CHILDREN LIVING IN RESIDENTIAL CARE IN GHANA:

Findings from a survey of well-being

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The survey described in this report was implemented by the Ghana Statistical Service, under the guidance of a national Technical Working Group composed of representatives from the Department of Social Welfare (acting as chair), the Department of Children, the Ghana Statistical Service, the Office of the Head of Local Government Service, and UNICEF Ghana.

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PREFACE

Accurate and reliable data on children living in residential care institutions are essential. However, these children are not identified through household surveys and, as a result, are not typically included in official national statistics on key indicators of child well-being. This includes indicators that comprise global monitoring frameworks, such as the Sustainable Development Goals.

To begin to address this critical data gap, the Ghana Statistical Service implemented a national census and survey on children in residential care. The work was carried out under the guidance of a national Technical Working Group composed of representatives from the Department of Social Welfare, the Department of Children, Ghana Statistical Service, the Office of the Head of Local Government Service, and UNICEF Ghana. The exercise represents the first application and testing of a standard methodology and protocol developed by UNICEF. It is also the first time that Ghana has collected data on children in residential care settings by applying a number of pre-existing tools from international survey programmes, such as the Multiple Indicator Cluster Surveys and other validated instruments, to an institutional population.

Many contributed to the development and implementation of the survey in the spirit of partnership. In particular, the Ghana Statistical Service would like to express its deepest gratitude to the Department of Social Welfare of the Ministry of Gender, Children and Social Protection for its leadership and for the opportunity to closely collaborate on this important project. The Ghana Statistical Service is also indebted to UNICEF for its technical and financial assistance from the planning stage of the survey to the final report writing. Additionally, our sincere thanks go to USAID for providing financial support for the successful completion of this survey.

I also wish to extend my appreciation to all the field data collectors for their tireless dedication and to the proprietors, caregivers and children of the residential homes for their generous participation in the survey.

Prof. Samuel Kobina Annim

Government Statistician
Ghana Statistical Service

FOREWORD

The Ministry of Gender, Children and Social Protection is mandated to ensure that all children in Ghana live in supportive, protective and caring environments that enable them to develop to their full potential. Children should only be removed from their families and placed in alternative care in cases of immediate danger and when a child's parents are unable or unwilling, even with support, to provide adequate care. In Ghana, residential care has historically been the main formal alternative care option for children whose parents or extended families are unable or unwilling to provide for them.

Global agreement is now widespread that children should grow up safe and protected in families rather than in institutional care, which can be harmful in a variety of ways. In Ghana, the Government has developed an ambitious programme of care reform and family strengthening that has seen many children reunited with families and communities since 2007. This programme is rooted in Ghanaian cultural values, which place strong emphasis on family care. Interventions have included legislative reform, strengthening of the social welfare workforce, and development of alternative family-based care options, such as foster care, for children in need.

To track progress in implementing the reforms and to better plan for an acceleration of efforts, it is crucial that the Government and relevant stakeholders have high-quality and reliable data. The Ministry, with support from the Department of Social Welfare, is committed to ensuring that current data on children in alternative care are available for planning and decision-making as well as for monitoring and evaluation of programmes at all levels. To achieve this objective, the Ministry partnered with the Ghana Statistical Service and UNICEF to collect data on children in residential care facilities across the country. Beyond providing baseline data for planning, findings from the census and survey will enhance our understanding of the effectiveness of the various interventions initiated by the Government and its collaborators to improve the lives of children in Ghana.

The Ministry is concerned that more than 3,500 children live in 139 care institutions in Ghana, where they are deprived of parental care or separated from their families. In many cases, these children have been institutionalized as a result of poverty, violence, abuse, neglect, substance abuse, or the death or illness of a parent, and often lack access to education, health care and family support services. The Ministry further recognizes the harm caused to children by unnecessary separation from their families, and is troubled that some children in Ghana are placed in unregistered residential facilities in violation of national and international standards of care. This situation is being addressed by the Ministry through the Department of Social Welfare and other partners.

The Ministry is committed to the de-institutionalization of all children and the establishment of strong gatekeeping mechanisms to prevent unnecessary family separation in the first place and the use of family-based care when alternative care is necessary. It is prioritizing implementation of the five-year road map for the de-institutionalization of all children in Ghana and the closing of substandard residential care facilities. The Ministry, through the Department of Social Welfare, is also committed to seeing that children remain in or return to the care of their parents or, when appropriate, are placed with other family members or in foster care. That commitment extends to ensuring that children have access to various forms of support and that families are able to provide safe, stable and nurturing care for their children.

The Ministry of Gender, Children and Social Protection is deeply appreciative of all the individuals and organizations that supported the implementation of this survey, which would not have been possible without the technical support received from the Ghana Statistical Service and UNICEF and the financial support of USAID's Displaced Children and Orphans Fund. The Ministry is, as always, profoundly grateful for the support and cooperation of our development partners.

Hon. Cynthia Mamle Morrison

Minister for Gender, Children and Social Protection

KEY FACTS

Ghana has **139 RESIDENTIAL HOMES** for children, which are largely concentrated in the **GREATER ACCRA** region.

A total of **3,530 CHILDREN** were found to be living in these residential homes, a slight **MAJORITY OF WHOM ARE BOYS.**

THE MAJORITY of residential homes for children have been open between **11 AND 20 YEARS.**

ALMOST 1 IN 4 of these homes are either not registered with the Department of Social Welfare or do not comply with **REGISTRATION REQUIREMENTS.**

ONLY ABOUT ONE THIRD of residential homes were found to have a **VALID LICENCE.**

Around **2 IN 3 CHILDREN** living in residential care have at least one **LIVING BIOLOGICAL PARENT.**

THREE IN FOUR CHILDREN living in such homes have been there for more than one year, with an **AVERAGE STAY OF 10 YEARS.**

Close to **90 PER CENT OF CHILDREN** who exited residential homes were **REUNITED WITH FAMILY.**

SIXTY PER CENT
of children living in residential homes still have **CONTACT WITH RELATIVES.**

Just over **HALF** of children in residential care have an **ASSIGNED CASEWORKER,** while about **ONE THIRD** are without an individual **CARE PLAN.**

Around **1 IN 3 CHILDREN** are lacking a **COURT ORDER** for their placement in a residential home.

MORE THAN HALF
of children in residential homes are reportedly exposed to **VIOLENT FORMS OF DISCIPLINE.**

FORTY PER CENT OF CHILDREN under age 5 living in residential homes in Ghana are moderately or severely **STUNTED.**

ONLY ONE THIRD
of children in such homes have **FOUNDATIONAL READING SKILLS,** while a much lower proportion have foundational numeracy skills.

Close to **1 IN 4 CHILDREN** living in large residential homes do not receive any **STIMULATION OR RESPONSIVE CARE.**

ONE IN FIVE CHILDREN in residential homes have **DIFFICULTY FUNCTIONING** in at least one domain.

ONE IN FIVE ADOLESCENTS were involved in a **PHYSICAL FIGHT** inside the residential home within the past year.

CONTENTS

INTRODUCTION

A child's care status profoundly affects his or her health, developmental outcomes and general well-being, both during childhood and later in life. A growing body of evidence shows that institutional care contributes to poor physical and cognitive development of children.[1] Children outside of a family setting are also more likely than their family-based peers to experience abuse, neglect, exploitation, lack of stimulation, poor nutrition and toxic stress.[2] The lifelong physical and psychological harm that institutionalization or lack of quality family-based care can cause is well documented, with numerous studies revealing that children who remain in institutions after the age of 6 months often face severe developmental impairments.[3]

Despite the importance of monitoring the situation of children in institutional care, most countries do not have systems in place to gather the necessary data. Official records in many countries capture only a small fraction of the actual number of children in residential care, and children living in privately owned facilities are often not counted. This is the case despite the fact that, under the United Nations Convention on the Rights of the Child and most national laws, every child without parental care is the responsibility of the State. What's more, children living in institutional settings are often not represented in available statistics since reporting for many indicators, particularly those that comprise global monitoring frameworks such as the Sustainable Development Goals (SDGs), rely heavily on data collected through household surveys. This lack of data, particularly high-quality and robust data, on the well-being of these children limits efforts to include the most vulnerable in SDG monitoring and to ensure that no one is left behind.

To address this gap, the Data and Analytics Section at UNICEF Headquarters in New York developed a data collection protocol and tools for mapping residential care facilities, enumerating the children living in them, and conducting a survey of the well-being of those children that can be replicated and adapted in a variety of country contexts.

This report presents findings from the first application and testing of the methodology, conducted in Ghana in 2019. The data collection was implemented by the Ghana Statistical Service, under the guidance of a national Technical Working Group composed of representatives from the Department of Social Welfare (acting as chair), the Department of Children, the Ghana Statistical Service, the Office of the Head of Local Government Service, and UNICEF Ghana.

The data collection had three primary objectives. To conduct a:

1. Census of all residential homes for children (RHC) in Ghana (including both licensed and unlicensed homes)
2. Thorough enumeration (count) of children living in residential care
3. Survey of a representative sample of children living in RHC.

It is important to acknowledge at the outset that the census and survey are cross-sectional in nature and therefore reflect the state and conditions of residential care in Ghana at the time of data collection. While the intention was to be as comprehensive as possible in collecting data on a wide range of issues and aspects of child well-being, it is not feasible within a survey of this nature to be all-inclusive. Certain relevant and important topics were not covered since no standard and validated measures for data collection currently exist, compounded by difficulties in reliably measuring the well-being of such children and other ethical and safety considerations. As a result, the data presented in this report do not reflect the full picture of children living in residential care in Ghana, nor do they capture the long-term effects and impacts that institutionalization can have on children's future health and well-being. These are key points to consider when interpreting the findings.

This publication includes a brief historical overview and perspective on residential care and care reform within the context of Ghana. This is followed by a section that outlines the census and survey methodology. Finally, it presents key results and findings, organized by thematic area. The publication concludes with a summary of main findings to connect the results to the national context and policies on children in residential care. It also provides recommendations and implications of the findings for care reform and systems strengthening in Ghana. Annex 1 outlines some important technical notes on the data and Annex 2 describes the detailed sampling design and weighting procedures.

AN HISTORIAL PERSPECTIVE ON CARE REFORM AND RESIDENTIAL CARE IN GHANA

Since gaining independence in 1957, Ghana has established a relatively comprehensive legal framework for child protection. Moreover, it was the first country to ratify the United Nations Convention on the Rights of the Child in 1990.[4] Since that time, Ghana has ratified a number of international instruments relating to child protection, including the African Charter on the Rights and Welfare of the Child in 2005[5] and, most recently, the 1993 Hague Convention No. 33 on the Protection of Children and Cooperation in Respect of Inter-country Adoption,[6] which entered into force on 1 January 2017.

The Children's Act of 1998 brought about several significant changes to child welfare and protection in Ghana. It provided for the regulation of residential care facilities that, up until that point, did not exist, while paving the way for the passage of other child welfare legislation. This included the Child Rights Regulations 2002 (LI 1705), the Juvenile Justice Act 2003 (Act 653), the Human Trafficking Act 2005 (Act 694), the Child and Family Welfare Policy (2015), the Justice for Children Policy (2015), and the Foster Care and Adoption Regulations (2018). The Children's Act also gave district assemblies the responsibility to liaise with other government departments to ensure the protection and welfare of children within their jurisdiction.

Over the years, several social protection initiatives have been introduced in Ghana to address some of the challenges that children and their families experience, including the National Health Insurance Scheme, the capitation grant for public schools, free school uniforms, free bus rides for schoolchildren, and the school feeding programme. The Livelihood Empowerment Against Poverty (LEAP) programme is the flagship among these initiatives. All of these programmes are intended to support families in caring for their children and to prevent unnecessary family separations. Despite these efforts, residential care has historically been the main formal alternative for children in need of care and protection and for whom family or kinship care is not an option.

In 2007, the Government of Ghana, in partnership with UNICEF, USAID and OrphanAid Africa, a non-governmental organization (NGO), launched the Care Reform Initiative under the National Plan of Action for Orphaned and Vulnerable Children. The initiative was launched specifically to de-emphasize overreliance on institutional care and to move towards a range of integrated family and community-based care services for children without appropriate parental support.

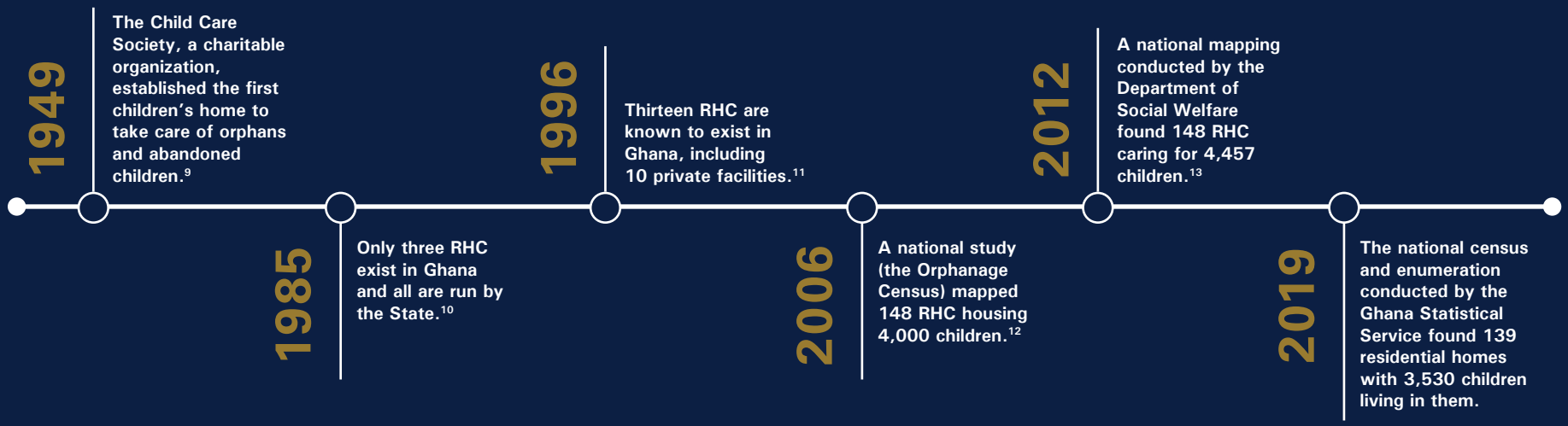
The following factors helped create the impetus for the Care Reform Initiative:

- Recent international studies showed unequivocally that long-term residential care had detrimental effects on children's development and their human rights. In light of this, the drastic increases in RHC in Ghana between 1996 and 2006 were disturbing, especially since allegations of sexual and physical abuse, corruption and human trafficking had emerged within several of these institutions.

- In January 2006, the Committee on the Rights of the Child, in its concluding observations on Ghana's report to the Committee, recommended that "the state party… provide active support for a significant increase in the availability of family-type alternative care such as the extended family or foster care to make institutional care a matter of last resort."[7] In response, the Department of Social Welfare met with all district officers and undertook the Orphanage Census of residential homes for children. They found 148 RHC, a significant increase from the 13 homes in 1996. The vast majority (80 per cent) of some 4,000 children living in RHC in 2006 were not orphans; rather, they were placed in institutional care because their families were poor. Residential homes were not following the prescribed procedures for operating, many had no Social Inquiry Reports, care orders or care plans, and conditions of care were substandard. For example, staff were found to be untrained and staff-to-child ratios were inadequate. Moreover, staff reportedly recruited children by convincing parents to send their children to orphanages to receive education and shelter. Most NGOs were using institutionalization as a first and not a last resort.

- It was clear that the provision of alternative care in Ghana needed to be changed, to align with the United Nations' 2009 'Guidelines for the Alternative Care of Children'.[8]

TIMELINE ON THE ESTABLISHMENT OF RESIDENTIAL HOMES FOR CHILDREN IN GHANA



The goal of the Care Reform Initiative has been the establishment of a more consistent and stable approach to caring for vulnerable children in Ghana, so that every child is assured of a permanent home in a supportive and loving family. The main components of the Initiative are the following:

- **PREVENTION** – preventing the disintegration of families/ unnecessary separation of children through linkages with strategies that strengthen families, such as the LEAP programme, scholarships, food packages, access to national health insurance and other support programmes.
- **REINTEGRATION OF SEPARATED CHILDREN WITH THEIR FAMILY** – finding one or both parents or living relatives of children in institutional care who are able to create a caring and stable environment. The reintegration of these children into the community and the education of the general public on the importance of family-based care is a major objective of the programme.
- **FOSTERING** – providing temporary or permanent foster families as an alternative, when kinship care cannot be arranged.
- **ADOPTION** – placing the child in an adoptive home, preferably with a Ghanaian family, when the possibility of a family reunion is exhausted. This is being accomplished by strengthening the capacity of social workers to handle adoption procedures through relevant education and training, in line with the provisions of the Hague Convention on Inter-country Adoption (to which the Government of Ghana has acceded).

Through its Care Reform Initiative, the Department of Social Welfare has taken significant steps to promote family-based alternative care for children in need of care and protection and has adopted a strong policy stance against institutionalization. New standards for institutional care were developed in 2010 and revised in 2018, and regional multi-agency teams were set up to inspect RHC. In 2017, all 10 regions developed a five-year road map for the closure of substandard residential homes for children. The intention of the road map is not to close down all RHC in Ghana, but rather to ensure that, for children for whom family or kinship care is not an option, a continuum of quality temporary, long-term and permanent alternative care options is available – including family-based alternative care options such as foster care and adoption and, as a last resort, residential care. The Department has also recently developed 'De-institutionalization Guidelines' and is revising the road map based on a new geographical regional structure.

Following the amendment of the Children's Act in 2016 and the passage of Foster Care Regulation, which was created to develop a family-based care option to residential care, the Department of Social Welfare trained over 500 foster parents and around 200 children in foster care.

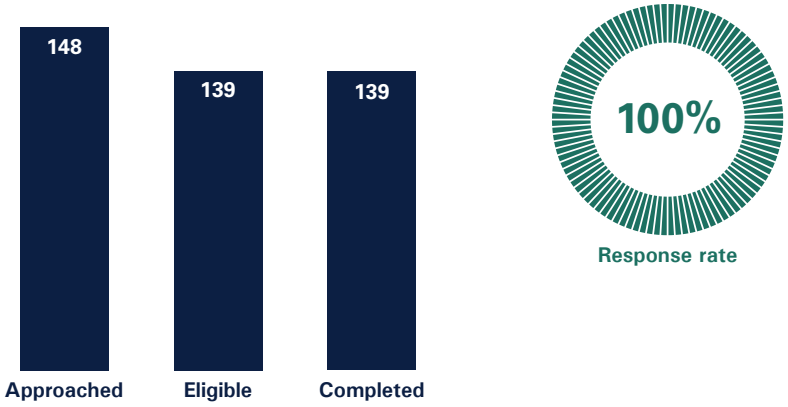
SURVEY METHODOLOGY

The objectives of the survey were achieved through two phases of data collection. Phase One aimed to collect data on the number, location and basic characteristics of all residential homes for children in Ghana as well as the number and basic characteristics of all children living in these institutions. Phase Two was a follow-up survey on a representative sample of children living in RHC to collect data on selected measures of well-being. Data collection was implemented using Computer-Assisted Personal Interviews (CAPI).

DEFINITIONS

RHC included non-family-based group settings with paid or unpaid staff where children live and receive care. This definition covers a wide range of care settings, from small group homes to large residential facilities, such as orphanages or institutions.

STUDY DESIGN AND RESPONSE RATES



A total of 148 RHC were identified across the country as part of the census frame and were visited during data collection. Of these, 139 were found to be eligible (eight had closed and one had only residents over age 18). Of these 139 homes, residents and staff in all of them were successfully interviewed, for a response rate of 100 per cent.

The final frame of 139 RHC and 3,530 children generated in Phase One was used to select a sample of homes and children for Phase Two. Of these 139 RHC, nine had fewer than five children, and the decision was made to exclude them from the frame. The final sampling frame consisted of 130 eligible homes with 3,505 children.

For Phase Two, a two-stage stratified sampling approach was used. The primary sampling units selected at the first stage were the RHC, and a fixed number of children per RHC were selected at the second stage. At the national level, a total of 48 RHC were selected at the first sampling stage using probability proportional to size, based on the number of children in each RHC. A total of 552 children were selected for Phase Two: 128 children aged 0-4 years, 239 children aged 5-14 years, and 185 adolescents aged 15-17 years.

Of the 128 sampled children under age 5, interviews were completed for 118, yielding a response rate of 92 per cent. Of the 239 sampled children between the ages of 5 and 14 years, interviews were completed for 216, resulting in a response rate of 90 per cent. Of the 185 sampled adolescents aged 15 to 17 years, only 139 had completed interviews, which corresponds to a response rate of 75 per cent. One of the main reasons for the lower response rate among this age group is the fact that a number of sampled adolescents were found to no longer be eligible due to their age at the time of Phase Two data collection. Of the total 552 sampled children and adolescents of all ages, interviews with social workers were completed for 510, resulting in a response rate of 92 per cent.

Sample weights were used for reporting Phase Two survey results. A more detailed description of the sample design and weighting procedures can be found in Annex 2.

