

FROM A WHISPER TO A SHOUT: A CALL TO END VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE



SOS CHILDREN'S
VILLAGES
INTERNATIONAL



University of
Bedfordshire



© SOS Children's Villages International, University of Bedfordshire, 2014

The material in this report has been commissioned by SOS Children's Villages International. The contents do not necessarily reflect the policies or the views of these organisations.

The designations employed in the presentation of the material in this report do not imply on the part of the commissioners or authors the expression of any opinion whatsoever concerning the legal status of any country or territory, or of its authorities or the delimitation of its frontiers.

Disclaimer: While all reasonable efforts have been made to ensure the accuracy and legitimacy of the data in this report, SOS Children's Villages International and the University of Bedfordshire cannot be held liable for any inaccuracies, genuine or perceived, of the information retrieved and presented in this document. The purpose of this report is to offer an insight into the nature and prevalence of violence against children in alternative care. The copyright holders will not assume responsibility for the consequences of the use of any information contained in the report, nor for any infringement of third-party intellectual property rights which may result from its use. In no event shall the copyright holders be liable for any direct, indirect, special or incidental damage resulting from, arising out of or in connection with the use of the information.

SOS Children's Villages International
Hermann-Gmeiner-Straße 51,
6020 Innsbruck,
Austria
T +43 512 3310-0
F +43 512 3310-5087
Email: lao@sos-kd.org
www.sos-childrensvillages.org

International Centre: Researching Child Sexual
Exploitation, Violence and Trafficking
University of Bedfordshire
Park Square,
Luton, LU1 3JU
UK
T +44 1234 400400
Email: Jenny.Pearce@beds.ac.uk
www.beds.ac.uk/ic

Any part of this handbook may be freely reproduced with the appropriate acknowledgement.

Editors: Rebecca Dobson and Stephanie Klotz
Editorial team: Malika Ait Si Ameer, Barbara Ammirati, Nabin Bajracharya,
Cynthia Pérez Dominguez, Jenny Pearce, Violeta Velkoska
Research team: Isabelle Brodie, Kate D'Arcy
Cover photo: Jens Honoré
Graphic design: typothese.at

CONTENTS

PREFACE	5
FOREWORD	7
ACKNOWLEDGMENTS	8
EXECUTIVE SUMMARY	10
Key findings	11
Recommendations	12
Conclusion	13
CHAPTER 1: Introduction	14
1.1 Structure	16
1.2 Methodology	16
CHAPTER 2: Conceptual framework	20
2.1 Understanding alternative care	20
2.1.1 Informal alternative care	21
2.1.2 Formal alternative care	21
2.2 Violence against children in alternative care	23
2.2.1 Vulnerability	23
2.2.2 Risk	23
2.3 Child protection	24
2.3.1 Preventive child protection	24
2.3.2 Responsive child protection	25
2.4 Quality care	26
2.5 Scope of the report	26
CHAPTER 3: Background to violence against children in alternative care	28
3.1 Legal framework	28
3.1.1 International and regional agreements	28
3.1.2 The Guidelines	29
3.1.3 National legislation	30
3.2 The population of children in alternative care	30
3.2.1 Reasons for entry into alternative care	31
3.2.2 Characteristics of children in alternative care	32
CHAPTER 4: Forms of violence, children's perceptions of violence and the effects of violence in alternative care	34
4.1 Abuse	35
4.2 Harmful institutional practice	37
4.3 Peer violence	38
4.4 Views and perceptions of children and young people on violence in alternative care	39
4.5 The grave effects of violence on children	41
4.5.1 Cycles of violence	41
CHAPTER 5: Social conditions that lead to violence against children in alternative care	42
5.1 Violence in families and communities	43
5.2 Social acceptance of violence against children	44
5.3 Discrimination	45
CHAPTER 6: Elements of alternative care that influence violence against children	48
6.1 Impact of quality care and child protection on violence against children in alternative care	49
6.1.1 Coordination among stakeholders	49
6.1.2 Registration of alternative care facilities, oversight and monitoring	50
6.1.3 Individualised assessments and interventions for each child	51
6.1.4 Relationships and resilience	52
6.1.5 Work with families of origin and follow-up after reintegration	53
6.1.6 Child protection and reporting and complaints mechanisms	54
6.1.7 Suitable caregivers, care professionals and staff	56
6.1.8 Participation and awareness of rights	57
CHAPTER 7: Conclusion and recommendations	58
7.1 Key findings	59
7.2 Recommendations	60
GLOSSARY	64
REFERENCES	66



FROM A WHISPER TO A SHOUT:
A CALL TO END VIOLENCE
AGAINST CHILDREN
IN ALTERNATIVE CARE

© Wissam Bachour

“We owe our children – the most vulnerable citizens in any society – a life free from violence and fear. In order to ensure this, we must be tireless in our efforts not only to attain peace, justice and prosperity for countries, but also for communities and members of the same family. We must address the roots of violence. Only then will we transform the past century’s legacy from a crushing burden into a cautionary lesson.”

– Nelson Mandela

PREFACE



This report is essential reading for all those involved in the care and welfare of children. It is an opportunity for us to identify and challenge the hidden or ignored abuse of children within the very settings that are expected to protect them. Such a focus can prove uncomfortable reading, but we can no longer

shy away from our responsibility to keep children safe. For the first time we have a comprehensive review of the extent and nature of violence against children living in alternative care settings. This is significant for three reasons:

- First, the 25th anniversary of the *UN Convention of the Rights of the Child* provides impetus for us to review our progress in upholding all children's rights, but specifically their right to protection from all forms of violence.
- Second, public awareness of the extent of sexual abuse, exploitation and other forms of violence against children is increasing at local, national and international levels, so that reticence to acknowledge abuse against children is being increasingly challenged.
- Third, the international agenda through the *Guidelines for the Alternative Care of Children* is specifically renewing efforts for safe and high quality alternative care.

Here, we are provided with sensitive and helpful insight into the range of problems that children experience before being placed in alternative care, including inter-related histories of abuse, neglect, abandonment and violence. The damage that these trajectories can cause encourages an appreciation of the resilience, bravery and personal resources of many children who might resist a simple deterministic "victim" label. This is important as the right of the child to be heard remains the central

platform for advancing child-centred practice both in and outside of alternative care environments.

We need to be better at listening and responding to children's experiences of bullying, verbal abuse, psychological and physical abuse and neglect; at creating and using evidence-based practice so that destructive patterns of the past are not repeated; and at creating a trained and appropriately resourced workforce, which understands and is supervised to respond appropriately to questions of attachment, discrimination, lifespan development, health and child wellbeing.

Not only does this report help us to understand our responsibility to identify and address the variety of forms of violence experienced by children before they enter into alternative care, but it gives us all the reasons and mechanisms we need to identify forms of violence experienced by children within alternative care. We need intervention and change to protect children and more studies like this to advance child-centred research, debate, and policy and practice reviews to keep the safety and wellbeing of children as the central platform of alternative care provision.

While giving us an understanding of children's experiences of violence and abuse in alternative care, this report makes suggestions as to how we can move forward to better protect children in the future. It is a "wake-up call". Now is the time for all child care providers to review and update their alternative care provision, using the findings from this report to create safe and supportive care with and for children.

Jenny Pearce
University of Bedfordshire



This is a crucial year for us to remember and act for every child's right to appropriate care. It was five years ago that the *Guidelines for the Alternative Care of Children* were endorsed by the United Nations General Assembly – standards that set out clear recommendations for both the prevention of family

separation and appropriate and suitable care measures to be put in place when separation is in the best interest of the child and unavoidable.

This year we also commemorate the 25th anniversary of the *UN Convention on the Rights of the Child* (UNCRC). Among the rights and responsibilities listed in this document, it urges states to take action to protect all children from all forms of violence, including in alternative care settings. Yet many countries still do not prohibit corporal punishment in such care settings, rendering children more vulnerable to physical violence from staff and non-parental caregivers.

Despite great progress made in children's rights since the adoption of the UNCRC, the rights and protection of some of the world's most vulnerable children are still not realised today. Millions of children are deprived of the opportunity to grow up and thrive in a nurturing family environment, and many more are at risk of losing their family. Yet very few have access to quality alternative care services, including residential, community, and family-based care. Instead, such services are unfortunately recognised worldwide as severely under-supplied and often of poor quality or even harmful to children.

Through decades of experience working with governments at policy level and with children in our programmes, SOS Children's Villages finds the evidence irrefutable – children without parental care

or at risk of losing parental care are among the most vulnerable and “left- behind” members of society. These children and young people who are temporarily or permanently deprived of a family environment face a heightened risk of violence, abuse, and neglect, and are increasingly exposed to multiple factors that can hinder their physical, psychological, and social development.

As major reforms of alternative care and protection systems are under way in many countries to implement the recommendations of the United Nations Study on Violence against Children and the Guidelines, we find ourselves at a particularly opportune moment to review the current state of affairs related to the prevention and elimination of violence in all alternative care settings. Through this publication and on-going and collaborative advocacy efforts, we ask all stakeholders to: re-state, reaffirm and act upon their commitment to bring the issues related to violence against children to the forefront of policy agendas and view all children as **full rights holders** and integral members of society, irrespective of their care status.

This report serves as a call to action that sits at the very centre of SOS Children's Villages' work – to bring about positive change to improve the lives of children without parental care and those at risk of being separated from their families. And further, to acknowledge that as society treats these children today, we determine how as adults, these children will treat society.

Richard Pichler
CEO, SOS Children's Villages International

A handwritten signature in black ink, appearing to read 'Richard Pichler', written in a cursive style.

FOREWORD



Today, millions of children continue to live in residential care throughout the world for a variety of reasons which range from loss of parents and family disintegration to physical and mental disability. Indeed, the majority of them are not orphans but children whose families encounter difficult

social and economic conditions.

Children who are in institutions are not born in institutions. The way leading to their institutionalisation has often been marked by violence, hardship and suffering. Once institutionalised, children are often exposed to all forms of violence including corporal punishment, restraints, sexual abuse. By isolating children from the rest of the society, the placement in institutions puts them at greater risk of violence with small chances that this violence be reported. One should also not forget that institutionalisation often constitutes a form of violence in itself and leads to social exclusion and segregation.

It is hence essential that we effectively tackle the root causes of institutionalisation and rapidly engage in the development of family and community-based services and alternative solutions to prevent the placement of children. The Committee on the Rights of the Child repeatedly asks states to take all necessary measures for the de-institutionalisation of children.

Equally so, we have to join all our efforts and constantly stay alert to ensure that children who spend part of their lives in institutions can develop in a healthy way, benefitting from a high quality of life and are free from any form of violence. I am particularly grateful for this valuable report by SOS Children's Villages, which is an extremely useful input as regards the elimination of violence against children.

Prof. Kirsten Sandberg
Chair, UN Committee on the Rights of the Child

A handwritten signature in black ink that reads "Kirsten Sandberg".

ACKNOWLEDGMENTS

This report is the product of a successful collaboration between SOS Children's Villages International and the University of Bedfordshire.

It would have been impossible without the research produced by authors in each of the 21 countries that undertook SOS Children's Villages' assessment of the implementation of the *Guidelines for the Alternative Care of Children*. We acknowledge the substantial contribution of the following authors and their supporters:

- In Argentina, Aldeas Infantiles SOS Argentina and Mbc Mori Consultores
- In Armenia, SOS Children's Villages Armenia and Kristine Mikhailidi
- In Benin, SOS Villages d'Enfants Bénin; the Ministry of Family, Social Affairs, National Solidarity, the Disabled and People of the Third Age; and the Network of Organisations for the Protection of Children in Need
- In Bosnia and Herzegovina, SOS Children's Villages and Bojan Pavlovic
- In Chile, Aldeas Infantiles SOS Chile and MIDE Pontificia Universidad Católica de Chile
- In Colombia, Aldeas Infantiles SOS Colombia and Ingrid Anzelin
- In Croatia, SOS Children's Villages Croatia and Nataša Škrbić, Sanja Orešković, Lidija Japiec, and Suzana Kunac
- In Gambia, SOS Children's Villages the Gambia
- In Kenya, SOS Children's Village Association Kenya and Brilliant Technologies (K) Limited
- In Kosovo, SOS Children's Villages Kosovo and MDA Foundation
- In Lithuania, SOS Children's Villages Lithuania
- In Malawi, SOS Children's Village of Malawi Trust and Humphrey Mdyetseni, Chiza Nyirongo, and Idrissa Mwale
- In Norway, SOS Children's Villages Norway
- In Paraguay, Aldeas Infantiles SOS Paraguay and Javier Chamorro, Cristian Cabrera, Andrea Vera, and Enrique Gauto
- In Peru, Aldeas Infantiles SOS Perú and Universidad Peruana Cayetano Heredia
- In Tanzania, SOS Children's Village of Tanzania Trust
- In Togo, SOS Villages d'Enfants and Togo and EUREKA EDU Consulting
- In Uruguay, Aldeas Infantiles SOS Uruguay
- In Venezuela, Aldeas Infantiles SOS Venezuela and Carlos Trápani
- In Zambia, SOS Children's Village of Zambia Trust and the University of Zambia, School of Medicine, Department of Public Health
- In Zimbabwe, SOS Children's Village Association of Zimbabwe and Musa Chibwana

The studies in each country also relied on generous contributions of time and insight from their own informants including government ministries, social work departments, international organisations, state, NGO and private sector care providers, and children in alternative care.

To download the original reports, please see: www.care-for-me.org

Thanks are due to members of the external review group including Marta Santos Pais, Delia Pop, Peter Newell, Nadine Perrault, Rajan Burlakoti, Bimol Bhetwal and Nawjeet Karmacharya.

We would especially like to thank Jenny Pearce of the University of Bedfordshire for her guidance and insight throughout the process.

Thanks also go to Isabelle Brodie and Kate D’Arcy who undertook a rapid review of the research literature available to inform the findings of this report.

Mieke Shuurman, children’s rights and EU expert, Professor Mike Fisher of the University of Bedfordshire, and Carol Vigurs of the University of London, are also due thanks for their notable assistance during the initial stages of research.

An invaluable support were the comments provided by SOS Children’s Villages’ member associations including from Sinisa Baljo (Bosnia and Herzegovina), Carla Prado (Peru), Lilit Melkumyan (Armenia), Alejandra Riveros (Chile), and Cyrille Boglo (Regional Office, West and Central Africa).

Thanks also go to SOS Children Villages International colleagues including Philip Doyle, Jan Folda, Inés Invernizzi, Alan Kikuchi-White, Raluca Verweijen-Slamnescu, and Stephanie Wies, for their valuable input and guidance.

Finally, we would like to show our appreciation to the entire research and editorial team, Barbara Ammirati, Cynthia Pérez Dominguez, Malika Ait si Ameer, Violeta Velkoska, Nabin Bajracharya, Isabelle Brodie, Kate D’Arcy, Rebecca Dobson and Stephanie Klotz for their personal contributions and commitment to leading this amazing journey.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CRC Committee	Committee on the Rights of the Child
Guidelines (the)	Guidelines for the Alternative Care of Children (UN Resolution A/RES/64/142), 2009
HIV	Human Immunodeficiency Virus
IACHR	Inter-American Commission on Human Rights
NGO	Non-governmental organisation
SRSG	Special Representative of the Secretary-General on Violence against Children
OHCHR	Office of the High Commissioner for Human Rights
UN	United Nations
UN study (the)	World Report on Violence against Children 2006
UNCRC	United Nations Convention on the Rights of the Child 1989
UNICEF	United Nations Children’s Fund
WHO	World Health Organisation

EXECUTIVE SUMMARY

“The true measure of any society can be found in how it treats its most vulnerable members.”
– Ghandi

The *UN Convention on the Rights of the Child* (UNCRC) recognises children as the subjects of rights, as well as their vulnerability and need for “special safeguards and care”.¹ Marking its 25th anniversary this year, the UNCRC is notably one of the most ratified UN conventions in history and has done much to progress the rights of children globally.

And yet, in our global society with international conventions endorsing the “rights” of all, some of our most vulnerable children continue to suffer from extreme forms of violence and abuse. This report demonstrates that even when children are presumed to be in the care of society itself they are vulnerable to and at risk of violence.

The UN Committee on the Rights of the Child has identified “children not living with their biological parents, but in various forms of alternative care” as one of the groups of children who are “likely to be exposed to violence”.²

Without the fundamental protection of a caring family, these children are vulnerable to abuse and neglect. Without “suitable” quality care, they risk violence at the hands of their caregivers, families, peers and the wider community.

In 2009, the UN endorsed the *Guidelines for the Alternative Care of Children* (the Guidelines). These set out “desirable orientations for policy and practice”

to “enhance” the implementation of the UNCRC for children in alternative care. The Guidelines reiterate the right of “Every child and young person [to] live in a supportive, protective and caring environment that promotes his/her full potential” (§4).

This report draws on evidence from an extensive global literature review, and assessments of the implementation of the Guidelines in 21 countries around the world.³ It makes bold claims about high levels of vulnerability and risk of violence facing children in alternative care, but concludes that violence is not inevitable, and with an emphasis on providing quality care it is possible to mitigate the risks of harm for all children.

Violence against children in alternative care is preventable, but finding the answers as to why children are subjected to violence and what can be done to protect them is complex. Violence is the result of multifaceted social issues and political decisions that can only be addressed with adequate knowledge, political will and resources.

In beginning to untangle this complexity and add to our knowledge of what makes children vulnerable and puts them at increased risk, this report provides policy-makers and practitioners with insight into the challenges of protecting children, and makes recommendations for change to ensure that every child is provided with safe and quality care.



© Marko Magi

KEY FINDINGS

Violence against children in alternative care must be stopped

A clear focus on protecting children and providing quality care through effective implementation of the Guidelines will mitigate violence and ensure that our most vulnerable children are protected and safe.

Children in alternative care face multifaceted vulnerability and persistent social conditions that lead to violence

A combination of multi-layered vulnerability and enduring social conditions are the basis of much violence in alternative care. A lack of legal protection, society's tolerance and acceptance of violence and the additional vulnerabilities experienced by children who are already discriminated against can mean that they are subjected to harm with impunity.

Between 80% and 98% of children suffer physical punishment in their homes, with a third or more experiencing severe physical punishment resulting from the use of implements.⁴

The quality of care plays a significant and determinant role in a child's risk of experiencing violence

Alternative care does not inherently perpetuate violence, but rather the incidence of violence is inextricably linked to the overall quality of care and the ability of states to monitor standards.

Improvements in the quality of care, including adequate planning and assessments to ensure "suitable" alternative care placements; the implementation of monitoring and effective oversight; and the provision of independent complaints mechanisms would reduce the risk of violence against children.

In Bolivia 60% of all residential facilities are accredited.⁵

In Malawi only 9.2% of the children surveyed had a care plan.⁶

Reliable data and substantive research on violence against children in alternative care are minimal

There are considerable gaps in the data available on children in alternative care. This limited knowledge not only demonstrates the marginalisation of these children and the hidden nature of their lives and experiences, but also places them at greater risk of violence.

Without knowledge of the ways in which violence manifests in alternative care, it is impossible to design and maintain adequate systems to protect them.

RECOMMENDATIONS

Preventing and responding to violence against children in alternative care is a shared responsibility. While states bear the primary responsibility to implement protective measures to prevent violence, all stakeholders – international and regional organisations, donors, NGOs, care providers, civil society, the private sector, communities, families, and children and young people – must be empowered to work together to hold states accountable and to do everything possible to protect children.

RECOMMENDATIONS TO STATES:

1. States should strengthen national legislation and policy to ensure that there are specific provisions against violence in all forms of alternative care.

Legislation should address all forms of abuse and neglect; harmful institutional practice that could include abusive forms of discipline or control; and peer violence.

2. States should ensure that removal of a child from the care of the family is viewed “as a measure of last resort ... and for the shortest possible duration” (§14).

States should invest in preventive services, including family strengthening and capacity-building to assist parents to care for and protect their children. In situations of violence and abuse, sanctions should be directed at the perpetrators rather than automatically removing children for protective purposes.

3. States should improve their ability and the capacity of their competent authorities to monitor the quality of alternative care provision.

This includes providing sufficient standards and guidelines to ensure that any monitoring is based on valid criteria; adequate resources to ensure authorities have the practical tools to fulfil their responsibilities, including the capacity to elicit the views of children; and the necessary follow-up mechanisms with the power to impose sanctions on alternative care provision that fails to meet standards.

4. States should assume their primary role as the coordinator of alternative care provision with all other stakeholders.

States have a primary role as coordinators or alternative care provision to ensure that alternative care providers within the care system provide a range of suitable alternative care options, fulfil their obligations to provide independent reporting mechanisms, and ensure meaningful child participation (see below).

RECOMMENDATIONS TO ALTERNATIVE CARE PROVIDERS/ CARE SYSTEM (STATE AND NON-STATE):

1. Alternative care providers should ensure that specialist services are available for families and children that experience violence, and that their services constitute quality care.

These services should be both preventive – to avoid removing the child from the family environment – and rehabilitative – to ensure that children and their families that have experienced violence are provided with the support to heal.

2. Alternative care providers should ensure that they develop adequate, independent and confidential mechanisms for children and others to report violence in alternative care.

Reporting mechanisms are essential to ensure that children do not suffer in silence and that violence is not perpetrated with impunity. Children should be provided with confidential support in order to report violence (or any other complaints) and adequate mechanisms to follow up on reports and protect children should be in place.

3. Alternative care providers should take measures to ensure that all children and where appropriate their families are able to meaningfully participate in any decisions relating to alternative care placements.

Children should be empowered to participate according to their capacity in all decisions affecting their alternative care provision. Parents and other family members should be kept



informed of decisions and where appropriate provided with the opportunity to participate in decision-making processes.

element of alternative care: either as a form of discipline or control. It also means challenging levels of tolerance in society that allow violence against children to continue with impunity.

RECOMMENDATIONS TO ALL STAKEHOLDERS:

1. All stakeholders should collaborate in collecting comprehensive data and expanding contributions to research on violence against children.

In particular, it is important to have information on the child population in alternative care, to ensure appropriate policies are in place and adequate resources are provided for their quality care. This also involves ensuring that children's voices are heard in research into their experiences of violence, and are provided with opportunities to offer their own understandings and solutions.

2. All stakeholders should contribute towards coordinated efforts to raise awareness and educate society on violence against children in alternative care.

This includes ensuring that children are informed that violence is not a necessary or legitimate

CONCLUSION

This report stands as a testament to the violence suffered by children in alternative care. It finds that to the best of our knowledge, children in alternative care are vulnerable to violence, and that the systems in place to care for them put them at further risk of harm.

This report also stands witness to the great resilience of children; who with strength and dignity prevail in the most difficult circumstances, even without the necessary care and protection.

