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Moving from Residential  
Institutions to  
Community-Based Social  
Services in Central and  
Eastern Europe and the  
Former Soviet Union

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*The World Bank  
Washington, D.C.*

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# Foreword

Since 1989 the world has witnessed one of the tragic and harmful legacies of the command economy: the institutionalization of more than 1 million children, disabled and elderly people. Even worse, the number of individuals under custodial care in institutions has increased. As the social and economic effects of economic decline weakened families, the lack of community alternatives forced families to rely on these large institutions. Today, more than 1.3 million people in the region live in 7,400 large, highly structured institutions. Few of these individuals need to be confined to institutions. International experience shows that residential institutions are harmful. They are also expensive. Countries spend significant resources on this care—as much as 2 percent of public budgets.

*Moving from Institutions to Community Based Services in Central and Eastern Europe and the Former Soviet Union* was commissioned by the World Bank to understand why this problem has proved so intractable, what are the ingredients of a successful change program to improve the lives of these vulnerable individuals, and what the World Bank and other donor agencies can do to support this change. The result of a year-long examination of World Bank and other donor experiences, it is the first comprehensive analysis of this complex syndrome.

The study identifies the key barriers to change in Central and Eastern Europe and the Former Soviet Union. These include financial and organizational pressures to maintain residential institutions; public acceptance of this form of care as appropriate; and the absence of a national social welfare infrastructure, of systematic monitoring and oversight, and of a legislative framework that focuses on protecting the rights of vulnerable individuals. The effects of

these barriers are compounded by an arbitrary placement process that does not consider emotional, social, and material strengths and needs. As a result, a vicious cycle is created. The institutions absorb much of the limited government (and often donor) resources that are needed to assist vulnerable groups. The lack of alternatives for families in crisis has pushed governments to rely increasingly on institutions, crowding more people into a deteriorating infrastructure.

How can the region make the transition from relying on residential institutions to developing community-based social services? Based on the review of successful strategies in both developed and transition countries, *Moving from Institutions to Community Based Services in Central and Eastern Europe and the Former Soviet Union* proposes a strategy that includes:

- Developing models of alternative care to demonstrate that the new approach works.
- Changing public opinion and mobilizing community support around the new approach.
- Creating a national social welfare infrastructure and training all key social service professionals in the new approach.
- Scaling up pilots by changing the legislation on classification, placement, and rights while developing new funding streams and monitoring systems and closing or converting existing institutions.

While no country in Central and Eastern Europe and the former Soviet Union has fully implemented this strategy, a number have implemented parts of the strategy with some success. Our research suggests that only with an understanding of the systemic relationships is it possible to develop an

effective strategy that prioritizes and sequences key actions. The bottom line is that while strategies and timing will vary from country to country, eventually all the key barriers to change need to be removed to break the cycle. If not, harmful insti-

tutions will remain, and more individuals will be damaged. This is an important conclusion for all those seeking to support the transition to a better life in Central and Europe and the former Soviet Union.

Johannes Linn  
Vice President  
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# Abstract

One of the most harmful, costly, and intractable legacies of the command economies of Central and Eastern Europe and the former Soviet Union is the reliance on residential institutions for the care of children, the elderly, and people with disabilities. As a result, there are almost no community-based alternatives to care for large and growing numbers of vulnerable individuals. At least 1.3 million children, people with disabilities, and elderly people in the region live in some 7,400 large, highly structured institutions. These institutions house almost 1 percent of the region's children, about 4 percent of people with disabilities, and about 1 percent of the elderly.

Poor, neglected, or disabled children live in institutions that stunt their physical, emotional, and intellectual development. Children with disabilities are segregated from society in grim facilities most of them will never leave. The elderly and disabled adults are cloistered in social care homes. Few, if any, of these individuals need to be confined to institutions. This legacy has created profound barriers that must be overcome if reliance on residential institutions is to be reduced.

The transition to market economies has caused economic and social conditions in the region to deteriorate rapidly. As many financial and social supports have been eliminated or cut back, more vulnerable individuals have been placed in residential facilities. Although the conditions have improved in some institutions and staff have received some training, the overall quality of care is worse today than it was 10 years ago. More children are cared for with fewer resources, and fewer options are available to them once they are too old to qualify for residential care. International donors—through their work to improve conditions in

these institutions—have reinforced, perhaps inadvertently, local reliance on residential care.

Other industrial nations have experienced similar periods of economic and social upheaval and also relied on residential institutions to care for vulnerable and marginalized groups. But most of these nations have switched from residential care for children, people with disabilities, and the elderly (except for the severely disabled) to community-based social services.

How can the countries of Central and Eastern Europe and the former Soviet Union make the same transition? A six-step strategy for the region includes the following:

- Changing public opinion and mobilizing community support.
- Strengthening community-oriented social welfare infrastructure.
- Establishing community-based social service pilot projects.
- Using pilot projects to reduce the flow of individuals entering residential institutions and to reintegrate individuals into the community.
- Redesigning, converting, or closing facilities.
- Creating a national system of community-based social services.

Although this study reviews the use of residential institutions throughout the region, it focuses on five countries—Albania, Armenia, Latvia, Lithuania, and Romania—where the World Bank is helping develop community-based social services to reduce the reliance on residential institutions. The study examines the use of residential institutions for three groups: children, people with disabilities (mental, physical, or sensory impairment), and the frail and isolated elderly.

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# Executive Summary

One of the most harmful, costly and intractable legacies of the command economies of Central and Eastern Europe and the former Soviet Union is the reliance on residential institutions and the lack of community-based alternatives to care for large and growing numbers of vulnerable individuals. At least 1.3 million children, people with disabilities, and elderly people in the region live in 7,400 large, highly structured institutions. These institutions house almost 1 percent of the region's children, about 4 percent of people with disabilities, and about 1 percent of the elderly.

Poor, neglected, or children with disabilities live in institutions that stunt their physical, emotional, and intellectual development. Children with disabilities are segregated from society in grim facilities from which most will never leave. The elderly and adults with disabilities are cloistered in social care homes. Few if any of these individuals need to be confined to institutions.

This legacy has created profound barriers that must be overcome if reliance on residential institutions is to be reduced. These barriers include:

- Organizational pressure to maintain residential institutions.
- Absence of a social welfare infrastructure and legislative framework to care for vulnerable individuals in the community.
- Financing mechanisms that promote institutional care.
- Public opinion that views residential care as one of the few useful resources still provided by the state.

The transition to a market economy in Central and Eastern Europe and the former Soviet Union has caused economic and social conditions in the region to deteriorate rapidly. As many financial and social

supports have been eliminated or reduced in size or scope, more vulnerable individuals have been placed in residential facilities. Although the conditions in some institutions have improved and staff have received some training, the overall quality of care for children, people with disabilities, and the elderly in residential institutions is worse today than it was 10 years ago. More children are cared for with fewer resources, and fewer options are available to them once they are too old to qualify for residential care. International donors—through their work to improve conditions in these institutions—have reinforced, perhaps inadvertently, local reliance on residential care.

## Breaking the Vicious Cycle

The reliance on residential institutions has created a vicious cycle in the region. These institutions absorb much of the limited governmental and nongovernmental resources that are needed to assist vulnerable groups. In Lithuania, for example, 1.75 percent of the national budget is used for institutional care of vulnerable individuals. The lack of alternatives has pushed donors and governments to increase their reliance on residential institutions. As a result vulnerable individuals will be further impaired, find it harder to reintegrate into the community, and become a bigger burden on the public sector. This cycle will likely result in both multigenerational dependency and wasted government resources. How can this cycle be broken?

In Western Europe and the United States community-based services are less expensive than residential care and far better for vulnerable indi-

viduals. Similar findings have emerged from new community-based service programs developed by governments within the region in collaboration with the World Bank, European Union, United Nations Children's Fund, Open Society Institute, Save the Children, Caritas, and other organizations. Although few projects have been evaluated formally, some are cost-effective alternatives to residential institutions, as has been found in foster care programs in Romania and special day programs for people with disabilities and home care for the elderly in Lithuania.

