Institutional Care for Children in Kenya

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Abstract

Drawing upon personal experiences as a social work professional, and inspired by 13 years of childhood experiences living in a care institution, this chapter reviews the history and glimpses of life in residential institutions for children in Kenya. Periods of emergence and re-emergence of institutional care for children are delineated along with the influences of 'voluntourism' and fund-raising fueling a growth industry for Kenya's residential institutions with Western charities. Implications for the continuing development of service for Kenya's children in care are highlighted.

Introduction

This chapter reviews the history and reality of institutional care for children in Kenya drawing upon personal experiences as a social work professional, and inspired by 13 years of childhood experiences living in a care institution. The history and reality of institutional care in Kenya is first examined through a literature review which highlights periods of emergence and resurgence in the institutionalization of children. Next, the realities of institutional practice are explored that highlight particular legal, socio-cultural, and economic contestations. Finally, personal reflections are

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offered about life experiences of growing up in institutional care – with the aim of clarifying and deepening understandings of institutional care. No effort is made to generalize from personal experiences in care to the wider population of children living in care in Kenya.

Institutional Care for Children in Kenya

According to the Kenya Demographic Health Survey (Oshako *et al*, 2011), Kenya is estimated to have 2.4 million orphans and vulnerable children. Within the continuum of care options for orphans and vulnerable children, these children can end up in institutional care, kinship care, adoption, foster care, or guardianship. However, there is a lack of clarity about the number of children in institutional care, nor is there clarity about the number of institutions. According to recently published guidelines on alternative care, it is estimated that 30-45% of the 2.4 million orphans and vulnerable children in the country end up in charitable children institutions (Government of Kenya, 2014, p.4). Research by Stuckenbruck (2013, p.4) approximates an existence of 700 institutions with around 50,000 children. A different projection by Williams and Njoka (2008, p.19) in a Government commissioned report, estimates the country to be having 1200 institutions with approximately between 30,000-200,000 children. Despite a lack of clarity on statistics, the majority of orphans and vulnerable children are supported within non-formal kinship arrangements (Government of Kenya, 2014, p.4).

The institutions denoted here refer to Charitable Children's Institutions (CCI's) and should not be conflated with borstal or remand institutions whose mandate is rehabilitation, and protection of children in conflict with the law. The Kenya Children's Act 2001 (s.58), defines a CCI as "a home or institution which has been established by a person, corporate or unincorporate, a religious organisation or a non-governmental organisation and has been granted approval by the council to manage a programme for the care, protection, rehabilitation or control of children".

This model of care is dominant because it is prioritized as the first steps towards adoption or foster care in Kenya. For example, young children to be adopted or fostered, by law, have first to be placed in institutional care before initiating placement for adoption or foster care. This validates and reinforces the existence of care institutions throughout the country, and contributes to a global narrative about the proliferation of institutional care resistant to de-institutionalization.

What Factors Influence Institutionalization of Children in Kenya?

To de-emphasize institutional care, and to promote family-based care, the UNCRC preamble lucidly identifies family as the 'fundamental group' in the society, and that children 'should grow up in a family environment' to achieve their full potential and for their well-being. The Kenya Children's Act 2001 (s. 6) reverberates the same spirit in UNCRC that a "child shall have a right to live with and to be cared for by his parents". However, these hopes have proven idealistic rather than feasible for many children placed in institutional care, for multiple reasons. Whether placed in institutional care because of physical or sexual abuse, neglect, disability, political and ethnic conflicts, harmful cultural practices, natural disasters or family breakdown (Government of Kenya, 2014, p.4), overlaid across all other social variables is poverty, along with a nation's HIV/AIDS epidemic as major reasons for institutionalization of children (UNICEF, 2003).

Material poverty in Kenya at the start of the international economic downturn stood at 46 percent (World Bank, 2008). Both globally and locally, poverty has been cited as a leading contributing factor to the institutionalization of children (CELCIS, 2012; Morantz, G. *et al*, 2015, p.6). The multi-dimensional social exclusion from livelihoods and lack of safety-nets during times of adversity leaves many families in precarious circumstances (Silver, 2007, p.5). Such predicaments impact disproportionately on children who experience severe economic hardship, making these children more susceptible to losing family care and protection, and ending up 'placed' in care institutions.

