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Institutional Care Policy and Operation in Nigeria

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Abstract

The purpose of the study was to examine Institutional care policy and operation in Nigeria. Qualitative research method was employed in the study. Information was obtained using textbooks, published and non-published Journals, libraries etc. Based on the literature review, the findings revealed that the development, appreciation and application of children's rights have become an integral part of child protection philosophy and practice in many countries around the world. The United Nations Convention of the Rights of the Child (UNCRC) has significant impact on child welfare policy development, standards of care, and programming related to institutional care. This framework has had and will continue to have a significant impact on the way that child protection and child welfare is practiced around the world. It has especially influenced how institutional care is implemented and the role it serves within the child welfare continuum. The study concluded that Institutions can be improved to be comparable to family living. The study recommended that Institutional care should not be the preferred option but rather the last resort. However, when it is provided as an option, there are components to that care, which should be included within the organizational and programmatic structure.

Keywords: institutional care policy, operations, application of children's rights, child protection philosophy, child welfare policy development

1. Introduction

Institutions have been one of the main placement options for orphaned, abandoned or vulnerable children (OAVC) for centuries; today, most institutionalized children live in low resource countries (Rosas & McCall, 2019). In industrialized countries, alternative care options are usually family-based (children are in some type of alternative family) and not institutional-based (children are in some type of group care); foster care, subsidized or unsubsidized kinship care, and adoption are more readily utilized. In many low resource countries in Africa, Asia and several countries in the region of Central and Eastern Europe and the Commonwealth of Independent States, foster care and adoption are not the main alternatives due to cultural beliefs, lack of child welfare systems, limited resources for child welfare funding, or lack of political will (Rosas & McCall, 2019; Dickens & Groza, 2014).

The term institutionalization used in this paper refers to short-term or long-term placement of a child into any non family-based care situation. Similar terms referring to institutionalization are residential care, group care, congregate care, or orphanage care. Common elements of institutionalization include care by paid, unrelated personnel living with other non-related children, children clustered by age group (i.e., homogenously), periodic transitions to new caregivers and age mates, a high child-to-caregiver ratio and lack of or limited stimulating and responsive interactions between child and caregiver (Rosas & McCall, 2019). One of the most common characteristics of institutional life is the lack of stable, long-term relationships between a child and a caregiver (Rosas & McCall, 2019).

Yet the reality is that institutional care is and for the foreseeable future will be the one of the main alternative

care options for many children, particularly in low resource countries. A 2003 UNICEF report found that 143 million single orphans (only one parent died) and double orphans (both parents died) were living in 93 countries in the world (Rosas, & McCall, 2019), and eight million children are in residential care (United Nations, 2016). Many children in low resource countries with little or no child protection system are living in institutions and there is ample evidence on the proliferation of group care facilities throughout Africa (Howard, 2018). This increase in institutional care could be the result of various issues including cultural and economic barriers (Rosas & McCall, 2019), as well as the devastation caused by HIV and AIDS, chronic poverty, conflict and a myriad of other political, cultural and economic factors (Tolfree, 2015).

Based on the considerable research documenting the numerous negative effects of institutionalization, one is led to believe that components of "good institutions" must be an oxymoron. Rosenthal, Bauer, Hyden and Holley (2019) caution that the danger of improving institutional care may inadvertently strengthen an outdated and less than ideal system. Critics of institutionalization assert that children "thrive better in bad homes than in good institutions". The other side of the spectrum includes those who argue that in certain countries institutions can be a better physical environment than those provided by families. Yet it is imperative to have a pragmatist view that recognizes that institutional care, although not the ideal option for children without parental care, must be acknowledged as a reality and therefore be improved upon in the short-term. The long-term goal should absolutely be a system built on family- and community-based services where institutionalization does not have to exist but, until that occurs concurrent work to improve the conditions of institutional care using evidence-based guidance on the essential components of a "good institution," is a must, especially for children for whom it is the only option. Many high resource countries took several decades to develop functioning family-based care systems, and it will most likely take low-resource countries a significant amount of time as well. This study, while using a pragmatic framework to discuss improving institutional care, leads us down a precarious path. There is a real danger that attempts to modernize child welfare systems to be family-based will be ignored or cast aside as efforts and resources are allocated toward improving group care. From a systemic perspective, the longer an institution runs in a community, the less likely it is to close or change. It becomes a major employer; it removes from the public eye the plight of OAVC, and takes on a culture and life of its own. It is perpetuated by foreigners who are willing to donate for bricks and mortar but not sponsor a child or a family to live in the community.

