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A SAFE PLACE TO GROW

Broadening the lens on care reform

A global review of progress and challenges in low- and middle-income countries



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Executive summary

Evidence from around the world underscores the central role of families in supporting children's rights, development and well-being. While the structure and definition of the family vary, there is broad agreement that nurturing and responsive caregiving practices are essential for children's physical health, psychosocial well-being and resilience.[1] Yet millions of children lack such care due to poverty, limited access to services, parental ill health, disability, family breakdown, stigma and discrimination, and conflict and emergencies, with many of these challenges increasingly exacerbated by climate change. As a result, many children remain in abusive or violent homes, grow up in residential care or live without parental or adult care.

In response, many countries are working to ensure that all children have access to safe, high-quality, family-based care. These efforts, referred to as 'care reform', include preventing unnecessary family separation, ensuring appropriate alternative care when needed, providing permanent care solutions such as adoption or forms of *kafalah* (a form of care used in Islamic contexts),[2] and supporting reintegration into families and communities.[3] This work involves phasing out institutional care and providing more suitable forms of alternative care, including kinship care, foster care and supervised independent living arrangements.

Progress in care reform is uneven across the globe, with notable advances in some contexts but stalled progress in countries in many regions. The reasons for these disparities and the priorities for accelerating reform remain insufficiently understood, particularly in low- and middle-income contexts. This paper seeks to address this gap through an analysis of the current care reform landscape, including care systems and services.

The paper draws on a review of literature published since 2019 and consultations with 10 United Nations Children's Fund (UNICEF) regional advisers and 18 civil society care reform experts working globally and across 12 countries in Asia, Africa, Latin America and Eastern Europe.[4] The paper primarily draws on evidence from low- and middle-income countries, with reference to higher-income settings where relevant.

Terminology

In this review:

- **family** refers to any caregiving arrangement in which children receive consistent care, protection, nurturing and emotional support, including nuclear, extended and multigenerational households, single-parent families, kinship care, foster care, adoptive families and other locally recognized family forms.[5]
- **family-based care** includes care in the 'domestic environment of a family'[6] and typically refers to parental care, kinship care and foster care.

According to the Guidelines for the Alternative Care of Children, endorsed by the United Nations in 2009:

- **alternative care** refers to the formal and informal care of children outside of parental care.[7]

The Guidelines outline several forms of alternative care including:

- **kinship care**, where children are cared for by relatives or friends of the family;
- **foster care**, which requires the recruitment and approval of foster carers, along with preparation, training and ongoing support;
- **supervised independent living**, where older children live alone or in groups under the supervision of a responsible adult;[8] and
- **residential care**, an umbrella term for all group-based care outside a family setting.

Although not defined in the Guidelines:

- **institutional care** is a subset of residential care, but the two terms are not synonymous. Institutional care refers to an impersonal form of group care, defined not only by size but by collective routines that overlook children's individual needs, shift-based staffing, dormitory living and separation from the community. This distinction is important because while some forms of high-quality, small-scale residential care may be appropriate in limited circumstances, institutional care is intrinsically harmful to children and, under the Guidelines, must be phased out.

- **A care system** is defined in relation to the legal and policy framework, structures, services and resources that determine and deliver alternative care, prevent family separation and support families to care for children well.[9] The care system includes formal components resourced, managed or delivered by the state and civil society, and informal supports provided by extended families and communities, including informal kinship care.
- **Care reform** refers to efforts designed to lead to improvements in the care system.

Key findings

Growing up in a stable, protective family environment is fundamental to children's rights, well-being and development. Residential care, particularly when institutional in nature, is associated with developmental delays and increased risks of abuse. Effective care reform to promote family-based care requires a strong care system, including:

- robust legal and policy frameworks,
- a skilled and supported workforce and coordinated services,
- efforts to challenge harmful social norms and enhance extended family and community supports,
- adequate resources and services to support families and prevent separation, and
- the provision of quality alternative care that prioritizes family-based options where needed.

Care reform can build on several strengths, including existing family and community caregiving arrangements. Across contexts, extended families and communities play a vital role in caring for children, even in situations of extreme hardship. International and national policies widely endorse family-based care, and a growing number of countries have reduced residential placements, reformed intercountry adoption in line with global standards, strengthened humanitarian responses and invested in the social service workforce. The voices of people with care experience are also increasingly influencing reform efforts.

However, significant challenges persist. In many care systems, services to prevent family separation and support reintegration and kinship care are not sufficiently prioritized, and many children continue to be placed unnecessarily in residential and institutional settings. Essential services are underfunded, and kinship carers are often left to care for children with little or no support, despite many being elderly and otherwise vulnerable. As a result, kinship care – the most common form of alternative care – is insufficiently supported, deepening disadvantages for children placed with extended families and communities.

Although in many contexts most families rely almost exclusively on informal supports from extended families and communities in their efforts to care for children, the role of these actors is often not recognized or strengthened. Additionally, the expertise of those with care experience is not consistently acknowledged or incorporated into care reform. Options for children who cannot be looked after by parents or wider kin are often limited, given the small scale of foster care, supervised independent living and adoption programmes. Where foster care is available, it is frequently offered in only one form, despite the many possible models. This lack of choice means children may be unable to access the type of care most suited to their needs. Poor support means that children and young adults leaving care to live independently often face difficulties.

Care systems face structural weaknesses, including gaps in legislation, limited workforce capacity, fragmented services, weak oversight and persistent evidence gaps. Gender, disability and other inequalities also remain inadequately addressed. Deficiencies in care systems are closely linked to wider social, economic and political pressures. Climate change, conflict, migration, displacement and pandemics are amplifying these pressures, heightening the risk of family separation and placing additional strain on already fragile systems.

Social norms that undervalue caregiving, a role undertaken primarily by women and girls, reinforce gender inequalities and contribute to the low prioritization and underfunding of care reform. Political and economic forces shape care policies, financing and services. These forces may include:

- **Political ideologies**, such as beliefs about the extent to which the state should play a role in children's upbringing. Such ideologies rationalized the use of institutional care during the communist era in several countries.
- **The use of care to exert state power**, such as using intercountry adoption to secure stronger diplomatic relationships.
- **The influence of state and non-state donors**, for example, the policies of donors such as the European Union (EU) and the United States Agency for International Development (USAID) have had a major impact on efforts to reduce reliance on institutional care.
- **The commodification of care**, where children's care is used to generate profit. Examples include corrupt intercountry adoption practices and residential care managers profiting from volunteers who pay fees to live and volunteer in residential care facilities.

Sustainable change is unlikely without addressing these external pressures.

Recommendations

The review findings point to four priorities for policymakers to strengthen care reform:

1. Broaden the lens of care reform

- Work within and outside of the child protection sector. Recognize the key role played by justice, education, social policy, social protection and health sectors and develop integrated responses.
- Locate efforts to remove children from institutional care within wider strategies to ensure safe, high-quality and sustainable family-based care for all children.

2. Recognize the broader drivers of care reform and future-proof this reform

- Recognize the political and economic interests and incentives that prevent care reform and develop strategies to address them.
- Challenge the low value assigned to caregiving and the gender and other social norms that shape how care is understood and provided.
- Recognize the family as the foundation for children's resilience in the face of climate change, conflict, growing rates of displacement and migration, and pandemics. Collaborate with those working to respond to these trends to ensure that improving children's care is a key part of this response. Make sure that care reform strategies consider the impacts of these trends.

3. Ensure that reforms are equitable and involve those with lived experience

- Explore and address the impacts of gender, disability and other inequalities on care reform; do not leave the hardest-to-reach groups behind in care reform processes.
- Listen to the perspectives of children, young adult care leavers and caregivers, and provide opportunities for their leadership and engagement with reform processes.

4. Enable sustainable reforms through a strong care and protection system

- Prioritize understanding and building on existing extended family and community support for children's care.
- Strengthen all aspects of the care system, including laws, policies and guidance, the social service workforce, the costing and financing of reforms, effective referral mechanisms and the integration and coordination of services.
- Ensure reforms are based on sound evidence by strengthening the collection of administrative data and conducting quality evaluations and research studies on children's care and care reform.

1. Introduction

1.1 Background and scope

Evidence from around the world highlights the critical role of secure, stable and loving families in supporting children's rights, development and well-being.[10] While the structure and definition of the family may vary across contexts, there is broad agreement that nurturing, responsive caregiving is essential for children's physical health, psychosocial well-being and resilience.[11] This understanding is reflected in global policies and guidance, which clearly state that children should grow up in safe and caring families.[12] Consensus around the importance of such care has been strengthened in recent years with global commitments and campaigns promoting family-based care.[13]

However, millions of children are deprived of such care due to a combination of poverty, lack of access to services, parental ill-health, disability, family breakdown, stigma and discrimination, and conflict and emergencies, often exacerbated by the social and economic impact of climate change.[14] Without appropriate family- and community-based alternative care, children may grow up in harmful institutional care or live on the streets without parental or other adult care.[15]

To address these challenges, many countries are reforming their care systems to ensure that all children have access to safe, high-quality, family-based care. These efforts, often referred to as 'care reform', encompass actions to prevent the unnecessary separation of children from their families, ensure the provision of quality alternative care when needed, and enable children's reintegration into families and communities.[16] A starting point is the phasing out of institutional care, where children are housed collectively in large groups without the individualized attention they need to thrive.

Global progress in care reform is uneven, with notable advances in some contexts but stalled progress in countries across many regions.[17] The reasons for uneven progress and the policy priorities in different contexts remain insufficiently understood, especially for low- and middle-income countries for which the evidence base remains particularly limited. Available evidence suggests that a combination of forces contributes to slow progress, including:

- **a lack of consensus** around the goals of reform,
- **inadequate and inappropriate investments in care systems**, such as over-investment in residential care and lack of investment in families,

- **national and international political and economic drivers**, such as political ideologies or donor policies that promote institutional care, and
- **global trends** such as climate change and mass migration.[18]

This paper provides an overview of the key issues shaping children's care reform. It argues that sustained reform requires changes to care services and the wider systems that support them, as well as action to address forces outside of the care system.

1.2 Outline of the paper

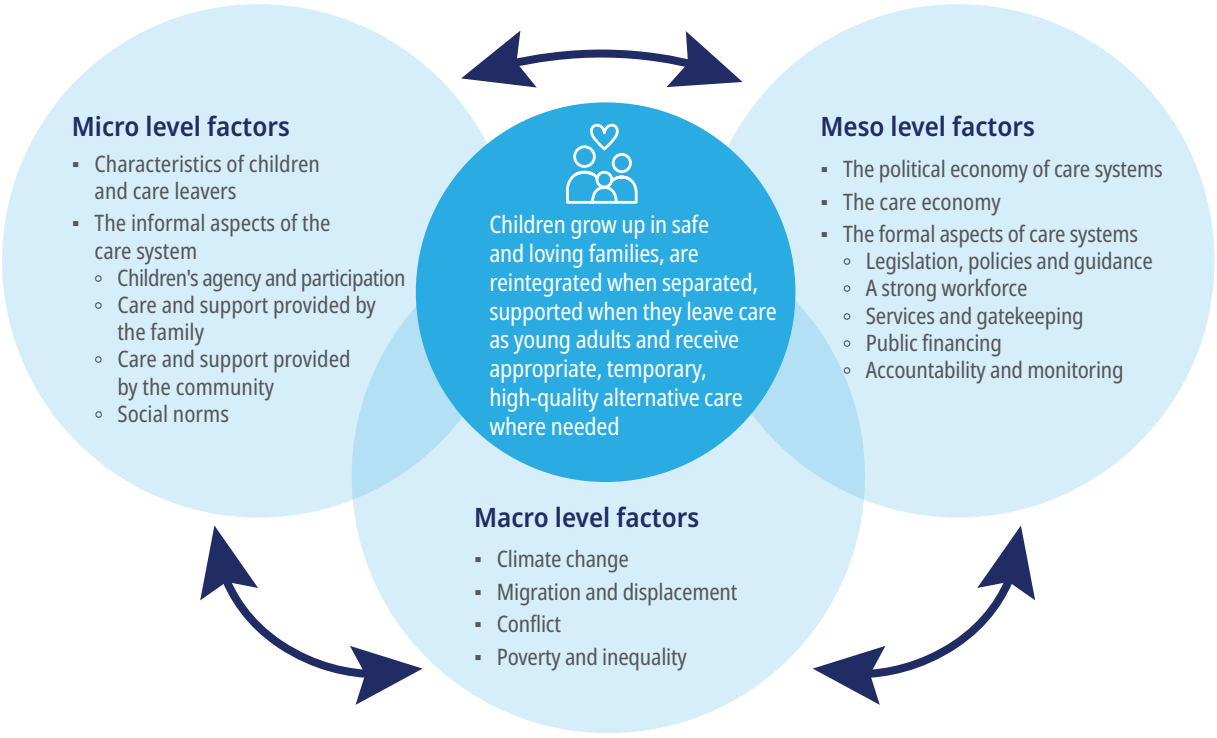
The paper begins by defining what it means for a child to be cared for well and explaining why such care is vital for the well-being of both the child and wider society. It outlines key components of a robust system for children's care and protection, highlights areas of progress in building this system, and identifies persistent challenges. It examines unresolved dilemmas related to what constitutes harmful forms of residential care and the most effective entry points for care reform. The paper then explores in greater depth two sets of forces that are shaping the pace and dynamics of care reforms worldwide: first, global megatrends such as climate change, conflict, migration, displacement and pandemics; and second, the political and economic drivers of care reform.

The paper concludes with recommendations for policymakers at the global, regional and national levels on priority actions to strengthen care systems.

1.3 Conceptual framework

The conceptual framework that has guided this research is presented in Figure 1 below. At its centre are the goals of care reform. Surrounding these are the interrelated factors operating at the micro, meso and macro levels that shape the achievement of these goals. The framework highlights that children's care and outcomes emerge from the dynamic interactions between these different levels. It draws on the concept of system strengthening, which is examined in further detail in Chapter 3.