The demand for care institutions for children in Kenya has also been driven by a lucrative local and inter-country adoption 'market'. As mentioned earlier, all adoptions in the country are facilitated through institutions. However, adoption has been for a long time marred by claims of human trafficking, and twisted into money-spinning ventures. As a result, such adoptions were banned in Kenya in 2014. During the ban, the Cabinet Minister claimed that inter-country adoption had been turned into a lucrative industry, and some institutions were being used for human trafficking under the pretext of charity (Nation Media, 2014, p.1). Similarly, Williams and Njoka (2008, p.4) drew attention to peculiar statistics that suggested adoption malpractices in a government commissioned report showing inter-country adoption peaking at 38% during one of the reporting periods. This figure is comparatively high bearing in mind that Kenya is a signatory to the Hague

Convention on Inter-country Adoption that emphasizes the subsidiarity principle. According to this principle, it is in the best interest of children to be adopted locally, and only when these local opportunities have been exhausted should inter country adoption be considered (ISS, 2007, p.1).

Most of the aforementioned factors are unsatisfactory explanations for placement of children in institutional care, especially when deep-seated structural factors such as poverty and HIV-AIDs are taken into consideration. A 'saviour mentality' by some donors, whether as individuals, groups or NGO's, helps to disguise the reality of the issue. We need to acknowledge the good intentions in giving and in responding to children's plight; on the other hand, we should examine, and appreciate how this affects the overall child protection system. Pells argues that such reactive responses leave children "detached from the broader socio-economic and political structures that shape their life chances..." (2012, p.563).

Similarly, a rush to "rescue" children, associated with the pouring of funds by some wealthy donors has often resulted not just in a proliferation of institutions in the country. This has also contributed to the manufacturing of "orphans" by unscrupulous individuals and organizations locally who view such activity as a profitable business venture. These unscrupulous people and organizations – through their depravity – prey on the ignorance and compassion of mostly Western donors, attracting funding that they misappropriate while exploiting the desperate circumstances and innocence of children.

Tracing Institutionalization in Kenya

While factors which drove the institutional care of children are clear, that history is poorly documented in Kenya, although selected historical and recent happenings shed some light on the advent and proliferation of these services. After gaining independence in December 12, 1963, Kenya embarked on economic self-determination marking a break away from the shackles of colonialization. However, it did not take long before the West scrambled for investment in Africa, spreading the cult of modernization and the institutionalization of children. Kenya like most African countries was loaned money at low interest to boost its economy. However, the economy stalled and then failed to achieve expected levels of growth. Interest rates went up as a result of the OPEC oil price hike in the late 1970's and Kenya, just like other developing countries globally, was burdened with debt (Ansell, 2005, p.44).

Burdened with debt, the hopes and joys of two decades of prosperity in the newly independent Kenya did not live long. Fearing default of repayment, the World Bank and the International Monetary Fund along with other international financial institutions introduced the Structural Adjustment Program (SAP) in the 1980's and 90's. This had deleterious ramifications as the structural adjustment program invaded, pervaded and decimated macro and micro systems combined (*ibid*). Children were openly and implicitly implicated by the Structural Adjustment Programs through cuts in public spending, removal of price controls and subsidies, and the privatization of public goods. Education and health were no longer free, and a covenant of cost sharing was introduced by the Government. High unemployment rates meant that families could hardly afford to pay (Ansell, 2005, p.46). Infant mortality rates increased. Children dropped out of school and high numbers of children scavenged in the streets begging because their families could not provide for them.