QUESTIONNAIRES

Eight questionnaires/tools were used in the two phases of data collection:

Facility Questionnaire

- Facility characteristics
- Staffing characteristics
- Water and sanitation
- Sleeping arrangements

Facility Roster

- List of residents
- Basic characteristics of residents
- Roster of exited children

Facility Observation Checklist

- Physical interior and exterior of the facility
- Basic amenities
- Health and safety issues
- Materials for children

Verification Count and Record Review

- List of residents
- Basic characteristics of residents
- Roster of exited children

Questionnaire for Children under 5

- Child's background
- Care of illness
- Early childhood development
- Child functioning
- Child discipline
- Anthropometry

Questionnaire for Children 5–14 Years

- Child's background
- Child's work and activities
- Child functioning
- Child discipline
- Foundational learning skills

Questionnaire for Adolescents 15–17 Years

- Adolescent's background
- Adolescent's work and activities
- Adolescent functioning
- Mental health
- Adolescent discipline
- Violence and unintentional injuries
- Resilience

Questionnaire on Children's Case History

- Child and adolescent case history

The Facility Questionnaire was administered to the director or other designated official/head of the RHC. The Questionnaire for Children under 5 and the Questionnaire for Children 5-14 Years were administered to caregivers of randomly selected children, and the Questionnaire for Adolescents 15-17 Years was directly administered to randomly selected adolescents. The Questionnaire on Children's Case History was administered to the social worker or assigned caseworker for each randomly selected child and adolescent aged 0 to 17 years.

Most of the modules included in the Phase Two questionnaires were adapted or modelled after the standard questionnaires used for the sixth round of the Multiple Indicator Cluster Survey (MICS6).[14]

The questionnaires were customized and translated into four local languages (Ga, Twi, Ewe and Dagbani); however, the majority of interviews were conducted in English.

ETHICAL PROTOCOL AND RESPONSE PLAN

The country protocol was submitted for ethical review and approved by the Ghana Health Service's Ethics Review Committee in July 2019.

For Phase One, written consent for the RHC to participate in data collection was obtained from the facility's director or other appointed official to be interviewed. For individual interviews with caregivers during Phase Two, verbal consent was obtained. For individual interviews with adolescents aged 15-17 years, written assent was secured (as required by the local ethics review committee).

Some of the questions included in the Questionnaire for Adolescents 15-17 Years are very personal and sensitive in nature. Therefore, the interviewer was required to deliver a short script at the end of the interview and to give the respondent a Service Information Card. On the card are phone numbers of local services (namely, the Department of Social Welfare and the Ministry of Gender, Children and Social Protection hotline), which the respondent could contact if he or she wanted to speak with someone. These local services were identified in consultation with the Technical Working Group and are free of charge and available/open 24 hours a day, 7 days a week (including holidays). Additionally, the script asked respondents if they would like to be linked directly to professional services. If the respondent expressed a desire to do so, the interviewer recorded details on the best and safest way and time to have professionals contact the respondent for follow-up. Interviewers were instructed to inform their supervisors when adolescent respondents requested a direct referral. The names and contact information for all those adolescent respondents who requested a referral were shared with the Department of Social Welfare to carry out the necessary follow-up.

A total of 94 adolescent respondents requested a direct referral to services; this represented roughly two thirds of all adolescents with completed interviews (n=139).

RECRUITMENT OF FIELDWORK TEAMS

As the implementing agency, the Ghana Statistical Service recruited members of the fieldwork teams from its existing pool of trained enumerators, all of whom had experience carrying out data collection for other surveys (such as MICS, Demographic and Health Surveys, and national labour force surveys).

TRAINING AND PILOT

A pre-pilot training workshop, pre-pilot test and interviewer debriefing were conducted in September 2019. The two-day training workshop was held in Dodowa, and the pre-pilot took place over two days in three separate facilities (chosen on the basis of location and representing different settings). Observations from the field and interviewer debriefing were used to inform revisions and improvements to the data collection tools and fieldwork procedures ahead of the actual fieldwork.

Training for the Phase One fieldwork was conducted for two days in Winneba, Central Region on 28 and 29 October 2019. Participants included all 48 members of the fieldwork teams (36 interviewers and 12 supervisors). Subsequently, all members of the fieldwork team participated in a one-day pilot in a residential home located in the same region as the training venue. Members of the fieldwork teams were divided into four groups and each team worked on completing

all the questionnaires, with the exception of the Verification Count, which was carried out by only one team to avoid disrupting the home's routine. Findings and observations from the pilot were collected and used to address minor procedural issues as well as to resolve outstanding issues with the CAPI application.

Training for Phase Two was conducted over four days, also in Winneba, from 2 to 5 December 2019. Dedicated sessions were included to provide guidance on interviewing children and adolescents and implementing the response plan. Measurers also received a dedicated parallel training on anthropometric measurements and participated in a one-day hands-on standardization exercise with volunteer caregivers and children from the surrounding community. Following the training, all members of the fieldwork team participated in a one-day pilot in two RHC (in the Central Region and in Greater Accra). Each RHC had teams composed of 12 interviewers, 6 supervisors and 6 measurers (responsible for collecting height and weight measurements). Observations from the pilot were collected and used to inform modifications to fieldwork and further adjust the CAPI application.

FIELDWORK

Prior to the start of fieldwork for both phases of data collection, the Department of Social Welfare issued notification letters to its regional directors and district officers as well as managers of residential homes for children to inform them of the upcoming data collection.

During Phase One, the data were collected by 12 teams; each was comprised of three interviewers, one driver and a supervisor. In most cases, fieldwork teams were accompanied to the RHC by the local district social welfare officer, who facilitated introductions and access. Fieldwork lasted for approximately two weeks, from 6 to 19 November 2019.

During Phase Two, the data were collected by 12 teams; each was comprised of two interviewers, one driver, one measurer and a supervisor. As with Phase One, fieldwork teams were generally accompanied to the RHC by the local district social welfare officer. Fieldwork was carried out for approximately 10 days, from 10 to 20 December 2019.

FIELDWORK QUALITY-CONTROL MEASURES

Supervisors were responsible for the daily monitoring of fieldwork and observation of interviewer skills and performance. During fieldwork for both phases of data collection, efforts were made to visit each team at least once by members of the survey management team from the Ghana Statistical Service, the Department of Social Welfare and UNICEF.

The intention was to produce field check tables for a selection of indicators throughout both phases of data collection to monitor quality while teams were still in the field, but this was not carried out in a systematic or timely way. However, field check tables were produced after the completion of data collection. Results did not suggest any serious issues that would compromise overall data quality.

DATA MANAGEMENT, EDITING AND ANALYSIS

Following completion of fieldwork, the original datasets in the Statistical Package for Social Sciences (SPSS) were checked for external and internal consistency. This review resulted in a number of secondary edits to the datasets.

Sample weights were calculated and added to the analysis files for Phase Two. The World Health Organization's standard anthropometry z-scores were calculated and added to the analysis file for children under age 5. In addition, a number of background variables (such as age groups, size of the residential home, etc.) needed for production of results tables were calculated and added to the analysis files.

Data were analysed using SPSS software. Model tabulation plans developed by UNICEF were customized and used for this purpose.

MAIN FINDINGS

KEY TERMS USED IN THIS SECTION

FOREIGN NATIONALS
People who are not citizens of Ghana.

PAID STAFF
People who have been hired by the RHC and who receive remuneration (a salary or wage) to work in the residential home. Those who receive an allowance (either in-kind of cash), even if only occasionally, are considered paid staff.

VOLUNTEER
People who work or provide services to the RHC without being paid (that is, they do not receive a salary or wage).

BASIC DRINKING WATER SERVICE
RHC that have both an improved source of drinking water and drinking water available from the main source at the time of data collection. Improved sources of drinking water include: piped water (into dwelling, compound, yard or plot, to neighbour, public tap/standpipe), tube well/borehole, protected dug well, protected spring, rainwater collection, packaged water (bottled and sachet), and delivered water (brought by a tanker truck or cart with small tank).

BASIC SANITATION SERVICE
RHC that have improved sanitation facilities that are separate for males and females and where at least one toilet/latrine is usable. Improved sanitation facilities include: flush or pour flush toilets, composting toilets, ventilated improved pit latrines (KVIP/VIP), and pit latrines with slab.

FIXED HANDWASHING FACILITY
Includes any device or infrastructure in any fixed location, such as a sink with tap or water tank with tap, that enables residents to wash or rinse their hands using running water.

MOBILE HANDWASHING OBJECT
A movable object such as a bucket, basin, container or kettle that enables residents to wash or rinse their hands.

HOW MANY RESIDENTIAL HOMES FOR CHILDREN DOES GHANA HAVE AND WHAT ARE THEIR CHARACTERISTICS?

FIGURE 1

Ghana has 139 residential homes for children, which are largely concentrated in the Greater Accra region

Number of residential homes for children in Ghana, by region

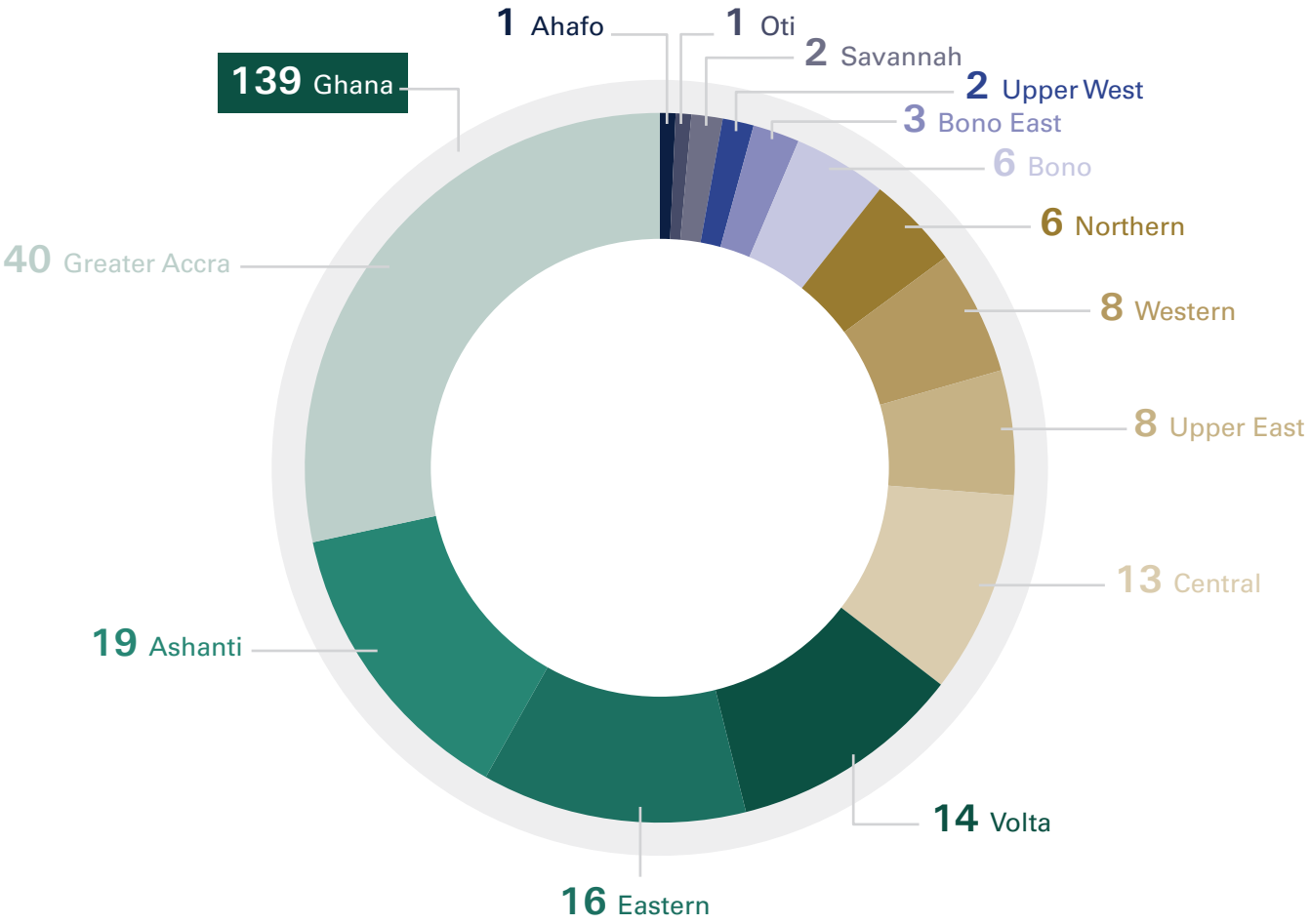
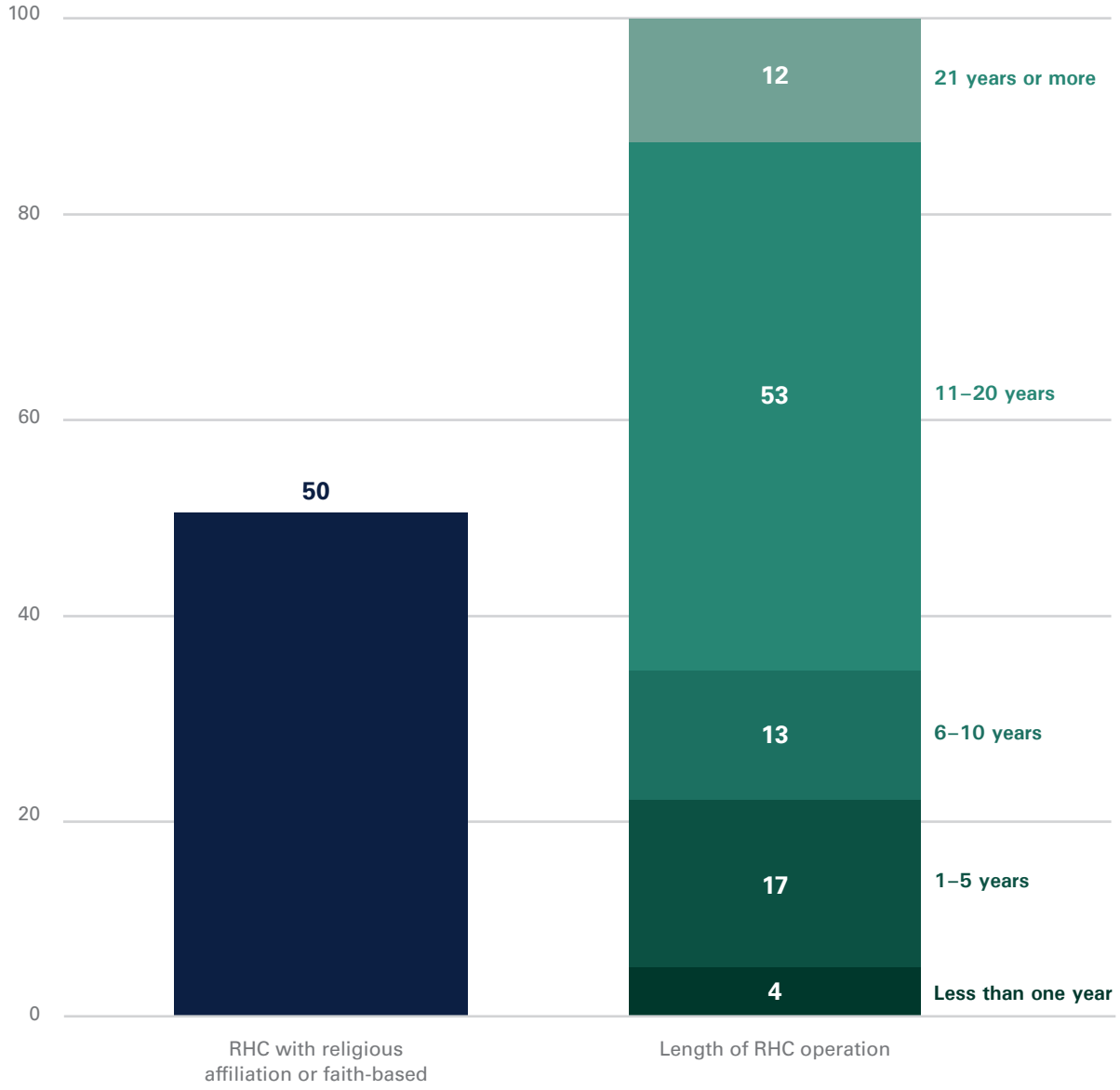


FIGURE 2

Half of all residential homes for children in Ghana were reported to have a religious affiliation, and all of them were Roman Catholic; the majority of residential homes have been open between 11 and 20 years

Percentage of residential homes for children in Ghana, by religious affiliation, and percentage distribution of residential homes by length of operation

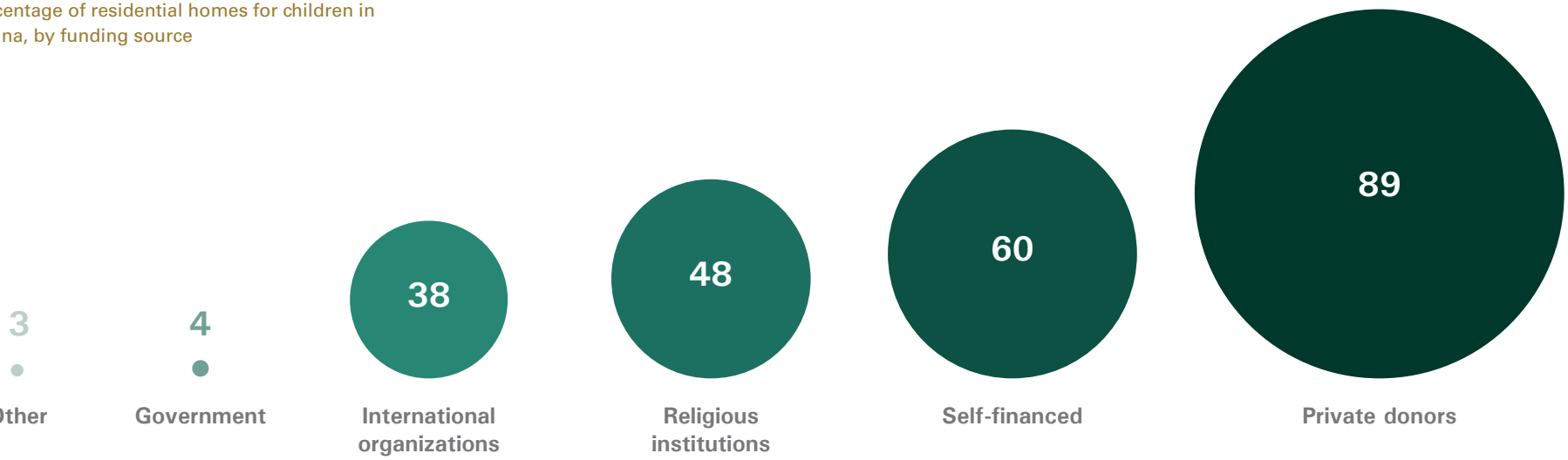


Note: Some figures do not add up to 100 per cent due to rounding.

FIGURE 3

The most commonly reported sources of funding for RHC were private donors, while close to 40 per cent were receiving funding from international organizations

Percentage of residential homes for children in Ghana, by funding source



Note: RHC could report more than one source of funding.

REGISTRATION AND LICENSING OF RESIDENTIAL HOMES FOR CHILDREN

Privately run residential homes for children in Ghana must first register with the Registrar General and then with the Department of Social Welfare to obtain a certificate to operate as an NGO. RHC that are registered only with the Registrar General do not comply with the requirements for registration.