Figure 1: A multi-level framework of factors influencing care outcomes and care reform



Note that the paper does not examine the quality of children's day-to-day care within families, except where this affects the risk of separation or the prospects for reintegration.

1.4 Methodology

The paper is based on a review of the literature and is complemented by insights from consultations with 10 UNICEF regional technical experts and 18 civil society care reform experts working globally and across 12 countries in Asia, Africa, Eastern Europe and Latin America. Regional data from middle-income countries in Europe and Central Asia are also included. Evidence from high-income settings is included where relevant.

Where divergent views exist regarding the suitability of specific interventions, the paper does not adjudicate between positions but rather considers their implications for overall coherence within care reform efforts. For more detail about the methodology used, see Annex 1.

A note on terminology used in this paper

Where possible, the terminology used in this paper follows the definitions provided by global guidance, particularly the Guidelines for the Alternative Care of Children (hereafter referred to as the Guidelines), endorsed by the United Nations General Assembly in 2009. Key terms are defined when they are first introduced and consolidated in a glossary provided in Annex 2. As the terms 'residential care' and 'institutional care' are often used inconsistently in debates on care reform, Box 1 sets out the definitions adopted in this paper.

BOX 1

What is 'alternative care' and how is it related to 'residential care' and 'institutional care'?

Alternative care refers to the formal and informal care of children outside parental care.[19] The Guidelines outline several different forms of formal and informal alternative care, including kinship care, residential care, foster care and supervised independent living.[20]

Family refers to any caregiving arrangement in which children receive consistent care, protection, nurturing and emotional support, including nuclear, extended and multigenerational households, single-parent families, kinship care, foster care, adoptive families and other locally recognized family forms.[21]

Residential care, according to the Guidelines, is an umbrella term for all forms of group-based care for children outside family care, and is defined as "Care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities including group homes."[22]

Institutional care is identified in the Guidelines as a subcategory of residential care but is not explicitly defined beyond being described as 'large-scale'.[23] In practice, the distinction between residential and institutional care extends beyond the size of the facility to the nature and quality of care provided.[24] Institutional care is characterized by collective rather than individualized caregiving, with staff working in shifts, strict sets of rules, children sleeping in dormitories and separation from the wider community.[25] Distinguishing institutional care from other forms of residential care therefore requires consideration of factors, including the size of the facility, the consistency of relationships between children and caregivers and the extent to which care is centred on the needs of the child rather than operational routines and requirements. There is extensive debate about the extent to which boarding schools fall within the definition of residential care. These issues are discussed further in Chapter 6.

Deinstitutionalization refers to efforts specifically to reduce the number of children in institutional care.

Care reform refers to broader changes to systems, legal and policy frameworks, structures, services and resources that prevent family separation, determine and deliver all forms of alternative care, and support families to care for children well.[26] Accordingly, this paper uses the term 'care reform' rather than 'deinstitutionalization'.

Care system is defined in relation to the legal and policy framework, structures, services and resources that determine and deliver alternative care, prevent family separation and support families to care for children well.[27] The care system includes formal components resourced, managed or delivered by the state and civil society, and informal supports provided by extended families and communities, including informal kinship care.

2. Why care about care?

2.1 What is quality care?

A well-established and growing body of evidence shows that children's long-term care is best provided in safe, stable and nurturing family environments. Key features of such environments include secure, meaningful attachments with caregivers, responsive caregiving, opportunities for early learning and play, and emotional warmth and protection.[28] Quality care should be tailored to children's developmental needs and provided in a culturally sensitive manner,[29] as articulated in the global *Nurturing Care Framework for Early Childhood Development*.[30]

Evidence demonstrates that forming secure bonds with caregivers is critical to children's development.[31] Cross-cultural studies of attachment show that while the ways attachments are formed and expressed may vary across contexts, their importance for child development is universal.[32] This applies equally to children who have more than one caregiver and those who experience exclusive parental care only in early infancy.[33] For example, in societies where young children spend substantial time in multi-age peer and sibling groups, the attachments they form with parents, older siblings, grandparents and other customary caregivers can be equally influential for their development and well-being.[34] These findings are reinforced by children's own views of quality care, which emphasize that feeling loved by caregivers is vital, even though 'love' is difficult to quantify and may be less visible in policy-level definitions of quality care.[35]

The same principles underpin alternative care for children who cannot be cared for by their parents or other customary caregivers and need temporary care in other settings. Evidence indicates that quality alternative care is most likely to be achieved in family-based settings, that children need stable arrangements that enable them to form and maintain attachments, and that institutional care is intrinsically harmful to children.[36] Debates continue, however, about whether high-quality short-term care should ever be provided in small-scale residential facilities. This question is discussed further in Chapter 6.

2.2 Why is it important to ensure quality care?

Quality care in safe, stable and nurturing family environments is strongly linked to positive physical, emotional, intellectual and cognitive outcomes.[37] Without this foundation, children are at increased risk of a range of adverse outcomes.[38] These include poor physical growth (such as stunting and undernutrition), cognitive and language delays,[39] emotional and behavioural difficulties,[40] disrupted education, increased risk of exposure to violence, HIV and substance use,

and heightened vulnerability to mental health disorders.[41] The negative impacts of poor-quality care are particularly well-documented in relation to institutional care, with decades of research showing harm across a range of aspects of child development.[42] While children may recover from some developmental delays caused by institutionalization once they return to a family, some delays persist, and prolonged periods in institutional care are associated with exacerbated developmental issues.[43]

The benefits of quality care extend beyond individual children to wider society. Care that supports children's mental health, resilience and social competence results in better educational outcomes, reduced involvement with the criminal justice system and greater self-sufficiency over the long term.[44] Conversely, inadequate care, such as neglect or inconsistent caregiving, can lead to detrimental social and health consequences that strain communities, burden public services and reduce economic productivity.[45]

Global guidance indicates that children have a right to be cared for well and that governments have an obligation to fulfil this right. There are three key international frameworks on children's care which articulate agreed goals and rights in relation to care: the United Nations Convention on the Rights of the Child (1989), the Guidelines (2009) and the United Nations Convention on the Rights of Persons with Disabilities (2006).[46] There are also numerous regional frameworks which reference children's care, including the African Charter on the Rights and Welfare of the Child (1990).[47] These frameworks set out the following principles:

- **Children should grow up in a family environment** and only be separated from their parents when necessary and in their best interests.
- **Families must have the support they need** to provide safe, nurturing care for children, including financial assistance and essential services.
- **Children should have access to a range of suitable alternative care options** if they cannot be cared for by their parents. Placement with extended family members or close family friends (kinship care) should be prioritized. Other suitable alternative care options include:
  - **foster care** provided by carefully selected, vetted and trained adults, with regular monitoring by social services to ensure safety and quality.
  - **supervised independent living** where children live alone or in small groups with regular adult monitoring and support.
- **Institutional care should be phased out,** as it is harmful to children's well-being and development. Children under the age of 3 should generally be cared for in family-based settings, with exceptions only in limited circumstances. There is ongoing debate around the extent to which other forms of residential care that are not institutional in nature (see Box 1) may be appropriate for the short-term care of older children, and this is discussed in Chapter 6.

- **Decisions about children's care should be made on a case-by-case basis**, with children's best interests as a primary consideration. In keeping with children's evolving capacities, they should participate in decisions about their care.
- **Alternative care** must be regarded as a temporary solution. Efforts to reunite separated children with their parents should be prioritized. Where reunification is not possible, long-term or permanent family care options such as kinship care, adoption or long-term or permanent forms of *kafalah*[48] should be pursued.
- **Children should be supported to maintain their cultural and religious identity** and, when separated from their families, should be cared for as close as possible to their home communities.
- **Young people leaving alternative care (care leavers)** to live independently for the first time must receive adequate preparation and ongoing support.
- **Care reforms should benefit all children and young adult care leavers** without discrimination based on gender, age, disability, ethnicity, refugee status or any other characteristic.

Being in a safe and loving family is also essential for the achievement of other child rights, including the right to education and the right to be free from exploitation and abuse.[49]

SUMMARY

The importance of quality care

Evidence and international guidance highlight the importance of quality care for children and wider society:

- Safe, stable and nurturing family environments are fundamental to children's rights, development and well-being.
- Secure relationships with caregivers, responsive care and opportunities for learning and play are essential to quality care across different cultural contexts.
- Poor-quality care can have lasting consequences for children's physical, cognitive and psychosocial development. Institutional care is intrinsically harmful to children and should be phased out.
- Quality care benefits wider society through improved educational, social and economic outcomes.
- International frameworks emphasize the importance of preventing unnecessary family separation, supporting families and prioritizing appropriate family-based alternative care when needed.
- Decisions about children's care should be guided by their best interests and participation, with appropriate support for reintegration and young people leaving care.

3. The care system and care reform

3.1 The care system and the continuum of care

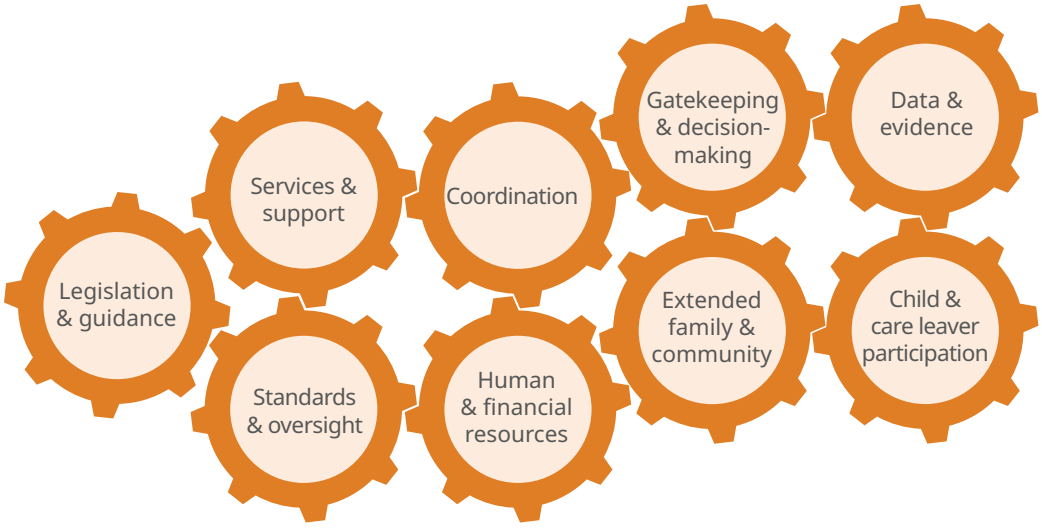
The care system can be defined as the legal and policy framework, structures, services and resources that prevent family separation, determine and deliver alternative care, and support families to care for children well.[50] Care reform refers to efforts to improve the care system.

As outlined in the previous section, a comprehensive care system should prioritize prevention of separation from families, reintegration and kinship care, support family- and community-based alternative care options such as foster care, potentially offer a limited role for forms of residential care that are not institutional in nature (see Chapter 6) and phase out institutional care. For children who cannot return to families, care systems should provide permanent care options such as adoption.

Currently, most children in alternative care are in kinship care arrangements, though, as shown in Box 3, substantial numbers remain in residential care, often in institutional settings. As discussed below, foster care and permanent options such as adoption remain underutilized in many countries.

3.2 Components of the care system

Figure 2: Components of the child protection and care system needed to support effective care reform



Key components of the care system that must be strengthened for effective care reform include the following:[51]

A robust legal and regulatory framework and guidance related to children's care

Ideally, each country should have a national care reform strategy, legislation that sets out principles and provisions across all aspects of children's care, and detailed guidance for practitioners.[52] This should draw on global and regional guidance on care reform, particularly the United Nations Convention on the Rights of the Child[53] and the global Guidelines.

Services and support

Care system services include:

1. **Assistance to prevent family separation.** According to the Guidelines, prevention should be prioritized in care reform processes. It is generally agreed that the causes of separation vary by context and involve a combination of factors for each individual child.[54] These drivers include household poverty, neglect and abuse within the family, parental ill-health or disability, family breakdown, substance abuse, stigma and discrimination, and prevailing social norms.[55]
2. **Support for family reintegration.** Families and children undergoing reintegration often require intensive support to rebuild relationships, deal with the trauma of separation, and help children adjust to family life.[56] For most children who have been separated, reintegration should include assessment, preparation of both the child and family, gradual reintroduction into the family and community, and follow-up support.[57]
3. **Alternative care services and support.** The Guidelines indicate kinship care should always be the first option that is considered when children cannot live with their parents. Kinship care can be either formal, involving the courts and social workers,[58] or informal, with arrangements made within families.[59] Informal kinship care is by far the most common form of alternative care globally, and support for this form of care is particularly vital.[60] Although kinship care should always be explored first when children cannot be cared for by parents, it is not always a safe option, and many kinship carers need additional support to be able to provide adequate care.[61]
4. **Residential facilities as service hubs.** Initiatives to transform residential care facilities into service hubs for families and communities could provide, for example, after-school or holiday clubs, rehabilitation services for children with disabilities, parenting programmes and support for foster carers.
5. **Support for care leavers.** Young adult care leavers transitioning to living independently for the first time may require life skills training, help finding employment and housing, mental health support and ongoing mentoring.

6. **Services to support permanent care options for children who cannot return to their families.** These options include adoption (the legal transfer of parental rights and responsibilities for a child on a permanent basis) and permanent or long-term forms of *kafalah* (a form of family-based care similar to adoption used in Islamic societies).

Addressing these drivers and ensuring effective support to keep families together require integrated interventions across sectors, including education, social protection and mental and physical health care. Box 2 illustrates the type and intensity of support that families at risk of separation may need, depending on the complexity of their circumstances.

BOX 2

Three tiers of support for effective prevention[62]

Primary or universal

Targeted to an entire population or subgroup, this level seeks to strengthen families before major problems arise. Examples of such interventions include access to universal services, campaigns to prevent violence against children, widely targeted parenting support, and efforts to shift social norms that contribute to family separation.

