DISCUSSION PAPER

CHILDREN IN INFORMAL ALTERNATIVE CARE

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Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
Guidelines	Guidelines for the Alternative Care of Children
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
MICS	Multiple Indicator Cluster Survey
NGO	Non-Governmental Organization
OVC	Orphans and vulnerable children
UNICEF	United Nations Children's Fund

Preamble

This paper was produced in response to a knowledge gap on informal care and to help determine the relevance and applicability of the 2009 Guidelines for the Alternative Care of Children to informal alternative care. The authors asked the questions "what constitutes 'informal care'?", "what forms of informal care are there?", "who needs informal care?", and "can they be clearly defined?" These questions and definitions are vital in the process of discussing and implementing the guidance included in the 2009 Guidelines for the Alternative Care of Children.

The paper provides initial, tentative answers to these questions from a global perspective, as well as drawing conceptual boundaries around "alternative care" and "informal alternative care". The paper is intended to serve as a discussion document to improve understanding of informal alternative care and to stimulate a wider dialogue among policymakers, practitioners, researchers and donors. The paper should therefore not be treated as "guidance", or as reflecting UNICEF's position on informal care.

Executive summary

This discussion paper is part of the first explorations of the worldwide phenomenon of children living in informal alternative care. As defined under the Guidelines for the Alternative Care of Children (hereinafter the Guidelines), these children are without parental care and live with relatives or family friends without State involvement in selecting or monitoring those arrangements. They, like all children, are entitled to protection and care, but little is known about them.

In Section 1, this paper provides a conceptual placement of informal alternative care within the larger framework of the Guidelines. Section 2 explores different types of informal care with the prevalence, benefits and risks of each as illuminated by research or field observation. Section 3 follows with an expanded conceptualisation of informal care in the larger child protection system and in the continuum of child welfare. In Section 4, the rights of children in informal care are discussed, followed by a discussion about the ways to support and promote those rights, and a presentation of a basic policy framework consistent with the Guidelines that could be used, as appropriate, to establish national policy. Finally, in Section 5, a brief discussion focuses on current methods of collecting data, along with suggestions to extrapolate findings from existing data as well as improving the Multiple Indicator Cluster Survey (MICS) instruments to collect more relevant data.

Five appendices are attached to the paper. Appendix 1 lists sources for references. Appendix 2 is a compilation of available data related to children's orphan status and living arrangements. Appendix 3 provides school enrolment ratios of orphans compared to their non-orphan peers. Appendix 4 is a selection of national laws regarding the care and guardianship of orphaned children, and Appendix 5 is a listing of some of the activities conducted around the world by governments, non-governmental organizations (NGOs) and communities to protect and enhance the rights of vulnerable children, including those in informal care.

There are several challenges in collecting data on children in informal care, beginning with the threshold issue of defining the parameters between informal "alternative" care and other forms of informal care living arrangements. This issue is compounded by the conflation in literature (both conceptual and data-based) on orphans, foster children and other groups of children who live away from their families for educational or employment purposes. Many of the data presented in the paper, therefore, focus not solely on children in informal care but also on studies on children in related categories.

Despite these challenges, both scholarly and professional literature were accessed to sift out the most relevant and reliable information, although most of them are using orphan status as proxy for informal care. The primary focus has been to review studies using nationally representative studies whenever available and relevant, e.g. those using Demographic and Health Surveys (DHS) and MICS data sets and national census data as well as meta-analyses, controlled experimental studies and longitudinal studies. Some small-scale and qualitative studies, when they filled a gap, have also been used, with limitations noted. Legal literature and national laws were also surveyed to select the most relevant provisions and many practice examples were

noted from the literature. UNICEF colleagues from New York Headquarters and regional offices provided relevant materials and input for this report.

This brief review has pointed out two urgent needs related to children in informal care: targeted research; and the establishment of national policies. Regarding research, existing data could be utilised to yield more information about children in informal care and new questions could be incorporated into existing data collection systems, such as DHS and MICS, to target data directly relevant to informal care. In terms of policy, the Guidelines provide a set of foundational concepts in establishing national policies for children in informal alternative care. They and other provisions will need to be examined for appropriateness for each national context, which will be largely informed by the data gathered through research.

Introduction and conceptual framework

The Convention on the Rights of the Child[1] (CRC) recognises that children have the best chance of developing their full potential in a family environment.[2] The primary responsibility for their care rests upon their parents and legal guardians,[3] who are entitled to support from the government in raising their children.[4] When parents are not able or willing to fulfil this responsibility, kinship and community resources may be relied upon to provide care for the children. However, the ultimate responsibility falls on the government to ensure that children are placed in appropriate alternative care.[5] Of the two major forms of alternative care—formal and informal—the purpose of this paper is to focus on informal care.

Defining informal alternative care

The threshold issue in exploring informal alternative care is to determine the conceptual boundaries of 1) alternative care, then 2) informal forms of alternative care.

Conceptualising "alternative care" is somewhat challenging because the standards under the CRC and the Guidelines differ in a potentially significant way. Neither document defines "alternative care", but under Article 18 of the CRC, "parents, or, as the case may be, legal guardians, have the primary responsibility of the upbringing and development of the child," and Article 20 mandates that alternative care be provided when a child is "temporarily or permanently deprived of his or her *family environment*" (Part 2). The Guidelines, however, imply that a child's right to alternative care springs into effect when he or she is deprived of "parental care" (Part 1–1).[6] "Family environment" is defined by cultural and social norms[7] while "parental care" is more clearly established, although in some cultures who is a "parent" can be questioned as well.

Despite these difficult conceptual issues, the important point of this discussion is to focus on those children who are somewhere in the continuum between parental care and State care, where little is known of their experiences. Potentially all children who are not being cared for by at least one parent or legal guardian are candidates for alternative care, and the next question is: what kind of alternative care?

Forms of alternative care

Under the Guidelines, alternative care is divided into two forms:

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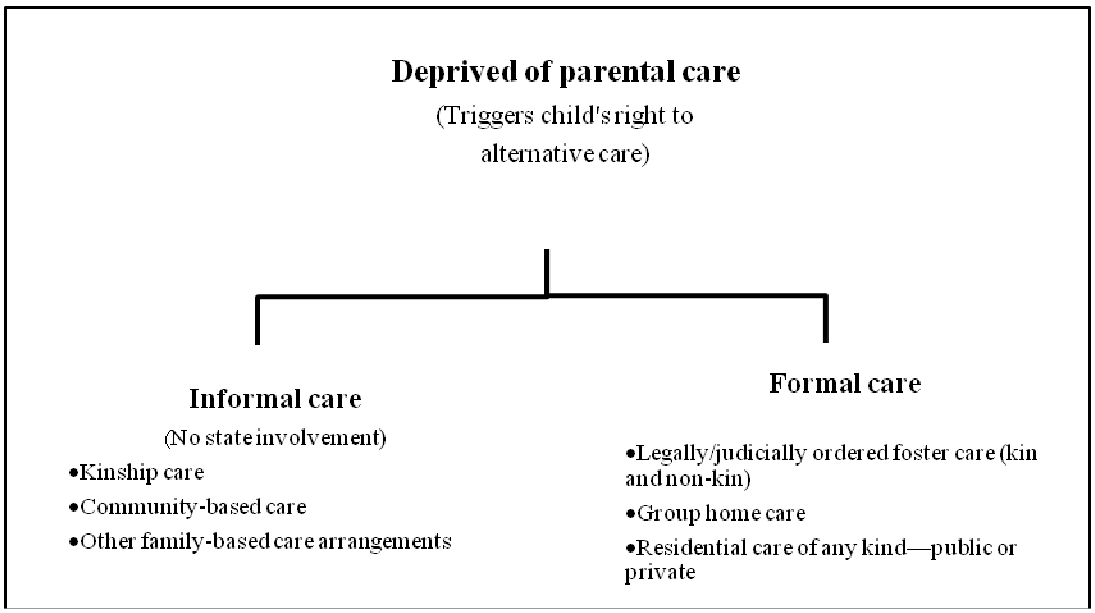
[1] Convention on the Rights of the Child, adopted by United Nations General Assembly Resolution 44/25 of 20 November 1989 and entered into force 2 September 1990. Hereinafter the CRC.
[2] Ibid., Preamble, para. 6.
[3] Ibid., para. 18.
[4] Ibid.
[5] Ibid.
[6] The CRC does not draw a clear line between the responsibilities of parents versus other caregivers, such as legal guardians or "other individuals legally responsible for him or her" (para 3.2). As such, it could be inferred that whoever has taken on the care of the child has a responsibility to that child if such a duty is legally recognized under the laws of the State.
[7] For example, in some African cultures, a child living with a grandmother may not be considered to be deprived of her family environment, while she may be considered to be under alternative care under the Guidelines.

1) Informal care is defined as "…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".[8]

2) Formal care is defined as "…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".[9]

Figure 1: Forms of alternative care under the Guidelines for the Alternative Care of Children



[8] Guidelines, Part III, 29 (b)(i).
[9] Ibid., Part III, 29 (b)(ii).

1. Types of informal care

There is considerable conflation in studies addressing informal care, kinship care, orphan care, care of orphans and vulnerable children (OVC) and informal foster care. The difficulty is even more pronounced because these various categories and ages of children are not standardised in research. This conflation makes it difficult to distinguish between different types of informal care. This section briefly reviews the available information, then considers the benefits and risks of several types of informal care.

1.1. Prevalence and pattern of informal care over time

In an effort to learn of children in informal kinship care, it may be instructive to start with existing data on fosterage rates compiled by DHS, as compiled in Appendix 2. "Fosterage" is used by DHS as a term indicating care provided to children who are not biological offspring of the head of the household, but the surveys do not differentiate between children in informal alternative care from any other arrangements, such as children who are visiting short-term or attending school. (For clarity, this paper will refer to such care as "non-parental" care or care of non-biological children.) Appendix 2 provides rates of non-parental care provided by households, percentage of double orphans as well as HIV/AIDS prevalence rates in 2001 and 2007 in 39 countries in Africa, Europe, Asia and South America for which data were available.

As can be seen in Appendix 2 and documented by others, non-parental care is very common in many parts of Africa. For example, in 1974, one in three Ghanaian women and nearly 40 per cent of women in Liberia aged 15 to 34 years with at least one surviving child reported a child living away from home, and 37 per cent of men and 33 per cent of women reported having children they had not borne living with them. In Sierra Leone, 1974 census data revealed that 36 per cent of children born to mothers 20 to 24 years of age were living away from home, and the proportion increased to 40 per cent and 46 per cent, respectively, for women aged 25 to 29 and 30 to 34 years.[10] The high rates of caring for others' children were viewed to be at least partly attributable to the increasing presence of women in the work force.[11] As shown in Figure 2, during the 1990s (time 1, black bars), care of non-biological children continued to be widely practiced, with between 17.7 per cent (Nigeria) and 35.3 per cent (Namibia) of all households providing such care. Again, it is not possible to know what proportion of such care was based on the loss of parental care, or what the relationships were between the host family and the non-biological children. What is known is that the higher the education level of the hosts, the more likely the family was to have "other" children living with them.[12] Single female households tended to have highest level of "other children" (40 per cent): they may have relied on girls to tend children while they work. Girls received non-parental care at a much higher rate than boys in this region, one reported as high as 273:1.[13]

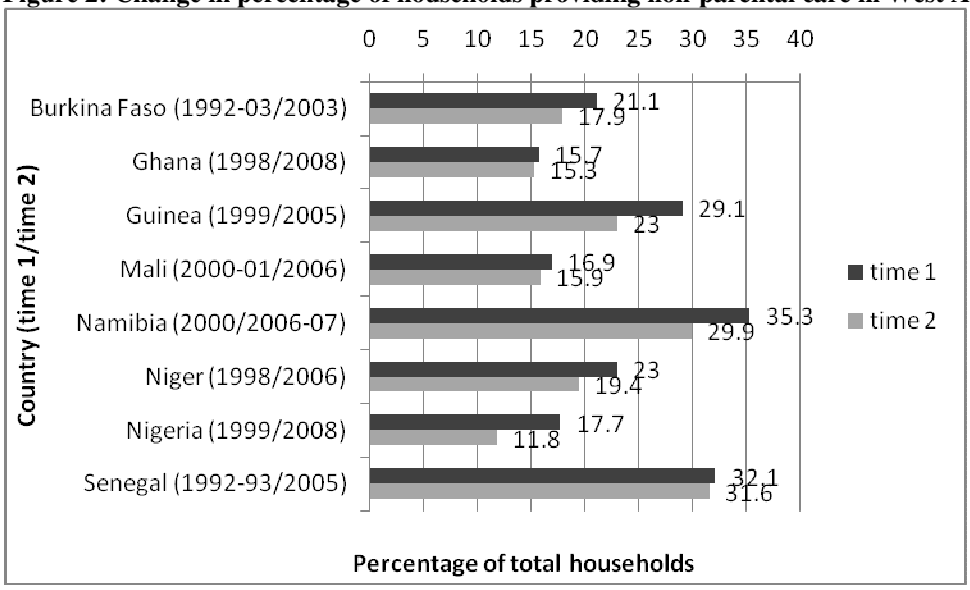
[10] Isiugo-Abanihe, 1985.
[11] Ibid.
[12] Research suggests that wealthier relatives were obligated to take in kin children. See, e.g. Pilon, 2003.
[13] Pilon, 1995, p. 713.

Data collected after 2005 (Figure 2, time 2, grey bars) show that the rate of households providing non-parental care declined slightly or substantially between the two time periods in all countries. As seen in a more detailed breakdown of these and other countries in Appendix 2, older children (ages 6 to 9 and 10 to 14 years) are represented in larger proportions than pre-school age children, and the rate of non-parental care in that region has been attributed largely to education of kin children.[14] This would result in a greater proportion of urban households providing such care than rural households. While this is true in some countries, the reverse is true in others in the same region. The reason for the decline is not known, but several are possible: AIDS death rates have been higher in the cities; girls may be sent to care for sick relatives;[15] older children may be sent away to work;[16] and some children may return home to tend to their sick family members. Urban households were taking in fewer children for schooling purposes since 1990 due to the economic downturn in the West African region.[17] In Côte d'Ivoire, the economic forces also redirected the flow of education-related care toward the inland cities and villages, where the costs were lower.[18] The flux may also have been related to the host families' ability to care for additional children. While some families are able to take in other children to care for, others may be overextended already. In a 2007 study, four typologies of extended families were discussed in terms of their capacity to foster orphaned children: rupturing, transient, adaptive and capable, ranging from worst- to best-case scenarios.[19]In their qualitative study, the authors found that approximately one quarter of the extended families providing non-parental care were represented in each typology.[20]

A comparison of urban and rural households in Africa regarding the proportion of children living with one or both parents, the mortality status of their parents and the rate of non-parental care raise many questions that would, if further explored, provide rich data on informal alternative care arrangements. To expound very briefly, as shown Appendix 2, in Namibia in 2006–2007, 16.2 per cent of urban households were providing care to "other" or non-biological children compared to 41.8 per cent of rural households, for a mean of 30 per cent for all households. There, only 27 per cent of children 0 to 14 years of age lived with both parents, and almost as many (23.6 per cent) lived with neither, even though both parents were alive. In Zimbabwe, the non-biological care rate is twice as high in rural households compared to urban households. In Swaziland, the contrast is even more dramatic, with 40.1 per cent of all rural households providing non-parental care, three times the proportion of urban households. There are no data on why such a large proportion of rural households is providing care to non-biological children, or why so many children who have at least one parent are living in others' households, although the literature suggests that there is substantial employment-related migration of the parent, thus leaving the child in care of another in the community. The impact of a high concentration of non-parental care in rural areas likely affects both the children and the caregivers. In addition, it appears that there may be a relationship between HIV prevalence rates and providing "other" child care, but the available information is not sufficient to establish a firm correlation.

