Localising De-institutionalistion

The Potentials of Article 20 of the Convention on the Rights of the Child in the Context of Rajasthan, India

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Article 20 of the United Nations Convention on the Rights of the Child recognises the vulnerability of children growing up outside a family environment, and sets the ground for the paradigm of 'institutions as a last resort'. However, 'care homes' or 'hostels' are still common forms of alternative care solutions for children from impoverished families in India. This article asks to what extent the clear impetus towards de-institutionalisation in human rights discourses, especially among international NGOs, has potential to change such practices. The study contributes to a body of scholarship on 'localising children's rights' by presenting findings from an ethnographic case study of an institution for HIV-infected/affected children in Rajasthan, India. The institution in question played a range of social functions other than childcare such as education, a means for parents to rescue their children from extreme poverty, and a supportive and de-stigmatised environment for the community of people living with HIV/AIDS. The article argues that social functions of existing institutions should be taken into account when developing rights-based de-institutionalisation strategies.

Keywords: De-institutionalisation, human rights, India, child rights, localisation

Growing up in childcare institutions such as orphanages most often implies rigid routines and a professional (rather than parental) relationship between children and carers. For decades, scholars have recognised that such institutional culture is potentially harmful for children's development (e.g. Chapin, 1926; McArthur, 2011; Greenberg & Williamson, 2010; Dunn, Jareg & Webb, 2003; Tolfree, 1995; Doherty, 1996; Mulheir, Parent, Simonin, Zelderloo, Bulic, Besozzi, Andersen, Freyhoff & van Remoortel, 2008), findings that are also reflected in international law on the rights of the child, which prioritises a 'family environment' as the most beneficial for children (Convention on the Rights of the Child, 1989, preamble). In line with the Convention on the Rights of the Child (CRC), there is a global trend of moving away from institutional care and towards family-based care of children deprived of their biological family environment. Since the 1960's, family-based alternative care (e.g. foster care or adoption) has in Western Europe and the United States been much more common than the use of institutions (Mulheir, Parent, Simonin, Zelderloo, Bulic, Besozzi, Andersen, Freyhoff & van Remoortel, 2008, p. 10). More recently, many post-Soviet countries have also 'transitioned' away from institutional care (Greenberg & Williamson, 2010, p. 12). Such a transition is known as 'de-institutionalisation'. The state of India has tentatively begun a de-institutionalisation process with the updated Juvenile Justice Act (Government of In-

dia, 2016), which translates many of the norms from the CRC, ratified by India in 1992 (Office of the High Commissioner for Human Rights, 2017), into the national legal system. But how do these international standards and national legal changes affect the long-time practice of orphanages run by NGOs? What are the social obstacles to de-institutionalisation in India? This article points to one particular obstacle, namely the social functions (other than childcare) that existing institutions play: they ensure an education that rural, impoverished families cannot provide; they are part of a network of socially motivated NGO-workers who address problems that the government is not addressing; and in the case of HIV-infected/affected children, they provide a de-stigmatised and supportive environment for patients. Pointing out these functions is not the equivalent of arguing against de-institutionalisation. Instead, in India's current slow move away from institutions, family-based alternative care options should acknowledge and try to replicate the functions that institutions play, importantly, by means other than institutionalisation.

De-institutionalisation has been connected with child rights in previous literature (e.g. Cantwell, 2015; Dunn, Jareg and Webb, 2003; McArthur, 2011); however, there remains a gap when it comes to analysing de-institutionalisation from the approach of 'localising child rights' (De Feyter, 2007), which is a branch of human rights studies that asks how international legal norms can be effective for prob-

lems of a local nature. This approach has been used to analyse other topics under the umbrella of human rights such as women's rights (e.g. Merry, 2006) and female genital mutilation (e.g. Sikka, 2015). According to Vandenhole (2012, p. 80), one of the central dimensions of this approach is whether the idea of 'rights' is culturally accepted in a given context. The present study will contribute to this dimension of child rights literature, by demonstrating how a phenomenon that is perceived as a human rights issue at the international level – the institutionalisation of childcare – is not considered a significant problem by local actors. Instead, institutionalisation is, at the community level, seen as a solution to other problems, such as poverty, lack of education, and the stigma of HIV/AIDS.

For terminological clarification, 'orphanage', 'institution', 'care home' and 'hostel' will be used synonymously to denote 'a group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society' (Dunn, Jareg & Webb, 2003, p. 1).

Article 20 of the Convention on the Rights of the Child

Children who are not living in a family environment are considered a particularly vulnerable group in international human rights law and are protected by Article 20 of the CRC (Cantwell & Holzscheiter, 2007, pp. 10-11). The article states,

> 1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
>
> 2. States Parties shall in accordance with their

national laws ensure alternative care for such a child.