Secondary

Targeted at communities or families at high risk of separation, this level aims to prevent problems from escalating. Interventions may include targeted awareness-raising, home visits, respite care, family or individual counselling, parenting programmes linked to social protection, and some forms of case management support.

Tertiary

Specialized interventions for families in acute crisis where separation or breakdown is imminent. Interventions may include intensive social worker support using case management, alongside those described at the secondary level.

Coordination mechanisms

These mechanisms may include national or subnational committees that develop and monitor care reform policies and programmes. Evidence on the varied causes of separation and the support needs of children in vulnerable families and alternative care underscores the need for cross-sectoral collaboration in care reform.[63] Many care services and supports in both low- and high-income countries are provided by non-governmental organizations (NGOs), faith-based organizations, the private sector and communities, making effective coordination between state and non-state actors vital.

Gatekeeping and decision-making

Formal decision-making by the courts and social services, also known as 'gatekeeping', plays an essential role in preventing unnecessary separation of the family and ensuring that children receive appropriate care. Gatekeeping ensures that separation occurs only when it is in the best interests of the child, reintegration happens as quickly as possible once families have the capacity to provide appropriate care, and children and families receive the support they need.[64]

Informal decision-making within families also plays a crucial role in ensuring that decisions are made with the best interests of the child as a primary consideration. Since most children in alternative care are placed through informal family arrangements, these family-based decisions ultimately have a broader impact than formal decision-making processes.

Minimum standards and oversight

This component includes standards established for residential care facilities and family-based alternative care providers, as well as mechanisms to ensure that those standards are applied in practice. Minimum standards should be developed which are appropriate to the context, and effective systems should be put in place to monitor implementation and enforce compliance.

Human, financial and infrastructure resources

This component includes budget allocations and public financing needed to support the care system, as well as a skilled workforce to deliver services. Ensuring sufficient financing of care systems requires costing of services, decisions regarding the responsibilities of the state, civil society and the private sector, and strategies to fill funding gaps. A range of human resources is needed to support care reform, with social workers often playing the most significant role.

Extended family and community engagement

In addition to providing kinship care and participating in decisions about care, extended families and communities contribute in numerous ways to children's care. Extended families often play a vital role in supporting parents and kinship carers. Community leaders, structures and volunteers can monitor and assist vulnerable families, refer families to social services when needed, track rates of separation and raise the alarm if those rates increase, provide mutual support through peer-to-peer groups, and work to shift social norms that do not support family-based care.[65]

Mechanisms for child and care leaver participation

These mechanisms may include, for example, efforts to consult children during assessments of their needs as part of case management processes, to involve children and care leavers in the design and monitoring of programmes, and to provide them with spaces to advocate for reforms.

Data collection and monitoring systems to build evidence and inform decision-making

This component includes determining the numbers of separated children and children in different forms of care, understanding the causes of separation, and assessing the quality of services.

SUMMARY

Building a comprehensive care system

Effective care reform requires a comprehensive care system that:

- prioritizes preventing unnecessary family separation, supporting reintegration and strengthening kinship care.
- provides suitable alternative and permanent care options, supports care leavers and phases out institutional care.
- is underpinned by robust legislation, policies and guidance, effective gatekeeping, minimum standards and oversight.
- has adequate financial resources, a skilled and supported social service workforce, and effective coordination across sectors and service providers.
- recognizes and strengthens the contributions of extended families and communities, and promotes the participation of children and care leavers in decisions about care and reform processes.
- collects and uses reliable data to monitor care arrangements, assess needs and inform decision-making.

4. Common strengths in care systems

4.1 Sustained support offered by extended families and communities

Globally, the vast majority of children who cannot be cared for by parents are taken in by extended family or friends of the family in kinship care arrangements (see Box 3). Evidence from humanitarian contexts shows that extended family and kin often care for children even in the most trying circumstances.[66] This form of care is generally preferred by both children and caregivers, and studies from high-income contexts indicate that kinship care is associated with consistently better outcomes than other forms of alternative care.[67] Kinship care is often reciprocal, with caregivers benefiting from children's company, affection and help in the home. As with all forms of care, however, it carries risks to children and caregivers,[68] as discussed below.

Community members may care for children who are not related to them in emergencies, sometimes taking in those who were not previously known to them without assistance from humanitarian agencies.[69] This form of care is often referred to as 'spontaneous foster care'. Community members also play a vital role in supporting caregivers by providing assistance that is often described by children and family members as more meaningful than that offered by the government or NGOs.[70] In many contexts, norms around collective responsibility for children's upbringing underlie kinship care and extended family and community assistance to caregivers.[71]

Given the extensive contributions by the extended family and wider community, supporting and building on these roles is foundational to effective care reform.

BOX 3

The proportion of children in kinship care across the world

Recent estimates show that kinship care is widely used. For example, 23 per cent of children in Thailand[72] and approximately 2 per cent of children in Moldova are in kinship care.[73] Data from a decade ago estimate that approximately 10 per cent of all children were in kinship care, with the highest rates in sub-Saharan Africa and the lowest in the Middle East.[74] In some African countries, up to a third of children were in kinship care.[75]

Children in kinship care far outnumber those in residential or foster care. For example, in Rwanda, for every child in residential care, there are at least 265 in kinship care.[76] In Europe and Central Asia, which have some of the highest rates of residential care placements globally, around 0.23 per cent of all children are in residential care, a proportion far lower than in kinship care.[77] In Thailand, there are around 38 times as many children in kinship care as in residential care.[78]

4.2 Expansion of services designed to support family-based care

Some progress has been made in preventing family separation and in supporting the reintegration of children who have been separated from their parents. For example:

- **Social protection and parenting support.** There has been a rapid expansion of services that could strengthen families and prevent separation, particularly through social protection and parenting programmes, although coverage is not universal and evidence does not capture impacts on family cohesion.[79]
- **Integrated service delivery.** Examples of promising practices in integrated service provision for families include cash-plus-care programming, which combines cash transfers with parenting or other family supports,[80] integrated multisectoral programmes to support family-based care for children with disabilities,[81] family strengthening interventions that incorporate health and education, and child protection programming to address root causes of entry into residential care.[82] Some countries have also established coordination bodies that help to facilitate service integration.[83]

Efforts have also been made to better understand kinship care and develop appropriate guidance and models for supporting both formal and informal forms of this care.[84] Foster care has been successfully piloted in several contexts[85] and brought to scale in some low- and middle-income countries, particularly in Eastern Europe and Central Asia.[86]

4.3 Advancements in policies and legislation

Significant progress has been made in care reform policies over recent decades. At the global level, this advancement can be seen in the development of the Guidelines in 2009, which augment the rights articulated in the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. Several international and regional bodies have made further commitments to care reform, culminating in the Global Charter on Children's Care Reform in 2025.[87]

At the national level, many care reform policies and strategies have been developed, and evidence suggests that regulations have been strengthened.[88] These regulations generally align with key international standards for children's care, emphasizing the importance of family upbringing and the availability of a range of family-based alternative care options. Many countries have also developed minimum standards for care, particularly in relation to residential care.[89] These cover areas such as safeguarding standards, child-to-staff ratios, and the need for care planning to ensure children are only in residential care when necessary. Detailed guidance for practitioners on other forms of care also exists in some settings.[90]

4.4 Reductions in the use of residential and institutional care in some contexts

Gaps in data make it difficult to fully ascertain global trends in the use of residential care, although there are several examples of substantial declines. The clearest evidence comes from Europe and Central Asia, where the share of children in residential care has fallen from 0.86 per cent in 2010 to 0.23 per cent in 2024.[91] Historical analysis since the end of the Soviet Union further illustrates progress in the region. For example, Georgia saw an 86 per cent drop in the number of children in residential care between 2003 and 2014.[92] As the use of residential care has declined, the use of foster care in the region has increased.[93] Other countries that have seen a fall in the number of children in residential care include Cambodia, Indonesia, Kenya, and Rwanda.[94] Evidence indicates growing community support for family-based care and an end to residential care in some contexts.[95]

Although gaps in data make it difficult to precisely determine the proportion of residential care that is institutional in nature, evidence from many low- and middle-income contexts suggests that much of this care has institutional characteristics and will therefore be intrinsically harmful to children.[96]

4.5 Strategies to end corrupt practices in intercountry adoption

Over the past 25 years, scandals relating to corrupt practices in intercountry adoption have led many low- and middle-income countries to impose moratoriums while governments investigate abuses and ratify and implement global standards,[97] notably the 1993 Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption.[98] Since 2004, global intercountry adoption rates have fallen by 80 per cent.[99]

Some high-income countries are also acknowledging their responsibility to address these corrupt practices. For example, the Netherlands recently established a committee to investigate intercountry adoption from Bangladesh, Brazil, Colombia, Indonesia and Sri Lanka.[100] The committee highlighted several deficiencies in Dutch government oversight and suggested necessary support for adopted children and their birth parents, who were often tricked into giving up their children by criminal networks.[101]

Adults who were illegally adopted across countries as children are increasingly sharing their experiences and advocating for redress. Challenges faced include being taken from families without consent, lack of oversight of adoption processes, loss of identity and other feelings of loss, and desire for recognition of harm and compensation.[102]

4.6 Improved approaches to children's care in humanitarian contexts

Evidence from humanitarian crises in the 1990s and 2000s showed a heavy reliance on residential care, with a rapid increase in such facilities following the genocide in Rwanda and the tsunami in South and South-East Asia.[103] Children separated from their parents continued to be placed for adoption, including international adoption, despite the chaos of these emergencies making it impossible to determine whether they had surviving family members. Since this time, humanitarian actors have jointly generated guidance in relation to children's care which discourages the building of new residential care facilities or the use of adoption and promotes family-based care.[104] In more recent emergencies, including the Ukraine war (2022–) and the Nepal earthquake (2015), those working on care reform have rapidly mobilized to try to prevent the use of adoption, child trafficking into residential care, and the expansion of residential care.[105]

Much innovative practice around family-based care has emerged from emergency contexts, providing valuable lessons for development actors. For example, foster care and kinship care programmes are a common feature of support to displaced populations, with foster care sometimes implemented at a larger scale than in non-emergency settings.[106] Despite challenges, foster care has also been established for children formerly associated with armed forces or groups.[107] Supervised independent living programmes have likewise been developed to support displaced older adolescents who do not want to or cannot live in a family environment.[108]

4.7 Efforts to build a social service workforce able to support reform

Social worker support is crucial for many aspects of care reform, including providing case management support to high-risk families and children in alternative care, conducting assessments, and supporting gatekeeping and reintegration services. Over the past decade, progress has been made in many low- and middle-income contexts to build workforce capacity for care reform, for example through the development of case management guidance and tools and the provision of training.[109] In some countries, such as Rwanda, care reform has acted as a catalyst for growing the workforce.[110]

4.8 Greater recognition of the voices of those with lived experience

Young adult care leavers, usually from residential care, are increasingly becoming activists in care reform, including through the creation of care leaver networks. Research across Latin America identified 63 child or young adult activists with lived experience from 19 countries in the region.[111] In Romania, care leavers are challenging the perception that children in care are to blame for using up state resources.[112] In Ukraine, care leavers from residential and foster care have contributed to an insightful position paper on care reform priorities.[113] Across Africa, national and regional care leaver networks are active,[114] and in 2020 an international care leavers' convention brought together over 1,000 individuals from around the world.[115]

SUMMARY

Building on existing strengths

The evidence points to considerable strengths within care systems on which future improvements can be built, including:

- International consensus around the importance of family-based care.
- The contributions of extended families and communities in the face of extreme hardship.
- Reduction in institutional care in countries with concerted care reform efforts.
- Reforms to intercountry adoption.
- A stronger care and protection system, with national policies and social service workforce reforms that support family-based care in some contexts.
- A more prominent voice for those with care experience.

5. Persistent gaps in care systems and challenges in care reform

5.1 Lack of support for family-based care

Despite growing recognition of the importance of family-based care, support for families and family-based alternative care remains inadequate in many contexts. The evidence highlights several recurring challenges, including:

The undervaluing of care

A fundamental challenge to care reform worldwide lies in the low value assigned to caring roles, including those involving the care of children. The care economy, defined as the system of paid and unpaid labour that sustains families and communities, is consistently underprioritized in policy frameworks.[116]

This lack of appreciation and recognition reflects deep-rooted gender and social norms that position caregiving as a private duty rather than a collective social good that warrants public investment.[117] Consequently, the costs and labour associated with care are largely invisible in national budgets and development strategies, and the disproportionate burden borne by women and girls goes unrecognized.[118] This neglect weakens incentives to strengthen family-based care and contributes to chronic underfunding of social protection and fragmentation of community services.

Examples of how the low value assigned to the care economy negatively affects children's care include:

- The expectation that grandmothers will care for children separated from their parents – regardless of the support available to them – is often used to justify limited investment in kinship care.[119]
- Low pay and poor working conditions in residential care facilities contribute to high staff turnover, undermining children's capacity to form stable, trusting relationships with caregivers even in smaller-scale residential care.[120]
- The low value assigned to foster care, along with inadequate payment and support for foster carers, makes recruitment difficult and compromises the quality of care.[121]

- In many high-income countries, an ageing population and low investment in care have created a care crisis. This is driving an increased reliance on female migrant workers who come primarily from low- and middle-income settings, many of whom leave their own children behind in kinship care arrangements.[122]
- Many women worldwide spend the bulk of their time in unpaid caregiving, which constrains their ability to engage in paid work and contributes to household poverty, a key driver of family separation.[123] The reliance on unpaid caregiving reduces income tax revenues, narrowing the fiscal space available for investment in care reform and other public services.[124]

These examples underline the need to invest in the care economy as a core element of effective care reform. Without a systemic shift in how care is valued, reform efforts are likely to remain piecemeal and unsustainable. Growing recognition of the care economy[125] creates an important opportunity to align this agenda with care reform and drive mutually reinforcing change.