But it is also a call for change. With knowledge, political will and resources it is possible to change the experiences of children in alternative care, so that they receive the quality care they deserve. In doing so we meet our obligations to respect and protect their rights, but we also demonstrate our true measure, as societies that care for our most vulnerable.



CHAPTER 1: INTRODUCTION

*“No violence against children is justifiable;
all violence against children is preventable.”*
– Paulo Sérgio Pinheiro

Violence against children crosses continents and cultures, it is in our homes, communities and institutions, and often it is perpetrated with impunity.

A recent study by UNICEF estimates that in 2012 almost 95,000 children and adolescents under the age of 20 were victims of homicide; that more than 10% of girls (120 million) have experienced a forced sex act; and that 60% of children between two and 14 are subjected to physical punishment by their caregivers.⁷

Violence against children is a violation of the *UN Convention on the Rights of the Child* (UNCRC), which aims to protect children from:

... all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse (Article 19).

The 2006 *World Report on Violence against Children* (UN study) draws upon a WHO definition where violence against children is described as:

... the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity.⁸

At its core, violence against children involves the imbalance and abuse of power – physical, emotional, or psychological – between a child and the perpetrator(s) and is used to inflict harm.

In recent decades there has been growing awareness of the forms of violence inflicted upon children, and tremendous strides have been taken by the international community and at local and national levels to care for and protect children.

In 2006, the United Nations Secretary-General published the first comprehensive global study on violence against children (UN study).⁹ A Special Representative on Violence against Children was appointed to follow up on the study, and in 2013 produced a Global Survey on violence against children.¹⁰ Despite some important achievements, the survey found that progress has been slow, uneven and fragmented and that we are left with many challenges.¹¹

These challenges are particularly acute for children in alternative care, who are especially vulnerable to violence. The UN Committee on the Rights of the Child has identified “children not living with their biological parents, but in various forms of alternative care” as one of the groups of children who are “likely to be exposed to violence”.¹²

Without the fundamental protection of a caring family, children in alternative care can become the focus of abuse and neglect, as well as other aggressions such as exploitation and trafficking. In many instances, these children are failed by the very system that is intended to keep them safe. They are at risk of violence at the hands of caregivers, staff, peers, members of their families and the wider community.

This study takes the heightened vulnerability of children in alternative care as its starting point. It examines how formal alternative care places vulnerable children without parental care at increased risk and asks what can be done to better protect them from violence.

Violence against children in alternative care is preventable. It is possible to protect children from harm and there are tools to help us to do so. The *Guidelines for the Alternative Care of Children* (the Guidelines) have been developed to enhance the implementation of the UNCRC for the “protection and wellbeing of children who are deprived of alternative care or who are at risk of being so”.¹³ Effectively implemented the Guidelines can offer safety and protection for children who have been separated from their families, help to protect them from further trauma, and aid in the healing process for those who have already been exposed to violence.

Too little is known about violence against children in alternative care settings. There is limited data to draw on, and too few international studies have focused on the subject. This scarcity may be due in part to under-reporting and the inherent problems in reaching such children and researching their experiences. There are considerable ethical implications that limit our ability to ask children about their experiences of violence. This means that these children remain unheard and invisible.

This study utilises material from a detailed literature review conducted by academics at the University of Bedfordshire and the findings of SOS Children's Villages International's research into the implementation of the Guidelines in 21 countries around the world. It provides policy-makers and practitioners with insight into the vulnerabilities and risks facing children in alternative care, and suggests practical recommendations for all stakeholders to ensure better protection of children.

The voices are loud and the message is clear: violence against children is unacceptable. Every child has the right to live a life free of violence and it is our responsibility to protect that right. This report seeks to fuel the movement and inform and encourage advocacy to tackle violence against children in alternative care.

1.1 STRUCTURE

This report is structured into seven chapters, which take us on a path towards greater understanding of the challenges inherent in protecting children in alternative care from violence.

- **Chapter 1 Introduction:** introduces the issue and describes the methodology, including the processes for managing any ethical issues and the limitations of the study.
- **Chapter 2 Conceptual framework:** examines the concepts and definitions used throughout this report to help us understand how violence manifests in alternative care settings.
- **Chapter 3 Background on violence against children in alternative care:** provides a legal background to violence in alternative care, and a sense of the status of children in alternative care – their previous experiences and other characteristics that can affect their vulnerability to violence.
- **Chapter 4 Forms of violence, children’s perceptions of violence and the effects of violence in alternative care:** presents the multiple forms of violence faced by children in alternative care, examining abuse and neglect, and considering the different ways that violence can be perpetrated, including through harmful institutional practice and peer violence. It continues with an examination of children’s perceptions of violence and what can be learnt from listening to their views and experiences and ends with a description of the short- and long-term effects of violence on children.
- **Chapter 5 Social conditions that lead to violence against children in alternative care:** discusses the role of social factors – including violence in families and communities, the social acceptance of violence against children, and discrimination – in increasing children’s vulnerability to violence in alternative care.
- **Chapter 6 Elements of alternative care that influence violence against children:** highlights

the main elements of the alternative care system that influence the incidence of violence against children in care, and compromise our ability to ensure quality care and protection for all children.

- **Chapter 7 Conclusions and recommendations:** describes the main findings of the research and makes recommendations for change to enhance quality care and child protection practice.

1.2 METHODOLOGY

This report is the result of a collaborative effort between SOS Children’s Villages International and the International Centre: Researching Child Sexual Exploitation, Violence and Trafficking at the University of Bedfordshire.¹⁴

It combines a comprehensive review on violence against children in alternative care with an analysis of experiences and data from 21 countries, as reported in assessments based on the *SOS Children’s Villages Assessment Tool for the Implementation of the UN Guidelines for the Alternative Care of Children*.¹⁵

DATA SET AND ASSESSMENT TOOL

In December 2009, the UN endorsed the Guidelines as a tool to enhance the implementation of the UNCRC for the protection and wellbeing of children without parental care or at risk of losing it.¹⁶

The Guidelines, are not binding commitments on states. Consequently, there is no official follow-up or monitoring mechanism to ensure compliance. In an effort to begin to address this gap, since 2011 SOS Children’s Villages International has been conducting assessments in countries around the world, using in-country child rights experts to measure national success in implementing the Guidelines.

These assessments are based on the *Assessment Tool for the Implementation of the UN Guidelines for the Alternative Care of Children*. To date, 21 countries worldwide have published their findings: Argentina, Armenia, Benin, Bosnia & Herzegovina, Chile, Colombia, Croatia, Gambia, Kenya, Kosovo, Lithuania,



Malawi, Norway, Paraguay, Peru, Tanzania, Togo, Uruguay, Venezuela, Zambia, and Zimbabwe.

A large amount of the material cited in the reports is secondary data, but primary data were collected from expert practitioners and government officials, and also included the voices of children. The ethical considerations related to working directly with these groups were considered individually as appropriate in each country.

Although the assessments have limitations and the list of countries that have published their findings is not comprehensive, they provide the opportunity to understand in greater depth and breadth common elements of and challenges faced by alternative care systems regionally and internationally. Some reports contained specific information on violence against children; for the most part, however, the assessments were used to gain a general picture of alternative care and its ability to protect children from harm.

LITERATURE REVIEW

The literature review, carried out by researchers from the University of Bedfordshire, complements the 21

country assessments. It aimed to uncover evidence of the extent and nature of violence against children in alternative care internationally. Therefore, a search and review was carried out of peer-reviewed academic literature, alongside 'grey' policy and practice literature.

The literature search and analysis was done using EPPI-reviewer software, developed by the University of London. This has been supplemented by additional searches via other search engines, relevant organisational websites, reference harvesting and recommendations by experts and SOS Children's Villages International's co-workers. These initial searches generated a sample of 233 items and abstract screening reduced this to 114.

The search focused on items post-2000 and material prior to this date was used as background only. While some foreign language publications were considered, the search examined mainly English language literature. For the purpose of the literature review, children were considered as all individuals under-18 years of age,¹⁷ while young people were considered to be between the ages of 15 and 24 years.¹⁸ The search adopted the definition of violence contained in the UN study:

... the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity.¹⁹

The review also adopted the definition of alternative care contained in the Guidelines, which distinguishes between informal and formal care. Within the formal care category, which is the focus for the literature review, residential care and different forms of foster care are described.

ANALYSIS AND REVIEW TEAM

A team of five SOS Children's Villages co-workers, two researchers from the University of Bedfordshire, and an independent communications expert carried out the analysis. The collective expertise of the team includes knowledge of child protection, alternative care, sexual exploitation, gender and domestic violence, violence against children, international law, advocacy and communications.

A review team was then set up to provide peer review to the report's findings and presentation. The team consisted of both SOS Children Villages' specialists, as well as independent peer reviewers from across the globe.²⁰ A first draft of the report was also made available for review in each of the countries included in the research in order to ensure accountability and essential feedback processes.

LIMITATIONS AND ETHICS

Despite the attention given to historical abuse in residential care in countries like the UK, Ireland and the US, data and research on violence against children in alternative care is limited internationally.²¹ The specific difficulties and ethical constraints that emerged in examining literature and compiling data for this report were as follows.

Quantity: There is a lack of available and reliable data not only on violence against children, but also on the situation of children in alternative care. This lack of data was cited in the assessments of several countries

specifically, and was evident across all 21 of the country assessments. Other comparative international research has demonstrated that the amount of official data (as distinct from research data) varies greatly worldwide.²² The same can be said of the amount of research into alternative care generally, and in respect to violence particularly, as it varies widely across the world.²³ Overall, the amount of research seems to correspond to the extent to which formal systems of alternative care are developed.

More information was available regarding violence in residential care than in foster care settings. The literature on foster care has in recent years expanded, but tends to be concentrated in the UK, US and Australia. This is indicative of a more general lack of international data on quality care in formal foster care.

Quality: The quality of research into the prevalence and nature of violence in alternative care is to a large extent dependent on the amount and quality of research into violence against children more generally. In some countries this is very sparse. Research in this area is difficult: for example, samples of children and young people may be hard to access and there are ethical challenges involved in asking children and young people about their experiences of violence.

There is also a danger of reductionism – specifically, children are discussed only in terms of their care status and other important characteristics, including gender and ethnicity, are not considered. Furthermore, the academic literature tends to focus on identifying the incidence of violence in alternative care settings rather than explaining why the violence takes place. Therefore, clear links between the incidence and type of violence, and the nature of the care setting were difficult to establish and were made at the discretion of the team.

This report relies, in part, on the accuracy of the 21 country assessments as written by in-country experts. Although recommendations and advocacy messages are derived from the analysis and findings across the reports, this does not mean that they are necessarily representative internationally, or even for all the countries analysed in this study. As such, caution was exercised in making generalisations.

Comparison: Establishing parallels and links between data and research were difficult due to the different ways in which violence is defined and measured. One author suggested that to study violence there needs to be clear operational definitions of the different types of violence and neglect children experience. They identify that further work is needed to develop tools for measuring the nature and prevalence of abuse.²⁴

Individual studies provide robust findings but unfortunately, these are not often replicated in other research. There are a number of issues that help explain this: not all types of violence are recognised in all countries; some definitions of violence may subsume violence against children within other categories, such as domestic violence; some measures may concentrate on referred cases of maltreatment while others on substantiated cases; in some countries reporting of maltreatment is mandatory while in others it is not.

The same problems were encountered when comparing studies on residential and institutional care, as the use of the terms can vary extensively between different regional contexts. In some cases residential care is used to describe smaller group-type settings of alternative care, while institutional care describes large dormitory-style settings,²⁵ as is used in the Guidelines. In other cases, the two terms are used interchangeably and during the literature review it was often impossible to discern between the two.

In this report, however, residential care and institutional care were considered as two different types of formal care, in accordance with the Guidelines. The literature review was further complicated by the different terms used to describe residential/institutional care, including: group care, group homes, congregate care, orphanage care, orphanages, children's homes, etc.

Context: In addition to these systemic problems, it is also important to consider the many reasons why violence may be kept hidden by society – consciously or unconsciously, leaving so many questions unasked. Attitudes towards what is meant by “violence against children” changes over time according to cultural and social contexts. Thus, corporal punishment may be viewed by some as a matter of ‘discipline’ rather than a

violent expression, or children with disabilities may be subject to violent medical interventions.

In some countries certain groups will be discriminated against, with the result that violence against children in these groups is not recognised or even legitimated. An example is the over-representation and treatment of Roma children in institutional care. Equally, there may be powerful social assumptions about who is most vulnerable to violence – girls rather than boys, younger children rather than older, children living in residential care rather than foster care – which inevitably steers the research towards those groups of children.

Furthermore, children and young people are often presented as being somehow responsible for the violence that takes place in alternative care settings. Specifically, violence is framed in terms of children's characteristics at entry to care rather than that of the perpetrator. Within the literature on abuse there is a tension between protecting children on the one hand and seeing children as the perpetrators of crime on the other.²⁶ There are a certain number of publications that “blame” children for violence or label them as the aggressors. In all cases of violence in alternative care, even in cases of peer-to-peer violence, it is important to keep in mind that children are victims of their circumstances and that the responsibility for their protection rests solely with adults.²⁷

Finally, the literature examining quality of care in different settings tends not to focus on violence. This can be explained again, by the invisibility of violence in alternative care and, in particular, efforts to defend the role of residential care.

Each of these issues is complex in its own right and it is important to recognise that none are the preserve of any one country or region. More importantly, the recognition of gaps in our knowledge base should also be seen as a red flag indicating areas of research that have been chronically ignored. These gaps have implications for the development of policy and practice, and it is important they are filled with robust data and research.



CHAPTER 2: CONCEPTUAL FRAMEWORK

This report is based on the definitions and concepts that underpin our understanding of violence against children in alternative care. Clear definitions and concepts enable us to analyse our material in order to answer our primary question about the way in which violence manifests in alternative care settings.

Our understanding is based on definitions of violence, forms of alternative care that present different kinds of risk, elements of vulnerability and risk that affect children in alternative care, and the role of quality care and child protection systems to help mitigate violence in these settings.

This chapter considers these definitions and concepts, which together provide a scope and framework for understanding the research and findings.

2.1 UNDERSTANDING ALTERNATIVE CARE

Alternative care can be defined as temporary or permanent full-time arrangements where children are looked after (night and day) by caregivers other than their parents.²⁸

The *UN Convention on the Rights of the Child* and the *Guidelines for the Alternative Care of Children* recognise *the family* as the “fundamental group of society and the natural environment for the growth, well-being and protection of children” (§3).²⁹ In this sense, children can be considered safest from harm and violence when their care is embedded within their own families and communities.³⁰

The Guidelines suggest that, “efforts should be primarily directed to enabling the child to remain in or return to

the care of his or her parents” (§3). They also suggest that the removal of a child should be “a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration” (§14).

If circumstances are such that it is not appropriate or in the best interests of the child to remain in their family environment, or when it is not possible for the family to provide adequate care for the child “the State is responsible for protecting the rights of the child and ensuring appropriate alternative care” (§5).

The Guidelines define a range of alternative care options:

- *Informal care* arrangements include care by extended family members, neighbours or friends (§29b(i)).
- *Formal care* arrangements include care provided in a residential environment and ordered by a competent administrative body or judicial authority (29b(ii)). These arrangements include kinship care, foster care, other forms of family-based or family-like placements, residential care, and supervised independent living (§29c).

2.1.1 INFORMAL ALTERNATIVE CARE

Informal care is widely accepted as an appropriate alternative care option. In fact, the majority of alternative care throughout the world is organised spontaneously between private individuals through informal, socially accepted practises.³¹

Although informal alternative care is practiced without the intervention of the state, the Guidelines emphasise their responsibilities to protect children in this form of

care. They recommend that, “states should seek to devise appropriate means... to ensure [children’s] welfare and protection while in such informal care arrangements” (§18). In particular, they advise states to “devise special and appropriate measures designed to protect children in informal care from abuse, neglect, child labour and all other forms of exploitation” (§79).

Informal care was particularly highlighted in the reports from Sub-Saharan Africa, where in Togo, Benin and Zambia it was considered a positive traditional and cultural practice. In recent decades this traditional form of care has become over-burdened, however, due to growing poverty and increasing numbers of orphans due to the effects of HIV/AIDS.³²

It is difficult to determine the precise number of children around the world living informal care. These children are often not registered and there is minimal data on their situations and experiences. Of all the countries assessed, only Zambia offered an estimate of 710,000 children in informal care, versus 4,500 children in formal care – indicating that it is indeed the dominant form of alternative care in the country.³³

2.1.2 FORMAL ALTERNATIVE CARE

The Guidelines acknowledge that effective formal alternative care services require a range of options, to ensure that children are provided with “suitable” alternative care to meet their individual needs. These include alternative care in both residential and family-based settings, which complement each other (§23).

In Western Europe, where family-based foster care has a longer tradition it is used more widely than residential

Risk of violence in informal care

The Guidelines recognise the potential of informal care for providing secure and nurturing environments for children in family-based and familiar settings, but it comes with its own risks that require appropriate protection mechanisms (§18).

The country assessments from Kenya, Malawi and Togo provided evidence that such children were vulnerable to child labour, domestic or agricultural work,

mistreated and abused in their extended families or communities, and had restricted access to health and education.

In Kenya, the country assessment reported concerns of sexual exploitation of children under the care of their community or other family members.

Excerpt from *Drumming Together for Change*, SOS Children’s Villages, 2014

care. In Norway the “measure in institutions” reduced slightly from 2003 to 2011, but during this same period, “measures in foster homes” had more than doubled.

In other regions, children in formal alternative care are predominantly cared for in residential care (with a few notable exception including Kosovo that relies mainly on foster care):³⁴

- Of the estimated 2 million children in alternative care in CEE/CIS and the Baltics, 800,000 (or 40%) live in institutional care.³⁵ In 2009 in Armenia 99.5% of children in formal placements were in residential settings versus 0.5% in foster families; and in Croatia 68% were in residential care.³⁶
- In 2008, UNICEF considered residential care to be the “most prevalent type of alternative formal care” in Southern Africa.³⁷ Benin, Kenya, Malawi, Tanzania, Togo and Zambia reported having a greater number of residential care facilities compared to other options, such as foster care.³⁸
- In Latin America there were similar findings. In Argentina 14% of children were in foster care versus 86% in residential care and in Chile 74% were in residential care compared to only 26% in foster care.³⁹

The Guidelines promote the use of family-based settings and small-group care, particularly for young children and those under the age of three (§22 and §23). They make a clear distinction between residential care and institutional care – a distinction that is often lacking from research, which tends to conflate the two.

Institutional care is defined as “large” (§23) and is generally considered to include residential facilities that care for more than 10 children. Another defining feature is its “... organised, routine and impersonal structure ... [resulting in] a professional relationship, rather than a personal relationship, between adults and children”.⁴⁰ Due to the sheer size of many of the residential care facilities surveyed in the country assessments many could be characterised as institutional.⁴¹

It is widely recognised that institutional forms of care are less able to safeguard and promote the rights of

children; and they can be particularly damaging to the wellbeing and development of children under three.⁴²

The CRC Committee in its General Comment No. 7 made the following observation:

Research suggests that low quality institutional care is unlikely to promote healthy physical and psychological development and can have serious negative consequences for long term social adjustment.⁴³

The Committee encourages states to “invest in and support forms of alternative care that can ensure security and continuity of care and affection, and the opportunity for young children to form long term attachments based on mutual trust and respect”.⁴⁴

The international movement for the de-institutionalisation of children under-three, led by UNICEF and the OHCHR, has been especially strong. In recognising the potential harm of institutions for all children, the Guidelines support the development of alternatives to allow for the “progressive elimination” of institutions (§23).

Many of the country assessments illustrate both the successes and challenges of de-institutionalisation. In Lithuania, while the necessary de-institutionalisation policy framework is in place, NGOs have reported that there is a lack of inter-institutional cooperation and teamwork between them and the state authorities. Figures indicate that the number of family placements has decreased in recent years, while the number of placements into institutional care has grown year on year.⁴⁵

In Armenia the number of children in institutions decreased from 7,597 in 2006 to 5,093 in 2011. However, critics have highlighted that the reforms have not focused enough on shifting to the provision of services for the child and family, but rather on a simple mechanical shift in placements.⁴⁶ A report on residential care in Zimbabwe noted that despite a clear government intention to reduce the number of residential care placements, they had doubled between 1994 and 2004.⁴⁷

Children under-three in institutional care

Institutional care is never recommended as a “suitable” form of alternative care. However, for certain groups of children it presents considerable risk of harm.

Research evidence suggests that:

... young children in institutional care are more likely to suffer from poor health, physical under-development and deterioration in brain growth, developmental delay and emotional attachment disorders. Consequently, these children have reduced intellectual, social and behavioural abilities compared with those growing up in a family home.¹

In particular it is recognised that for children under the age of three institutional environments:

... may have the potential to negatively affect brain functioning at the most critical and unparalleled period for brain development, and have long-lasting effects on social and emotional behaviour.²

As a response to this, the Guidelines suggest that “alternatives” to institutional care “should be developed in the context of an overall deinstitutionalization strategy, with precise goals and objectives, which will allow for their progressive elimination” (§23). Unfortunately for many children the goal of eliminating institutionalised care is far from being realised.

¹ Browne, K., *The Risk of Harm to Young Children in Institutional Care*, London: Save the Children, 2009, p.1.

² Referenced in Browne 2009, p.15.

2.2 VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE

Violence against children can be understood in many ways. The UN study, describes violence as:

... the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child’s health, survival, development or dignity.⁴⁸

UN reports, as well as national and international studies have observed and documented the ways in which children suffer and witness violence; highlighting that violence against children cuts across boundaries of culture, class, education, income and ethnic origin.

Children in alternative care are recognised as being particularly *vulnerable*, however. Without the fundamental protection of their families, and without effective and well-managed alternative care provision children are exposed and at high *risk* of experiencing violence.

These concepts help frame the two lenses through which we will approach the study of violence in alternative care: vulnerability and risk.

2.2.1 VULNERABILITY

The concept of *vulnerability* acknowledges that some children may be more “exposed to the possibility of being attacked or harmed, either physically or emotionally”.⁴⁹

Vulnerability recognises that children in alternative care may be vulnerable due to their care status. However, they may also have multiple and overlapping vulnerabilities to violence, due to their past experiences, ages, gender, HIV status, ethnic group or disability.

In many of the country assessments children were defined as “orphans and vulnerable children” (OVC). The term was originally linked to children affected by HIV/AIDS, but is now considered a more inclusive term to describe children who have been orphaned or suffer from a range of vulnerabilities, including extreme poverty, food insecurity, disability or violence.⁵⁰

Vulnerabilities will not be the same for each child or in every context. This emphasises the need for “suitable” alternative care provision to recognise and cater for the individual vulnerabilities and needs of each child.

