Alternative Care in India

Stakeholder's Report on the Universal Periodic Review IV of India

Submitted By: Udayan Care, New Delhi, India. www.udayancare.org. An organisation with Special Status with ECOSOC since 2019

Introduction

The 2018 report by Ministry of Women and Child Development, Govt. of India, states that over 370,000 Children in Need of Care and Protection are housed in over 9500 Child Care Institutions (CCIs) all over India. These CCIs are governed by the JJ Act. of 2015 [7], with 91% of these homes being run by NGOs with or without support from the government, and 9% run by the government. These numbers for CCIs and children in institutional care are likely to be an underestimate, as knowledge of the JJ Act is still being disseminated, and many institutions remain unaware of the need to register under the JJ Act [8]. All the children in these CCIs are temporarily under the guardianship of the government, which has a responsibility to provide for all their basic needs such as food, shelter and education

Family-based care models are at their nascent stages in India[1]While its implementation has been advocated in the country to address issues faced by children in institutional care, **several systemic challenges, such as the large population of vulnerable children, and a dearth of family and community systems willing or able to engage, sustains the dependence on institutions and complicates transition to family-based models[2]**

COVID-19 has pushed children without parental care (CWPC) and care leavers (CLs) in India further beyond the margins. Clubbed with COVID related challenges, there remain significant gaps between the political, legal commitments, budgetary allocations and implementation of a uniform policy on family based care. Without a common strategy and action plan from the Govt. of India (GoI), such efforts remain ad-hoc and undocumented in the country, leading to a continued dependability on institutional care.

While globally, there is clear evidence of the harm of institutional/residential care, no such study or evidence has been collected by the govt of India to inform future deinstitutionalization policy. There is no data maintenance system for aftercare and care leavers. A report done by Udayan Care on aftercare in 2019[3] was submitted with recommendations to the GOI but no action has been taken so far.

The GoI Ayushman Bharat scheme, the national policy for youth 2014, the national policy on skilling and entrepreneurship, 2015 and similar policies such as Sports policy, exclude CLs totally and have no special provisions to include them. This prevents a level playing field for CLs who are one of the most vulnerable young population in the country.

There is no data system with the GoI to know the number of CLs in the country, leading to no budgetary planning or independent support for them. Even during the pandemic, while many CLs lost jobs and became homeless or went through trauma crisis, there was no effort by the GoI to

[1] Chandrashekhar, R., McKinsey, K., & Mancassola, G. (2017).

[2] Bansal, A. (2018). Family based care as an alternative care option. Scottish Journal of Residential Child Care, 17(2)

[3] https://www.udayancare.org/upload/Reports/2019-20/Full report_ Beyond 18.pdf

offer any support to them, leaving them jobless, homeless and taking to criminal activities or substance abuse. CWPC and CLs are the lowest prioritised population for the GoI

1. The GoI should notify a comprehensive policy on Alternative Care in India (Sri Lanka already has such a policy). Such a policy must be backed with human and financial resources for its effective implementation.
2. Foster care, including group foster care must be promoted and clear implementable frameworks must be made
3. The Juvenile Justice Act of 2015 must allow scope for small group homes to be managed by NGOS instead of the exiting minimum norm of 50 children. The Udayan Care small group model was recognised in the UPR CRC report of 2011 on page 96 as follows: "*A few attempts have been made by NGOs such as Udayan Care (a Delhi-based NGO) to promote group foster-care model, providing long-term residential care for orphaned and abandoned children above six years of age*"[4]. But as of today, the 2015 JJ Act does not allow any scope for such small group homes to function, making it difficult for the model to continue.
4. Clear Guidelines for Group Foster Care must be laid out by the GoI and this should not be considered as institutional care. It must promote family like care for children in need of care and support.
5. The GoI should start programs to support NGOs working on community gatekeeping, family strengthening and family based care options.
6. The GoI must come out with a study mapping care leavers and work being done on aftercare and document best practices. Guidelines on Aftercare must be notified soon with provisions of issuing an identity card to each child who leaves care on turning 18, which allows the young person to establish linkages and continued support from various governmental schemes and social welfare programs
7. The GoI must publish a list of accredited NGOs to provide structured training to all child protection functionaries on family based care.
8. The GoI must issues directions to all central universities to ensure affirmative action to care leavers who wish to pursue their education as state wards and provide them personalised support to complete their studies.
9. The National Policy for Youth 2014 must be revised and must acknowledge care leavers as a vulnerable youth category for whom special provisions shall be made.
10. The National Policy for on Skill Development and Entrepreneurship 2015, must be reviewed to include children in care and car leavers as a focused population for skilling training at scale with speed, standard (quality), and sustainability, and provides an umbrella framework for skill development. Children in care and care leavers must be supported with schemes that provide subsidies and scholarships.
11. Similarly, the GOI must include care leavers in their housing schemes for subsidies and housing support
12. Moreover, certain changes should be made in the existing JJ Act 2015, JJ Model Rules 2016, and Child Protection Scheme to make aftercare more comprehensive, such as:
    a. the expansion of the definition of aftercare so that children who turn 18 and leave foster care, group foster care, and other alternative care options are also entitled to