Inadequate services to prevent family separation and enable reintegration

The complexity of providing effective support for prevention and reintegration makes it difficult to assess the extent to which such support is being delivered across low- and middle-income countries. However, evidence suggests that prevention is not universally prioritized in care reform processes[126] and children continue to be reintegrated with limited or no preparation or follow-up support.[127]

Where support for families is available, it is often not delivered across all three tiers of support required to prevent separation and meet the diverse needs of families (see Box 2).[128] Essential services are frequently underfunded and vulnerable to funding cuts.[129] Social protection can provide an important entry point, especially when cash transfers or livelihoods assistance are combined with other services such as parenting programmes, referrals to social services or efforts to shift social norms.[130] However, in many contexts, social protection schemes are not specifically designed to support families, and family-friendly policies such as paid parental leave remain limited.[131]

There is a lack of coordination between providers, threatening the successful integration of services (discussed in detail below). Such coordination is vital as reasons for family separation are often complex, combining poverty, lack of access to services and child protection concerns.[132] Case management support for families with complex needs is hindered in many countries by a lack of social workers, particularly social workers at the community level (see below).

In some cases, services that should support family unity are either ineffective or actually increase the risk of separation. For example, poorly designed social protection programmes that do not deliberately seek to address the structural drivers of family separation can fail to prevent or may even exacerbate family separation.[133] Parenting programmes can be counter-productive if delivered inappropriately or without addressing the structural causes of poor care.[134]

Limited support for kinship care

In contrast to continuing government investment in residential care, evidence from around the world shows minimal state support for both formal and informal kinship care.[135] Kinship carers and the children in their care often have complex and unmet needs.[136] For example:

- Many kinship carers are elderly grandparents, with related health issues and financial insecurity.[137]
- Kinship carers often have to navigate difficult family dynamics, including relationships with parents who may have harmed their children or who live abroad.[138]
- Where parents have died, kinship carers may be managing their own grief alongside that of the children in their care.[139]
- While many children in kinship care are well looked after, they remain vulnerable to abuse and exploitation, especially if placed with more distant relatives or friends of the family.[140]
- Many kinship carers look after large numbers of children, limiting their ability to provide the level of adequate supervision and care that each child needs.[141]
- Kinship carers can face particular challenges caring for children in humanitarian contexts, and children in kinship care may be especially likely to be discriminated against in these settings.[142]

Unchallenged harmful social norms relating to kinship care can also create problems. Norms about who should care for children may result in automatic placement with maternal or paternal relatives, even if they are unwilling or unable to provide adequate care. Kinship carers may also take in children out of a sense of obligation, despite not wanting or feeling able to care for them, which can place children at risk of harm.[143] In some such cases, children may eventually enter residential care.[144]

Care reform strategies make frequent references to the need to better monitor or regulate kinship care. However, there is often little consideration of what the formalization of kinship care might look like, and the benefits and risks associated with it. Box 4 outlines the key dilemmas involved in formalizing kinship care. Additional research is needed to assess the benefits, risks and necessity of different types of formalization, including the perspectives of children and caregivers across a range of different kinship care arrangements.

BOX 4

The formalization of kinship care

Kinship care can be formalized in two ways:[145]

1. **Registration of kinship care arrangements**, giving kinship carers parental responsibility and enabling them to make decisions about a child's health, education and care.
2. **Formal placement of children in kinship care by the courts or social services**, with ongoing monitoring by social workers.

Registration carries many benefits, allowing caregivers access to services and the ability to make decisions about a child's health, education and care.[146] However, registration is not welcomed by all kinship carers or children in kinship care. Some report that it can feel like a severing of ties with parents, which children, parents and kinship carers may not want or be ready for.[147] As with other groups in alternative care, children from marginalized communities are often disproportionately represented in kinship care. Caregivers from these groups can mistrust the state because of the discrimination they have experienced and be resistant to any involvement in their lives.[148]

Placement and monitoring by social workers and the courts can help kinship care families access support and ensure that children in kinship care are not abused or exploited.[149] However, given the combination of substantial numbers of children in kinship care and a small social service workforce in many contexts, formalizing all kinship arrangements is often not feasible. Indeed, expecting social workers to regulate a large number of placements has been shown to distort entire child protection and care systems, leaving them with limited time to respond to child abuse and monitor foster care.[150] As with the registration of kinship care placements, kinship carers are often resistant to this formalization and to the involvement of the state in the family.[151]

Evidence shows that different forms of kinship care carry varying risks. In general, children living with friends of the family or more distant relatives are more at risk of abuse and exploitation than they are if they live with close relatives.[152] Children living with kinship carers who are raising their own children may also experience discrimination from both the carers and their children.[153] Children living with grandparents are often vulnerable to poverty and may have to take on caring responsibilities.[154] These important distinctions in the quality of care children receive in different kinship settings demonstrate the need to differentiate approaches to the formalization of kinship care.

In some contexts, such as Rwanda and Kenya, lighter-touch methods of monitoring kinship care have been used, with community volunteers keeping an eye on kinship care families and reporting any concerns to professional social workers.[155] However, there is limited evidence on the extent to which this model adequately protects children from harm.

Limited use of foster care and domestic adoption

Where children cannot safely remain with their parents or extended family, foster care and domestic adoption can provide family-based alternatives to residential care. However, their use remains limited, especially in low- and middle-income countries. Across low- and middle-income contexts, foster care is most widely used in Eastern Europe and Central Asia, with the growth in foster care often accompanying a fall in the use of residential care.[156] For example, in 2021 there were around 16,000 children in foster care in Hungary compared to around 7,000 in residential care.[157] However, even in this region, foster care is considered underdeveloped in many countries, particularly with respect to short-term and emergency placements.[158] For example, in Moldova in 2021 there were 811 children in foster care provided by 405 foster carers. Of these foster carers, 280 provided long-term placements, 167 short-term placements and 80 emergency placements, with some carers providing more than one type of placement.[159]

In many low- and middle-income countries, foster carers and children in foster care number in the hundreds rather than the thousands. For example, Thailand has around 300 children in formal foster care.[160] In the Maldives, 2023 data indicate that only 9 per cent of the 187 children in alternative care were in foster care.[161] Guatemala has 122 accredited foster care families, with growth in this form of care progressing slowly.[162] In countries such as Ghana,[163] India,[164] Paraguay[165] and the State of Palestine,[166] successful pilots have yet to result in the widespread use of foster care. Similar evidence can be found on domestic adoption, which is also underutilized in many low- and middle-income settings.[167]

The failure to scale up adoption and foster care in many countries reflects the significant investments required in the wider care system to ensure that it is safe and effective.[168] These investments include efforts to:

- build awareness of foster care and adoption,
- shift social norms to increase cultural acceptance of foster care and adoption,
- develop legislation that allows for the use of foster care and adoption and ensure that the judiciary is willing to place children in foster care or adoption,
- build a skilled community-based social service workforce and provide it with clear guidance to recruit, monitor and support carers,
- ensure services are available for foster carers, adoptive parents and the children in their care,[169] and
- improve domestic adoption procedures, which are commonly described as either overly onerous and time-consuming, or lacking proper safeguards against corrupt practices.[170]

Failure to utilize extended family and community support

Given the limited reach of the social service workforce, parents, kinship carers and foster carers frequently rely on their extended families and community as their key sources of support in low- and middle-income countries.[171] Extended family and communities also contribute in numerous ways to care reform processes, particularly by monitoring and supporting vulnerable families and children in family-based alternative care, and by shifting social norms to ensure support for family-based care.[172]

Despite these benefits, the potential of family and community support remains underutilized in care reform strategies, which often place greater emphasis on strengthening the formal rather than the informal care system.[173] Families and communities need to be recognized as agents of change in care reform processes. However, to play this role effectively, they require adequate support. This assistance is particularly vital in the context of climate change, conflict and migration, which can erode the willingness and capacity of extended families and communities to sustain children's care over time (as discussed below).

5.2 Ongoing widespread use of residential care, including institutional care

The most reliable global estimates of the number of children in residential care date back to 2015.[174] These figures, now over a decade old, suggested a population of around 5.2 million, with the highest prevalence in Europe and Central Asia and the lowest in sub-Saharan Africa.[175] More recent research appears to confirm the continued widespread use of residential care worldwide, though calculating accurate numbers remains challenging due to definitional and methodological limitations, as well as uncertainty about the quality of available data.[176]

BOX 5

Examples of the scale of residential care

- Recent figures from 23 countries in Europe and Central Asia show that, on average, 0.23 per cent of children are in residential care.[177] Despite generally positive trends, progress across this region is uneven, with some countries continuing to rely heavily on residential care.[178]
- A review of administrative data and a survey of unregistered facilities indicate that there are 20,800 children in government-run facilities in Thailand and 58,000 in private facilities, many of which were unregulated.[179]
- In Iran, there are around 8,500 children in residential care.[180]
- In Ghana, government research carried out with the support of UNICEF identified 3,530 children living in 138 residential care facilities.[181]
- In 2020, the Ministry of Social Affairs in Indonesia reported that 102,482 children were living in registered residential care facilities.[182]
- In 2020, the NGO Lumos estimated that there were 187,000 children in residential care in Latin America and the Caribbean,[183] with around 4,000 in Guatemala alone.[184]
- Estimates from 2019 showed that there were 600,000 children in residential care in Myanmar.[185]

Most data on residential care are not disaggregated by type of facility, making it difficult to determine whether facilities can be definitively classified as institutional and therefore intrinsically harmful to children, or represent other forms of residential care (see Box 1).

Evidence from many low- and middle-income contexts suggests that much of residential care is low in quality and often institutional in nature. Studies consistently report that residential care is provided in large-scale facilities, with poorly trained staff, limited child protection policies and inadequate safeguarding mechanisms.[186] Some research also documents abuse by staff and other children.[187] In many cases, children are not routinely assessed to determine whether they need to be in residential care, and clear plans for their reintegration or placement into family-based alternative care are often lacking.[188] Residential care can be of particularly poor quality in emergency contexts or when provided to migrant children.[189]

5.3 Inadequate support for care leavers

Although life in residential care is often difficult, children's lives do not necessarily improve once they leave. Young adults transitioning from care to independent living face numerous challenges, many of which have persisted for decades.[190] Many children in alternative care have experienced the trauma of separation from their families as well as violence or abuse while in care.[191] Those

raised in residential care often struggle to adapt to life in the community, particularly if they have not been taught basic life skills.

The evidence suggests that preparation for leaving care is often minimal.[192] Care leavers without family support networks, including those whose parents are unknown, commonly encounter difficulties securing employment or housing and are highly vulnerable to exploitation.[193] These challenges are often compounded by stigma and discrimination,[194] whether related to the reasons they entered care, such as being born outside marriage, or to broader prejudice against those with care experience.[195]

Such stigma can lead to social isolation, prompting some care leavers to hide their past and lead double lives.[196] These problems can be especially acute for care leavers with disabilities.[197]

Care leavers often struggle to form safe and meaningful intimate partner relationships, with many feeling compelled to compromise in their choice of life partner due to their care leaver status.[198] As a result of these and other challenges, many care leavers suffer from low self-esteem and mental health issues.[199]

Evidence from multiple contexts shows that care leavers often lack the services and support needed to overcome these challenges.[200] Assistance is frequently piecemeal and, when it is available, tends to be overly focused on young people leaving residential care, with those from kinship or foster care often overlooked.[201] Support is typically centred on children preparing to leave care, with little or no follow-up once they are living independently.[202]

Supervised independent living can offer a valuable care option for young people transitioning from residential care.[203] Although many have largely positive experiences in such arrangements,[204] they may also be at risk of harm, including from other residents in the household.

5.4 Inadequacies in the structures, resources and processes

Weaknesses in the structures, resources and processes that underpin children's care systems limit the quality, consistency and sustainability of care reform. These challenges affect every stage of the care system, from decisions about children's care to the legislation, workforce, coordination, oversight and data needed to support effective implementation.

Poor decision-making and gatekeeping mechanisms

The vast majority of alternative care placements involve informal decisions made between family members, with no involvement of the state or social services.[205] Evidence on how these decisions are made is limited, though some findings suggest that cultural norms and traditions can take precedence over the best interests of the child.[206] Further research on both informal decision-making and effective strategies to strengthen decision-making is vital.[207]

Formal gatekeeping systems are also problematic in many settings. Common gaps include unclear legislation, insufficient guidance and decision-making tools, inadequate rigour in assessing child and family needs, limited opportunities for child and caregiver participation and poor coordination in decision-making processes across sectors responsible for children's well-being.[208]

The lack of registration of many residential care facilities means that decisions are often made at the facility level with no state involvement.[209] Even when the state is nominally responsible for determining entry into residential care, facilities may find ways to circumvent official processes.[210] In addition, there is often little recognition of the role of cultural and personal bias in decision-making about children's care, despite growing evidence from high-income settings demonstrating the importance of identifying and addressing this bias.[211]

Gaps in legislation and its implementation

Despite general progress in relation to legislation, numerous challenges and gaps remain in developing care regulations. Ideally, each country should have a national care reform strategy, legislation that sets out principles and provisions across all aspects of children's care, and detailed guidance for practitioners.[212] In many countries, there are gaps in at least one of these areas.[213] Moreover, despite the existence of strong policy frameworks, the lack of implementation of legislation in some countries results in only limited improvements in children's care.[214]

Gaps in the capacity of the workforce to deliver care reform

Although progress has been made in strengthening the social service workforce, in many countries this workforce does not have the capacity to fully support reform. Social worker numbers are often insufficient, leading to high caseloads and staff turnover.[215] Professional social workers are particularly scarce at the community level, hindering the ability to provide case management and other support to vulnerable families.[216] Community volunteers and paraprofessionals are often brought in to fill these gaps.[217] Although these individuals make vital contributions, they are often poorly supported, with unrealistic expectations placed on their roles.[218] As these volunteers work in their home communities, they may also face challenges navigating local power structures.[219]

Typically, the social service workforce responds reactively to abuse, neglect and family separation, rather than focusing on prevention.[220] Social workers often lack the basic resources they need to work with families, such as funding for transport.[221] Many are also poorly trained and supervised, particularly in their work supporting families and enabling the participation of those with care experience in decision-making.[222]

Research in India and Uganda shows that children, young adults and caregivers with experience of alternative care often have clear expectations about how they should be treated by social workers and which forms of support should be prioritized.[223] These expectations are not always reflected in the way social service workers behave or the tasks assigned to social service workers.[224]

Challenges related to social service workforce capacity are associated with the generally low value assigned to caring professions, as outlined above. Social service workers also need the support of other frontline workers to deliver services and support to children, families and care leavers. Deficiencies in the health, education, justice and social protection workforces are likely to have an impact on children's care.