2. Literature Review

The development, appreciation and application of children's rights have become an integral part of child protection philosophy and practice in many countries around the world. The United Nations Convention of the Rights of the Child (UNCRC) has had significant impact on child welfare policy development, standards of care, and programming related to institutional care. Many of the standards related to institutional care that have been developed in the past two decades have been based on the UNCRC and the articles therein (Browne & Mulheir, 2017). The Convention was designed to protect children's rights by setting standards in the areas of health, education, protection, and legal services. This framework has had and will continue to have a significant impact on the way that child protection and child welfare is practiced around the world. It has especially influenced how institutional care is implemented and the role it serves within the child welfare continuum.

An essential component of quality institutional care is public policy that establishes professional standards for both services and personnel. Professional standards or guidelines set the type and quality of services to be delivered to the child by the social service agency, in a child-centered/child rights framework. Standards should exist for all alternative care placements within a continuum of care; including family preservation and support, kinship care, temporary foster care, domestic adoption, intercountry adoption and institutionalization. Personnel standards establish professional employment requirements (knowledge, values and skills) necessary to perform the duties with the highest level of expertise. Standards reflect and promote evidence-based child development strategies and child care practices. Standards provide goals for the continuing improvement of services to children and their families. Standards promote nationwide consistency. They serve as a resource for people in other fields who are concerned with the care and protection of children — legislators, judges, attorneys, educators, health and mental health professionals, law enforcement personnel, opinion shapers in the media, child advocates, faith leaders, and the general public. Standards provide the basis for licensing and accreditation nationwide. From a rights-based perspective, children living outside of parental care have the right to be cared for by qualified personnel who adhere to standards that are based on ensuring quality and conditions of care are conducive to maximize a child's development (United Nations, 2016).

A best practice model for developing standards is to work at the Ministry or central authority level that is responsibility for the group care of children. This is not as simple as it appears. Typically, children of certain ages or children with different disabilities are under the care and management of different authorities, as was the case in Romania in the early 1990s and in the Ukraine. In order to develop standards, it is better for all the

children in institutions to be under one government authority. When this is not possible, and standards are developed for children only under one authority, it creates strife and competition between authorities. This derail attempts to improve quality care. Such a situation currently exists in Ethiopia where accreditation of institutions, supervision and oversight of those institutions are divided among three different government bodies (Ministry of Justice, Bureau of Labor and Social Affairs, and the Ministry of Women's Affairs), making it difficult for effective monitoring and evaluation of institutional care and challenging the development of comprehensive standards (Family Health International, et al, 2019).

3. Accreditation and Licensing

Developing standards is only the first step. Concurrent with developing standards must be a national study of institutions. The country must know how many institutions they have, where they are located, and how many children are in each institution. A recent example of this type of study is the work of Perez (2018) in Guatemala. Up until this study, there were estimations but no specifics. Even in the former communist countries of Romania and Ukraine, getting the specifics about children in institutional care was a moving target because not all locations were known and numbers were manipulated based on who was asking and how the information was to be used. If it was the government in order to allocate funding, numbers were higher. If it was an investigation, the numbers were lower. In Romania when the country moved to foster care, court orders were required in some locations to remove children from institutions and only with the authority of the police were the exact number of children discovered.

Once a country has standards, they must move toward accrediting and licensing institutions to care for children. Accreditation requires that the institution document, in writing, how they meet or exceed the standard with the evidence to support their claim. Once a written report is received, a review panel of professionals with no ties to institutional staff or political decision-makers should review the report and schedule a visit. The visit is designed to provide further evidence of compliance with stated standards, highlighting strengths and areas for improvement. For example, if the audit of compliance asserts that staff is trained every month, records of the topic of training, who was trained, who attended the training, and evaluations of the training must be on file. Cases should be randomly pulled to ascertain that all the assessment and planning documents are in place, signed and dated. A predetermined threshold or minimum set of requirements must be met in order to accredit and license an institution. If they don't meet the threshold, they are not accredited. A second review can be scheduled in 30 or 60 days to see if the institution can meet standards; if it cannot, it should be closed. If it can meet standards, then routine re-accreditation and licensing should be established on a yearly or bi-annual basis, utilizing established standards and both unannounced and announced inspections and monitoring of the quality of care.

