

Residential childcare in Ghana: Analysing current trends and drivers

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Abstract

The paper describes the findings of a geographical mapping and analysis of residential care facilities in four regions of Ghana. The mapping exercise study identified 24 residential facilities with 944 children, amounting to 22% of residential facilities and 27% of children in residential facilities in Ghana. Most of the residential facilities were privately run with their budgets funded by international donors. Seventy-five percent of the residential facilities were unlicensed because they did not meet the national standards for residential care facilities. Most of the children in the 24 residential facilities were male and aged 11 to 17 years. Nine percent of the children in the residential facilities were 0-3 years, but 28% had been admitted aged 0 to three years. The average length of time the children spent in the residential facilities ranged between three and five years. In many of the residential facilities, the main reason for children's admission was poverty-related without involvement of social welfare officers. The implications for future service development emerging out of the study include ensuring that the residential facilities are licensed and have functional administrative systems to enumerate the children in their care, screen volunteers before they work in the facilities and reunify children in care because of poverty.

Keywords

Residential care, deinstitutionalisation, alternative care, Ghana;Article

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Introduction

In Ghana, residential care is the main alternative for children without adequate parental care. A national survey conducted in 2006 revealed that between 1996 and 2006, residential care facilities for children (residential facilities) increased by 91%. There were about 4,500 children in care, 80% of them because of poverty (Csaky, 2009). Most residential facilities were not operating in line with the requirements set out by the Children's Act, 1998 (Act 560) because they did not have a licence from the Department of Social Welfare. In response to the situation, childcare reforms began under the Department of Social Welfare in 2007 to de-institutionalise the care of orphans and vulnerable children and shift towards family-based options such as kinship or foster care.

Since the reform started, however, there has been little information on its progress, including information on residential care and the characteristics of children living in the care option. The study describes a geographical mapping and analysis of residential facilities in Ghana to identify the 'hot spots' - high concentration of residential facilities - to develop an understanding of current trends, flows, and drivers of children in residential facilities in these areas. The study is relevant because it adds to the scant knowledge on the characteristics of children living in residential facilities especially in developing countries (Petrowski, Cappa, and Gross, 2017; Stark, Rubenstein, Pak and Kosal, 2017).

Method

Identification of residential facilities began in November 2016 through analysis of a national list of 98 residential facilities maintained by the Department of Social Welfare. Four 'hotspot' regions (Ashanti, Central, Greater Accra, and Volta), were identified, and 24 residential facilities in 10 Districts in these Regions, representing 22% of all residential facilities in Ghana, were selected for in-depth data collection. Development of regional level data collection tools for gathering information on mapping related to questions (e.g., trends and drivers; monitoring systems and tools) was done with the Department of Social Welfare and refined following pilot interviews in Greater Accra and site visits to residential facilities in one region. At the residential facilities level, we asked

specific mapping related questions, followed by an in-depth assessment of implementation of the Standards for Operation of Residential Care Settings in Ghana (GoG, MMYE and DSW, 2010). We developed four checklists for this assessment: manager, caregivers, premises and children. The mapping team included the staff of the Department of Social Welfare, a non-governmental organization, and two of the authors. Regional and district social welfare officers took part in site visits in the residential facilities and received a hands-on orientation to the assessment tools.

Data collection activities for the mapping exercise took place in the first quarter of 2017. Data collection involved multiple sources including interviews with social welfare officers, district assembly representatives and staff (social workers, managers, and caregivers) and children in the residential facilities. The authors also examined the facility records and conducted observations of the premises.

Drawing on information from registers and records of children, the authors captured data on children in the residential facilities in a standardised MS Excel format, which allowed for quantitative analysis. Individual data reports for each residential facility were prepared using a standardised template after which the data from the interviews were thematically collated. Findings from the interviews and individual data reports were triangulated and regional data reports were prepared. Key findings from these Regional data reports were synthesised and are presented in this report.