### **Finding a Solution**

How can the countries of the region make the transition from relying on residential institutions to developing community-based services? Other industrial nations have experienced similar periods of economic and social upheaval and also relied on residential institutions to care for vulnerable and marginalized groups. Most of these nations no longer rely on residential care for children, people with disabilities, and the elderly (except for the severely disabled). Instead they rely primarily on community-based social services provided in a framework of protection for the vulnerable. Six elements are part of a comprehensive and integrated strategy in the region.

#### *Changing public opinion and mobilizing community support*

A multipronged public information campaign could be developed to change the attitudes of the public, policymakers, administrators, and the line staff of residential institutions. Such a campaign has begun in Armenia and at the local level in Hungary. One important vehicle for such a campaign is the United Nations Convention on the Rights of the Child as well as other human rights conventions, which have been signed by all countries in the region. In Romania, for example, the Convention on the Rights of the Child has contributed to changing public opinion and the attitude of policymakers on children's rights, the rights of

people with disabilities, and the role of residential institutions.

#### *Strengthening community-oriented social welfare infrastructure*

Social work schools are needed to train staff in residential institutions, local social assistance offices, new community-based social service programs, and the bureaucracies that oversee all these programs. In recent years basic social work programs have been created in many transition economies, with some success. Many programs could benefit, however, from additional study tours, technical assistance, and training in basic social work skills and specific service modalities. They could also benefit from collaborating to provide training or conduct research to create new social service programs, as is being done in Lithuania. Expanding the role of nongovernmental organizations (NGOs) and their cooperation with the public sector are important elements of the social welfare infrastructure that should be strengthened.

#### *Establishing community-based social service pilot projects*

There are many advantages to using pilot projects to develop a network of community-based social services:

- The flexibility to test a wide range of approaches—service modalities, organizational auspices, geographic locations.
- Opportunities to identify and correct inappropriate approaches and mistakes made on a small scale.
- Time and data to gain popular support to carry out the project on a larger scale.
- Limited investment and risk by donors.
- The opportunity to initiate a dialogue on policy.

Each pilot project could operate as a joint effort by the government, municipalities, donors, and NGOs, with cost sharing for investment funds, training, and recurrent costs. The most effective and sustainable service programs are based on citizen participation, including family members, direct consumers of service, and professionals.

*Using pilot projects to reduce the flow of individuals entering residential institutions, to protect the rights of individuals in institutions, and to reintegrate individuals into the community*

As social service projects begin to provide alternatives for individuals at risk at selected residential institutions, pilot projects should be established that reduce the number of individuals entering residential facilities and increase the number returning to the community. This approach was used by UNICEF and others in collaboration with local governments in Romania. It is far more difficult, however, to reunite a person with his or her family once those bonds have been broken and the individual has been placed in residential care. Reintegration programs in the region have had only limited success.

*Redesigning, converting, or closing facilities*

Alternate uses can be found for residential institutions. In Hungary part of a large children's home has been converted into apartments for young, single mothers and their children. The mothers receive job training and help finding work. In Armenia parts of several boarding schools have been converted to apartments for refugees. In Romania part of an infant's home has been converted into apartments for mothers and their children.

*Creating a national system of community-based social services*

After pilot projects have been tested and redesigned to address community needs, programs can be implemented nationwide. A paradigm shift, however, is needed to focus assistance on the larger group of people in poverty and to prevent the causes of institutionalization. This paradigm shift needs to focus on prevention and the causes of institutionalization.

National legislation and public policy should focus on:

- Restricting the use of residential institutions.
- Improving the care in residential facilities.
- Creating alternative ways to assist vulnerable groups in the community.

- Ensuring quality and specialized services as a human right.
- Ensuring sustainability through long-term funding for recurrent costs.
- Making evaluation a central component of a national social safety net to ensure quality services.

## **Increased Demand and Additional Resources**

The transition to a market economy has greatly increased poverty within the region and decreased the resources available to help the growing number of vulnerable individuals. New community-based social services will increase the number of poor and vulnerable people who request or demand assistance. Residential institutions serve only a small portion of vulnerable individuals. It is often impossible to determine which individuals will be placed in a residential facility and which, in a similar situation, will not. Thus the target population for community-based services must be larger than those individuals who are placed (or would be placed) in a residential institution. The increase in the number of recipients provides much-needed assistance to previously unserved people but will require additional resources beyond the money saved by closing residential institutions.

The approaches presented in this study can be part of the World Bank's poverty reduction strategy. But this strategy is not without risks. Vulnerable individuals could be forced out of residential institutions before community services are available to assist them. Long-term funding may not be available. Governments may not request or support adequate staff training, supervision, or other technical assistance. Nevertheless, the approaches presented here, provided in a framework of protection for the vulnerable, can create cost-effective, sustainable alternatives to residential facilities to ease the pressures of poverty in the region.

## **Focus of the Study**

Although this study reviews the use of residential institutions throughout the region, it focuses on five

countries—Albania, Armenia, Latvia, Lithuania, and Romania—where the World Bank is helping develop community-based social services to reduce the reliance on residential institutions.

The study examines the use of residential institutions for three groups in Central and Eastern Europe and the former Soviet Union: children, people with disabilities (mental, physical, or sensory impairment), and the frail and isolated elderly. (The elderly in hospital settings are not included.) These groups were selected for several reasons. First, they represent the majority of individuals in residential institutions. Second, these

groups were severely affected by conditions created in the transition to a market economy. In many ways the problems these individuals confront and the reasons they are institutionalized are applicable to other groups in residential institutions. Third, remedial actions have begun in Central and Eastern Europe and the former Soviet Union to prevent the institutionalization of these individuals and to promote their reintegration into the community. Finally, the study uses the findings of research on residential institutions, most of which examines the effects on children, both able and with disabilities, and some of which focuses on the elderly.

## CHAPTER 1

# Residential Institutions under the Command Economies of Central and Eastern Europe and the Former Soviet Union

Social policy throughout Central and Eastern Europe and the former Soviet Union during the socialist period focused on supporting labor productivity, creating a collectivist consciousness, and ensuring at least a minimal standard of living for the work force. To achieve these goals, extensive economic and social supports were provided to individuals and families by the state, mainly through the enterprises in which they worked.

These supports and services included social insurance (pensions, family and child allowances, health care), social assistance (for the poor and people with disabilities), free education from primary school through the university level, child care, and subsidized food, housing, transportation, culture, and leisure activities (Madison 1968; Kuddo 1998). In the former Soviet Union family benefits and other material supports were high. In many Central European countries, benefits as a percentage of GDP were more than twice the OECD average (UNICEF 1995).

### History

Residential institutions were a central part of social policy in most of Central and Eastern Europe and the former Soviet Union, though the use of residential institutions and the impact they had on their residents varied. Residential institutions were more than merely housing for marginalized populations. They served a dual role of social protection and social regulation. They also:

- Socialized individuals into the collectivist culture.
- Deculturated ethnic minorities such as Roma (gypsies).

- Educated and trained children and channeled them into the work force.
- Trained physically and mentally individuals with disabilities who could work and created sheltered workshops in the institutions.
- Reeducated juvenile delinquents and adult criminals.
- Removed and isolated individuals who had severe mental or physical disabilities.
- Assisted and protected groups of vulnerable individuals—orphans, dependent children, children at risk of abuse or neglect, the elderly, and people with disabilities.