[14] Pilon, 2003.
[15] Robson, 2004; Abebe & Skovdal, 2010.
[16] Ansell & Van Blerk, 2004.
[17] Charmes, 1993.
[18] Guillaume, et al., 1997, cited by Pilon, 2003.
[19] Abebe & Aase, 2007.
[20] Ibid., p. 2063.

Figure 2: Change in percentage of households providing non-parental care in West Africa



The HIV/AIDS pandemic has pushed child circulation practices from socialisation of children to utilising their labour.[21] While the adult infection rate is stabilising and even decreasing in some regions,[22] other regions are still seeing increases in both infection and numbers of children affected,[23] and the needs of the children and families will remain acute for many decades to come.

The relationship between double orphans and the rate of non-parental care is also key to understanding the prevalence of informal alternative care. Figure 3 provides a glimpse of the percentage of double orphans in households revealed by DHS data, first during the period covering 1992 to 2001, and later in the 2000s. These figures do not include double orphans who live outside of households, including group homes, boarding schools, institutions or other residential care settings. Considering the orphan numbers reported by these countries, the increase in the percentage of children in households who are double orphans is not dramatic, except perhaps in Namibia and Senegal; in Burkina Faso and Nigeria there is a decrease. This may be a function of the actual rate of double orphans being still quite small, and/or the phenomenon of children entering institutions or other residential care centres; but further research is warranted.

1.2. Types of informal care, with benefits and risks

Because informal care in developing countries often exists without a system to track and monitor such arrangements, most information is produced piecemeal by location-specific research. Even when they are available, data are often organised along different criteria and are inconsistent, so the total number and percentage of children in alternative care, and more specifically in informal care, are difficult to estimate. Informal care is provided in three major settings: kinship,

[21] Pilon, 2003.
[22] UNAIDS, 2008.
[23] UNAIDS, 2007.

community and other family-based arrangements.[24] The following section reviews each of these types of informal care, with the available information on prevalence and the known and potential benefits and risks to the affected children.

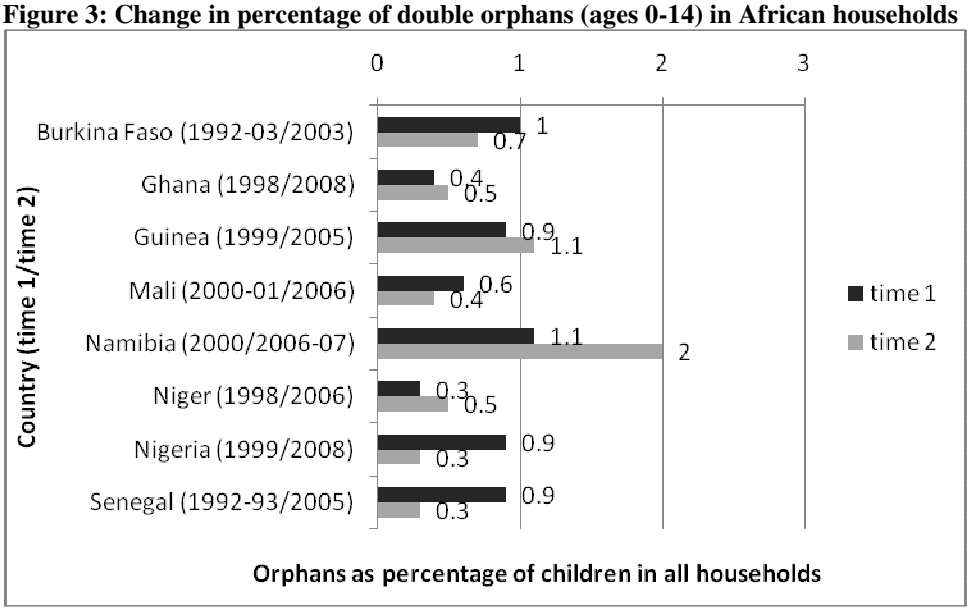
1.2.1. Kinship care

The Guidelines refer to informal kinship care as "…[a] private arrangement whereby the child is looked after on an ongoing or indefinite basis by relatives or friends."

Prevalence of kinship care

The prevalence of kinship care is still largely unknown and evidence is fragmented, although some large-scale data are emerging. One of the broadest studies, which covered households in 51 countries using nationally representative samples collected largely through DHS and MICS data instruments, found that at least 90 per cent of double orphans lived with relatives.[25] This was assuming that children listed as "adopted/foster children" were kin children. The study noted that in some cultures these children would not be differentiated as non-biological children.

Figure 3: Change in percentage of double orphans (ages 0-14) in African households



In another broad study, national household surveys collected through MICS and DHS in 40 sub-Saharan countries[26] showed that information was available on the relationship of children to the head of the household in only 13 countries.[27] In those 13 countries, the extended family was caring for approximately 90 per cent of double orphans and children not living with a surviving

[24] Small family-like group homes where unrelated children live with a parent figure, which are not be overseen by the State or the State's agent, may be viewed as falling under 'informal care', but they are more appropriate to be categorized under 'community-based care' in the previous section. All residential and institutional care arrangements are categorized as 'formal' care under the Guidelines.

[25] Ainsworth & Filmer, 2006, p. 1106. This includes 15 countries from Eastern and South Africa, 20 from Western and Central Africa, 8 from Latin America, 2 from the Caribbean and 6 from Asia.

[26] Data were collected during 1998–2002, with 23 MICS and 17 DHS surveys.

[27] Monasch & Boerma, 2004.

parent.[28] The main caretakers for these children were "grandparents" and "other relatives",[29] with grandparents as main caretakers for approximately half of the orphans, ranging from 24 per cent (Cameroon) to 64 per cent (South Africa). Double orphans were more likely to live in a female-headed household than children living with parents. In three countries (Namibia, the United Republic of Tanzania and Zimbabwe) the caring responsibilities seemed to be shifting to grandparents in recent years, while Kenya and Uganda showed the opposite trend, of shifting from grandparents to other relatives.[30] Overall, one in six households was caring for an orphan, ranging from 7 per cent to 37 per cent.

Another study, using DHS data in Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria and Uganda, found that 85 per cent of children not living with at least one parent were living with the extended family and that grandparents were more likely to be caretakers in high HIV-prevalence countries (in more than 50 per cent of the cases), while that rate was more likely to be 20 to 40 per cent of the cases in lower prevalence countries.[31]

A 2008 UNICEF working paper relying on DHS data[32] reported that in Zambia 710,000 children, or 33 per cent of orphans and 12 per cent of non-orphaned children, were being cared for by grandparents. In Malawi, 20 per cent of all children were living with non-parents and nearly half (49 per cent) of the total households were female headed, although there was no information as to the caregivers being mothers, grandmothers or aunts. In the United Republic of Tanzania, 50 per cent of orphaned children were being cared for by their grandmothers, and in Swaziland, 47,000 children were staying with grandmothers or alone, but it was not known whether they were orphans. The same paper reported that in South Africa, where extended family care has been formalised, 41 per cent of 421,000 foster care children were with grandmothers, 30 per cent with aunts, 12 per cent with other relatives and only 12 per cent with non-relatives. These figures provide a sense of the previously existing proportion of informal care arrangements prior to their formalisation.

In a mixed-methods study on 768 adults at 85 different sites throughout Thailand, it was found that of all the children orphaned due to AIDS, 47 per cent were cared for by grandparents (56 per cent of the double orphans).[33] About 37 per cent of children orphaned due to AIDS in Jamaica were taken care of by grandparents,[34] and, based on national data, 44 per cent of all households in 2001 were reported to be female headed.[35]

In the United States, according to a meta-analysis using national data, more than 2.5 million grandparents were caring for more than 4.6 million grandchildren in 2005. These grandparents

[28] Ibid., p. S57. It should be noted that in this study, the authors defined an orphan as a child under age 15 who has lost one or both parents.
[29] "Other relative" was not defined in the paper.
[30] Monasch & Boerma, 2004, p. S57.
[31] USAID & UNICEF, 2008, p. 25–26.
[32] United Nations Children's Fund, Alternative Care for Children in Southern Africa: Progress, Challenges and Future Directions, Working Paper,
Social Policy and Social Protection Cluster, Nairobi, Kenya, 2008.
[33] Knodel & Saengthienchai, 2005
[34] USAID & UNICEF, 2008.
[35] Lim ah Ken, 2007.

tended to be of ethnic minorities, poorer, less educated and single, compared to other grandparents.[36]

In some parts of the world, informal kin care seems to be shifting from paternal to maternal kin. Research in south central Uganda[37]showed that mothers who were HIV-positive were already receiving much more help from their natal kin—mostly their mothers and sisters—and they preferred them as guardians for their children over paternal kin, in anticipation of their death. Their reasoning was based on a high degree of distrust in the paternal kin, citing indifference and lack of genuine concern on the part of the father's family. This pattern was consistent with research in the northern[38]and eastern [39] parts of Uganda and across tribal lines. In the Mutasa district of eastern Zimbabwe, while 53 per cent of orphan caregivers were grandmothers, twice as many were maternal rather than paternal.[40]

In contrast, informal care is provided largely by paternal kin in other parts of the world. For example, in China a recent regional study[41] showed that while the State provided formal foster care in the cases of *san wu* orphans (double orphans), it did not intervene in the case of the "patriarchal orphans"—children whose fathers had died and whose mothers had left them for remarriage. The patriarchal orphans constituted 87 per cent of all orphans and they were absorbed into the paternal kin network with grandparents, aunts, uncles and older siblings, with only a few children being cared for by maternal kin. As in many other parts of the world, grandparents constituted the largest group of kin caring for orphaned children and the same concerns—the caregivers' own poverty, health status, and ability to deal with behaviour problems—were noted. Due to heavy cultural expectations, the author noted that paternal kin will likely continue to be the presumed caregivers for orphaned children in China.

Benefits related to kinship care

In terms of benefits, kinship care is believed to preserve continuing contact with family, if desirable, siblings and the extended family network, to help maintain identity, to decrease trauma and distress of relocation and grief of separation from parents, to reduce the likelihood of multiple placements and to expand capacity for self-sufficiency, ongoing support throughout life, and that children and relatives provide mutual care and support.[42]

But does research back up those beliefs for all countries? The evidence is mixed, depending on the outcomes being measured. On the one hand, there is positive evidence that kinship care is advantageous to the child. One of the most clearly established findings from research is that the degree of relatedness is a pivotal factor in the quality of care that children in informal care receive. Biological relatedness is an important predictor of the quality of care given to children in Uganda.[43] In numerous studies reported below, school enrolment increased with kinship care (versus non-kin informal foster care). Research in the United States has shown that kinship care

[36] Sazonov, 2010.
[37] Roby, Shaw, Chemongos & Hooley, 2008.
[38] Oleke, et al., 2005, 2006.
[39] Whyte & Whyte, 2004.
[40] Howard, et al., 2006.
[41] Shang, X., 2007.
[42] Namibia Foster Care Report.
[43] Bishai, et al., 2003.

provides stability and greater sense of identity, and produces fewer behavioural problems in the children than non-kinship foster care.[44] In Hunan province, China, researchers have reported that children do not lack care and affection in the homes of their kin, most of whom are grandparents. In eastern Zimbabwe, the degree of relatedness and financial ability were the most important factors in whether caregivers were willing to accept children into their homes to foster.[45] An analysis of household data completed in 2008 suggests that living arrangements are important to children's well-being outcomes. This finding is being further researched.[46]

On the other hand, the benefits of kinship care cannot be taken for granted, as it might be overrated in some regards compared to other forms care. In Eritrea, for example, war orphans reunited with extended family had more adaptive skills but had as many signs and symptoms of emotional distress as children cared for in orphanages.[47]They also rated themselves lower than children in group homes on overall personal adjustment, self-reliance and relationship with a parental figure.[48] This may have been a function of the poverty on the part of the relatives; the per-child expense for the group home was much higher. In China, a study comparing the life satisfaction among double orphans in orphanages, group homes and foster care with extended family revealed that orphans living in kinship households had the lowest scores in perceived life satisfaction.[49] Adamson and Roby, using the Children's Hope Scale, found that children living in an orphanage had slightly higher level of hopeful thinking than did their counterparts living with their parents or foster parents in the Eastern Cape, South Africa.[50] Here again, the institution was well funded, children were in cottages with a "mother" in each; and the children had access to many adult staff and a live-in social worker. It is very important to reiterate that these selective pieces of localised research do not negate the overwhelming evidence of the damaging effects of institutional care.[51]

It is imperative that more reliable evidence is produced in this area. Much of the outcome may depend on the age and sex of the child, the degree of relatedness between the child and caregiver, the local culture regarding non-parental care, the relative wealth or poverty of the caregiver, the circumstances under which the child is being brought into the family and many other factors we do not yet know. Longitudinal and controlled studies conducted on a large scale would inform us of the long-term advantages and disadvantages of the various types of care.

Risks related to kinship care

Since informal care lacks regulation and support in most cases,[52] and most kinship care is informal, there are many potential risks inherent in this type of care. These range from economic, social and personal difficulties both on the part of the caregivers and the children.

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[44] Cuddeback, 2004.
[45] Howard, et al., 2006.
[46] Akwara, et al. 2010.
[47] Wolfe & Fesseha, 2005.
[48] This may have been a function of poverty on the part of the relatives; the per child expenses for the group home was much higher.
[49] Zhao, et al., 2009.
[50] Manuscript in press with *Vulnerable Children and Youth Studies*.
[51] See e.g. Johnson, et al., 2006; Zeanah, et al., 2009; and Sigal, et al., 2003.
[52] Ansah-Koi, 2006.