2.2.2 RISK

The concept of *risk* acknowledges that certain environments and situations, such as alternative care can entail “exposure to danger”.⁵¹ It recognises that

some alternative care environments can be dangerous for children, and that these risks should be mitigated.

It also puts the onus on those responsible – the state and care providers – to ensure that alternative care environments are set up to protect the most vulnerable children from the risks of harm and violence and establish *quality care*.

Children can be at risk in any care setting – within their own homes, in residential and institutional care, and in family-based settings, such as foster care. However, different forms of alternative care present different kinds of risk, depending on the environment and the vulnerabilities of the children involved.

There is a widespread consensus that violence is more prevalent in institutional and residential care than in foster care, and that children are better protected in their own homes. A report based on data from 101 helplines across the world indicates that one in 25 contacts on abuse and violence against children involved a worker in an alternative care facility, with physical and sexual abuse ranking as the most common forms of violence involving care workers.⁵²

There is some evidence that physical abuse is more prevalent in residential settings.⁵³ The UN study points to research that found violence in residential institutions is six times higher than violence in foster care, and that children in group care are almost four times more likely to experience sexual abuse than children in family-based care.⁵⁴ This tends to be attributed to the characteristics of residential settings, including a lack of appropriate training and qualifications amongst caregivers. These risks are exacerbated when children are housed with adults or older children, potentially leading to physical and sexual victimisation,⁵⁵ as in the case of many institutions for children with disabilities.

Our understanding of risk of violence in alternative care is incomplete, however. There is not as much international research or data on violence in foster care, for example, as there is on violence in institutional or residential care. Additionally, residential and institutional care tends to be more closely monitored than foster care, so cases of abuse are more likely to

come to light. This is not only because in many parts of the world foster care is not as established as other forms of alternative care, but also because the de-institutionalisation movement often promotes foster care, following a basic assumption that violence is more prevalent in residential and institutional forms of care.

Literature from countries with a longer tradition of foster care (such as Canada, the UK and the United States) suggests that violence in foster care is also prominent. In the United States, a study found that rates of sexual abuse of children in the foster care system were four times higher than among the general population of children.⁵⁶

As a consequence it is not safe to assume that certain forms of care constitute greater risk than others. All children should be provided with adequate protection that recognises their vulnerabilities and the risks of their particular alternative care placement.

2.3 CHILD PROTECTION⁵⁷

Child protection systems are designed to protect children from violence and harm. They should be holistic, multi-disciplinary and multi-sectoral. UNICEF defines a child protection system as:

... the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and response to protection-related risks.⁵⁸

As part of the continuum of care,⁵⁹ alternative care involves the “protection and well-being of children who are deprived of parental care or who are at risk of being so” (§1). In this sense, alternative care is part of a holistic child protection system that includes both *preventive* and *responsive* components to protect children and families.

2.3.1 PREVENTIVE CHILD PROTECTION

The Guidelines place an emphasis on preventing family breakdown and implementing measures to empower



© Christian Martinelli

families “to provide adequately for the protection, care and development of their children” (§34). This entails comprehensive assessments to be carried out by child protection services (§39), and effective preventive services to be in place to assist children and families.⁶⁰

The Guidelines also place responsibility on governments to combat poverty, discrimination, marginalisation, stigmatisation, violence, child maltreatment and sexual abuse, and substance abuse (§32). In this way prevention of some of the social conditions surrounding the incidence of violence are addressed.

2.3.2 RESPONSIVE CHILD PROTECTION

Responsive child protection comprises effective procedures to respond to allegations and findings of violence, exploitation, neglect and abuse. The Guidelines (in line with Article 37 UNCRC) prohibit

the use of behaviour management or discipline that constitutes “torture, cruel or inhumane treatment” (§96) and restricts the use of force or restraints and prohibits treatment that may harm a child (§97).

Child protection mechanisms include processes for reporting and receiving complaints (§98), effective mechanisms for following-up complaints (§99) and ensuring a culture of nurturing alternative care for children in need of protection.

Responsible child protection through the provision of alternative care is also subject to monitoring by a competent authority to ensure that children are effectively protected against abuse and exploitation (§92 and §93). This form of protection of children in alternative care is discussed in more detail in chapter 6, and is an intrinsic element in any system of quality care.

Violence in the juvenile justice system

The treatment of children regarded as being anti-social or criminal is likely to be more physically and psychologically punitive than that of other groups in other environments.¹ In some 38 states, corporal punishment – including caning, whipping or flogging – is permitted as a court sentence for children.²

A study of young people in Austria, Cyprus, England, the Netherlands and Romania revealed that violence was a common experience in penal detention centres, both as inflicted by staff and between young people.³

Although most countries require the separation of adults and young people in conflict with the law, in many cases detention with adults still occurs.⁴ This leaves children and young people at a high risk of violence, particularly at night when there is often inadequate supervision.

Children living or working on the streets are particularly vulnerable to abuse by law enforcement services.⁵ Indeed, one report has suggested that “force used in police cars, police stations and police cells is often greater than the use of force by staff in other custodial settings”.⁶

¹ Pinheiro, S., *World Report on Violence against Children*, Geneva: United Nations, 2006.

² Global Initiative to End Corporal Punishment 2014.

³ The Children's Rights Alliance for England, *Speaking Freely: Children and Young People in Europe Talk about Ending Violence against Children in Custody*, London: CRAE, 2013.

⁴ Pinheiro, 2006.

⁵ Ibid.

⁶ The Children's Rights Alliance for England 2013.

2.4 QUALITY CARE

Unlike other rights – such as the rights to survival and development – the right to quality care is not explicit in the UNCRC. Rather it is an interpretation of many rights as defined under the UNCRC and its Guidelines. Quality care involves the care of a child, whether in his or her own family or in a form of alternative care, which enables the child to experience positive, empowering, stable and caring relationships to ensure full personal development. Quality care is essentially empowering and supportive and places the child's best interests and rights at the core of every action. Ensuring that children are provided with quality care means creating an environment in which they are protected and provided with a range of services to meet each child's individual needs – emotional, physical and educational.

The Guidelines recognise the importance of quality care and place responsibility on states to “establish care standards to ensure the quality and conditions that are conducive to the child's development” (§23). In doing so, they state that “special attention should be paid to the quality of alternative care provision, both in residential and in family-based care, in particular with regard to the professional skills, selection, training and supervision of carers” (§71).

High quality care requires that the alternative care setting works effectively, with clear aims and objectives, confident leadership and [in residential care] shared objectives.⁶¹ It implies not only better services for children in alternative care, but also a management style that aims to maximise the welfare of the child.

A system of quality care could be defined as one that has implemented the Guidelines and in doing so has set up systems that adequately protect children and nurture their development.

2.5 SCOPE OF THE REPORT

In recognising these basic concepts – vulnerability, risk, child protection and quality care – as the underlying conceptual framework, this report focuses specifically on violence against children in alternative care.

It recognises the importance of preventive services in keeping children with their families and holistic child protection as part of a continuum of care, and their primary importance for mitigating violence against children. However, it also takes the position that while formal alternative care is necessary and functioning



© Joris Lugthuis

it is essential to understand how and why violence manifests within the system and what can be done to alleviate it.

The report concentrates on violence in *formal* alternative care. This includes all forms of foster care, and residential or institutional care. While children in informal care are also at risk of experiencing violence, the underlying issues are somewhat different, given that they remain within their extended families and communities, and the state does not have jurisdiction

over their care and upbringing. The immensity of subject coupled with the sheer lack of data suggests that violence in informal care is a subject to be tackled in its own right. Although the Guidelines include kinship care as a type of foster care, it was also considered to be out of scope, due to its similarity to informal care; although in this situation children are placed with their families by the state, their placements are rarely subject to the same oversight as formal foster care.

This report focuses on the following forms of violence: abuse (including psychological, emotional, physical and sexual abuse, including sexual exploitation), neglect (and negligent treatment), harmful institutional practice, and peer violence.

While other forms of violence, such as violence in the juvenile justice system and child trafficking are important, they were largely considered to be beyond the scope of this report. Juvenile justice is not considered under the Guidelines, as it is already covered in international law under the United Nations Standard Minimum Rules for the Administration of Juvenile Justice.⁶² Similarly child trafficking, while a considerable risk for children in alternative care, as well as other vulnerable groups, is covered in international law under the UNCRC's Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.⁶³

Child trafficking

Child trafficking is one of the most heinous violations of children's rights.

While not considered common, there is some evidence that alternative care may be used as a hub for the trafficking of children. The Kenya country assessment contained anecdotal evidence that without proper inspections, some "charitable children's institutions" may be used as a "source and transit point for trafficking".¹

Norway also expressed concern that unaccompanied asylum-seekers have gone missing from alternative care. Between 2008 and 2012, 237 children went missing and it is suspected that some of these children were victims of exploitation.²

In the UK, there is growing evidence that a significant number of unaccompanied children who are placed in local authority accommodation subsequently go missing, and are subject to exploitation by traffickers.³ There was evidence in a 2007 study that almost 60% of trafficked children who were placed in local authority care had disappeared.⁴

¹ Kenya country assessment, p.13.

² Norway country assessment, p.43.

³ Anti-Trafficking Monitoring Group, *Wrong Kind of Victim? One Year On: An Analysis of UK Measures to Protect Trafficked Persons*, London: Anti-Trafficking Monitoring Group, 2010.

⁴ Referenced in Anti-Trafficking Monitoring Group 2010.



CHAPTER 3: BACKGROUND TO VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE

The background to this study aims to paint a picture of the legal and social context to violence in alternative care. It illustrates that while there is a legal framework in place to protect children, lack of information about their experiences – and indeed who they are – as well as poor implementation of legislation means that they remain at risk of violence.

The ways in which children enter alternative care, their past experiences and their often multi-layered vulnerabilities also increase the complexity of needs and the challenges for alternative care to protect them from violence.

3.1 LEGAL FRAMEWORK

3.1.1 INTERNATIONAL AND REGIONAL AGREEMENTS

Children are protected in various international human rights treaties. The principal legally binding mechanism that identifies the rights of children without parental care is the UNCRC, the most widely accepted human rights treaty in history.⁶⁴ In Article 20, the UNCRC seeks to protect children “deprived of a family environment”, outlining their right to “special protection and assistance” from their governments, including suitable alternative care.

There are various articles in the UNCRC that relate to violence against children, including the right to physical and personal integrity. Article 19, protects children against “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse” while in the care of their parents or “any other person who has the care of the child”. Likewise, articles 36 and 37 protect children from exploitation and “torture or other cruel, inhuman or degrading treatment or punishment”. These three articles are strongly linked to a broad range of provisions in the UNCRC beyond those relating directly to violence: non-discrimination; best interests of the child; the right to life, survival and development; and respect for the views of the child.⁶⁵

Other international treaties, such as the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*⁶⁶ and the *Convention on the Rights of Persons with Disabilities*⁶⁷ also partially cover violence in alternative care settings.

Regional treaties reinforce the international framework protecting children against violence including those adopted by the Council of Europe, the European Union, the Organization of American States, the African Union, and mechanisms established to monitor and enforce them.

As the only regional child rights treaty, the *African Charter on the Rights and Welfare of the Child* is particularly relevant to protecting children from violence in alternative care.⁶⁸ It entitles children “permanently or temporarily deprived of his family environment” to “special protection and assistance”, including alternative care in the child’s best interests. It also protects children against “abuse and torture” (Article 16) and “sexual exploitation” (Article 27).

3.1.2 THE GUIDELINES

The *Guidelines for the Alternative Care of Children* are non-binding UN-endorsed principles, with no obligation on the part of states or any other concerned parties. Instead, they represent desirable orientations for policy and practice to assist governments in fulfilling their commitments under the UNCRC and to guide other actors concerned in developing their programmes.

As Guidelines for states on the management of alternative care, they are strong in their approach to banning all kinds of treatment that could result in violence being inflicted on vulnerable children. For example:

§13 states that in all care settings, children “must be treated with dignity and respect at all times and must benefit from effective protection from abuse, neglect and all forms of exploitation”, from care providers, peers and others.

§32 highlights that states must pursue policies that support families in meeting their responsibilities towards the child. These policies should, amongst others, promote measures to “combat poverty, discrimination, marginalisation, stigmatisation, violence, child maltreatment, and sexual abuse”.

§37 stipulates that households with legal guardians “benefit from mandatory protection from all forms of exploitation and abuse, and supervision and support on the part of the local community and its competent services”.

§46 requires that teachers and “others working with children” should receive specific training to help them “identify situations of abuse, neglect, exploitation or risk of abandonment” and that they should refer these situations to the competent authorities.

§79 indicates that states should formulate special and appropriate measures to protect children in informal care from “abuse, neglect, child labour and other forms of exploitation”, especially when the care is provided by non-relatives.

§92 highlights that the accommodation and supervision provided to children in alternative care must effectively protect them against abuse, in conformity with the law and without constraining their liberty.

§93 stipulates that all alternative care settings should protect children against abduction, trafficking, sale and other forms of exploitation.

§96 says that all disciplinary measures and behaviour management which could be considered “torture, cruel, inhuman or degrading treatment”, including confinement and other forms of physical or psychological violence, must be strictly prohibited. It also urges states to “prevent such practices”, ensuring that they are punishable by law. This paragraph also highlights that restriction of contact with members of the child’s family and should never be used as a sanction.

§97 stipulates that force and restraint should not be used “unless strictly necessary for safeguarding the child’s or others’ physical or psychological integrity”, and it urges that restraint by means of drugs and medication should only be used for therapeutic needs and never without evaluation and prescription by a specialist.

3.1.3 NATIONAL LEGISLATION

These international legal frameworks for children’s rights have helped to push national legislation and policy. One author described the UNCRC as a “turning point” in the provision of alternative care in Croatia.⁶⁹ Increasingly, national frameworks are prioritising not only the welfare of the child,⁷⁰ but the rights of children in alternative care.

The Inter-American Commission on Human Rights has noted that in Central and South America, “important efforts have been made to harmonise internal legislation, public policy and practice with UNCRC and other child rights treaties”.⁷¹ There is evidence across the country assessment reports that this is also the case in many other regions.

However, laws and policies are of limited value in the absence of effective enforcement and implementation. This is demonstrated by various studies and reports, which highlight that despite legislative reforms it has generally been difficult to translate them into practice. This is reinforced in the country assessments, where the implementation of legislation was a challenge echoed in almost all countries.

In Chile there is not one over-arching law or code that regulates the protection of children. There are fragmented public policies and legislation on children, which are interpreted differently by individual ministries, leading to practical problems in applying legislation.⁷²

The African country assessments showed limited evidence of the necessary harmonisation of domestic legislation or that reforms had been appropriately implemented.⁷³ In Gambia despite the number of laws and policies that addressed the issue of child protection, their effective implementation remained a challenge due to financial constraints coupled with inadequate human resources. As noted in their assessment report “this situation has a direct impact on the realisation of the rights and the protection of the most vulnerable children”.⁷⁴

Research suggests that, while causal relationships are difficult to demonstrate, the presence of a robust legal framework for the protection of children and young people is essential in driving the development of a protective care system. However, where legal frameworks are not in place or inadequately implemented, children remain at considerable risk of violence, without safeguards for their protection.

3.2 THE POPULATION OF CHILDREN IN ALTERNATIVE CARE

There is limited information and knowledge on children living in alternative care or in need of care and protection. Global figures can act only as estimates of the true scale of children in need.

In 2012, UNICEF estimated that 150 million children worldwide had lost both their parents.⁷⁵ However, it has been suggested that least 80% of children in institutional care have at least one parent alive,⁷⁶ and many orphans will never enter formal alternative care as they are cared for by their extended families. Therefore, the best estimate we have for children in need of alternative care is an extrapolation based on the estimation that 1% of children worldwide (24 million) are living without parental care.⁷⁷

There are also few reliable figures on how many children are in the different forms of alternative care, although attempts have been made to provide estimates. UNICEF has estimated that more than 2 million children live in institutional care facilities around the world,⁷⁸ while other evaluations indicate the number may be closer to 8 million.⁷⁹ The disparity in these figures – even the highest of which is considered to be an underestimate – gives an indication of the lack of reliable statistics on the situation of children without parental care worldwide.

On the one hand, this lack of data is due to the poor national systems for collecting data on children in alternative care; on the other, it points to a more general problem of discrimination, stigmatisation and marginalisation of children in alternative care.

Despite this paucity of data, this section uses the material that does exist, alongside national data gathered by the SOS Children’s Villages country assessments to show some regional tendencies and trends in alternative care provision,⁸⁰ which begins to shed some light on the complex interplay of factors that affect a child’s risk of experiencing violence in alternative care.

3.2.1 REASONS FOR ENTRY INTO ALTERNATIVE CARE

The reasons cited for children entering alternative care provide a significant insight into the child population and their characteristics. They also provide some indication of the challenges and vulnerabilities children in alternative care are likely to face.

Although countries regulate entry into alternative care differently and therefore categorise the reasons for entry differently, there are some common reasons for entry into alternative care that were found in all regions and also cited in the literature reviewed.

The most common reasons for entry into care included:

- Poverty
- Parental death or separation (due to migration, armed conflict or natural disasters)
- Illness or disability of the parents (especially due to HIV/AIDS in Sub-Saharan Africa)
- Mental illness or substance abuse of parents

- Disability of the child
- Behavioural issues of the child
- Violence (domestic violence, abuse and/or neglect of the child, exploitation, etc.)

Many of the reasons children enter alternative care are preventable: the Guidelines promote the importance of preventive services to mitigate the need for family separation (IV). In particular, poverty is highlighted as an inadequate justification for removing a child from family care (§15).

However, where there are ineffective preventive services and social support, poverty – often in combination with other factors, such as disability or HIV⁸¹ – becomes a strong determinant for a child’s entry into alternative care.

A number of reasons are more prevalent in some regions or contexts than others: HIV for example is widespread in some parts of Sub-Saharan Africa and has led to considerable hardship whereby families have been unable to continue looking after their own children without adequate support.⁸² Similarly, emergency situations such as armed conflict or natural disasters, which can devastate communities and give rise to mass migration, are also more prevalent in certain areas and during certain periods of time.⁸³

Other reasons are more global, such as mental health, disability, behavioural issues and violence. In the UK it was estimated that 50–90% of parents on a social worker’s caseload have either mental health problems or issues with substance or alcohol abuse.⁸⁴ Such families tend to have complex needs, with many children also exhibiting difficulties that need to be assessed and managed.⁸⁵ Yet, mental health services are globally chronically under-performing, with inadequate resources in most countries.⁸⁶

Of the 21 country assessments, 13 listed disability as a “root cause” of alternative care, including all eight African countries. Children with disabilities are separated from their families not only because of an often deeply entrenched shame and stigma attached to disability, but also because families are given inadequate support to care for their children. In the absence



© Julius Theo Castroverde

of sufficient support, they are often encouraged to surrender their children to institutions, even as babies.⁸⁷

Behavioural issues can lead to children entering alternative care: in Norway 8.8% of children are placed in alternative care because of behavioural issues.⁸⁸ This was also alluded to in African reports, such as in Kenya, where children – especially boys – were over-represented in ‘public care centres’ that consist of ‘rehabilitation centres’, ‘children remand homes’, rescue centres, and drop-in centres.⁸⁹ Challenging behaviour in children can lead to inappropriate responses by parents and caregivers, potentially leading to violence.

Finally, previous experiences of violence can lead children to enter alternative care as a protective measure. In 15 out of 21 country assessment reviewed, violence was a primary cause for entering the care system – meaning these children were either victim or witness of violence before entering alternative care.

In Colombia it was estimated that 21% of children were in alternative care because of maltreatment and 11.6% due to sexual abuse.⁹⁰ In Bosnia and Herzegovina and Croatia, over 50% of children entered alternative care because of neglect and in Argentina, an alarming 70% of all children were placed in alternative care because of previous experiences of violence.⁹¹ In one Polish study, young people from residential institutions in Warsaw were five times as likely to witness violence between adults, most often their family members, as their peers who were living with their families.⁹²

3.2.2 CHARACTERISTICS OF CHILDREN IN ALTERNATIVE CARE

Not only do children in alternative care lack the protection of a caring family, but they often experience multiple traumas, ranging from abuse and armed conflict to natural disasters.⁹³ Their circumstances may result in attachment disorders, cognitive impairment, and mental health problems such as anxiety and depression.

The circumstances and characteristics of many children who enter the alternative care system, consequently play a role in the violence that they may experience while in care. Factors such as age, gender, disability, ethnicity, reasons for entering the care system, and previous experiences of violence can all have an influence on their level of vulnerability.

Age and gender

The age and gender of children in alternative care can affect their level and type of vulnerability. As discussed in the conceptual framework, children under three years old are particularly vulnerable to developmental delays when placed in institutional care.

However, as data on children is often not disaggregated by age and gender – mentioned specifically in the country assessments from Armenia and Chile – knowledge of the child population and the ability to plan for particular vulnerabilities is limited.

Where data is available different countries paint very different pictures. In Lithuania, for example, 67.3% of all children in alternative care were between 10 and 17 years old – a relatively old population considering figures from other countries.⁹⁴ In Chile, approximately 22% of children in state-controlled alternative care were under five,⁹⁵ while in Argentina this figure reached 26%.⁹⁶ In Paraguay over 50% of children in alternative care were under three years old.⁹⁷

Many country assessments, such as Armenia, Paraguay, Benin and Malawi, indicated more or less equal numbers of boys and girls in alternative care, but in some countries a particular gender dominated in a certain type of alternative care. As mentioned, in Kenya, boys clearly dominated in “public care centres”.⁹⁸

Exactly what role age and gender play in the vulnerability towards violence in alternative care is still an open question and research is deficient. What is clear, however, is that there are powerful social assumptions about who is most likely to experience violence in alternative care – girls rather than boys, younger children rather than older – that cause other groups to be forgotten. It may be for this reason, that violence experienced by adolescents has typically been underestimated,⁹⁹ or that violence against boys is often disregarded.

Children of ethnic minorities

Data on the ethnicity of children in alternative care is often not available in the central databases of governments, or at times even the individual files of children. It would be necessary to conduct in-depth research to develop an accurate picture.¹⁰⁰ However, where research has been carried out, it demonstrates that in some countries there is a significant over-representation of ethnic minority children.

In Norway, children who have immigrated or who have parents that immigrated are over-represented in the alternative care system.¹⁰¹ In CEE/CIS countries, ethnic minorities represent a disproportionately large number of children in the alternative care system. A recent study in six- EU member-states, illustrates the dramatic over-representation of Roma children in institutions.¹⁰²

The picture is not uniform, however and other studies have produced findings indicating that the over-representation of ethnic minorities is not so significant.¹⁰³

What we do know is that children from ethnic minorities may experience particular forms of violence, or may be discriminated due to their ethnicity. This issue will be discussed further in chapter 5.