Findings

Status of residential facilities

Over half (58%) of the residential facilities were established before the care reform initiative, and 33% between 2008 and 2012, with no new home established since 2016. Apart from one facility run by the state, the rest were established by international and local nongovernmental or faith-based organizations (12); and Ghanaian individuals, either on their own or in partnership with foreigners (11). In terms of size, eight accommodated fewer

than 30 children, 17 residential facilities had over 30 children (Figure 1) and five of them accommodated between 100-120 children. Thirty-eight percent of the residential facilities provided dormitory-style accommodation. The 24 residential facilities had 1371 beds, but they were operating at 66% of their total capacity.

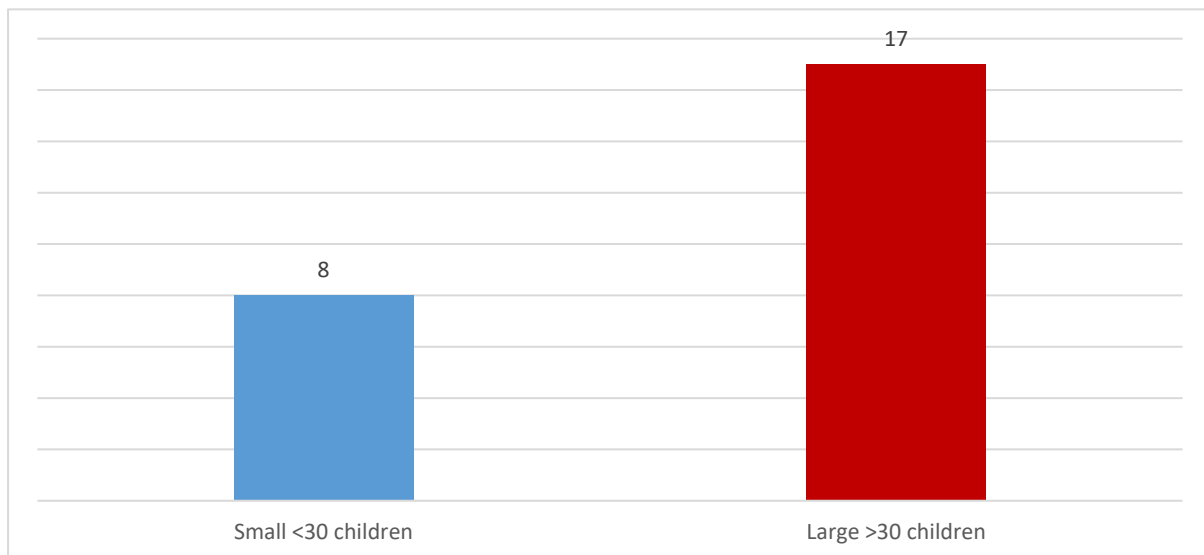


Figure 1: Size of residential facilities

Just under a quarter (seven) of the residential facilities had a licence to run at the time of the mapping. According to the regional social welfare officers, the residential facilities were unlicensed because they did not meet the 2010 Standards for Residential Homes for Children. The residential facilities reported that their funding came from a range of sources (e.g., volunteers, international donors) as displayed in Figure 2. However, the sources of funding varied in the size of their contributions in relation to the residential facility’s budget. For instance, for 62% of residential facilities that accessed international donor funds, this was their primary source of income.

Local donors tended to provide more in-kind support (clothes, food) and were not a reliable source for meeting the costs of the facilities. Figure 2 does not include government funding because it is not government policy to fund private residential facilities. The one state-run residential facility in the Ashanti Region received government funding, although it was not regular and covered only about 30 percent of their funding needs with the remaining 70% of funds coming from local donors and income-generating activities.