Once registered, the RHC must separately apply to the Department of Social Welfare to operate as a licensed residential home for children. This process involves a needs assessment by the district social welfare officer and an inspection[15] of the premises to ensure compliance with National Standards for Residential Homes for Children in Ghana.[16]

FIGURE 4

Almost 1 in 4 homes are either not registered with the Department of Social Welfare or do not comply with registration requirements

Percentage distribution of residential homes for children in Ghana, by registration status

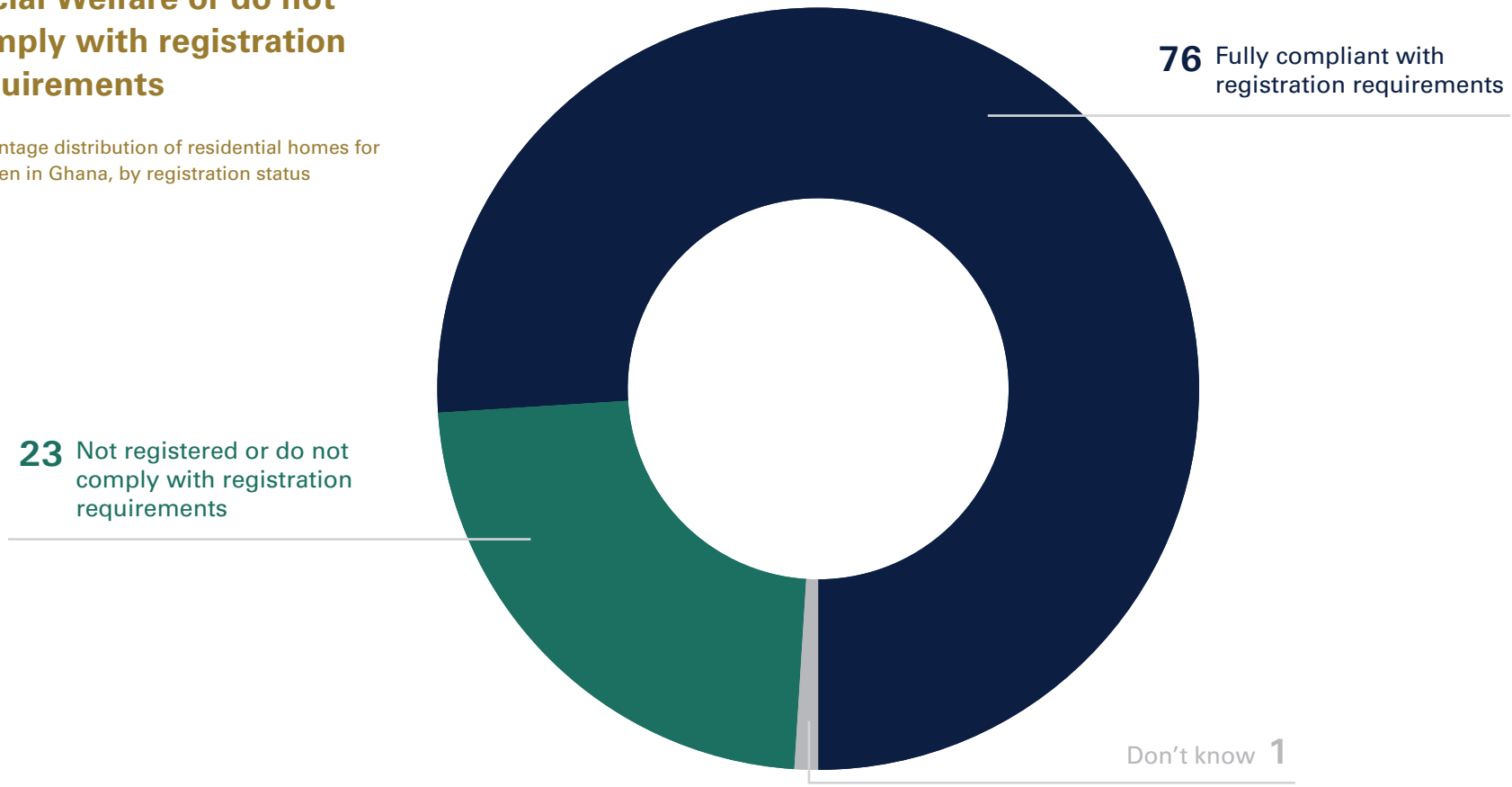


FIGURE 5

Only about one third of residential homes were found to have a valid licence

Percentage distribution of residential homes for children in Ghana, by licensing status

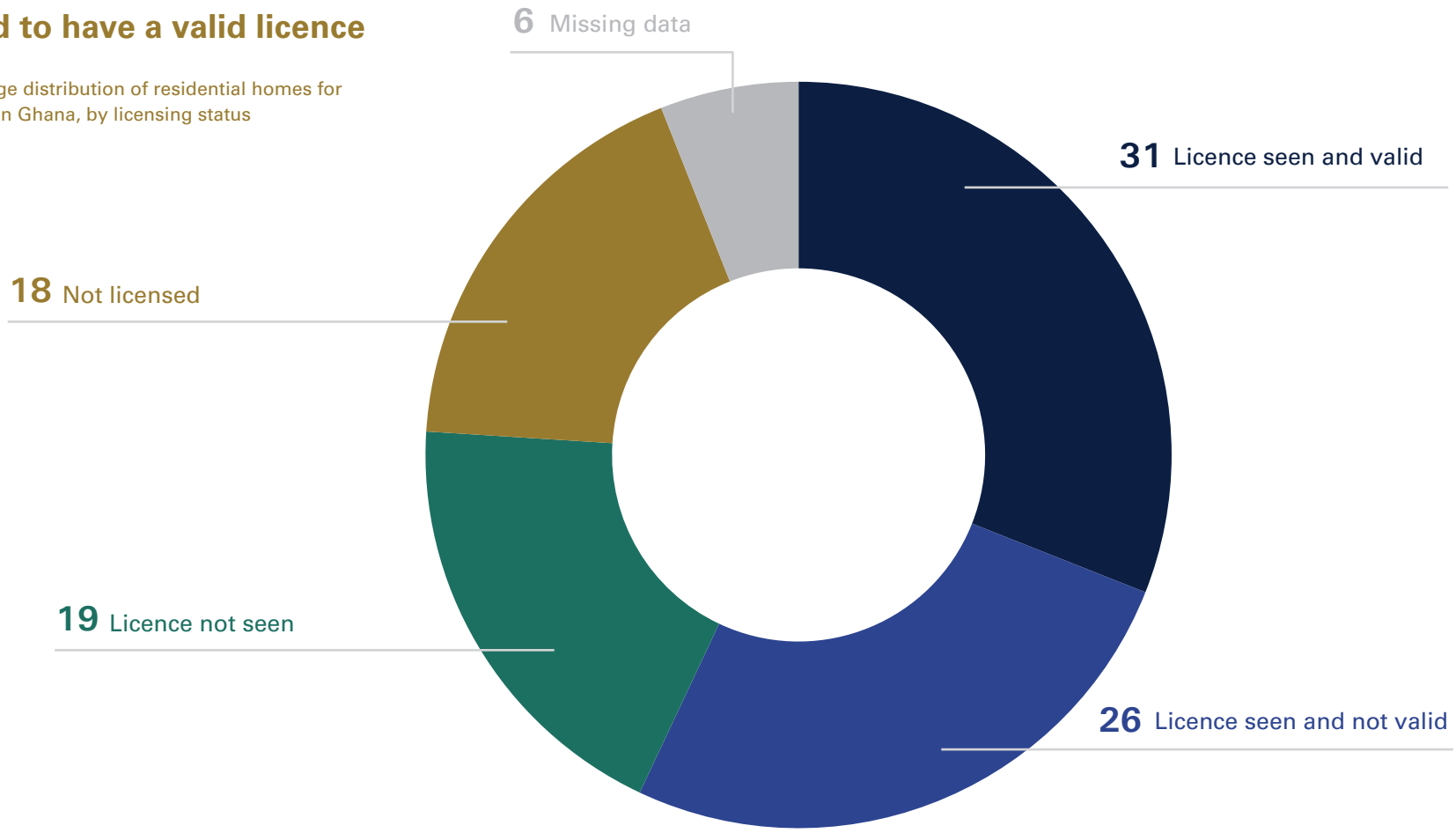
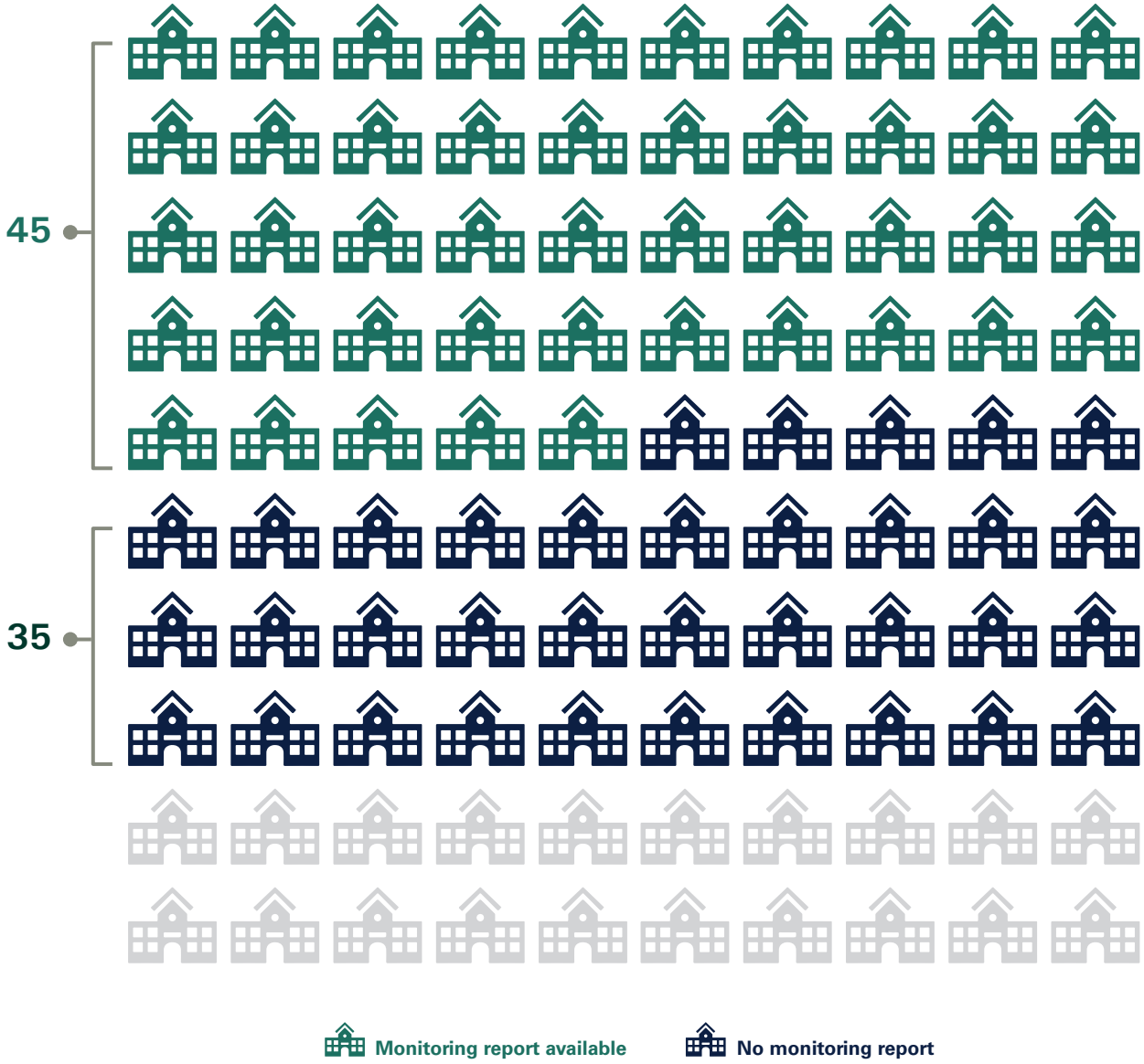


FIGURE 6

While the vast majority of RHC in Ghana have been recently monitored by the Department of Social Welfare, many of them lack documentation in the form of a monitoring report

Percentage of residential homes for children in Ghana that have been monitored by the Department of Social Welfare within the three months preceding the survey, by availability of a monitoring report



Note: The category 'monitoring report available' includes those RHC that said a monitoring report was available, regardless of whether or not it was seen by the interviewer.

FIGURE 7

A majority of residential homes in Ghana have paid staff, but only about half conduct police or background checks on personnel and volunteers

Percentage of residential homes for children in Ghana with volunteers and paid staff, and that conduct police/ background checks on staff and volunteers

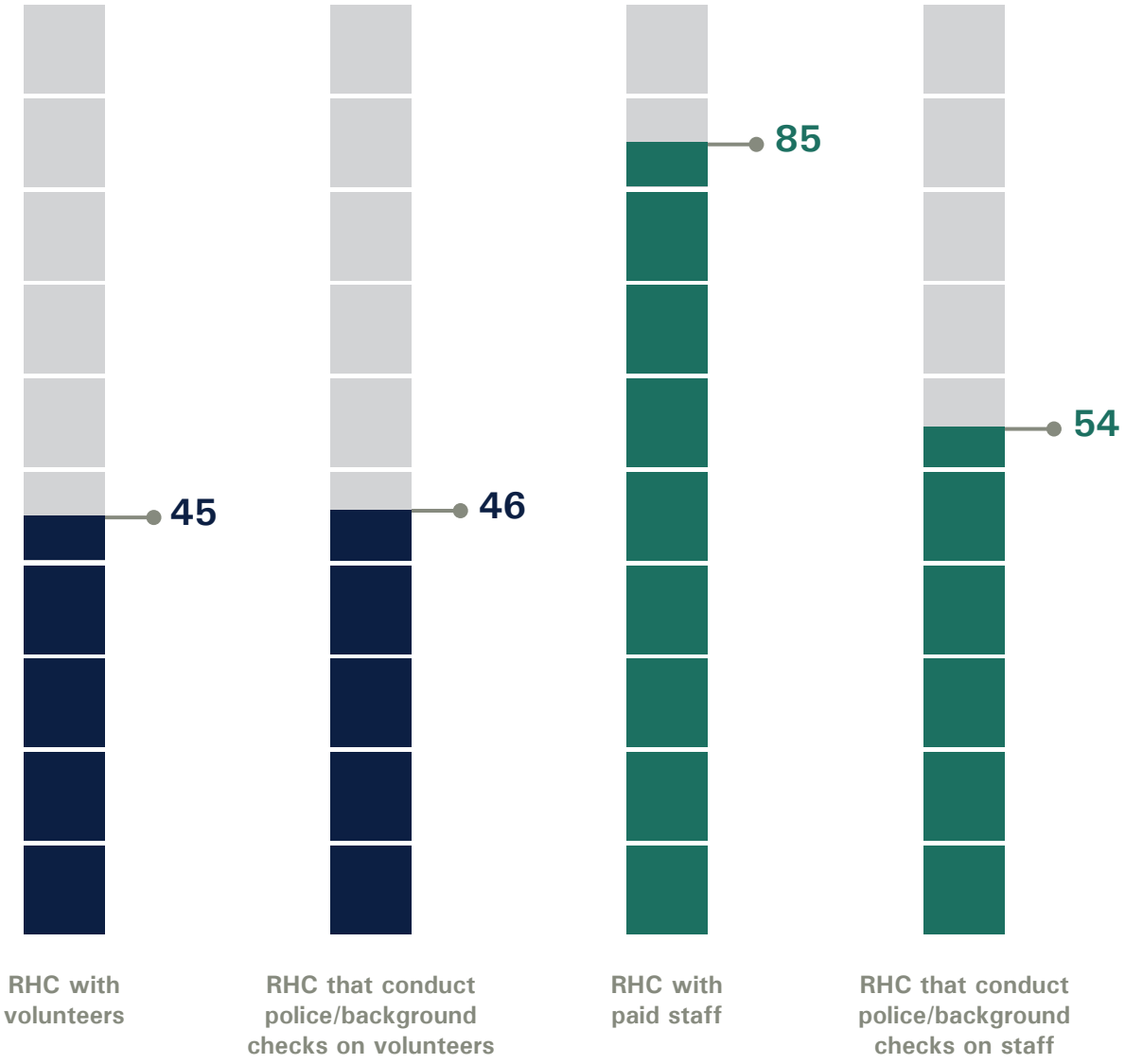


FIGURE 8

Close to half of RHC with volunteer workers hosted foreign nationals

Percentage distribution of residential homes for children in Ghana with volunteer workers, by whether or not any of the volunteers are foreign nationals

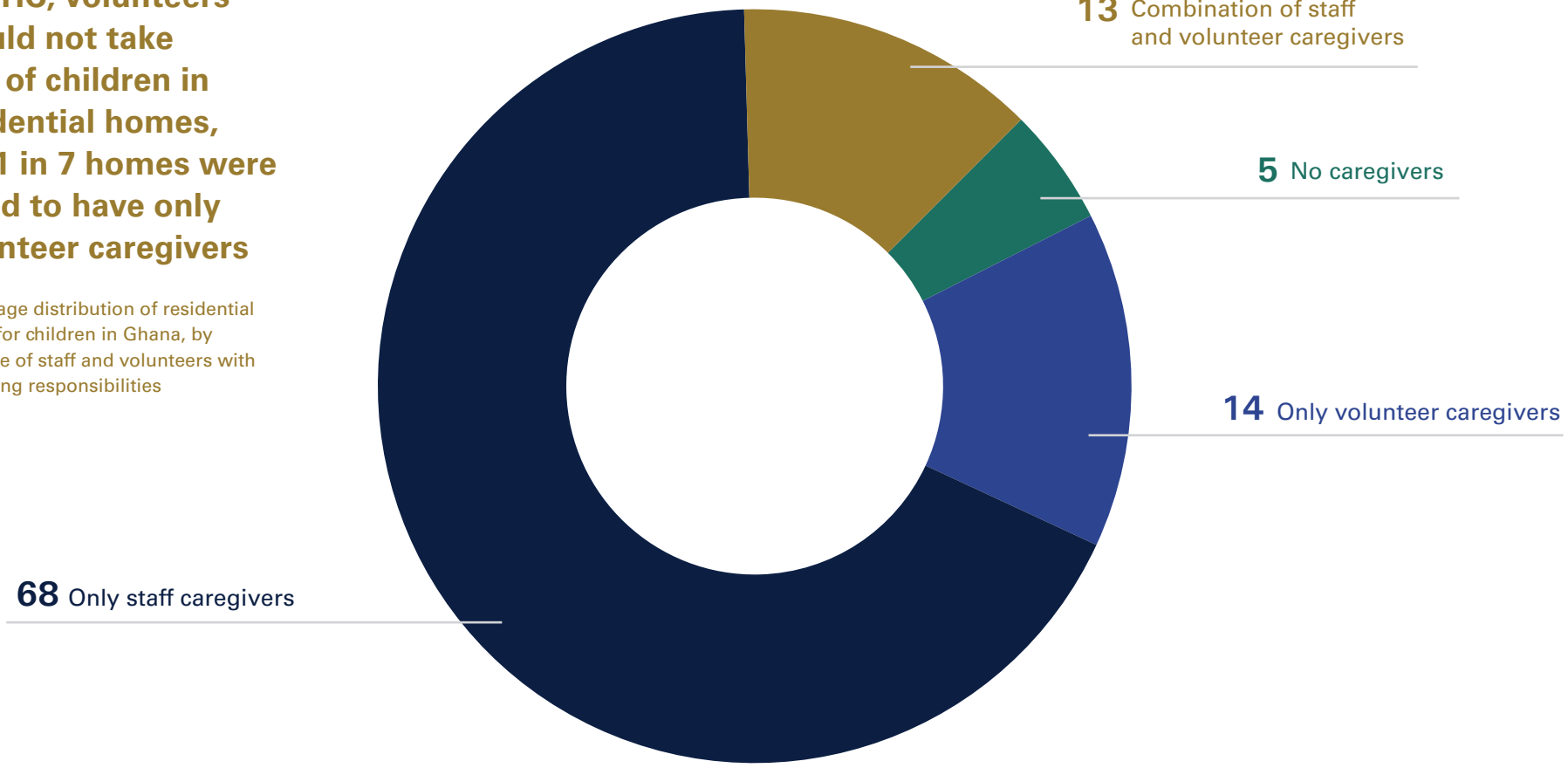
54 per cent
do not have foreign nationals

46 per cent
have foreign nationals

FIGURE 9

According to the National Standards on RHC, volunteers should not take care of children in residential homes, but 1 in 7 homes were found to have only volunteer caregivers

Percentage distribution of residential homes for children in Ghana, by presence of staff and volunteers with caregiving responsibilities

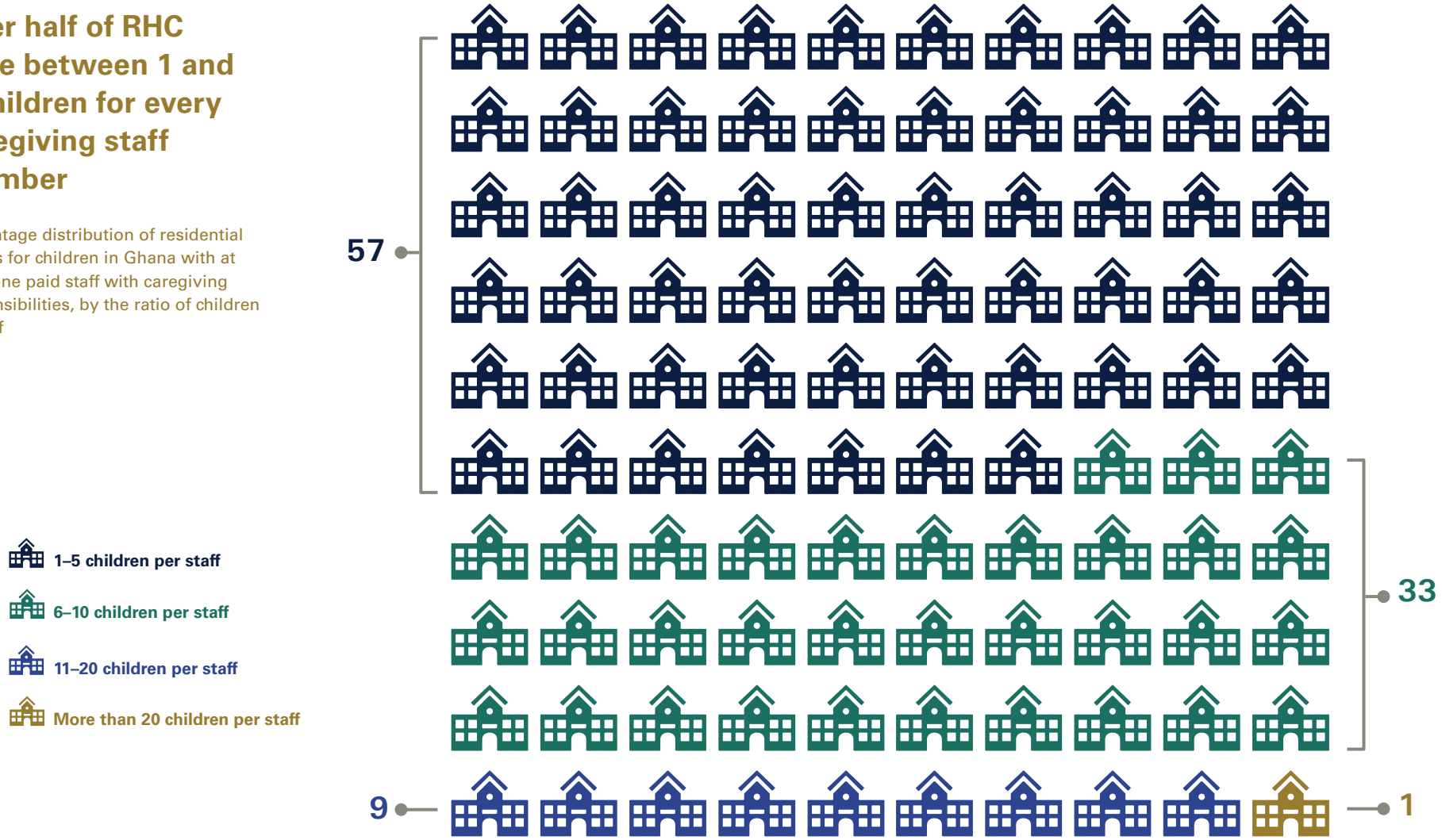


Note: 'Caregiving responsibilities' refers to daily care of children, such as feeding, dressing, putting to bed, etc.