Failures in coordination and integration

Although some countries have established coordination bodies,[225] fully integrated responses remain rare.[226] In many contexts, policy frameworks are fragmented, and coordination between agencies is weak, without clearly defined roles and responsibilities.[227] Failure to work effectively across sectors means that care systems can only address the immediate symptoms of inadequate care and family separation that fall within the remit of the child protection sector.[228] The structural causes of separation and poor care that lie outside this sector often go unaddressed.[229] National governments bear some responsibility for fragmented care systems, but the problem is also fuelled by splintered funding and siloed working within the aid sector.[230]

Limited oversight to ensure the safety and quality of care services

Although many countries have developed minimum standards for residential care,[231] there are fewer examples of such standards for other forms of alternative care. Evidence from multiple contexts indicates that existing standards are often not enforced. In many settings, a large proportion of residential care facilities remain unregistered, and therefore outside the purview of government oversight. Regular monitoring of residential care is also limited.[232] As noted earlier in this chapter, the monitoring of children in kinship and foster care is hindered by a shortage of community-based social workers and a reluctance in some contexts to intervene in the private sphere of the family.

A lack of data required for effective planning of care reform

As noted throughout this paper, there are substantial gaps in evidence on children's care across many low- and middle-income countries. Common gaps include:

- basic data on the number of children in different care arrangements, disaggregated by age, gender, disability status and other characteristics.
- evidence on attachment and the need for permanency and stability across contexts, including children's perspectives and feelings on frequent placement changes between parents and kinship care.
- informal decision-making processes around care and the extent to which the best interests of the child are considered, and children's agency in decision-making about their care.
- insights into the current use of domestic and intercountry adoption and ***kafalah***.
- evidence on groups left behind by care reform, including deeper insights into vulnerabilities due to age, gender, ethnicity, sexual orientation and gender identity.
- evidence on the costs and benefits of using different entry points for care reform.
- evidence on the risks and benefits of small group homes, including evidence from outside Europe and concerning a range of different groups of children.
- evidence of the risks, benefits, role and nature of boarding schools and centres for religious instruction across a range of settings.
- evidence on the most appropriate forms of care for displaced or migrant children.

5.5 Barriers to participation

The meaningful participation of children and young adult care leavers can be restricted by assumptions that they need rescue and protection, by a lack of trust in their capacities and by fears about the inconvenient and complex truths they may share.[233] Funding models with rigid timelines, predefined activities and burdensome reporting requirements may also hinder participation by leaving little scope to adapt processes to the needs and circumstances of children and young adult care leavers.[234]

For those who have grown up in residential care, expressing their perspectives can be particularly difficult; a lack of autonomy in their daily lives often means they are not used to forming and expressing their own views.[235] The voices of children in alternative care and care leavers may be further marginalized because disadvantaged groups, such as those with disabilities or from certain ethnic groups, are disproportionately represented in alternative care. Being in alternative care and belonging to groups that are widely discriminated against can make it especially difficult to get heard.

Care leavers have strong views and expectations about what meaningful participation should look like, including opportunities to:

- have a say in decisions about their own care,
- provide regular feedback on care services,
- be involved in the running of care services and coordination bodies,
- join the social service workforce, and
- participate in policymaking.[236]

Too often, these expectations are not met. At best, children and care leavers are consulted as part of care reform processes,[237] sometimes repeatedly by different agencies. However, the lack of payment or follow-up action leaves many feeling exploited and ignored.[238]

Although children and young adult care leavers are often seen as passive recipients of care and protection, they can, in fact, exercise agency in decisions about their own care.[239] They often develop their own coping mechanisms when they are separated from their families, while in alternative care and after they leave. Strategies such as establishing their own peer support networks[240] demonstrate agency and further emphasize the potential for children and young people to play a stronger role in care reform.

Children often have complex views about their care which may not fit neatly into care reform priorities. Studies in India,[241] Latvia,[242] Tanzania[243] and Thailand[244] reveal that children often have mixed feelings about residential care. Boys and girls often miss their families, dislike the strict rules and report witnessing or experiencing violence. Nevertheless, some appreciate the educational opportunities, protection from poverty or abuse and the relationships formed in residential care. Adults with albinism who grew up in institutions in Africa have described feeling isolated from the wider community, while also recalling a sense of protection within residential care, where they were shielded from the stigma, discrimination and threats of violence they faced in their communities.[245]

There is a risk that positive views on residential care, including institutional care, could be used to justify its continued use. A fear that the complexity of children's views on residential care will confuse policymakers may also be used as a rationale for not seeking out these views. However, it remains vital to hear children's perspectives and to acknowledge their goals for education, safety and access to services. These views can and should be used as an impetus for developing strategies to achieve these goals while also enabling children to grow up in safe and caring families and communities.

5.6 Uneven progress in care reform due to discrimination

Care reform processes rarely benefit all groups of children equally, and the groups that are advantaged or disadvantaged vary across contexts. There is often significant overlap among disadvantaged groups, with many children experiencing multiple forms of discrimination. Disadvantaged groups commonly include the following:

- **Children under 3.** Global guidance based on decades of research indicates that residential care is particularly harmful for children under 3 years old and recommends that all children be placed with families.[246] However, despite some reductions in residential care for children in this age group, substantial numbers remain.[247] For example, in Moldova, 58 per cent of children in residential care are under 6 years old, of whom 17 per cent, or approximately one in six, are under 3 years old.[248]
- **Adolescents.** Care options are often more limited for adolescents than for younger children because foster carers and adoptive parents often prefer to take in younger children.[249] Adolescent boys can be particularly difficult to place in foster and residential care,[250] due to concerns about housing them with unrelated adolescent girls or about managing behaviour perceived as 'difficult'. It is often easier to place adolescents in kinship care, and older children are better able than younger children to express their preference for this arrangement.[251] Caregivers may also prefer older children because of the perceived financial and household contributions they may make, including through paid work, domestic tasks, and in some contexts, inheritance, dowries or bride price.[252]
- **Children with disabilities.** Many children with disabilities are pushed into residential care by stigma, social exclusion or lack of access to education, rehabilitation and other services within their communities.[253] In some contexts, professionals and families commonly believe that children with disabilities need the medicalized care offered by institutions.[254] Discrimination and lack of access to services affect the capacity and willingness of kinship and foster carers and adoptive parents to care for children with disabilities.[255]

  Once in residential care, children with disabilities can be at greater risk of neglect, violence and abuse than other children.[256] Much of this care is institutional in nature and of poor quality. Recent research in Mexico revealed how children in residential care are subjected to violence and sexual abuse, forced abortion and sterilization, the use of restraints and cages and prolonged periods immobilized in bed, resulting in muscle atrophy.[257] Care leavers with disabilities also experience heightened vulnerability.[258]

  Evidence from Bangladesh and Gaza shows that children with disabilities are at greater risk of separation from their families during conflicts and other emergencies.[259] For example, children with disabilities may not be physically able to flee alongside family members.[260] Care reform

processes often leave the reintegration of children with disabilities from residential care until after other groups have been reintegrated.[261] Consequently, large numbers of children with disabilities remain in residential care even in settings where care reform is more advanced. In Europe and Central Asia, where significant progress has been made in care reform in many countries, children with disabilities are 6 to 30 times more likely than other children to be in residential care.[262] For example, children with disabilities account for 87 per cent of children in residential care in Turkmenistan[263] and 38 per cent in Moldova.[264]

- **Children whose behaviour is perceived as 'challenging'.** Children with certain disabilities, such as those on the autism spectrum, may display behaviours caregivers perceive as challenging. These behaviours may also be associated with mental health conditions or trauma related to family separation or abuse. Without adequate support, families may struggle to cope, leading to placement in alternative care.[265] Such perceptions and behaviours can also limit children's care options, as residential care facilities, foster and kinship carers and prospective adoptive parents may be unwilling to care for them.[266]
- **Young adults with disabilities.** In some settings, young adults with disabilities remain in residential care well into adulthood because community-based options are not available.[267] In Europe and Central Asia, although the proportion of children living in residential care is falling in many countries, the proportion of young adults in residential care appears to be rising, a trend linked to disability.[268]
- **Children from ethnic minority groups.** Globally, children from certain ethnic groups are disproportionately represented in alternative care.[269] For example, in Myanmar and Thailand, Karen and Chin children are over-represented in residential care.[270] In a statement on intercountry adoption, the United Nations has noted that discrimination against minorities and indigenous peoples has been a key driver of illegal adoption in many countries.[271] Racism also affects children's experiences within alternative care. For example, Haitian and Venezuelan migrant children living in Brazil and Mexico report discrimination by residential care staff, leading some to prefer to live on the streets.[272]
- **Children and young people facing discrimination on the grounds of sexual orientation and gender identity.** A multi-country study on the causes of family separation found that discrimination within families on the grounds of sexual orientation and gender identity may cause children to run away from home.[273] Such discrimination may continue in residential care. For example, children in shelters for migrant and trafficked children in Latin America and the Caribbean have reported experiencing insults from other residents due to their sexual orientation or gender identity.[274]
- **Children of adolescent mothers, particularly those whose mothers grew up in care.** Evidence from countries such as Rwanda shows that adolescent mothers can struggle to provide adequate care, especially if they themselves grew up in residential care and have no strong parental role models.[275] This can result in children being placed in residential care.

5.7 The complex relationship between gender and care

Boys and girls experience different forms of disadvantage in relation to placement in alternative care, which vary greatly across contexts. For example:

- Boys may be placed in residential care or religious boarding schools more frequently than girls in contexts where boys' education is more highly valued.[276]
- In Thailand, the daughters of single or remarried mothers are more likely than sons to be placed in residential care. This tendency is attributed to mothers' concerns about their capacity to protect their daughters from harm whilst fathers are absent from the home.[277]
- Across many settings, the willingness of kinship carers to look after children is influenced by prevailing gender roles. For example, girls may be more readily accepted than boys in households that value their help with housework and the prospect of a dowry upon marriage, while boys may be preferred in contexts where sons are likely to receive an inheritance after a parent dies.[278]
- The vulnerabilities of children in alternative care vary by gender.[279] For example, girls with disabilities in Mexico are especially vulnerable to sexual abuse in residential care.[280]
- Male and female care leavers also face different vulnerabilities. Female care leavers have been found to be particularly vulnerable to sexual exploitation by employers.[281]
- In countries where it is socially unacceptable for women to live alone, female care leavers without families are often forced into early marriages, often with much older men.[282]
- In Egypt, male care leavers are allowed to stay in residential care until they complete their education, while female care leavers must leave this care when they marry.[283]
- In Iran, female care leavers face greater stigma and pressure to conceal their care history, which may contribute to social isolation.[284]
- In China, the strong expectation that men should provide financially for their families can place male care leavers, who may have limited access to employment, at a particular disadvantage when forming a family.[285]
- In Latvia, male care leavers report higher rates of involvement in criminal activity than female care leavers.[286]

SUMMARY

Persistent challenges in care reform across the world

Despite progress in many contexts, care reform continues to face persistent challenges, including:

- insufficient prioritization and funding of services to prevent family separation, promote reintegration and strengthen kinship care, including informal support from extended families and communities,
- ongoing widespread use of institutional care,
- the limited scale of foster care and domestic adoption,
- failure to support the meaningful participation of children and young adult care leavers in decisions about their lives and in care reform processes,
- inadequate support for care leavers,
- structural weaknesses in care systems, including gaps in legislation, limited workforce capacity, fragmented services, weak oversight and persistent evidence gaps, as well as inadequate efforts to address gender, disability and other inequalities.

6. Unresolved dilemmas in care reform

6.1 The use of small-scale residential care

The use of small-scale residential care is widely regarded as a central area of contention in children's care globally.[287] Disagreements on this issue are often blamed for a lack of a unified purpose amongst actors in the sector, preventing global progress.[288] Box 6 explores these debates.

The resolution of dilemmas on this issue is hindered by limited and contradictory evidence on outcomes for children.[289] Debates often centre on the use of residential care for children with disabilities, and fail to consider the needs of other groups, such as children who have been living on the streets. It is important that any further care reform efforts examine the appropriateness of small-scale residential care for a much wider range of different groups of children and emphasize the varied and overlapping vulnerabilities that affect the individual care needs of every child.