Poverty: The most prominent among the concerns related to kinship care is the overextension of the hosting households, who may already be struggling with illness, poverty or other issues. These are the aforementioned "rupturing" families in extreme deprivation, typically headed by older females.[53] For example, a 2002 study showed that in Uganda households with orphans earned 25 per cent less per capita income than those without orphans, and it was worse in Zimbabwe, where households with orphans earned 31 per cent less.[54]

A study utilising MICS and DHS data on orphans in 40 sub-Saharan countries found that households with orphans had a higher dependency ratio—the ratio of young children and elderly people (60 years of age and older) depending on each adult in the 18 to 59 year range in the household.[55] Households with no orphans had a dependency ratio of 1.5, compared to households with orphans with a dependency ratio of 1.8. Rural households and female-headed households showed higher dependency ratios, compared to urban and male-headed households. In addition, heads of households raising orphans were approximately four years older than heads of households with no orphans. This difference grew to 10 years in households raising double orphans in Niger, Sao Tome and Principe, Uganda, the United Republic of Tanzania and Zimbabwe. In a MICS data study from 2000, of 1,854 households in 208 communities caring for orphans in Botswana, almost half reported financial difficulties arising from orphan care.[56] In the worst cases, these households, already poor, were caring for both sick adults and orphans while receiving no assistance. In a very large study using 102 sets of national data, including 67 MICS and 23 DHS data sets, poverty was significantly linked to poor outcomes in school enrolment, separate from orphan status.[57]

Health and nutrition disparities: The health status of children in informal care is not known, but may be inferred with limited confidence from research on orphaned children, and the results are mixed. A 2000 study found that children under age five who had experienced adult mortality in the United Republic of Tanzania were negatively impacted in three important health indicators: morbidity, height-for-age and weight-for-height.[58] As a result, the study stressed the importance of measures that can help counteract those impacts—immunization against measles, oral rehydration salts and access to health care. In China, the paternal grandparents, on whose shoulders the day-to-day care of orphaned children rested, seldom had retirement pensions, coped with many serious health issues of their own and depended on their adult children (if they had any) for support and care. However, orphaned children living in their care in a mountainous area in Hunan province in the southeastern part of China were observed to be mentally and physically healthy and developing normally, except those with developmental disabilities.[59] A study of orphaned children living in kinship care in western Kenya did not find compelling evidence of disadvantage between orphans and non-orphans on most health indicators, except

[53] The other types of foster families are transient, adaptive and capable, ranging from worst to best case scenarios.
[54] UNICEF, 2003.
[55] Monasch & Boerman, 2004.
[56] Miller, Gruskin, Rajaraman & Heymann, 2006
[57] Ainsworth & Filmer, 2006.
[58] Ainsworth & Semali, 2000. The data for this analysis come from a longitudinal living standards survey of households conducted in the Kagera region of Northwestern Tanzania from 1991–94" (p. 7). The data set was the Kagera Health and Development Survey (KHDS), so it is longitudinal, but regional within the country and therefore not nationally representative.
[59] Shang, 2008.

that the weight-to-height scores of orphans were 0.3 standard deviations lower than those of non-orphans.[60] The study also noted that the difference was more noticeable among paternal orphans and those who had lost a parent more than a year previously. Most recently, a 2010 study using 60 DHS and MICS data sets from 36 countries found that better household health and sanitation, not orphan status, were significantly related to less wasting in children aged 0 to 4.[61]

School attendance: It is difficult to find enrolment rates of children receiving non-parental informal care, but assuming that most double orphans living in households are living with kin, it may be possible to estimate the comparable enrolment rates. A broad study of orphan school enrolments found that out of 105 nationally representative surveys, double orphans had a significantly lower rate of enrolment than their non-orphan counterparts on 92 of the surveys.[62] The enrolment differences ranged from negative 29 percentage points in Mozambique in 1997 to positive but insignificant in Gambia. However, it is possible to see that by 2008 the difference in Mozambique was negative nine points. Children living with kin have a higher risk of not attending school than their peers who live with parents, although they are more likely to go to school than children living with non-kin. As shown in Appendix 3, the ratio of school enrolment of orphans compared to their non-orphan peers is almost universally lower. Although there are spots where research has shown higher rates for orphaned children, particularly for girls, the global picture puts orphans at a significant disadvantage. Since there is some conflation and overlap between orphaned children and children in informal care, these figures should be viewed with caution. However, lacking specific data on informal care, these are the best sources. A 2009 UNICEF progress report on OVC shows that most countries in sub-Saharan Africa have made significant progress towards parity in school attendance for orphans and non-orphans 10 to 14 years of age.

In eight high HIV-prevalence countries[63] in sub-Saharan Africa, orphaned adolescents 15 to 17 years of age had a lower enrolment rate than their non-orphan peers, by 1 per cent difference in Côte d'Ivoire and by 12 percentage points in the United Republic of Tanzania.[64] A number of qualitative studies in the Russian Federation and countries in Asia and Africa cite lack of funds as a factor of great concern for caretakers related to ensuring schooling for children orphaned by AIDS.[65]

As a case study, in southern China, where government and families share the cost of compulsory education through the ninth grade, a family providing kinship care can expect to spend upwards of 6,400 yuan ($940 USD) to get one child that far. To complete senior secondary, or the tenth to twelfth grades, an additional 2,000 yuan per year, for a total of 12,400 Yuan ($1,765 USD) would be required. This cost can be prohibitive for even the average family, with an annual per capita income of 2,832 yuan ($416 USD), compared with the average annual expenditure of 3,390 yuan per person. Although in theory children in informal kinship care can receive a fee

[60] Lindblade, et al., 2003.
[61] Akwara, et al., 2010.
[62] Ainsworth & Filmer, 2006, p. 1108.
[63] Cameroon, Côte d'Ivoire, Kenya, Lesotho, Malawi, Uganda, United Republic of Tanzania and Zimbabwe.
[64] Mishra & Bignami Van-Assche, 2008. USAID, 2008. DHS and AIDS indicator survey data, both nationally representative, were used in this study.
[65] New ERA Team, 2006; UNICEF, 2002; USAID-AED, 2004; HRW, 2005; Jianhua, et al., 2006.

waiver, only a handful of children actually do receive it and, as a result, it was noted that their risk of school dropout rate was much higher than in other arrangements.[66]

Abuse, neglect and exploitation: Children absorbed into the extended family in Africa experience "extensive" abuse and exploitation, according to personal observations in a 2001 study.[67] The study found that many orphaned children were at risk of losing their inherited properties under the cover of "kinship". A 2006 study[68] documented a common practice of paternal relatives taking the property of their brother or son while abandoning the widow and orphans when a husband dies, and this type of "property grabbing"[69] is frequently reported by others in Africa.[70] Children living with kin but treated as servants are discussed in a separate section of this paper.

Disparate treatment within the household: Research seems in agreement that grandparents are typically neutral to all the grandchildren in their care, although the health and earning power of the grandparent may put the child at risk. In a study in a rural district in eastern Zimbabwe,[71] grandmothers expressed the highest willingness to foster grandchildren, with others showing decreasing willingness with distance in relatedness. Thus, in cases where younger relatives, e.g. aunts or uncles, are caring for relative children, there are some indications of disparate treatment between the two sets of children.[72] For example, in a study of orphans in 10 African countries using DHS data,[73] researchers tested a hypothesis based on the so-called "Hamilton's Rule", which, in effect, showed that outcomes for orphans depend on the degree of blood relationship between orphans and their household heads. The probability of school enrolment was inversely proportional to the degree of relatedness of the child to the household head. Matching orphans and non-orphans in the same household in eight high-prevalence countries in sub-Saharan Africa, a 2008 study found that orphans aged 15 to 17 always had lower school attendance rates than non-orphans[74]. Intra-household discrimination by relatives and step parents have been reported in a qualitative study of AIDS-affected (but not infected) children in Brazil[75] and Nepal.[76]

Qualitative research in Benin suggests that fostered orphans and other vulnerable children are often treated differently than the biological children of the head of household, including having to do extra work and being served less food.[77] In that study, of 145 children who had recently been ill, orphaned and vulnerable children were more than twice as likely as other children to be required to work despite their illness.[78]

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[66] Shang, 2007.
[67] Varnis, 2001.
[68] Bennett, Faulk, Kovina, & Eres, 2006.
[69] McPherson, 2006.
[70] Gilborn, Nyonyintono, Kabumbuli, & Jagwe-Wadda, 2001; Wakhweya, et al., 2002.
[71] Howard, et al., 2006.
[72] Clacherty, G., 2008.
[73] Case, Paxton & Ableidinger, 2004.
[74] Mishra &Bignami-Van Assche, 2008.
[75] Abadia-Barrero & Castro, 2006.
[76] UNICEF, 2002.
[77] GECA, et al., 2005, reported in USAID & UNICEF, 2008.
[78] USAID & UNICEF, 2008.

Lack of legal status: Informal care, by definition, is outside the purview of the legal system and children in such care arrangements may not be able to enjoy a legally secure status in relation to the caregiver. For example, a child who lacks a legal guardian may be refused access to critical services.[79] In some industrialised countries, when relatives step in to provide care, whether in formal foster care or in informal kinship care, it has been shown that the children stay in legal limbo for longer. In the United States, for example, some researchers have found that grandparents providing kinship care are generally reluctant to adopt or take full legal guardianship of the child due to the sensitive family issues these legal steps would cause.[80] The caregivers often do not wish to offend the biological parents or to take away their parental rights. Because of this, in many industrialised countries, children who are not adopted do not have the right to inherit from their grandparents if the biological parent is still alive, unless the children are specifically named in the grandparent's will.

Emotional and psychological stress: In addition to lacking resources, the caregivers may lack the parenting skills needed to deal with the psychosocial issues of children suffering from the loss of their parents. A 2006 study found that emotional stress is very high among kin foster caregivers, and that they were disproportionately older, female, poor and without a spouse. Raising kin children can also cause conflict within the family especially if the family is stretched thin with limited resources already, or there may be jealousy issues between the caregiver's biological children and the fostered children. In the United States, grandparents caring for grandchildren have consistently been found to have increased levels of depression, lower levels of marital satisfaction and poorer health when compared to other grandparents.[81]

1.2.2 Community-based care

Although community-based care refers to both the direct caring role assumed by the leadership or members of a community and the supportive role community-based organisations play in assisting direct caregivers, in this analysis the term refers to overnight care provided by members of the community in their own homes. A 2006 study discusses an African belief that once a child is born, he or she is assumed to belong to the whole community, with members of the community sharing the responsibility for providing nurturance to the child, especially during times of crisis.[82] Accordingly, some societies have a traditional structure of assigning responsibility to care for orphaned children who do not have available extended family care, such as village chiefs taking children into their own homes on a temporary or permanent basis. Reports can also be found of teachers, monks and religious instructors caring for children. A 2003 study reports that community-based alternative care should be based on such a sense of ownership by the community, but with the support of an agency with strong knowledge of child rights and child development along with detailed knowledge of cultural norms.[83] The foster family and its other children should be prepared, and the child involved should also have input into the arrangement.[84]

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[79] For example, in the United States, children cannot receive non-life threatening surgery without permission by a parent or legal guardian. See, e.g. the California law: <www.courtinfo.ca.gov/selfhelp/family/juv/guard.htm>.
[80] Cuddeback, 2004. This is a meta-analysis of a large amount of research related to kinship care.
[81] Ibid.
[82] Ansah-Koi, 2006.
[83] Tolfree, 2003.
[84] Save the Children Sweden, 2003.

The incidence of community-based informal care is rarely reported in data. However, anecdotal accounts report some such arrangements, usually as a temporary measure that sometimes go on permanently. For example, in the Dedza district of Malawi, a headman of a village is reported to have taken in three orphans under age eight, in addition to 10 children of his own. He is reported to have said "I don't have a choice but to take these children under my wing. They lost both their parents, and I can't leave them to roam around the village without parental care"[85]. Further, this headman said that he took the children in "to set an example for others [to do the same]". Another example of communities caring for orphaned children is when "queen mothers" (wives of traditional leaders) take on the care of orphans with the expectation that the children will be incorporated into their own household and families.[86]

Traditional village leadership of caring for children has also been observed in parts of Southeast Asia. For example, in Cambodia at a provincial consultation meeting in 2009, there were reports of commune and village leaders who took orphaned children into their households and had informally adopted them over time.[87]The Buddhist religion in Southeast Asia has also been involved in providing community-based informal care for children. Monks have traditionally been viewed as guardians of not only the villagers' spiritual welfare but also temporal, especially in the case of children. Buddhist temples have served as a sanctuary and a place of learning primarily for boys, and monks provide care for them in a group-living setting. While some families send their boys simply to learn Buddhist teachings and to receive disciplined education, the temples also allow children in crisis to be admitted for overnight care. The arrangement, while it could be considered a group home or residential care, is often closer to a family environment compared to an institution since children living there are expected to perform household chores and have ready access to adults. Most importantly, since temples are typically placed within the community, the children do not lose contact with their families.[88] Also, since many wealthy families send their children for religious training, there is no shame associated with this form of informal care. Monks are currently actively involved in a family preservation project with Save the Children Australia in Cambodia, providing food, educational supplies, hygiene items and other assistance to prevent family disintegration.

Prevalence of community-based informal care

The prevalence of community-based informal care, where children are cared for in a family setting overnight,[89] has not been researched, and reports of it tend to be descriptive and anecdotal. Based on recent literature, however, this form of care seems to be growing, especially in the high HIV-prevalence countries, but it may not be "open" or permanent arrangement, so its fit with the Guidelines' view of informal care may not be optimal.

Benefits related to informal care in the community

Community-based informal care is believed to benefit children for several reasons. The children are able to maintain relationships with their biological families. They receive the benefits of developing in a family environment and learn culture-appropriate skills. This form of care is

[85] Ngozo, 15 March 2010.
[86] Ansah-Koi, 2006, p. 559.
[87] Observations of the author, 2009.
[88] See USAID, Success Story.
[89] See the Guidelines, para 29(a).

cost-effective and helps to maintain the children's community ties. The arrangement is also conducive to family reunification with their biological families.[90] Unfortunately there are no research data to confirm or counter these beliefs. Long-term longitudinal studies are especially lacking.

Risks related to informal care in the community

Research is lacking on the impact of community-based informal care, but some risks may be deduced from what is already known. If there are no kinship ties or obligations, there is a greater risk to children of abuse or exploitation. Families that take in these children may feel that it is acceptable to use them as household servants. For example, in Cambodia some NGOs will only allow children to be put into foster families in pairs because wealthy families often make servants of the children they provide care for. The child's presence in a non-kin family in the community may cause shame to the birth family, straining the relationship between the child and his or her parents and siblings. In some cultures, especially in parts of Africa, an importance placed on ancestral spirits and their protection makes it difficult for families to truly welcome others' children into their home.[91] The reluctance to accept non-relative children have been confirmed by several studies, among them one finding that in Zimbabwe only 25 per cent of potential caregivers were willing to foster orphaned children who were not related to them by blood.[92] In addition, how children from marginalised groups will be accepted and cared for may also raise concerns as communities tend to exert their social norms and cultural standards as a control mechanism.[93] Children of ethnic or social minorities, for example, children of sex workers or children with disabilities may not receive optimal care in the community setting.

Living with unrelated caregivers may jeopardise the child's education. Here again, research findings are consistent that household structure and relationships affect the probability of children attending school.[94] For example, in Ghana, while orphans living with grandparents had no difference in enrolment rates from non-orphans, children living with non-relatives were four times less likely to be enrolled. In Niger, the same trend held, although the difference was not as stark.