[4] (https://bettercarenetwork.org/sites/default/files/Care%20Section%20of%20India%E2%80%99s%20third%20and%20fourth%20combined%20report%20to%20the%20CRC.pdf).

aftercare support;

b. the introduction of mandatory transition planning for all children living in CCIs who are 14 years and older;
c. the development and implementation of an individual aftercare plan for every CL; and
d. the provision of at least one support centre for CLs in every district to provide such services as a range of development, settlement, and advancement choices, referrals, and access to information.
e. the establishment of a grievance redressal system for CLs, with a simultaneous increase in investment on aftercare.
f. Budgetary norms under CPS should be increased from Rs. 2,000 per month per child to a range of Rs. 8,000 to Rs. 10,000 per youth per month.

13. For physical and mental health, the CLs should have easy access to health services, subsidised medical services, specialised counsellors for therapy, and health insurance via the PM-JAY (National Health Protection Scheme).
14. The GoI must building an effective communication network to coordinate the provision of aftercare between various Ministries at the Union level, and Departments at the state and district levels, along with aftercare service providers such as CCIs, NGOs, community-based agencies, and corporations, is a critical step in developing the provision of aftercare services in the country.
15. The National Legal Aid Services Authority (NLASA) should ensure that adequate assistance is provided to CLs in legal documentation, legal awareness, and provision of legal aid. Furthermore, in order to secure financial independence and careers for the CLs, workshops should be organised where CLs can explore opportunities for training and career enhancement.
16. GoI must undertake research and evidence collection on the harms of institutional care in India and the situation of aftercare, and also document best practices on family based care options that can be replicated at scale in the country.
17. GoI must strengthen the voices of CLs themselves. For the CLs to develop the needed social support and interpersonal skills, we recommend that every CL have individual mentors to provide guidance in making life choices throughout transition and to be a stable source of emotional support. The collectivising of CLs into support groups and networks will provide another layer of support, where CLs can become contributors, and older CLs can mentor younger CLs. Technologies like MIS, social media, and text applications have the potential to organise CLs into a collective aimed at peer support and could be optimally used to benefit CLs. Models already exist at nascent stages. These should be supported and strengthened by state governments; successful models could then be replicated in other states.

About the Udayan Care Alternative Care Model

Udayan Care, is an NGO working on Alternative Care in India. It has developed the 'Udayan Ghar Program' in 1996, which is derived from the idea of 'Sunshine Homes'; a unique group home model developed by the Founder on the core concept of 'L.I. F.E.', an acronym for 'Living in Family Environment'. The term 'Sunshine Homes' was formulated with the vision that each child is provided the opportunity to grow, develop and shine in their lives. The purpose of these Ghars is to nurture Out-of-Home Care (OoHC) children, including once parentless, abandoned, or abused children in need of protection. Udayan Care is different from both a traditional orphanage system and a foster care system on several grounds. Udayan Ghars are homes with an average number of 12 children per home. The care model consists of mentor parents — a group of socially committed, civil society members, who voluntarily commit themselves for a lifetime to nurture children in care; caregivers —