BOX 6

Debates around the use of small-scale residential care

Perspectives on small-scale residential care

Views on small-scale residential care fall along a continuum,[290] with three broad positions that are particularly evident:

1. **At one end** sit organizations such as SOS Children's Villages, which make extensive use of this model, including for children's longer-term care.[291] Many organizations providing small-scale residential care do make efforts to ensure it is of high quality and safe, though this is not universally the case.
2. **The centre** of this continuum is articulated by the UNICEF Europe and Central Asia Regional Office (ECARO) in its 2020 white paper,[292] which argues that the term 'small-scale residential care' should refer not only to the size of a facility, but also to residential care that is non-institutional in nature, where children have the opportunity to form attachments with caregivers and receive care tailored to their individual needs.[293] This entails, for example, consistent and trained caregivers, robust safeguarding mechanisms and flexible routines that respond to each child rather than imposing rigid, collective schedules.[294] UNICEF ECARO argues that such conditions cannot realistically be met in units of more than six children.[295]

UNICEF ECARO further suggests that temporary placement in high-quality small-scale residential care may be appropriate for some children in specific circumstances.[296] These placements should have a clearly defined purpose that cannot be met in a family-based setting, be time-limited and be embedded in care plans that prioritize family reintegration, permanent placement with a new family, or, in the case of older children, transition to independent living in the community.[297] Evidence from a range of contexts illustrates situations where such temporary placements may be warranted, including:

- children who face severe risks of being targeted and killed, such as those with albinism in communities where there is known trafficking in body parts.[298]
- children who have spent long periods outside a family environment and need time to adjust, for example, children who have been living on the streets who are unfamiliar with the routines or expectations of family life.
- older children approaching adulthood whose primary experience of family life has been one of trauma, violence and instability, and who may prefer to be with peers in residential care as they prepare for independence.[299]

UNICEF ECARO[300] provides multiple caveats regarding when small-scale residential care could be considered an appropriate option. For example, they stress that this form of care should never be used for children under the age of 6, whereas the Guidelines recommend the age of 3 as a cut-off.[301] UNICEF ECARO further states that small-scale residential care should not be used in response to poverty, lack of access to services or discrimination on the grounds of gender, disability or other status.[302] UNICEF ECARO's position aligns with the limited framing in the Guidelines.[303] Several other agencies working on children's care have adopted similar middle-ground positions.[304]

3. **At the far end** of the continuum are organizations that primarily view this issue in relation to the rights of children with disabilities.[305] The Committee on the Rights of Persons with Disabilities, in its general comment on Article 19 of the Convention on the Rights of Persons with Disabilities, clearly states that all children with disabilities should grow up in family settings.[306] In line with this view, the NGO Lumos recently published a position paper on small-scale residential care facilities, which it refers to as 'small group homes',[307] arguing that care in such facilities is fundamentally flawed as it is not provided in a family environment.[308]

Stepping stone or stumbling block towards care reform?

Small-scale residential care can be used as a stepping stone as systems shift towards family-based care. Countries that were formerly part of the Soviet Union often relied on this model during initial efforts to reduce reliance on institutional care.[309] In some cases, this meant that children moved from one form of residential care to another, without a substantial overall increase in the number of children transitioning from residential to family-based care.[310]

Some practitioners argue that the use of small-scale residential care is a necessary step in care reform, whereas others contend that it has slowed down reform processes.[311] Evidence shows that small-scale residential care continues to be widely used across a range of contexts, including higher-income countries which have made considerable efforts to deinstitutionalize.[312]

To conclude, ongoing reliance on small-scale residential care, combined with evidence of the value of this form of care for some children, suggests that the middle-ground position may be the most realistic and appropriate. In practice, the key questions for policymakers are therefore how small-scale residential care is defined and regulated, when it is used within a continuum of services, and for which children and under what safeguards, rather than whether it should exist at all.

6.2 The place of boarding schools in care reform

In many parts of the world, there is a thin dividing line between residential care and boarding schools or other residential education or training, with facilities often sharing similar characteristics. This issue is significant because in many countries there are large numbers of children in boarding schools or other forms of residential education. For example, in Thailand, Buddhist temples care for some 76,000 children while they receive religious education – a figure comparable to 79,000 children living in residential care.[313] Box 7 outlines the debate over whether boarding schools should be classified as a form of residential care.

BOX 7

The blurred boundary between boarding school and residential care in children's care reform

Common features of boarding schools and residential care

In many parts of the world, children are separated from their families for education or religious instruction.[314] Some are placed in facilities described in terms associated with residential care, such as orphanages or children's homes. Others attend and live in facilities designated

as boarding schools, special residential schools for children with disabilities, residential sports academies or residential centres for religious instruction such as Quranic schools or monasteries.[315] Despite the varying terminology used, children in both types of facilities have much in common. For example, they:

- are often separated from their families for long periods of time or return home regularly during school holidays.[316]
- may be placed primarily to receive an education, due to poverty or because their families are unwilling or feel unable to care for them.[317]
- are vulnerable to abuse by staff or peers living in the facility but may be unable to report it because of the closed environment.[318]
- receive their daily care from a professional outside of their family.[319]
- may find it hard to adjust to life with their families and communities when they return home.[320]

The case for including boarding schools in care reform

Including facilities described as boarding schools (or residential schools) within care reform strategies acknowledges these similarities and allows them to be monitored and regulated in the same way as residential care.[321] It also discourages the separation of children from their parents for the purposes of education and encourages the development of educational options close to home.[322] This may be especially important for children with disabilities who are regularly denied opportunities to be taught in mainstream schools in their communities.[323] In some countries, renaming residential care facilities as boarding schools has been used to evade the scrutiny and implementation of care reforms.[324] Including boarding schools and other residential education facilities within care reform would overcome this practice.[325]

Reasons to exclude some boarding schools from care reform processes

In many countries, boarding schools fulfil diverse purposes. Some offer prestigious programmes and are attended primarily by children from affluent families, while others provide access to more basic education for children living in remote areas where there are no schools. Children in boarding schools may maintain regular contact with parents or other family caregivers who monitor and retain primary responsibility for their care. It is debatable whether reducing this use of boarding schools is a priority for care reform, especially given the limited resources and many challenges that need to be addressed across many different care settings.

There are substantial gaps in the evidence about the benefits and risks associated with boarding schools.[326] Evidence suggests that the way boarding schools are organized and managed varies greatly between contexts.[327] It may therefore not be possible to make blanket recommendations about the inclusion of these facilities in care reform processes. Further research, debate and discussion are required in different contexts.

6.3 Determining entry points for care reform

Two key questions can be raised about appropriate entry points for care reform:

1. **Should the goals of care reform centre on reducing the number of children in residential care, particularly those in institutional care, or should these goals seek to improve, more broadly, the care of all children?**
   Care reform goals focused on removing children from institutional and other harmful forms of residential care have clearly defined and measurable outcomes. Such goals allow a focus on ending the considerable harm caused by institutionalization. However, in many low- and middle-income settings, the vast majority of children at risk of inadequate care live outside such residential care. This includes those living with abusive or violent families, surviving on the streets without adult care or living in unsafe kinship care. A focus only on reducing reliance on residential care leaves the needs of these children unmet.

2. **Where should efforts to enhance family-based alternative care be directed?**
   Reform efforts often begin by developing foster care in parallel with the closure of residential care facilities. Efforts to prevent family separation and strengthen informal kinship care often come later, despite global guidance recommending that both be prioritized.[328] Foster care may not be a feasible starting point in contexts where the workforce, legislation and oversight needed to bring it to scale are poorly established. Strengthening kinship care may provide a more practical initial step in care reform where it already exists at scale and is culturally acceptable. Practitioners have suggested several reasons for limited investment in kinship care, including government reluctance to intervene in the private sphere of the family and an unwillingness to take responsibility for improving care for the often very large numbers of children in kinship care. Further research is needed to understand how different entry points influence the effectiveness of care reform.

SUMMARY

Areas of continuing debate

Progress in care reform is hindered by several unresolved dilemmas:

- what constitutes institutional or other harmful forms of residential care, and when small-scale residential care is an appropriate option.
- the dividing line between boarding schools and residential care, and the extent to which care reform should prioritize efforts to reduce the use of boarding schools.
- the question of the most effective entry points for care reform.

7. Factors outside of the care system that affect care reform

7.1 Megatrends

Large-scale global phenomena such as climate change, conflict, migration and displacement, pandemics and demographic change are profoundly reshaping children's lives in low- and middle-income countries, including how they are cared for.[329] These intersecting trends affect families' capacity to care for children, the support available from communities, and the level of demand for care services. The nature and extent of these megatrends, both individually and collectively, vary by context.

Climate change, conflict, migration and displacement

Climate change and rising levels of violent conflict are reshaping the environments in which children grow up. These overlapping pressures are driving unprecedented levels of migration and displacement within and between countries.[330] According to UNICEF, between 2016 and 2021, 43 million children were displaced by climate-related disasters, an average of 20,000 every day.[331] In 2025, there were an estimated 35.5 million international migrant children and 19.1 million refugee and asylum-seeking children worldwide.[332] An additional 29.4 million children were internally displaced because of conflict and 4.4 million due to disasters, many of which were caused by or related to climate change.[333]

Parental labour migration, a defining feature of many low- and middle-income countries, tends to increase in contexts of economic, political and environmental instability.[334] Meeting the increasing and compounding needs of families and communities in these circumstances places ever greater demand on governments and care systems.

Increasing family separation

In low- and middle-income countries, intensified climate-induced events such as floods and cyclones are a direct cause of children becoming separated from their families. For example, in Mozambique, Cyclone Idai (2019) displaced hundreds of thousands of people, and many children were separated from caregivers during evacuation and resettlement.[335] Between 2016 and 2021, approximately 19 million children were displaced by floods and storms in East Asia and the Pacific, and family separation during evacuation and in emergency shelters has been common.[336] Children displaced in these circumstances face heightened risks to their health, well-being and protection,

and, without the safety of family, are especially vulnerable to exploitation, abuse and recruitment by armed groups or criminal gangs.[337] These risks are particularly acute for children already disadvantaged by poverty, gender, ethnicity, religion, disability or other forms of marginalization.[338]

Conflict is also a major driver of family separation. Caregivers may be killed, injured, detained or forced to flee, while children may lose contact with family members during attacks, evacuation or displacement. Available humanitarian data generally count unaccompanied and separated children rather than all children affected by family separation; available figures are likely to understate the full scale:

- **Gaza.** Following the escalation of hostilities in October 2023, UNICEF estimated in February 2024 that at least 17,000 children were unaccompanied or separated from their parents.[339]
- **Sudan.** In response to ongoing conflict that began in 2023, in 2025 alone UNICEF provided family tracing, reunification or alternative care services to 20,190 unaccompanied and separated children (this is the number reached by these services, not the total number affected).[340]
- **Ukraine.** The conflict, which began in 2014 and escalated with Russia's full-scale invasion in February 2022, has included the unlawful deportation and transfer of children from occupied Ukrainian territory, creating prolonged barriers to family reunification.[341]

Abduction and recruitment by armed forces and armed groups are additional causes of family separation. Across West and Central Africa, including the Central Sahel and Lake Chad Basin, more than 21,000 children were verified as recruited and used between 2016 and 2020.[342] In Colombia, verified cases of recruitment and use increased fourfold between 2020 and 2024, reaching an average of one child every 20 hours in 2024.[343]

Conflict and climate-related emergencies are compelling caregivers to face impossible choices between keeping children at home as conditions deteriorate and arranging for them to leave in the hope that they will be safer and have better opportunities.[344] Such intentional separations contribute to the global rise in climate migration.[345] Parents may send children to temporary camps, settlements or urban centres or across borders. Children themselves may also choose to leave in search of safety, services or humanitarian assistance. These decisions are often made to protect children and safeguard the family.[346] In some circumstances, families may see separation as a way of spreading risk across different locations, securing additional sources of income, easing immediate pressure on households in fragile settings or drawing on extended family and transnational support networks.[347] These are not straightforward or freely made choices, but responses to severe constraints and uncertainty.

Children who leave may be able to secure a foothold in a safer area, sometimes gaining access to education, health services or humanitarian assistance otherwise unavailable in their place of origin. Older children may find work and send remittances to support family members left behind. In some contexts, relocation to join extended family in urban centres or abroad enables children to benefit from better schooling or training opportunities.[348]

Intensified drivers of family separation

In addition to directly separating families, growing evidence shows that climate change and conflict exacerbate the conditions that can lead to separation. Both sudden-onset events such as floods, cyclones and wildfires, and slow-onset processes such as droughts and sea level rise can cause illness or death, increasing pressure on families and undermining their ability to care for children.[349]

Climate change also damages livelihoods. In Bangladesh, for example, recurrent floods and droughts have destroyed crops, disrupted incomes and pushed more children into residential care.[350] Similar patterns have been observed in many other contexts.[351] Food insecurity can add to these pressures by increasing parental stress, particularly in single-parent households, straining family relationships and functioning.[352]

For children who remain in their communities, conflict and disasters may destroy schools, health care facilities and essential infrastructure,[353] cutting them off from education and basic services that can help protect them from further risk.[354]

Impacts on family capacity to care for children

The effects of migration on the capacity of families to care for children are complex. When fathers migrate, remittances can improve household income and sometimes children's access to schooling and health care.[355] However, their absence can leave mothers with greater caregiving and financial responsibilities, while children may take on additional household and care tasks or other forms of work.[356] When remittances are not received, the vulnerability of the household can worsen, and family members can be left in even more precarious circumstances, exacerbating the drivers of separation and inadequate care.

When mothers are separated from families, the effects on children are often more profound. Studies in China, South-East Asia and sub-Saharan Africa show that when mothers migrate, children are frequently left in the care of extended family.[357] As noted above, children in kinship care can thrive when relationships are stable, and caregivers have adequate resources. However, the risks of neglect, abuse and poor developmental outcomes increase when caregivers face poverty and stress.[358]

Studies in Indonesia and the Philippines, among other countries, show that many kinship care arrangements provide continuity for children whose parents have migrated. However, some arrangements break down when caregivers lack the support needed to manage additional responsibilities, which sometimes leads to children being placed in residential care.[359] So-called 'left behind' children may also face discrimination and maltreatment, social isolation, emotional distress, school difficulties and reduced adult support and guidance.[360]

Even when children stay together with family, the combined effects of poverty, insecurity, distress and grief can undermine families' ability to provide responsive and stable care. Mounting evidence underscores children's heightened susceptibility to violence in these circumstances, as economic strain, prolonged separations and caregiver stress increase the risks of harsh discipline and neglect.[361]

Impacts of crisis-induced separation on child well-being

Children who migrate without their families in search of safety and opportunity can face risks to their health, well-being and protection.[362] In the context of conflict and weak rule of law, they are at higher risk of trafficking, sexual and labour exploitation.[363] Evidence from recent humanitarian emergencies illustrates how family separation, inadequate reception and shelter arrangements, and disruption of essential services can compound these risks, undermining children's access to health care and education and delaying family reunification and appropriate alternative care placements.[364] The potentially serious effects of these experiences on children's mental health are increasingly well documented. Travelling with caregivers or known and trusted adults can help protect children during climate shocks, conflict or other emergencies.[365]

Crisis-induced separation also has an impact on the type of alternative care services that children need. Many children separated from their families during crises spend time without any adult caregiver, either alone or in groups with other children.[366] These periods without adult care can make it difficult for children to readjust to family structures and routines.[367] Some older children, particularly those approaching adulthood, may therefore prefer supervised independent living.[368] Children who have been trafficked, migrated alone, survived on the streets or entered into marriage may also, in some circumstances, benefit from temporary placement in high-quality, small-scale, specialized residential care. However, as discussed in Box 6, more evidence is needed on the benefits and challenges associated with this form of care.