Some people question the viability of community-based informal care. Over four decades ago, one study noted that extended family support may not be sufficient in urban centres of Africa.[95] The study found that modern social influences, such as individualism, urbanisation and migration to cities, had changed the role of communities and traditional arrangements. One study believes that community-based care of orphans, while perhaps more economical and beneficial to the community when it is attached to external funding, underestimates the role of parents in African child-rearing. The study argues that, at best, communities can share in the practice of "socially distributed parenting" but they cannot replace the unique roles that fathers and mothers fill in the child's upbringing.[96] More specifically, the father provides social status for the child, where the mother provides the care and emotional needs of the child. The study states that "[no] necessary

[90] Oswald, 2009.
[91] Ibid.
[92] Howard, et al., 2006.
[93] Wakefield & Poland, 2004.
[94] Case, et al., 2004.
[95] Goody, 1969.
[96] Varnis, 2001, p. 150.

relationship has been identified between the 'care' that the nebulous 'community' takes on in a derivative child rearing role and the provision of substitute parenting for orphans; there is little evidence that the obligations of, or care provided by, the community extend to parental-type support. By overemphasising the role of the community, the roles of parents are diminished, which also obscures what orphans have lost and what communities are expected to replace."[97]

1.2.3 Other family-based care arrangements

Informal care or domestic work?

Sometimes overlapping with informal kinship care, some children living in kin or non-kin households away from their communities are being treated as child servants. Some may have been placed in these households for educational purposes but end up becoming household servants or children in domestic servitude. Since there are a great number of children involved in these arrangements their situation bears some discussion here.

The Guidelines' definition of informal alternative care is "…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".

The Guidelines may have anticipated covering situations related to children that fall into exploitative work, as it mentions that "States should devise special and appropriate measures designed to protect children in informal care from abuse, neglect, child labour and all other forms of exploitation, with particular attention to informal care provided by non-relatives, or by relatives previously unknown to the children or living far from the children's habitual place of residence."[98]

Whether the arrangement can be considered informal alternative care, may depend on a number of variables, as discussed below. In a 2007–2008 survey of 1,458 households in several urban neighbourhoods in Haiti,[99] 30 per cent of all households had children present who were not biological children of the household head, with some households having more than one such child.[100] Of these children surveyed, 16 per cent had been placed as child servants, or *restaveks* (meaning "to stay with"), and 22 per cent more were being treated as *restaveks* even though they were boarders who had come to the city to attend school. The status of *restaveks* in the survey was established primarily by the amount and nature of the work the children did, with *restavek* children or boarders whose parents did not pay enough doing significantly more chores than other children in the household. Over half (54 per cent) of the children being treated as *restaveks* were nieces or nephews of the head of the household, while 3 per cent were "god children" and

[97] Ibid.
[98] Guidelines, para. 78
[99] Pan American Development Foundation (PADF), 2009. This survey was not nationally representative but used a cluster sampling method in the urban neighbourhoods using aerial photographs.
[100] In the survey, children aged 5 through 17 were included. PADF, p. 16.

21 per cent were "other relatives".[101] These figures show that the vast majority of the children treated as servants were related to the head of the household.[102]

The International Labour Organization (ILO) estimates that 54,000 children under age 15 work as domestic servants in South Africa, and 38,000 children between ages 5 and 7 in Guatemala.[103] In Côte d'Ivoire, approximately 30,000 girls were believed to be working as child domestics.[104] They were categorised roughly into 1) "little nieces" 2) "hired help" and 3) "little waged maid". The "little nieces" worked in the household of a family member and did not receive monetary remuneration but were fed, clothed and housed, and were expected to receive some form of dowry or household items upon completion of their stay. They were rarely sent to school or supported to learn a trade. According to the author, "the local ideal of fosterage all too often serve[d] to cloak with the language of kinship, situations in which uneducated live-in hands [were] on call for 11 or more hours a day to perform menial and repetitive tasks from which they acquire[d] no skills at all".[105] The "hired hand" was purchased through an intermediary called the "guardian" or "maid's mum", who received the wages the child makes. The "little waged maid" was unrelated to the employer and is paid directly under an oral contract. It seems that the actual paid domestics had better protection than the kin children, with both groups doing similar work.

Several studies have emerged from Southeast Asia. In a study conducted in 2005 in Ho Chi Minh City, Vietnam,[106] most of the child domestics (70 per cent of girls, 30 per cent boys) were listed as relatives by the employers. The children worked on average 13 hours per day 7 days a week and most did not attend school. The ILO also reports that more than 688,000 children are in domestic servitude in Indonesia alone. In Cambodia, an ILO study[107] in Phnom Penh estimated that 27,950 children (59 per cent of girls, 41 per cent of boys) 10 to 17 years of age were engaged as child domestic workers[108], and 60 per cent were reported to be relatives. Most were not paid nor attended school.

In Central and South America, 175,000 children under age 18 are reportedly employed in domestic service.[109] A separate study using census data estimates that approximately 871,500 children are domestic servants in Argentina, Brazil, Chile, Colombia, Costa Rica and Mexico.[110] The ILO estimates that 38,000 very young (5 to 7 years of age) children are in domestic work in Guatemala. The kinship statuses were not reported in these studies.

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[101] PADF, p. 30.
[102] Since the boarders' expenses are paid for by their parents and they are sent for defined time periods, they are excluded in this report beyond this mention. However, the researchers estimated larger numbers of children being treated as *restaveks* assuming that because of the stigma and possible legal issues involved, the household likely reported fewer than actual numbers of children.
[103] ILO, n.d.
[104] Jacquemin, 2004, p. 391.
[105] Ibid., p. 395.
[106] ILO, 2006.
[107] 2004.
[108] 'Domestic servitude' is work in a slavery-like condition, while 'domestic work' does not have an immediate implication of slavery-like conditions.
[109] ILO.
[110] Levison & Langer, 2010.

In these situations, the analysis and solutions become complex when children are in informal care with relatives, because the line between normal expectations imposed on a fostered kin child and exploitation becomes blurred. Deciphering at what point a cultural practice should be considered harmful[111] is a very difficult and delicate task. The reality of the continuum can range from informal alternative care to domestic worker to hazardous forms of child labour or domestic servitude, and the criteria for assessing the status of the care arrangement would likely include the intention behind the arrangement, and the actual treatment the child is receiving as measured by comparable treatment in food, clothing, school attendance, emotional support, sleeping arrangement, availability of leisure time, and other factors that should be defined in a socio-cultural context. In addition, that balance may shift over time depending on the reciprocity of the relationship between the parents and the hosting household, jeopardising children whose parents may lose, or have lost, the ability to provide continuing support. More empirical research and discussion are needed to further explore the needs of children and standards of care to be expected in these arrangements.

Child-headed households

Another group of children that merit special mention are children living in child-headed households. They are without parental care, but rather than triggering a need for alternative care under the Guidelines, their situation is seen as meriting special protection in order to prevent the need for alternative care. The Guidelines urge mandatory protection, supervision and support for children who choose to remain together, to the extent that the oldest sibling is willing and capable of acting as the head of the house.[112]

[111] CRC, Art. 24.3.
[112] Guidelines, paras. 34, 35.

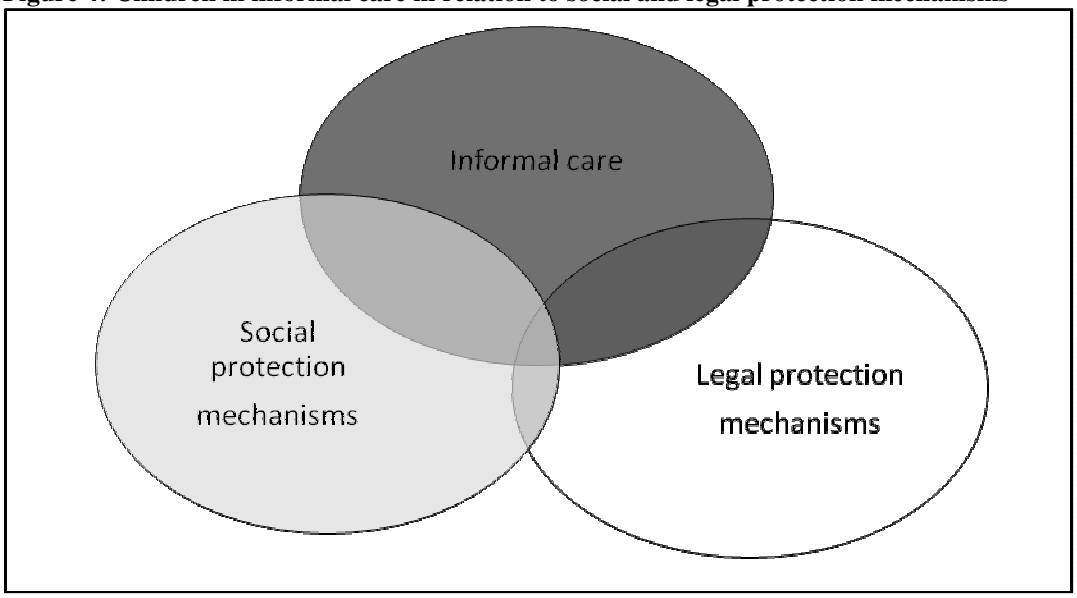
2. Informal care as pertaining to child protection systems

Placing informal care within the overall context of child protection systems helps to contextualise both the benefits and the risks as well as the recommended approaches to protecting children in such care.

2.1. Informal care in the larger system of child protection

By definition, informal alternative care is outside the legal and administrative regulatory and supportive mechanisms of the State, although there are a number of overlaps. Although the placement may not be screened or supervised by the State, children in informal care are entitled to all rights available to all children within the jurisdiction. For example, some developing countries have succeeded in achieving high levels of birth registration for all children without regard to their care setting. Mandatory child abuse laws, where they exist, are applicable to all children, as are some basic health services. Universal primary education targets all children, although in reality the additional fees and other expenses make it difficult for some families to keep children in school. In short, while the regulatory mechanisms may not have targeted children in informal care, the benefits may flow by their presence in the coverage area.

Figure 4: Children in informal care in relation to social and legal protection mechanisms



However, children in informal care lack the full protection of the law relative to children in parental care or formal care. For example, some children in informal care may not be entitled to inheritance even though they may have been in a *de facto* adoption relationship with their informal care givers. Without a legally recognised guardianship or adoption, the fostered child has an uncertain status under the law. If the fostered child is still under age 18, the caregiver's death may trigger the need for another arrangement, although the situation for the biological children of the caregiver may have been arranged through will or tradition. In many countries informal care is also mostly outside the social protection mechanisms such as social security and

other forms of assistance. However, there are overlaps where a certification of guardianship can be issued by a governmental office for an informal caregiver to access services, such as a health identification card, cash transfers, community counselling centres, home visit programmes and other social protection mechanisms.

2.2. Informal care in the continuum of care

Both the CRC and the Hague Convention on the Protection of Children and Cooperation in Respect of Inter-country Adoption provide some guidance. Under the CRC, a family environment is recognised as the natural setting for the harmonious development of the child, and repeatedly recognises the role and responsibility of parents and legal guardians as part of the first layer of a care scheme for the child. When the child is deprived of the "family environment" he or she is entitled to appropriate alternative care, including foster care, *kafalah* of Islam and adoption according to the laws of their countries.[113] Placement in a suitable institution is also allowable but only "if necessary", with "due regard" given to continuity in the child's upbringing.[114] In this continuum of care, informal care could occur throughout the entire continuum without a formal recognition of that relationship. The Hague Convention lays out a similar continuum of care, with an emphasis on family-based care in the country of origin before inter-country adoption is considered.

Figure 5 is a conceptualisation of the continuum between informal and formal care, based on a model developed in South Africa by Desmond and Gow (2001). In terms of cost, they found that the informal side of the continuum, i.e. informal fostering and community-based models, was generally much less costly than the formal statutory services. These models, however, do not take into account the full ratio of cost and benefits, making true comparisons difficult. Further, the informal models struggle to provide adequate material care to sustain their care of children. Ideally, it is optimal for every child to be placed in a family setting but they concluded that emergency care and care for very ill children are not likely to be taken up within the community, so the entire continuum of options, including residential care for children in need of intensive care, for example, children with serious medical conditions, is still necessary.

In many industrialised countries, informal care has been a prominent part of child care among indigenous groups. Examples include informal care practiced among the First Nations people of Canada, Native American tribes of the United States, the Maori of New Zealand and Aboriginal people of Australia. The child welfare histories of these nations are peppered with examples of how the informal care system and the State-imposed systems collided, particularly ideologies regarding the role of nuclear versus extended family, at times providing the systematic removal of children from their families and kin network.[115]

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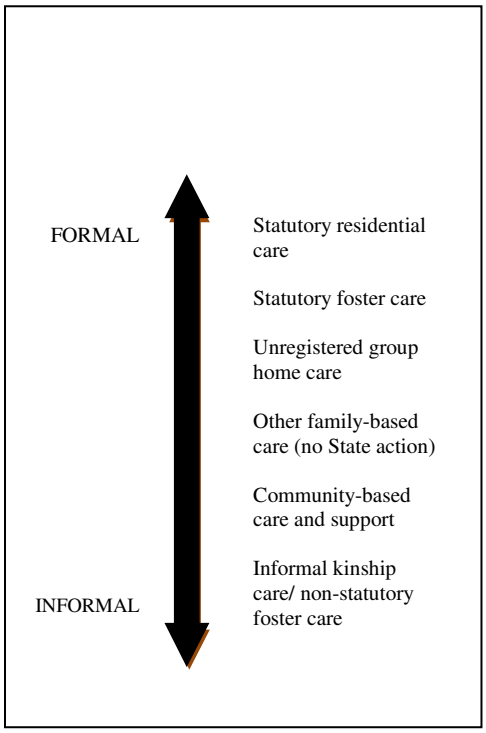
[113] Para. 20, parts 1, 2 and 3.

[114] CRC, Art.21.3. UNICEF states "For children who cannot be raised by their own families, an appropriate alternative family environment should be sought in preference to institutional care which should be used only as a last resort and as a temporary measure…In each case, the best interests of the individual child must be the guiding principle in making a decision regarding adoption: <www.unicef.org/media/media_41118.html> [accessed 27 May 2011].

[115] For an overview of these practices, see Blackstock, et al., 2006.

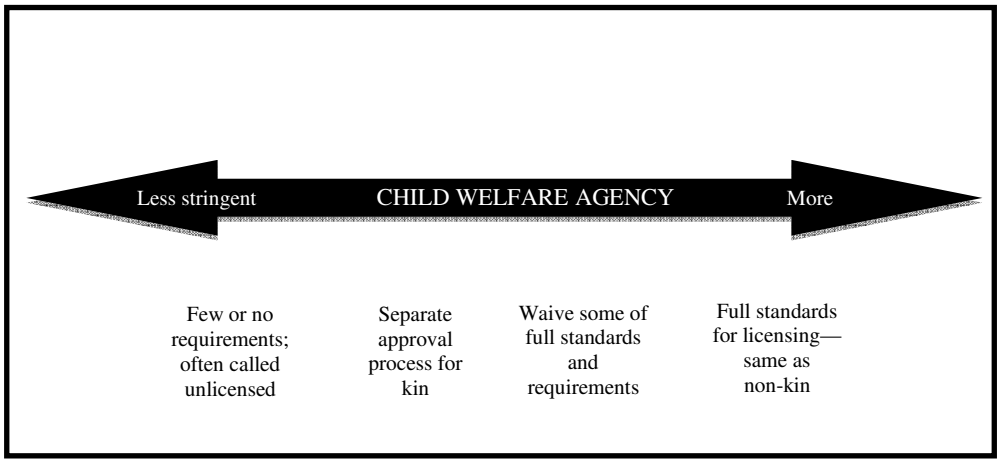
Again, cultural practices which are harmful to children must be identified and addressed, while at the same time respecting the independence and traditions of many groups—a delicate balance under the CRC and national laws. At the present, children of minority ethnic backgrounds in the United States are still disproportionately represented in the public foster care system, including Native American children as well as children of African American and Hispanic descent.