### *Children*

Long before the Soviet period, Russia relied on large residential institutions to care for abandoned, illegitimate, and delinquent children. Peter the Great (1682–1725) decreed that orphanages be opened at monasteries and that the costs be covered by government subsidies and private donations. Ivan Betsky, a researcher who had studied the care of illegitimate children in Western Europe, petitioned Catherine the Great (1762–96) to create large institutions for these children based on the models he had seen. In 1763 a home for illegitimate children opened in Moscow and in 1771 another one opened in St. Petersburg. In the first four years, 82 percent of the children in these homes died.

No other country's metropolitan social services handled the volume of abandoned children that Russia's did. At the height of its operations in the second half of the 19th century, the central children's home in Moscow received 17,000 children a year—most of whom were sent to wet nurses and foster

families in the countryside. Infant mortality in homes for illegitimate children and foundlings was frightening—three times higher than in the general population. In 1912 only 11 provincial regions maintained orphanages; in other regions children were sent to almshouses, private orphanages, or foster homes where infant mortality was about 80 percent (Madison 1968, ch. 1; Ransel 1988).

The use of residential institutions went through three distinct periods during the command economy of the former Soviet Union: the revolutionary period, the Stalinist period, and the Khrushchev years and beyond (Harwin 1996, p. 3).

**REVOLUTIONARY PERIOD.** At the beginning of its transition to socialism, Russia experienced a “demographic earthquake” caused by World War I, the civil war, epidemics, and famine. Prior to the revolution in 1917, 2 million homeless children (*besprizorniki*) were believed to have been roaming the streets and villages of Russia. By 1922 this number is reported to have increased to 7 million. To respond to this crisis, the government began evacuating homeless, famine-stricken children from cities to abandoned and confiscated estates and churches in the country’s agricultural heartland. The number of children in state facilities increased from 30,000 in 1917 to 540,000 in 1921 (Harwin 1996, pp. 3, 6).

The use of institutions to care for these children reflected the social philosophy on which the Soviet society was initially built: collective upbringing was more effective in raising the new Soviet citizen.<sup>1</sup> The work of Anton Makarenko in the 1920s and 1930s formed the basis for the collective upbringing approaches used for the next 50 years in nurseries, schools, camps, youth programs, and children’s institutions in the Soviet Union and subsequently in Central and Eastern Europe (Makarenko 1976). In the early 1920s Makarenko was made responsible for setting up rehabilitation programs for some of the 7 million homeless children roaming the Soviet Union. His approach emphasized work, collective discipline, and group competitiveness. The success of his approach led to its use in residential institutions throughout much of the socialist world (Bronfenbrenner 1973, p. 41).<sup>2</sup>

With the adoption of the New Economic Policy in 1921 and the strict curtailment of state spending, the Russian government reduced funding to children’s institutions and transferred responsibility for them to local governments. With few local funds available, thousands of children’s institutions closed. The remaining institutions became severely overcrowded and conditions deteriorated. In the late 1920s, as economic conditions in the country improved and the number of homeless youth diminished, the reliance on residential institutions decreased.

**STALINIST PERIOD.** The death of as many as 27 million Soviet citizens in World War II, following the collectivization of land by Joseph Stalin and the famine of 1933, greatly increased the number of orphans in the country and in institutions. Stalin’s main goals after World War II were industrialization, collectivization, and rebuilding the national population.

In an attempt to rebuild the population, Stalin created a multifaceted pro-natalist family policy that outlawed abortion, restricted the right to divorce, and made it easier for mothers to place their children in state care. The child protection measures of the 1930s allowed for greater surveillance of the family and easier child removal from the home. As a result the number of children’s homes and the number of children in them increased rapidly (Harwin 1996, p. 19).

The conditions in many of these homes were appalling. In 1931 the Commissar of Health described the conditions in children’s homes as “completely unbearable.” In 1935 legislation was passed to allow for a differentiated system of children’s homes, separating children seven and older from younger children. In addition, a new law on foster care was introduced that paid foster parents to care for children from 5 months to 16 years. Despite the efforts to promote foster homes, the use of children’s homes increased rapidly (Harwin 1996, pp. 15, 23).

**THE KHRUSHCHEV YEARS AND BEYOND.** During the early years of Nikita Khrushchev’s administration (1953–64) the number of orphans declined as the population stabilized. The number of children in

children's homes was reduced by nearly half, from 635,900 in 1950 to 375,000 in 1958, then decreased at a slower rate into the 1960s (Harwin 1996, p. 30). With the population growing, the emphasis on pronatalist policy was reduced and the prohibition on abortion was lifted.

In 1956, to promote industrialization and increase productivity, Khrushchev used boarding schools (*internati*), nurseries, and kindergartens to educate children and free their mothers for employment. The government projected that by the 1980s all children in the Soviet Union would be educated in boarding schools (Madison 1968, p. 69).

Several factors worked against the successful implementation of this policy. Parents strongly opposed this approach, so educating children in boarding schools was made optional. Boarding schools were also very expensive—about four times the cost of regular schools (Harwin 1996, p. 29). In addition, in the early 1960s Soviet researchers and newspapers reported on the harmful effects of residential care and the importance of family upbringing (Harwin 1996, p. 67). Soon thereafter boarding schools were no longer considered a solution for educating and raising most chil-

dren and were used primarily to care for children from underprivileged families (Madison 1968, p. 74). In 1963 about 1.8 percent of the 82 million children in the Soviet Union lived in residential institutions (table 1.1).

When Leonid Brezhnev came to power in 1964 he was confronted with a falling birth rate, a high divorce rate, an increasing number of single-parent families, and controversy over women's roles in the home and the workplace. In response, Brezhnev promoted social policies to strengthen the family and relieve mothers of household responsibilities so that they could work. His policies led to the creation of family support programs in the 1970s, increased the number of day schools, and increased the number of socially vulnerable, marginalized children under the state's care.

During *glasnost* official reports and articles began to appear on the abuse of children in orphanages and the deplorable conditions of children's homes and boarding schools. In July 1987 a national decree sought to "radically improve the care, education and material welfare of orphans and children left without parental care." Although the government also encouraged the development of services to assist

**TABLE 1.1**  
**Estimated Number of Children 0–18 in Residential Institutions in the Former Soviet Union, 1963 and 1987**

Type of institution	1963	1987		
	Number of children	Number of children	Number of institutions	Average number of children per home
Boarding schools for normal children	1,047,900			
Social orphans		71,000	237	300
Nonsocial orphans		94,000	—	—
Children's homes for normal children	246,000			
Infants		35,000	422	83
Children		84,000	745	113
Schools (primarily boarding) for children with intellectual and physical defects	217,000	—	—	—
Institutions for severely retarded and grossly handicapped children	3,500	—	—	—
Residential treatment centers for "nervous" children	1,250	—	—	—
Total children in institutions	1,515,650	284,000	—	—
Total children in the Soviet Union	82,000,000	—	—	—
Children in institutions (percent)	1.8	—	—	—

— Not available.

Source: For 1963: Madison 1968, p. 175; for 1987: Waters 1992.

troubled families, these initiatives remained modest and few (Harwin 1996, pp. 67, 84).

The social welfare infrastructure for children further deteriorated because of fewer government resources and competing priorities for those resources. As a result fewer children entered residential care. By the late 1980s there were 284,000 children in residential institutions in the former Soviet Union (see table 1.1) (Harwin 1996, p. 66). Thus, at the start of the transition to a market economy, the number of children living in residential care was relatively small compared to earlier periods in Soviet history, although the 1987 figure excludes children in boarding schools who are not in the custody of the state.

In the late 1980s public criticism of the care provided by residential institutions grew. The homes were poorly furnished, and the children lacked proper clothing and nutrition. In one case journalists exposed the conditions of a boarding school where children who misbehaved were locked in a tiny, empty room without heat, light, or adequate ventilation for up to three weeks (Waters 1992).

The transition to market economies caused conditions in residential institutions to deteriorate (Harwin 1996, p. 91). In earlier periods significant resources were allotted to child care institutions in socialist countries to maintain good conditions. But with the transition conditions declined, so that eventually the consumption levels provided by many of these institutions were lower than those of the average household with children (Zamfir and Zamfir 1996, p. 29).