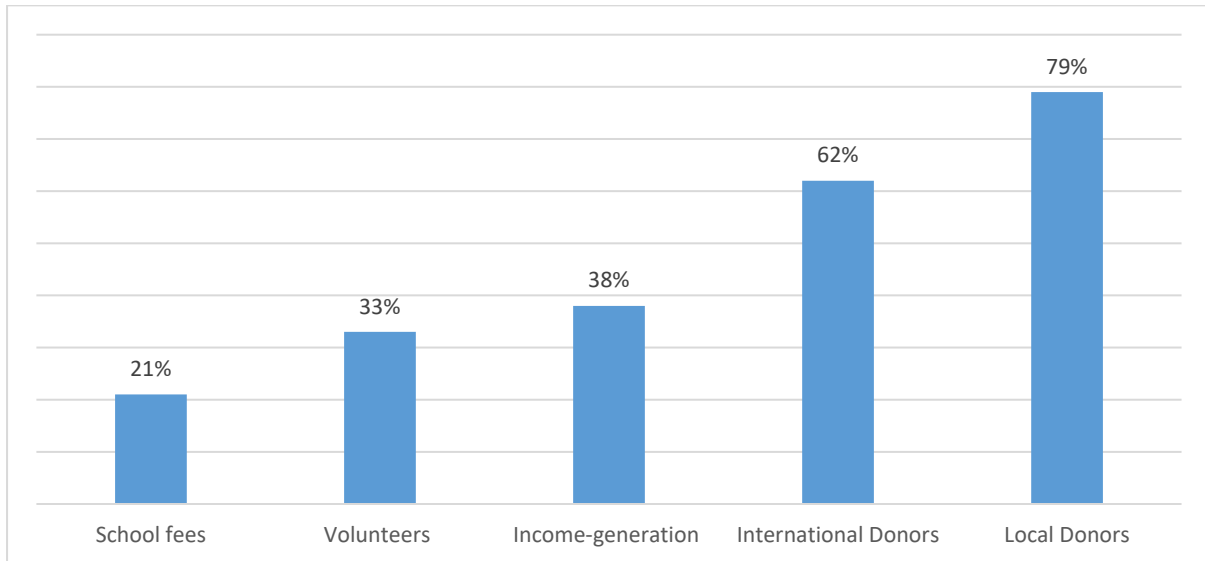


Figure 2: Range of funding sources accessed by the residential facilities

The residential facilities had an average caregiver to child ratio of 1:12, with the highest being 1:15, which is not aligned with the standards for operating residential care settings. Few residential facilities had any structured training programmes for their caregivers; many of whom were uneducated and employed because of their 'love of children'. Most of the caregivers were paid just above the minimum wage, did not have prescribed annual leave, and on duty 24 hours a day, seven days a week, for weeks on end. Children interviewed in many of the residential facilities reported the use of corporal punishment and, in one case, withholding of food as punishment.

Twelve residential facilities (50%) reported using international volunteers in their operations. Of these, five residential facilities used volunteers 25 years or older and had a professional qualification (e.g., teachers, doctors). Seven residential facilities used younger volunteers (18-20 years) who stayed for short periods (Figure 3). The residential facilities reported using volunteers sourced from volunteer placement organizations (e.g. Solution for Life Project Abroad) or the institution's international headquarters. Volunteers were not screened by social welfare officers and were used by residential facilities to supplement the low numbers of salaried caregivers.