Figure 5: Models of alternative care: Formal to informal



Informal care in many countries may move toward formal care or move through different phases. For example, kin-based care in the United States as a whole has gone from predominantly informal to largely formal care within the last several decades.[116] Data are not available on children currently in informal care, but in 2008, 24 per cent of all children were in formal kinship care, compared to 47 per cent in non-kin formal foster care.[117] As seen in Figure 6, foster care in the United States ranges from very strictly formal to informal, and kinship care can fall on any part of that continuum. For example, at the point of approval less stringent standards are applied to kin in many states, such as the number of bedrooms, income level, the age of the caregiver or number of children in the home. Benefits also tend to vary depending on the state, with some states providing kin foster caregivers benefits equal to non-kin foster caregivers. In some cases after the initial set up of the arrangement, kinship care arrangements can become completely informal with no further government involvement.

Figure 6: Public kinship care (United States): Requirements to become a foster parent



[116] Jackson, 1999; Kolomer, 2000.
[117] United States Administration on Children and Families.

In Namibia, a transition regarding informal kinship care has reached a threshold. Under the proposed final draft of the Child Care and Protection Bill[118] kinship care and foster care are sharply distinguished. Kinship care can be arranged without involvement of the court, by a written agreement between parents and the care giver. The parents and kinship caregiver can spell out how they will exercise their rights and responsibilities in regards to the child. If they wish to access maintenance benefits for the child, kinship caregivers must register the care agreement with the court clerk.[119] The agreement must also have a defined duration and be supervised by a "designated" social worker. Foster care is provided by a trained professional and is provided by the State by court order.

[118] See: <www.mgecw.gov.na/documents/CCPA_FINAL_DRAFT_as_amended_by_TWG_%2807dec09%29.pdf> [accessed 27 May 2011].
[119] Section 104.

3. Supporting the rights of children in informal care

3.1. What are the rights of children in informal care?

All children have rights in relation to their care and protection, including children in informal care. Most of the rights are founded on the CRC, but other international instruments, such as the Optional Protocol to the CRC on the Sale of Children and ILO Convention No. 182 on the Worst Forms of Child Labour, are also applicable. Some of those include:

- A right to know and be cared for by parents (CRC Art. 7–1);
- A right to preservation of identity including family relations (CRC Art. 8–1);
- A right not to be separated from parents against his or her will except in case of abuse and neglect (CRC Art. 9–1);
- If separated, a right to maintain contact with parents on a regular basis unless it is contrary to the child's best interest (CRC Art. 9–3);
- A right for their parents/caregivers to receive assistance in child rearing (CRC Art. 18–2);
- When deprived of their family environment, a right to alternative care with regard to continuity and ethnic, religious, cultural and linguistic background (CRC Art. 20–2,3);
- A right to periodic review (CRC Art. 25);
- A right to be heard on matters affecting the child, depending on the child's capacity (CRC Art 12–1);
- A right to protection from abuse, neglect and exploitation (CRC Art. 19);
- A right to access to health care, nutrition, and safe drinking water (CRC Art. 24);
- A right of protection from harmful traditional practices (CRC Art. 24–3);
- A right to benefit from social security, including social insurance (CRC Art. 26);
- A right to compulsory primary education (CRC Art. 28–1);
- A right to rest and leisure (CRC Art. 31);
- A right to protection from economic exploitation, and from doing hazardous work, or work that interferes with education (CRC Art. 32);
- A right of protection from being sold for forced labour (CRC, Optional protocol on sale of children);
- A right of protection from the worst forms of labour—including by debt bondage and slavery, or forced or compulsory labour (ILO Convention No. 182);
- A right to be protected by regulations of hours and conditions of employment (CRC Art. 32–2(b));
- A right not to be forced to work below the minimum age (ILO Convention No. 60).[120]

In order for these rights to be realised in the lives of children, it is not enough that the CRC has been ratified, or that domestic implementation legislation has been promulgated, although those are important first steps. For children to enjoy the rights to which they are entitled, there is a need for a concerted effort at all levels to create an environment of support and protection.

3.2. Supporting the rights of children in informal care in context of broader systems

Children in informal care and their caregivers should be assisted within the broader protection systems. The points of entry can be found at the family, community, sub-national and national levels, as well as at the level of the international community of donors, NGOs and international organizations.

3.2.1. Supporting families

Family support can be provided in order to prevent the necessity for alternative care. It can also prevent secondary and tertiary separation of children from their informal caregivers. Current research strongly suggests that households providing informal care are experiencing unprecedented strain. As increasingly older, female-headed households are taking on the responsibility to care for children without parental care, the financial, physical and psychological toll is as heavy on the caregivers as the children. The assistance can be in the form of economic, in-kind, or psychosocial support.

Income support programmes: Income support programmes can help a child stay with a family by providing assistance to the most vulnerable households. Most such programmes are designed to meet a minimum level of subsistence and can include cash assistance, food commodities or tokens, in-kind transfers, such as school-based food programmes, school supplies and uniforms, or income generation opportunities. They can also include fee waivers for schooling, transport, utilities, health care or other essential services.[121] Unconditional or conditional cash grants have shown positive results in improving the nutritional and health outcome of children. Old age pensions have also been shown to be beneficial both economically and psychosocially.[122] Some countries have created or are considering creating a special foster care subsidy. As some of these programmes are fairly new in many States, there are challenges to be addressed, mostly involving human and material resources to administer the programmes. For example in Namibia, maintenance grant application is a time-consuming process monopolising the time and energy of social work staff who have very little time left to provide the psychosocial aspects of assistance, such as counselling, providing parenting advice and monitoring the progress and well-being of children.[123] In addition, kinship caregivers have difficulty accessing all the other support available and use most of the grant for school fees, supplies, and uniforms, resulting in their spending their own meagre income, including their old age pension, on food and clothing for the children. All of these demands place additional strain on the families that may already be living under the poverty line. Namibia is now re-evaluating whether kinship caregivers should be facilitated through a more streamlined process, whether once eligible for cash assistance the children would then be able to access school fee waiver and other services without separate qualification processes.

[121] Weigand & Grosh, 2008.
[122] Oswald, 2009.
[123] Namibia Foster Care Report.

Psychosocial support: Psychosocial health of the caregiver is emerging as a key issue in securing the stability and safety of the child in informal care.[124] The term "psychosocial" emphasises the close connection between the psychological aspects of one's experience (i.e. thoughts, emotions and behaviour) and one's wider social experience (i.e. relationships, traditions and culture).[125]While there is considerable literature on the psychosocial well-being of children affected by HIV/AIDS and orphans in general,[126] the psychosocial well-being of children in informal care or that of informal caregivers is still a new field of research. In the studies that have been conducted with kinship foster caregivers in the United States, the factors that have been identified as relevant to the stress of the kinship caregiver have been family resources, social support and physical health of the caregiver, so that support in each of these areas can help to boost psychosocial health of the caregiver.[127]

The connection between psychosocial health and physical health is also an important factor in providing security for children and for the caregivers. The form of psychosocial support will be culture-specific, but common practices include spiritual activities such as praying or attending church,[128] home visits by community members and others, companionship of friends and neighbours, recreational activities, such as group singing or other group-based activities, attending or participating in community festivities or traditional ceremonies and having access to counselling to cope with difficult issues. Child care cooperatives have been helpful in some villages where women take turns caring for children so that they have some time to rest or pursue an enjoyable activity, or volunteers have been organised to provide a few hours of respite. In many communities around the world, including the Pacific, Africa and South America, support systems are formed around religious organizations.

3.2.2. Supporting community-based responses

For children in informal care, the community is the next line of care after the family. Community-based groups can become essential in identifying and monitoring children in informal care and providing assistance and support.

Since communities can offer monitoring and protective mechanisms, sustaining them over time is critical. A 2006 study of community-based efforts in Malawi and Zambia, which had been in existence for 8 to 10 years, concluded that sustainable community mobilisation and capacity building are founded upon the degree of "ownership" of the priorities that leads to participation.[129]

Despite the positive impact that community-based initiatives can provide, a 2002 study warns against being too complacent about the effectiveness of communities, stating that, extraordinarily, all the evidence suggests that the traditional fostering systems in Africa, backed by community programmes, will continue to meet most of these children's basic needs, provided

[124] Richter, et al., 2009.
[125] Psychosocial Working Group, n.d.
[126] Biemba, et al., 2009.
[127] Kelley, et al., 2000; Musil, et al., 2009.
[128] See Hodge & Roby, 2010.
[129] Donahue & Mwewa, 2006.

that those coping mechanisms are not undermined.[130] Because these systems are so effective, they are the ones that we need to support. Indeed, it is somewhat paradoxical that the effectiveness of the traditional African social system in absorbing millions of vulnerable children has contributed to the complacency of governments and agencies in addressing the orphan crisis.[131]

3.2.3. Ensuring access to essential services

Access to school: In previous sections, research evidence was reviewed that suggests that children in informal care (whether classified as orphans or "other" children in households) have lower rates of school attendance than children living under parental care, although better rates than those living with non-kin. In some situations the child or youth may be saddled with too many responsibilities or experience intra-household discrimination resulting in absence from school. As well, misconceptions and discrimination by teachers and school administrators can also result in children dropping out of school. At times enrolment rates vary greatly from the actual attendance rate, as shown in Nigeria, where 83 per cent of the orphans who were enrolled were not attending school. Many had been expelled for failure to pay fees and other costs. Once the fees were covered, the children were attending consistently and there were no more cases of expulsion.[132]

The cost of "free public education" can be misleading, and since orphaned children tend to live in poorer households, cost can be a barrier. In some parts of Cambodia, for example, students are required to pay for routine school supplies such as paper and pencils, for tutorial sessions or to take an exam to progress into the next grade. Many two-parent households find such a burden very difficult to meet, let alone relatives caring for multiple needy children. Some NGOs provide school supplies and assist with fees so that children from impoverished families can stay in school, but only a small fraction of children are assisted. Very few households caring for orphaned and vulnerable children were receiving external support, a median of 12 per cent.[133]

Efforts to enhance children's access to school can target a waiver of fees, school fee subsidies and in-kind assistance. As an example, in the Democratic Republic of the Congo, UNICEF conducted a project specially targeting orphans and vulnerable children in six primary school sites. UNICEF convinced the schools that were already receiving UNICEF support to remove school fees for orphans. This effort was combined with advocacy campaigns, community mobilisation and seed money for schools to develop income-generating activities to recover the loss stemming from the removal of fees. These activities resulted in improving the overall orphan school enrolment to 70 per cent, compared to 48 per cent for single orphans and 58 per cent for double orphans at the beginning of the project.[134]

Some advocate for in-kind educational transfers, although in-kind targeting poor children has not produced positive school attendance in South Africa. Since schools collect and use the fees on

[130] Foster, 2002.
[131] See: <www.nejm.org/doi/full/10.1056/NEJMsb020718> [accessed 27 May 2011].
[132] Amolo, et al., 2003.
[133] Children and AIDS: Third Stocktaking Report, 2008.
[134] Dekens & Charruau, 2003.

site, waiving school fees works against them. Because of this, a recommendation has been made that school fee waivers be worked out at the central administrative level rather than with the specific school.[135] A 2003 study also reported that targeting OVC in Nigeria caused some jealousy, escalating the discrimination and stigma against these children.[136]

Access to health care: Research is somewhat spotty in this area, but a study in the United Republic of Tanzania found that almost 40 per cent of all households with orphans could not afford the basic necessities of education, food, medical care and clothing.[137] Another study[138] found that children in foster care had significantly less access to measles and diphtheria vaccinations and Vitamin A supplementation, compared to other children who lived with their parents. Several studies have shown that cash transfers make an improvement in the children's nutrition and health outcomes by enabling parents or caregivers to purchase appropriate foodstuffs.[139]

Access to child protection services: As discussed in a previous section, children in informal care can often be invisible to the child protection system. This is often related to the fact that the State's involvement is limited, if present at all, in their care situation. It may also be related to their general isolation and barriers to the information relative to accessing the available protections. Rural families may especially struggle with lack of access to larger systems.[140] Something as basic as the lack of birth registration can become quite a formidable challenge. For instance, a grandmother raising several grandchildren may have no means of transportation or information concerning obtaining such services.[141]

3.2.4. Ensuring improved policy and legislation

The Guidelines state that "It is a responsibility of the State or appropriate level of government to ensure the development and implementation of coordinated policies regarding formal and informal care for all children who are without parental care."[142]

What features would a normative legal framework providing protection for children in informal alternative care contain? Many of the components are found in the Guidelines.

Components provided under the Guidelines

Under the Guidelines, a number of provisions are recommended as explicitly pertaining to informal care. Depending on the national context, many of these could be considered as the basis for a proposed legal framework:

1) States should recognise the *de facto* responsibility of informal carers for the child;[143]

[135] Case & Ardington, 2004.
[136] Amolo, et al., 2003.
[137] UNICEF, 2006a.
[138] Deininger, et al., In Situational Analysis, 2002.
[139] Biemba, et al., 2010.
[140] Kiyaga & Moores, 2003; Monasch & Boerma, 2004.
[141] Schatz & Ogunmefun, 2007.
[142] Guidelines, para. 69.
[143] Ibid., para. 78.

