaires/tools used in the two phases of data collection

Phase One			
Facility Questionnaire	Facility Roster	Facility Observation Checklist	Verification Count and Record Review
Facility characteristics	List of residents	Physical interior and exterior of the facility	Verification count
Staffing characteristics	Basic characteristics of residents	Basic amenities	Record review
Water and sanitation Sleeping arrangements	Roster of exited children	Health and safety issues Materials for children	
Phase Two			
Questionnaire for Children under 5	Questionnaire for Children 5-14 Years	Questionnaire for Adolescents 15-17 Years	Questionnaire on Children's Case History
Child's background	Child's background	Adolescent's background	Child and adolescent case history
Care of illness	Child's work and activities	Adolescent's work and activities	
Early childhood development	Child functioning	Adolescent functioning	
Child functioning	Child discipline	Mental health	
Child discipline	Foundational learning skills	Adolescent discipline	
Anthropometry		Violence and unintentional injuries Resilience	

children under 5 questionnaire and a life satisfaction module and menstrual hygiene management module (the latter administered only to girls) in the adolescent 15-17 questionnaire. Kazakhstan also added questions on sexual violence in the adolescent questionnaire.

In India, the Phase Two follow-up survey only was piloted in the state of Karnataka in March 2020. A previous mapping of all residential care facilities had been carried out in 2019, and this listing (which included 886 eligible RCFs and 37,571 children) served as the sampling frame for the survey. A sample of 120 RCFs and 1,032 children were selected. As the Phase Two survey was implemented during a period that included the COVID-19 lockdown in the country, however, it was only possible to conduct interviews in 68 facilities (out of the 120 sampled), and only roughly half the planned number of interviews were completed. The sample weights for calculating results were adjusted to account for this nonresponse at both the facility and child levels. Questionnaires were customized as needed and translated into the local language of Kannada. The India team obtained local ethical clearance.

In Kazakhstan, data were collected only in the Karaganda region in March 2020. Initially, the plan was to conduct data collection for both phases in all 23 residential care facilities. However, due to the COVID-19 pandemic, five facilities were placed in lockdown during the period of data collection so only 18 facilities were visited, and interviews for Phase Two were conducted on a sample of 258 children. Because all of these facilities had children between the ages of 14 and 17 years, and this closely corresponds to the 15-17 age group, the adjustment of the basic weights for nonresponse was limited to this age group.

Questionnaires were customized as needed and translated into both Russian and Kazakh. The protocol received ethical review and clearance from the Health Media Lab (HML) Institutional Review Board (IRB) in Washington, D.C.

In Ghana, 148 residential care facilities were visited during Phase One in November 2019; 139 were eligible, and all completed data collection for a response rate of 100%. The census frame generated in Phase One was used to select a sample of 48 RCFs and 552 children for Phase Two, conducted in December 2019. The response rates were as follows: 92% for caregivers of children under age 5, 90% for caregivers of children between the ages of 5 and 14 years, and 75% for adolescents aged 15 to 17 years. The response rate among social workers (for children of all ages) was 92%. Questionnaires were customized to be understandable in the local context and translated into four local languages (Ga, Twi, Ewe, and Dagbani), although most interviews were conducted in English. The protocol was reviewed and approved by the Ghana Health Service's Ethics Review Committee.

Observations and lessons learned from the pilot exercises

Generating the facility roster

Preparing the list of residents in each facility proved to be one of the more difficult, and time-consuming, aspects of implementing the protocol. For instance, in the case of Ghana, there is no centralized database of children living in residential care; as such, records are maintained by each individual facility, some in electronic format (as was generally the case with those that were larger and government-run) and others only as handwritten records. Regardless of format, the process of building the roster was often tedious, and interviewers frequently had to consult with facility staff to ensure the listing was complete and updated. It was found to be helpful to request the facility to print out or have the records ready in advance of the data collection team's arrival to facilitate and speed up the process. The situation differed considerably in Kazakhstan, where the Government has a web-based information management system for tracking children in institutions. As a result, a roster of the name, age and sex of each child in the residential facilities in Karaganda was obtained prior to beginning data collection in the field. Data collectors relied heavily on these pre-existing registries to generate and verify the Facility Roster.

Conducting the verification count

One of the most critical components of the protocol is carrying out the verification count as a means of verifying the Facility Roster to ensure it accurately reflects all those children currently residing in the institution. Because this necessitates the physical presence of all children in the facility, it sometimes required fieldwork teams to return at a later time when most children were expected to be present or to wait until a time when children were around (such as after school hours). Careful monitoring of fieldwork teams, especially when implementing this tool, was often necessary to ensure adherence with the protocol and fieldwork procedures.

Testing a measure of mental health

The Questionnaire for Adolescents 15–17 originally included the Revised Children's Anxiety and Depression Scale (RCADS), Youth version short form (Chorpita et al., 2000), a self-report measure of symptoms of anxiety and depression. The results generated from application of the RCADS in Ghana were inconclusive and difficult to interpret (for example, no adolescents reported symptoms of depression that exceeded cut-off scores). It was ultimately felt that the questions were not specific or sensitive enough to reliably capture symptoms of anxiety or depression among this population. Additionally, many of the questions were found to be especially sensitive, and respondents (adolescents living in care) often became visibly upset during the interview. In light of these observations, the decision was made to remove the measure from the protocol for the time being since methodological work is ongoing to develop a revised version of the RCADS for use in household surveys that could potentially be tested for use with children living in residential care at a later stage.