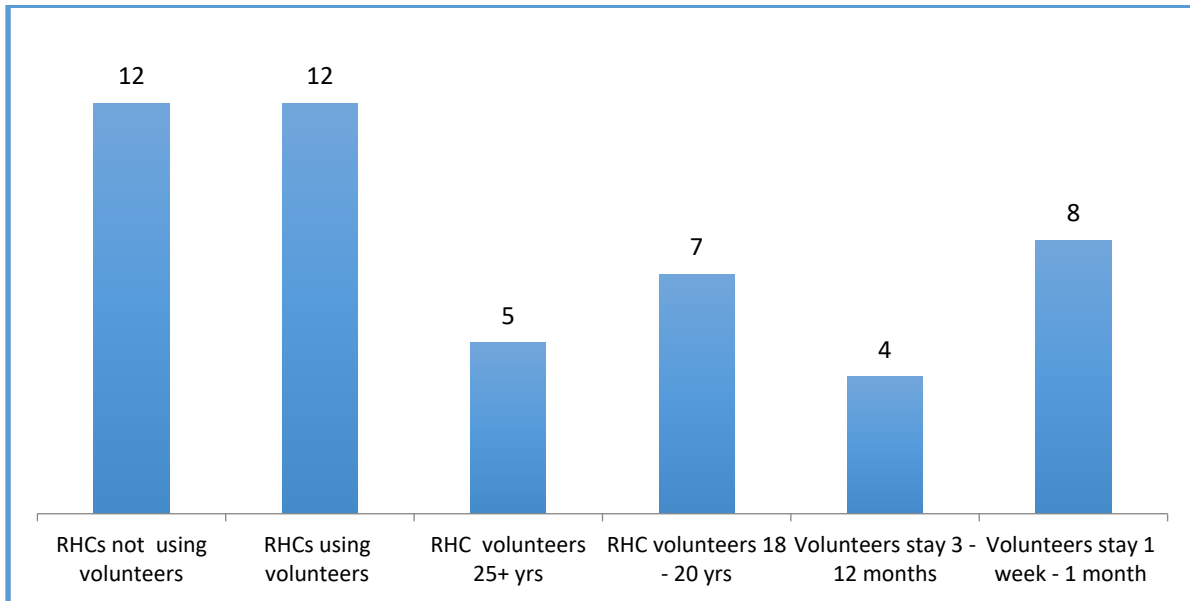


Figure 3: Trends in use of volunteers in residential facilities

Children in residential facilities: Trends, flows and drivers

At the time of the mapping exercise, there were 944 children in the 24 residential facilities. The majority of the children were male (57%), aged 11 to 17 years (66%), with an average age ranging between 10 and 14 years. Twenty-four percent of children were admitted when aged 0 to three years, but only nine percent of all children in the residential facilities at the time of the mapping exercise were aged 0 to three years (Table 1).

With the average length of stay ranging from 3.5 to five years, it is likely that many of the children admitted aged 0 to three years have spent at least one or more of their early years in residential care. While the average length of stay provides an overall picture of trends, it does not reflect the nuances of individual residential facilities. For instance, children in the government residential facility stayed for an average of three months, with the exception of children with special needs, while several private residential facilities had a policy of keeping children until they completed their education and children stayed on average for seven years in these facilities.

Region	Age Admitted to Residential Facility			
	0-3 years	4-10 years	11-17 years	Total (n=795) ¹
ASHANTI	37%	50%	13%	336
CENTRAL	12%	63%	25%	211
GREATER ACCRA	32%	43%	25%	223
VOLTA	8%	38%	54%	26

Table 1: Age of children when admitted into the residential facilities

Inconsistencies in record keeping by the residential facilities made it difficult to single out one main reason children were admitted to the facilities. There were often multiple factors at play that were exacerbated by poverty. Apart from the Greater Accra Region, the available information suggested that most children were not admitted to the residential facilities because of issues related to child protection. The category 'other' in Figure 4 below includes vulnerabilities related to financial constraints and parental ill-health.

Children were mainly referred and/or admitted to residential facilities by social welfare officers, the police or family members, with different Regional trends. For example, in Volta region social welfare officers referred most children while in Greater Accra region children were often referred by family or other people.

¹ Information/records were only available on 795 children and not on the 944 children residing in the 24 residential facilities.