2) States should encourage carers to notify the competent authorities so that they and the child may receive any necessary financial and other support that would promote the child's welfare and protection;[144]
3) States should seek to devise appropriate means, consistent with the Guidelines, to ensure the child's welfare and protection with due respect for cultural, economic, gender and religious differences and practices that do not conflict with the rights and best interests of the child;[145]
4) Decisions regarding children should have due regard for the importance of ensuring children a stable home, and of meeting their basic need for safe and continuous attachment to their caregivers, with permanency generally being a key goal;[146]
5) Where possible and appropriate, States should encourage and enable carers to formalise the care arrangement after a suitable amount of time, if the child's best interest will be served and the relationship will be for the foreseeable duration;[147]
6) States should recognise the role played by informal caregivers and take measures to support its optimal provision, paying attention to the settings which may require particular oversight;[148] and
7) States should devise special and appropriate measures designed to protect children in informal care from abuse, neglect, child labour and all other forms of exploitation, with particular attention to informal care provided by non-relatives, or by relatives previously unknown to the children or living far from the children's habitual place of residence.[149]

In addition to these specific provisions expressly applicable to informal care, many of the more general provisions of the Guidelines, such as those in Section II, may also apply to informal care.[150] These more general provisions may include:
1) States should provide family reunification services through supportive services;[151]
2) States should ensure the supervision of the safety, well-being and development of the child through regular reviews;[152]
3) The child should be consulted and his/her views should be duly taken into account in accordance with his/her evolving capacities, in his/her preferred language;[153]
4) States should seek to prevent the separation of children from their parents through appropriate and culturally sensitive measures;[154]
5) Children should be treated with dignity and respect at all times and receive protection from abuse, neglect and exploitation in whatever setting they may be in;[155]
6) They should have access to education, health and other services, the right of identity, freedom of religion or belief, language and protection of property and inheritance rights;[156] and

[144] Ibid., paras. 56, 77.
[145] Ibid., para. 18
[146] Ibid., para. 12
[147] Ibid., para. 56
[148] Ibid., para. 76
[149] Ibid., para. 79.
[150] Personal communication with Nigel Cantwell, a lead drafter of the Guidelines, 11 October 2010.
[151] Guidelines, para. 3
[152] Ibid., para. 5
[153] Ibid., paras. 6, 7
[154] Ibid., para. 9
[155] Ibid., para. 13
[156] Ibid., para. 16

7) Siblings with existing bonds should not be separated unless there is a clear risk of abuse or other justification.[157]

In addition to the above components, States may also consider each of the following, if appropriate to their specific culture and situation:

- A requirement that parents are responsible for the care of their child even when they are away, but without stripping them of their parental rights as long as they have not abandoned their parental responsibilities or have a record of abuse or neglect towards the child;
- A default legal mechanism of assigning the responsibility of care for each child who lacks parental care (usually the person currently caring for the child, or jointly with the person who has the default legal duty—if not the same person);
- Government assistance to provide access to legal services to formalise long term informal relationships (assuming the consent of appropriate persons, including the child);
- A "common-law" form of guardianship or other permanency arrangement under which a *de facto* informal carer is considered to be the legal guardian or parent upon passage of a predetermined time frame if determined to be in the child's best interest (with safety features against abuse);
- Use of community-based and traditional authorities for the initial determination of the best interest of children and the appropriateness of formalising informal relationships; and
- Coordination between community child protection mechanisms and government to monitor informal care situations until they are formalised.

Case study: The Namibian framework

In Namibia, where 42 per cent of rural households and 16 per cent of urban households are providing foster care, most of it informal, there has been much discussion about the social policy framework surrounding informal care. The recommendations from the Namibia Foster Care Report on managing informal kinship care under the new child welfare legislation (The Child Care and Protection Bill) share some of the features recommended in the Guidelines, and adds some of its own. The Namibian debate and the issues raised are relevant for discussion as more and more countries will be grappling with these policy issues. It is proposed that the new law should:

- Draw a clear distinction between the caregivers referred to as "kinship carers" and the non-related, trained caregivers referred to as "foster carers", and incorporate this distinction into the new legislation;
- Formalise the parental roles and responsibilities of kinship carers with a family agreement—a "kinship care contract" –signed by parents and proposed care givers and registered with the court;
- In case of dispute about the appointed kinship caregiver, offer the family support for reaching an agreement by introducing the family group conferencing (FGC) methodology;

[157] Ibid., para. 17.

- Where the family cannot reach an agreement, even with support and mediation, allow for a court order application to be made through the Ministry of Gender Equality and Child Welfare (MGECW) regional social worker;
- Give specific attention to heads of sibling households and ageing caregivers;
- Provide financial support to kinship carers as soon as the parental responsibility is transferred to them, and bring the administrative process of application in line with the application for a maintenance grant;
- Develop monitoring mechanisms to ensure the safety and well-being of all children in kinship care; and
- Develop support groups to provide social and emotional support to children and carers.

In terms of monitoring the 14,000 children in kinship care, it was recommended that the MGECW and the NGO sector could collaborate to enable families to access safety nets and coordinated services. They also envision collaborating between the ministry, traditional authorities and NGO volunteers to monitor progress and report to the social workers, who could then focus on the more difficult cases requiring professional attention. Social maps of all services (both government and non-government) could be utilised to locate children and services and social workers could provide regional assessments of coordinating and monitoring of kinship cases. Regarding registering kinship care, the MGECW has an application that the caregiver completes, the application is sent to the court, where the Commissioner of Child Welfare approves the placement, and this is returned to the MGECW to effectuate the social transfer and other benefits. There was, however, some concern about the time lag in this process.

In addition to the Namibian model, Appendix 4 examines various national laws containing provisions related to informal alternative care and discusses some common links across continents.

4. Capturing data on informal care

In the course of research for this paper, studies using four sets of data were most frequently found:

1) Multiple indicator cluster surveys (MICS)
2) Demographic and health surveys (DHS)
3) National programme statistics
4) National census data

Of these sets of data, the studies relying on DHS and MICS data sets often provided the most relevant information for this study. Previous studies in West Africa of non-parental care patterns also relied on DHS data (e.g. Pilon, 2003). These appeared to contain the "richest information" regarding children living in such arrangements (p.8). The largest study cited in this paper, by Ainsworth and Filmer, also used integrated household surveys (HIS), such as national socioeconomic surveys (SES) or living standards surveys (LSS). The national census data from Latin America relied upon by Levison and Langer (2010) were also useful in that the data format had a category for domestic servants, and the number of child domestics could be extrapolated with some assumptions.

The current DHS and MICS question 4 (MICS4) data can be useful to obtain information through multivariate analyses, for example, using orphan or non-orphan status and type of caregiver with child well-being outcomes such as school enrolment, educational achievement, nature and amount of work or issues of child discipline. However, the gap and the overlap in data between orphans and those who are in informal alternative care, make such an analysis somewhat off the mark. Current DHS and MICS instruments do not allow for that important differentiation or from those in formal foster care. Further, the current forms do not differentiate between adult relatives who are related by blood as opposed to by marriage, for example, aunts and uncles, or the degree of relatedness. These are directly relevant variables as shown by research, that should be included in future data collection.

Specifically focusing on the possibilities of building upon MICS4 to learn more about the prevalence of children in informal care, the following ideas could be incorporated to garner additional information:

- On the Household Questionnaire (HH) form, the number of all men and women of all ages should be documented since about half of the children in informal care are believed to live with grandparents. Currently the form only documents women 15 to 49 years of age.
- On the Household Listing (HL) form, currently each child's relationship with only the head of the house is asked. It would be very helpful to ask the degree of relatedness by blood, and whether on the paternal or maternal side of each child to each adult. Both of these factors (degree of blood relationship and maternal and paternal side of kin) are emerging as relevant to the care received by children without parental care. For example, an aunt caring for her sister's child may be different from an aunt who is the child's uncle's wife. In addition, the category of adopted/foster/step child should be separated out so that each becomes its own category. However, such detailed information may be

difficult to accommodate on household surveys, and may need to be collected through smaller, targeted samples.

- In addition to the mortality status of the mother and father, if it is appropriate, it would be helpful to know how long ago they died. If they are alive but not present, it would be helpful to know why they do not live there (employment migration, abandonment, etc.).
- On the Education (ED) form, it would be helpful to ask who provided for their school supplies and uniforms (if any).
- On the Household Characteristics (HC) form, after the question "how many rooms in this house are used for sleeping?" (HC2) it would be helpful to know where each person sleeps (bedroom, kitchen, outside, etc). This may be an indication of intra-house discrimination.
- After HC7, it might be natural to ask "who does the cooking?" Some researchers[158] report that children in informal care do most of the cooking.
- On the Insecticide Treated Nets (TN) form, question 12 ("Who slept under the mosquito net last night?") may be relevant to the household status of children in informal care.
- On the Child Labour (CL) form, it would be helpful to increase the age of children included to 17, or at minimum, to 15.
- On the Child Discipline (CD) form, using a random method of selecting children is presumably based on research methods, but it may "miss" an opportunity to take a closer look at how children in informal care may receive differential punishment. This should be explored in more depth.

In addition to the above, the following questions should be considered:

- the amount of time each child has lived in the household;
- the amount of time each child is anticipated to remain in the household;
- the reason non-biological child(ren) joined the household; and
- injuries or disabilities and their causes.

If it is not possible to ask all of them, a priority question might be to add one more item after HL14, to ask: "What is the main reason the child is in the house?" Then provide the following choices: "to be cared for, to work, to attend school, or _____ (fill in the blank)".

In addition to household surveys, village mapping methods widely used in developing countries should also be explored for the possibility of learning more about children in informal care. Such mapping often utilises the community's internal organisation structures, using a community map and having boundary-specific leaders report the numbers of various household members. In some communities, random sampling, or stratified sampling methods, may also be used to corroborate those reports or as an independent research method. Depending on the use of the data, representative samples may be defined at various levels and/or regions or tribal or ethnic boundaries.

[158] See, e.g. Oleke, et al.

5. Summary and way forward

Informal care, on the very basic end of the child care continuum, is a very large yet often invisible system laden with many complexities. While in the past kinship care may have been based more on reciprocity with the purpose of child socialisation, its current swell may be more related to crises in both developing and industrialised countries. Research reviewed in this paper shows that the vast majority of children in informal care, perhaps 90 per cent in some regions, are living within their extended family network, and a critical mass lives with grandparents. HIV/AIDS has a huge role in creating and negatively impacting affected children, many of whom live in informal care. In addition, children affected by AIDS experience multiple layers of physical, psychosocial, and emotional burdens. Children in industrialised countries also experience abuse, neglect, separation and other harm due to parents' personal problems and poverty. Further, the impact of disability on the part of the children and caregivers need to be explored, especially in areas where access to services and programmes may not reach them. Regardless of the region, informal caregivers tend to be older, poorer, and in worse physical and mental health than others who are not providing care. Many children who work as domestic servants are subjected to abuse, mistreatment or exploitation.

Informal care, by definition, is unregulated, but it often overlaps with regulated social and legal systems, although the overlaps tend to be accidental rather than planned. Children in informal care need to be identified and provided with the same degree of protection that other children enjoy, such as the right to birth registration, right of inheritance, access to services which require parental permission or guidance, and protection from premature adult roles. For resource-strapped countries, this type of protection can be very costly, both in terms of material and human resources. Many countries are grappling with how to balance the rights of the child with available resources of the country, as well as the rights and responsibilities of caregivers.

Going forward, there is a critical need for States to collect better data on informal care and establish national policies regarding informal care. A survey of national laws shows that informal care is not addressed by many, and when such legislation exists, it is a small piece of the whole structure that needs to be thoughtfully established, not left to chance. The Guidelines have articulated a set of components that should be included in a legal framework addressing the needs and rights of children in informal care. The CRC provides broader guidelines. In establishing policies, other relevant international instruments, such as the ILO conventions on child labour and child trafficking, should be considered. States should harmonise their national child welfare scheme so that the various parts correspond with and reinforce each other.

Of course, in order to create an effective policy, more must be known about the very real and widespread phenomenon of informal alternative care. Areas of much-needed research include the types and prevalence of children in informal care, the causes for such placements, the need for protection for children and their caregivers, and the current and desired roles of government and civil society in improving policies and access to essential services. Other urgent research questions include the psychosocial needs of caregivers in developing countries, cost-effective means of family preservation, effective methods of public campaigns addressing the needs of

children in servitude, and ways to increase support for family preservation, reunification and other preventative services. Combining knowledge with sound policy and resources, supported by a sense of collective ownership, will provide the impetus for reaching the millions of children currently in informal care.

Appendix 1: Sources

Note: All websites were accessed 27 May 2011.

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Appendix 2: Fosterage, orphanhood and HIV prevalence in African, Asian, South American and Caribbean countries

	Residence and Survival Status of Parents					Fostering	HIV/ AIDS	
	Living with both parents	Living with neither, both alive	Living with neither, father alive	Living with neither, mother alive	Living with neither, both dead	Foster House-holds	2001	2007
Benin 2006								
Age of household members								
0-2	82.4	1.2	0.1	0.1	0			
3-5	74.5	6.8	0.4	0.7	0.2			
6-9	65.2	11.4	0.8	1.6	0.5			
10-14	57.2	13.6	1	2.7	1			
Residence								
Urban	65.2	10.8	0.7	1.5	0.5	1.9		
Rural	70.7	7.7	0.6	1.3	0.4	2.6		
Total								
Total	68.8	8.8	0.6	1.4	0.5	2.3	1.3	1.2
Cameroon 2004								
Age of household members								
0-2	70	3	0.3	0.3	0			
3-5	64.2	10.1	0.7	0.7	0.3			
6-9	56.4	13.4	1.2	2.2	0.7			
10-14	49.5	15.4	1.9	2.9	1.4			
Residence								
Urban	56.2	12	1.3	1.9	0.9	19.9		
Rural	60.9	10.3	0.9	1.5	0.5	20.8		
Total								
Total	58.8	11.1	1.1	1.7	0.7	20.3	6	5.1
Chad 2004								
Age of household members								
0-2	83.4	1	0.2	0	0.1			
3-5	76.7	5.5	0.9	0.9	0.2			
6-9	72.5	7.9	1	1.2	0.7			
10-14	65.5	10	1.6	3	1.3			
Residence								
Urban	64.3	7.4	1.2	2	2.1	19.9		
Rural	76.1	6.2	0.9	1.2	0.3	16.5		
Total								
Total	73.9	6.5	1	1.4	0.6	17.2	3.4	3.5
Congo (Brazzaville) 2005								
Age of household members								
0-2	65.6	2.5	0.5	0	0.1			
3-5	59.7	8.9	0.7	0.2	0.2			
6-9	53.7	12	1.5	1.5	0.9			
10-14	43.5	14.6	2.2	3.4	2.3			

Residence									
Urban	51.6	10.7	1.2	1.6	1.1		20.1		
Rural	57.4	9.2	1.4	1.3	0.9		20		
Total									
Total	54.6	9.9	1.3	1.5	1		20	4.4	3.5
Congo Democratic Republic 2007									
Age of household members									
0-2	74	2.4	0.5	0.2	0				
3-5	67.9	7	1	0.8	0.3				
6-9	64.5	8.5	1.4	1.5	0.7				
10-14	56.5	12.4	1.8	3.4	2.2				
Residence									
Urban	61.5	9.5	1.2	1.5	1.1		21.5		
Rural	67.8	6.7	1.2	1.6	0.8		17.8		
Total									
Total	65.2	7.8	1.2	1.6	0.9		19.3	1.2-1.5	1.2-1.5
Ethiopia 2005									
Age of household members									
0-2	88	1.1	0.2	0.1	0.1				
3-5	82.3	4.1	0.4	0.4	0.3				
6-9	74.1	6.7	0.9	1	1.1				
10-14	65.2	8.5	1.3	2.2	1.9				
Residence									
Urban	57.6	9.2	1.7	1.9	2.8		17.2		
Rural	77.2	5.4	0.7	1	0.8		15.7		
Total									
Total	75.6	5.7	0.8	1.1	1		15.9	2.4	2.1
Ghana 2008									
Age of household members									
0-2	67.2	3.8	0.3	0.1	0.2				
3-5	60.6	11	0.7	0.5	0.4				
6-9	53.9	15.5	1.1	1.1	0.4				
10-14	47.3	18.9	1.4	2	1				
Residence									
Urban	50.7	15.2	1.1	1.2	0.7		14.5		
Rural	58.9	12.3	0.9	1	0.4		16.1		
Total									
Total	55.7	13.5	1	1.1	0.5		15.3	2.3	1.9
Guinea 2005									
Age of household members									
0-2	80.9	1.4	0.1	0	0.1				
3-5	72.7	9.7	0.6	0.8	0.6				
6-9	65.6	12.6	0.7	1.5	1				
10-14	60.6	13.9	1	2.2	2				
Residence									
Urban	60.6	13.6	0.8	1.7	1.9		29.1		
Rural	71.4	9	0.6	1.1	0.8		20.6		
Total									
Total	68.5	10.2	0.7	1.3	1.1		23	1.2	1.6
Lesotho 2004									
Age of household members									
0-2	54.7	6.6	0.8	1.4	0.4				
3-5	50.2	15.2	1.2	4.3	1.6				
6-9	47	13	1.5	6.2	4.1				
10-14	41.4	12.4	2.4	7.3	7.4				