At the start of the transition three main groups of children lived in residential institutions. The first group—normal children—attended boarding school for a variety of reasons, including:

- Family, home, or work stresses on their parents.
- Difficulty in another school.
- Living far from a neighborhood school.
- Family difficulties in caring for the child.
- The desire of parents and teachers for gifted students to attend specialized boarding schools.

The second group of children who lived in residential institutions were socially vulnerable, dependent, or neglected children—who were not able to be

cared for adequately by their families—and orphans. Armenia's 1984 Decree for Secondary Boarding Schools stated that children who came from "socially vulnerable families, including parents with medical problems, families with many children, single parents, and parents who do not work" were entitled to attend boarding schools (Soviet Socialist Republic of Armenia Ministry of Education 1984). Often parents petitioned the local children's commission for permission to place a child in an institution (Madison 1968, p. 161). Schools and nurses in polyclinics also recommended the placement of children in residential institutions (Kadushin 1980, p. 662).

Although children in residential institutions are often referred to as orphans, very few do not have living biological parents. An estimated 2–3 percent of institutionalized children in Central and Eastern Europe and the former Soviet Union are orphans except in countries where wars or natural disasters have caused the death of both parents. According to one study in Romania, for example, 97 percent of the children in residential institutions have parents and only 3 percent are orphans (World Bank 1998, p. 43). Another study in Romania reported that 80 percent of children in institutions received occasional visits from parents or other family members (Zamfir and Zamfir 1998, p. 34). The confusion has developed in part because these children are often referred to as "social orphans"—children whose parents are unable to care for them because of economic or social factors.

The third and largest group of children in residential institutions—those with physical and mental disabilities—were placed into two types of institutions—those for children who could become productive workers and those who could not. The belief was that "normal" children should be separated from "defective children," the physically handicapped, and the retarded (Madison 1968, p. 149).

### *People with disabilities*

Under socialism, the approach toward people with disabilities was defined by the Soviet science of "defectology." Developed in the Soviet Union in the 1920s, defectology is both the theory and treat-



ment of disability with its own methods and techniques (UNICEF 1998a, p. 50). Defectology has a strong medical orientation that defines disability as a diseased state (invalid, defective, abnormal children with mental or physical disease) or a problem of the “abnormal” individual. The role of the environment in supporting the individual is ignored; treatment consists of a diagnosis, segregation of the “normal” and “abnormal” individuals, and correction of the defect (Jonsson 1998).

Defectology and the categorization and treatment of people with disabilities were based on an individual’s potential productivity. Categorizations often occurred between three and four years of age and generally became permanent labels. Mistakes were often made by the “expert” commissions that determined a child’s level of disability. The most common mistake was placing too many children in the borderline category of disabled.

Adults with disabilities were often housed and cared for with the elderly; children with disabilities were placed in special schools, segregated from other children. Children who could be taught to work were placed in institutional schools for children with less severe disabilities. The institutions for educable children with disabilities isolated them from their families and often further disabled the children as a result of the custodial care they received. Staff members were poorly trained, and in 1960 each was responsible for an average of 23 children. There was also a high staff turnover rate (Madison 1968, pp. 165–66).

Children who were not able to learn work skills were placed in other institutions. In the Soviet Union 89 percent of the “defective” group was considered educable; the rest was considered uneducable (Madison 1968, p. 426). Children with disabilities who were considered uneducable were placed in institutions for the “irrecuperables.” The deplorable conditions in these institutions in Romania defined the world’s perception of residential institutions in Central and Eastern Europe and the former Soviet Union after the fall of Nicolae Ceausescu’s regime (Himes, Kessler, and Landers 1991).

The philosophy and science of defectology and the care provided to people with disabilities remained fundamentally unchanged through the

end of the socialist period and continue to dominate the treatment of them today.

### *The elderly*

Prior to the transition, the primary assistance provided to the elderly was financial support in the form of pensions for retired persons and workers who had become disabled. Pensioners benefited from heavily subsidized goods and public services and had access to housing, summer cottages, and land. However, as the economic situation deteriorated in the mid-1980s, the incomes and social status of pensioners fell dramatically. Their savings became devalued and they became totally dependent on heavily eroded social transfers from the pension systems (Kuddo 1998, p. 153).

In these countries men were able to receive a retirement pension at the age of 60 and women at the age of 55. Although pensions were quite low in the Soviet Union, in several Central European countries, pensions were relatively high, reaching the level of 55–65 percent of the average wage in Czechoslovakia, Hungary, Poland, and Yugoslavia (World Bank 1994, p. 366; Kuddo 1998, p. 155).

Families, women, and informal community networks provided the elderly with long-term assistance when they became frail, were unable to care for themselves, or were living alone. In the late 1980s, however, urban migration, increased employment of women, shortages of apartments, and an increased reliance on the state reduced the capacity of families to act as caregivers to the elderly.

Few nonmedical community-based services were available to assist the elderly. There was no clear recognition that some pensioners required help in reconstructing their lives, resuming their family roles, and living through emotional upheavals. The few available social services were provided by “indigenous nonprofessionals” and were organized by the state or provided by trade union committees (Madison 1968, ch. 10). Voluntary or church organizations also provided limited assistance to the elderly (Calasanti and Zajicek 1997, p. 457).

The types of in-home assistance for the elderly available in other Western European nations—such

as delivery of food, assistance with household chores and personal hygiene—were largely absent. In Hungary, one of the Central and Eastern European countries where these types of services were most available, as much as 4 percent of the elderly had home care in the 1980s, and only 2 percent of the elderly attended day centers (Szeman 1997, p. 28).

Long-term residential institutions were the main resource available to the elderly when their families could not care for them and they were unable to care for themselves. These institutions were generally social care homes located on the outskirts of towns in pleasant natural settings, but isolated from public life. The standard of care provided in these homes was often unsatisfactory (Madison 1968, p. 194). In the former Soviet Union the average social care home housed a minimum of 127 people (Georgia) and a maximum of 341 people (Moldova) (table 1.2).

In Poland about 1.5 percent of the elderly lived in social care homes in 1989 (Velkoff and Kinsella 1993). In Hungary about 2.6 percent of individuals over 60 lived in social care homes in the mid-1980s (Szeman 1997, p. 28). In the republics of the former Soviet Union 364,500 people lived in institutions for the elderly and people with disabilities in 1990. The range was from 0.2 percent of the population in

Azerbaijan and 0.3 percent in Georgia, to 1.8 percent in Belarus and Russia (see table 1.2).

Because social care homes were often the only resource available, there were long waiting lists to enter them (Sadowski 1997, p. 34; Madison 1968, p. 191). Albania was an exception—it had few residential institutions for the elderly and relied almost exclusively on families and communities to care for the elderly. At the start of the transition no more than 300 people were living in the country's five old people's homes (Shehu 1997, p. 17).

## Legacy

The most visible legacy of the reliance on residential institutions under the command economies are the thousands of residential institutions themselves and the individuals whose lives have been stunted or shortened because of long years in residential care. These and other elements of this legacy that are barriers to change are discussed below.

### *Thousands of large residential institutions*

Central and Eastern Europe and the former Soviet Union contain an estimated 5,500 large residential

**TABLE 1.2**  
**Number of People in Residential Institutions for the Elderly and People with Disabilities in Republics of the Soviet Union, 1990**

<i>Republic</i>	<i>Number of institutions</i>	<i>Number of beds</i>	<i>Number of beds per 1,000 people</i>	<i>Number of residents</i>	<i>Average number of beds per institution</i>
Azerbaijan	8	1,410	.20	1,190	149
Armenia	7	1,260	.37	1,030	147
Belarus	75	18,720	1.83	17,580	234
Georgia	9	1,470	.27	1,140	127
Kazakhstan	66	17,240	1.03	18,090	274
Krygyz Republic	13	3,600	.82	3,100	238
Moldova	10	3,490	.80	3,410	341
Russia	886	262,620	1.77	248,980	281
Tajikistan	7	1,140	.21	1,110	159
Turkmenistan	5	1,510	.41	980	196
Uzbekistan	32	10,050	.49	9,410	294
Ukraine	274	61,880	1.20	58,480	213
Total	1,392	384,390	.78 <sup>a</sup>	364,500	262

a. Nonweighted average.