4. Inspections and Monitoring Quality of Care

Setting up a system which is able to monitor implementation and adherence to national standards is just as important as developing standards. Ethiopia is a good case in point. The National Guidelines for Alternative Childcare were developed in 2002. The standards were based on the UNCRC and the development of those standards was viewed as a positive step towards unifying good practice, especially within child residential institutions. Unfortunately, the standards have not been formally approved by the Government, and an accompanying monitoring system is not in based to ensure that standards are adhered to. A recent study conducted by Family Health International and UNICEF found that the majority of child care institutions were not even aware of the existence of the standards. What may be perceived as a positive step forward in developing standards was severely limited by lack of approval, dissemination and inexistence of necessary monitoring and evaluation systems (Family Health International et al, 2019).

One of the major concerns that should be dealt with in the creation of standards and monitoring processes is child abuse within institutional care. Children in care are already in a vulnerable state when they enter the institution. Children have been abandoned, neglected, spent years in institutional care, or in some cases have been living on the streets or in child-headed households. Children in institutional care are especially vulnerable to physical punishment from staff, bullying from other residents, and sexual exploitation (Gavrilovici & Groza, 2017). Any mistreatment negatively shapes the environment for all residents whether or not they are a victim of abuse or neglect (Groze, 2020). If the mistreatment is a pattern, it undermines the ability of institution to carry out its mission and goals (Sundrum, 2016). One problem in determining the incidence and prevalence of mistreatment in institutional settings is the lack of uniform definitions of what constitutes abuse or neglect. A second problem is even if maltreatment occurs there is no reporting or investigation system in most countries. Fear of reprisal is a major deterrent for staff to report problems, and most governments lack an adequate system for child maltreatment within the family, so a system for documenting, investigating and remedying maltreatment within institutions is even less likely to exist. If there is no adequate system to respond to the problem, there can never be an accurate assessment of scope and depth of the problem. There can also never be a

solution to the problem. So, the most vulnerable OAVC are made even more vulnerable.

It is for this reason that any country using group care as a major child welfare intervention needs to develop definitions of mistreatment. Sexual abuse means any sexual activity prohibited by law, including sexual exploitation—the use of a child by a person responsible for her or his health or welfare for personal gratification—or procuring or knowingly causing or permitting any person to sexually abuse or exploit the child, including other children. Neglect means the willful act of omission which directly results in the child suffering or being exposed to risk of suffering physical or emotional injury. This includes but is not limited to the failure to provide food, clothing, appropriate shelter, bedding, or medical care to the child. Inappropriate treatment means harm or threatened harm to a child's safety, health or welfare which is caused by violating state, local or program rules, laws, policies, procedures or statues. It includes the failure to provide care for the child in manner consistent with universal professional standards and practices, including anything that violates the right of a child that is not classified as abuse or neglect, that injures a child or puts a child at-risk for harm (Groze, 2020). Inappropriate treatment is unique to the institutional setting, adding the additional level of expectation for those working in these settings.

5. Structural Characteristics

A common trait of institutions is homogenous groups, specifically children clustered together based on age (Rosas & McCall, 2019). In Russia and Romania, institutions were divided into age groups. Children aged 0-3 were in one orphanage; ages 4-7 were in another orphanage; and finally from age 7-18 were in another institution (Groza, 2020). This homogeneity is detrimental to children and their development for several reasons. The first is that the grouping together of children by age groups and then transferring them to another institution creates a scenario whereby children have to leave familiar caregivers and surroundings. Secondly, grouping homogenously frequently results in little to no individualized attention from caregivers (Rosas & McCall, 2019). As indicated above, institutions across the globe have common characteristics (Rosas & McCall, 2019) including large group sizes, high child: caregiver ratios, homogeneous age and disability groupings, many and frequently changing caregivers, caregiver work schedules in which individuals work long hours and then are off for 2-3 days, and transitioning children from one ward or institution to another when they reach certain milestones of development (e.g., crawling, walking, social play). The research literature on non-residential early care and education suggests that each of these characteristics is associated with poorer development in young children. In addition, there is often an "institutional mentality" in which caregivers do not get close to children and carry out their caregiving duties in a rather perfunctory, businesslike manner with little in the way of warm, caring, sensitive, and contingently responsive interaction with children. This set of characteristics means that children have little consistency in their caregivers or in the way adults respond to them and have little opportunity to experience typical adult-child interactions and certainly not relationships with caregivers. Some have speculated that these characteristics may be among the most corrosive aspects of institutional care for children's development.