> 3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background' (Convention on the Rights of the Child, 1989, art. 20).

In terms of application, this article is intended for situations in which the state and parents have already failed to, or are unable to, ensure a family environment (Cantwell and Holzscheiter, 2007, p. 9), namely to children who do not have the overnight care of at least one of their parents for 'whatever reason' (United Nations General Assembly, 2010, para. 29), including, inter alia, death of parents, abandonment by parents, permanent or temporary incapacity of parents (such as illness), and voluntary placement by parents (Cantwell & Holzscheiter, 2007, pp. 38-39). Article 20 requires state parties to ensure alternative care for the child and lists options for such care in Article 20, paragraph 3. According to the article, 'alternative care' ranges from kinship care, foster care and other forms of family-like care placements, to non-family-based care such as residential institutions. In the drafting process of the CRC in 1982, it was the delegation from India that introduced a list of alternative care options to Article 20 and proposed the inclusion of 'placement in community and State childcare institutions' (ibid., p. 30). The Indian delegation did not differentiate between family-based and other forms of alternative care, but in the final wording of Article 20, there is arguably an implicit ranking of what is most beneficial for the child (ibid., p. 13). The drafters of the CRC

chose to place institutions at the bottom of the list, which hints to a promotion de-institutionalisation. However, accepting that institutions should be a last resort, still implies the inevitability of their existence. The existing institutions therefore need to be 'suitable', that is, they have to live up to some general criteria and be suited to the individual child's needs (Cantwell, 2015, pp. 260-62).

One of the situations in which institutions are deemed by the UN Committee on the Rights of the Child to be inevitable, is in relation to children affected by HIV/AIDS. The Committee has thus acknowledged that, 'Although institutionalised care may have detrimental effects on child development, States parties may, nonetheless, determine that they have an interim role to play in caring for children orphaned because of HIV/AIDS when family-based care within their own communities is not a possibility' (United Nations Committee on the Rights of the Child, 2003, para. 35). The Committee does, however, underline that institutions should always be a last resort and non-permanent, even in the case of HIV-affected children (ibid., paras 34-35).

Methods

This study is a case study of Aashray Care Home (Aashray) located in an urban, residential part of Jaipur, Rajasthan, India. Aashray is a care home for children infected with or affected by HIV/AIDS. It is funded primarily by donations from private individuals and foundations. The home receives children through the Child Welfare Committee (CWC) of Jaipur District, and is currently home to 37 children (25 boys and 12 girls). They live in rooms with 6-8 beds, go to school in the area, and spend the rest of their day eating meals, doing homework, playing, doing yoga, watching TV, cleaning, and going on the occasional outing financed most often by individual donors. They have the opportu-

nity to visit relatives twice a year. Even though there is a core staff of caregivers, managers, cooks etc., the fixed roles are not immediately visible during everyday life at the care home, which rather gives the impression of a collaboration among a group of people – including the older children – in the running of the place.

My approach to this case study is similar to that of legal anthropologists such as Merry (2000) and Das (1993), who analyse how law meets everyday life. This type of approach is valuable when exploring how obstacles to global norms, which are created to improve the lives of people who inevitably live in a certain locality, are materialising at the local level. The bulk of the data consists of semi-structured interviews. These are complemented by participant observation carried out over six weeks, where I took an active part in the daily routines at Aashray such as in the preparation and consumption of meals, homework, laundry, and playing games. Such participation brought knowledge that would be difficult to get from formal interviews, for instance the social status of the informants, the atmosphere in the institution and the interactions between different informants.

Respondents were divided in six groups (see Table 1). The first three respondent groups (except manager level staff at the care home) were all either infected with HIV themselves, or affected by it through family members. As a result of the stigma attached to HIV/AIDS described by virtually all informants, the status of being HIV positive resulted in these people socially marginalised. The six informant groups can therefore be divided in three sub-groups: those infected with HIV/AIDS (children, parents, and most of the staff), those not infected but sympathetic to the former (staff, HIV professionals), and lastly, the authorities and experts who, in this context, saw HIV/AIDS as only one obstacle amongst many for de-insti-