Source: ISCCIS 1997.

institutions for children with and without disabilities.<sup>3</sup> Each facility—ranging from small homes for 40 infants to large residences for 400 or more school age children—has an average of 100–200 residents. In addition, there were 1,392 social care homes for adults with disabilities and the elderly in the republics of the former Soviet Union when the transition began (ISCCIS 1997). (Aggregate data for the elderly in social care homes in Central and Eastern Europe are unavailable.) Residential institutions are both a vast physical resource and a costly asset for the countries of the region to maintain.

Many but not all of these institutions could be referred to as *total institutions* (Goffman 1961). According to Goffman (p.5), in modern society

Individuals tend to sleep, play and work in different places, with different co-participants, under different authorities, and without an over-all rational plan. The central feature of total institutions ... [is] a breakdown of the barriers ordinarily separating these three spheres of life. First, all aspects of life are controlled in the same place, under the same single authority. Second, each phase of a member's daily activity is carried out in the immediate company of a large batch of others, all of whom are treated alike and are required to do the same thing together. Third, all phases of the day's activities are tightly scheduled ... Finally, the various forced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.

Goffman describes a process of “mortification”—destruction of selfhood—upon entry into a total institution. Some losses are temporary; others are irrevocable and painful. He refers to this process as “civil death.”

Not all residential institutions in Central and Eastern Europe and the former Soviet Union were or are total institutions in ways defined by Goffman. Some institutions—creches or boarding schools that allow children to return home on weekends or children's homes where children live in the institution but go to a regular school—provide children with regular

contact with the outside world. Still, such institutions are harmful to child development. Infant homes, residential institutions for people with disabilities, and children's homes with their own schools, however, have the characteristics of total institutions.<sup>4</sup>

The physical characteristics of these institutions varied greatly at the end of the 1980s. Some were adequate though austere structures; others were dilapidated and rapidly deteriorating because programs were underfunded and resources for social welfare were decreasing. Some, particularly for people with disabilities, were bleak, archaic, and barren structures. A few facilities were comfortable, adequately staffed facilities in pleasant settings. These tended to be special programs such as Loczy (the Pikler Institute), a training center providing specialized care for infants in Hungary, or an orphanage run by the Catholic church in Otorovo, Poland. Nevertheless, they suffered from being total institutions.

### *Damaged individuals unprepared to live in a changed world*

An estimated 790,000 children with and without disabilities were living in residential institutions in Central and Eastern Europe and the former Soviet Union at the start of the transition.<sup>5</sup> A total of 364,500 elderly and older handicapped persons resided in social care homes in the republics of the former Soviet Union in 1990 (ISCCIS 1997). (Aggregate data for the elderly in social care homes in all the countries of Central and Eastern Europe are unavailable.)

Many children, both with and without disabilities, lived in residential institutions during their entire formative years; very few left before they were too old to live in a children's institution. In extreme cases children remained in institutions for their entire lives. In Romania, for example, in the early years of the transition, 10-40 percent of children remained in institutional care their entire lives, moving from a maternity hospital to an orphanage to an adult institution (Zamfir and Zamfir 1996). Children's isolation was intensified because institutions were often located far from the individuals' communities, and contact between children and their families was often discouraged.

Young people received vocational training while in the institutions and were placed in jobs and housing when they left. Now, during the transition, placement in a job and provision of housing in the community have become unavailable.

Although the command economies favored collectivist upbringing, research within the region documented the harm caused to children by institutional life and emphasized the importance of family in raising healthy children (Bronfenbrenner 1973, ch. 3). The society and particularly residential institutions produced children who were more disciplined, dependent, and conforming as well as less rebellious, delinquent, or aggressive than children in the United States (Bronfenbrenner 1973, p. 95).

In the 1970s Langmeier and Matejcek reviewed a series of studies conducted in Czechoslovakia that compared infants and young children raised in institutions with children raised at their own homes. Although institutionalized children's physical development was normal, they suffered deficits in language and social development (Kadushin 1978, p. 131). In Russia there were reports of child beatings, suicides, and the appointment of staff with criminal records (Harwin 1996, p. 103). One Soviet researcher concluded that, "children brought up without the participation of the family are at far greater risk of one-sided or retarded development than those who are members of a family collective" (Kharchev 1963, p. 63, Cited in Bronfenbrenner 1973, p. 88).

At the end of the socialist era and the beginning of the transition to a market economy, few if any comparative assessments were done on the impact of residential institutions on individual development. Nevertheless, many assessments and anecdotal reviews were conducted of healthy and children with disabilities living in residential institutions soon after the transition began or who were adopted from such institutions. The impression from a review of these studies and visits to nearly 100 institutions in eight countries of Central and Eastern Europe and the former Soviet Union during the early years of the transition is that many children were damaged by regimented, impersonal, institutional life and became dependent, isolated from their fam-

ilies and the outside world, and ill-equipped to function independently outside the institution. Vast numbers of children who have been socialized for one world are unable to fit into another.

### *Barriers to change*

The legacy of the reliance on residential institutions profoundly shapes and constrains the development of the social welfare systems that are emerging today. Many barriers must be overcome before community-based social services can be a credible alternative to large residential institutions. These obstacles have been created by the legacy of the command economy, the deteriorated socioeconomic conditions resulting from the transition to a market economy, and the loss of much of the preexisting social safety net. This section reviews barriers that are a result of the region's reliance on residential care.

**ORGANIZATIONAL PRESSURE TO MAINTAIN RESIDENTIAL INSTITUTIONS.** The long history of reliance on residential institutions in the former Soviet Union and the more recent reliance on them in Central and Eastern Europe has created a large and influential constituency interested in preserving these institutions. In Romania, for example, 70,000 people work in residential institutions that care for 100,000 children (Innes 1999).

Many of the people who managed residential institutions during the socialist era continue to do so today. They are a powerful force for the preservation and continued reliance on residential facilities. As employment options have narrowed during the transition, these groups have become increasingly dependent on residential institutions for their work, income, and social well-being (Herczog 1997, p. 116).

**ABSENCE OF A SOCIAL WELFARE INFRASTRUCTURE.** Four barriers impede the creation of a supportive social welfare structure. The first is the lack of sufficient social services to help individuals with problems. Before the transition, policies in Central and Eastern Europe and the former Soviet Union focused on maximizing economic production. As a result the social

welfare system promoted universal employment and productive workers. This policy orientation, however, caused the absence of social work knowledge and community programs to help individuals and families when difficulties arose. Nurses and teachers, community volunteers, and individuals connected with trade unions provided minimal assistance with few resources to children, families, and the elderly (Kadushin 1980, p. 663). These individuals were largely untrained to intervene with social or personal problems and often played more of an investigative and monitoring role than a supportive social services role to resolve problems.

Another barrier to the development of a supportive social welfare infrastructure is the use of a medical model of social care. The medical model used physical health—rather than emotional or social factors—to determine the care people needed. Social welfare personnel—physicians and civil servants—generally were untrained in social work or child development, and had difficulty seeing the social causes of an individual's problems. This medical approach has limited the care provided to individuals and constrained the policy options that are considered immediately feasible during the transition.