Capacity of care systems to respond to megatrends

The sweeping impacts of these megatrends are widening the gap between the growing needs of children and the limited capacity of care systems to respond effectively.

Policy frameworks and strategies. Policy frameworks and strategies frequently overlook climate risks and the central role of families in adapting to the impact of intensifying megatrends. Strategies for disaster preparedness and response and climate change adaptation often fail to include measures for keeping families together.[369] Long-term care reform strategies do not routinely include reference to climate change.

Social service workforce. The social service workforce in many low- and middle-income countries is ill-prepared for climate-related emergencies. Systems often lack the capacity to address the new forms of distress and trauma associated with large-scale environmental loss and displacement, and social service workers are rarely trained to respond to climate-related risks.[370]

Public financing. Public resources are frequently redirected to disaster recovery, leaving less funding for family-based care. National care reform strategies rarely consider the growing threats to children's care posed by climate change or outline how systems should respond.[371]

Availability of kinship care and support from extended family. Displacement scatters relatives and fragments social networks, reducing the availability of kinship care and safety nets that can protect children during crises.[372] In flood-affected areas of Ghana[373] and drought-stricken parts of Ethiopia[374], families that once relied on extended kinship networks now struggle to access the support they need to care for children. Beyond limited food rations or cash grants in some humanitarian settings, kinship carers rarely receive systematic assistance.[375]

Loss of services for vulnerable families. Conflict, climate change and fragility strip away the services and institutions that support children to remain in or return to families. Health, nutrition, education and social protection systems are often disrupted or destroyed, cutting children off from education and basic services that act as protective buffers from further risk.[376] Family tracing and reunification services face serious obstacles due to restricted mobility, damaged infrastructure and overwhelmed social workers.[377] The loss or weakening of these services leaves families with little support, increases the likelihood of separation and contributes to rising rates of institutionalization.[378]

Limited formal alternative care options for migrant and displaced children. Many migrant and displaced children are denied access to foster or residential care. Older children on the move often prefer to live independently as they have become used to being outside of a family setting and want the freedom to work. Supervised independent living arrangements have been shown to be a valuable option for these groups but are not universally offered.[379]

Poor-quality alternative care for migrant and displaced children. Residential facilities for migrant and displaced children are frequently overburdened and under-resourced, with insufficient capacity for family tracing and reunification.[380] In some circumstances, the availability of residential care may also contribute to family separation. For example, child-only shelters in Guatemala provide protection and services for unaccompanied boys and girls. Parents may choose to send their children to these facilities because they offer services that are otherwise unavailable, even when this means separating the family. Where shelter capacity and family tracing services are weak or overstretched, children who are already separated may also remain apart from their families longer than necessary.[381]

Community support to caregivers. Large-scale economic and climate-driven migration is driving population increases in urban areas, eroding the dense, place-based kin and neighbour networks that traditionally provided care and shared responsibility for child rearing.[382] At the same time, 'sending' communities are frequently left with demographic extremes – households composed of the old and the young – which reduces local capacity to care for children left behind and places this responsibility on older, often resource-poor grandparents.[383] In conflict-affected communities, population flows and insecurity fracture community structures, weakening their capacity to protect and support children.[384] They can also interrupt education and health services and restrict access to humanitarian assistance, further limiting the formal support available to children and their caregivers.[385] These overlapping dynamics combine to reduce the availability, stability and quality of care options for children in many settings.[386]

Disease outbreaks and pandemics as stress tests for care systems

The HIV/AIDS epidemic, Ebola outbreaks, the COVID-19 pandemic and other disease outbreaks are major stressors on child protection and alternative care systems. They can disrupt access to health, psychosocial and social protection services, increase economic vulnerability and often intensify the risk of family separation.

During the COVID-19 pandemic, widespread lockdowns, school closures and mobility restrictions disrupted essential services, worsened poverty and amplified family vulnerabilities. Across many low- and middle-income countries, these conditions placed severe strain on children's care both within families and in alternative care settings. In Bangladesh and the Philippines, loss of income and limited access to social protection left many caregivers unable to meet children's basic needs, increasing the risk of neglect and separation.[387] Meanwhile, when residential care facilities were forced to close, many children faced abrupt and unsupported reunification with their families, placing many at risk.[388] Children who remained in residential care faced prolonged confinement due to lockdown-related visitation bans, as reported in Uganda,[389] India[390] and more broadly across South Asia.[391] Staff shortages and restrictions also compromised the quality of care and the emotional support available to children.[392]

During the 2014–2016 Ebola epidemic in West Africa, service breakdowns and illness and deaths among caregivers led to the rapid establishment of interim residential care. A general lack of care options resulted in the widespread placement of children in these facilities, reversing years of progress away from residential care toward family-based care.[393] This situation was exacerbated by delays and shortcomings in family tracing and reintegration efforts.[394] Evaluations of the Ebola response found that interim care centres were both costly and at risk of becoming permanent, even though family-based reintegration was shown to yield better long-term outcomes.[395]

Opportunities and innovations triggered by crises

Responses to infectious disease threats have also spurred innovation, highlighted gaps in care reform efforts and prompted the realignment of policy toward more resilient, family-centred systems. For example, in many countries where deinstitutionalization efforts had been ineffective and slow, thousands of children in residential care rejoined their families during COVID-19-related closures of care facilities.[396] Although these processes sometimes led to poorly supported and rushed reunifications, in other cases, government and NGOs mobilized quickly to help children return home, demonstrating that successful and sustainable reintegration is possible.[397]

Advances in service provision were made in many countries during the COVID-19 pandemic, including in Nepal, where remote or virtual case management and new models of psychosocial support for children were introduced.[398] Anecdotal evidence from India and elsewhere suggests that the pandemic also accelerated judicial and administrative decision-making to allow faster placements or reunifications under emergency protocols.[399]

Emergency cash transfer and social protection 'top-ups' were also provided to vulnerable families to reduce economic pressure and help keep children and their families together. For example, UNICEF's cash-based support in Madagascar, Sierra Leone, Sri Lanka, Tajikistan, Thailand and elsewhere helped families to cope through COVID-19 economic shocks.[400]

While these innovations show that care reform efforts can pivot under stress, they require intentional design to be safe, equitable and sustainable in the longer term. Government responses to pandemics and other health emergencies have generated many valuable lessons that could benefit care reform in both emergency and non-emergency contexts (see Box 8).

BOX 8

Care reform and lessons from pandemic response[401]

Pandemics magnify existing fragilities in care and protection systems, but they also create impetus for reform that might be harder to catalyse in 'normal' (or non-emergency) times. For care reform efforts in low- and middle-income countries to be resilient during future shocks, policymakers and practitioners should consider the following key principles:

- Care reform plans should enforce strong gatekeeping, ensure family tracing begins promptly and build capacity for foster, kinship or community-based care alternatives rather than defaulting to residential centres.
- When households are under multiple economic pressures, such as those triggered by pandemics, children are more likely to be separated from their caregivers. Combining social protection, for example, cash transfers, with parenting support or psychosocial services in a 'cash-plus' approach can strengthen family resilience. Care reforms should, therefore, provide integrated support that links assistance across social protection, health, education and child protection sectors.
- Care systems need mechanisms to maintain safe communication between children and their caregivers and social workers even when travel is restricted. Virtual contact, tele-monitoring and remote supervision protocols should be developed as part of alternative care case management systems, although face-to-face contact should remain prioritized where possible.
- Disruptions to psychosocial support or protection referrals can cause indirect harms, including increased violence, that compound the risk of separation. Systems must build surge capacity and continuity plans so that essential child welfare and health services remain functional throughout crises.
- Pandemic impacts are not evenly distributed: poorer families, rural communities and marginalized groups are often hardest hit. Care reform must be equitably implemented, targeting resources to the most vulnerable, ensuring that emergency protocols do not privilege better-connected families and monitoring for unintended harms such as children being reunified without follow-up.

These lessons demonstrate that long-term care reform strategies should anticipate future crises. Doing so means embedding flexibility, digital readiness, emergency protocols, contingency funding and intersectoral coordination across health, social and child protection systems, and the judiciary into the design of care systems *before* a crisis emerges.

7.2 Political and economic factors influencing care reform

A range of political and economic factors influence care systems, yet these factors are often not considered in care reform processes. They include:

Political ideology

Communist ideology supports a strong role for the state in the family and identifies the state as the main caregiver of children. Through this lens, the provision of residential care by the state is regarded as a symbol of successful child welfare policies. This role is often extended to strict family planning policies, with implications for children's care.[402] In Romania, under the former communist government, family planning was banned, which resulted in increasing demand for residential care because more 'unwanted' children were born.[403] In China, the one-child policy led to infant girls and babies with disabilities being placed into residential care as parents were keen to have only able-bodied male children.[404]

Across the Soviet bloc, political change at the end of the 1980s led to a rapid ideological shift from the idea of children as the property of the state to the recognition of children as persons with rights who are better cared for within a family.[405] The introduction of neo-liberal policies across many of these settings led to a smaller state role and reduced social welfare services, which further consolidated reductions in the use of residential care.[406]

Exerting state power or enhancing relational connections

There is evidence across multiple contexts of states using children's care as a means of exerting power. Power over children's care may be exercised directly through coercive state action and political interests. Power may also be exercised indirectly through informal relationships within care systems that influence decisions, allow harmful practices to escape scrutiny and weaken the enforcement of state regulation.

State actors in many conflicts have abducted vulnerable children from opposing countries or sides and placed them with their supporters. This strategy is used to punish opponents, weaken children's ties to their families and communities and influence their identity and beliefs.[407] At its most extreme, systematic state actions against children can amount to crimes against humanity, as the United Nations Independent International Commission of Inquiry on Ukraine concluded in March 2026 in relation to the deportation and forcible transfer of Ukrainian children by Russian authorities.[408]

Whilst some countries have used intercountry adoption as a means of enhancing diplomatic ties,[409] others have avoided action on corrupt intercountry adoption to prevent damage to diplomatic relations with sending countries.[410]

In many countries, there are also limits to state power, with relational connections superseding state regulation. For example, in Myanmar and Cambodia, the relationship between residential care directors and state officials has led to gatekeeping and inspection policies being circumvented.[411] In Myanmar, families often have personal relationships with residential care directors based on kin networks. These directors are seen as benefactors, and families are reluctant to complain about low-quality care or to follow reintegration programmes if directors suggest the child should remain in residential care.[412]

Influence of decentralization on care reform

The extent to which government decision-making is centralized or decentralized can have major implications for care reform. For example, decentralization has offered opportunities for experimentation in care reforms in Kenya and Nepal.[413] However, a disconnect between national and local-level funding has disincentivized deinstitutionalization in Moldova.[414]

Influence of donors and regional and international bodies

At the international level, governments, United Nations agencies and intergovernmental bodies shape care reform through their development policies and funding. The United Nations, the EU and the US Government have been particularly influential, helping to promote global consensus on the need to reduce reliance on institutional care.[415] For example, EU accession criteria have pushed care reform in countries such as Moldova, contributing to successful reforms.[416] The sudden cessation of USAID operations in July 2025 and the termination of funding for care reform programmes are reported to be having a catastrophic impact on families vulnerable to separation and on care services across multiple contexts.[417] One survey of five large child protection agencies found that 1.1 million children across more than 23 countries are directly impacted by cuts.[418]

Evidence suggests, however, that the beneficial influence of international donors should not be overstated. In the immediate aftermath of the fall of the Soviet Union, donor policies on care reform were often ad hoc and, in some cases, contradictory, with some funding used to renovate institutional care facilities.[419] In countries such as Georgia, small international NGOs stepped up to fill the gap created by the sudden collapse of the state and successfully promoted care reform at this time.[420]

Rich individuals, private trusts and foundations have also affected care both positively and negatively in many settings. For example, in Nepal, 90 per cent of residential care facilities were reported to have received donations from such sources, with US$9.1 million donated to residential care by philanthropic funders, compared to US$3.7 million to family-based care in 2018.[421] A similar pattern has been documented in Thailand, where a substantial proportion of residential care is funded by foreign donors, many of whom are Christian faith-based organizations.[422]

Commodification of care

In addition to donor influence, global and national economic forces can shape care reform through the commodification of children's care. In countries such as Cambodia and Nepal, children are trafficked into residential care so that owners can charge foreign tourists to volunteer in these facilities.[423] In recent years, campaigns have successfully reduced this form of 'orphanage voluntourism', though evidence suggests that exploiters may simply shift their business models in the face of this change. In Nepal, corrupt intercountry adoption was used to extract money from prospective adoptive parents until a moratorium on intercountry adoption was introduced.[424] There is evidence of corrupt intercountry and domestic adoption, both currently and historically, in several contexts, including Bangladesh, China and Nigeria.[425]

Economic downturns

Finally, national and global economic downturns have major ramifications for children's care. These forces can often pull in multiple directions at once. In Lebanon, the economic crisis has led to increasing demand for residential care, but also the closure of some facilities due to a lack of funding.[426] In Romania, an economic downturn in the 2000s led to rising rates of institutionalization and a fall in funding for care reform programmes. Care leavers were also increasingly ostracized because of the perception that they had used up too great a share of state resources during a period of hardship.[427]

SUMMARY

Impact of external pressures on care systems

External pressures strain care systems, and their impact should be considered in care reform processes:

- Megatrends, including climate change, conflict, migration, displacement and pandemics, increase family separation and challenge already fragile systems.
- Political and economic forces shape care policies, financing and implementation and need to be more extensively considered in care reform strategies.