Residence									
Urban	43.5	10.4	1.7	4.1	3.9		15.1		
Rural	47.4	12.3	1.7	5.7	4.3		27.8		
Total									
Total	46.8	12.1	1.7	5.5	4.2		24.8	23.9	23.2
Liberia 2007									
Age of household members									
0-2	57.6	6.2	0.2	0.3	0.1				
3-5	52.9	14.2	0.6	1.2	0.3				
6-9	47.6	19.7	0.8	1.8	0.9				
10-14	40.5	24.3	1.6	2.6	1.2				
Residence									
Urban	40.3	22.4	1	1.5	0.6		32.5		
Rural	53.8	13.8	0.8	1.6	0.7		24.4		
Total									
Total	48.9	16.8	0.9	1.6	0.7		27.4	1.4	1.7
Madagascar 2008-09									
Age of household members									
0-2	77.8	2.5	0.2	0.1	0				
3-5	72.4	8.4	0.4	0.3	0.1				
6-9	67	10.8	0.8	1.1	0.4				
10-14	60	13.5	1.6	2.2	0.9				
Residence									
Urban	63.5	11.7	1.3	1.2	0.5		16		
Rural	68.6	9.3	0.8	1.1	0.4		17.3		
Total									
Total	68	9.5	0.9	1.1	0.4		17.1	0.1	0.1
Madagascar 2003-04									
Age of household members									
0-2	76.7	3	0.3	0.1	0.1				
3-5	70.4	8.9	0.5	0.5	0.2				
6-9	64.6	10.6	1	1.2	0.4				
10-14	58.5	12	1.5	2.1	1.3				
Residence									
Urban	64.2	11.5	0.9	1.3	0.3		16.8		
Rural	66.9	8.6	0.9	1.1	0.6		16.8		
Total									
Total	66.4	9.1	0.9	1.1	0.6		16.8	0.1	0.1
Malawi 2004									
Age of household members									
0-2	75.8	2.3	0.2	0.2	0.3				
3-5	66.3	9.3	1	1	1.2				
6-9	55	14.3	2.2	2.8	2.9				
10-14	47.5	14.8	3.1	4.4	6				
Residence									
Urban	61.8	9.7	1.8	3.4	3.7		22.3		
Rural	59.3	10.9	1.8	2.2	2.8		23.2		
Total									
Total	59.7	10.7	1.8	2.3	2.9		23	13.3	11.9
Mali 2006									
Age of household members									
0-2	84.8	1.5	0.1	0.1	0				
3-5	80.7	6.5	0.4	0.5	0.1				
6-9	76.9	8.6	0.9	0.8	0.5				
10-14	70.3	10.8	1.3	2	0.9				

Residence								
Urban	69.6	10.1	1.4	1.4	0.5	20.6		
Rural	80.8	6	0.5	0.7	0.4	13.8		
Total								
Total	77.7	7.1	0.7	0.9	0.4	15.9	1.5	1.5
Namibia 2006-07								
Age of household members								
0-2	34.5	13.5	0.6	0.3	0			
3-5	30	27.2	1.8	1.8	0.5			
6-9	26.8	26.9	3	4	1.5			
10-14	20.7	25.2	5.8	7.3	4.5			
Residence								
Urban	37.1	13.5	1.8	1.8	1.5	16.2		
Rural	21.7	28.9	3.9	5	2.3	41.8		
Total								
Total	27	23.6	3.2	3.9	2	29.9	14.6	15.3
Niger 2006								
Age of household members								
0-2	75.2	2.8	0.3	0.1	0.1			
3-5	70.3	8.6	0.4	0.6	0.3			
6-9	65.4	9.3	0.9	1.4	0.6			
10-14	63.8	9.2	1.2	1.9	0.9			
Residence								
Urban	69.1	8.5	0.7	1.1	0.9	20.3		
Rural	68.1	7.5	0.8	1.1	0.4	19.2		
Total								
Total	68.3	7.6	0.7	1.1	0.5	19.4	0.7	0.8
Nigeria 2008								
Age of household members								
0-2	83.8	1.6	0.2	0.1	0			
3-5	78	5.8	0.4	0.4	0.1			
6-9	71.6	8.7	0.5	1.1	0.3			
10-14	63.8	11.2	0.8	1.9	0.7			
Residence								
Urban	72.9	7.8	0.6	0.9	0.4	11.6		
Rural	74	6.8	0.5	0.9	0.3	12		
Total								
Total	73.7	7.1	0.5	0.9	0.3	11.8	3.2	3.1
Rwanda 2005								
Age of household members								
0-2	79.7	1.7	0.1	0.1	0.1			
3-5	71.9	5.4	0.6	0.7	0.9			
6-9	60.7	6.8	1.4	2	2.3			
10-14	44	7	2.7	4	7.4			
Residence								
Urban	58.3	4.5	1.4	1.8	3.8	19.2		
Rural	63.4	5.5	1.3	1.9	2.8	18.7		
Total								
Total	62.7	5.3	1.3	1.9	3	18.8	4.3	2.8
Senegal 2005								
Age of household members								
0-2	66.1	1.9	0.2	0.1	0.1			
3-5	60.6	9.3	0.6	0.4	0.3			
6-9	56.4	13.4	0.9	1.4	0.7			
10-14	51.5	14.6	1.2	2.1	1.6			

Residence								
Urban	54.8	9.8	0.8	0.8	0.9	26.3		
Rural	60	10.5	0.8	1.3	0.6	36.6		
Total								
Total	58.1	10.3	0.8	1.1	0.7	31.6	0.4	1
Sierra Leone 2008								
Age of household members								
0-2	66.6	6.9	0.6	0.5	0.5			
3-5	55.8	17.5	1.1	1.7	1.1			
6-9	51.2	19.9	1.3	2.8	1.9			
10-14	41.4	21.8	1.5	4.7	2.9			
Residence								
Urban	41.6	21.8	1.5	3.9	2.6	41.2		
Rural	56.2	15.8	1.1	2.4	1.4	33.3		
Total								
Total	51.8	17.6	1.2	2.8	1.8	36	1.3	1.7
Swaziland 2006-07								
Age of household members								
0-2	25.7	12.7	0.9	0.9	0.2			
3-5	24.1	23.4	2.1	3.9	0.8			
6-9	22	20.4	3.8	6.4	3.4			
10-14	20.1	18.3	4.5	7.2	7.5			
Residence								
Urban	33.1	11.9	1.9	3.2	3.3	13		
Rural	20.5	20	3.4	5.5	3.7	40.1		
Total								
Total	22.5	18.8	3.2	5.1	3.7	31.3	26.3	26.1
Tanzania 2004-05								
Age of household members								
0-2	76.1	2.5	0.2	0.1	0.1			
3-5	66.9	8.7	0.5	0.7	0.3			
6-9	60.1	11	1	1.6	0.8			
10-14	52.2	13.1	2.5	3.2	2.2			
Residence								
Urban	58.4	10.5	1.3	2.3	2.1	19.1		
Rural	64.1	8.8	1.1	1.3	0.6	18.8		
Total								
Total	63	9.1	1.2	1.5	0.9	18.9	–	–
Uganda 2006								
Age of household members								
0-2	72.1	3.4	0.4	0.5	0.1			
3-5	61.7	10.3	0.8	2.2	1			
6-9	53.4	13.3	2.1	3.5	2.6			
10-14	45	13.4	2.4	4.9	5.5			
Residence								
Urban	49	10.9	1.6	4	2.3	20.1		
Rural	57.5	10.5	1.5	2.9	2.6	27.2		
Total								
Total	56.6	10.5	1.5	3	2.6	26.1	7.9	5.4
Zambia 2007								
Age of household members								
0-2	75.5	2	0.4	0.1	0			
3-5	70.3	7.4	1	0.8	0.6			
6-9	58.6	11	1.8	2.9	2.5			
10-14	44.9	15	3.2	5.1	6.3			

Residence									
Urban	57.3	9.6	1.8	2.6	3.9		26.2		
Rural	62	9.4	1.7	2.5	2.2		24.2		
Total									
Total	60.6	9.4	1.8	2.5	2.7		24.9	15.4	15.2
Zimbabwe 2005-06									
Age of household members									
0-2	56.2	5.7	0.5	1	0.5				
3-5	47.5	14.2	1.5	3.3	2				
6-9	38.4	15.7	2.2	6.2	5.3				
10-14	33.1	13.4	2.7	7.2	10.7				
Residence									
Urban	52.1	10	1.5	3.2	3.1		17.4		
Rural	38.3	13.7	2	5.6	6.4		34.2		
Total									
Total	41.8	12.8	1.9	5	5.6		28.4	26	15.3
Armenia 2005									
Age of household members									
0-2	88.3	0	0	0	0				
3-5	84.4	0.6	0.1	0	0				
6-9	83.1	0.9	0	0.1	0				
10-14	78.2	1.5	0.1	0	0				
Residence									
Urban	81.7	1.5	0.1	0.1	0		1		
Rural	83	0.3	0.1	0	0		0.4		
Total									
Total	82.2	1	0.1	0	0		0.8	0.1	0.1
Azerbaijan 2006									
Age of household members									
0-2	87.4	0.7	0	0	0.1				
3-5	85.5	0.7	0.1	0	0.1				
6-9	86.8	0.9	0.1	0.1	0.3				
10-14	82.8	0.8	0.3	0.1	0.1				
Residence									
Urban	87.1	0.7	0.2	0.1	0.3		0.9		
Rural	82.9	0.9	0.1	0.1	0.1		1.3		
Total									
Total	85	0.8	0.2	0.1	0.2		1.1	–	0.2
Egypt 2008									
Age of household members									
0-2	96.8	0.2	0	0	0				
3-5	95.3	0.3	0	0	0				
6-9	92.2	0.3	0	0.1	0.1				
10-14	88.6	0.6	0.1	0.1	0.2				
Residence									
Urban	92.6	0.5	0.1	0.1	0.1		0.6		
Rural	92.7	0.3	0	0	0.1		0.7		
Total									
Total	92.6	0.4	0.1	0	0.1		0.6	< 0.1*	< 0.1*
Egypt 2005									
Age of household members									
0-2	97.6	0.1	0	0	0				
3-5	95.8	0.2	0	0.1	0				
6-9	93	0.4	0	0	0.1				
10-14	89.1	0.5	0.1	0.2	0.2				

Appendix 3: Orphan school attendance ratio

Note: Percentage of children 10 to 14 years old who have lost both biological parents and are currently attending school as percentage of children of the same age whose parents are both alive, are living with at least one parent and are attending school.

Source: Children and AIDS:Country Fact Sheets 2009. UNICEF/UNAIDS/WHO.

	Source of information	Early data (year)	Next available data (year)	Most Recent data (year)
Bangladesh				.84 (2006)
Benin				.90 (2006)
Bolivia			.82 (1998)	.74 (2003)
Burkina Faso			1.09 (2003)	.61 (2006)
Burundi			.70 (2000)	.85 (2005)
Cambodia			.71 (2000)	.85 (2005)
Cameroon	MICS, 2006		.99(2004)	.91 (2006)
Central African Republic	MICS, 2006	.72(1994)	.83(2000)	.83 (2006)
Chad	DHS, 2004		.96 (1996-1997)	1.05 (2004)
Colombia	DHS, 2005			.85 (2005)
Congo	DHS, 2005			.88 (2005)
Dominican Republic	DHS, 2007		.96 (2002)	.77 (2007)
Ethiopia	DHS, 2005		.60 (2000)	.90 (2007)
Gambia	MICS 2005-2006		.85 (2000)	.87 (2005-2006)
Ghana	MICS 2006	.93 (1998)	.79 (2003)	1.04 (2006)
Guinea	DHS, 2005		1.13 (1999)	.73 (2005)
Guinea-Bissau	MICS, 2006		1.03 (2000)	.97 (2006)
Haiti	DHS, 2005	.76 (1994)	.87 (2000)	.86 (2005-2006)
Honduras	DHS, 2005-2006			1.08 (2005-2006)
India	NFHS-3, 2005-06			.72 (2005-2006)
Indonesia	DHS, 2002-2003		.76 (1991)	.82 (2002-2003)
Iraq	MICS, 2006			.86 (2006)
Kenya	DHS, 2003	.74 (1998)	.94 (2000)	.95 (2004)
Lesotho	DHS, 2004		.87 (2000)	.95 (2004)
Liberia	DHS, 2007			.85 (2007)
Madagascar	DHS, 2003-2004		.55 (1997)	.75 (2003-2004)
Malawi	MICS, 2006	.93 (2000)	.96 (2004)	.97 (2006)
Mali	DHS, 2006	.71 (1995-1996)	1.04 (2001)	.87 (2006)
Mauritania	MICS, 2007			.66 (2007)
Mongolia	MICS, 2005			.96 (2005)
Mozambique	MICS, 2008	.47 (1997)	.80 (2003)	.89 (2008)
Namibia	DHS, 2006-2007	1.06 (1992)	.92 (2000)	1.00 (2006-2007)
Niger	DHS, 2006		.40 (1992)	.67 (2006)
Nigeria	DHS, 2003		.87 (1999)	.64 (2003)
Rwanda	DHS, 2005		.83 (2000)	.82 (2005)
Senegal	DHS, 2005	.20 (1992-1993)	.74 (2000)	.83 (2005)
Sierra Leon	MICS, 2005		.71 (2000)	.83 (2005)
Somalia	MICS, 2006			.78 (2006)
Swaziland	DHS, 2006-2007)		.91 (2000)	.97 (2006-2007)
Thailand	MICS, 2005-2006)			.93 (2005-2006)
Togo	MICS, 2006	.87 (1998)	.96 (2000)	.94 (2006)
Uganda	DHS, 2006	.95 (2000-2001)	.94 (2004-2005)	.96 (2006)
Ukraine	State Statistics Committee, 2005			.98 (2005
United Republic of Tanzania	HMIS, 2007-2008	.80 (2003)	1.02 (2004-2005)	.97 (2007-2008)
Zimbabwe	DHS, 2005-2006	.85 (1999)	96 (2003)	.95 (2005-2006)

Appendix 4: National informal care laws in selected countries

In order to assess existing provisions related to informal alternative care, the national laws of several countries in each continent were examined. Although the amount of information found was not large in quantity, they provide some common linkages regarding the care of children in the absence of parental care. Some laws clearly spell out the parents' responsibility for children even when they are away from the child while others make it clear that the person who has taken on the care of the child has the de facto responsibility (with some combining both concepts); some provide a default system of identifying the person who has legal responsibility for the child in the event of parental death or abandonment; some provide an order of preference for guardians to be appointed for children of aboriginal ethnicity; and some provide for *de facto* adoptions or address issues of government assistance to relatives raising kin children. In most cases these provisions are listed in the child welfare or domestic law sections of the civil code, but some, such as Namibia, have incorporated these provisions directly into their national constitution.