Disability

Children with disabilities tend to represent a large proportion of children in alternative care, particularly in residential and institutional care. In Eastern Europe and Central Asia, around a third of children in residential care were classified with a disability in 2007.¹⁰⁴ Even in countries where foster care exists, it is often not available to children with disabilities.

In Croatia, the “majority of children in [residential care] are children with disabilities and children with behavioural disorders, while children without parental care tend to be placed in foster care more frequently than in children’s homes”.¹⁰⁵

In Latin America there were few figures on children with disabilities. However, there was significant anecdotal evidence from leading child rights organisations that expressed concern at the over-representation of children with disabilities in institutional care. They also indicated that children with disabilities spend on average much longer in institutions, sometimes their whole lives. This is corroborated by a UNICEF study of Latin America, which indicates that in several countries, children with disabilities represent a significant proportion of children in institutional care.¹⁰⁶

Disability has an influence on a child’s vulnerability to violence and will be discussed further in chapter 5.

Behavioural issues

Focusing on behavioural issues is significant because it places a degree of “blame” on children and young people for their placement. It reduces complex problems associated with the children’s wellbeing and need to “behavioural issues” that remove responsibility from adults.

Characterising children with behavioural issues as challenging or to blame for their treatment, may incite a certain prejudice against children in alternative care; at the worst, in countries where corporal punishment is acceptable, it may lead to a more heavy-handed attitude in alternative care professionals.

Furthermore, children with behavioural issues may exhibit challenging conduct while in alternative care that, when left untreated or unattended, may manifest itself as aggression against care providers, peers or themselves. There is research evidence that supervision in care settings is not always adequate and that staff are not always clear on how best to respond to children and young people whose behaviour is putting them at risk,¹⁰⁷ a situation that results in children being placed at further risk of violence in both alternative care settings and the community.



© Sebastian Posings

CHAPTER 4: FORMS OF VIOLENCE, CHILDREN'S PERCEPTIONS OF VIOLENCE AND THE EFFECTS OF VIOLENCE IN ALTERNATIVE CARE

Identifying the specific nature of violence against children in alternative care, whether in institutions, residential care, or in foster care, is complex. This is due to the lack of research on violence against children internationally and the fact that this kind of violence is often still hidden, unrecognised, or even sanctioned. This may appear surprising given the attention given to cases of historical abuse in institutional care in countries like the UK, Ireland and the USA.¹⁰⁸

A wide range of data is needed, but “information on violence against children remains sketchy in both coverage and scope”.¹⁰⁹ In Croatia a 2011 report by the Ombuds-woman for Children stated that “violence in residential care facilities remains invisible, and in some of its forms, inadequately recognised”, even though “sporadically children and/or parents turn to the media to launch the investigation of cruel and degrading behaviour in child care institutions”.¹¹⁰

For the purposes of this report, we consider violence against children to include all forms of abuse or neglect that may be perpetrated by anyone – adult or child – who has contact with children in alternative care.¹¹¹ In this chapter we describe these forms of violence and reflect in more detail upon harmful institutional practice, which makes violence a part of the alternative care system, and peer violence, which involves violence being perpetrated by other children in alternative care.

The chapter then goes on to discuss the importance of children's perspectives, views and perceptions in informing our understanding of violence; in particular the role of harmful institutional practice and peer violence on their daily lives.¹¹² It concludes with an assessment of the available evidence indicating the grave effects of violence on children's future development and wellbeing.

4.1 ABUSE

Abuse of children is defined as an action or intentional omission that causes physical or psychological harm.¹¹³ It can take many forms; sometimes referred to as maltreatment, it includes physical, psychological, emotional, and sexual abuse (including sexual exploitation).

Child labour

Child labour is largely driven by vulnerabilities caused by poverty, and often children without parental care are forced to find work. According to UNICEF, "violence in the home, at school or in institutions can drive children to run away and become vulnerable to child labour".¹

The Kenya, Malawi and Togo country assessments provided evidence that children in informal or kinship care were vulnerable to child labour. Guardians sometimes exploit children in their care as domestic workers or to labour in the agricultural or commercial sectors.

¹ UNICEF, *Child Labour and UNICEF in Action: Children at the Centre*, New York: UNICEF, 2014.

PHYSICAL ABUSE

Physical abuse in alternative care involves acts of physical force against a child by another child or an adult, which cause physical harm or injury or have the potential for "harm to the child's health, survival, development, or dignity".¹¹⁴

There is a broad range of actions that are considered physical abuse, including: hitting, beating, grabbing, kicking, choking, pulling hair, shaking, biting, strangulation, burning, and assault with an object or weapon.

Physical abuse can be the result of corporal punishment, which is commonplace in many parts of the world. Children living in alternative care are highly vulnerable to physical abuse, especially under the guise of "discipline". As of October 2012, 52 states explicitly prohibit corporal punishment of children in residential and institutional care, while only 40 prohibit corporal punishment of children in all formal foster care.¹¹⁵ At least 123 states have no prohibition of corporal punishment in any form of alternative care or day care.¹¹⁶

Physical restraint – whereby adults use physical force to protect children from doing harm to themselves or others – is a highly contested practise and in some instances borders on physical abuse. The Committee on the Rights of the Child¹¹⁷ and the Guidelines¹¹⁸ allow for physical restraint in some cases, but emphasise that it should be applied with caution under the direct supervision of a skilled professional. Studies have found that if physical restraint is applied poorly or in inappropriate circumstances, it can easily slip into abuse.¹¹⁹ It is associated with injury to children, young people and staff and unwarranted and excessive use of restraint has been a feature of inquiries into abuse in residential care.¹²⁰

PSYCHOLOGICAL AND EMOTIONAL ABUSE

Physical abuse in alternative care is often coupled with psychological and emotional abuse. In Armenia a survey of violence in alternative care structures revealed that in residential care 44% of the children surveyed suffered from both physical and psychological abuse.¹²¹

Emotional and psychological abuse also includes a wide range of behaviours, for example: bullying, verbal abuse, ridicule, degradation, humiliation, psychological domination or control, isolation, confinement, restricting family visits, sleep deprivation, destruction of personal belongings, and degrading and menial labour.

While there has been limited research specifically on emotional and psychological abuse in alternative care, it is very much associated with harmful practices applied in these settings. For example, the country assessment in Peru indicated cases of emotional and psychological abuse in the guise of “corrective actions” including: limitation of free time, banning of preferred activities, imposition of domestic work, suppression of food, restriction on study time and family visits, as well as humiliating punishment.

SEXUAL ABUSE

Children in all forms of alternative care are at risk of sexual abuse, even in situations where there is no evidence of apparent physical abuse.

As with other forms of abuse, sexual abuse may be more widespread in residential or institutional care settings. A study in the Netherlands found that children and adolescents in residential care are at increased risk of child sexual abuse compared to children in foster care.¹²² Authors suggest a reason for this may be that in large care settings with many children and care providers working in shifts, the lack of individualised and continuous care make it difficult to establish and maintain stable relationships with both care providers and peers, leaving children more exposed to sexual abuse.

However, in the United States, studies found that rates of sexual abuse of children in the foster care system are four times higher than among the general population of children;¹²³ with other recent reports echoing these findings in other parts of the world.¹²⁴

Girls are especially vulnerable to sexual abuse in alternative care. A study of violence in children’s homes in England, found that girls were three times more likely to experience sexual violence than boys, and also the severest forms.¹²⁵

It is perhaps this disconnect and lack of strong relationships that puts children in alternative care at particular risk of facing sexual abuse outside the care setting: there is substantial evidence that residential care settings may be targeted by abusers in the wider community.¹²⁶

NEGLECT

Although neglect is one of most common forms of violence experienced by children in alternative care, it is often overlooked. It can be defined as the failure to provide for child development, when in a position to do so, in one or more of the following areas: nutrition, clothing, supervision, and medical care.¹²⁷

Neglect in alternative care can only occur in cases where reasonable resources are available to provide for children and therefore it is difficult to measure, resulting in a lack of international research evidence. However, the consensus seems to be that neglect is widespread, especially in residential and institutional settings.

In addition to other concerns, many children in large-scale institutions face problems of neglect caused by poor quality standards.¹²⁸ This includes life-threateningly poor nutrition, hygiene and healthcare, lack of access to education, and a chronic lack of physical and emotional attention and affection. The Committee on the Rights of the Child has also noted this on several occasions across Latin America, Africa and Asia.

Several reports indicate the neglect of children in relation to medical treatment. A study of the situation of children in alternative care in Latin America found that children were often either denied medical treatment or it was delayed.¹²⁹ The Benin country assessment indicated that children were given inappropriate health remedies such as herbal tea, prayers, or referral to unqualified and un-licensed physicians.

Children with disabilities may also face significant neglect in institutions. Research has found that compared to their non-disabled peers, children with disabilities are 1.8 times more likely to be neglected and 2.8 times more likely to be emotionally neglected in institutions.¹³⁰

Neglect of the mental health needs of children and young people living in alternative care is also an emergent problem. There is a growing body of research demonstrating the high level of mental health problems amongst children living in alternative care,¹³¹ ranging from the trauma experienced by the victims of war and displacement, to the psychological effects of family rejection or different forms of abuse. Equally, research indicates that, internationally, there is a lack of sufficient and appropriate services.

Neglect in the form of lack of supervision is also an issue of concern. Research shows that the supervision in alternative care settings is not always adequate and that staff are not always clear on how best to respond to children and young people whose behaviour puts them at risk. In a survey of adolescents living in foster care in the UK, it was found that they are not always supervised, even when carers have known that they are vulnerable to sexual abuse and exploitation.¹³²

4.2 HARMFUL INSTITUTIONAL PRACTICE

Harmful institutional practice refers to all forms of abuse and neglect that occur on a regular basis and as the result of a care “regime” imposed by adult caregivers or staff. It can be particularly brutal, as the violence usually occurs over prolonged periods of time or throughout the duration of an alternative care placement.

Instances of harmful institutional practice have been well documented around the world, and the list is alarmingly long.¹³³

A Romanian study found that 38% of seven to 18-year-olds in residential care reported severe punishments or beatings.¹³⁴ A report for the Committee on the Rights of the Child in Kyrgyzstan found that children living in institutional settings were beaten, forced to do physical exercise and deprived of sleep.¹³⁵

In Kazakhstan, violence by institutional staff, for the purpose of “disciplining” children was found to include

beatings with hands, sticks and hoses, and hitting children’s heads against the wall, restraining children in cloth sacks, tethering them to furniture, locking them in freezing rooms for days at a time and leaving them to lie in their own excrement.¹³⁶ Armenia’s country assessment made reference to a baseline study carried out in four of the country’s institutions, where children indicated that they had been beaten, humiliated in front of their peers or forced to stand in a corner. The survey indicated that teachers had ignored 10% of the children when they reached out for help.¹³⁷

In Latin America, similar patterns of violence have been revealed.¹³⁸ In institutions, punishment can quickly turn into serious cases of abuse, for example when children are deprived of their liberty, restricted family visits, physically punished or humiliated, made to stand or kneel for hours, or even kept in solitary confinement. It was also found that this form of punishment was even more serious in the case of children with mental disabilities.

Paraguay revealed cases of children being locked in their rooms after bedtime, with no facilities to relieve themselves in a toilet, so they had to go on the floor or in a container.¹³⁹ In Benin, a survey found that children in residential care were regularly subject to corporal punishment (caning and hitting), deprivation of food, and additional [domestic] duties.¹⁴⁰

A recent study on the emergence of residential care programmes in Spain indicates that residential care had been identified as inadequate by the authorities; operating a severe disciplinary regime.¹⁴¹ In the UK, official enquiries into historical abuse have identified a range of such practices.¹⁴² These may include both acts of physical or sexual violence, or deprivation of food, liberty or contact with families.¹⁴³ There is on-going evidence that some residential institutions may still operate regimes that are violent as well as neglectful in meeting young people’s needs.

In some cases, this type of violence will be under the guise of “treatment”. The UN study on violence against children indicates that electric shocks are used as an “aversive treatment” to control children’s behaviour in some institutions, while psychiatric drugs are used to

“dominate or coerce” children. Drugs may be prescribed by doctors without a prior diagnosis of a psychiatric ailment that would justify their use.¹⁴⁴

A comparative study of the use of psychotropic medication for a sample of young people in alternative care in the US, found those in residential settings to be more likely to receive medication than those in foster care; attributed to a more medicalised model in residential care versus the psychosocial approaches which tend to be used in foster care.¹⁴⁵

In some states of Argentina, 68% of all institutions report to be using psychiatric drugs on children and young people, with this number rising to up to 93% in the case of specialised facilities for children with disabilities.¹⁴⁶ Children with disabilities may also be subject to violent medical interventions, such as electric shock treatment.¹⁴⁷

The practice of institutionalising children with disabilities together with adults is also an alarming trend in some countries. It was mentioned in the country assessments of Paraguay and Croatia. In these cases, children with disabilities face an increased risk of suffering from physical and sexual abuse.

The causes for such levels of harmful institutional practice have mainly been attributed to: the size of institutions; the mixing of different age groups; the lack of resources; poor management and lack of support to management; lack of clear aims and objectives; and poorly trained residential staff.¹⁴⁸ Other studies attribute it to the closed and often isolated nature of institutional care and the fact that many resident children are unaware of their rights and are powerless to defend themselves, with children with disabilities often being the most vulnerable.¹⁴⁹ There are also examples where staff perpetrators deliberately created institutional environments that promoted abuse.¹⁵⁰

4.3 PEER VIOLENCE

Peer violence refers to the different forms of violence that are inflicted on children in alternative care by other children. Until recently, this manifestation of violence had been widely ignored.

From the 1990s, as children’s voices were slowly included in studies on violence in alternative care, it became apparent that peer violence is a serious issue for children. According to children and young people, this is one of the most significant ways they experience violence in alternative care and it is a form of violence that tends to be underestimated by carers.

Although, there is a gap in specific research on this subject, a few studies demonstrate its significance. Research in England has shown that children in residential care are at greater risk of physical and sexual assault from their peers than from staff.¹⁵¹ An analysis of 223 questionnaires from children in 48 different children’s homes found that 13% of children had been sexually assaulted by a peer and 40% had been bullied.¹⁵²

Research on state-run institutions in Kazakhstan reported that nearly 43% of children in shelters and 50% in orphanages and institutions reported witnessing violence among children. Between 40% to 80% of staff, working in different types of institution (including infant homes, facilities for children with disabilities, and correctional facilities), reported violence between children.¹⁵³ In the United States, abuse was confirmed for 12% of all children in homes, with an alarming 70% of the perpetrators being other children.¹⁵⁴

It is important to emphasise that peer violence is a product of institutional life and/or children’s experience of past abuse and violence, and not the sole responsibility of the child perpetrators. The UN study indicates that children are particularly vulnerable to peer violence in residential and institutional care when conditions and staff supervision are poor. Lack of privacy and respect for cultural identity, frustration, overcrowding, and a failure to separate particularly vulnerable children from older, more aggressive children often lead to peer violence.¹⁵⁵

One of the few studies on peer violence in residential care has also pointed to the importance of the dynamics of the residential peer group and its norms in shaping violence amongst residents.¹⁵⁶ Young people residing in residential care were found to have their own rules, with hierarchy (“top dogs”), age/maturity, and time in placement (the “new” kids being tested) all playing a role. A normalisation of violence was also identified,

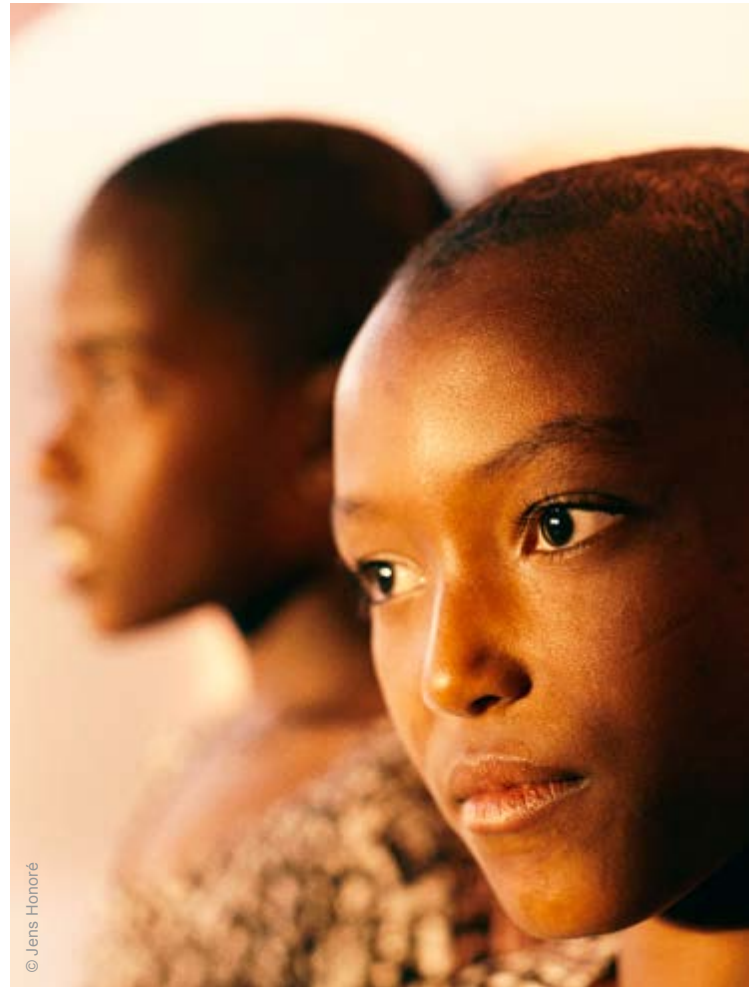
with young people perceiving that violence depended on their place and role within the peer group.

In the same study, young people identified deprivations (such as lack of pocket money, quality of food, or school equipment), stigmatisation, and frustration, as well as poor relationships with staff as vital factors that influence the relationship between the group and peer violence amongst residents. Furthermore, young people reported they often felt ignored by staff or that they made decisions considered to be illegitimate and unfair. They also reported incidents of staff violence amongst residents as a means of punishment. But above all, young people stated that they did not respect staff and would never confide in them if they were subjected to peer violence.

Similar circumstances and conditions can also be found in foster care. A study of foster care in England revealed that the biological children of foster carers had abused 4.5% of children in the study.¹⁵⁷ A sample of 133 children maltreated while in foster care found that in a fifth of cases, they had been sexually abused by other children, including other fostered children (in a half of these cases), siblings, the foster carers' children or other unrelated children.

Children are victims of their circumstances and child perpetrators of aggression or violence should not be treated as adult perpetrators. Unlike adults, children are developmentally not capable of the same kind of intellectual capacity for reasoning, planning and understanding the implications of their actions.¹⁵⁸ Once the situation of violence has been interrupted and measures have been taken to protect the victim, it is critical that a child perpetrator be guaranteed access to specialised therapeutic services. Treatment and recovery are critical to stopping patterns of repeated violence.

4.4 VIEWS AND PERCEPTIONS OF CHILDREN AND YOUNG PEOPLE ON VIOLENCE IN ALTERNATIVE CARE



Despite the growing recognition of the severity of violence against children in alternative care, there is still limited specific research on how children and young people view the issue. There is widespread recognition of the importance of children's views, and a growing body of research on how they experience the alternative care systems in different countries.¹⁵⁹ Studies can also be found on how to support children to express their views of risk and protection,¹⁶⁰ and on the needs of specific groups of children in care in relation to their disabilities, sexual orientations, minority status or when leaving care.¹⁶¹

This kind of research provides considerable insight into the forms of violence children experience and also gives voice to a population of children who may otherwise remain invisible and voiceless. Listening to the voices of children and young people is not only the right thing to do; it can also play a vital role in identifying the issues surrounding violence against children in alternative care, as well as the solutions.

A contribution to a consultation process from England indicated that of all the different types of violence they face, violence against children in both foster care and residential care was of concern to children. The children in foster care indicated that they were “keen for social services to check on their welfare regularly and see them in private: some were, tellingly, even worried about the consequences about coming to the consultation”.¹⁶² The list of things they wanted social services to check included: “that they were not being beaten”, “that they were eating properly” and “that they felt safe with their carer”. All these are telling of some abuse and neglect in their foster placements.

In the same study, children in residential care had strong and worrying things to say about the way residential staff used physical restraint. Their experiences included being restrained after avoidable conflicts for trivial reasons or as a means of punishment, and they described being restrained by dangerous or painful methods, such as being sat on or having their arms wrenched behind them. They proposed a number of restrictions on the practices, including asking children before a placement how they liked to be calmed down or treated when they were upset.

One boy said on restraint:

*It makes you feel like you're nothing.
People holding you down brings bad
memories. It's horrible.*

During a violence consultation in the Middle East and North Africa children also discussed violence in institutions. Two children, from Sudan and Tunisia, talked about the physical and psychological abuse they experienced in institutions, which included being “exposed to all sorts of violent acts such as pulling out nails [and] stand[ing] in the sun for long periods

for time”. Their recommendations for how to stop it included creating legislation, which abolishes all forms of violence. Children from South Asia and the Caribbean also highlighted the importance of legislation protecting children and young people from violence in institutions.¹⁶³

Children’s views can also inform the way we think about violence and define it. One study examined the meanings assigned to violence by young people in institutions.¹⁶⁴ It considered children’s experiences in Finnish reform schools, which are part of the social welfare system, not a juvenile detention centre. The young people defined violence as an “elusive and ambivalent concept because it refers to different forms of behaviour and relationships with various contextual meanings, even though popular notions tend to represent it as a stereotypically universal phenomenon with an evil perpetrator and an innocent victim”.¹⁶⁵

In that same study, young people also suggested that violence needs to consider dimensions of gender as boys’ and girls’ positions are often different: girls were considered victims or passive observers of violence and boys reported that group violence for example functioned as creating respect and internal hierarchy in residential centres. The authors suggested that certain practices maintain violent relationships in residential care and these include small incidents such as how male staff members interpret girls’ behaviour, to what extent it is understood that “boys will be boys” and the “accepted” behaviours that go along with this abuse/violence.¹⁶⁶

Other findings have also highlighted the importance of gender in violence against children in alternative care; noting that understanding exactly how gender influences the experience of violence by listening and documenting young people’s accounts is crucial. It helps to challenge existing assumptions and “normalised” behaviours in a variety of institutions and environments.¹⁶⁷

Given the general lack of reporting of violence and children’s own views on the issues it is clear that more information is needed about what prompts children to seek help, what makes them reluctant to do so and what might encourage them to seek support. It was by incorporating their views, for example, that bullying

and other forms of peer violence first came to light. Children and young people with alternative care experience are experts in the daily challenges of living in alternative care and no study would be complete without their views.¹⁶⁸

4.5 THE GRAVE EFFECTS OF VIOLENCE ON CHILDREN

Violence against children has devastating consequences for their health and wellbeing, both in the present and in the future, as it threatens their survival and development. The Committee on the Rights of the Child has captured this toll, including:¹⁶⁹

- Fatal or non-fatal injury (possibly leading to disability)
- Health problems (including failure to thrive, and lung, heart and liver disease and sexually-transmitted infections in later life)
- Cognitive impairment (including impaired school and work performance)
- Psychological and emotional consequences (feelings of rejection, impaired attachment, trauma, fear, anxiety, insecurity and shattered self-esteem)
- Mental health problems (anxiety and depression, hallucinations, memory disturbances and suicide attempts)
- Risky behaviours (substance abuse and early initiation of sexual activity)
- Developmental and behavioural consequences (non-attendance at school, and antisocial and destructive behaviour, leading to poor relationships, school exclusion and conflict with the law)

This research also found that the consequences of violence are lasting and severe. Physical abuse often causes some form of harm or injury, and can result in disability or even a child's death.