There is some evidence that these characteristics can be changed to provide more consistent care and better social-emotional caregiver-child interactions, and such changes can be maintained on the institution's original budget in some cases. For example, the St. Petersburg-USA Orphanage Research Team (2018) changed essentially all of these characteristics in an institution for children birth to four years and produced very substantial improvements in children's physical and behavioral development. Specifically, group sizes were reduced from 10-14 to 5-7 by physically dividing each living room in half (the 10-14 children still all slept in one room). Two primary caregivers and a substitute were assigned to a subgroup who worked five days a week in staggered shifts so that one was present during nearly all of the children's waking hours. Groups were made heterogeneous by age, and transitions to new wards were stopped. Groups were also integrated with respect to the disability status of children. A family hour in the morning and in the afternoon was established in which no visitors (including specialists) were allowed, and children and caregivers were to be together. In addition, caregivers were trained to provide sensitive, responsive care, especially during routine caregiving duties. The results showed that typically developing children increased in Battelle total DQs from an average of 57 to 92 = 45 DQ points, perhaps the largest increase reported for any intervention in the literature. Children also increased in height, weight, and chest circumference, more children showed organized attachments to their caregiver, and children displayed more mature social and emotional behaviors with caregivers. In Eritrea, Wolff & Fesseha (2019) designed an intervention to restructure an institution so that children were mixed by age and group size was reduced. A consistent primary caregiver was assigned to live in each room, and two assistants were permanently assigned to each group: similar to the model utilized by SOS Kinderdorf. Results were mixed. On the one hand, the number of behavioral symptoms decreased. On the other hand, mood disturbances such as depression and anxiety were more prevalent. The problem in interpreting this study is to know whether the effect was due to changing the mix of ages or changing a caregiver. Still, the combination of age differences and a consistent caregiver did have some positive effects.

6. Personnel Standards

Consistent caregivers should be evaluated, trained and monitored by appropriate regulating authorities with a special focus on positive care-giving, provision of individualized attention, and early cognitive stimulation of children. Article 73 of the UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children states that special attention should be paid to the quality of alternative care provision; both in residential and family-based care, particularly in regard to the professional skills, selection, training and supervision of carers. Their role and functions should be clearly defined and clarified with respect to those of the child's parents or legal guardians.

For optimal developmental outcomes, children need consistent caregivers that are trained and monitored by appropriate regulating authorities. There are challenges to ensuring professional, well-trained staff in low-resource countries. This was the case in Guatemala where Perez (2018) found that 80% of children's shelters operate in accordance with available resources and do not guarantee that ideal, qualified personnel will be present to provide services to institutionalized children. For infants and toddlers, staff training resulting in changed behavior for as little as 5 minutes a day for 5 days a week from 1 to 6 weeks has a significant positive impact immediately on children's development, cognition or health, staff training and changes in behavior may also have advantages at least up to 6 months after the intervention. The aforementioned Rosas & McCall study showed that if these minimal improvements in staff interaction are stopped, the positive effects displayed by children will not continue, emphasizing the need for consistency and continuity of positive caregiver interactions (Rosas & McCall, 2019). Even if staff training does not improve child health and developmental outcomes, it might prevent children from getting worse.

7. Programming Standards

Any child welfare service must begin with a good child assessment; any ongoing service must have continuous, regular child assessment in multiple domains of functioning. Regardless of the reason for a child to enter the child protection system, before any long-term decisions can be made, assessments must be completed and recorded in the case file. Of course, this assumes that every child has a file. At a minimum, there should be a medical evaluation (physical exam) by licensed medical staff, developmental assessment by child development specialists, social history by trained and accredited social workers, and if the child is school-age, an educational evaluation by a professionally credentialed educator. Photos should be taken of the child and if any relative is available, a comprehensive family history should be obtained with the names, addresses, and phone of all relatives recorded. Assessments should be updated monthly for infants, quarterly for toddlers, and every six months to a year for older children. The reassessment should include the child's health, development, behavior patterns, social functioning, psychological/psychiatric screening and educational performance (if appropriate). These assessments and re-assessments allow for more appropriate placement, better monitoring of children and for the early identification of problems. A report from each assessment, summarizing strengths as well as child's needs, must be written.