A third barrier is the absence of schools of social work. Social work training programs were dismantled throughout Central and Eastern Europe in the decades after World War II and never developed in the Soviet Union. Yugoslavia retained social work education, and Hungary reintroduced social work education in 1986 (Ruzica 1998; Herczog 1997, p. 108), but in most countries there was little knowledge of social work practices. Although social work research and training centers, sites for practicums, and adequately prepared staff were generally absent, social pedagogues served an educational and supportive role.

Social work departments have recently emerged in existing departments of sociology, psychology, or pedagogy in the region. Romania has seven universities with departments of social work that graduate 500 social workers a year. On the other hand, the first qualified social workers trained in Albania will not begin working until the year 2000 (UNICEF 1997, p. 109).

A fourth barrier to the development of a social welfare infrastructure is the dearth of NGOs. Few operated in Central and Eastern Europe and the former Soviet Union during the socialist era. Some voluntary organizations began to appear in the early 1980s, first in Poland and later in Hungary. In 1985, with the advent of glasnost, religious organizations, international relief agencies, and other NGOs were finally permitted to provide some social services in the region (UNICEF 1997, p. 107).

Many large international NGOs operating in the social sector began by establishing emergency relief programs in the region. Although some of these programs evolved into longer-term development and technical assistance projects, most are small programs that affect few people. Almost 10 years after the start of the transition, most NGOs in Central and Eastern Europe and the former Soviet Union are underdeveloped.

According to UNICEF (1997, p.107), three main factors have contributed to the underdevelopment of NGOs. First, legislation that clearly defines the prerogatives and responsibilities of NGOs is rare. As a result, NGOs providing residential care for children have often operated outside of a legal framework without government licensing, standards, or approval. Second, many individuals who work for NGOs lack basic managerial skills and know little about generating public awareness. Third, local and national governmental subsidies—a primary source of revenue for NGOs—are decreasing.

**ABSENCE OF A LEGISLATIVE FRAMEWORK.** Legislation that affects the transition from residential institutions to community-based services include laws on residential institutions, social assistance (cash and noncash), family law (foster care and adoption), people with disabilities, and the role of NGOs. Other laws that shape the social welfare context for this transition include laws on social insurance (pensions, family benefits, unemployment insurance) and the decentralization of government.

Legislative reform has occurred in several relevant areas, including social insurance (creating self-supporting systems) and social assistance (consolidating multiple cash benefits, decentralizing the provision

of cash benefits, and targeting limited financial assistance). But few countries have significantly changed laws to reduce reliance on residential institutions or to create community-based social services. Residential institutions in many countries follow laws from the Soviet era that are no longer in force but continue to guide practice. In Armenia, for example, the 1984 Soviet Law on Boarding Schools defines practice within boarding schools for vulnerable children though the law is no longer operative.

The United Nations Convention on the Rights of the Child, adopted by the U.N. General Assembly in 1989, discourages the use of residential institutions for children. The convention has been ratified by all but two countries. So far, however, this convention appears to have had a limited effect on changing the conditions in or reliance on residential institutions in most countries of Central and Eastern Europe and the former Soviet Union—with some exceptions. In Romania, for example, the convention played a role in improving conditions in the worst facilities. But there has been no sustained reduction in the number of children in residential care.

Although adequate legislation for community-based social services is lacking in most countries in the region, several countries have passed relevant legislation, including Poland (1990), Latvia (1995), Romania (1997), and Lithuania (1998). In Lithuania the Law on Development of Social Service Infrastructure authorizes the Ministry of Social Security and Labor to assist municipalities in developing social services pilot projects for vulnerable groups. Funding has been made available by the government and, through a tender offer, municipalities and NGOs have developed proposals to provide social services.

In Romania legislation for the Organization of the Activity of the Local Public Administration Authorities in the Field of the Protection of Children's Rights created a national system of child protection under each county council. The new system allows the creation of family-type alternatives to institutions and the provision of social services for vulnerable children in each county. Adequate funding has not yet been provided, however, to create an effective system of community-based social services throughout the country.

Legislation on foster care and adoption in the region is outdated. Legislation that allows short-term foster family care with nonrelatives is absent in many countries in the region, though countries such as Hungary and Romania had such legislation prior to the transition (Herczog 1997, p. 113; UNICEF 1997, p. 73). In Hungary professional foster families account for about a quarter of the children in foster care (Herczog 1997, p. 114).

Legislation for people with disabilities has changed in two significant ways. First, categories of eligibility have changed thereby increasing the number of beneficiaries. The largest increases have occurred in Estonia, Lithuania, and Russia. Second, legislation has been passed in several countries, including Armenia and Lithuania, that allows children with disabilities to go to mainstream schools. Implementation, however, lags far behind the legislation.

FINANCIAL INCENTIVES TO PLACE INDIVIDUALS IN RESIDENTIAL INSTITUTIONS. During the transition responsibility for administering social assistance services has been transferred to municipalities in most countries while responsibility for residential institutions generally has been transferred to regions or remained with the state. This disparity has created a financial incentive for municipalities to reduce their expenses by placing vulnerable individuals in residential facilities financed by other levels of government. In some countries, however, some social care homes for the elderly have been transferred to or developed by municipalities. This new financial responsibility of municipalities will likely promote the development of alternative, less expensive community-based care by municipalities.

A new funding approach for social services may be tried in Latvia. Under one proposal, municipalities would receive a lump sum payment from the national budget for each at-risk individual. The funds could be used to pay for community-based services or for an individual to live in a residential institution. This approach may create a financial incentive to use community services because they are less expensive than residential care.

PUBLIC OPINION. Although residential facilities increasingly are seen as a last resort, many people of

Central and Eastern Europe and the former Soviet Union believe that residential institutions are a valuable resource provided by the state to assist vulnerable individuals. In Armenia, for example, while very poor or overwhelmed parents (often single mothers) of children who reside in boarding schools generally prefer to care for their children themselves, they believe that their children are better off living in an institution with adequate food, shelter, and heat—regardless of how inadequate the institution might be (Gomart 1998; Bertmar 1999). The institutional and civil service staff that manage residential institutions express a similar belief.

Social fears also affect a family's decision to use residential care—particularly for people with disabilities. In Albania and Armenia, for example, parents believe that their other children would not be able to find spouses if the existence of a sibling with disabilities became known. Residential institutions are a way to solve some of the problems associated with having a family member with disabilities.

The sentiment in favor of residential institutions is widespread, but not universal. In Albania, for example, residential institutions were not provided by the government or desired by the community; as in many other countries in the region, the extended family or neighbors helped individuals when they had problems. Families in Albania today do not consider residential institutions to be a solution to their economic or social problems or a way to care for children, people with disabilities, or the elderly.

**CENTRALIZED FRAGMENTED BUREAUCRACIES.** A centralized, fragmented national bureaucracy with little accountability for the care provided within residential institutions was a defining result of social welfare policies in Central and Eastern Europe and the former Soviet Union. As might be expected in bureaucratic systems of the size and complexity used for residential institutions, there were many areas of confusion, fragmentation of authority, and unclear delegation of responsibility. The diminished sense of managerial accountability that arises under such conditions contributes to the discontinuities in care (Tobis, Krantz, and Meltzer 1993).

The thousands of residential institutions for children, people with disabilities, and the elderly were subordinated to one of four national ministries in each country or republic: health, education, social welfare, or interior. Throughout the region, children under 3 years of age were generally the responsibility of the ministry of health. At age 3 they were placed in pre-school institutions under the auspices of the ministry of education. When they reached school age, they remained the responsibility of the ministry of education but were transferred to boarding schools. Children with disabilities who could be educated remained the responsibility of the ministry of education. Adults with disabilities and those who could not be educated or trained and the elderly were the responsibility of the ministry of social welfare. Juvenile delinquents were the responsibility of the ministry of interior. These national ministries set standards and loosely monitored the performance of each institution. Regional and local offices (inspectorates) ensured that national policy was carried out. Monitoring the performance of residential institutions was minimal, particularly for program activities, and was divided among several national ministries and their regional offices (Madison 1968, ch. 9).