8. Conclusion and recommendations

Conclusion

Some progress has been made towards ensuring that children can grow up in stable and protective family environments. At the micro level, extended families and communities play a vital role in caring for children, even in situations of extreme hardship. At the meso level, international and national policies widely endorse family-based care, and a growing number of countries have reduced institutional placements, reformed intercountry adoption and invested in the social service workforce. The views of people with care experience are also increasingly sought in reform efforts. At the macro level, much learning on care reform has been generated from global pandemics and humanitarian responses to climate change-related emergencies.

However, significant challenges persist. At the micro level, the role of extended families and communities is often not recognized or strengthened by service providers. Social norms lead to discrimination against certain groups, including those with disabilities, placing them at heightened risk of separation and institutionalization.

At the meso level, there are multiple common failings within the care system. Service provision often centres on residential care and does not prioritize support to children's own families or offer family- and community-based care options at scale. Poor support means that children and young adults leaving care to live independently for the first time often face difficulties. Care systems are structurally weak in many countries, with gaps in legislation, limited workforce capacity, fragmented services, weak oversight and evidence gaps. Children's views are not consistently incorporated into care decisions, and those with care experience are denied an active role in reform processes. Gender, disability and other inequalities continue to limit access to services and support.

Inadequate attention is paid to the impacts of the care economy on care systems, though the undervaluing of caregiving roles contributes to the low prioritization and funding of care reform. Political and economic forces shape care policies, financing and implementation, and need to be more extensively considered in care reform strategies.

Macro-level external pressures further strain care systems. Climate change, conflict, migration, displacement and pandemics increase the risk of family separation and challenge already fragile care systems. Limited efforts have been made to ensure that care systems respond to these global megatrends.

Recommendations

1. Broaden the lens of care reform

- Work within and outside of the child protection sector. Recognize the key role played by justice, education, social policy, social protection and health sectors and develop integrated responses.
- Locate efforts to remove children from institutional care within wider strategies to ensure safe, high-quality and sustainable family-based care for all children.

2. Recognize the broader drivers of care reform and future-proof this reform

- Recognize the political and economic interests and incentives that prevent care reform and develop strategies to address them.
- Challenge the low value assigned to caregiving and the gender and other social norms that shape how care is understood and provided.
- Recognize the family as the foundation for children's resilience in the face of climate change, conflict, growing rates of displacement and migration, and pandemics. Collaborate with those working to respond to these trends to ensure that improving children's care is a key part of this response. Make sure that care reform strategies consider the impacts of these trends.

3. Ensure that reforms are equitable and involve those with lived experience

- Explore and address the impacts of gender, disability and other inequalities on care reform; do not leave the hardest-to-reach groups behind in care reform processes.
- Listen to the perspectives of children, young adult care leavers and caregivers, and provide opportunities for their leadership and engagement with reform processes.

4. Enable sustainable reforms through a strong care and protection system

- Prioritize understanding and building on existing extended family and community support for children's care.
- Strengthen all aspects of the care system, including laws, policies and guidance, the social service workforce, the costing and financing of reforms, effective referral mechanisms and the integration and coordination of services.
- Ensure reforms are based on sound evidence by strengthening the collection of administrative data, and evaluations and research on children's care and care reform.

Annex 1. Methodology

Overall approach

This paper is based on a scoping review of published and grey literature on care reform in low- and middle-income countries. The review aimed to identify and synthesize key themes, trends and gaps in the literature published since 2019, rather than to assess the effectiveness of specific policy or programmatic interventions. To ensure the review was feasible within the available timeframe, a publication date cut-off was applied, and the number of stakeholder interviews was limited. Consequently, some earlier scholarship and promising practice examples were not included.

Stakeholder consultations

Before undertaking the literature review, interviews and consultations were held with 28 practitioners engaged in care reform globally and within specific low- and middle-income contexts to explore perceived areas of progress and ongoing challenges. Insights from these consultations informed the scope of the review and the development of the conceptual framework used to guide the analysis.

Literature search, selection and analysis

Literature was identified through a structured search of the Better Care Network online library and Google Scholar, alongside additional documents recommended by practitioners during interviews and consultations. Searches were conducted on a region-by-region basis to ensure broad geographic coverage. The initial literature search focused on publications released between 2019 and mid-2025, with selected more recent sources incorporated during subsequent revisions.

Inclusion criteria were guided by topical relevance, geographic focus and quality considerations. Priority was given to peer-reviewed journal articles, policy documents, situation analyses, NGO reports and publications from United Nations agencies. Where research was included, greater weight was placed on papers published in peer-reviewed journals with clearly described methodology, an appropriate sample size, and a stated analytical rationale. Practitioner guidance and more descriptive documents were reviewed selectively where they offered relevant contextual insight.

The review focused primarily on low- and middle-income countries, with literature from selected high-income countries included where it provided relevant comparative or conceptual insights. Only English-language publications were included. Given the breadth of material identified, documents were selected for full review based on their relevance to care reform, methodological rigour and significance for policy and practice. In total, 220 publications were included in the final analysis.

Following the review, the literature was analysed thematically using a combination of predefined areas of interest from the conceptual framework and themes identified inductively through close reading of the material. Studies and documents were first grouped according to broad domains of care reform (for example, legislation and policy development, service delivery and workforce), before recurring issues and patterns were identified within and across these domains. Additional themes and sub-themes were incorporated where they extended or refined the initial framework.

The frequency with which issues appeared is described using qualitative terms such as 'commonly reported' or 'raised in a small number of cases', rather than numerical counts. Findings were also compared across settings and types of sources to identify issues that appeared consistently and those that were more context-specific. This analysis informed the identification of key patterns, emerging issues and areas where evidence remains limited, both in relation to care reform policies and their implementation across low- and middle-income countries.

Practitioner interviews

The practitioner interviews were conducted with individuals and groups directly involved in care reform, including government officials, staff of international, national and local NGOs and representatives of multilateral agencies, such as UNICEF.

Participants were selected purposively to capture perspectives from people working at different levels of the system, rather than to provide a statistically representative sample. Their views should therefore be understood as illustrative of key stakeholder perspectives, rather than as representative of all actors in every context. Interviewees' organizational positions and responsibilities may have influenced how they described challenges and priorities. Where relevant, the findings distinguish issues raised consistently across interviews and settings from those that reflected particular organizational or country contexts.

Limitations

This methodology has several limitations. Restricting the review to English-language sources may have resulted in the exclusion of relevant evidence published in other languages. The mix of policy documents, grey literature and interviews also means that some areas are more heavily documented than others, which may affect how strongly particular themes appear in the findings. In addition, the availability of published material varied across regions, and the literature included limited perspectives from individuals with lived experience of care. As a result, the findings should be interpreted as indicative rather than exhaustive. They are intended to provide a structured overview of recent developments and recurrent issues, rather than a comprehensive assessment of all care reform activity in low- and middle-income countries.

Annex 2. Glossary of key terms

THE CARE SYSTEM & CARE REFORM	
care system	A care system is comprised of the legal and policy framework, structures, services and resources that determine and deliver alternative care, prevent family separation and support families to care for children well.[428]
care reform	Care reform encompasses efforts designed to lead to improvements in the care system.[429]
TYPES OF ALTERNATIVE CARE	
alternative care	The formal and informal care of children outside of parental care.[430] The Guidelines for the Alternative Care of Children, endorsed by the United Nations in 2009, outline several different forms of formal and informal alternative care, including kinship care, residential care, foster care and supervised independent living.[431]
formal alternative care	"All care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures."[432]
informal alternative care	"Any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity, at the initiative of the child, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body." [433]
family	Any caregiving arrangement in which children receive consistent care, protection, nurturing and emotional support, including nuclear, extended and multigenerational households, single-parent families, kinship care, foster care, adoptive families and other locally recognized family forms.[434]
family-based care	All care within a family, including parental care, kinship care, foster care and adoption.[435]
family-based alternative care	All alternative care within a family, specifically foster care and kinship care.[436]
foster care	"Situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family that has been selected, qualified, approved and supervised for providing such care."[437]
kinship care	"Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature." [438]
informal kinship care	Any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends at the initiative of the child, his or her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body.[439]

TYPES OF RESIDENTIAL ALTERNATIVE CARE	
residential care	"Care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes." [440]
institutional care	"Institutional care is a form of residential care where residents are compelled to live together within an 'institutional culture'. It segregates residents from the broader community and tends to be characterized by depersonalization, rigid routines, block treatment and isolation. The requirements of the institution take precedence over individual needs." [441]
small-scale residential care	There are no universally agreed cut-offs for the number of children in small-scale facilities, though some argue that facilities with more than six children cannot be considered small-scale.[442] The term 'small-scale residential care' refers not only to the size of a facility, but also to residential care that is non-institutional in nature, where children have the opportunity to form attachments with caregivers and receive care tailored to their individual needs.[443] This entails, for example, consistent and trained caregivers, robust safeguarding mechanisms and flexible routines that respond to each child rather than imposing rigid, collective schedules.[444]
PERMANENT CARE OPTIONS FOR CHILDREN	
adoption	The legal transfer of parental rights and responsibilities for a child on a permanent basis.[445]
domestic adoption	Involves adopters who live in the same country as the child. Also known as 'national adoption'.[446]
intercountry adoption	Involves adopters who live in a different country from the child.[447] Also known as 'international adoption'.
kafalah	A form of family-based care used in Islamic societies that does not involve a change in kinship status, but does allow an unrelated child, or a child of unknown parentage, to receive care and legal protection.[448]
CHILDREN & YOUNG PEOPLE	
care leaver	"A young person, typically over the age of 16, who is leaving or has left a formal alternative care placement." [449]
unaccompanied child	"A child who has been separated from both parents and other relatives and is not being cared for by any adult who, by law or custom, is responsible for doing so." [450]
separated child	"A child separated from both parents or from his/her previous legal or customary primary caregiver, but not necessarily from other relatives." [451]

PEOPLE & PROCESSES IN THE CARE SYSTEM	
the care economy	Activities and relations involved in meeting the physical, psychological and emotional needs of adults and children. The sector of economic activities, both paid and unpaid, related to the provision of social and material care, which contribute to nurturing and supporting present and future populations.[452]
deinstitutionalization	"The process of transforming the alternative care system away from using residential care institutions to providing family-based care and services within the community. It involves all types of efforts to return the child or adolescent to family care or, where that is not possible or in their best interests, to provide them with family-based alternative care." [453]
family strengthening	"Programmes, strategic approaches and deliberate processes of empowering families with the necessary capacities, opportunities, networks, relationships and access to services and resources to promote and build resilience and the active engagement of parents, caregivers, children, youth and other family members in decisions that affect the family's life."[454]
reintegration	"The process of a separated child making what is anticipated to be a permanent transition back to his or her family and community (usually of origin), in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life."[455]
social service workforce	"The social service workforce refers to a broad range of governmental and non-governmental, paid or unpaid professionals and paraprofessionals who work with vulnerable children, youth, adults, older persons, persons with disabilities, families and communities to ensure healthy development and well-being. The social service workforce focuses on preventative, responsive and promotive services; they prevent and respond to violence, abuse, exploitation, neglect and family separation."[456] "The social service workforce constitutes a broad array of practitioners, researchers, managers and educators, including – but not limited to: social workers, social educators, social pedagogues, child care workers, youth workers, child and youth care workers, community development workers/community liaison officers, community workers, welfare officers, social/cultural animators and case managers."[457]

Endnotes

Executive summary

1 Cross-cultural research on child-rearing and development shows that what counts as 'nurturing and responsive' care is shaped by locally shared beliefs, caregiving arrangements and daily routines, and may be expressed differently from caregiving practices emphasized in some child-development literature. See, for example: Harkness, S., and C. M. Super, 'Shared Child Care in East Africa: Sociocultural origins and developmental consequences', in *Child Care in Context: Cross-cultural perspectives*, edited by M. E. Lamb, K. J. Sternberg, C.-P. Hwang and A. G. Broberg, Psychology Press, New York, 1992, pp. 441–459; LeVine, R. A., et al., *Child Care and Culture: Lessons from Africa*, Cambridge University Press, Cambridge, 1994; Super, C. M., and S. Harkness, 'Culture Structures the Environment for Development', *Human Development*, vol. 45, no. 4, July–August 2002, pp. 270–274; Super, C. M., and S. Harkness, 'The Developmental Niche: A conceptualization at the interface of child and culture', *International Journal of Behavioral Development*, vol. 9, no. 4, December 1986, pp. 545–569.

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3 United Nations General Assembly, Guidelines for the Alternative Care of Children, A/RES/64/142, 24 February 2010, para. 2(a).

4 To keep the review manageable, a publication cut-off date was applied, and the number of stakeholder interviews was limited. These necessary constraints mean that some earlier scholarship and additional examples of promising practice are not reflected in the findings.

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Annex 2. Glossary of key terms

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About the project

UNICEF Office of Strategy and Evidence – Innocenti, Child Frontiers International, the Centre for Evidence and Implementation and Johns Hopkins University have partnered on a research programme examining how family-based care for children can be strengthened, particularly in low- and middle-income countries.

The programme brings together systematic evidence reviews, discussions with policymakers and practitioners, and primary research with children and families to understand progress and challenges in care reform, the factors that shape success and opportunities for action.

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