GROUP	Type of interviews	Number of interviews in group/ number of persons in group	Month and year	Interview codes
CHILDREN: male and female residents of Aashray Care Home.				
	Semi-structured individual interviews	26/26	March, 2017	G1C1-G1C26
PARENTS: parents and relatives of group 1, living mainly in rural areas of Rajasthan.				
	Semi-structured individual and group interviews	5/7	March, 2017	G2P1-G2P5
STAFF: staff at the care home, ranging from middle-class, educated manager level staff to HIV/AIDS-infected care takers from rural areas.				
	Semi-structured individual interviews	8/8	March, 2017	G3S1-G3S8
AUTHORITIES: two representatives from the authorities (an ex-member of the CWC of Jaipur District, and a Program Manager of the Rajasthan Child Rights Department).				
	Semi-structured individual interviews	2/2	March, 2017	G4A1-G4A2
EXPERTS: two academically educated experts on child rights, one from the NGO Antakshari Foundation which focuses on child protection and development, and one from Foster Care India, an organisation that promotes de-institutionalisation.				
	Semi-structured individual interviews	2/2	March, 2017	G5E1-G5E2
HIV PROFESSIONALS: HIV professionals ranging from nurses to outreach officers who work closely with people living with HIV/AIDS in Rajasthan.				
	Unstructured individual and group interviews	3/18	March, 2017	G6H1-G6H3

Table 1: Overview of Interviews and Interviewees

-tutionalisation. As is clear from the analysis below, the closeness to the disease determined the preference for the institution versus family-based care.

Localisation of child rights in Aashray Care Home

One way to go about studying the relationship between international law and local realities is to apply an 'implementation gap approach'; that is, to assume that the law is 'right', and if there are mismatches between law and reality, the problem is implementation (Vandenhole, 2015, pp. 38-39). However, it became clear during the present ethnography that successful de-institutionalisation is not as simple as implementing a human rights obligation because institutions are not only harmful places where children's development is at risk, they are also places where children get educated and fed, and they also serve as a platform where the local NGO community can assist impoverished people. Instead, a 'localisation approach' is necessary, as it questions the law's relevance to local people and situations (Vandenhole, 2012, p. 80). This approach argues for a 'translation' between the local and the global in both directions (Merry, 2006). One way of taking the point of departure at the local level, which I focus on here, is to recognise the social functions of institutions.

One such function is education. Most parents and children saw access to proper education as the main reason for living at the institution (G2P2; G1C5; G1C17; G1C18). Many of the parents themselves were illiterate, while their children were studying in secondary school and spoke and wrote both Hindi and English, often in addition to speaking a local dialect. As one child said, 'in the village I cannot study' (G1C13). Similarly, a father said that he put his children in the care home because, 'I only want that they study and their life gets better'

(G2P2). In addition, informal talks with the parents and staff made it clear that the village was considered a 'backward' place without study opportunities, while the urban care home provided these opportunities for their children. The care home furthermore helped the older children to become independent by providing skills courses, and renting out rooms to them during their studies or while they looked for a job; for instance, when the care home decided to move all the children to a new building outside Jaipur, two older boys were instead given money to rent a room near their school so they could finish 12th grade and become more independent (G1C3).

Another social function fulfilled by Aashray was financial support, as it had become a means for parents to rescue their children from extreme poverty. The institution was seen by some parents as a 'boarding school' to which they could send their children during the school year. This was reflected in the interviews by many children using the term 'hostel' when they talked about the institution. A 23 year-old man who had grown up at the institution (G1C2) described how he 'was already living at another hostel before'. Similarly, a 12 year-old boy living at Aashray (G1C6) said that his sister was living 'in another hostel'. 'Hostel' implies education and non-permanency in India, and even 'care home' – which was used by most adult respondents to denote the institution – has a much more positive ring to it than 'institution'.

For some informants, the institution had a disciplinarian function. Aashray's consultant nurse said that the children from poor families who did not go to care homes would end up doing labour work or 'get associated with crime' (G6H1), a statement that hints to a correlation between poverty and crime. This view had also seeped through to some of the children themselves, such as a 13-year-old boy

who, when asked why he came to Aashray, said 'I couldn't go to school, I couldn't wake up in the morning, therefore they sent me to a hostel' (G1C23). This finding was confirmed by the founder of the NGO Foster Care India who said that, 'childcare institutions […] are thought of as babysitting places, as places where children can go to get a proper meal and education' (G5E2).

The fact that parents did not see it as a problem to send their children to live in an institution is also deeply rooted in local child rearing norms. When the extended family is not willing or able to take care of a child, institutional care is the predominant system of care in India (Foster Care India, 2014, p. 6). Parents and care home staff expressed exclusively positive statements about the care home. However, this could be because the parents saw me, the interviewer, as someone they needed to convince of the good conditions at the institution. Similarly, the care home staff had an interest in 'promoting' the care home since it was their livelihood, and for some, their life project – to which I, as a foreigner, was a potential donor. Nonetheless, the nurses and pharmacists from an HIV Care and Support Centre also expressed that children would get 'better care' in the care home than in a village, and a nurse said that there was 'nothing bad in a gap in seeing your parents' (G6H2), both of which imply that institutional care was not only a preference of the uneducated or impoverished, but rather a norm in the broader society. Most of the children also expressed in formal interviews that they preferred living in the care home. In spite of this, the day before Holi, a major holiday, some families came to pick up their children and it was clear that this was a joyous day for those children, who had talked with excitement about seeing their families several days in advance (Field notes, 10 March 2017).