Psychological, emotional, and sexual abuse often have highly traumatic effects on children. A recent study revealed that "prolonged or excessive exposure to fear and anxiety can cause levels of stress that impair brain

development, early learning and later performance in school, in the workplace and the community".¹⁷⁰ When consulted about emotional violence, children and young people in England indicated it made them feel like they are "not worth anything", or like "less of a person".¹⁷¹

The same have been echoed in studies in Eastern Europe, where substantial evidence has been gathered on the impact of institutional neglect on the health and development of children in alternative care. It has been found that overcrowded environments lead to a lack of stimulation and opportunity for children to develop "warm and continuous" relationships with caregivers.¹⁷² This can result in serious developmental delays and long-lasting consequences and effects on children.

4.5.1 CYCLES OF VIOLENCE

Cycles of violence refer to the phenomenon whereby children who experience violence may themselves become aggressors. One established finding in the psychological literature on aggressive and violent behaviour is that "violence begets violence": once violence becomes a part of a child's life, it tends to recur in different settings, and may even be passed from one generation to another.¹⁷³

Children who grow up in institutions where violence is rampant are more likely to engage in aggressive behaviour, become involved in crime or prostitution, inflict self-harm, or commit suicide.¹⁷⁴ Indeed, research shows that much of the violence experienced by children in alternative care is peer violence.

There is also evidence that the vast majority of children who sexually harm other children have been subjected to multiple forms of abuse and neglect within their own families and that this could contribute to the onset of sexually harmful behaviour.¹⁷⁵ One study reveals that around 55% of adult sex offenders admit to committing their first offences during their youth.¹⁷⁶

If quality alternative care systems are not in place to address their emotional and physical needs, cycles of violence are likely to continue throughout alternative care placements, and long after children and young people have left care, perpetuating violence in future generations.



© Martin Jakubowicz

CHAPTER 5: SOCIAL CONDITIONS THAT LEAD TO VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE

The preceding chapters have illustrated the forms and extent of violence observable in alternative care systems across the world. In the “background” chapter, we painted a picture of the alternative care population – vulnerable children in need of support, consideration and protection. In the “forms of violence” chapter we provided evidence of the extent and types of violence suffered by children in alternative care settings, their perceptions of violence and the effects violence can have on their long-term development and wellbeing.

In this and subsequent chapters we move on to the questions of why and how violence manifests in the alternative care system, and begin to unravel some of the

challenges that face alternative care policy and practice.

This chapter describes some of the social and cultural factors that lead to an acceptance or tolerance of violence against children. These include violence in families and communities, which has implications for tolerance of violence in children and young people; the social acceptance of violence against children; and levels of discrimination against particular groups of children.

These factors combine to make children more vulnerable to violence in alternative care settings, and provide a starting point for considering advocacy measures and policy changes that could help to protect them.

5.1 VIOLENCE IN FAMILIES AND COMMUNITIES

Children may experience various degrees of violence in their families. While the family has the potential to be the single greatest protection against violence for a child, it can also be a place of violence.

The Gambia country assessment pointed out: “It is important to recognize the fact that not all families are caring and protective of their children or provide the love, warmth and enabling environment children require to reach their fullest potentials in life. Abuse, neglect, and the exploitation of children at the hands of family members is not uncommon”.¹⁷⁷

Five years after the UN study, a follow up survey reported that across regions, reports of violence against children in the home are rising in certain countries.¹⁷⁸ The United Kingdom, for example, reported a record 16,385 serious cases, many of them of severe neglect, to police or social services in 2010–2011, a 37% rise from the previous year. In Taipei, government statistics show that child abuse cases increased by 30% between 2005 and 2009.¹⁷⁹

According to the UN study, it is estimated that annually 133 to 275 million children witness violence in the home on a frequent basis, usually in the form of fights between parents.¹⁸⁰ Domestic violence is often accompanied by violence against children. Dutch studies have estimated that 30 to 70% of children with abused mothers are also subject to violence.¹⁸¹ Research suggests that children living in situations of gender-based domestic violence may be considered victims of violence, since they directly suffer the consequences, not only physical and emotional, but also those “resulting from having lived and formed their personality in an atmosphere of inequality of power”.¹⁸²

High levels of physical punishment may also be associated with social and cultural norms. The UN study indicated that in all regions of the world between 80% and 98% of children suffer physical punishment

in their homes, with a third or more experiencing severe physical punishment resulting from the use of implements.¹⁸³ In 2014 a UNICEF survey suggested that almost 60% of children (1 billion) worldwide between the ages of two and 14 are regularly subjected to corporal punishment by their caregivers.¹⁸⁴

A 2011 report by UNICEF in which the use of violent discipline by parents was studied in 37 low and middle-income countries found that, “on average, 86% of children experienced physical punishment or psychological abuse, and 17% experienced severe physical punishment”.¹⁸⁵ A study of children’s views in a residential setting in Botswana found corporal punishment to be a regular occurrence, and attributed to “normal parenting practices”.¹⁸⁶ While in Ghana, among children ages 10 to 16, approximately 62% of children reported beatings by their parents, most frequently with a cane.¹⁸⁷ In Latin America physical abuse is often an “accepted form of discipline”, with corporal punishment being used frequently in alternative care institutions.¹⁸⁸ In Peru, a survey in which women were asked about the forms of punishment used to reprimand children, the most common forms of punishment cited were hitting and slapping.¹⁸⁹ In that survey, 24.4% of the women interviewed believed that corporal punishment was necessary in order to discipline their children.

Children and young people also experience violence in their communities. They often witness violence – such as gang related violence and armed conflict – and suffer abuse at the hands of community members, and often from individuals they should be able to trust, such as teachers, religious leaders and the police.

In Kenya, a national survey found that parents were the most common perpetrators of physical violence by family members, while teachers were the most common perpetrator of physical violence by a public authority figure, followed by the police.¹⁹⁰

In the UK, a study revealed that while generally children had reported feeling safe in their foster placements, a high proportion felt much less safe when they ventured into their communities: one third had been assaulted and almost two thirds had witnessed an assault.¹⁹¹ Another study noted that daily life within

the children's homes was relatively peaceful, with young people and staff experiencing more violence in the community immediately outside the home.¹⁹²

A child's previous experiences of violence, either having witnessed or having been a victim of any form of violence, is a significant factor in his or her subsequent vulnerability to violence in alternative care.

Vulnerable children risk becoming 'poly-victims', meaning that they are exposed to multiple manifestations of violence in different settings.¹⁹³ For example, a child might suffer from corporal punishment by parents, physical assault by a peer, and bullying in school. A 2009 study on violence against children from Tanzania, found that young women and men aged 13 to 24 who had experienced sexual violence also tended to report exposure to physical and emotional abuse.¹⁹⁴

In the USA, a 2008 survey found that multiple experiences of violence were common; children who were exposed to one type of violence were at far greater risk of experiencing other types of violence.¹⁹⁵ A study in the UK indicated that young people who enter into care "due to past sexual abuse from within their families (or sexual exploitation outside them) sometimes become a target for sexual abuse by peers within their children's home".¹⁹⁶

One possible reason for this is that as children grow older, they accept violence in their daily lives and might even consider it necessary or deserved. In a study that looked at children's own views and experiences of corporal punishment in England, children between the ages of five and seven overwhelmingly disapproved of smacking and saw it as something that adults often regretted, and which made children upset, angry and sometimes want to smack someone else.¹⁹⁷ Older children, however, displayed a general acceptance of a limited degree of corporal punishment, believing it to be necessary for younger children.

A similar ambiguity about corporal punishment was found in another consultation of young people; some thought it was a legitimate form of discipline, with some even seeing it as a form of affection from parents and caregivers.¹⁹⁸ The discrepancy between the views

of young and older children shows violence can become internalised as "normal" as children grow up.

5.2 SOCIAL ACCEPTANCE OF VIOLENCE AGAINST CHILDREN

Persistent social acceptance of some types of violence against children is a major factor in its perpetuation in almost every state.¹⁹⁹ Children, parents, caregivers and communities may consider violence against children to be inevitable.

In every region of the world much violence against children remains legal, state-authorised and socially approved.²⁰⁰ Laws in a majority of states still condone "reasonable" or "lawful" corporal punishment and reflect societal approval of violence when it is described or disguised as "discipline".²⁰¹ While most societies reject the most severe forms of violence, these same societies may accept or even condone "lesser forms" of violence against children. The same can be said about violence against women, or minority groups, and people with disabilities.

Social acceptance can mean simply "turning a blind eye". In many cultures violence against children, especially sexual abuse, comes with such a deeply entrenched sense of shame for the children and families that adults may actively ignore or reject cases of violence.

This acceptance of violence against children is strong in alternative care systems. As violence is accepted as a mechanism to control or educate a child, violence in alternative care may be deemed especially "worthy" given the fact that children may be considered problematic or from flawed backgrounds.

In Western Europe and North America where the population of children in alternative care is generally older, behavioural issues of the child becomes a common reason for placement. Tellingly, it is in these regions where violence in residential care is often attributed to the fact that the residential population tends to be



adolescent.²⁰² This points to a general acceptance of violence in alternative care amongst young people either because they have behavioural issues that need to be “dealt with” or because it is just an inevitable part of growing up.

A study in Finnish institutions revealed that certain practices perpetuate violent relationships in residential care, including the acceptance of violence amongst boys and the behaviour that goes with this abuse.²⁰³ This acceptance perpetuates peer violence not only by tolerating aggressive behaviour in children, but also by allowing adults to ignore their roles and responsibilities to prevent and stop abusive situations among peers in alternative care.

5.3 DISCRIMINATION

Discrimination is a powerful factor that leads to violence before, during and after a placement in alternative care. The reasons children are shunned from or discriminated against by society may also be reasons for entry into alternative care, such as being born out of wedlock or due to superstitious beliefs. The Togo country assessment noted allegations of child witchcraft were cited as reasons for families abandoning their children to alternative care, while in Malawi a belief in spirits was one of the reasons limiting families’ willingness to foster children unrelated to them.²⁰⁴

This discrimination is then amplified once children have entered alternative care, as in many countries children are discriminated against, stigmatised and marginalised for their care status. This makes them more vulnerable to violence from their community and caregivers. It may also make treatment and recovery all the more difficult. In Argentina, it was noted that

families who have children in alternative care are often stigmatised, as there is an assumption of culpability. Caregivers and social workers are often reluctant to work with the families of origin, making reintegration difficult.

While discrimination affects all children in alternative care, some groups of children are particularly discriminated against, putting them at increased risk of experiencing violence.

In Sub-Saharan Africa HIV/AIDS is one of the most frequent reasons for children entering alternative care. A study of 189 young people living in residential institutions in Zimbabwe revealed that young people felt verbally abused by staff, who taunted them with reference to being abandoned or their parents having AIDS.²⁰⁵

Children with disabilities are systematically discriminated against and excluded from society, which renders them disproportionately vulnerable to neglect and abuse.²⁰⁶ Children with disabilities are over-represented in alternative care, especially in institutional care and studies have consistently shown that children with disabilities are more likely to experience violence in alternative care than their peers.²⁰⁷ They may be especially likely to experience

severe corporal punishment because of their presence in large numbers in care institutions and their particular disabilities, which may make it more difficult for them to report their experiences or defend themselves.²⁰⁸

In some cases, discrimination of girls may make them more vulnerable to violence, especially sexual abuse.²⁰⁹ The Malawi country assessment noted that girls are more vulnerable than boys. Men may take advantage of their financial needs by offering cash or shelter to girls on the streets, leaving girls highly exposed to abuse by men. There are also several studies indicating that girls, and especially girls with disabilities, are subjected to medical procedures for the purposes of limiting their fertility.²¹⁰

Children from minority groups may also be more likely to experience corporal punishment than others, and corporal punishment may have a gender dimension, with girls and boys experiencing different types or frequencies of violent punishment.²¹¹ A salient example is Roma children in institutional care in countries such as Bulgaria and Hungary.

In Bulgaria, this is recognised as an issue by those professionals committed to equality of care, but due to the fact that data on ethnicity is not collected there is no hard evidence to make a case for improvements.²¹²

Discrimination influences violence: An example of Romani children in Hungary

Discrimination against certain groups of children, especially ethnic minorities, can make them particularly prone to violence in alternative care:

Romani children are more likely than non-Romani children to be placed in children's homes, especially large institute-style homes. Some child welfare workers exhibit anti-Roma attitudes, which undoubtedly influence their work in support of Romani families at risk of separation or in support of the return of Romani children to their families.

In State-run children's homes, Romani children are reported to experience discriminatory treatment on account of their ethnicity as well as their status as an institutionalised child. They face negative

treatment and remarks from their caregivers and their peers in the homes, as well as in accessing public services outside the homes such as schools. Some children's homes have reportedly become collectors of children that other homes do not want. Such homes often house a large proportion of Roma and may offer material conditions of a lower standard than other homes.

An excerpt from European Roma Rights Centre, *Life Sentence: Romani Children in State Care in Hungary*, Budapest: European Roma Rights Center, 2011, p.47 available at: www.errc.org/cms/upload/file/life-sentence-romani-children-in-state-care-in-hungary-20-june-2011.pdf



© Jens Honoré

The social exclusion that is associated with discrimination also makes children in alternative care less likely to receive the services they need within the community or access to child rights specialists, making the recovery from violence all the more difficult.

Whatever the form of care, the reasons children in alternative care are more vulnerable to violence are extremely complex and go beyond the loss of the protective family structure. The factors that intervene

are many and varied, and interact with each other. This point is well illustrated in Armenia's country assessment, which highlights that children who live in residential care institutions because of difficult social-economic conditions are among the most stigmatised and marginalised social groups. They might find themselves at "significantly increased risk because of stigma, negative traditional beliefs, lack of social support".²¹³



CHAPTER 6: ELEMENTS OF ALTERNATIVE CARE THAT INFLUENCE VIOLENCE AGAINST CHILDREN

The act of removing a child from his or her family in circumstances where separation could be avoided can in itself be considered an act of violence. The Guidelines are clear that children should only be removed from their families “as a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration” (§14).

In this sense, alternative care systems that do not function appropriately and provide adequate gatekeeping mechanisms and preventive services to keep children out of alternative perpetuate violence by failing to fully support families.²¹⁴

What we are interested in here, however, is the experience of children once they enter alternative care and the systems that should be in place to protect them from the risks of violence. Despite acknowledgement of the increased risks of violence faced by children in alternative care, remarkably little consideration has been given to the possible aspects of alternative care that influence and enable violence to be perpetrated on this vulnerable group of children.²¹⁵

While evidence exists to link alternative care and violence against children, a causal connection between the two is not inevitable. It is possible to provide children with caring and safe alternative care. The Guidelines are in place to assist in this endeavour to ensure that “the

most suitable forms of alternative care are identified and provided, under conditions that promote the child's full and harmonious development" (§1b).

There is also evidence that this is possible. A recent study in Finland revealed that children and young people experience more physical and psychological abuse by adults in their homes than in residential or foster homes.²¹⁶ Another study of the safety of young children in alternative care in New Zealand found that the majority were safe in care,²¹⁷ while children in one study of foster care in the USA indicated that children felt very safe in their placements, and significantly safer than in their birth family home.²¹⁸ Rates of perceived safety, however, were lower in residential settings.

These findings indicate that alternative care does not inherently perpetuate violence against children and young people, but rather that the incidence of violence is inextricably linked to the overall quality of care.²¹⁹

This chapter proposes that the failure to provide quality care and child protection mechanisms heightens the risk of children experiencing violence in alternative care. It describes weakness within systems that compromise their ability to ensure quality care.

6.1 IMPACT OF QUALITY CARE AND CHILD PROTECTION ON VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE

The Guidelines provide comprehensive guidance on the elements that should be in place to ensure quality care and protect children from violence. From preventing the need for alternative care (IV) to providing a framework of care provision (V), determining the most appropriate forms of alternative care (VI) and provision of alternative care (VII), they provide a structure with which to assess and plan "suitable" alternative care services that meet the particular and individual needs of children.

Quality alternative care focused on the prevention and mitigation of violence will undoubtedly have a positive impact on the risk of violence for vulnerable children. In all care settings, these improvements will refer to the extent to which measures from the Guidelines are implemented to respond to the best interests of the child.

Below we consider some of the main weaknesses identified that compromise the ability of alternative care systems to protect children from violence.

6.1.1 COORDINATION AMONG STAKEHOLDERS

According to the Guidelines, the state has the main role and responsibility for coordinating alternative care. In particular, it has the responsibility to "facilitate active cooperation among all relevant authorities" (§24).

Poor communication and information sharing, and lack of coordination between stakeholders responsible for child welfare can mean that warning signs of violence in alternative care are missed.²²⁰ Sharing information, making sense of the information and identifying its significance are all important processes to recognise emerging patterns of behaviour and poor outcomes.²²¹ There is evidence that poor working relationships detrimentally affect the quality of care, not only by making the system inefficient but also because stakeholders have no feeling of accountability.²²²

In Croatia it was suggested that the activities of the social welfare centres are affected by the lack of coordination between different services within the social welfare centres themselves, and between them and other institutions, resulting in the lack of continuity in the monitoring of the child and the un-integrated support system.²²³

Evidence in the UK shows that the threshold at which children's social care is likely to accept a referral for children at risk of harm or children in need of protection is a frequent source of inter-professional tension and confusion. Scarcity of resources also creates threshold tensions between cases of children "in need" and child "at risk". The reasons for becoming a child "in need" mirror those for entry to care: abuse or neglect and family dysfunction.²²⁴



© Danielle Pereira

Existing research supports the premise that pro-active, well-coordinated partnership approaches are vital in preventing abuse and neglect. Where organisations such as the police, children’s services and NGOs work together to *identify and address* violence, a significant number of cases have come to light.²²⁵

Effective inter-professional communication has to be embedded in care practices and systems to enable a holistic assessment to be made of the carer, child, and quality of care provided.²²⁶ Good relationships can also support the care process when things go wrong, allegations are made, or complaints or concerns are raised.

6.1.2 REGISTRATION OF ALTERNATIVE CARE FACILITIES, OVERSIGHT AND MONITORING

An international review of foster care, suggests that poor assessment and supervision of foster carers may increase the risk of abuse.²²⁷ The same can be said about residential care.²²⁸

Whether state-run or private, alternative care facilities and caregivers must be regularly assessed and monitored to make sure that they operate under the highest possible standards. This is particularly challenging for countries with a mixed economy of care, or where resources are lacking.

However, the Guidelines propose that states are “responsible for ... ensuring appropriate alternative care, with or through competent local authorities and duly authorized civil society organizations” (§5). This means that alternative care providers should be “subject to regular monitoring and review ... [to assess] the professional and ethical fitness of care providers for their accreditation, monitoring and supervision” (§55).

For residential care, the process of oversight and monitoring must start with the proper registration of facilities. Of the countries assessed, many reported a large number of unregistered institutional facilities. In Paraguay, of the 61 institutions offering alternative care services in the country, 48 are unregistered and thus operate without the permission of the government.²²⁹

Similarly in Benin, many informal non-accredited institutions take care for a great many children whose number is unknown by the authorities. In fact, until now it has not been possible to identify those centres that operate illegally.²³⁰ While in Malawi, only 34% of the facilities sampled were registered.²³¹

In a recent report, the IACHR highlights concerns about the high number of care institutions in Latin America that operate without the necessary registration or authorisation from the state.²³² The report indicates that in Bolivia, for example, 60% of all residential facilities are accredited and that throughout the region alternative care facilities are not regularly monitored or evaluated.

The Guidelines also provide standards to ensure that “agencies, facilities and professionals [are] accountable to a specific public authority, which should ensure, inter alia, frequent inspections comprising both scheduled and unannounced visits, involving discussion with and observation of the staff and children” (§128). This monitoring and inspection should be independent.

A Council of Europe report surveyed 42 member states and found that monitoring and administrative responsibilities were not separated, so that they lacked independence. It also found that more attention should be paid to ensuring children have an opportunity to participate in monitoring processes and relate their experiences.²³³

There was evidence that regular monitoring and inspection of facilities was not carried out in many cases. In Chile, for example, the state only has the jurisdiction to control and monitor those institutions that receive government subsidies, which effectively means that the government does not monitor any privately funded forms of formal alternative care at all. They operate with their own standards and norms.²³⁴

In Benin, it was reported that the alternative care sector works without standards. Each provider gives support in accordance with its capabilities. As a result practices are mostly informal; each alternative care centre or organisation has its own standards that often differ from the norms implemented in other organisations.²³⁵

This has severe implications for the ability of the state to protect children from violence. Alternative care that is not registered, or regularly monitored and inspected, can operate in ways that violate the rights of children.

In Malawi it was reported that unregistered facilities were recruiting children from local communities in order to increase their share of donor funds.²³⁶ In Kenya there were concerns that where the authorities fail to regularly inspect facilities, they may become a source and transit point for child trafficking.²³⁷

6.1.3 INDIVIDUALISED ASSESSMENTS AND INTERVENTIONS FOR EACH CHILD

The Guidelines state that decisions made on the placement of children in alternative care should consider the “best interests of the child” in identifying “the most suitable forms of alternative care ... under conditions that promote the child’s full and harmonious development” (§2). All alternative care should be provided in a way that is “best suited to satisfying [children’s] needs and rights” (§7).