FIGURE 10

Over half of RHC have between 1 and 5 children for every caregiving staff member

Percentage distribution of residential homes for children in Ghana with at least one paid staff with caregiving responsibilities, by the ratio of children to staff



Note: These ratios are based only on those staff reported as having caregiving responsibilities.

FIGURE 11

A majority of RHC in Ghana have basic sanitation and drinking water services

Percentage of residential homes for children in Ghana with basic sanitation services and basic drinking water services

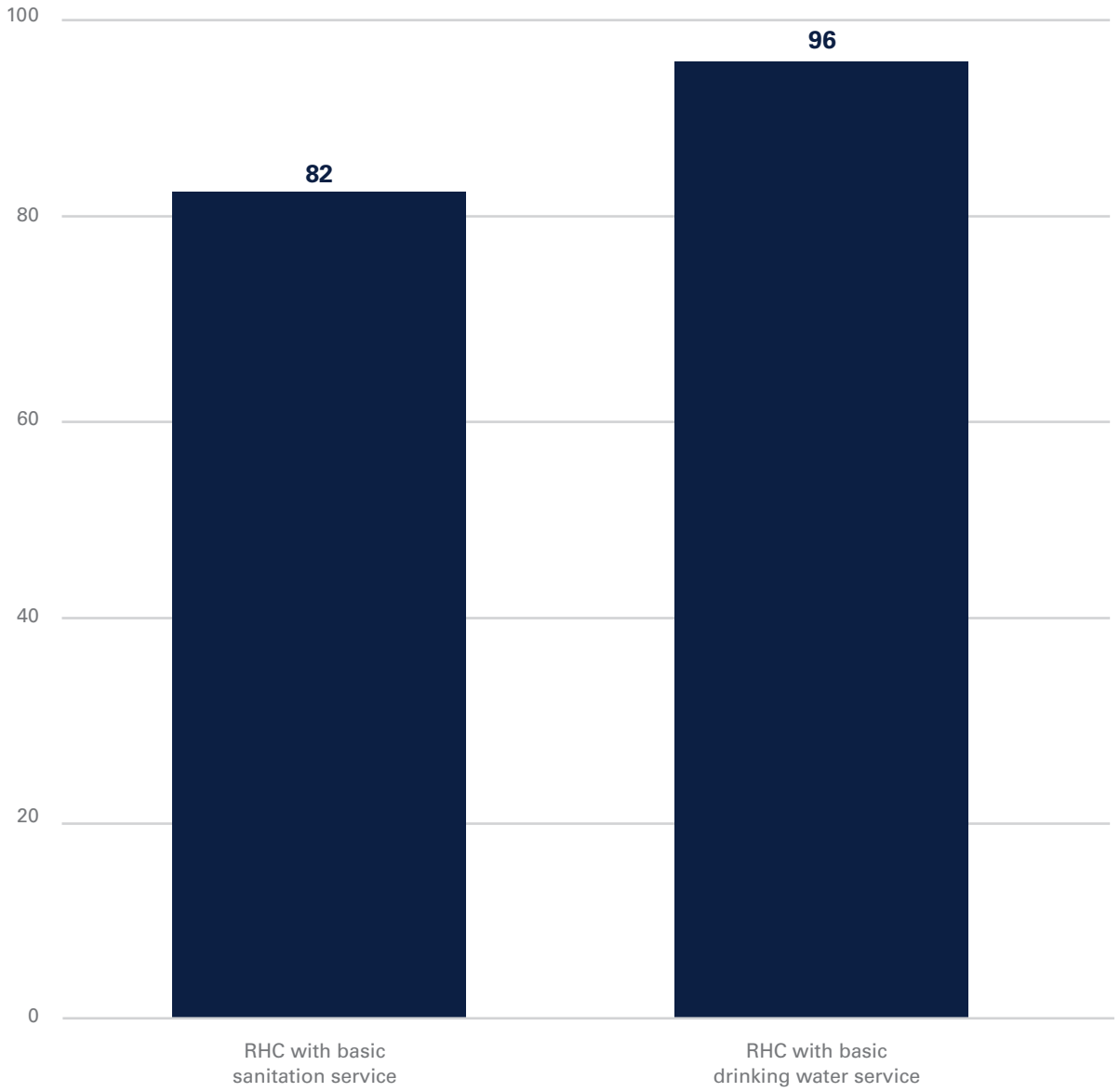


FIGURE 12

Nearly 1 in 7 RHC lack handwashing facilities

Percentage distribution of residential homes for children in Ghana, by type of handwashing facility

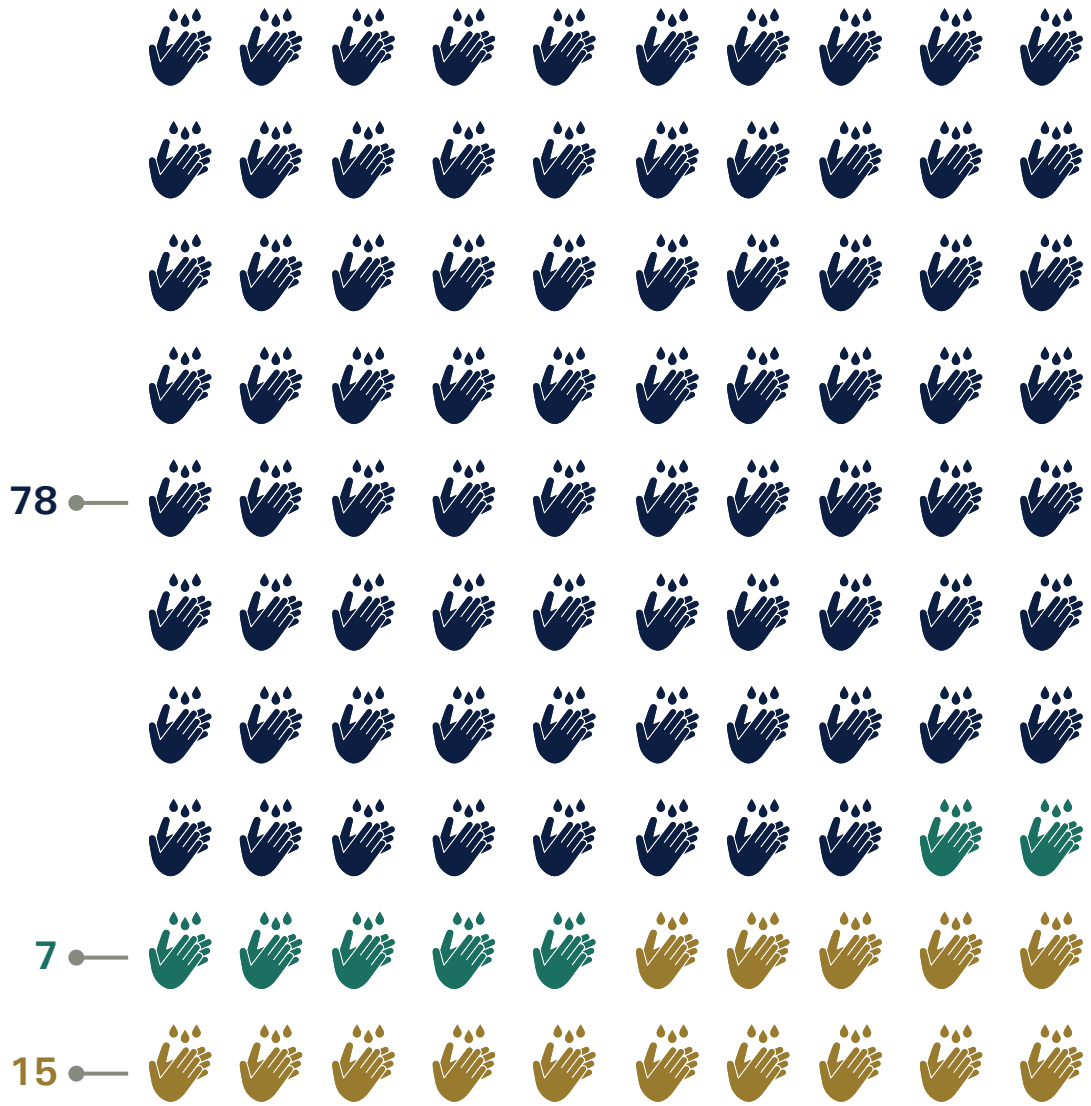
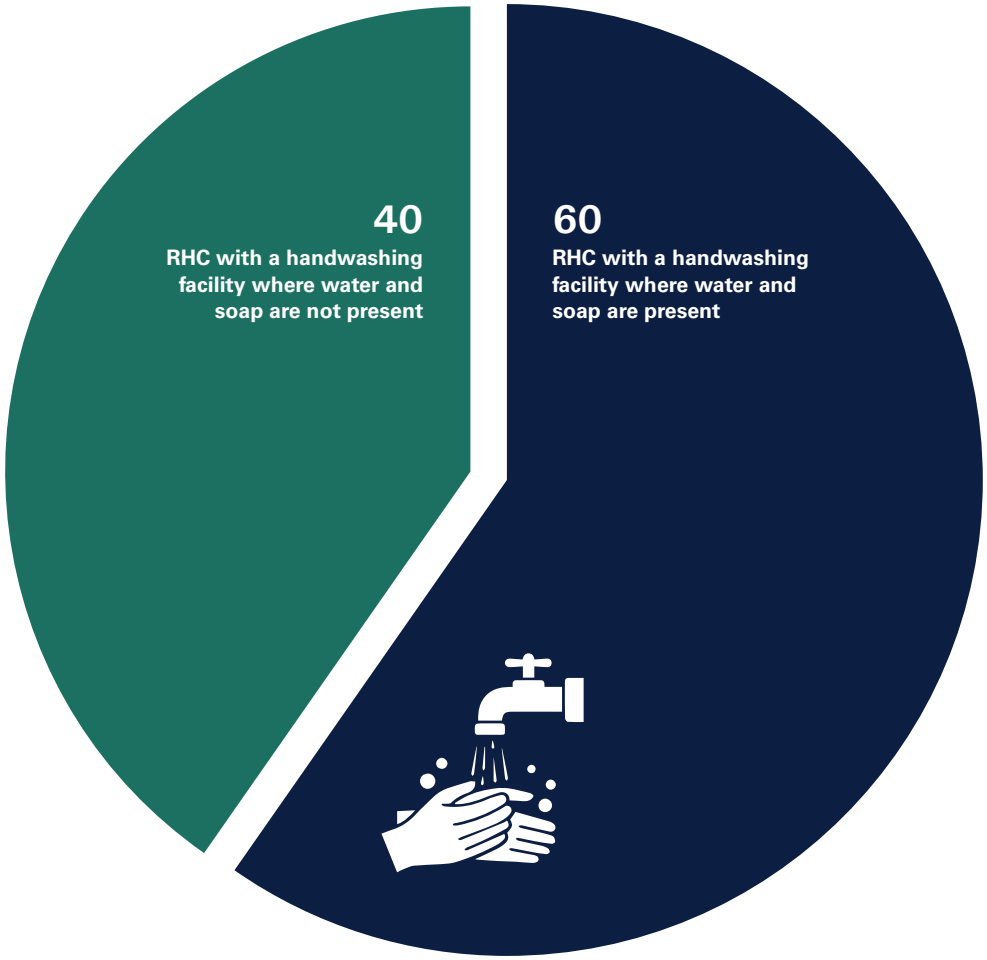


FIGURE 13

Forty per cent of handwashing facilities in RHC lack soap and water

Percentage distribution of residential homes for children in Ghana, by whether handwashing facilities had water and soap



WHAT IS THE PROFILE OF CHILDREN LIVING IN RESIDENTIAL CARE?

FIGURE 14

A total of 3,530 children live in residential homes in Ghana, a slight majority of whom are boys

Number and percentage of children living in residential homes for children in Ghana, by sex

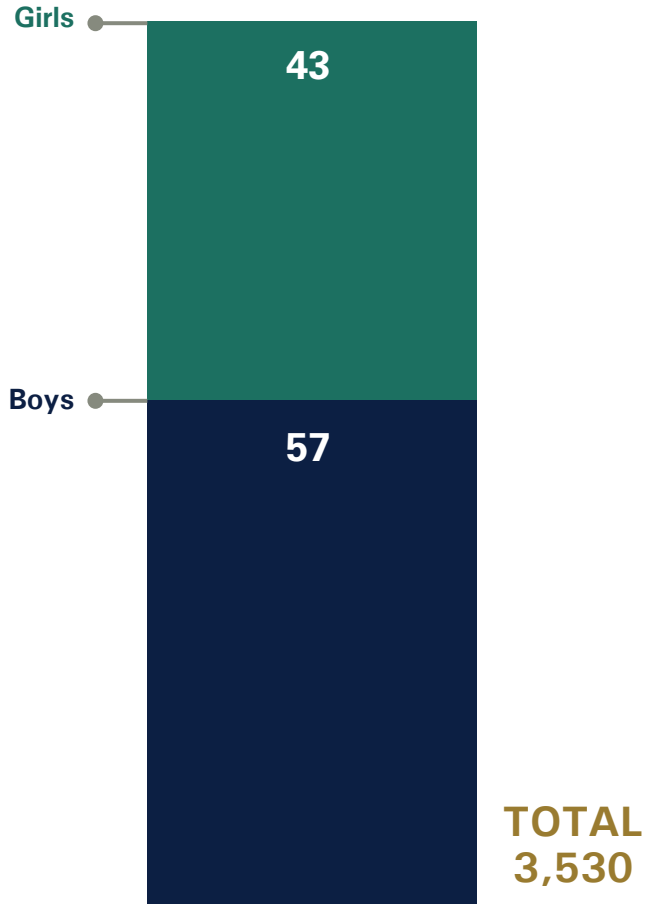
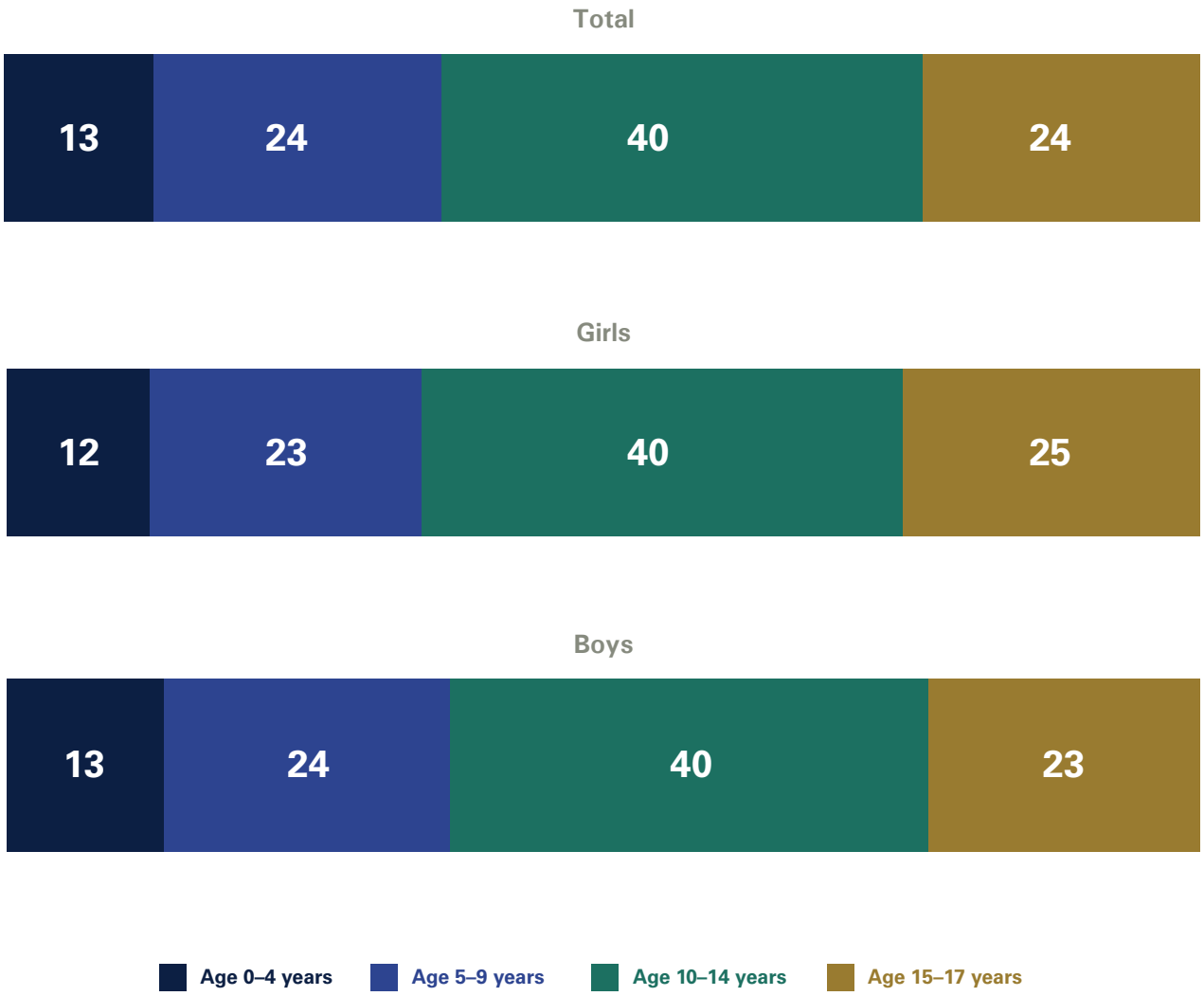


FIGURE 15

Nearly 2 in 3 children living in residential care are aged 10 or older

Percentage distribution of children living in residential homes for children in Ghana, by sex and age

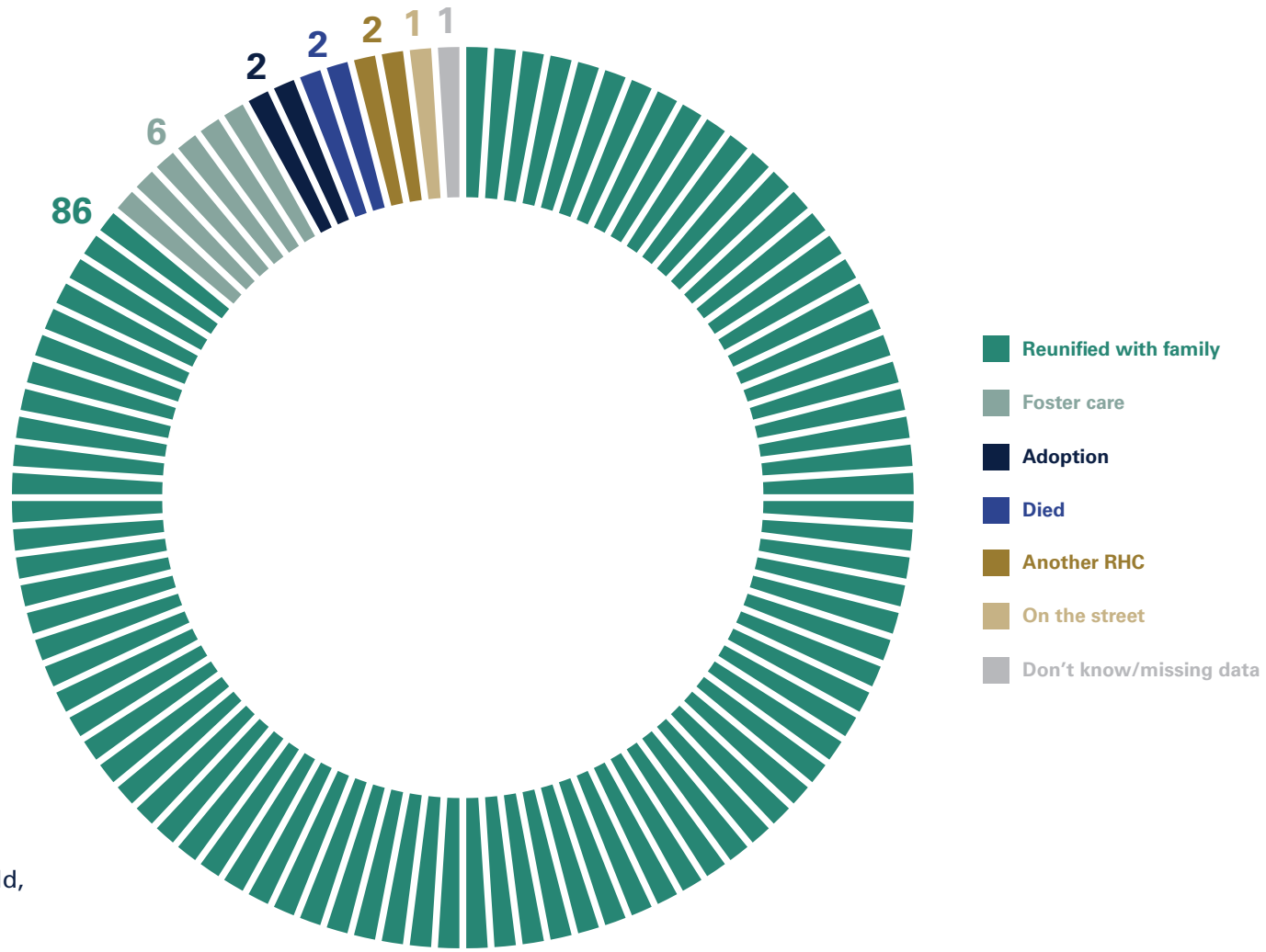


Note: Some figures do not add up to 100 per cent due to rounding.