The Soviet welfare system was characterized by centralized policymaking in Moscow and financial planning and decentralized administration in the Soviet republics (Madison 1968, p. 88). This model stands in contrast to that used in Central and Eastern Europe, where national ministries played a central role in developing policy.

**THE PLACEMENT PROCESS.** The criteria for placement and the role of directors of residential institutions contribute to the excessive number of children, people with disabilities, and elderly placed under residential care. The criteria for placing an individual in a residential institution are often vague, inappropriate, outdated, and arbitrarily applied. In most cases more attention is paid to compiling case documentation (such as birth certificates or medical certificates) than to assessing individual or family problems and strengths.

Individuals with disabilities are categorized based on poorly defined medical conditions rather than on

functional abilities. In most countries, for example, a medical panel determines a person's level of disability, whether residential placement is needed, and the type of institution into which the individual should be placed. The person's social, emotional, material, and often intellectual strengths and needs are rarely taken into consideration. Minor medical conditions such as epilepsy, harelip, crossed-eyes, cleft palate, and scoliosis are sufficient reasons for placement in a long-term residential facility. One study in Russia reported that "between one-third and two-thirds of the children living in orphanages for mentally handicapped children were of average, or above average intellectual ability" (Cox 1991, p. 4. cited in Harwin 1996, p. 104). This approach increases the number of residential placements dramatically by including cases where minimal intervention would be sufficient. Other individuals whose material, social, and health situations are considerably worse reside in the community—at considerable risk but with minimal assistance.

The directors of residential institutions face substantial organizational pressure to keep their beds filled to preserve their budgets, which are largely determined by the number of residents in their care. Directors exercise excessive influence in determining which individuals are placed in their institutions and how many are placed. They may also selectively choose which children are admitted to their institutions, taking the most desirable and easily manageable children.

The influence of the directors of residential institutions varies depending on the formal placement process. Placement decisions are made at three levels—centralized, decentralized, and at the residential institution. The more decentralized the decisionmaking process, the greater the influence of institution directors.

- *Centralized.* Albania—with the lowest placement rate in residential institutions of any Central and Eastern European country or former Soviet Union republic—has a centralized decisionmaking process. Any child, person with disabilities, or elderly person placed in residential care must be approved, generally in person, by the director of social care in the General Administration of

Social Services in Tirana. The extremely low placement rate in Albania, conditioned by a national culture of community and family responsibility, has enabled this centralized decisionmaking process. The directors of residential institutions have relatively little influence in determining how many or which individuals enter their institutions, particularly when beds are filled to capacity.

- *Decentralized.* Romania—which has the highest placement rate of children in residential institutions—has had a decentralized decisionmaking process since the Ceausescu period. Each county (*judet*), sector of Bucharest, and several large cities has an intergovernmental commission for the protection of minors. The commissions make all decisions to place children in residential institutions, including children with disabilities.

Each commission, subordinated to the County Council, has a representative from the local inspectorates of the Ministries of Health, Social Protection, and Education, the police, and the local residential children's institutions. The directors of residential institutions have significant influence to decide which children are placed in their institutions and which are sent to other institutions in other judets.

- *At the residential institution.* In several former Soviet republics the decisionmaking process for placement in a residential institution has broken down. No formalized, consistent process has replaced it. The directors of residential institutions fill this void. They have broad discretion (constrained only by their budget and bed capacity) in deciding who and how many individuals are placed in their institution. In Armenia, for example, a parent seeking to place a child in a boarding school or infant home goes directly to the institution. If the director approves, the child is placed. If the child is not accepted, the parent has the right to petition the regional or relevant national ministry (education, health, or social welfare) to place the child. Most children are placed directly into institutions with the approval of the institution's director.



## Notes

1. A. Goikhbarg, responsible for the committee that drafted the first Soviet Code in 1918 on Marriage, the Family and Guardianship, summarized this position: “Our [state institutions of guardianship] ... must show parents that social care of children gives far better results than the private, individual, inexpert and irrational care by individual parents who are ‘loving,’ but in the matter of bringing up children, ignorant” (Madison 1968, p. 36).

2. Despite the recognition he received for institutional upbringing, Anton Makarenko never regarded residential upbringing as ideal for the child. In fact, his work was also the primary guide for raising children within families during the same period (Bronfenbrenner 1973, p. 41). Uri Bronfenbrenner, the child psychologist, in his introduction to Makarenko’s *Book for Parents* (called in English *The Collective Family*) wrote that “its closest counterpart in the West is Benjamin Spock’s *Baby and Child Care*, with the

important difference that the Russian volume is concerned not with physical health but with the development of character” (Makarenko 1967, ix).

3. Based on an estimate of 820,000 children in residential institutions in Central and Eastern Europe and the former Soviet Union and an average of 150 children per institution.

4. According to Kadushin (1978, p. 143), in the United States “most children’s institutions are not ‘total’ institutions in that they do not carry out all life-supporting functions in isolation from the outside world. Most are mediatory institutions oriented to and interacting with the surrounding community.”

5. The estimated number of children in residential institutions between 1989 and 1995 based on the data gathered by UNICEF. Data for 13 countries were available for 1989 or 1990 and 1994 or 1995. The countries had about 4 percent fewer children in infant or children’s homes at the start of the transition than in 1994–95.



## CHAPTER 2

# The Transition and Residential Institutions

The transition from reliance on residential institutions to community-based services has created opportunities as well as problems for the region. Rapidly deteriorating socioeconomic conditions and limited government resources have increased the use of residential institutions. At the same time, a slow but growing interest in community-based alternatives by people in the region and international organizations has laid the groundwork for change.

### Socioeconomic Conditions

The transition from a command economy to a market economy in Central and Eastern Europe and the former Soviet Union caused rapid deterioration in economic and social conditions throughout the region. Between 1990 and 1994 countries in the region fell an average of 32 positions in their ranking on the Human Development Index (UNDP various years). At the same time, many of the financial and social supports that had been available during the socialist period were eliminated, reduced in size or scope, or deteriorated in quality. Limited means-tested financial assistance and few community-based services have developed to replace the supports that were eliminated. The overall result has been a significant increase in the number of people who are poor, vulnerable, demoralized, and who are forced to cope with profound and rapid changes with very little assistance. Residential institutions increasingly have become a primary resource for a small percentage of children, the elderly, and people with disabilities to survive the socioeconomic crisis.

### *Economic conditions*

The region's economic conditions deteriorated dramatically during the early years of the transition. In the mid-1990s the general decline in economic output began to abate, but in 1997 real GDP in many countries was still about 40 percent below the level in 1989. Transition in the countries of the former Soviet Union has generally been much more difficult than in the countries of Central and Southeastern Europe (UNICEF 1998a, p. 2).

Unemployment, almost nonexistent in the command economies of the region, rose rapidly. Employment rates in the 18 countries for which data are available were almost 15 percent lower in 1995 than in 1989 (UNICEF 1997, p. 6); moreover, real wages were more than 45 percent lower. The percentage of the population living in poverty rose dramatically throughout the region, affecting families (particularly single mothers with children) and the rural, isolated elderly most acutely. According to a World Bank study of 18 countries of the region the estimated number of poor people increased twelve fold from 1987 to 1988 and 1993 to 1995, with substantial variations among countries (Milanovic 1998, p. 67).

### *Social supports*

The movement to a market economy encouraged the privatization of services that had previously been free or heavily subsidized. Millions of children, families, and the elderly, lost the benefits they had received as entitlements. For example, thousands of nurseries, day care centers, and kindergartens closed—between 1991 and 1995 more than 30,000 preschools were

closed in the countries of the Commonwealth of Independent States. Access to health care became more restricted. In Georgia 670,000 primary school children received a health checkup in 1989; only 250,000 had one in 1996 (UNICEF 1998a, p. ix). Subsidies for food, housing, and transportation were dramatically reduced or eliminated. Childcare leaves, after-school programs, and free or subsidized vacations were also eliminated.