Testing questions on sexual violence in Kazakhstan

In Kazakhstan, a module was added to the Questionnaire for Adolescents 15–17 to capture self-reported experiences of various forms of unwanted sexual contact experienced since arriving in the facility. These ranged from sexually suggestive comments to unwanted sexual touching and physically forced sexual intercourse. Consent was obtained prior to administering the module. However, only 29% of the adolescents interviewed (n=101) consented to answer the questions related to sexual violence, compared to the overall response rate among adolescents of 67%. Among the few (n=53) who did consent, none reported experiences of sexual violence of any type. The decision was made not to include the sexual violence module in the protocol given the low response rate and in light of observations from the field suggesting that the questions were sometimes perceived as being awkward, intrusive, and lacking sensitivity and would require significant revision. As there is currently no dedicated and validated set of questions on experiences of sexual violence for use with this population, other existing measures would need to be tested in the future to explore their feasibility to reliably collect such data on children in residential care.

Respondent fatigue

In all three countries, some level of respondent fatigue among caregivers was noted since they were often required to complete interviews for multiple children. In Kazakhstan, caregivers sometimes spent nearly a full day in interviews and would occasionally have difficulty remembering which child they were being interviewed about. This situation is not so different from that encountered during household surveys where there are a large number of children present.

Low response rates for some modules/questionnaires

As noted earlier, the response rate among 15–17 year-olds in Ghana was very low (only 75%). It was discovered that this was likely due to the fact that many of the sampled adolescents were no longer eligible to be interviewed on account of their age when revisited during Phase Two. Additionally, some of the selected adolescents could not be interviewed because they were away at boarding school (which is not considered a form of residential care in Ghana) at the time of data collection. The sample size of adolescents was increased to account for some non-response, but these situations were more frequent than anticipated, and since the sample design did not include any strategies for replacement, this resulted in many incomplete interviews among this age group. In Kazakhstan, there was a large amount of missing data for the Foundational Learning Skills module collected in the Questionnaire for Children 5–14. It was unclear whether this was due to an issue with the computer-assisted personal interviews (CAPI) and data entry or whether interviewers were intentionally skipping the module, given it can be quite demanding to implement and requires direct interaction with the children.

Sensitivity

The original version of the Questionnaire for Adolescents 15–17 included a number of questions on the reasons and context within which children were placed into residential care. In the pre-pilot in Ghana, it was found that the most sensitive question posed to adolescents was ‘Why are you living in this facility?’. This question elicited many emotional reactions, and adolescents often struggled (painfully) to provide a response. Such questions were dropped from the final fieldwork. However, the information is important for informing policy and programming, so these questions are now asked of social workers as part of the Questionnaire on Children’s Case History as opposed to asking children directly.

Discussion

A key advantage of the UNICEF protocol is that it can be adapted for use in a wide variety of country contexts. The protocol is not intended to be a one-off, standalone data collection exercise but rather to provide countries with an approach and tools for producing a baseline for official records, such as a national registry or database on this population of children. Countries should aim to build on the census and enumeration in order to undertake, at regular intervals, assessments and inspections of RCFs measured against national standards. Additionally, building or strengthening an individual case management system for this population is a critical follow-up step.

Data generated from application of the protocol can also be used to inform and shape discussions on policy reform, and to monitor trends over time. For example, a series of policy documents were developed following completion of the survey in Ghana to accelerate care reform efforts. With UNICEF support, the Department of Social Welfare developed deinstitutionalization guidelines and a training manual for caregivers of children with disabilities (Ghana Department of Social Welfare and the United Nations Children’s Fund, 2020). The Department is currently developing national and regional

roadmaps for the deinstitutionalization of children. The results of the survey reiterated the importance of having family-based care options for children in need of alternative care, and the Department has also scaled up its foster care program with the development of the National Standards for Foster Care, the training of 544 foster parents, and placement of over 200 children in foster care (Ghana Department of Social Welfare, 2020).

Piloting of the protocol in three countries highlighted the following vital considerations to be kept in mind when planning implementation of the protocol: the need for strong relationships with, and buy-in from, key partners (especially the government ministry with the mandate and regulatory authority over residential care in a country); the importance of being clear on the objectives and desired outcome of the data collection, as this can have implications for customizing/adapting questionnaires; the need for adequate training, and monitoring, of fieldwork teams to ensure data quality and adherence to ethical protocols; and clarity on the response plan from the outset, including how to handle referrals for professional services among adolescent respondents.

The United Nations Guidelines on the Alternative Care of Children states that residential care should have the objective of providing only temporary care while efforts are made to actively secure stable care in an alternative family setting, or reintegrate children within their families when possible (United Nations General Assembly, 2009). Reforming national systems to reflect this shift is a sensitive and complex process requiring strong political commitment and the tackling of challenges along the way, including addressing the root causes of family separation (Herczog, 2017). Understanding the problem is half the solution, and having accurate data on the number and location of residential care facilities, the children who live in them, the problems they face, and the reasons why they are there is an essential first step.

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