FIGURE 16

Close to 90 per cent of children who exited residential homes were reunited with family

Percentage distribution of children who exited RHC in the previous 12 months, by location or status after exiting the RHC



Among children who exited RHC in the last year, the majority were 5 to 14 years old, with an equal distribution of boys and girls

FIGURE 17

Around 2 in 3 children living in residential care have at least one living biological parent

Percentage distribution of children living in residential homes for children in Ghana, by parent survival status

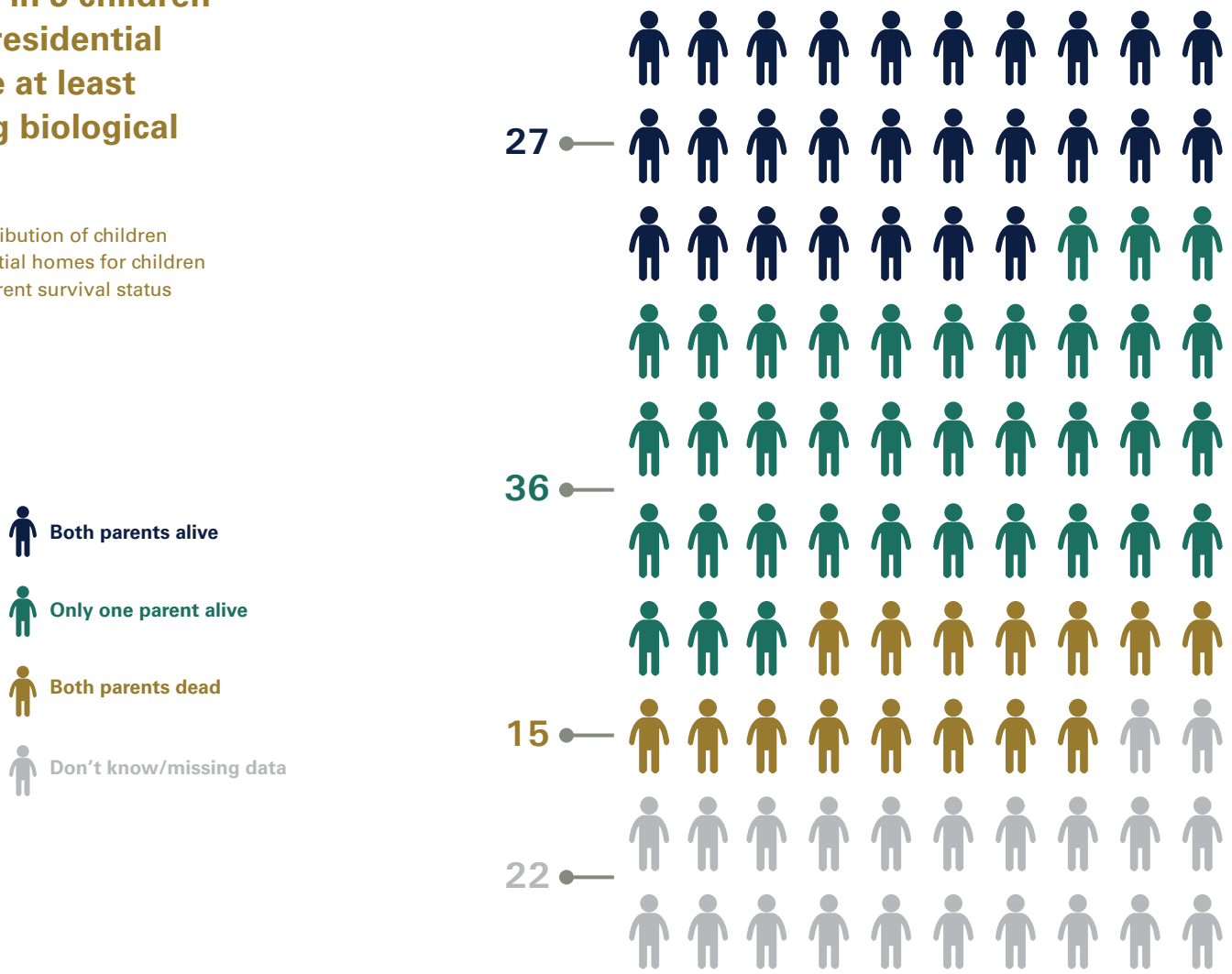


FIGURE 18

Sixty per cent of children living in residential homes still have contact with parents or relatives; around one third of children have at least one sibling also living in the same home

Percentage of children living in residential homes for children in Ghana, by background characteristics

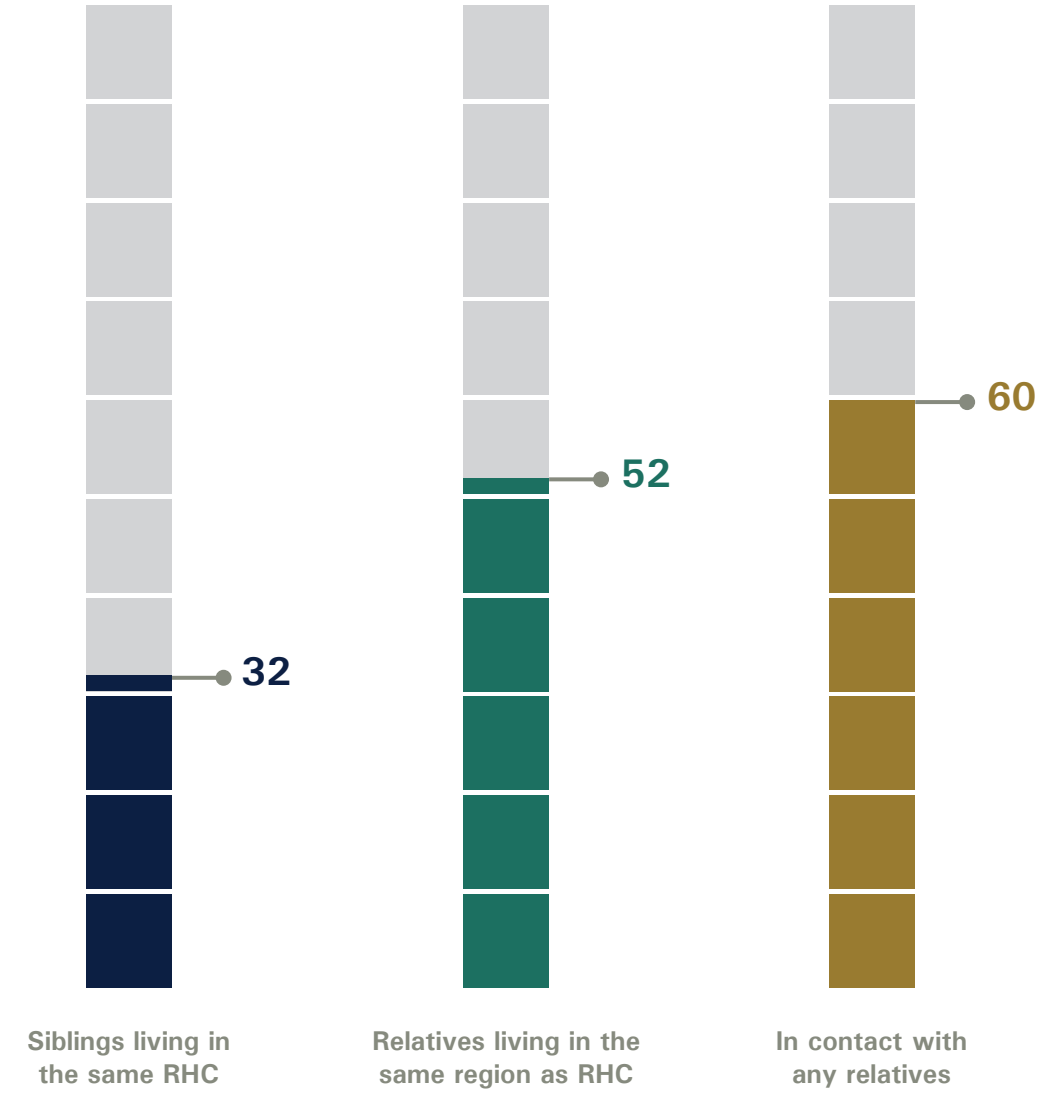
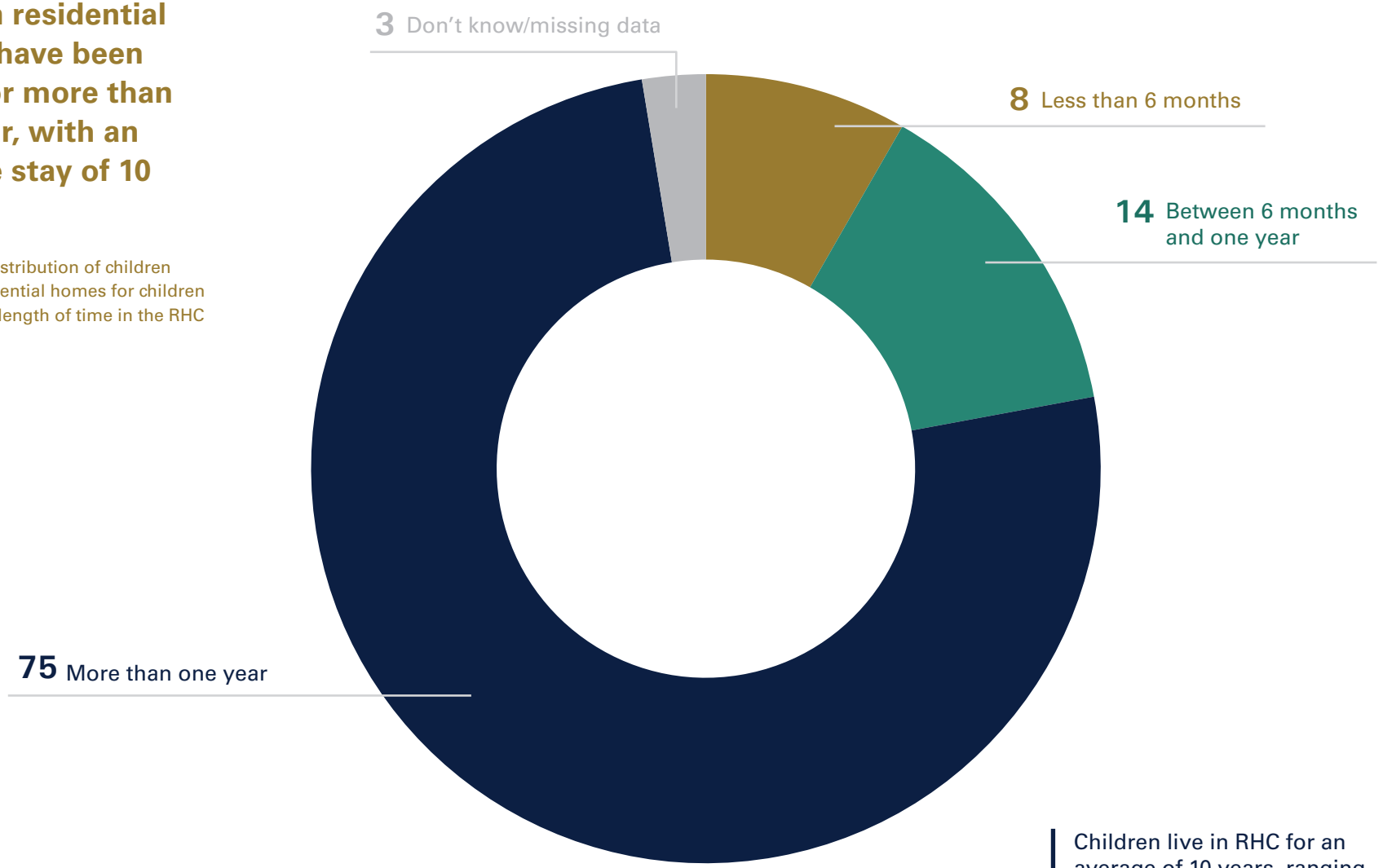


FIGURE 19

Three in four children living in residential homes have been there for more than one year, with an average stay of 10 years

Percentage distribution of children living in residential homes for children in Ghana, by length of time in the RHC



Children live in RHC for an average of 10 years, ranging from less than 2 months to nearly 18 years

KEY TERMS USED IN THIS SECTION

COURT ORDER

Defined in the Children's Act as an order issued by the Family Tribunal to remove the child from a situation where she or he is suffering or likely to suffer significant harm and to transfer the parental rights to the Department of Social Welfare. Children require a court order to be placed in an RHC. Residential homes for children may admit children in emergency situations, but must inform the Department of Social Welfare within 24 hours of a child's arrival. The Department of Social Welfare has the responsibility to obtain a court order within seven days of the child's arrival in a RHC.

BIRTH REGISTRATION

Children under age 5 who were registered at the time of the survey. The numerator of this indicator includes children reported to have a birth certificate, regardless of whether or not it was seen by the interviewer, and those without a birth certificate whose caregiver says the birth has been registered.

NON-VIOLENT DISCIPLINE

Explaining why a behaviour is wrong, taking away privileges, or giving the child something else to do.

PHYSICAL PUNISHMENT

Shaking, hitting or slapping a child on the hand/arm/leg, hitting on the bottom or elsewhere on the body with a hard object, spanking or hitting on the bottom with a bare hand, hitting or slapping on the face, head or ears, and hitting or beating hard and repeatedly.

SEVERE PHYSICAL PUNISHMENT

Hitting or slapping a child on the face, head or ears, or hitting or beating a child hard and repeatedly.

PSYCHOLOGICAL AGGRESSION

Shouting, yelling or screaming at a child, as well as calling a child offensive names such as 'dumb' or 'lazy'.

VIOLENT DISCIPLINE

Any physical punishment and/or psychological aggression.

DO CHILDREN LIVING IN RESIDENTIAL CARE RECEIVE SUFFICIENT CASE MANAGEMENT AND WHAT ARE THE MAIN PROTECTION ISSUES THEY FACE?

FIGURE 20

Just over half of children in RHC have an assigned caseworker, while about one third are without an individual care plan

Percentage of children living in residential homes for children in Ghana, by case management characteristics

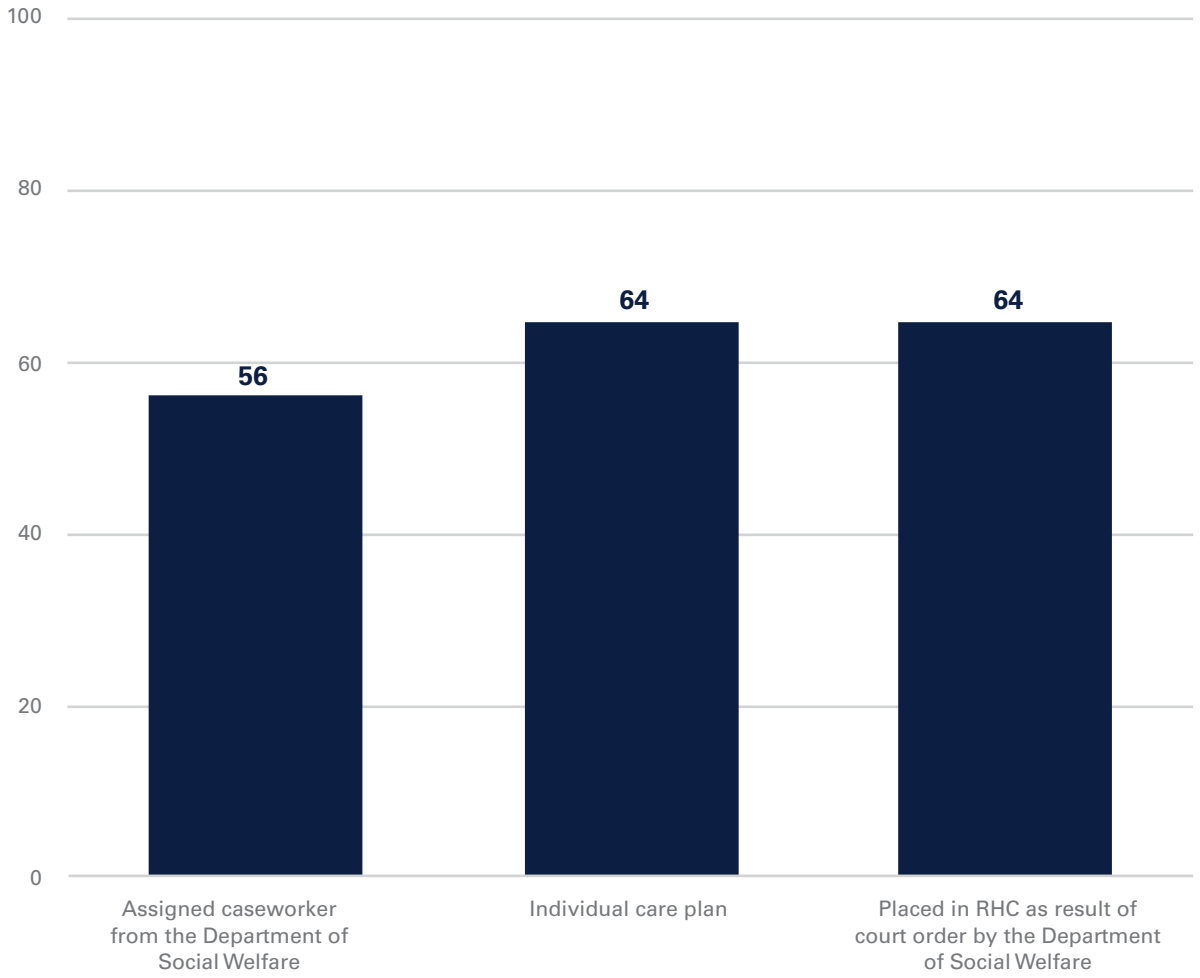
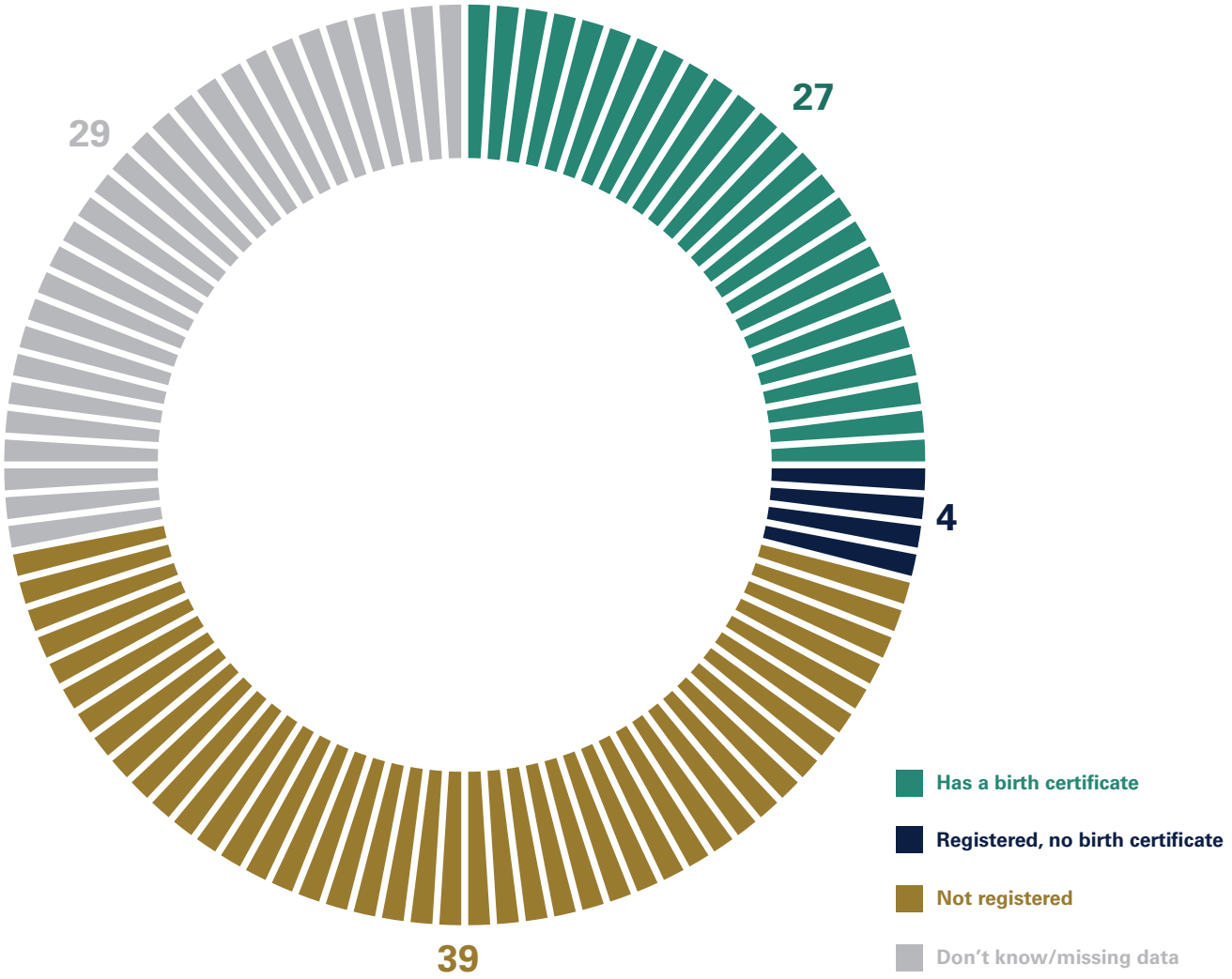


FIGURE 21

Close to one third of children in RHC have had their births registered, nearly 40 per cent have not, and birth registration information for a significant portion of others was either missing or unknown

Percentage distribution of children living in residential homes for children in Ghana, by birth registration status

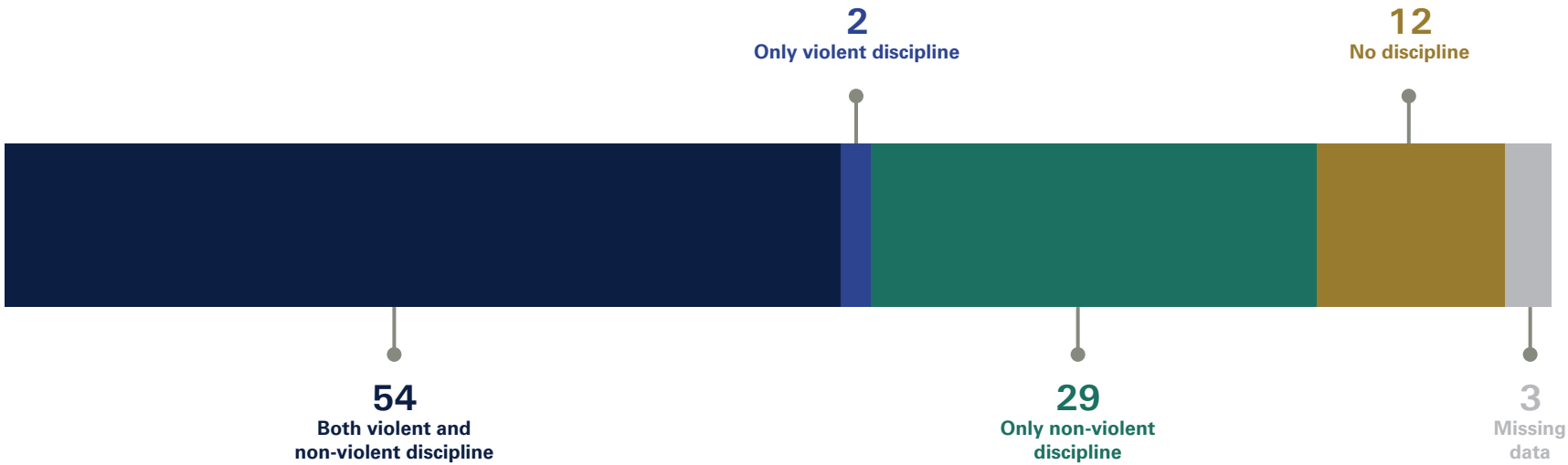


Note: Figures do not add up to 100 per cent due to rounding.