Any decision-making should be based on: “...rigorous assessment, planning and review, through established structures and mechanisms, and should be carried out on a case-by-case basis ... It should involve full consultation at all stages with the child, according to his/her evolving capacities, and with his/her parents or legal guardians” (§57).

This process of providing children with the most “suitable” form of alternative care, according to their individual needs and best interests, also serves to protect them from violence. Assessments allow caregivers to prevent further violence, identify risk, and implement measures to foster emotional recovery. For example, if a child has been a victim of previous violence, providing that child with a suitable placement and with caregivers equipped to deal with the child’s circumstances will limit the risk of further violence to that child or the possibility of them inflicting violence on others. A suitable alternative care placement should help the child to heal and increase the prospects of breaking the cycle of violence.

Every child should have an individualised care plan that stipulates interventions that are tailored to the child's needs. It is important to recognise that many children will have complex needs, that specialist services will often be required, and that caregivers will require support in meeting the individual needs of these children. It is also essential to ensure that care plans focus on what is in the best interests of the child throughout their life in alternative care, and as such require on-going assessments of need.²³⁸

Evidence from the country assessments indicated that in most of the countries assessments and care planning were inadequate to protect children and provide them with individualised quality care.

In Croatia, the country assessment indicated that social welfare staff did their best to draw up a plan for each child, but they admit the failure to do so in every single case. The 2011 Report by the Ombudswoman for Children in Croatia clearly recognised this problem, and questioned how care plans are drawn up for each child in placement, given that centres often do not monitor children placed in social welfare homes.²³⁹

In Malawi there are regulations regarding the regular review of care plans, but still many organisations had not developed them: on average, only 9.2% of the children surveyed in the research had a care plan while only 2.3% of children had had their care plan reviewed in the previous three months.²⁴⁰

6.1.4 RELATIONSHIPS AND RESILIENCE

A very basic element of high quality care is that children and young people experience positive and empowering relationships. The Guidelines promote the child's right to developing positive, safe and nurturing relationships with their carers (§90).

Children, and particularly infants, need to develop a long-term and secure relationship with at least one primary caregiver to promote the successful development of their self-esteem, emotional stability, and capacity to form social relationships.²⁴¹ The deprivation of a caring family environment makes

children highly vulnerable to attachment disorders, cognitive impairment, and mental health problems such as anxiety and depression.²⁴²

Children who have not had these relationships at home may respond well if a caregiver treats them with kindness and consistency.²⁴³ Strong relationships between children and their primary caregiver also promotes resilience in the child, especially if caregivers remain supportive, and children are able to assume roles that are socially valued, rewarded and within their developmental capacity.²⁴⁴

In addition to resilience, a positive relationship between a child and one other trusted adult or even a peer is enough to unlock a range of outcomes such as: ensuring safer accommodation, exploring and understanding risky behaviours and addressing abuse, increasing overall wellbeing and recovering from abuse.²⁴⁵

Children also have a right to maintain relationships with their families. The Guidelines reiterate the right of all children to have a "relationship with both parents" (§32). For children in alternative care, "contact with his/her family, as well as with other persons close to him or her, such as friends, neighbours and previous carers, should be encouraged and facilitated, in keeping with the child's protection and best interests" (§81).

Maintaining and supporting family relationships whilst children are living in alternative care placements is a practice that tends to be promoted by legal frameworks. Research evidence supports the view that the maintenance of family relationships is important to the protection of children as well as contributing to their overall wellbeing.²⁴⁶

Young people in alternative care have identified peer relationships as very important. In a study of children in alternative care in England,²⁴⁷ young people's value systems included the appreciation of friendship, solidarity and peer support. Peer friendship offered the opportunity to share their problems and to receive support, help and understanding from others. This was seen as a better form of support than from staff who might judge them.

6.1.5 WORK WITH FAMILIES OF ORIGIN AND FOLLOW-UP AFTER REINTEGRATION

Adequate leaving care and aftercare provisions are not only an essential feature of quality care, but also have a tremendous impact on reducing a young person's risk of experiencing violence. The Guidelines suggest that there should be adequate policies for providing appropriate aftercare and follow-up of children leaving alternative care (§131).

Young people who are well-prepared to leave care, with appropriate skills, self-confidence and support, are more likely to have a successful transition out of alternative care. They are more likely to find housing and jobs and are less likely to become young parents, fall prey to mental illness, or depend on financial assistance.²⁴⁸

The Guidelines are also clear that decisions concerning alternative care should facilitate contact and potential reintegration with the child's family (§11), but this should only be when the causes of the separation have been resolved.

Since reasons for placement can be extremely complex and interrelated, the process towards reintegration must be done with all necessary caution, support and monitoring, especially in cases where there is a history of violence, as children who return home may still be at risk of experiencing violence and/or returning to alternative care.

A literature review examining research on successful reintegration of children in their families after foster care concludes that most studies show relatively high rates of foster care re-entry in the United States. The review stresses that the evidence is conclusive that return home is unlikely to be successful unless the issues that resulted in the initial placement are addressed.²⁴⁹

Studies have found that where appropriate interventions have not taken place to reduce levels of violence, children returning home may be at greater risk of violence than if they remained in alternative care.²⁵⁰ Children who were subsequently reintegrated with their families reported more than twice the incidence of physical violence than those children who remained in alternative care.²⁵¹

An English study examining patterns of reintegration of 180 children from alternative care²⁵² found that almost a half of the children were abused or neglected after their return. In only 26% of cases had all the problems for the children and their parents been addressed prior to their return, leaving many issues, which had the potential to jeopardise the process, including violence within the home.

In Malawi, a local NGO, Chisomo Children's Club, reported success at reintegrating children with their families, but equally identified the dangers, particularly for young girls who, on leaving care, could find themselves in risky environments such as "bars and bottle shops". In another study of post-care activities, the Samaritan Trust found that up to 30% of children who return to their former care setting are unable to cope with life in their communities and approximately 10% were affected by sexual exploitation, criminal offending or imprisonment.²⁵³

Many country assessments indicated that work with families and follow-up up rarely take place. For example, in countries as diverse as Benin, Peru and Lithuania there was no evidence of monitoring systems or continual follow up measures once a child has been reunited with his or her family.

In Bosnia and Herzegovina, in a questionnaire carried out with 60 centres for social work, in 27% of the cases centres were implementing programmes that encouraged reintegration of children in alternative care with their families of origin; however, 73% of the centres indicated that they did not have programmes to support or follow up with families after the children leave care.²⁵⁴

The reason most often cited for this gap in services was scarcity of personnel and resources. For example, in Malawi support for the reintegration of children to their families is supposed to be planned and managed by the Ministry of Gender, Children and Social Welfare, but the "procedures were not followed due to lack of financial resources".²⁵⁵

In peer research carried out by SOS Children's Villages in four countries (Albania, Czech Republic, Finland,

and Poland) young people identified their relationships with siblings and peers as very important to their leaving care process.²⁵⁶ Many of the respondents in alternative care said they would turn to friends, siblings, and a “family member” for support with problems, and those who left care identified the same people as having been helpful. Care leavers find advice and support in their peers, helping them to navigate the process better and increasing their chances of success.

6.1.6 CHILD PROTECTION AND REPORTING AND COMPLAINTS MECHANISMS

An essential element to enable effective responses for children experiencing violence in their families or communities is an effective child protection system. Such systems are necessary to “prevent and respond” to violence against children.

Children and young people in alternative care who are isolated from their families and communities, without regular access to public services – such as health care and education – are particularly vulnerable to violence in alternative care.²⁵⁷ Without regular contact with responsible adults in their community such as social workers, doctors and teachers, the chances are higher that violence in the alternative care goes undetected. Ensuring that children in alternative care are well integrated in their communities and maintain regular

contact with “the outside world” is an important measure to both prevent and detect violence against children in alternative care.

Only a very small proportion of all acts of violence against children are reported and investigated. One study cited various reasons for this including, amongst others: the lack of capacity of young children to report; fear of reprisal; or the desire to protect perpetrators.²⁵⁸ In Kenya, a key informant indicated that “most child abuse and abandonment cases go unreported because there is public fear in reporting to the police”, as people may be unnecessarily interrogated and or forced to take in the children themselves.²⁵⁹

More specifically, the Guidelines provide for children to have “access to a known, effective and impartial mechanism whereby they can notify complaints or concerns regarding their treatment or conditions of placement” (§99). However, these mechanisms are not always in place, and where they are, they may not be effective. The UN study found that “effective complaints, monitoring and inspection mechanisms and adequate government oversight are frequently absent”.²⁶⁰

Formal complaints mechanisms go hand in hand with reporting. If children and young people do not know or understand how to report on violence, or they are too

Young people leaving care

International research has shown that alternative care leavers are likely to be among the most socially excluded young people in society.¹

Young people who have been in alternative care are more likely to be undereducated, unemployed or underemployed, homeless, or living below the poverty line. They are more likely to become young parents, to be dependent on social assistance, and have a higher risk of mental illness and substance abuse.² They are also vulnerable to experiencing violence.

With quality care and support on leaving care young people can experience positive outcomes, however.³ Better preparation to leave care and support afterwards, as well as a good care experience (e.g. stable placement,

strong contact with families or origin, individualised care plans) create the necessary conditions for young care leavers to succeed in their transition.

For more information on leaving care see SOS Children's Villages / *Matter* campaign: www.sos-childrensvillages.org/what-we-do/childrens-rights/imatter.

- ¹ Stein, M., “Promoting the Resilience of Young People Leaving Care: Messages from Research, Preparation for Independent Living”, Briefing Paper Issue 1, SOS Children's Villages, 2009a.
- ² SOS Children's Villages, Brochure: ‘I Matter -Preparation for Independent Living’, 2009, available at: www.sos-childrensvillages.org/getmedia/e2b5b339-9d1f-4ce3-8ce9-f2caadd1ce36/I-Matter-folder.pdf?ext=.pdf.
- ³ Stein, 2009a.



© Julius Theo Castroverde

scared to use the mechanisms available, then incidents of violence will surely go unreported.

The research found that very few states consistently record placement of children in alternative care and even fewer report and record incidents of violence in these settings.²⁶¹ This finding was echoed in many of the country assessments. Moreover, research reveals that very few countries have reliable and robust mechanisms to collect data on children in alternative care, making the reporting of violence much more challenging, if not impossible.

In Armenia, it was noted that all residential facilities have formal complaints mechanisms as required by the minimum social standards, including complaints boxes and child helplines. In reality, however, these boxes

remain empty and no cases of abuse or neglect have registered through the hotline. For children in foster care no clear complaints mechanisms were identified.²⁶²

In Norway, the CRC Committee has specifically recommended that the government improve their complaints mechanism, as it is not adequate or readily available for children, suggesting that the Children's Ombudsman should be given the mandate to receive complaints from children, and resources to follow up in a quick and efficient way.²⁶³

In Kenya, it was found that while there is a policy on complaints mechanisms for children, abuse was rarely reported to the authorities.²⁶⁴ In Zambia, there was a lack of a regulatory framework for ensuring that complaints could be made openly and there was no independent system to provide oversight when addressing grievances.²⁶⁵

Research has also drawn attention to other more subtle barriers that may exist within care systems that prevent reporting. This may include blindness to recognising how children experience violence in alternative care. While evidence points to different levels of vulnerability towards violence in alternative care based on gender,²⁶⁶ disability or ethnicity,²⁶⁷ if caregivers or other care professionals fail to recognise this vulnerability they will not report the violence in detail and so the violence experienced by some groups of children and young people in alternative care remains hidden. Caregivers may also fear reprisals, or want to protect co-workers or family members.

Another difficulty in reporting the prevalence of violence in alternative care is that incidents of maltreatment can describe poor standards of care rather than actual abuse. A recent international review of foster care, suggests that it is important to distinguish allegations of violence from those concerning poor standards of care, as the boundary between the two may sometimes be unclear.²⁶⁸

Finally, reporting and complaints mechanisms need adequate follow up if they are to prove effective. In the UK, investigations into allegations of abuse in alternative care settings typically fall into unproven

or inconclusive categories and inquiries often reveal previous allegations that have not been followed up, hence the extent of abuse ultimately reflects deeply embedded social attitudes and associated structures of social justice.²⁶⁹

Without adequate confidential and safe reporting mechanisms and robust follow-up of all allegations of abuse and violence, it is impossible to protect children from the risks of violence posed in alternative care.

6.1.7 SUITABLE CAREGIVERS, CARE PROFESSIONALS AND STAFF

A major element in protecting children from violence is to ensure that suitable and competent carers care for them. This involves a twofold commitment on the part of states and others to ensure that only suitable candidates are recruited to responsible positions caring for children and that they possess adequate qualifications and training to fulfil their roles.

The 2013 Global Survey found that the high risk of violence is exacerbated where staff are poorly-trained and ill-paid, and where the institutions are stigmatised by attitudes in the local community.²⁷⁰

The Guidelines stipulate that authorised agencies should have written policies on “the standards applied for the recruitment, monitoring, supervision and evaluation of qualified and suitable carers” (§106). They should also “develop a staff code of conduct... that defines the role of each professional and of the carers in particular and includes clear reporting procedures on allegations of misconduct by any team member” (§107).

However, these standards are not necessarily applied and implemented consistently, and put children at considerable risk of violence. In Kenya, there was no evidence of vetting processes for foster carers.²⁷¹ In Armenia there was no functional practice of background checks for staff working in residential facilities, even though they are required by international organisations, due to the absence of relevant procedures and the low reliability of police records.²⁷²

There is a widespread recognition that staff support and training is vital to prevent violence and conflict in care.²⁷³

Children and young people who enter into the alternative care system have difficult pasts, especially those who have been either victims or witnesses of violence, and may exhibit challenging or aggressive behaviour.

The Guidelines outline the necessary training for caregivers including “training in dealing appropriately with challenging behaviour, including conflict resolution techniques and means to prevent acts of harm or self-harm” (§116). This is essential for caregivers who provide support and guidance to children who might have experienced violence in the past. They also play an important role in resolving difficulties between parents and children, as evidence from foster care has shown.²⁷⁴

Across the world, foster carers, residential caregivers, social workers and staff often work in very difficult conditions, without adequate support or training. Almost all of the country assessments reviewed indicated that care professionals are underpaid and overworked, and many times under-qualified or not qualified at all.

In Malawi, while capacities and infrastructure have developed over the past years, most of the alternative care facilities were reported to be overcrowded and without the capacity to handle the number of children.²⁷⁵

Similarly, in Colombia there is a lack of human resources and a high turnover within the alternative care system. This is not only because of carers’ often-precarious working contracts; low wages, inadequate staffing ratios, work overload and physical and mental burnout, all contribute. In addition, caregivers often have little or no education and are not equipped to deal with the pressure and demands of the job.²⁷⁶

The professional training required of care professionals varies from country to country. For example, in the United States, some foster care agencies require professional qualifications for all carers, whereas in Australia carers are not expected to have any tertiary qualifications.

In Venezuela, there is no system of accreditation or training for caregivers at all in the country, while in Zimbabwe the lack of funds to employ professionals leads to the recruitment of untrained staff for social

work.²⁷⁷ In Malawi, it was reported that 71% of care providers were not trained in child care related issues.²⁷⁸

In Togo, where each organisation has its own recruitment process, it was observed that children in facilities were exposed to violence, abuse and difficulties related to their supervision because most facilities did not have enough resources and employ unskilled staff in the care of children.²⁷⁹

More importantly, the behaviour of children is directly influenced by that of caregivers. A study of peer sexual abuse in residential care noted that the most common staff response to sexual activity was to deny or ignore it, attitudes that affected children's sexual behaviour and understanding.²⁸⁰ The study illustrated a lack of support training, policies and guidelines – staff responses were framed by fear, embarrassment and their own gender and sexual values.

This situation puts children at danger for several reasons. A lack of appropriate supervision by caregivers, their inability to see signs of violence, and poor relationships with children may leave children in alternative care vulnerable to violence from their peers, family and the community.

Research identifying positive outcomes for children in foster care indicates that robust recruitment of carers, and providing training and on-going support, are key ingredients for quality care. Carers who are under stress are less able to provide sensitive care for children and young people.²⁸¹ Regarding residential care, evidence supports the view that managers need to be supported in developing and sustaining a clear role and purpose for residential homes,²⁸² and that staff receive on-going and appropriate training and support.²⁸³

According to one recent report:

Professionals lack the necessary training to identify early signals and address incidents of violence in an ethical, and gender- and child-sensitive manner. They lack guidance as to whether and how they are expected to report, or whom to refer the case to. And even when they are addressed, incidents of violence continue to be considered separately and subsequently

by different professionals and through the lens of disconnected disciplines, creating renewed risks of re-victimisation of the child and of jeopardising children's safety and protection.²⁸⁴

6.1.8 PARTICIPATION AND AWARENESS OF RIGHTS

What becomes very clear when listening to children and young people is that their involvement is essential in improving care and preventing violence – this comes out in many reports and recommendations.²⁸⁵

As children participate in different areas of social life, so we develop a better understanding of how protective systems and practice can be implemented. A study in Liberia,²⁸⁶ for example, discussed how a participatory exercise eliciting children's views of risk and protection had helped change the way in which child protection messages were delivered nationally.

Participation may also help young people to support their peers. Studies have highlighted that children and young people have indicated that they are more likely to tell their peers about violence than caregivers or staff.²⁸⁷ When making recommendations on ending violence against children in institutional settings, children said “children in institutions should be supported to form their own group so that they can share their views, access information, and organise collective action on issues affecting them, such as violence”.²⁸⁸

They also indicated that “children in institutions should be given a strong voice, so that they can discuss and report on any form of violence that faced” and that there “need[s to be] more participatory research with girls and boys in institutions to understand the kinds of violence they face and their suggested action to end violence”. This research should involve “younger children, children with disabilities, and children from ethnic minorities”.²⁸⁹



CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

This report stands as a testament to the violence that children in alternative care suffer. It finds that to the best of our knowledge, children in alternative care are vulnerable to violence, and the systems in place to care for them put them at further risk of harm.

This report also stands witness to the great resilience of children; who with strength and dignity prevail in the most difficult circumstances, even without the necessary care and protection.

It acknowledges the complexity of answering the questions of **why** this is and **what** can be done to protect children. However, by reviewing existing international literature, and using the experiences and knowledge of SOS Children's Villages researchers in 21 countries, it begins to unravel this complexity and to weave a picture

of our alternative care services and the challenges they face.

What we do know – and have illustrated here – is that violence in alternative care is not inevitable. It is the result of multifaceted social issues and political decisions that can be addressed with adequate knowledge, political will and resources.

The knowledge base is growing – and this paper makes its own contribution – and political will is growing too. In 2009, the UN endorsed the Guidelines and there is evidence that they are beginning to change the ways in which alternative care is arranged around the world. Resources are always a challenge, but focused research and advocacy on the importance of the rights of the child and in particular the need to protect our most

vulnerable children in alternative care is a starting point for ensuring that they get the political and financial support they deserve, and the protection and care they need.

7.1 KEY FINDINGS

Violence against children in alternative care must be stopped

Children are vulnerable and put at risk of violence by the alternative care systems that should be in place to protect them.

They are made vulnerable by their past experiences of violence and legal and societal mores that tolerate violence against them. They are at risk of violence when alternative care systems do not ensure that they are provided with quality care and robust and responsive child protection mechanisms.

A clear focus on protecting children and providing quality care through effective implementation of the Guidelines will mitigate violence and ensure that our most vulnerable children are protected and safe.

Children in alternative care face multifaceted vulnerability and persistent social conditions that lead to violence

The circumstances and characteristics of children who enter the alternative care system play a role in increasing their vulnerability to violence. Factors such as age, gender, disability, ethnicity, reasons for entering the care system, socio-economic background, and previous experiences of violence all have an influence on children's vulnerability to violence.

A combination of multi-layered vulnerability and enduring social conditions are the basis of much violence in alternative care. A lack of legal protection, society's tolerance and acceptance of violence and the additional vulnerabilities experienced by children who are already discriminated against can mean that they are subjected to harm with impunity.

Acceptance of violence against children can be strong in alternative care settings, where violence may be used as mechanism to control, discipline or educate children that are considered problematic or 'flawed'.

The quality of care plays a significant and determinant role in a child's risk of experiencing violence in alternative care

Alternative care does not inherently perpetuate violence, but rather the incidence of violence is inextricably linked to the overall quality of care and the ability of states to monitor standards.

The research found that the ways in which children are assessed and provided with alternative care do not necessarily ensure that they are given "suitable" care, catering for their individual needs. There was also a lack of emphasis on assisting them to build resilient relationships, maintain contact with their families and communities and on ensuring that reintegration processes were adequately managed, monitored and supported.

The quality of care was further compromised by inadequate oversight of facilities and carers by state authorities. There were insufficient processes in place to ensure that care providers were registered, monitored and inspected according to the necessary standards and criteria. This oversight did not extend to ensuring that all staff working with children were adequately vetted and trained for their positions of responsibility.

In many cases there were insufficient reporting mechanisms in place. Effective complaints mechanisms are essential for uncovering violence in the alternative care system; they are also part of a process of ensuring that children's voices are heard, respected and taken seriously and that children are encouraged to participate in the processes that should be designed to keep them safe.

Improvements in the quality of care, including adequate planning and assessments to ensure "suitable" alternative care placements; the implementation of monitoring and effective oversight; and the provision of independent complaints mechanisms would serve to reduce the risk of violence against children.



Reliable data and substantive research on violence against children in alternative care are minimal

The research found considerable gaps in the data available on children in alternative care. It is rarely disaggregated by age, sex, ethnicity and socio-economic background, or substantive enough to paint a complete picture of the national or international alternative care system. A particular omission that was noted was the lack of research involving the views of children and young people themselves. While there are considerable practical and ethical challenges relating to researching this group of vulnerable children, until their voices are heard, our understanding will be limited.

Reliable research on the prevalence of violence in alternative care is even more elusive. Social taboos, shame, fear and disempowerment result in chronic underreporting. This leaves our knowledge on violence against children in alternative care settings both fragmented and sparse.

This limited knowledge not only demonstrates the marginalisation of children in alternative care, and the hidden nature of their lives and experiences, but also places children at greater risk of violence. Without knowledge of the ways in which violence manifests in alternative care, it is impossible to design and maintain adequate systems to protect them.

7.2 RECOMMENDATIONS

Preventing and responding to violence against children in alternative care is a shared responsibility. While states bear the primary responsibility to implement protective measures to prevent violence, all stakeholders – international and regional organisations, donors, NGOs, care providers, civil society, the private sector, communities, families, and children and young people – must be empowered to work together to hold states accountable and to do everything possible to protect children.

RECOMMENDATIONS TO STATES:

1. States should strengthen national legislation and policy to ensure that there are specific provisions against violence in all forms of alternative care.