Stigma of HIV/AIDS

Aashray also played the important function of uniting the otherwise stigmatised community of people living with HIV/AIDS. Many of the care home staff themselves were HIV/AIDS patients, and they had found the 'family environment' they had been deprived of at home in the care home. For example, one care taker had had a daughter who passed away from HIV/AIDS (G3S5). Ousted from her own family, and now childless, the care home was a way for her to live in a comfortable environment while earning a living.

There was a direct causal relationship between HIV/AIDS discrimination and stigma and institutionalisation according to many informants. A mother of three children at the care home (G2P1) said that in the village, 'everyone throws you out' because of the 'untouchable disease'. Another mother expressed that her daughter could not play with other children because they would not touch her, and that this was the main reason that the daughter lived at the care home. If the daughter lived at home, 'then all the other children would say: Disease, stay away! So she would begin to cry, here she is happy, so I am also happy' (G2P2). A care giver at Aashray who herself was HIV-positive said that when she made food in her village, people would not eat it, but throw it away (G3S8).

According to nurses working with HIV/AIDS patients, it would be in the best interest of the child to live apart from such discriminatory practice in the villages. In the institution, the children would get 'better education, they get better medication, they get better environment' (G6H2). 'What would better care be?' one nurse asked rhetorically (G6H2). This view was prevalent among all the groups of informants that lived close to HIV and had experienced the stigma (parents, low-level care home staff and HIV professionals).

From the viewpoint of the child protection

experts and authorities, the priorities were different. 'People think that children get luxurious care in institutions [...], but from a child rights perspective, it is very necessary to have a family,' said the representative of Antakshari Foundation (G5E1). Similarly, an ex-member of the CWC said, 'if [the child] has a family, then the child should be established in the family. Because there is no better institution than the family' (G4A1). We can thus see that the informants' priorities were different depending on how closely they lived to HIV/AIDS and poverty: the educated informants (authorities and experts) agreed with international norms on de-institutionalisation and underlined the importance of a family environment, and HIV/AIDS was simply one of many obstacles; the uneducated informants (care home staff and parents) and also the educated HIV professionals who worked closely with patients saw HIV/AIDS stigma as the main problem, and childcare institutions as the solution. The latter group were not aware of the supposed potential harmful social development, and if told of it, they chose to prioritise the immediate health and education of their children.

Aashray's consultant, a trained social worker, said that he found it interesting how international norms emphasised a family environment, because in his view, the people who wrote this did not know India. He questioned how they could assume that these specific children would not get the necessary emotional, mental and physical development in institutions, which they would have gotten in a family environment. In the case of HIV-infected children in rural Rajasthan, he argued, it was the exact opposite: once the children had been diagnosed with HIV, they were marginalised within the extended family with separate room, bed, eating utensils etc. They were made to do more work, they did not get to play with the other kids – all things that would harm their development. However, if they grew up in an institution like Aashray, they would be surrounded by people who knew that HIV does not transmit in children's everyday activities, and they would be treated as any other child (Field notes, 4 March 2017).

Concluding remarks

This article has argued that the classic 'implementation gap approach' to children's rights studies needs to be complemented by a 'localisation approach' that emphasises contextualisation in order for human rights to be relevant in diverse contexts. While acknowledging the decades of undisputed psychological studies demonstrating the harmful developmental effects of institutional upbringing, this study has argued for the need for a contextualisation of the dominant paradigm among child rights advocates, which is 'institutions as a last resort'. The case study of Aashray demonstrates that for the most vulnerable children in countries without a comprehensive alternative care system, institutions become the only resort because an institutional upbringing is preferred to a life of poverty and stigmatisation. Such a preference is deeply rooted in local child-rearing norms, and for a de-institutionalisation process to be successful in the Indian context, there is a need for social acceptance of the alternative care options, which currently exist primarily under the Juvenile Justice Act. Therefore, while a 'global call' to end a practice such as institutionalisation sounds powerful, it is unrealistic to expect it to succeed as a global solution. Children's rights as enshrined in the Convention on the Rights of the Child are useful as overall guidelines; for example, Article 20's acknowledgment that children living outside a family environment are vulnerable, can be a point of departure at both local and global levels. However, if not contextualised, de-institutionalisation cannot be effective. It

is true that there is a need to be aware of the harmful effects of institutionalisation on children at the local levels, but at the same time as something 'global' needs to be translated down to the 'local', the social functions played by existing institutions need to be translated up and be a central part of de-institutionalisation strategies.

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