FIGURE 22

More than half of children in RHC are reportedly exposed to violent forms of discipline

Percentage distribution of children aged 1 to 17 years living in residential homes for children in Ghana, by type of discipline experienced in the past month

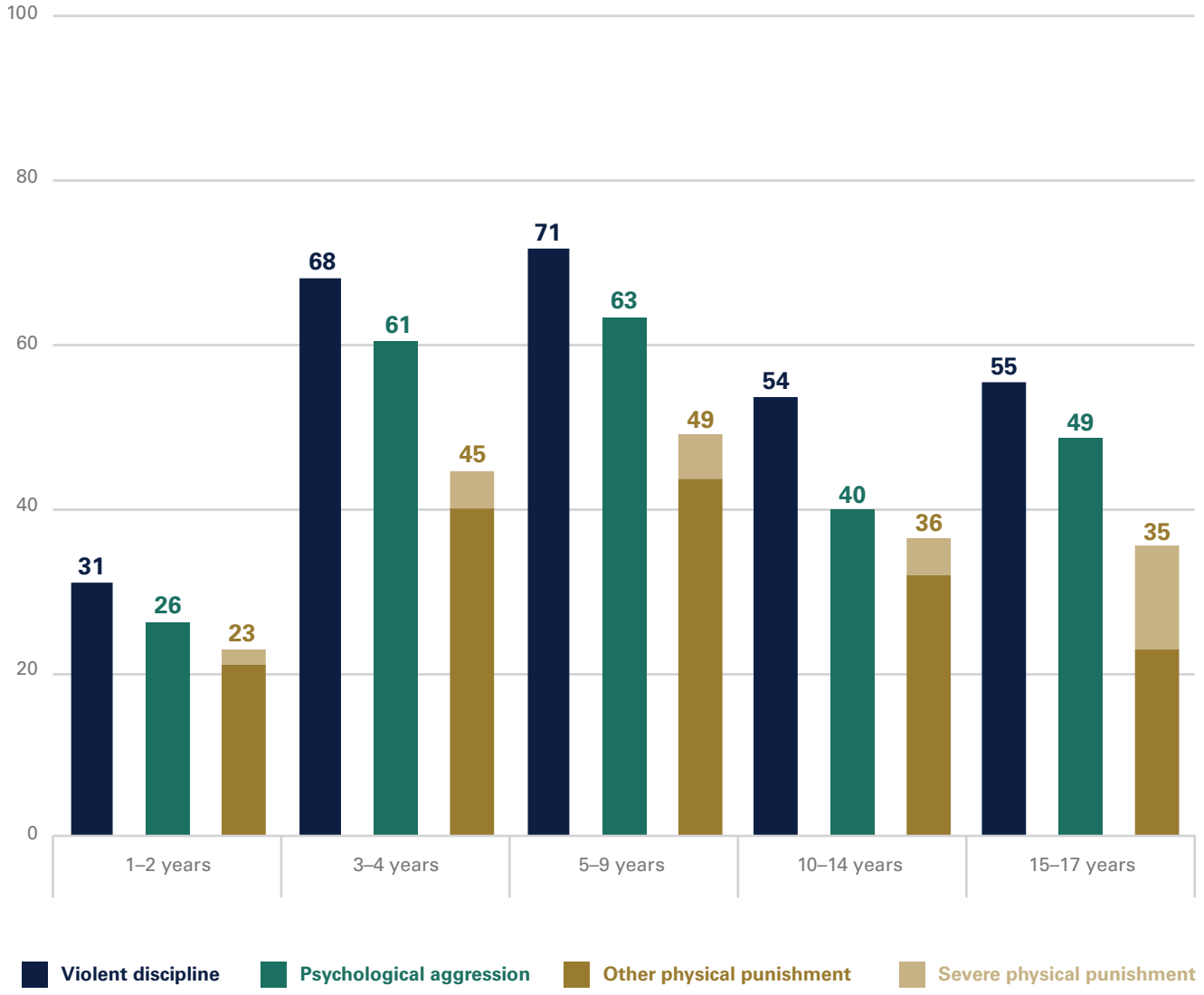


Note: For children aged 1 to 14 years, respondents to the child discipline module were caregivers; for adolescents aged 15 to 17, respondents were the adolescents themselves.

FIGURE 23

Among children living in residential homes, exposure to violent discipline tends to peak from ages 5 to 9 years; older adolescents (aged 15 to 17) reported the highest level of severe physical punishment

Percentage of children aged 1 to 17 years living in residential homes for children in Ghana, by age and type of violent discipline experienced in the past month

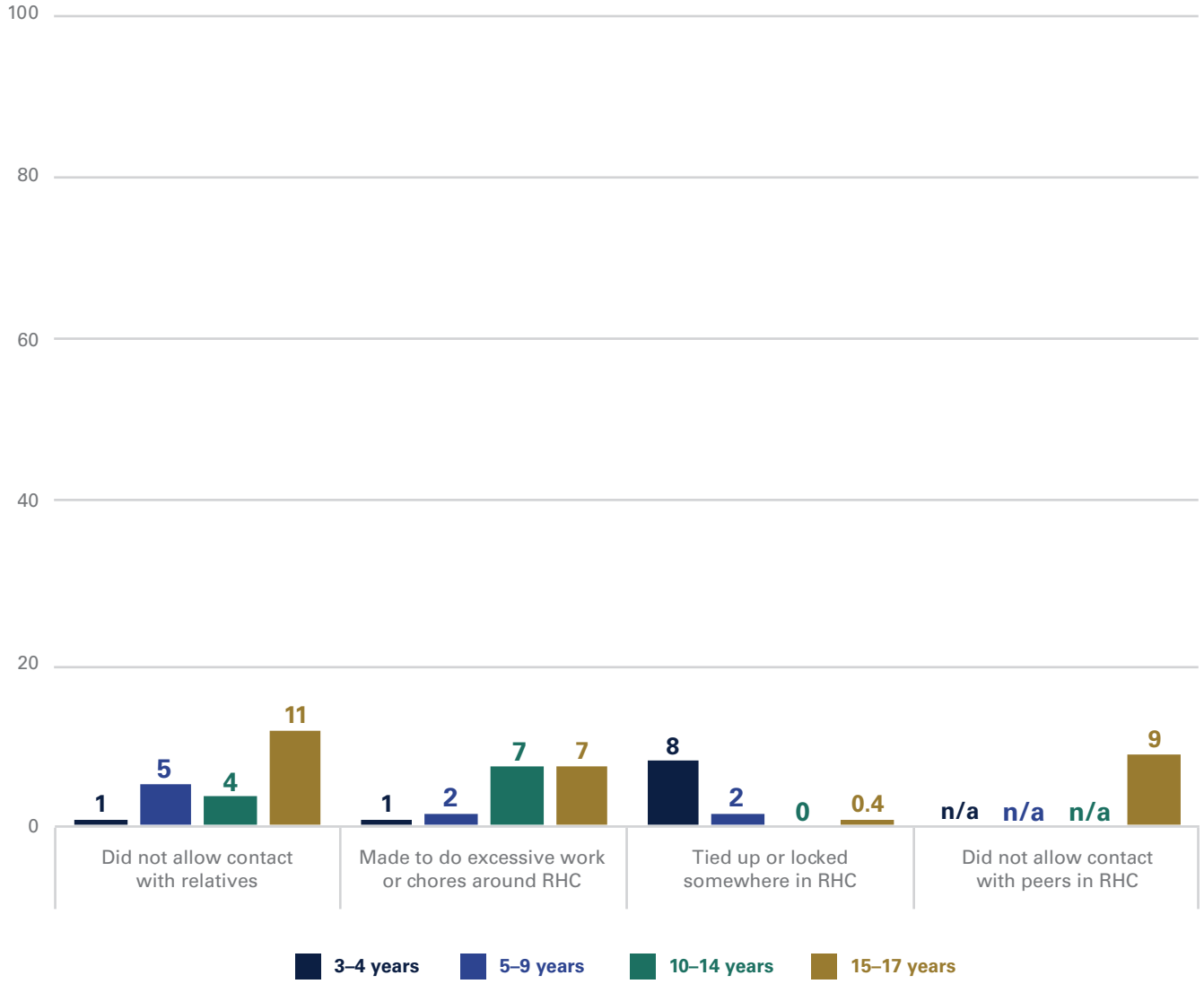


Notes: For children aged 1 to 14 years, respondents to the child discipline module were caregivers; for adolescents aged 15 to 17, respondents were the adolescents themselves. Data for children aged 1 to 2 years should be interpreted with caution since they are based on 25-49 unweighted cases.

FIGURE 24

One in 12 very young children were reportedly tied or locked up as a form of discipline

Percentage of children aged 3 to 17 years living in residential homes for children in Ghana, by age and type of discipline experienced in the past month



Notes: There were no reported experiences of other types of discipline among children aged 1 to 2 years. The question about restricting contact with peers in the RHC as a form of discipline was only asked of adolescents aged 15 to 17 years. For children aged 1 to 14 years, respondents to the child discipline module were caregivers; for adolescents aged 15 to 17, respondents were the adolescents themselves.

KEY TERMS USED IN THIS SECTION

EARLY CHILDHOOD EDUCATION
Includes any early childhood education programme such as day care, nursery school or kindergarten.

FOUNDATIONAL NUMERACY SKILLS
Children who successfully completed four foundational number tasks.

FOUNDATIONAL READING SKILLS
Children who successfully completed three foundational reading tasks.

WHAT IS THE EDUCATIONAL STATUS OF CHILDREN LIVING IN RESIDENTIAL CARE?

FIGURE 25

Three quarters of young children in RHC are attending early childhood education, with no significant disparities found by sex

Percentage of children aged 3 to 4 years living in residential homes for children in Ghana who are attending early childhood education, by sex

Note: Data for boys and girls should be interpreted with caution since they are based on 25-49 unweighted cases.

FIGURE 26

Among children living in RHC, attendance in primary school is much higher than attendance in secondary school

Percentage of children of primary school age living in residential homes for children in Ghana who are attending primary or secondary school, percentage of children of lower secondary school age living in such homes who are attending lower secondary school or higher, and percentage of children of upper secondary school age living in such homes who are attending upper secondary school or higher

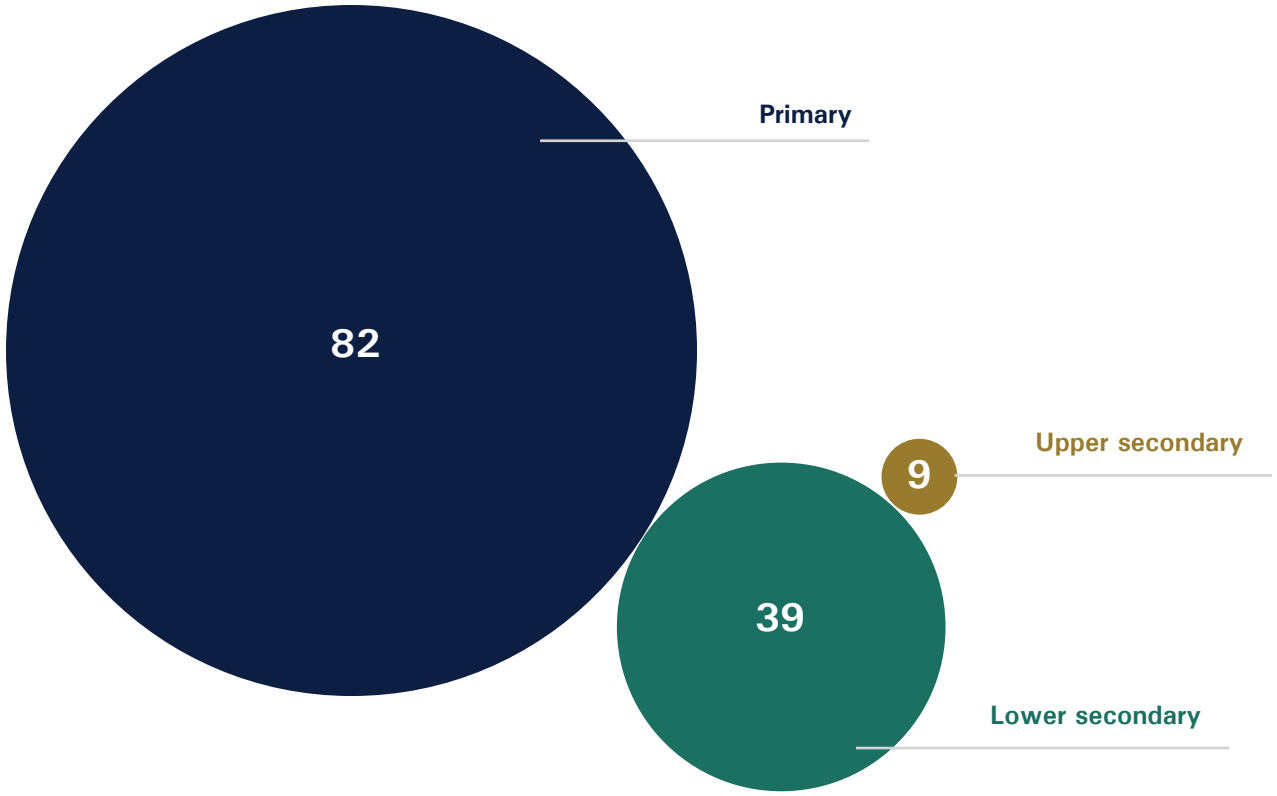


FIGURE 27

Only one third of children in RHC have foundational reading skills, while a much lower proportion have foundational numeracy skills

Percentage of children of grade 2/3 age living in residential homes for children in Ghana with foundational reading skills and foundational numeracy skills

33 per cent
have foundational reading skills

13 per cent
have foundational numeracy skills

Note: Data should be interpreted with caution since they are based on 25-49 unweighted cases.

KEY TERMS USED IN THIS SECTION

EARLY STIMULATION AND RESPONSIVE CARE

Staff or volunteers have engaged in at least four of the following activities in the past three days: reading books to the child; telling stories to the child; singing songs to the child; playing with the child; and naming, counting or drawing things with the child.

LARGE FACILITY

RHC with 30 or more children, as defined by the National Standards for Residential Care for Children in Ghana.

SMALL FACILITY

RHC with less than 30 children, as defined by the National Standards for Residential Care for Children in Ghana.

EARLY CHILDHOOD DEVELOPMENT

Literacy-numeracy: Children are identified as being developmentally on track based on whether they can identify/name at least 10 letters of the alphabet, read at least four simple, popular words, and know the name and recognize the symbols of all numbers from 1 to 10. If at least two of these are true, then the child is considered developmentally on track in the literacy-numeracy domain.

Physical: If the child can pick up a small object with two fingers, like a stick or a rock from the ground, and/or the caregiver does not indicate that the child is sometimes too sick to play, then the child is regarded as being developmentally on track in the physical domain.

Social-emotional: Children are considered to be developmentally on track in the social-emotional domain if two of the following are true: If the child gets along well with other children, if the child does not kick, bite or hit other children, and if the child does not get distracted easily.

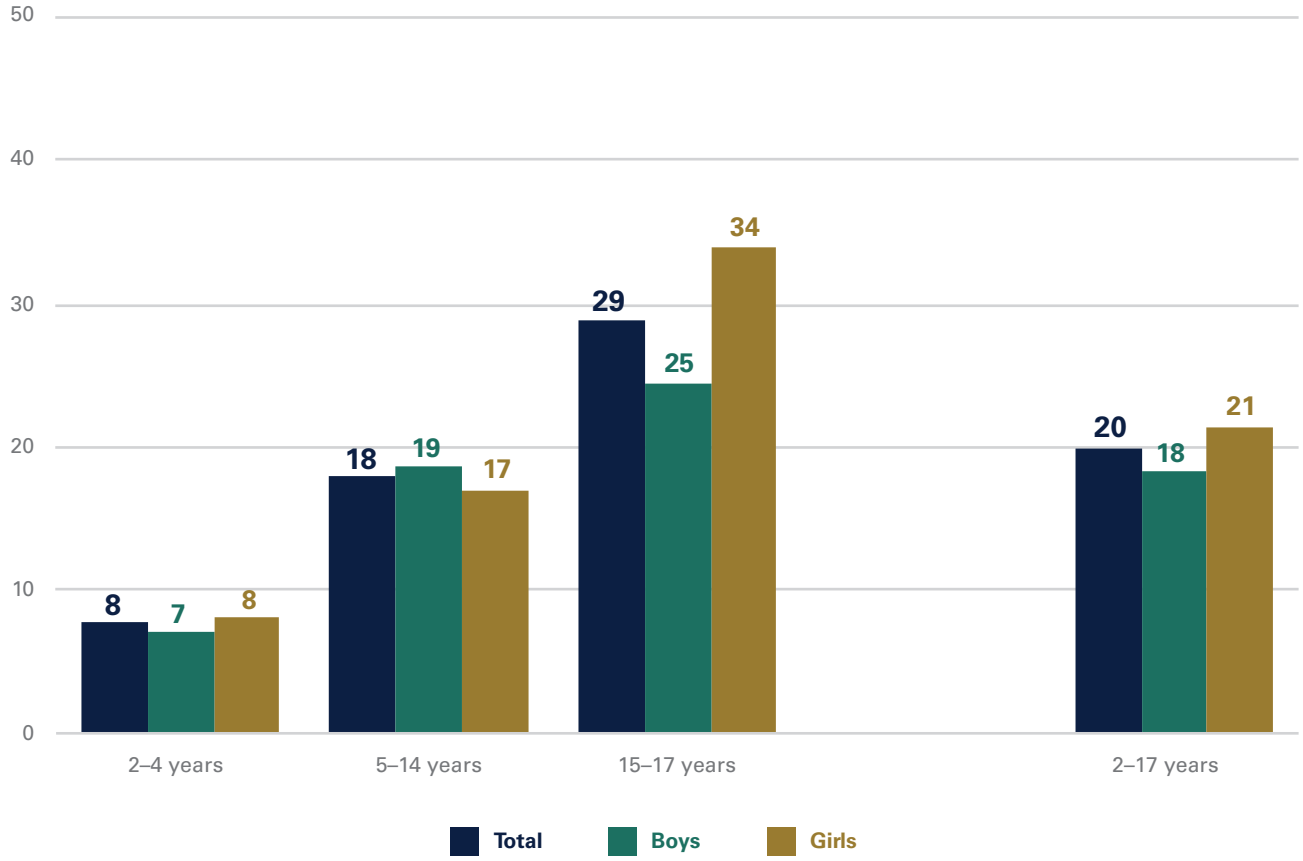
Learning: If the child follows simple directions on how to do something correctly and/or when given something to do is able to do it independently, then the child is considered to be developmentally on track in the learning domain.

WHAT IS THE LEVEL OF FUNCTIONAL DIFFICULTY AMONG CHILDREN LIVING IN RESIDENTIAL CARE AND DO THEY RECEIVE APPROPRIATE STIMULATION AND CARE TO SUPPORT THEIR DEVELOPMENT?

FIGURE 28

One in five children in residential homes have difficulty functioning in at least one domain

Percentage of children aged 2 to 17 years living in residential homes for children in Ghana with functional difficulty in at least one domain, by age



Notes: For children aged 2 to 14 years, respondents to the child functioning module were caregivers; for adolescents aged 15 to 17, respondents were the adolescents themselves. Data for children aged 2 to 4 years by sex should be interpreted with caution since they are based on 25-49 unweighted cases.