Legislation should address all forms of abuse and neglect; harmful institutional practice that could include abusive forms of discipline or control; and peer violence.

States have an obligation to ensure that any gaps in the national implementation of legally binding conventions, such as the UNCRC, are filled and that they meet their obligations as primary duty-bearers. The Guidelines are designed to assist governments in fulfilling their obligations to children in alternative care.

Commitment, however, cannot stop at the implementation of legislation and policy. They must be constantly monitored and evaluated to ensure that systems of alternative care is of high quality, meeting the needs and best interests of individual children, and that programmes to prevent and mitigate violence are functioning effectively.

2. States should ensure that removal of a child from the care of the family is viewed “as a measure of last resort ... and for the shortest possible duration” (§14).

States should invest in preventive services, including family strengthening and capacity-building to assist parents to care for and protect their children. In situations of violence and abuse, sanctions should be directed at the perpetrators rather than automatically removing children for protective purposes.

In all cases, and in line with the Guidelines, effective gatekeeping measures and comprehensive and individual assessments for each child by trained professionals must be carried out. The principles of necessity and best interests of the child must be maintained.

If placement in alternative care is deemed necessary, individual care plans tailored to the needs of each child must be developed and regularly reviewed, with the aim toward family reintegration when possible.

3. States should improve their ability and the capacity of their competent authorities to monitor the quality of alternative care provision.

This includes providing sufficient standards and guidelines to ensure that any monitoring is based on valid criteria; adequate resources to ensure authorities have the practical tools to fulfil their responsibilities, including the capacity to elicit the views of children; and the necessary follow-up mechanisms with the power to impose sanctions on alternative care provision that fails to meet standards.

As a minimum all care providers – public or private, residential or foster care – must be registered and regularly inspected. However, where standards are lacking resources and training should be made available to build capacity.

4. States should assume their primary role as the coordinator of alternative care provision with all other stakeholders.

States have a primary role as coordinators or alternative care provision to ensure that alternative care providers within the care system provide a range of suitable alternative care options, fulfil their obligations to provide independent reporting mechanisms, and ensure meaningful child participation (see below).

RECOMMENDATIONS TO ALTERNATIVE CARE PROVIDERS/ CARE SYSTEM (STATE AND NON-STATE):

1. Alternative care providers should ensure that specialist services are available for families and children that experience violence, and that their services constitute quality care.

These services should be both preventive – to avoid removing the child from the family environment – and rehabilitative – to ensure that children and their families that have experienced violence are provided with the support to heal.

Adequate resources are needed to recruit sufficient numbers of highly qualified care staff. In all forms of alternative care, recruitment process must be vigorous, with proper vetting to ensure caregivers are equipped

with necessary personal and professional qualifications to work with children.

Caregivers in all alternative care settings must also have the proper training, which should include: prevention and identification of violence against children, as well as child-centred and child-sensitive assessment and reporting.²⁹⁰ They must also be extensively trained on the appropriate use of physical restraint and skilled in their profession so that they can effectively help children build meaningful relationships, while fostering self-esteem and resilience.

Care staff must receive decent living wages, as well as ample support, continuous professional training and regular oversight. Support is important for retaining care workers and diminishing the number of placement breakdowns.²⁹¹

2. Alternative care providers should ensure that they develop adequate, independent and confidential mechanisms for children and others to report violence in alternative care.

Reporting mechanisms are essential to ensure that children do not suffer in silence and that violence is not perpetrated with impunity. Children should be provided with confidential support in order to report violence (or any other complaints) and adequate mechanisms to follow up on reports and protect children should be in place.

It should be a requirement that those working with children are fully bound by codes of conduct and trained on how to identify signs of violence against children. They must be encouraged to report any suspicions to relevant authorities and have safe and effective reporting mechanisms in place and accessible to do so. Parents, extended family, and members should also be encouraged to report any suspicions and have access to safe and effective reporting mechanisms.

There should be child friendly mechanisms in place and accessible in all alternative care settings and should include effective systems to follow-up and investigate allegations.

3. Alternative care providers should take measures to ensure that all children and where appropriate their families are able to meaningfully participate in any decisions relating to alternative care placement.

Children should be empowered to participate according to their capacity in all decisions affecting their alternative care provision. Parents and other family members should be kept informed of decisions and where appropriate provided with the opportunity to participate in decision-making processes.

Empowering children and young people to express their views will create an atmosphere where they feel comfortable to create relationships and voice their opinions. This will in turn, increase their ability to report any violence and help caregivers learn to take these allegations seriously.

Children and young people's participation is an invaluable resource when gathering data and research on the issues surrounding violence against children in alternative care. Meaningful participation necessarily involves a change in attitude of both adults and children.

RECOMMENDATIONS TO ALL STAKEHOLDERS:

1. All stakeholders should collaborate in collecting comprehensive data and expanding contributions to research on violence against children.

In particular, it is important to have information on the child population in alternative care, to ensure appropriate policies are in place and adequate resources are provided for their quality care. This also involves ensuring that children's voices are heard in research into their experiences of violence, and are provided with opportunities to offer their own understandings and solutions.

All stakeholders must come together and push states to ensure better data collection on children without parental care and children in alternative care, and establish national databases with robust and disaggregated indicators. They should collaborate to generate detailed research into the nature of violence in alternative care, its prevalence and, above all, its root causes across all



types of alternative care settings in national, regional and international contexts.

Reliable data and research is essential to support government legislation, policy, planning and budgeting. Above all, they are critical for raising awareness, challenging social norms, and enhancing protection for children at risk.

2. All stakeholders should contribute towards coordinated efforts to raise awareness and educate society on violence against children in alternative care.

This includes ensuring that children are informed that violence is not a necessary or legitimate element of alternative care: either as a form of discipline or control. It also means challenging levels of tolerance in society that allow violence against children to continue with impunity.

Where there is a persistent culture of resistance to tackling the subject of violence against children in alternative care, campaigns aimed at raising awareness around the impact of violence against children can be powerful.

Targeted training and awareness-raising amongst caregivers, particularly for children in alternative care, can help to shift deep-seated attitudes on violence and minimise its acceptance.

GLOSSARY

Alternative care (also referred to as alternative child care and out-of-home child care): a temporary or permanent full-time arrangement where a child is looked after (night and day) by a caregiver other than the parents, due to the family's inability to provide appropriate care for the child. There is a range of alternative care options including those that are informal (care by family members, neighbours or friends) and those that are formal (foster care or residential care).

Caregiver (also referred to as carer): a person with whom the child lives and who is primarily responsible for providing daily care to the child. This does not necessarily imply legal responsibility. He or she is responsible for the child's upbringing and supports the child's physical, emotional, intellectual, social, cultural and spiritual development.

Care plan: a documented plan developed in order to fulfil the developmental needs of a child in alternative care. The caregiver, social workers, parents, and children, should collaboratively prepare the plan, in conjunction with other authorities if necessary as a result of assessments related to the needs of the child.

Child: every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier (Article 1 UNCRC).

Children without parental care: all children not living with at least one of their parents for whatever reason and under whatever circumstances.

Children at risk of losing parental care: children whose families are in difficult or vulnerable circumstances and are at risk of losing parental care of children.

Family of origin: the family into which the child was born and includes biological parents, siblings, grandparents, aunts and uncles, or a network of extended family members.

Family strengthening: programmes to strengthen the capacity of a family to provide quality care for their children and prevent separation. Family strengthening programmes include both direct capacity-building for families, as well as community capacity building to bolster community support services for families.

Formal care: all alternative care provided in a family environment that has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures.

Foster care: a full-time alternative care arrangement, whereby a child is placed in the domestic environment of a family other than his or her own family. Formal foster care is authorised and arranged by welfare authorities or child-placing agencies following legal order. The arrangement can be either short-term or long-term and takes many forms, depending on the child's situation and best interests. Often, the legal rights for the child remain with the biological parents and are not transferred to the foster carer.

Informal care: an alternative care placement provided in a family environment, whereby the child is looked after on an on-going or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, without the involvement of an administrative or judicial authority or a duly accredited body.

Institutional care: a full-time alternative care arrangement in an official residential setting where larger groups of children live in a dormitory style arrangement with common living areas. Care is provided, often in rotating shifts, by paid adult staff or volunteers who usually do not assume a traditional caregiving role. Institutional care is often considered the same as *residential care*; but others interpret residential care as small family-type group homes with a more intimate feel than a large institution.

Kinship care: a form of alternative care where a child lives with a member of the extended family, older siblings, or in some cases with family friends. The care can be either formal or (as in most cases) informal and arranged privately.

Leaving care: a term describing the transition process that young people living in alternative child care go through when they reach the age of majority, when, in most cases they need to leave care and commence their lives as independent adults.

Orphan: a child whose biological (or legal) parents have died. *Single orphan* refers to a child who has lost one parent. *Double orphan* refers to a child who has lost both parents.

Quality care: the care of a child, whether in his or her own family or in a form of alternative care, whereby the child experiences the positive, empowering, stable and caring relationships that he or she needs for a full personal development. Quality care is essentially empowering and supportive and places the child's best interests and rights at the core of every action.

Reintegration (also referred to as family reintegration): the process by which a child who has been placed in alternative care returns to his or her family of origin, when it is deemed consistent with his or her best interests.

Residential care: a full-time alternative care arrangement whereby a child is placed in a group setting which is not family-based, together with a small number of other children in a building or facility designated for this purpose. Care is provided, often in rotating shifts, by paid adult staff or volunteers who usually do not assume a traditional caregiving role. Residential care is often considered the same as institutional care; but others interpret residential care as small family-type group homes with a more intimate feel than a large institution.

Stakeholders: a person, group, organisation or entity that can either affect or be affected by legislation, policy, measures and practices of alternative care.

Violence against children: the intentional use of power or physical force to cause actual or potential harm to a child. It includes all forms of psychological, emotional, physical or sexual abuse; neglect and negligent treatment; maltreatment and exploitation.

Violence against children in alternative care: violence inflicted on children and young people living in alternative care, either by carers, peers or by members of the community.

Young person/youth: young people between the ages of 15 and 24 years old.²⁹²

REFERENCES

- 1 UNCRC Preamble, §10.
- 2 Committee on the Rights of the Child, General Comment No.13: The right of the child to freedom from all forms of violence, 2011, CRC/C/GC/1318.
- 3 The literature review was completed by the University of Bedfordshire. The 21 country assessments were conducted by SOS Children's Villages based on the *Assessment Tool for the Implementation of the UN Guidelines on the Alternative Care of Children*, available at: www.sos-childrensvillages.org/retired/quality-care-assessment.
- 4 Reference in Newell, P., *Challenging Violence against Children: A Handbook for NGOs Working on Follow-up to the UN Study*, International Save the Children Alliance, London, 2008, p.59.
- 5 Inter-American Commission on Human Rights, *The Rights of Girls and Boys to a Family: Alternative Care: Ending Institutionalization in the Americas*, Washington DC : IACHR, 2013.
- 6 Malawi country assessment.
- 7 UNICEF, *Hidden in Plain Sight: A Statistical Analysis of Violence against Children*, New York: UNICEF, 2014.
- 8 E.G. Krug et al. (eds.), *World Report on Violence and Health*, Geneva: World Health Organization, 2002, p.5. Referenced by Pinheiro, S., *World Report on Violence against Children*, Geneva: United Nations, 2006.
- 9 Pinheiro 2006.
- 10 Office of the Special Representative of the Secretary-General on Violence against Children, *Toward A World Free From Violence: Global Survey On Violence Against Children*, New York: SRSG on Violence against Children, 2013.
- 11 These challenges include insufficient investment in violence prevention; fragmented or non-existent national strategies; uncoordinated policy interventions; unconsolidated and poorly enforced legislation; a weak focus on gender; insufficient attention given to the situation of particularly vulnerable children who remain hidden and overlooked; inadequate attention to the cumulative impact of violence across children's lives; weak investment in child sensitive mechanisms for counselling, reporting and complaints; lack of recovery and reintegration services; and scarce data and research, with little information on the extent and impact of violence against children.
- 12 Committee on the Rights of the Child 2011.
- 13 UN Resolution A/RES/64/142.
- 14 See: www.sos-childrensvillages.org and www.beds.ac.uk/ic.
- 15 The original version of the tool can be found online at: www.sos-childrensvillages.org/retired/quality-care-assessment. To download the original reports, please see: www.care-for-me.org.
- 16 UN Resolution (64/142).
- 17 Article 1 UNCRC.
- 18 Definition endorsed by the United Nations General Assembly, Resolution A/RES/36/28, 1981.
- 19 Referenced in Pinheiro 2006.
- 20 For a full list of independent peer reviewers, please see the acknowledgments.
- 21 Colton, M., M. Vanstore, C. Walby, "Victimization, Care and Justice: Reflections on the Experience of Victims/Survivors Involved in Large-Scale Historical Investigations of Child Sexual Abuse in Residential Institutions", *British Journal of Social Work* 32, 2002, 541–551. Ericsson, K., "The Punitive Repertoire of Children's Homes and Reformatories", *Journal of Scandinavian Studies in Criminology and Crime Prevention* 13(2), 2012, 76–93.
- 22 Thoburn, J., "Globalisation and Child Welfare: Some Lessons from a Cross-national Study of Children in Out-of-home Care", Social Work Monographs, Norwich: University of East Anglia, 2007.
- 23 See, for example, Bronsard, G., C. Lançon, A. Loundou, P. Auquier, M. Rufo and M. Siméoni, "Prevalence Rate of DSM Mental Disorders among Adolescents Living in Residential Group Homes of the French Child Welfare System", *Children and Youth Services Review* 33 (10), 2011, 1886–1890; Gilbert, R., C. Spatz Widom, K. Browne, D. Fergusson, E. Webb and S. Janson, "Burden and Consequences of Child Maltreatment in High-income Countries", *The Lancet* 373 (9657), 2008 (online), 68–81.
- 24 Haarr, R., "Violence against Children In State-Run Residential Institutions In Kazakhstan: An Assessment", 2011; World Health Organisation, Child Maltreatment, available at: www.who.int/violence_injury_prevention/child/en/.
- 25 See the glossary definitions of residential care and institutional care and a more detailed discussion in the "Conceptual framework".
- 26 Berelowitz, S., C. Firmin, G. Edwards and S. Gulyurtlu, *I Thought I Was the Only One: The Only One in the World*, Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Interim Report, London: Office of the Children's Commissioner, 2012.
- 27 As described in the UNCRC.
- 28 Also referred to as out-of-home (child) care.
- 29 UNCRC Preamble. The Guidelines are UN-endorsed and aim to assist states to fulfil their obligations to children in alternative care under the UNCRC.
- 30 The 2011 International Conference on Combating Violence against Children in Kiev, Ukraine, which the SRSG-VAC convened with UNICEF, the Council of Europe and the EU, called for enhanced efforts to prevent the separation of children from their families.
- 31 Cantwell, N., J. Davidson, S. Elsley, I. Milligan, N. Quinn, *Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children'*. Glasgow: Centre for Excellence for Looked After Children in Scotland, 2012, p.31.
- 32 Chiwaula, L., R. Dobson and S. Else, *Drumming Together for Change: A Child's Right to Quality Care in Sub-Saharan Africa*, Glasgow: SOS Children's Villages International, the Centre for Excellence for Looked after Children in Scotland (CELCIS) and the University of Malawi, 2014.
- 33 Chiwaula et al. 2014.
- 34 Please note that Asia and the Middle East were not represented in the country assessments.
- 35 UNICEF's TRANSMONEE Database, 2013.
- 36 Armenia and Croatia country assessments.

- 37 UNICEF, *Alternative Care for Children in Southern Africa: Progress, Challenges and Future Directions*, Nairobi: UNICEF, 2008.
- 38 Chiwaula et al. 2014.
- 39 Argentina and Chile country assessments.
- 40 Browne, K., *The Risk of Harm to Young Children in Institutional Care*, London: Save the Children, 2009, p.1.
- 41 Chiwaula et al. 2014. This was particularly identified in the assessments from Sub-Saharan Africa.
- 42 Cantwell et al. 2012, p.34; Browne 2009, p.1, p.10.
- 43 UNCRC Committee General Comment No.7, §36.
- 44 Ibid., §36.
- 45 Lithuania country assessment.
- 46 Armenia country assessment.
- 47 Powell, G., T. Chinake, D. Mudzingi, W. Maambira and S. Mukutini, *Children in Residential Care: The Zimbabwean Experience*, Harare: Ministry of Public Service, Labour and Welfare and UNICEF, 2004.
- 48 Referenced in Pinheiro 2006.
- 49 Oxford Dictionary: www.oxforddictionaries.com/definition/english/vulnerable.
- 50 UNICEF, "Developing and Operationalizing a National Monitoring and Evaluation System for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS", Working Paper, September 2009, p.52.
- 51 Oxford Dictionary: www.oxforddictionaries.com/definition/english/risk.
- 52 Child Helpline International, *Violence Against Children: Child Helpline Data on Abuse and Violence*, Amsterdam: Child Helpline International, 2012.
- 53 Euser, S., L.R.A. Alink, A., Tharner, M.H. Van I. Jzendoorn and M.J. Bakermans-Kranenburg, "The Prevalence of Child Sexual Abuse in Out-of-home Care: A Comparison between Abuse in Residential and in Foster Care", *Child Maltreatment*, 2013, doi: 10.1177/1077559513489848; Freundlich, M., R.J. Avery and D. Padgett, "Care or Scare: The Safety of Youth in Congregate Care in New York City", *Child Abuse & Neglect* 31, 2007,173–186; Berridge, D., N. Biehal and L. Hendry, *Living in Children's Homes*, DFE-RR201, London: Department for Education, 2011.
- 54 Barth, R.P. 2002, referenced in Pinheiro 2006.
- 55 Pinheiro 2006.
- 56 National Coalition for Child Protection Reform, "Foster Care vs. Family Preservation: The Track Record on Safety and Well-being", Issue Paper 1, January 2011, p.1.
- 57 Much of the text for this section comes from Chiwaula et al. 2014.
- 58 See UNICEF, *Child Protection Strategy*, United Nations Children's Fund, 2008.
- 59 On elements of a continuum of care see, Inter-agency Group on Child Protection Systems in Sub-Saharan Africa, *Strengthening Child Protection Systems in Sub-Saharan Africa*, Working Paper, 2012, p.39.
- 60 Cantwell et al. 2012, p.55.
- 61 Stein, M., *Quality Matters in Children's Services*, London: Jessica Kingsley Publishers, 2009.
- 62 Available at: www.un.org/documents/ga/res/40/a40r033.htm.
- 63 Available at: www.ohchr.org/EN/ProfessionalInterest/Pages/OPSCCRC.aspx.
- 64 All the assessments used in this study were from countries that have ratified the UNCRC, and are therefore bound by its principles. Worldwide only the US, South Sudan and Somalia have not ratified the UNCRC.
- 65 Implementation of these articles must be situated in the context of Article 5 parental guidance and the child's evolving capacities; Article 9 separation from parents; Article 18 parental responsibilities; and Article 27 standard of living.
- 66 Available at: www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx.
- 67 Available at: www.un.org/disabilities/convention/conventionfull.shtml.
- 68 Available at: <http://acerwc.org/the-african-charter-on-the-rights-and-welfare-of-the-child-acrcw/acrwc-en/>.
- 69 Adjudovic, M. and B. Franz, "Behavioural and Emotional Problems of Children by Type of Out-of-home Care in Croatia", *International Journal of Social Welfare* 14, 2005, 163–175.
- 70 Stein, M. and Dumaret, A. "The Mental Health of Young People Ageing Out of Care and Entering Adulthood", *Children and Youth Services Review* 33(12), 2011, 2504–2511.
- 71 Inter-American Commission on Human Rights, *The Rights of Girls and Boys to a Family: Alternative Care: Ending Institutionalization in the Americas*, Washington DC : IACHR, 2013.
- 72 Chile country assessment.
- 73 Chiwaula et al. 2014.
- 74 Gambia country assessment.
- 75 UNICEF, *Every Child Counts: The State of the World's Children in Numbers: Revealing Disparities, Advancing Children's Rights*, New York: UNICEF, 2014, p.53.
- 76 Csáky, C. *Keeping Children out of Harmful Institutions: Why we should be Investing in Family-based Care*, London: Save the Children, 2009, p.5.
- 77 Delap, E., *Every Child Deserves a Family: EveryChild's Approach to Children without Parental Care*, London: EveryChild, 2009, p.5.
- 78 UNICEF, "Progress for Children: A Report Card on Child Protection", Number 8, 2009, p.19.
- 79 Save the Children Alliance 2003 referenced by Pinheiro 2006.
- 80 At the time of publication, no Asian countries had published country assessments.
- 81 For example, Mulheir, G., "Deinstitutionalisation – A Human Rights Priority for Children with Disabilities", *The Equal Rights Review*, 9, 2012, 117–137; Braithwaite, J., D. Mont, "Disability and Poverty: A Survey of World Bank Poverty Assessments and Implications", *ALTER, European Journal of Disability Research* 3(3), 2009, 219–232; ILO, "HIV/AIDS and Poverty: The Critical Connection", ILO/AIDS Brief, October 2005.
- 82 Chiwaula et al. 2014.
- 83 The Guidelines provide a whole section on providing alternative care for children during emergencies (IX).
- 84 Diggins, M., *Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare*, London: Social Care Institute for Excellence, 2011, p.8.
- 85 Ibid.
- 86 WHO, *Mental Health Atlas 2011*, Geneva: WHO, 2011.
- 87 Mulheir 2012.
- 88 Norway country assessment.