Throughout Kenya, more households could not meet the basics due to unemployment. Another toxic ramification of the Structural Adjustment Programs saw the bourgeoning of institutional care facilities for children. Some of the children neglected due to poverty ended up on the streets where they were rounded up by police and city council officers and taken to institutions as orphans. Mothers who could no longer afford health care and education relinquished their responsibilities to institutions. Additionally, individuals, private donors, local and international NGO's and Faith-Based Organizations joined forces and stepped in with multiple interventions claiming to support the best interests of Kenya's children. Saving and rescuing the children through institutionalization became part of the game plan. A "needs" approach was employed that viewed children as objects of development. Such an approach disregarded children as rights-holders and this enabled government to overlook its responsibilities as a duty bearer accountable to the children. Children were disconnected from communities and families and taken to institutions in the name of care and protection. To fund-raise for children's projects – in this case the children's institutions – heart-wrenching stories with images of suffering children were broadcast to the North. The North, perturbed and touched by the images and statistics of starving Kenyan children, responded with funds and projects that turned children into objects of Western intervention. Such interventions rarely looked at the context of institutional placements, the children's social and family histories, or wider considerations about the best interests of children.

International Aid and Voluntourism

A second explanation for the intensification of institutional care placements for children could be *voluntourism*. According to Wearing in Tomazos and Butler, *voluntourism* refers to "tourists who for various reasons volunteer in an organised way to undertake holidays that might involve aiding or alleviating the material poverty of some groups in society, the restoration of certain environments or research into aspects of society or environment" (2012, p.196). The discourse on voluntourism and institutionalization gained the limelight in Kenya during the first decade of the new century. Such activities continue, despite spirited awareness and advocacy campaigns against voluntourism.

Due to the scarcity of historical evidence, I can only reflect on this issue from my own personal experience. From around the age of 6, I had jostled with fellow institutionalized children on the barbed wire fences of the institution to behold and welcome international tourists who came in mini-vans. These tourists were from all over the world. On different occasions, they streamed in and left through the rusty black-painted gates of the institution. The volunteers came clad in shorts and sunglasses. They smiled at us, as they took photos. Guided, they strolled round the institution, were shown the facilities in the institution, and the children therein. To wrap up their visit we gathered around a tree centered in the institution and sang a "thank you" song for them before they started waving us goodbye. At some point I felt like there was no difference between us and the animals in the zoos, to be seen, to entertain them and then to be left in the same cocoon of an institution. Some left money, others cheques and some left food, clothing and toy donations. Some committed to continue funding the institutions after their first experience while others could only give once. Some even committed to going back to their respective countries to fundraise for the institution.

At the same time, the role of local voluntourists has often gone unnoticed in sustenance and establishment of institutions. Since independence, Kenya has experienced a burgeoning upper and middle class that always existed but has subsequently grown. In this category one might include local corporate organizations, individuals, churches and institutions of higher learning. These local entities have also contributed to funding institutions, and some have established them. Local churches have also been at the forefront, supported by their congregations, have established residential institutions for children and some are supported by affiliated Western churches. The emergence of institutions in Kenya can also be traced to the arrival of missionaries. As

stated by Pinheiro, "in many African countries the only orphanages that existed until recently were set up by missionaries before independence" (2006, p.184). Missionaries intensified their missions to Kenya from the late 19th and early 20th Centuries. Empirically, Anglicans, Catholics, Muslims, Mormons, Baptists, and Presbyterians have continued to run residential institutions across Kenya.

After looking at the advent and re-emergence of residential institutions for children in Kenya, it is important to glimpse the realities of daily living as a child growing up in institutional care. In what follows, I will reflect on life in institutional care from a very personal/subjective perspective, hoping that – as a reader – the image will become clearer, and the experiences more blatant.

Personal Experience in Residential Care in Kenya

I was born into a family of three sisters and three brothers. I was around 5 or 6 when I witnessed my mother and youngest sibling being decapitated by a man we lived with. I knew the man to be my stepfather, this is after my mother had separated from my father some time earlier. Soon after my mother's horrendous murder, we were taken to a hospital, and subsequently driven alongside my elder brother and younger sister to an established residential institution approximately 300 kilometers away from the place I knew as home, to a place along the edge of Nairobi. Throughout the journey, we were watched but also nobody talked to us. We had no idea about where we were being taken. It was a long and quiet ride.

I could never have foreseen spending almost my entire childhood going round in circles within a cold and callous place, separated from the rest of the world by concrete walls, barbed wire and tall thorny bushes. Our school was located inside the institution, and this further complicated our movements outside the institution. The institution was quite eclectic in its composition of over 100 children from various backgrounds; some with disabilities, some found abandoned, some taken from the streets, and some like my siblings and me were given the new identity of "orphan," for having just lost our mother.