TABLE 1

The most commonly reported functional difficulties were in learning

Percentage of children aged 2 to 17 years living in residential homes for children in Ghana with functioning difficulty in at least one domain, by age and domain

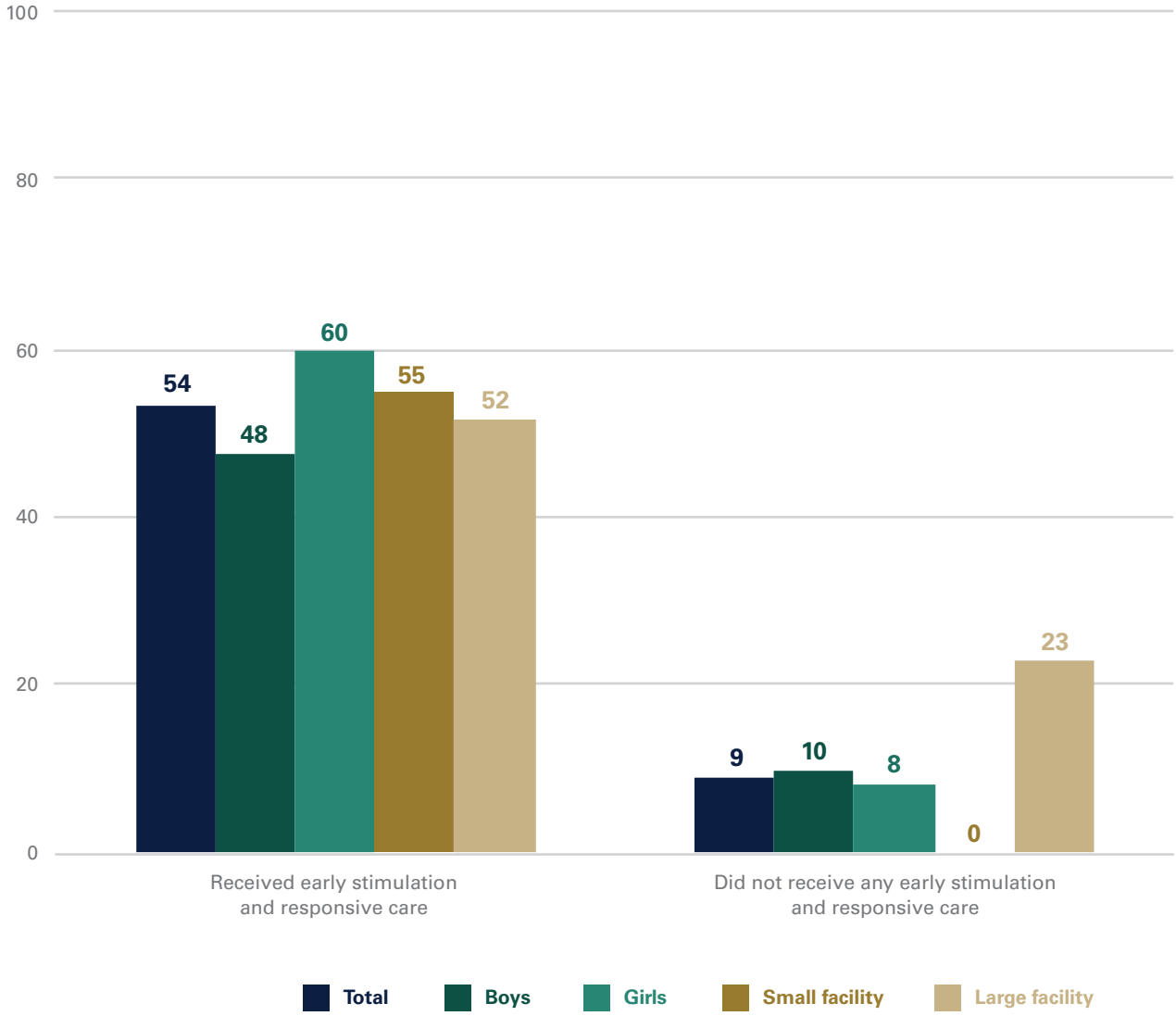
	Seeing	Hearing	Walking	Fine motor	Communication	Learning	Playing	Controlling behaviour	Self-care	Remembering	Concentrating	Accepting change	Making friends	Anxiety	Depression
2–4 years	3	0	7	5	6	6	3	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5–14 years	1	1	2	n/a	4	7	n/a	4	3	7	3	4	5	3	3
15–17 years	4	1	4	n/a	0.4	9	n/a	4	0	4	2	5	5	8	4

Note: For children aged 2 to 14 years, respondents to the child functioning module were caregivers; for adolescents aged 15 to 17, respondents were the adolescents themselves.

FIGURE 29

Close to 1 in 4 young children living in large residential homes do not receive any stimulation or responsive care

Percentage of children aged 2 to 4 years living in residential homes for children in Ghana with whom any staff or volunteer has engaged in four or five activities over the past three days and percentage of children aged 2 to 4 years living in such homes with whom no staff or volunteer engaged in any activities over the past three days, by child's sex and size of the residential home



Note: Data by sex and by the size of the RHC should be interpreted with caution since they are based on 25-49 unweighted cases.

FIGURE 30

Young children living in RHC are more likely to receive forms of stimulation that can be delivered in groups, such as playing or singing songs, as opposed to those requiring more one-on-one interaction

Percentage of children aged 2 to 4 years living in residential homes for children in Ghana receiving early stimulation and responsive care in the past three days by any staff or volunteer, by type of activity

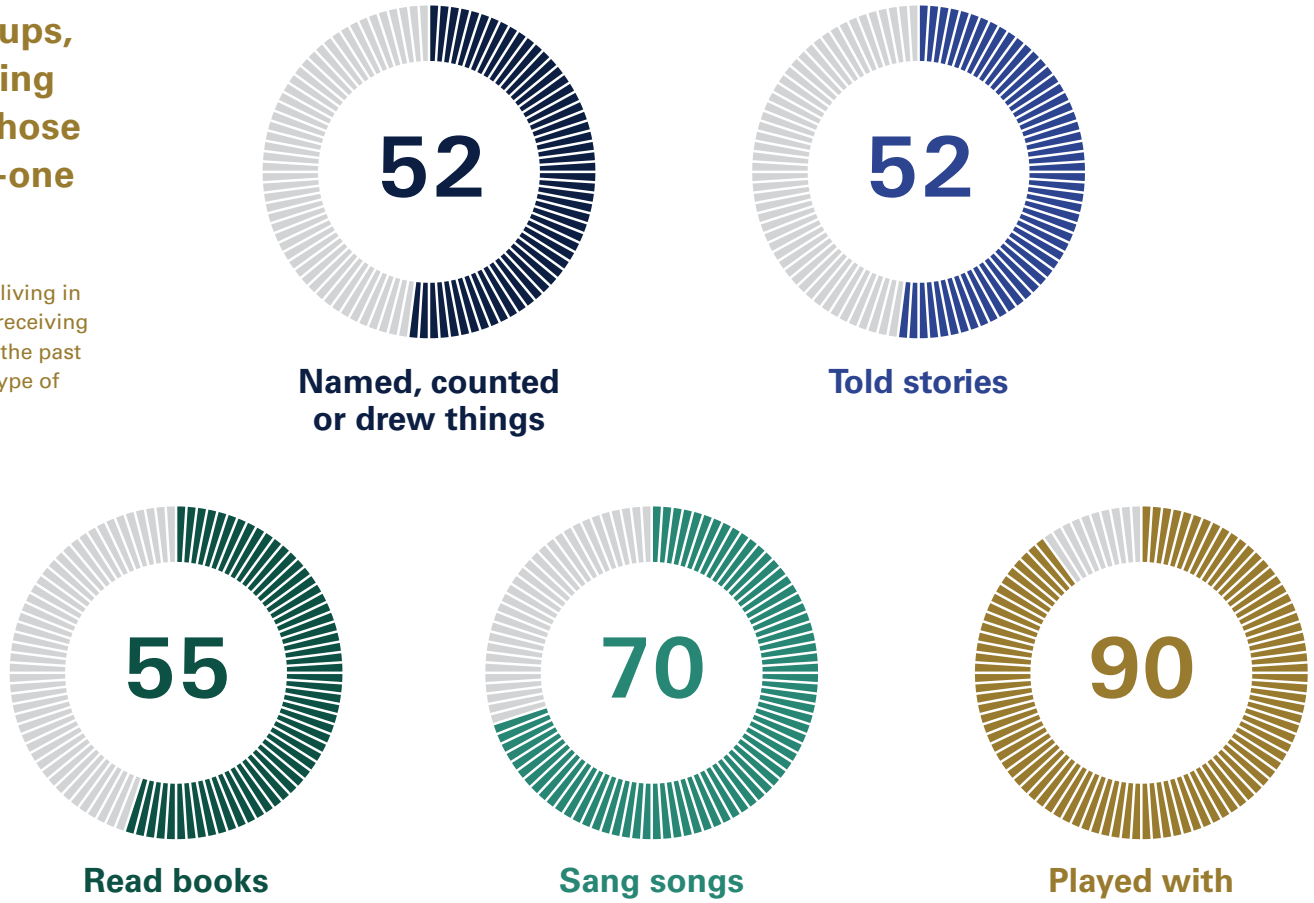
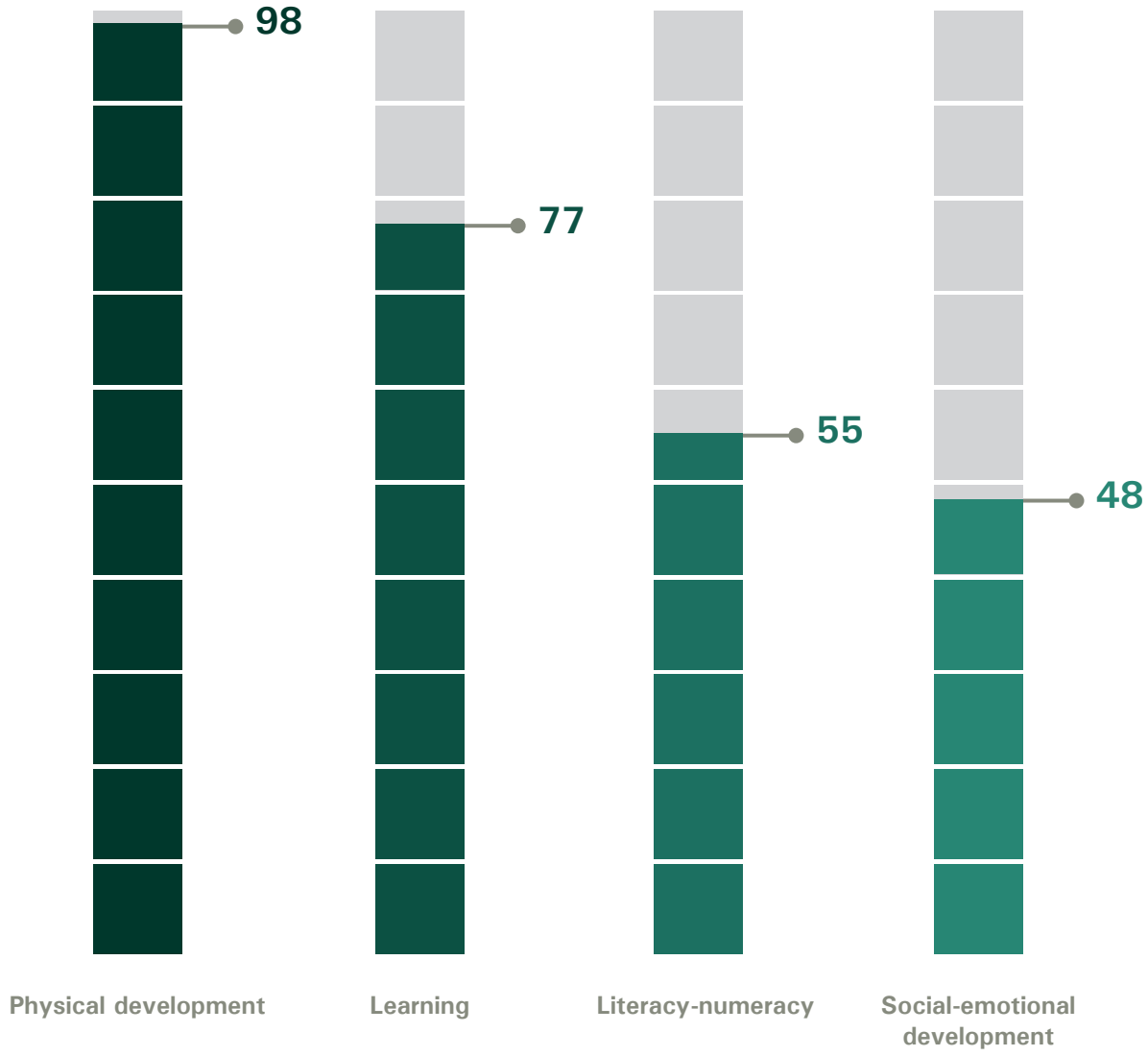


FIGURE 31

Less than half of young children living in RHC are developmentally on track in terms of social-emotional development

Percentage of children aged 3 to 4 years living in residential homes for children in Ghana who are developmentally on track, by domain



KEY TERMS USED IN THIS SECTION

OVERWEIGHT (MODERATE AND SEVERE)
Children under age 5 who are above two standard deviations of the median weight for height of the World Health Organization (WHO) standard.

STUNTED (MODERATE AND SEVERE)
Children under age 5 who fall below minus two standard deviations of the median height for age of the WHO standard.

UNDERWEIGHT (MODERATE AND SEVERE)
Children under age 5 who fall below minus two standard deviations of the median weight for age of the WHO standard.

WASTED (MODERATE AND SEVERE)
Children under age 5 who fall below minus two standard deviations of the median weight for height of the WHO standard.

WHAT IS THE NUTRITIONAL STATUS OF YOUNG CHILDREN LIVING IN RESIDENTIAL CARE?

FIGURE 32

Forty per cent of children under age 5 living in residential homes in Ghana are moderately or severely stunted

Percentage of children under age 5 living in residential homes for children in Ghana who are overweight, wasted, underweight or stunted

KEY TERMS USED IN THIS SECTION

Many of the questions included in the violence and unintentional injuries module were taken or adapted from WHO's Global School-based Student Health Survey. The measure used to assess resilience is the Child and Youth Resilience Measure (CYRM-R), Youth version.

BULLYING

Occurs when someone or a group of people say or do bad and unpleasant things to another person. It is also bullying when someone is teased a lot in an unpleasant way or left out of things on purpose. It is not bullying when two people of about the same strength or power argue or fight or when teasing is done in a friendly and fun way.

PHYSICAL ATTACK

Occurs when one or more people hit or strike someone, or when one or more people hurt another person with a weapon (such as a stick, knife or gun). It is not a physical attack when two people of about the same strength or power choose to fight each other.

PHYSICAL FIGHT

Occurs when two people of about the same strength or power choose to fight each other.

SERIOUS INJURY

An injury is defined as serious when it makes a person miss at least one full day of usual activities (such as school, sports or a job) or requires treatment by a doctor or nurse.

RESILIENCE

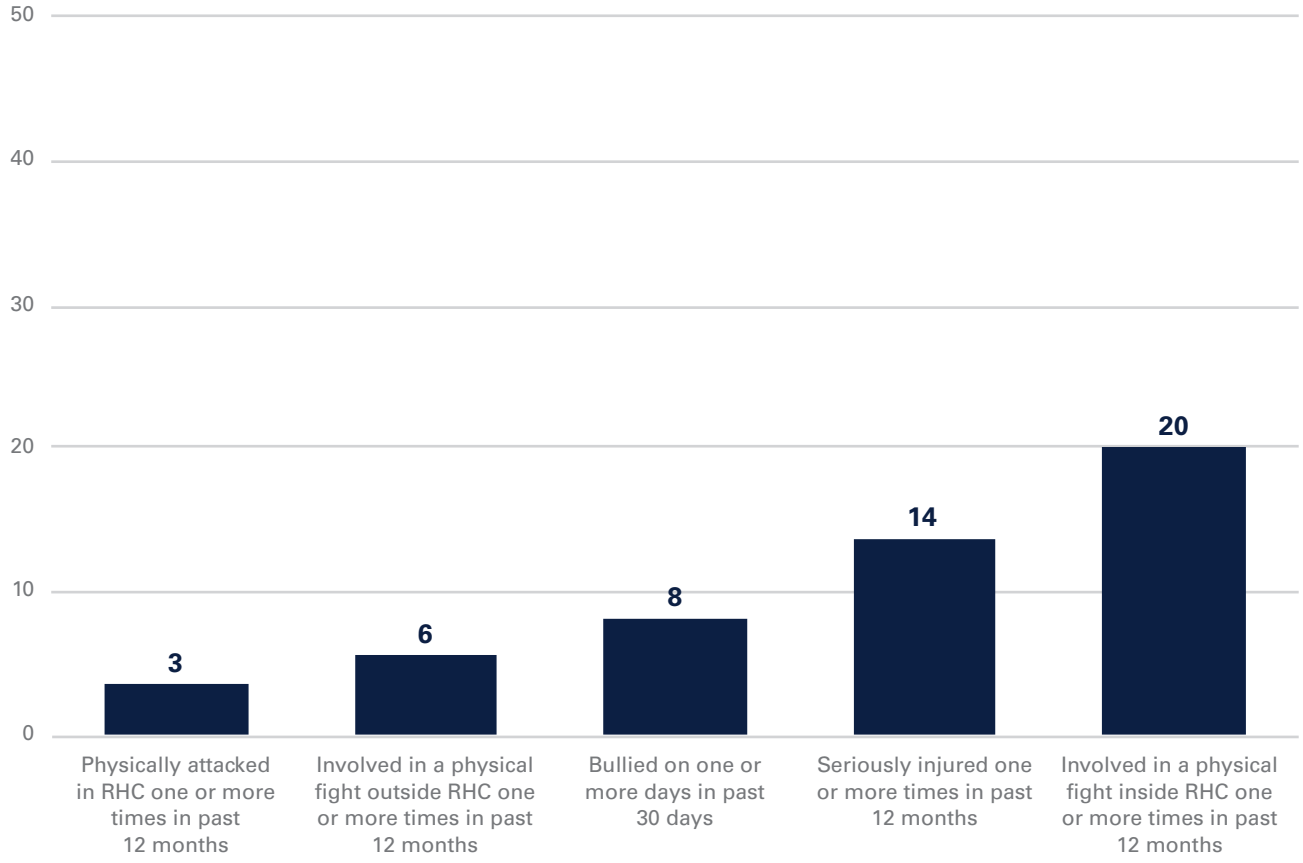
Generally refers to an individual's ability to overcome adversity and continue with his/her 'normal' development, routines and lifestyle. The measure of resilience (CYRM-R) includes items assessed on a 3-point scale to indicate the frequency with which the adolescent feels that the statement applies to him/her. For all items, the response options are: no, sometimes or yes.

HOW MUCH ARE ADOLESCENTS IN RESIDENTIAL CARE EXPOSED TO VIOLENCE AND WHAT IS THEIR LEVEL OF RESILIENCE?

FIGURE 33

One in five adolescents reported having been involved in a physical fight inside the residential home in the past year, while 1 in 7 have been seriously injured one or more times over the same period

Percentage of adolescents aged 15 to 17 years living in residential homes for children in Ghana who were physically attacked in the RHC one or more times in the past 12 months, involved in a physical fight inside the RHC one or more times in the past 12 months, involved in a physical fight outside the RHC one or more times in the past 12 months, seriously injured one or more times in the past 12 months, or bullied on one or more days in the past 30 days

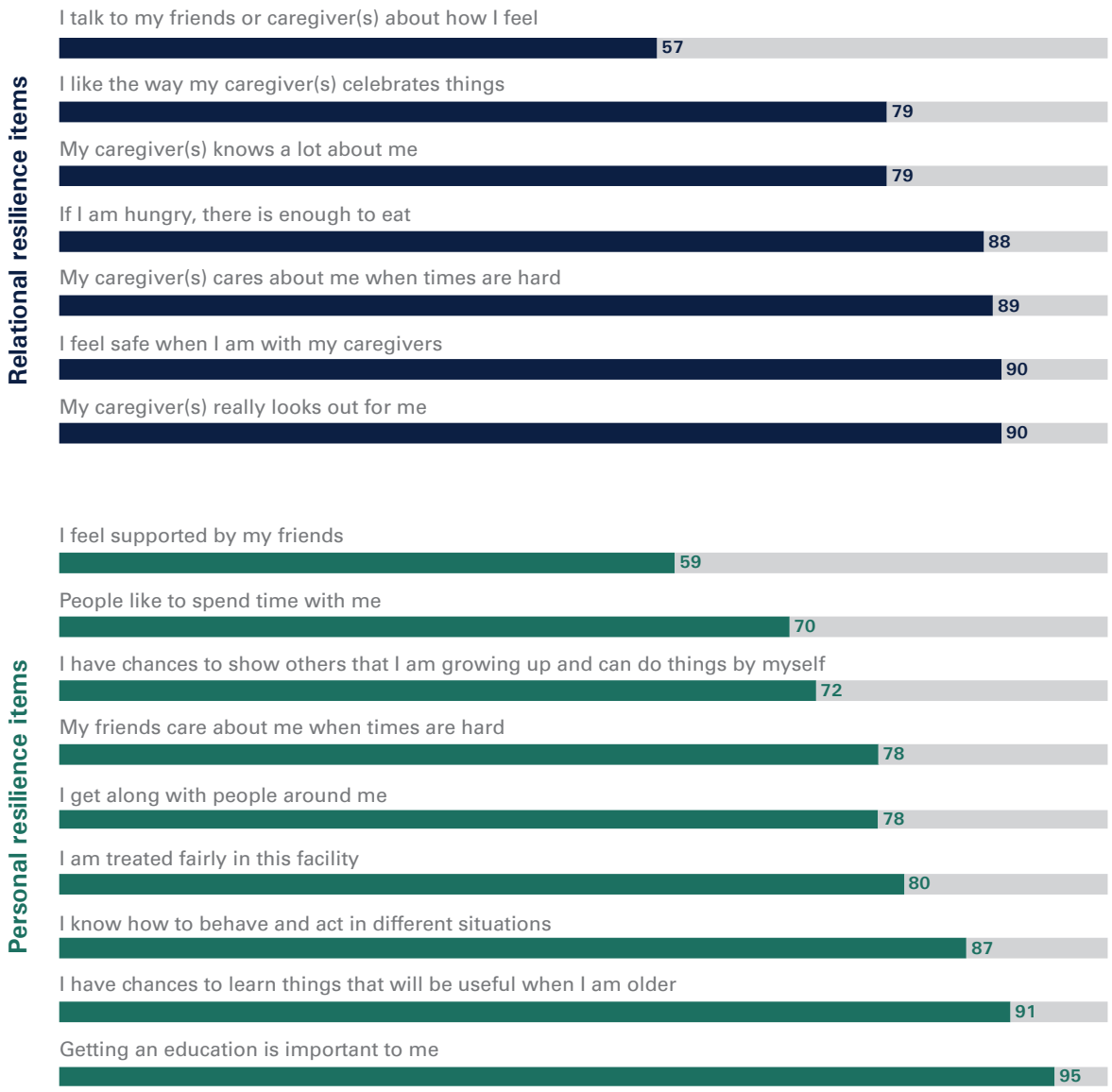


Note: These data are based on self-reports by adolescents.