Due to the high risk for attachment disorders and disturbances in children from institutions, attachment assessments and early care and intervention to promote attachment are critical. Attachment may be a pivotal developmental foundation on which many aspects of emotional and behavioral functioning are based. Children raised in institutions have fewer opportunities to develop selective attachments. Of most concern are indications that children in institutions are at greater risk for disorganized attachment, and disorganized attachment is a serious risk factor for later problems. Programming must be altered to allow children to develop and maintain a selective attachment with at least one primary caregiver.

8. Case Management

Case management or case planning should begin at the earliest possible time and be comprised of meeting both long-term and short-term needs based on the child assessment and congruent with the best interest of the individual child. Case management has the main objective of getting a child into family-like, safe and permanent care in the least amount of time. Article 25 of the UNCRC states that children placed outside their own family are entitled to periodic review of all aspects of their placement. This is vital to ensure that the child's best interest is being pursued. Good case planning is a critical component of keeping institutionalization temporary; without it, children are much more likely to remain institutionalized long-term (Perez, 2018). Determining the eligibility and appropriateness of alternative care options for an individual child should be addressed within the case plan which is updated a minimum of every six months. Including alternative care options within an institution either as part of the institution's own programming or in collaboration with other government and nongovernmental organizations is essential.

9. Cost of Institutionalization

Community-based orphan support programs are cost-effective as they enable large numbers of orphans to be

supported within their own communities. In the CEE/CIS region, institutional care is twice as expensive as the most costlier community residential/small group homes; three to five times as expensive as foster care (depending on whether it is provided professionally or voluntarily), and around eight times more expensive than providing social services-type support to vulnerable families. In Africa, Perez (2018) found that institutional care is nearly nine times more expensive than community-based care (Desmond & Gow, 2021). The cost per visit of a child is US$1.55, much lower than the US$14 to $38 per visit reported in some Zambian home care programs (Chela *et al*., 1994). This is largely because visits are carried out by volunteers who live in the same communities as the beneficiaries. Skeels (2016) compared 13 children removed from group care (age 7-30 month; IQ ranged from 35 to 89) into foster care to a matched group of 12 children (age 12 to 22 months; IQ ranged from 50 to 103) who remained in an orphanage for the mentally handicapped. Two year later, those in foster care gained 28.5 IQ points while those who remained in orphanage care lost 26.2 IQ points. After 21 years, all cases were located. Those raised in family care completed a median grade of 12 while those in group care had a median grade of three. The cost of care for children in group care was five times the cost for children in family care.

10. Research Methodology

Qualitative research method was employed in the study. Information was obtained using textbooks, published and non-published Journals, libraries etc.

11. Findings

The development, appreciation and application of children's rights have become an integral part of child protection philosophy and practice in many countries around the world. The United Nations Convention of the Rights of the Child (UNCRC) has had significant impact on child welfare policy development, standards of care, and programming related to institutional care. The Convention was designed to protect children's rights by setting standards in the areas of health, education, protection, and legal services. This framework has had and will continue to have a significant impact on the way that child protection and child welfare is practiced around the world. It has especially influenced how institutional care is implemented and the role it serves within the child welfare continuum. From a rights-based perspective, children living outside of parental care have the right to be cared for by qualified personnel who adhere to standards that are based on ensuring quality and conditions of care are conducive to maximize a child's development.

12. Conclusion

Institutions can be improved to be comparable to family living. There is growing global consensus on the need to promote family-based alternatives to institutional care for children and adolescents. Yet, in the interim, institutional care will be a reality for many low resource countries still working within inadequate or antiquated legal frameworks related to alternative care, cultural attitudes which at times promulgate only the benefits of institutional care and not the negative effects, and a donor community which has been slow to recognize that providing funds for family and community-based care is more cost effective and beneficial to the majority of OVAC than institutional care. Recognizing these factors does not justify institutionalization; rather, it is acknowledgement of a current dynamic which must be dealt with in the longer-term goal of promoting family-based care as priority within the continuum of care. Therefore, a pragmatist approach includes the development of a child welfare strategy with both short-term and long-term plans that include a continuum of care approach with the bulk of care options being family-based. Institutional care should be considered only in exceptional and emergency circumstances and until a system of family-based alternative care can be established.

13. Recommendations

Institutional care should not be the preferred option but rather the last resort. However, when it is provided as an option, there are components to that care, which should be included within the organizational and programmatic structure. The components are vital to children's physical, psychosocial and intellectual development and wellbeing. Institutional care without them is irreparably harmful.

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