During my first years in care, I witnessed government efforts to "clean up" the streets, rounding up children – those who called the street home – like a herd of cattle, and taking them to care institutions. Many were brought to the institution in which I grew up, though few remained. Compared to the streets where they could move about when, how and where they chose, they experienced the institution like a prison. In the institution, the boys sang songs of life on the streets, describing the hardships they endured and the irony of freedoms they experienced. At night, they recanted stories of police

harassment, described the diverse menu of foods they would scavenge from the garbage dumps, and boasted about the money they earned through begging. Their stories enabled me to understand why they now felt so confined, and, as the institution could not provide the variety of food, or the freedom, I understood why some of the boys did not spend even a week in the institution before jumping over the fence and running back to the streets. My older brother with whom I came could also not stay in the institution for long. After a month or so, he also fled and left us behind.

My sister and I stayed on in the institution. I lived in a dormitory with over 50 children, supervised by one or two staff in shifts – and often not supervised at all. My sister lived in a girls' dormitory, and we rarely interacted although from a distance we could see each other. My memories of staff were not that of a mother interacting with a son. Although referred to as *housemothers,* they were employed to carry out their list of chores, none of which included expressing genuine love and care. There were no 'fathers'. The closest man was a harsh disciplinarian who doubled as a cook. The rest of the men worked in other sections and we scarcely interacted with them.

The institution was very regimented and in what it offered, life was very predictable. We were restricted by schedules and rules, leaving little room to think or act independently. Freedom of expression was confined among ourselves (children), everything with adults was 'do as you are told'. Free expression was met with aggression, and life was as it was defined to us, not as we would have liked it. Within the confines of the gated compound we were verbally abused, and regularly and harshly, beaten with plastic pipes and green hard twigs that left contours on our bodies. Any behavior that contradicted the normative standards of conformity was immediately beaten out of us. Abuse came not only from staff but also from the older children who lived together in one dormitory with the younger children. These young adults could physically and sexually abuse the younger boys in the evenings, lure them with food that was scarce. And silently this went unnoticed, often no one to tell, and nowhere to go, unless one decided to flee the institution.

In the institution, quantity was preferred to quality. The dormitories were always full, and as soon as one child left, he or she was easily and quickly replaced. The number of children being looked after seemed to attract sympathy, and hence a magnet to donation from well-wishers, which sustained the institution. Consequently, the institution seemed to go out on scavenger hunts, searching for orphans and vulnerable children to add to the observable numbers of children. Although some of the children were genuine orphans, most had caring parents. Often it was because of poverty or

disability that they had been brought to the institution. I felt like I was merely a statistic in the institution, not just from there being many of us living there. It was also because of the conformity that was demanded from all of us. To the donors and visitors, it appeared that some good work was going on.

Visitors, volunteers, and staff were constantly taking photos and videos of us. Happily, we beamed and posed on the dining halls and like Hollywood stars we performed. We were never asked whether we minded or not. Most of the time we never knew who it was that was taking the photos or videos of us. We didn't know where our photos would end up, or why they were being taken. Younger children and those with severe disabilities were the darlings. However, their utility diminished as these children grew older or when I realized later that the institution needed new images to front a new fundraising campaign, seeking new images that would attract funding. Those of us who were older and "able-bodied" as they would call us, were paid little attention.

My life in care had already "expired" a few years before I finally exited. Constantly being reminded that I was over the age of 18, I was "too old" to be in the institution. I was reminded that donors did not want to see older children in the institution, and hence the institution was finding a solution for us. Without much support and preparation, I was "dropped off" in the community. It took me time to cope with what felt like re-abandonment. I became socially withdrawn and psychologically re-traumatized. Although educational support from the institution played a significant part in positively influencing my life path, I have always felt the life stories of children growing up in institutions need to be shared, so as to further understanding, as well as deepen and influence scholarly and practice discourses on institutional care

Is There a Place for Institutional Care?