Australia's law (Section 513) prioritises preferences when placing a child or young person in out-of-home care for an Aboriginal or Torres Strait Islander. The order of preference is: kinship; a member of the child's ethnic community; or a non-aboriginal that is sensitive to their needs and will provide contact with family, community and culture. The adoption codes also reflect similar preferences. Kinship foster care is formalised in most cases and foster care grants are provided.

In Belize, under the Families and Children Act, 1998 (Act No. 17 of 1998, as amended in 1999), the law allows for a *de facto* adoption. Under this law, any child in the care and custody of a person or two spouses as their child under a *de facto* adoption for at least two years (where they have been in the custody and so brought up, maintained and educated) may be adopted without requiring consent of any parent or guardian as long as the case seems equitable and for the good of the welfare of the child (Section 144).

In Cambodia, the Civil Code (Section 1140) obliges relatives to provide support to orphaned children in the order of: cohabiting relatives; lineal relatives by consanguinity (blood); adult siblings; and, in special circumstances, an obligation on relatives up to the third degree. The law also allows for a "simple" adoption where a child can be adopted by a person or couple without depriving the rights of the natural parents, and the adoption can be nullified upon petition by the child, adoptive or birth parents, upon showing of "good cause".[159]

Ethiopia's Civil Code (Art. 207) has a default guardianship provision in the event that a child is orphaned and a legal guardian has not been specifically appointed by one of the parents. The order of legal duty to care for the child goes, in order, to the paternal grandfather, paternal grandmother, the eldest paternal uncle or aunt, then the maternal uncle or aunt, and finally to the youngest granduncle or grandaunt of the child. Interestingly, all women and persons aged 65 or older are exempted from accepting such default guardianship appointments. This has implications for children in the care of their female relatives and elderly grandparents.

[159] Cambodia's intercountry adoption laws are much more complicated and do require the full termination of parental rights first ("full adoption").

The law in Guatemala (Act on the Comprehensive Protection of Children and Adolescents, 2000) varies significantly from many other countries, in that children and adolescents may live in single-parent families, extended families or nuclear families but regardless of with whom they live, both the father and the mother have common obligations and shared responsibilities as well as rights, in terms of their children's upbringing, development and appropriate guidance.

In Guyana, the Childcare and Protection Bill (2008) gives the responsibility and authority to oversee foster care, guardianship and child maintenance issues to the Childcare and Protection Agency, and to provide counselling and protection to children in foster care as well as their caregivers (Part II, Section 4). Here, the "foster care" is presumably formal foster care, as the agency would accept petitions and make investigations. It is not clear whether it also includes informal kinship care.

Mozambique assigns the care of children to both parents and the person they are living with. The law explicitly spells out that even an absent parent has the obligation to follow the laws (Law on the Protection of the Rights of Children and Adolescents, Art. 21). The law prescribes that children cannot be removed from the care of their parents simply because of poverty or lack of resources and that a mother who lives away from her children in order to work and provide for them will not be adjudicated to have "abandoned them" without a protection order or some showing of violence or neglect (Art. 23).

The Constitution of Namibia, in Article 14, recognises the family as the natural and fundamental unit of society and it is entitled to assistance. Article 15 provides that children have the right to know and be cared for by their parents and also provides them protection against hazardous work or work that excludes them from attending school. The proposed draft law, the Child Care and Protection Act, outlines the process of formalising foster care, however, does not address whether all informal care arrangements should be converted to formal cases, or if informal care arrangements will be afforded any of the benefits of the formal care arrangements.

Under the laws of Romania (Law 272/2004 and Law 329/2009 on the Protection and Promotion of the Rights of the Child), any child who is either temporarily or definitively deprived of the care of his or her parents has the right to alternative protection, which includes legal guardianship, the special protection measures stipulated under the present law or adoption. When choosing one of these solutions, the competent authority must appropriately take into account the need to ensure continuity in the child's education, as well as his or her ethnic, religious, cultural and linguistic background. Article 42 gives priority in appointing a relative or a friend of the child's family, who is capable of fulfilling this task as legal guardian (kinship care), if there is no justified opposition.

In South Africa, under Children's Act, 2005, a child in need of alternative care may be placed in foster care with a suitable foster parent, foster care with a group of persons or an organization operating a cluster (group) foster care, shared care where different caregivers or centres alternate in caring for the child or other formal placements. Children in kinship foster care are entitled to child support grants regardless of their blood relationship with the foster parent(s).

In Uganda, under Chapter 59 of the Children's Act, parental responsibility may be passed on to relatives of either parent or, by way of a care order, to the warden of an approved home or to a foster parent (Section 6). In practical terms, the person who is providing foster care has the legal duty to care for the child, unless someone else or another entity has been ordered by the court.

The United States law that first emphasised placement with kinship carers was the Indian Child Welfare Act (ICWA, 1978), applicable to Native American children. Under the ICWA the placement priorities are almost identical to those enumerated in the Australian law regarding indigenous children. For all other children in the United States (including all other racial and ethnic minorities), the Adoption and Safe Families Act of 1997 prioritises kin placement over non-kin placements. Subsidies for kin foster carers vary state by state, as are approval criteria for placement. However, under the new Fostering Connections to Success and Increasing Adoptions Act of 2008, kinship care and adoptions will receive guaranteed subsidies, although the amounts can still vary between states.

No country has a separate set of laws regarding informal care and no country reviewed above completely meets the requirements of the recommended framework for informal care under the Guidelines, but Namibia's proposed Child Care and Protection Bill has most of them and some additional features. It is possible that there are other forms of policies, such administrative policies, that may address informal care. While it is not necessary that a separate set of legislation be devoted to informal care or alternative care, when "rights" are conferred at the sub-legislative level, such as through administrative regulations, they are not as secure. Still, a coordinated set of policies at some level will provide a measure of protection. Further research is needed to identify policies more thoroughly.

Appendix 5: Examples of practice in addressing needs of children in informal care

Below are some documented examples of social mobilization to create a supportive environment for all children, or specifically for orphans and vulnerable children, resulting in greater support for children in informal care. While some of the activities do not specifically target children in informal care, they will likely have a positive impact on them. These are listed as examples of practices and is not an exhaustive list of efforts that could be made.

Community-level efforts

Needs of OVC as part of community plan and budget: In Luwero District in Uganda, where 10 per cent of the children had been orphaned and one-third are living in kinship care, Christian Aid and community members assessed needs of the children and incorporated the expense of meeting those needs into the plans and budgets of the district.

Community-based family preservation efforts: In Kampala, Uganda, a local NGO, Action for Children, has conducted family preservation efforts for many years in collaboration with community leadership. The families are assisted on eight indicators of sufficiency: food security; all children in school; access to healthcare and immunizations; safe drinking water; sanitary latrines; psychosocial support; income generation; and community involvement. In 2005, the programme was evaluated for its efficacy in keeping vulnerable families together and for its potential to support lasting permanency for the children in the families, including about half of the sample of 315 families raising 527 kin children. Using mixed methods, the results showed that the families had significantly improved their level of sufficiency from the baseline. Most promising, 94 per cent of the children were confident they would be able to stay with the family until they grew to age 18, and 92 per cent of the caregivers felt they could continue to care for the children until adulthood. The few caregivers who were not sure cited their poor health. No significant differences were found between the biological and foster children in the households in terms of feeling loved, the amount of work or the reported amount and quality of food.[160]

Succession planning: In Entebbe, Uganda, the AIDS Support Organization (TASO) conducted workshops to provide will preparation and memory book writing services for hundreds of HIV-positive patients. This was done on the grounds of an outpatient clinic that patients visited. On their regular visits, patients were informed of the advantages of preparing these documents and they were told of the date and time of the workshops. Free lunches were served and transportation allowances were reimbursed to those who attended. On the workshop days, staff and volunteers trained by a representative from the Women Lawyers Association of Uganda (FIDA) assisted the parents to complete the wills already printed with blanks to fill in, and printed memory books that guided them through to completion. As a result, hundreds of parents and guardians were able to appoint legal guardians for their children, bequeath their property (reducing the fear of property grabbing) and leave a legacy of memories for their children. In

[160] Roby & Shaw, 2008.

addition, trained staff held these workshops in communities for those who could not travel, taking prepared food with them. For sustainability purposes, the trained staff then trained staff at other TASO locations to replicate the success of the project. [161]

Child protection committee: In West Bengal, Save the Children helped to set up village-level committees, each with 13 to 20 members, including influential community leaders, parents, school teachers, employers and child representatives. They worked to raise awareness about child trafficking and other forms of abuse and exploitation then brought referral information from the formal child protection system to the informal sector. In three to four years, the committees helped more than 1,200 children to leave work and return to school and aided in the arrest of 100 traffickers.[162]

Village mapping: In northern Afghanistan in 2003 to 2005, Child Fund Afghanistan worked with child participants to conduct village mapping of dangerous places. The children shared the results in plays, leading to corrective actions by adults and the establishment of child well-being committees, including children that mobilized around not only safety issues but also healthcare, hygiene, non-formal education and forced early marriage. (A similar method could be used to identify children living in informal care).[163]

Community watch groups: World Vision Philippines helped to set up community watch groups made of local leaders, parents, teachers and others chosen by the community that would receive training on child rights and child labour. The committees then identified children who were engaged in dangerous work and who did not attend school regularly. They worked with parents and local schools to make sure the children returned to school. Nearly 17,000 boys and girls were assisted in leaving hazardous work and returning to school.[164]

National-level efforts

Increasing birth registration: A birth certificate is critical in documenting the identity of the child so that the larger systems of protection can gain access to the child. Children in informal care may have been placed in a time of crisis and may not have legal identity documents. Birth registration is also important for all children to gain access to healthcare (including immunizations), to enrol at school at the right age, and to be protected from premature entrance into work, military service or marriage. Many good practices can be found around the world. Among them, Uganda increased its birth registration rate from 4 per cent to 62 per cent of the population between 2001 and 2005, using village volunteers who went door to door and helped to complete necessary documents, which were then entered into a central data base at the district level. The initiative also recognised the most marginalised communities, including ethnic minorities, nomadic groups, orphans, street children, migrants and refugees. (Children in informal care would also fit into one of more of these categories). Cambodia launched a nationwide campaign to raise awareness, with mobile buses showing films, television advertisements on the child's right to registration and birth poetry contests. Capacity-building

[161] The author of this paper obtained funding and assisted in training staff and volunteers in 2006.
[162] Wessells, 2009, Executive Summary p. 7.
[163] Ibid., p. 11.
[164] Ibid., p. 13.

activities were conducted in storing and processing of data in a computerized system. A two-month mobile civil registration pilot programme was then used in all 1,621 communes (collections of smaller villages) in the country. As a result, registration rates rose from 5 per cent before 2005 to nearly 92 per cent of the population by June 2008. Zimbabwe is making efforts to register all children regardless of the *lobola* (bride price) of their mother, as 80 per cent of the mothers were not *lobola* brides. Currently only children whose mothers are married through the payment of the *lobola* are considered legitimate.

Conditional and unconditional cash transfers: Many countries are now using conditional cash transfers as a major means of investing in the long term self-sufficiency of the poor. By attaching conditions such as obtaining immunizations for the children or school attendance, the society at large makes a contribution to the short-term needs of the child and also helps to build the long-term human capital of the beneficiaries. In an evaluation looking at six countries'[165] conditional cash programmes, Rawlings and Rubio (2005) found clear evidence of success in four of the six countries, with mixed results for the others. The evidence included increasing school enrolment rates, improving preventative health care and raising household consumption. For example, in Nicaragua, school enrolment rates jumped from 68.5 per cent to 88.5 per cent, although the gains were uneven across the countries. In terms of health and nutrition, children were taken more frequently to growth monitoring clinics and showed lowering of stunting in very young children.

Social pension for elderly caregivers: Some countries have used social pensions for the elderly poor resulting in higher quality of care for the children in the household. In a controlled experimental group study in the United Republic of Tanzania, Hoffmann, et al. (2008) found that the pension helped to reduce extreme poverty and improve the quality of life for both the elderly caregiver and the children in the household. Providing improved food and varied nutrition, as well as the basic necessities of life, such as soap and salt, the pensions bettered the general health and psychosocial well-being of the family members. The participant group was less ill, felt more satiated after eating, felt less anxious and stressed and more confident than the control group of elderly people who were not receiving the pensions. Children in their care had more time to play, study, read and talk to friends, rather than constantly working. The researchers believed that after a year of receiving pensions they had some evidence that the children's nutritional status improved. The children in receiving households also had higher attendance rates, scored higher on depression scales (felt less depressed) and felt more loved when their grandmothers were able to meet their material needs.

Formalising informal relationships: The Guidelines encourage States to enable informal caregivers to formalise the relationship when it will serve the best interest of the child. In many countries, kin who are raising children with the plan to do so permanently do not have the means with which to legally formalise that relationship.[166] However, the Guidelines do not clarify which form of legal relationship is preferable. While in the United States adoption is considered the ultimate form of permanent legal relationship for children in alternative care, perceptions about what type of formalisation is in the child's best interest in the long run vary. For example, New Zealand, Australia and the Netherlands encourage a permanent guardianship rather than

[165] These were Colombia, Honduras, Jamaica, Mexico, Nicaragua and Turkey.
[166] Guidelines, para. 56.

adoption, based on the belief that adoption might distort biological family relationships.[167] As another example, under the *kafalah* of Islam, children can enjoy a long term stable relationship with the care giver(s).

Acknowledging *de facto* adoptions: In many traditional societies in Africa, the Americas and the Pacific, *de facto* adoption was a prominent tool in securing a child's relationship to the caregiver. These tend to be open and flexible, without the loss and replacement often accompanying adoptions in industrialised States. For example, in Ethiopia, a child could be adopted by a new family by consent of the child's parents or relatives, and sanctioned by a ritual ceremony. The adopted child then would take the name of the adoptive family and have succession rights but could continue to have a relationship with the biological family. In New Zealand, efforts have been made to incorporate such *de facto* adoptions among the Maori people to be acknowledged within the formal adoption system, such as through an additional guardianship.[168] In the Marshall Islands, "customary" adoptions are converted into formal adoptions quite routinely without the many hurdles that a formal adoption requires, as long as there is mutual consent on the part of birth and adoptive parents.[169]

[167] United Nations, 2009.
[168] United Nations, 2009.
[169] Marshall Islands Revised Code, Title 26, §105.