who reside with the children 24/7; social workers, mental health care staff and supervisors, all of whom form the core carer team. The program focuses on providing good education, nutritious food, excellent physical and mental health, and plenty of growth opportunities to the children. The care homes are positioned in middle-class neighborhoods, facilitating ample community participation and interaction. Presently, Udayan Care has 17 Ghars, spread across four states in India. Udayan Care does not select the children that come into the Ghars. Each district in India has a specific District Child Protection Unit (DCPU) and a Child Welfare Committee (CWC), which comprises of CWC members. These units ensure the implementation of the Juvenile Justice (Care and Protection of Children) Act, 2015 (JJ Act, 2015), and other child protection measures in their respective districts. The CWC, on gathering sufficient evidence to determine that a child is in need of care and protection, may, on consideration of the Social Investigation Report submitted by Child Welfare Officer (CWO) and taking into account the child's wishes in case the child is sufficiently mature to take a view, pass one or more of the following orders: (a) declaration that a child is in need of care and protection; (b) restoration of the child to parents, guardian or family with or without supervision of CWO or designated social worker; (c) placement of the child in a children's home or fit facility, as stipulated by the JJ Act, 2015. Depending on the needs of the child and the availability of accommodation, CWOs contact the Udayan Care administration to discuss and place vulnerable children in the Ghars.

The age range of children living in the Ghars is between 6 and 18 years. Common reasons due to which children are placed in the Ghars include extreme economic deprivation, orphanhood, abandonment, matrimonial disputes between parents, natural calamities, children who are displaced, lost, unaccompanied or trafficked, and those who are victims of substance abuse, sexual abuse, and child labour. They share common scars of poverty, social apathy, abuse, neglect, poor-health, malnourishment, emotional trauma, and lack of continued quality education. The administrative team at Udayan Care, early in its inception, recognized the unparalleled role of stable, caring adult relationships in the lives of the children. The mentor model was thus conceived with some important objectives in mind: (1) to appropriately address and reduce the psychological and behavioral issues of children (2) to increase the resilience of children by reinstating in them a sense of stability, trust and belongingness (3) to develop interlinkages that would foster socioemotional bonding, as well as opportunities, through the mentors, for growth, education, career and other positive adult life outcomes (4) to foster a larger sense of purpose and fulfillment in the lives of mentors, who are individuals seeking to support their community and give back. Mentor parents are not officially in-charge or managers of the Udayan Ghars, rather each Ghar is assigned with a separate home incharge, according to the legal mandate. As a voluntary and independent model, each home must have at least one mentor, with most of the homes having two to three mentor parents. The administration operates five mentor parent committees (those for education, health, special needs, aftercare, and alumni), and each mentor is required to be part of at least two committees, thus supporting holistic aspects of child care. All issues around children are addressed in these committees. The mentors do not receive remuneration for this role and work for these homes on a pro bono basis. Mentors are recruited by referrals, and by their interest in serving the children. Most mentors join as volunteers, and by showing their sensitivity and commitment, they are promoted to being mentors. They are available according to the children's needs, but they are required to invest at least 4 h of their time per week. Induction and training of mentor parents are a mandate, which includes training on soft skills and legalities, children's mental health concerns, interpersonal skills, and trauma-informed therapeutic interventions. Mentor parents are dedicated lifetime volunteers, who with their own experience of raising children, act as a pillar to the Udayan Ghar model by supporting, mentoring, and nurturing the children throughout the duration of their

stay in care, and well after into their independent lives. Mentor parents do not reside with the children, and in the carer team, it is the caregivers that are the residential staff that stay with the children at the homes. Mentors have their families and mostly belong to the upper strata of the community (middle class or upper-middle class), as volunteers seeking to support the children of the community. The mentoring approach instills a level of stability and care not usually afforded to children in care, especially in the Indian context. The Udayan Ghar program has an advantage in that the children have relatively stable homes and are afforded multiple levels of care and mentoring through the dual caregiver/ mentor parent relationships. Furthermore, given the relatively small number of children per home, Udayan Care children are able to grow and form close relationships with their peers as they grow up together with the same group of 'siblings'. Interestingly, the model is leveraging quite well the Indian sociocultural context of extended family and community upbringing of children, especially valuable where primary caregivers are deceased, unavailable or unable to provide appropriate care. This paper attempts to capture Udayan Care's mentor model, from interviews with mentor parents engaged in the program, to explore its scope and impact, the positive outcomes, and the challenges faced, and makes some recommendations to strengthen this care initiative.