Referring to a wide body of research, Browne argued that children who have lived in institutional care "have reduced intellectual, social and behavioral abilities compared with those growing up in a family home" (2009, p.1). Such outcomes have resulted in well-intentioned drives towards de-institutionalization internationally, without consideration given to whether some children may have few, if any other options to residence in institutional care. Adopting such a stance as an absolute is, on the one hand simplistic and demonizes institutional care, while on the other hand, it romanticizes family care.

There are several reasons for not rushing to 'bash' institutional care in Kenya. Firstly, for most children living with HIV/AIDS, adoption and foster

care are far from common due to stigma and discriminatory attitudes which continue to persist in some communities. Secondly, Kenya is also grappling with negative cultural perceptions about children with disabilities and children born out of wedlock. It is not uncommon for these children to be threatened with death in some communities (Williams & Njoka, 2011, p.20). Another issue is female genital mutilation. After rescue, young girls are taken to institutions as a place of safety. For these girls, it could be due to a lack of well-established protective care systems. However, in the meantime, let us face the reality that institutional care still has a place in Kenyan society. With proper systems of support, family-based care could also become a reality at some point.

What is Wrong with Institutional Care for Children in Kenya?

Good research arguments now challenge the routine use of institutional care for children in any country when alternative care placement options with family, extended family and foster carers may be more beneficial. However, it is important to note that most of these research arguments are Eurocentric – British and North American – and informed by positivist findings on early childhood development. These research findings have been generalized from nation- and culture-specific populations to become universalized 'truths' which, as a consequence, camouflage the lived experiences of institutionalized children in specific countries. Kenya offers an illuminative account of nation-specific challenges associated with the residential care of children and de-institutionalization discourses.

Firstly, Kenya does have policies, regulations and guidelines when it comes to protecting children in and out of care. The United Nations Convention on the Rights of the Child (UNCRC) has been ratified. That Convention was used to craft the Children's Act 2001, the fundamental legal framework around which the care of children is managed. Kenya has *Best Practice Standards for Charitable Children Institutions*, developed in 2013, and more recently *Guidelines for Alternative Care of Children*. In spite of these initiatives, the institutional care of children is still marred by malpractices and by the indolence of Government officers. This, coupled with malpractices by some NGO's, individuals and private donors, means that "the existence of laws and protocols cannot be trusted as indicators of success in protecting vulnerable children" (Cooper, 2012, p.495).

Second, international research has highlighted possible effects and challenges faced by care leavers as they move into young adulthood; these are young people typically over the age of 18 who have grown up in care. And yet, care leavers have been largely neglected when it comes to identifying what expertise is essential to child welfare policy-making, programming and the operations of residential institutions. Little is achieved when 'outcomes' associated with living in residential care are ignored as the views of care leavers are neglected in discourses that view their childhood in dismissive terms. Until recently, the voices of care leavers were largely silenced – but not anymore! Even the Oscar for Best Picture was awarded to the film 'Spotlight' which gave voice to young people abused in residential schools. The Guidelines on Alternative Care which are about to be launched in Kenya draw attention to the plight of care leavers, and moreover, in a landmark step, the Guidelines advocate better support for care leavers.

Third, some of the institutions in Kenya start as rescue centers, without financial or professional capacity, and some even start up without approval from the government. Once children are in residence, they are unable to explore family-based care options, unable to develop care plans, nor execute exit strategies. As a result, these residential institutions 'get stuck' with the children and quickly metamorphose into long-term residential care centers.

Fourthly, abuse, neglect and exploitation have been identified in residential institutions all over the world. Some studies have suggested violence to be six times higher in institutions than in other care models (Pinheiro, 2006 p.183). For Kenya, this is not peculiar. Institutions have been easy targets for pedophiles. Between April and June 2014, Mathew Durham – a missionary from Oklahoma – was found guilty of defiling multiple children in a residential care center in Kenya (Daily Mail, 2014). A British Airways pilot Simon Wood was also found guilty of molestation of girls during stopovers in Kenya, Uganda and Tanzania (Press Association, 2014). However, these are foreign examples whereas abuse meted out by locals more often goes unnoticed. Children are often forced to suffer silently because the people in-charge, with whom they share their daily lives are the perpetrators. Most fear the consequences of reporting or sharing their abuses.