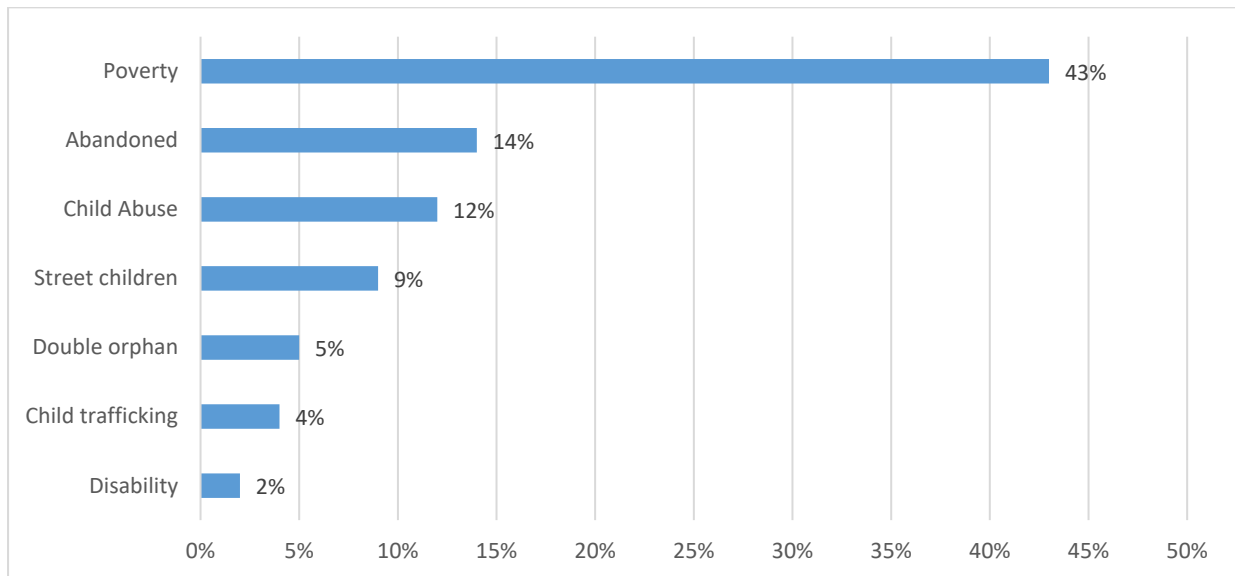


Figure 4: Reasons for admission to residential facilities

Even though the placement of children needs to be authorised by a judicial care order obtained by a social welfare officer, only 10 of the 24 residential facilities had some children with care orders. Reasons given for the lack of care orders included financial and capacity constraints. Information on districts and towns/villages where children were referred from was patchy and inconsistent. Available data shows that in many cases children are moved across Regions to be placed in a particular residential facility.

At the end of 2016, 925 children were in 23 of the 24 residential facilities². During 2016, 200 children were admitted and 226 children were discharged (Figure 5). However, the discharge numbers are not reflective of the situation in most residential facilities as children were only discharged from nine residential facilities.

²Complete information on admissions and discharge was only available for 2016 and only for 23 facilities