- 89 Kenya country assessment.
- 90 Colombia country assessment.
- 91 Bosnia and Herzegovina, Croatia and Argentina country assessments.
- 92 Nobody's Children Foundation, *Sexual Violence against Children: A Study of the Phenomenon and Dimensions of the Violence against Children Raised in the Residential Institutions in Poland*, Warsaw: Nobody's Children Foundation, 2009.
- 93 Whetten, K., J. Ostermann, R. Whetten, K. O'Donnell, N. Thielman, and the Positive Outcomes for Orphans Research Team, "More than the Loss of a Parent: Potentially Traumatic Events among Orphaned and Abandoned Children", *Journal of Traumatic Stress* 24(2), 2011, 174–182.
- 94 Lithuania country assessment.
- 95 This refers to public and private facilities in the network of the Chilean SENAME (or National Service for Minors).
- 96 Argentina country assessment.
- 97 Paraguay country assessment.
- 98 Kenya country assessment.
- 99 Stein 2009.
- 100 Mulheir 2012.
- 101 Norway country assessment.
- 102 European Roma Rights Centre, *Life Sentence: Romani Children in Institutional Care*, Budapest: European Roma Rights Centre, Bulgaria Helsinki Committee, Milan Šimečka Foundation and osservAzione, June 2011.
- 103 LUMOS studies, referenced in Mulheir 2012.
- 104 UNICEF, *At Home or in a Home? Formal Care and Adoption of Children in Eastern Europe and Central Asia*, New York: UNICEF, 2010.
- 105 Croatia country assessment, p.5.
- 106 UNICEF Regional Office for Latin America and the Caribbean, *La situación de niños, niñas y adolescentes en las instituciones de protección y cuidado de América Latina y el Caribe*, Panama: UNICEF, 2013.
- 107 Farmer, E. and S. Pollock, "Managing Sexually Abused and/or Abusing Children in Substitute Care", *Child and Family Social Work* 8, 2003, 101–112; Hicks, L., I. Gibbs, H. Weatherly and S. Byford, *Managing Children's Homes: Developing Effective Leadership in Small Organisations*, London: Jessica Kingsley, 2007.
- 108 See Colton et al. 2002; Ericsson 2012.
- 109 UNICEF "Hidden in Plain Sight" 2014, p.14.
- 110 Croatia country assessment, p.116.
- 111 Research suggests that it may be useful to study the characteristics of perpetrators further, as there is no one typical perpetrator. For example, one study regards professionals who sexually abuse the children with whom they work as a small but significant problem with characteristics that do not set them apart from others, confirming that any assumption of professional perpetrators being easy to identify is "at odds with reality", see Sullivan, J., and A. Beech, "Professional Perpetrators: Sex Offenders Who Use Their Employment to Target and Sexually Abuse the Children with Whom They Work", *Child Abuse Review* 11, 2002 153–167.
- 112 Barter, C., E. Renold, D. Berridge and P. Cawson, *Peer Violence in Children's Residential Care*, Basingstoke: Palgrave Macmillan, 2004; Berridge et al. 2011; Morgan, R. "Children's Care Monitor 2013/14: Children on the State of Social Care in England", London: OFSTED, 2014.
- 113 CEIP, SIPIAV, UNICEF, "Mapa de ruta para las situaciones de maltrato y abuso sexual en niños, niñas y adolescentes detectadas en el ámbito escolar", UNICEF Uruguay, 2013.
- 114 Pinheiro 2006.
- 115 Global Initiative to End All Corporal Punishment of Children 2012.
- 116 Ibid.
- 117 General Comment 10 (2007), §89.
- 118 Guidelines, §97.
- 119 Davidson, J., D. McCullough, L. Steckley and T. Warren, *Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People*, Glasgow: Scottish Institute for Residential Child Care, 2005; deCordova, S., R. Hodgkin, L. King and S. Rustemier, "You Feel Like You're Nothing" UN Study on Violence Against Children, London: NSPCC & Children's Rights Alliance for England, 2008.
- 120 Steckley, L. and A. Kendrick, "Hold on: Physical Restraint in Residential Child Care", in A. Kendrick (ed.) *Residential Child Care: Prospects and Challenges*, Research Highlights 47, London: Jessica Kingsley, 2008.
- 121 Data from the project *Reduced Violence towards Children in Armenia's Care Structures*, quoted in the Armenia country assessment.
- 122 Euser et al. 2013.
- 123 National Coalition for Child Protection Reform 2011.
- 124 See for example: Dunn, A., E. Jareg and D. Webb, *A Last Resort: The Growing Concern about Children in Residential Care, Save the Children's Position on Residential Care*, London: Save the Children, 2003.
- 125 Barter et al. 2004.
- 126 The All Party Parliamentary Group for Runaway and Missing Children and Adults and the All Party Parliamentary Group for Looked After Children and Care Leavers, *Report from the Joint Inquiry into Children Who Go Missing From Care*, London: HM Government, 2012; Office of the Children's Commissioner, *Briefing for the Rt Hon Michael Gove MP, Secretary of State for Education on the Emerging Findings of the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups with a Special Focus on Children in Care*, London: Office for the Children's Commissioner, 2012.
- 127 Haarr 2011.
- 128 Csáky 2009.
- 129 UNICEF Regional Office for Latin America and the Caribbean 2013.
- 130 Sullivan et al. 1997 referenced in Mulheir 2012; Cross et al. 1993 referenced in Mulheir 2012.
- 131 See, for example, Garland, A., R. Hough, K. McCabe, M. Yeh, P. Wood and G. Aarons, "Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care", *Journal of American Academy of Child and Adolescent Psychiatry* 40(4), 2001, 409–418.; Bronsard et al. 2011.
- 132 Farmer and Pollock 2003.
- 133 See for example, Colton et al. 2002, Haarr 2011.

- 134 Gilbert et al. 2008.
- 135 Utesheva, N., J. Votslava and M. Medetov, *Shadow Report of NGOs on Compliance of Obligations under the UN Convention on the Rights of the Child by the Kyrgyz Republic*, Bishkek: Association of NGOs for the Protection and Promotion of Child Rights, 2013.
- 136 Haarr 2011.
- 137 Reference to data from the project Reduced Violence towards Children in Armenia's Care Structures.
- 138 UNICEF Regional Office for Latin American and the Caribbean 2013.
- 139 Paraguay country assessment.
- 140 Benin country assessment, reference to the Ministry of Family 2011.
- 141 Sainero, A., A. Bravo, and J. del Valle, "Examining Needs and Referrals to Mental Health Services for Children in Residential Care in Spain: An Empirical Study in an Autonomous Community", *Journal of Emotional and Behavioural Disorders* 22(1), 2013, 16–26.
- 142 Berridge, D. and I. Brodie, "Residential Child Care in England and Wales: The Inquiries and After", in M. Hill and J. Aldgate (eds), *Child Welfare Services: Developments in Law, Policy, Practice and Research*, Jessica Kingsley, 1996; Colton et al. 2002.
- 143 See, for example, Levy, A. and B. Kahan, *The Pindown Experience and the Protection of Children*. Stafford: Staffordshire County Council, 1991; Kent, R., *Children's Safeguards Review*, Edinburgh: Scottish Office, 1997; Utting, W., *People Like Us: The Report of the Review of the Safeguards for Children Living Away from Home*, London: Department of Health and the Welsh Office, 1997; Waterhouse, R. *Lost in Care: Report of the Tribunal of Inquiry into the Abuse of Children in Care in the Former County Council Areas of Gwynedd and Clwyd since 1974*, London: The Stationery Office, 2000.
- 144 UNICEF Regional Office for Latin American and the Caribbean 2013.
- 145 Breland-Noble, A., E. Elbogen, E. Farmer, M. Dubs, H. Wagner and B. Burns, "Use of Psychotropic Medications by Youths in Therapeutic Foster Care and Group Homes", *Psychiatric Services* 55(6), 2004, 1176–1179.
- 146 UNICEF Regional Office for Latin American and the Caribbean 2013.
- 147 UNICEF, *State of the World's Children: Children with Disabilities*, Geneva: UNICEF, 2013.
- 148 Brkic, M., A. Jugovic and W. Glumbic, "Residential Care for Children with Intellectual Disabilities in the Social Protection System in Serbia", *European Journal of Social Work* 17(2), 2014, 237–251; Browne, K., "A European Survey of the Number and Characteristics of Children Less than Three Years Old in Residential Care at Risk of Harm", *Adoption and Fostering* 29(4), 2005, 23–33; Browne 2009.
- 149 Csáky 2009.
- 150 Colton et al. 2002.
- 151 Barter 2003, quoted in deCordova et al., 2008.
- 152 Ibid.
- 153 Haarr 2011.
- 154 Spencer, J. W. and D.D. Knudsen, "Out-of-home Maltreatment: An Analysis of Risk in Various Settings for Children", *Children and Youth Services Review* 14, 1992, 485–492.
- 155 Pinheiro 2006.
- 156 Barter et al. 2004.
- 157 Biehal, N., L. Cusworth, J. Wade and S. Clarke, *Keeping Children Safe: Allegations Concerning the Abuse or Neglect of Children in Care, Final Report*, London: NSPCC, 2014.
- 158 Crooks et al. 2005, referenced in Jones, V., "Children and Young People Exhibiting Sexually Harmful Behaviour –What have we Learned and What do we Need to Know to Propose Effective Intervention?" in *Protecting Children from Sexual Violence: A Comprehensive Approach*, Strasbourg: Council of Europe, 2010.
- 159 See, for example, Bessell, S., "Participation in Decision-making in Out-of-home Care in Australia: What do Young People Say?", *Children and Youth Services Review* 33, 2011, 496–501.; Dunn, D.M., S.E. Culhane and H.N. Taussig, "Children's Appraisals of their Experiences in Out-of-home Care", *Children and Youth Services Review* 32, 2010, 1324–1330; Kufelt, K., M. Simard and J. Vechon, "Improving Outcomes for Children in Care: Giving Youth a Voice", *Adoption and Fostering* 27(2), 2003, 8–19.
- 160 Ruiz-Casares, M., C. Rousseau, J. Morlu and C. Browne, "Eliciting Children's Perspectives of Risk and Protection in Liberia: How to Do It and Why Does It Matter?" *Child Youth Care Forum* 42, 2013, 425–437.
- 161 See, for example, SOS Children's Villages International, *Ageing Out of Care: From Care to Adulthood in European and Central Asian Societies*, Innsbruck: SOS Children's Villages International, 2010; Ragg, M., D. Patrick and M. Ziefert, "Slamming the Closet Door: Working with Gay and Lesbian Youth in Care", *Child Welfare* 85(2), 2006, 243–265; Craig-Oldsen, H., J.A. Craig, T. Morton, "Issues of Shared Parenting of LGBTQ Children and Youth in Foster Care: Preparing Foster Parents for New Roles", *Child Welfare* 85(2), 2006, 267–280.
- 162 deCordova et al., 2008.
- 163 Taken from the Global Initiative to End All Corporal Punishment of Children, *Ending Legalised Violence against Children: Prohibiting and Eliminating Corporal Punishment in All Alternative Care and Day Care Settings*, London: Global Initiative to End All Corporal Punishment of Children and Save the Children Sweden, October 2012.
- 164 Honkatukia, P., L. Nyqvist and T. Pösö, "Violence Talk and Gender in Youth Residential Care", *Journal of Scandinavian Studies in Criminology and Crime Prevention* 8, 2007, 56–78.
- 165 Ibid., p.57
- 166 Ibid.
- 167 Firmin, C., Speaking at the International Centre: Researching CSE, Violence and Trafficking, One-Day Conference, London, 3 July 2014; Shuker, L., *Safe Accommodation for Sexually Exploited and Trafficked Young People*, Bedford: University of Bedfordshire, 2011.
- 168 It was considered out of the scope of this report to undertake a meaningful consultation of children and young people; however, part of the desktop research was to scan studies that have included the views and opinions of children and young people.
- 169 Committee on the Rights of the Child 2011.
- 170 SRSG on Violence against Children 2013.
- 171 deCordova et al., 2008.
- 172 Browne 2009.

- 173 Huesmann, L. 2012, referenced in SRSG on Violence against Children 2013.
- 174 Pinheiro 2006.
- 175 Jones 2010.
- 176 Díaz Morfa, J. *Ofensores sexuales juveniles* [Juvenile Sex Offenders] *Revista de Estudios de Juventud* 62, 2003.
- 177 Gambia country assessment, p.3.
- 178 United Nations Secretary-General's Study on Violence against Children, *Global Progress Survey on Violence against Children*, New York: United Nations Secretary-General's Study on Violence against Children, 2011.
- 179 Covell, K. and J. Becker, *Five Years On: A Global Update on Violence against Children*, NGO Advisory Council for Follow-up to the UN Study on Violence against Children, October 2011.
- 180 Pinheiro 2006.
- 181 Covell and Becker 2011.
- 182 Referenced in Save the Children, *Children Witnesses of Gender Violence in the Domestic Context: Analysis of the Fulfillment of their Specific Needs through the Protection System*, Madrid, Save the Children Spain, 2011.
- 183 Reference in Newell 2008.
- 184 UNICEF "Hidden in Plain Sight" 2014.
- 185 UNICEF 2010, referenced in Covell and Becker, 2011.
- 186 Morantz, G. and J. Heymann, "Life in Institutional Care: The Voices of Children in a Residential Facility in Botswana", *AIDS Care* 22(1), 2010, 10–16.
- 187 Twum-Danso 2010, referenced Covell and Becker 2011.
- 188 UNICEF Regional Office for Latin America and the Caribbean 2013.
- 189 Survey of Demographics and Family Health 2010, referenced in the Peru country assessment.
- 190 UNICEF Kenya 2010, referenced in the Kenya country assessment.
- 191 Fox, A. and J.D. Berrick, A Response To: 'No-one Ever Asked Us: A Review of Children's Experiences in Out of Home Care', *Child and Adolescence Social Work Journal* 24(1), 2007, 23–51.
- 192 Berridge et al. 2011.
- 193 Pinheiro 2006, p.131.
- 194 Violence against Children in Tanzania: Findings from a National Survey 2009, referenced in SRSG on Violence against Children 2013.
- 195 Finkelhor et al. 2008, referenced in SRSG on Violence against Children 2013.
- 196 Biehal et al. 2014, p.25.
- 197 Willow and Hyder 1998, referenced in deCordova et al. 2008.
- 198 deCordova et al. 2008.
- 199 Pinheiro 2006.
- 200 Ibid.
- 201 Ibid.
- 202 Euser et al. 2013; Freundlich et al. 2007; Berridge, et al. 2011.
- 203 Honkatukia et al. 2007.
- 204 Togo and Malawi country assessments.
- 205 Powell et al. 2004.
- 206 UNICEF "State of the World's Children" 2013.
- 207 See, for example, Inter-American Commission on Human Rights, *The Rights of Girls and Boys to a Family: Alternative Care: Ending Institutionalization in the Americas*, Washington DC: IACHR, 2013; Pinheiro 2006, UNICEF "State of the World's Children" 2013.
- 208 Global Initiative to End All Corporal Punishment of Children 2012.
- 209 Pinheiro 2006.
- 210 UNICEF "State of the World's Children" 2013; Mulheir 2012.
- 211 Ibid.
- 212 Petrova-Dimitrova, N. "Sexual Abuse of Children Analysis of the Situation in Bulgaria", Recommended from the Oak Foundation, 2005.
- 213 Armenia country assessment, p.49.
- 214 An analysis of gatekeeping and preventive services is beyond the scope of this report, but useful sources for information on these issues are available at: www.bettercarenetwork.org/bcn/topic_more.asp?topicID=1022&themelD=1003.
- 215 Colton et al. 2002.
- 216 Ellonen, N. and Y. Pösö, "Violence Experiences in Care: Some Methodological Remarks based on the Finnish Child Victim Survey", *Child Abuse Review* 20, 2011, 197–212.
- 217 Connolly, M., I. de Haan and J. Crawford, "The Safety of Young Children in Care: A New Zealand Study", *Adoption and Fostering* 37(3), 2013, 284–296.
- 218 Fox and Berrick 2007.
- 219 Stein 2009.
- 220 Biehal et al. 2014.
- 221 Cosis- Brown, H., *Social Work and Foster Care, Learning Matters*, London; Sage Publications, 2014.
- 222 Ibid.
- 223 Croatia country assessment.
- 224 Brodie, I., *Providing Safe and Supported Accommodation for Young People who are in the Care System and who are at Risk of, or Experiencing, Sexual Exploitation or Trafficking for Sexual Exploitation*, London: NSPCC & University of Bedfordshire, 2011; Department for Education, *Tackling Child Sexual Exploitation: Action Plan*, London: Department for Education, 2011.
- 225 CEOP, "Making Every Child Matter, Everywhere: Executive Summary", CEOP Thematic Assessment, June 2011; D'Arcy, K. and J. Pearce, J., "Preventive Measures and Support Regarding Child Sexual Exploitation", University of Bedfordshire, 2013 (not yet in print).
- 226 Cosis- Brown 2014.
- 227 Biehal et al. 2014.
- 228 Behar, L., R. Friedman, A. Pinto, J. Katz-Leavy and W. Jones, "Protecting Youth Placed in Unlicensed, Unregulated Residential 'Treatment' Facilities", *Family Court Review* 45(3), 2007, 399–413; Sen, R., A. Kendrick, I. Milligan and M. Hawthorn, "Lessons Learnt? Abuse in Residential Care in Scotland" *Child and Family Social Work* 13(4) 2008, 411–422.
- 229 Paraguay country assessment.
- 230 Benin country assessment.
- 231 Malawi country assessment.
- 232 IACHR 2013.
- 233 Guðbrandsson, B., *Rights of Children in Institutions*, Strasbourg: Council of Europe, 2008.
- 234 Chile country assessment.
- 235 Benin country assessment.
- 236 Malawi country assessment.
- 237 Kenya country assessment.

- 238 See Better Care Network: www.bettercarenetwork.org/BCN/topic_more.asp?topicID=1020&themeID=1003.
- 239 Croatia country assessment.
- 240 Malawi country assessment.
- 241 SOS Children's Villages International, *A Solid Investment: Integrating Children without Parental Care into the Post-2015 Development Framework*, Innsbruck: SOS Children's Villages International, 2014.
- 242 UNICEF 2010.
- 243 Bostock, L., *Promoting Resilience in Fostered Children and Young People*, London: Social Care Institute for Excellence, 2004.
- 244 Newman, T. and S. Blackburn, *Transitions in the Lives of Children and Young People: Resilience Factors*, Edinburgh: Barnardo's Policy, Research and Influencing Unit, Scottish Executive Education Department, 2002.
- 245 Gilligan, R., *Promoting Resilience: A Resource Guide on Working with Children in the Care System*, London: BAAF, 2001; Shuker, L., Speaking at the International Centre: Researching CSE, Violence and Trafficking, One-Day Conference, London, 3rd July 2014, London.
- 246 Sanou, D., H. Turgeon-O'Brien, S. Ouedraogo and T. Desrosiers, "Caring for Orphans and Vulnerable Children in a Context of Poverty and Cultural Transition: A Case Study of a Group Foster Homes Program in Burkina Faso", *Journal of Children and Poverty* 14(2), 2008, 139–155; Brkic et al. 2014.
- 247 Sekol, I., "Peer Violence in Adolescent Residential Care: A Qualitative Examination of Contextual and Peer Factors", *Children and Youth Services Review*, 2013, 1901–1912.
- 248 SOS Children's Villages International, *When Care Ends: Lessons from Peer Research*, Innsbruck: SOS Children's Villages International, 2012.
- 249 Kimberlin, S., E.K. Anthony and M.I. Austin, "Re-entering Foster Care: Trends, Evidence, and Implications", *Children and Youth Service Review* 31, 2009, 471–481.
- 250 Litrownik, A.J., R. Newton, B.E. Mitchell and K.K. Richardson, "Long-Term Follow-Up of Young Children Placed in Foster Care: Subsequent Placements and Exposure to Family Violence", *Journal of Family Violence* 18(1), 2003, 19–28.
- 251 Ibid.
- 252 Farmer, E., W. Sturgess and T. O'Neill, *The Reunification of Looked after Children with their Parents: Patterns, Interventions and Outcomes*, London: Department for Children, Schools and Families, 2008.
- 253 Malawi country assessment.
- 254 Bosnia and Herzegovina country assessment.
- 255 Malawi country assessment.
- 256 SOS Children's Villages International 2012.
- 257 IACHR 2013.
- 258 Newell 2008.
- 259 Kenya country assessment.
- 260 Pinheiro 2006, p.16.
- 261 Pinheiro 2006.
- 262 Armenia country assessment.
- 263 Norway country assessment.
- 264 Kenya country assessment.
- 265 Zambia country assessment.
- 266 Green, L. and H. Masson, "Adolescents who Sexually Abuse and Residential Accommodation", *British Journal of Social Work* 32, 2002, 149–168.; Barter, C., Discourses of Blame: Deconstructing (hetero) Sexuality, Peer Sexual Violence and Residential Children's Homes", *Child and Family Social Work* 11, 2006, 347–356; Coy, M., "Moved Around like Bags of Rubbish Nobody Wants: How Multiple Placement Moves can make Young Women Vulnerable to Sexual Exploitation", *Child Abuse Review* 18, 2009, 254–266.
- 267 Pinheiro 2006.
- 268 Biehal et al. 2014.
- 269 Colton et al. 2002.
- 270 SRSG on Violence against Children 2013, p.38.
- 271 Kenya country assessment.
- 272 Armenia country assessment.
- 273 Davidson, J., C. Wilkinson, B. Docherty and M. Anderson, *Higher Aspirations, Brighter Futures: NRCCI Workforce Report*, Glasgow: SIRCC, 2009; Colton, M. and S. Roberts, S., "Factors that Contribute to High Turnover among Residential Child Care Staff", *Child and Family Social Work* 12(2), 2007, 133–142.
- 274 Sellick, C., J. Thoburn and T. Philpot, *What Works in Adoption and Foster Care? Barkingside: Barnardo's*, 2004.
- 275 Malawi country assessment.
- 276 Colombia country assessment.
- 277 Venezuela and Zimbabwe country assessments.
- 278 Malawi country assessment.
- 279 Togo country assessment.
- 280 Green and Masson 2002.
- 281 Sellick et al. 2004; Sinclair, I. *Fostering Now: Messages from Research*, London: Jessica Kingsley, 2005.
- 282 Hicks et al. 2007.
- 283 Kendrick 2008; Berridge et al. 2011.
- 284 SRSG on Violence against Children, Safe and Child-sensitive Counselling, Complaint and Reporting Mechanisms to Address Violence against Children. New York: Joint report of the Special Representative of the Secretary-General on Violence against Children and the Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography, 2012, p.8.
- 285 Warrington, C., Young People's Advisory Group, Annual Report 2010-2011, www.beds.ac.uk/___data/assets/pdf_file/0015/293100/14361_PR-and-M_WWVU-report_v7_HR_1.pdf; Morgan 2014.
- 286 Ruiz-Casares et al. 2013.
- 287 Sekol 2013; SOS Children's Villages International 2012; Barter et al. 2004.
- 288 Save the Children, *Save the Children's Contribution to End Violence against Children in Institutional Settings: Sharing Good Practice and Key Recommendations*, London: Save the Children, 2005.
- 289 Ibid.
- 290 Conclusions of the International Conference "Combatting Violence against Children: From isolated actions to integrated strategies", 24-25 May 2011, Kiev, Ukraine.
- 291 Sellick, et al. 2004.
- 292 Definition endorsed by the United Nations General Assembly (Resolution A/RES/36/28, 1981).

FROM A WHISPER TO A SHOUT: A CALL TO END VIOLENCE AGAINST CHILDREN IN ALTERNATIVE CARE



SOS CHILDREN'S
VILLAGES
INTERNATIONAL



University of
Bedfordshire