FIGURE 34

Almost all adolescents living in residential homes said that getting an education is important to them; they are less likely to feel connected to and supported by caregivers and friends

Percentage of adolescents aged 15 to 17 years living in residential homes for children in Ghana who responded 'yes' to various statements about relational and personal resilience



Note: These data are based on self-reports by adolescents.

ADVANCING THE RIGHTS OF CHILDREN IN RESIDENTIAL CARE

In Ghana, residential care has historically been the main option for formal alternative care of children when parents or extended families are unable or unwilling to provide for them. The period between 1996 and 2006 saw a dramatic increase in the number of RHC, rising from 13 to 148. In response, the Care Reform Initiative was launched in 2007, under the Department of Social Welfare, to prevent unnecessary separation, close down substandard RHC and reintegrate children with families. Emphasis was placed on family strengthening and family-based care alternatives, including kinship care and formal foster care.

Since the establishment of the Care Reform Initiative, a series of successes can be attributed to it, notably in the legal and policy framework. These include the passing of the Child and Family Welfare Policy, the amendment to the Children's Act, and the accession to the 1993 Hague Convention on Inter-country Adoption in 2017. They also include the passage of regulations on foster care and adoption in 2018, the accreditation of foster care and adoption agencies, and the release of standards for residential homes for children and standards for foster care. Despite these important advances, results have been slow due to a number of factors, including a lack of reliable and accurate data on the number of residential care facilities and children who reside there.

The 2019 survey revealed that the number of privately run RHC across the country has decreased. This positive development can be attributed to the work carried out under the Care Reform Initiative over the years, which has recently been strengthened through programme activities financed by USAID's Displaced Children and Orphans Fund. However, it was also discovered that about one in five homes have been open for less than six years, despite the fact that the Department of Social Welfare has not registered any new RHC since 2016. Regional disparities were also found, with just over half of all RHC countrywide located in three regions (Ashanti, Eastern and Greater Accra). It is noteworthy that many RHC are voluntarily scaling back on the number of children they admit, which has resulted in an overall decrease in the number of children in residential care – from around 4,500 in 2012[17] to around 3,500 in 2019, according to the survey results.

SUMMARY OF FINDINGS AND POLICY IMPLICATIONS

LICENSING. Despite the amended Children's Act, 1998 (Act 560), the Child Rights Regulations, 2003 (legal instrument no. 1705) and the 2018 National Standards for Residential Homes for Children in Ghana, which require all RHC to be licensed, only one third were found to be operating with a valid licence. This is due, in part, to inadequate government budget allocations to the Department of Social Welfare, which limits the ability of national, regional and district staff to conduct the joint inspections necessary to grant RHC licences.

VOLUNTOURISM. Volunteering in residential care facilities continues to be a popular activity in Ghana, especially for young travellers, many of whom combine a week or more of 'giving back' in a residential home with more typical tourist activities. Most people who want to volunteer have good intentions. However, this has proved to be misguided. In fact, 'voluntourism' has been shown to not only affect children's well-being negatively, but also to actively encourage the proliferation of residential homes.[18] The survey revealed that close to half of RHC using volunteers hosted foreign nationals. Also troubling is the fact that only about half of the RHC were found to conduct police or other background checks on staff and/or volunteers, which could potentially pose a direct threat to vulnerable children. Another source of concern is the fact that international organizations continue to fuel the 'orphanage industry' and constitute an important source of funding for RHC, according to the survey. This could jeopardize national efforts to shift to a family-based care system that emphasizes family and community strengthening.

CHILD WELL-BEING. Data from this survey suggest that some of the basic needs of children living in RHC are being met, such as those related to accessing basic drinking water and sanitation services and education. However, the data also show that living in institutions has harmful effects on children's health, development and opportunities throughout their lives: Forty per cent of children under age 5 living in RHC in Ghana are moderately or severely stunted; more than half are exposed to violent disciplinary methods; only one third of children have foundational reading skills while a much lower proportion have foundational numeracy skills; and 1 in 5 older adolescents were involved in a physical fight inside the RHC within the past year. These

conditions are unacceptable and highlight the statutory obligation of district assemblies to conduct quarterly (or more frequent, as required) inspection and monitoring visits of RHC, to ensure that children are receiving adequate care and protection and that their rights are not being violated.

It is important to reiterate here that there are subtle nuances to the living situations of these children that are not, and cannot, be reflected in survey data of this nature. In other words, the data presented in this report cannot adequately portray the full experience of children living in residential care. Nor can they capture the long-term effects that institutionalization can have on children's future health and well-being.

FAMILY REUNIFICATION. On a more positive note, the vast majority of children who exited RHC in the 12 months preceding the survey were reunited with parents or relatives. This demonstrates that reunification efforts are yielding results. However, it is vital that district assemblies continue to dedicate sufficient energy and resources to ensuring sustainable reintegration within families and communities.

INSTITUTIONALIZATION AS A LAST RESORT AND TEMPORARY MEASURE. The placement of children in residential care should be a last resort and children should remain there for the shortest amount of time possible. That said, the survey revealed that children in RHC in Ghana have been there for nearly 10 years, on average. Evidence shows that the placement of children under age 3 in family-based care alternatives (that is, formal foster care) pending reunification with family or adoption must continue to be prioritized to minimize the negative impacts on the development of these children.[19] The survey confirms that residential care facilities are not, in fact, 'orphanages', since around two in three children living in RHC have at least one living biological parent who could potentially take care of them if they were targeted for appropriate holistic support. While not directly confirmed by this survey, it is clear from other surveys that poverty is the key driver for the institutionalization of children in Ghana.[20] However, poverty – monetary or material – should never be the only justification for removing a child from parental care, receiving a child into residential care, or preventing his/her reintegration.[21] What poverty does signal is the need for the Government to provide appropriate support to families.[22] When a child has been placed in alternative care, it should be temporary, while the Government actively explores the possibility of family reintegration or, if this is not possible, alternative care in a family setting.[23]

ROLES AND RESPONSIBILITIES OF DISTRICT OFFICERS. District social welfare officers need to be actively involved in the assessment of children before they are admitted to an RHC in order to identify and make use of family-based care alternatives. This will ensure that children are only admitted into residential care as a last resort and for the shortest period possible.

Even though Ghana has put in place strong gatekeeping mechanisms, the fact that one in three children still do not have a court order for their placement in residential care is a cause for concern. Placements of children in RHC must be authorized by a court order, and it is the responsibility of district social welfare officers to obtain this. Many children in RHC have been admitted without the involvement of social welfare officers, meaning that these children were taken into residential homes in defiance of Ghanaian law. District social welfare officers need to play a more active role in the case management of children in RHC, participating in the development of care plans and ensuring that they encompass reintegration and/or a permanent family placement. The fact that only half of the children in RHC have an assigned caseworker from the Department of Social Welfare while about one third are without an individual care plan is distressing; it also undermines the possibility of these children being permanently placed in a family-based care alternative.

GENERATING EVIDENCE AS A STARTING POINT FOR REFORM. Finally, the survey showed that a functional administrative system for tracking children in residential care is critical, but that this is still lacking in Ghana. The Ministry of Gender, Children and Social Protection and its partners have developed a digital Social Welfare Information Management System (SWIMS); however, it does not necessarily include all children in residential care. SWIMS is a case management tool used to help district social welfare officers and RHC to better manage child protection cases, including children without parental care, and to generate routine data on their situation. However, the roles and responsibilities of national, regional and

district officers from the Department of Social Welfare need to be further strengthened if they are to deliver on the Government's statutory mandate in relation to children in RHC. Strong political will at decentralized levels is needed to ensure that robust data on RHC and the children living within their walls are available – the starting point for implementing the care reform agenda.

By producing high-quality and reliable data, the survey described in this report represents a milestone. Such data will help government officials track progress in implementing care reform initiatives and plan how best to accelerate the process. The Ministry, with support from the Department of Social Welfare, is committed to ensuring that up-to-date data on children in alternative care are available for planning and decision-making, as well as for monitoring and evaluating programmes at all levels. Beyond providing baseline data, findings from the survey have enhanced understanding of the effectiveness of various actions undertaken by the Government and its partners to improve the lives of children in Ghana. With this knowledge, stakeholders can critically review strategies and interventions, enabling them to redirect – and redouble – efforts to achieve positive outcomes for children.

ANNEXES

ANNEX 1. TECHNICAL NOTES ON THE DATA

In addition to basic information on the children, the Phase Two survey also collected data on involvement in economic activities and engagement in chores (such as cooking and cleaning) around the RHC among children and adolescents aged 5 to 17 years. The results revealed low levels of children's involvement overall in these types of activities. The findings were generally inconclusive and therefore are not included here.

Additionally, data were collected for adolescents aged 15 to 17 years on symptoms of anxiety and depression as measured by the Revised Children's Anxiety and Depression Scale (RCADS). Upon further examination of the results, it was felt that the measure was not sensitive or specific enough to reliably report on symptoms of anxiety and depression among this population, and the findings were generally inconclusive. For this reason, the data are not presented here. The questionnaire for adolescents aged 15 to 17 also included questions on perpetrators of physical attacks, types and causes of injuries, and perpetrators and types of bullying. However, estimates had to be suppressed due to low denominators (that is, fewer than 25 unweighted cases).

Low denominators also impacted a number of education and child health indicators for which estimates could not be produced.

The proportion of children under age 5 with a reported episode of diarrhoea, symptoms of acute respiratory infection or a fever in the two weeks preceding the survey were much lower than expected in comparison with results from household surveys. A combination of factors, including potential reporting issues, likely contributed to the unexpected results.

All figures in percentages have been rounded.

ANNEX 2. SAMPLE DESIGN AND WEIGHTING PROCEDURES

The major features of the sample design for Phase Two are described in this annex. Sample design features include defining the sampling frame, target sample size, sample allocation, stratification and sampling stages. The primary objective of the sample design was to produce statistically reliable and representative estimates of the indicators, at the national level.

A two-stage stratified sampling approach was used. The census frame generated in Phase One was used to select a sample of facilities for Phase Two. The primary sampling units (PSUs) selected at the first stage are the facilities, and a fixed number of children per facility is selected at the second stage.

2.1 SAMPLING FRAME OF RHC AND CHILDREN

The initial sampling frame had 148 RHC. However, eight of these were not eligible because they were closed, and one was not eligible because it only had residents aged 18 years and older. The final valid sampling frame, therefore, had a total of 139 eligible RHC with 3,530 children. In reviewing the distribution in the frame by the number of children, it was found that nine RHC had fewer than five children, and the decision was made to exclude these from the frame. As a result, there were 130 RHC in the final sampling frame used for selecting the sample homes for Phase Two: 3 Government-run RHC and 127 private RHC. The 130 eligible RHC in the frame had a total of 3,505 children.

Computer-Assisted Personal Interviews (CAPI) were used for Phase One data collection. A database with the roster of all the enumerated children in each home was used to determine the total number of children in each home by age group. This information was incorporated into the sampling frame of RHC for determining the stratification. Table 1 shows the distribution of RHC and children in the Phase One frame by the combination of age groups found in each home. Table 2 shows the distribution of RHC and children by government and private categories. Table 3 shows the distribution by licensed and unlicensed categories.

Table 1. Distribution of RHC and children in Ghana sampling frame by combination of age groups

Age groups	No. of RHC	Percentage of RHC	No. of children	Percentage of children
0–4	2	1.5	19	0.5
0–4, 5–14	11	8.5	211	6.0
0–4, 5–14, 15–17	64	49.2	2,119	60.5
15–17	1	0.8	6	0.2
5–14	2	1.5	15	0.4
5–14, 15–17	50	38.5	1,135	32.4
Total	**130**	**100.0**	**3,505**	**100.0**

Table 2. Distribution of RHC and children in Ghana sampling frame by government and private categories

Category	No. of RHC	Percentage of RHC	No. of children	Percentage of children
Government-run	3	2.3	234	7.0
Private	127	97.7	3,271	93.0
Total	**130**	**100.0**	**3,505**	**100.0**

Table 3. Distribution of RHC and children in Ghana sampling frame by licensed and unlicensed categories

Category	No. of RHC	Percentage of RHC	No. of children	Percentage of children
Licensed	105	80.8	3,063	81.4
Unlicensed	25	19.2	442	18.6
Total	**130**	**100.0**	**3,505**	**100.0**

The stratification of the frame of RHC and the sample allocation were based on the plans for the analysis of the survey data. The plan was to tabulate the data by age group, government/private and licensed/unlicensed categories. Since there are only three Government-run homes in the frame, all of these were included with certainty in the sample for Phase Two.

Based on the distribution of the RHC by the combination of age groups shown in Table 1, it was decided to establish three separate age-group strata:

Stratum 1 - All RHC without the 0-4 age group

Stratum 2 - RHC with the 0-4 age group, but without the 15-17 age group

Stratum 3 - RHC with all three age groups.

2.2 FIRST-STAGE SELECTION OF RHC

Based on the objectives and available resources, it was decided to select 48 RHC for the Phase Two survey. There were 12 teams of enumerators, resulting in a sample of approximately four homes for each team. Within each stratum, RHC were selected at the first stage systematically with probability proportional to size (PPS), based on the number of children in each home. At the second sampling stage, up to 15 children were selected in each home, or five children per age group. Since many RHC do not include all age groups, the final number of sample children in each home depended on the distribution of the final sample of RHC by age-group strata.

Based on the systematic PPS selection, if the RHC within each stratum were sorted by licensed and unlicensed categories, the number of sample homes in each category would be approximately proportional to the total number of children in the category. In order to increase the number of unlicensed RHC in the sample, the measure of size for the unlicensed homes in the frame was calculated as double the total number of children.

There was also an interest in comparing results for those RHC with 30 or fewer children to those with more than 30 children. This threshold is based on the National Standards for Residential Care for Children in Ghana. Since 104 RHC in the frame fall into the category of smaller facilities, there was no need to have a special stratum by size of facility because a proportional allocation would provide a sufficient sample size for these smaller facilities.

Since the three Government-run RHC were included in the sample with certainty, it was only necessary to determine the allocation of the 45-sample private residential homes by age-group stratum. First, the distribution of the final frame of eligible private homes and children by age group was examined to determine a proportional allocation by stratum. Then this sample allocation was adjusted to increase the number of RHC with children 0-4 years. Table 4 shows the distribution of the eligible private residential homes and children in the frame by age-group strata, and the proportional and adjusted allocation of the sample of private homes. Table 4 shows that the adjusted allocation increases the number of sample RHC for strata 2 and 3, which both include the 0-4 age group.

Within each stratum, RHC were sorted by licensed/unlicensed and identification code, and the number of sample homes specified in Table 4 (adjusted allocation) was selected systematically with PPS. The measure of size was equal to the number of children in each licensed home, and double the number of children for the unlicensed homes (to increase their probability of selection). In the process of selecting the RHC with PPS, it was found that a few had a measure of size greater than the sampling interval, so they are self-representing

(SR), and included in the sample with a probability of 1. Then a new sampling interval was calculated for selecting the remaining sample RHC in the stratum systematically with PPS. The SR homes are identified in the information for the sample RHC, since the weight for these is calculated differently, as described later in the section on weighting procedures.

Table 4. Distribution of private RHC in Ghana sampling frame by age-group strata, and proportional and adjusted allocation of sample private RHC

Age-group strata	Number of RHC in frame	Percentage of RHC in frame	Number of children in frame	Percentage of children in frame	Proportional allocation, 44 RHC	Adjusted allocation, 44 RHC
1	53	42.1	1,156	35.7	16	12
2	12	9.5	197	6.1	3	4
3	61	48.4	1,885	58.2	25	28
Total	**126**	**100.0**	**3,238**	**100.0**	**44**	**44**

2.3 SECOND-STAGE SELECTION OF CHILDREN

Initially, the plan had been to select four children in each age group within each sampled RHC. However, considering that some of the selected children may not be present during the data collection, the target number of sample children per age group was increased to five. It was decided not to implement any procedures for replacement, which may have introduced some bias into the sample. Also, because some RHC do not have all age groups represented, this will reduce the overall number of sample children.

Information on the name, sex and age of each child from the roster of children for all RHC from Phase One was merged into an SPSS database with the identification code for each home. This file was matched to the sample of 48 RHC in order to extract the roster of children by age group for the 48 sample homes. An age-group stratum variable was introduced for the sample selection process. The SPSS complex samples module was then used to select the sample of up to five children in each age group within each sample RHC. The roster for each age group in each sample RHC was sorted by sex, and the sample children were selected using systematic random sampling, providing a proportional distribution of the sample boys and girls. In the case of age groups with less than five children in the sample home, all were selected. Table 5 shows the final distribution of all the selected children by age group and sex. A total of 552 children were selected for Phase Two: 128 in age group 0-4 years, 239 in age group 5-14 years, and 185 in age group 15-17 years. Given the larger proportion of male children in the RHC, the final sample includes 301 boys and 251 girls.

Table 5. Distribution of Phase Two sample of children by age group and sex

Age group	Girls	Boys	Total
0–4	68	60	128
5–14	139	100	239
15–17	94	91	185
Total	**301**	**251**	**552**

2.4 CALCULATION OF SAMPLE WEIGHTS

In order for the sample estimates of indicators for facilities and children to be representative of the frame, it was necessary to apply appropriate weights or expansion factors to the sample data. The basic weight for each sample RHC and child was equal to the inverse of its probability of selection (calculated by multiplying the probabilities at each sampling stage).

A stratified two-stage sample design was used for the survey. At the first stage, a sample of RHC was selected systematically with PPS within each stratum, and at the second stage a sample of up to five children was selected within each age group in a sample of RHC. The first-stage probability of selecting an RHC can be expressed as follows:

$$P_{1hi} = \frac{n_h \times MS_{hi}}{\sum_h MS_{hi}}$$

where:

P_{1hi} = first-stage probability of selection for the i-th sample RHC selected in stratum h

n_h = number of non-self-representing (NSR) RHC selected in stratum h

MS_{hi} = measure of size for the i-th sample RHC selected in stratum h, equal to the total number of children in the RHC, or double this number if the RHC is unlicensed

In the case of the self-representing (SR) homes, p_{1hi} is equal to 1. For the remaining (non-self-representing) homes, the denominator of the probability is equal to the sum of the measures of size for all the non-self-representing (NSR) homes in the frame for stratum h.

In the case of any estimates of RHC-level characteristics, it was necessary to use an RHC weight, which is the inverse of the first-stage probability, expressed as follows:

$$W_{1hi} = \frac{1}{P_{1hi}} = \frac{\sum_h MS_{hi}}{n_h \times MS_{hi}}$$

where:

W_{1hi} = weight for the i-th sample RHC selected in stratum h

In the case of SR homes, the weight would be equal to 1.

The second-stage probability of selection of sample children within an RHC in each stratum is calculated by age group. This probability can be expressed as follows:

$$P_{2hia} = \frac{c_{hia}}{C_{hia}}$$

where:

P_{2hia} = second-stage probability of selection for the sample children in age group a of the i-th sample RHC in stratum h

c_{hia} = number of children selected in age group a of the i-th sample RHC in stratum h

C_{hia} = total number of eligible children in age group a listed in the roster of the i-th

sample RHC in stratum h

The weight of the sample children is the inverse of the overall probability of selection, which includes the first- and second-stage probabilities. Therefore, the child weight is expressed as follows:

$$W_{hia} = \frac{1}{P_{1hi} \times P_{2hi}}$$

where:

W_{hia} = basic weight for the sample children in age group a of the i-th sample RHC in stratum h

An Excel spreadsheet was developed for calculating the preliminary probabilities and weights for the children by age group within the 48 sample homes, based on the information in the sampling frame. The weights were finalized following the Phase Two interviews, based on the final survey data.

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