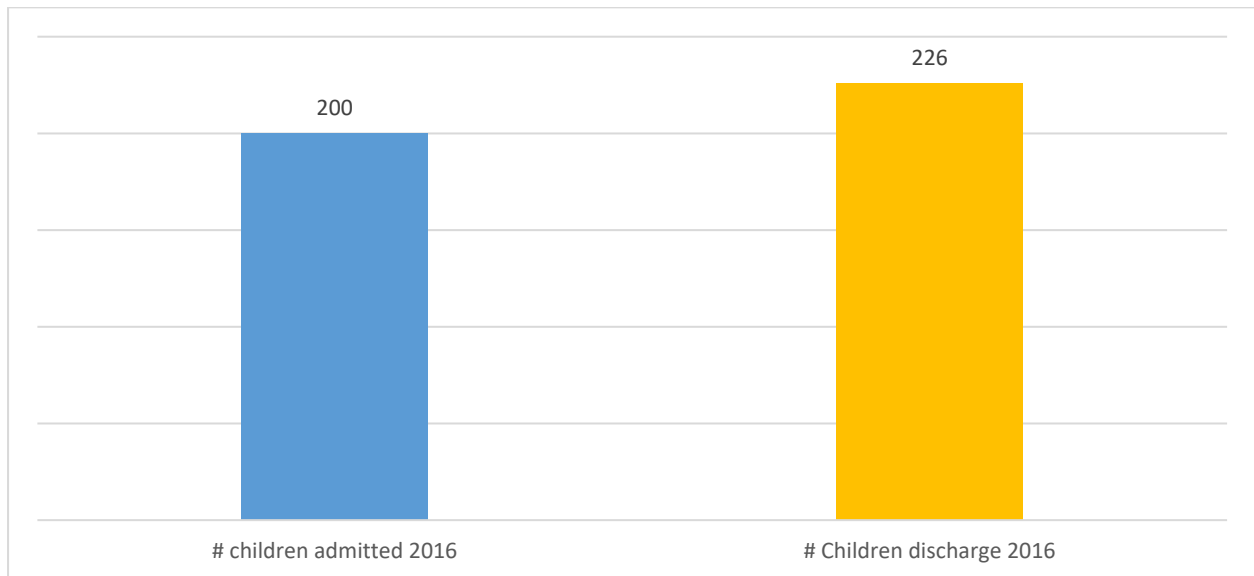


Figure 5: Flows of children into and out of 23 residential facilities

Discussion

While it was possible to collect some primary data from residential facilities, accurate numbers of children in the 24 residential facilities and the situation of these children were not always available indicating the lack of functional administrative systems for enumerating children. Allocation of adequate resources and investment in establishing and maintaining a standardized monitoring system is required. In spite of these limitations, the mapping study provides valuable insight into children in residential facilities in the country. The baseline data on the trends in the four regions can inform policy and practice and be a starting point for further mapping exercises in the remaining regions.

Private residential facilities continue to operate without the required government approval, licence or inspection despite this being a major requirement for the operation as stipulated by the Children’s Act, 1998 (Act 560) and 2010 Standards for Residential Homes for Children in Ghana (UNICEF, DSW and MoGCSP, 2010). The Department of Social Welfare is currently not able to prevent these unlicensed residential facilities due to limited financial and human resources, leaving the children in these residential facilities at risk of abuse, neglect, and trafficking.

The mapping study found that most residential facilities in Ghana are established and funded by donors from the developed world, confirming findings from other studies (Ainsworth, 2014; Davidson, Milligan, Quinn, Cantwell, and Elsley, 2016). As in other developing countries in Africa, Asia and Latin America (Cantwell and Gillioz, 2017), residential facilities persist despite efforts to de-institutionalise because the state has outsourced alternative care provision to non-state actors, placing them in a powerful position to resist change and oversight. If the state can regulate and check residential care, it has to take more responsibility in its provision.

The mapping exercise confirmed the findings of other studies that volunteering in residential facilities is popular among tourists and travellers who come to Ghana (Voelkl, 2012). However, in recent years, volunteering in residential facilities (orphanage volunteering) has been recognised as a serious international child protection issue (van Doore, 2015). Using volunteers affects children's psychological wellbeing and places them at risk of sexual abuse, especially when there is no screening of volunteers, and their engagement is short term (Carpenter, 2015; Guiney, 2017; Richter and Norman, 2010).

It is positive that only nine percent of children in the residential facilities are aged 0 to three years. Of concern though, is that 24% of children in care were admitted when they were aged 0 to three years, and many of them stayed in care for long periods because with a few exceptions, the policy of many of the residential facilities is to keep children in care until they completed secondary school. Children should only stay in these facilities on a temporary basis before reintegrating them with their families or a long-term family-based alternative. Residential facilities which fail to reintegrate children in care because of poverty should not be allowed to operate.

Years of research has shown the detrimental effects of residential care on children's physical growth, cognitive functioning, and socio-emotional development, especially in residential facilities with high child to caregiver ratios (Berens and Nelson, 2015; Fluke et al., 2012; McCall, 2013). The caregiver stress resulting from the high child to caregiver ratio could also be the reason many children mentioned experiencing corporal punishment and maltreatment.

The findings show that many children are in residential care for poverty-related reasons similar to findings from earlier studies (Herczog, 2017; Ruiz-Casares and Phommavong, 2016; Stark et al., 2017). However, poverty should never be the justification for separating children from their parents or prevent their reintegration with them, but a signal to support at-risk families. Since most family separations are poverty related, the State needs to ensure that at-risk families are prioritised and provided with cash transfers through the Livelihood Empowerment Against Poverty (LEAP) social protection programme.

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