Finally, the idea of discharging young people from care when they reach the age of 18 as practiced by most residential institutions in Kenya makes huge assumptions about young people's readiness for independent living. Many young people leave care ill prepared for what faces them. The majority of those leaving care in Kenya are unprepared and ill equipped for what they may face (Roeber, 2011, p.13). The age of 18 is cemented into Kenya's

Children's Act 2001 which provides that young people should exit care at the age of 18 and only in special circumstances can this care be extended. A paradigm shift is required to look at exit from a capability and social competence perspective. Age needs to be viewed as cultural and relational, far more social than chronological (Huijsmans *et al*, 2014). Even the United Nations views youth as continuing on through to age 25! Using chronological age as a marker for exiting care is both narrow and simplistic, and as Furlong states, "age, once a strong marker, is no longer a trustworthy indicator" (2009, p.32). Age should not be used as a normative indicator of maturity or justification for exiting care. Critical personal development skills are very important for each prospective care leaver exiting from life in a residential institution.

Conclusion

To conclude, six points are highlighted for the future of residential care of children in Kenya. First, institutional care in Kenya needs to move from being a default model of care, to a last resort approach. In order to achieve this change, an evidence based approach should be employed by government and non-governmental agencies where interventions and institutional frameworks are based on solid research findings. Subsequently, government, donors and funders should allocate resources, enhance and change practices, policies and legislative frameworks to match that evidence. Second, with the current overuse of the model, uncertainties around statistics and the well-being of thousands of children in institutions, along with reports of child rights violations and the deleterious effects of institutionalization, a moratorium on the use of institutional placement – except in extreme circumstances – is in order.

Third, it is time to re-examine the charity orientation to child care and protection and adopt an approach that ensures children are rights holders, and the government can be held responsible and accountable, as duty bearer in meeting the needs of and protecting the children. As the primary duty bearer, the government needs to strengthen and prioritize alternative family care models by allocating sufficient resources, and reinforce monitoring and supervision of the care system as a whole. It is a precarious existence for Kenyan children to live in obscurity, daily susceptible to any number of child rights violations.

Fourth, children placed in residential care are not objects that require care and protection. They are individual subjects and children in their own right, with whom a personal relationship is formed in the daily life spaces of care.

What is in the 'best interests of the child' – this child, and these children – needs to be critically reviewed on a daily basis to ensure that each child's voice and opinions are heard and taken seriously – before they enter a residential institution on placement, during his or her stay in that institution, and in the months after leaving care.

A fifth conclusion is that, communities need to be sensitized by both government and non-governmental agencies to the implications of institutionalization on children's social, emotional, cognitive and physical well-being – both in the short and long term. This is important if community members are to take a more active role in finding community and family-based solutions.

Sixth, demonizing institutional care and romanticizing family care does not resolve anything. Best interest assessments by professional social workers need to be used in order to determine the best option of care. However, this cannot be achieved without a social work workforce that is qualified and determined. Workforce development has to become a priority.

Finally, care leavers need to be supported as they prepare for and after they exit the residential institution in which they have been living. A young person's social, emotional and economic competencies need to be the indicators of exit and not chronological age. Support for care leavers is critically important to support the personal well-being of each youth during this critically important transition time in their life. It is also an investment in what potential contributions that young person can make both socially and economically to his or her community in Kenyan society.

Questions for Small Group Discussion or Guided Reflection

1. In what ways might it be argued that the *institutional care of children in Kenya began with the missionaries*?
2. What is *Voluntourism* and how might it impact on daily life practices with children in long-term residential care?
3. How do the organisers of Voluntourism – colleges, universities, churches and service clubs – screen for paedophiles?
4. Explain how the number of places in residential institutions for children in Kenya increased after the World Bank and the International Monetary Fund imposed Structural Adjustment Programs on the country after it could not repay foreign loans?
5. What voice do you think care leavers should have in continuing policy and practice reforms and about the re-structuring of residential care institutions for children and young people?

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