Many of the cash benefits that had been provided during the socialist period were either eliminated, dramatically reduced in value (due to high inflation), or provided to smaller segments of the population. Family and child allowances were phased out and replaced with cash assistance targeted on the most needy. In many poorer countries, such as Albania and Armenia, means-tested financial assistance to families approximately equals the cost of a loaf of bread a day.

The number of pensioners increased in many countries, even as the real value of pensions decreased (Bezrukov 1997). During the first five years of reforms the number of pensioners increased by almost 3 percentage points in Kazakhstan, Latvia, Russia, and Ukraine. Between 1991 and 1995 the number of pensioners grew by 20 percent in Armenia, and by 17 percent in Kazakhstan (Kuddo 1998, p. 153). Poverty among the elderly has grown though there is considerable debate about its extent and depth. In all eight countries in the region reported on by Milanovic, poverty rates decline with age (Milanovic 1998, p. 102). Other studies report high poverty rates for the elderly in countries such as Albania, Russia, and Ukraine (Bezrukow 1997; Simonova 1997; Shehu 1997).

The dramatic decrease in government revenues, especially among countries of the former Soviet Union, has been a driving force in the reduction of social supports and resistance to reducing the reliance on residential institutions. Public revenues decreased as a percentage of GDP throughout the region, at the same time that GDP decreased. Between 1990 and 1995 public revenue as a percentage of GDP decreased in Lithuania (−5.4 percent), Romania (−6.1 percent), Poland (−6.7 percent),<sup>1</sup> Albania (−20.1 percent), and Armenia

(−28.0 percent).<sup>2</sup> Latvia was one of the few countries in the region that showed any increase during this time period (+0.6 percent) (UNICEF 1997, p. 134). Recently, however, there have been modest improvements in public finances.

### *Social consequences*

The unprecedented peacetime deterioration in the standard of living, coupled with the loss or reduction of social supports and financial assistance, resulted in profound consequences—particularly for children, people with disabilities, and the rural elderly living alone. Most of the demographic, economic, and social changes in the region have increased the health, psychosocial, and developmental risks for children. Life expectancy has fallen dramatically, leaving more children vulnerable to the premature death of parents from such factors as poor nutrition, alcoholism, smoking, stress, and deteriorated living conditions (UNICEF 1997, pp. 37, 39). In Poland, for example, 100 people froze to death in the first month of the 1998-99 winter season, almost twice as many as in the entire winter of 1997-98. Most of the victims were men aged 40 to 60 who had been drinking and fell asleep in the cold (*New York Times* 1998).

With the decrease in marriages, more children are being born out of wedlock. The number of single mothers has increased and represents an increasing portion of the poor. In Poland 11.7 percent of children live in single-parent families. Births to teenage mothers have also increased in most countries, reaching a high of 22.6 percent in Bulgaria (UNICEF 1997, pp. 37, 38, 129).

The deterioration in the quality of people's lives may also have heightened both the incidence of child abuse and wife battering within the marriages that remain (UNICEF 1997, p. 13). In Lithuania, for example, one survey of 1,000 married women reported that 18 percent were severely beaten by their husbands (Lietuvos Aidas 1998). Data, however, are unavailable to compare with the incidence of domestic violence before the transition.

A growing share of children do not attend schools because of truancy, work, or family problems. In

Romania secondary school enrollment rates in 1995 were 14 percent lower than in 1989. In Poland nearly 1 in 10 7-to-9-year-olds were left without adult supervision for more than two hours a day in the mid-1990s, a large increase over the beginning of the decade (UNICEF 1997, pp. ix, viii).

The number of children involved in juvenile crime, child prostitution, and drug abuse has also increased throughout the region. The number of children living on the street, many of whom are homeless, has increased as well. Between 1992 and 1995 the number of street children held in detention centers grew 300 percent in Bishkek, Kyrgyz Republic (Goldman 1998b).

These growing social problems have increased the percentage of children who are placed in residential care by a court order. In Russia court-ordered placements accounted for 20 percent of children left without parental care in 1991. By 1994, 33 percent of children were entering the care system by court order (Harwin 1996, p. 137).

Deep historical prejudice toward and discrimination against ethnic minorities have also been unleashed. These attitudes have led to armed conflict in many parts of the region and to pogroms of Roma in Romania, Hungary, the Czech and Slovak Republics, and other countries. Historical prejudices have contributed to extreme disproportionate representation of Roma in many residential institutions in several countries of the region. The number of children registered with disabilities has grown sharply because of broadening categories and levels of disability. In addition, deteriorating maternal and child health during the transition may indicate that part of the registered increase in some of these countries is due to a rise in the number of new cases of children with disabilities. In addition, there are indications that only a portion of individuals with disabilities are actually registered as disabled. In Russia, for example, the number of children with recognized disabilities is almost 400,000, though one estimate places the actual figure at no less than 1 million (UNICEF 1997, p. 47).

There are strong incentives to classify healthy children as disabled and place them in residential institutions. As poverty has increased, the number of

healthy children whose families seek residential care has increased. Being labeled as disabled is necessary for placement in a specialized boarding school. In addition, adoption legislation in several countries permits international adoptions only for children with disabilities. And the lack of proper supervision and monitoring of the adoption process facilitates international adoption of healthy children who are classified as disabled.

The number of children who have become refugees because of war or natural disasters has increased. In Armenia the earthquake in 1988 and the war with Azerbaijan in 1992 created 1.28 million refugees and displaced persons (380,000 in Armenia, 900,000 in Azerbaijan). The 1991–92 civil war in Georgia created 280,000 refugees and displaced persons, including roughly 90,000 children under the age of 16—of whom 1,700 had disabilities and 8,000 were orphans. In 1995 more than 1 million refugees resulted from the conflict in Chechnya, Russia. In Tajikistan the number of displaced persons peaked at 660,000 in 1993. The 1991–95 conflict in the former Yugoslavia created about 4.2 million refugees and displaced persons; about 1.4 million were children. Most recently, in Kosovo there are roughly 1 million displaced persons; about one-third are children (UNICEF 1997, pp. viii, 29).

The social, economic, and health effects of the transition on the elderly have also been severe, though there is still a lack of adequate knowledge about the full impact (Calasanti and Zajicek 1997, p. 452). In Albania homelessness among the elderly is increasing. In Hungary an estimated 32 percent of the elderly require home help. In Ukraine 10 percent of the elderly and 23–30 percent of the very old need periodic or constant help and care (United Nations 1997, pp. 56, 119).

### **Increased Reliance on Residential Institutions**

Although residential institutions have always cared for a small percentage of vulnerable individuals, more children and people with disabilities are resid-

**Box 2.1****Two Families Whose Children Attend a Boarding School in Yerevan, Armenia**

The long-term placement of poor children in residential institutions is often the result of chance, as well as arbitrary or inappropriately applied placement criteria. In Armenia there is often very little difference between the family living situation of children who live in a boarding school and those children who attend a school during the day and go home to their families each night.

The following are profiles of two families, both of which are very poor. A child in the first family lives in a boarding school in Yerevan. In the other family, equally poor and vulnerable, the child attends the boarding school during the day but goes home to her family every night because she lives within walking distance of the school.

*Family 1: Child resides in the boarding school.* The family consists of a single mother, her two children, the mother's sister, and the sister's child. The 12-year-old daughter lives in a boarding school. Her sibling is 9 and her cousin is 14.

The girl lived at home when she was younger. One day she was severely burned by the heater in her kindergarten. Her face is severely disfigured as a result of the burn.

The mother buys and roasts sunflower seeds and sells them in Republic Square. Her husband has died, which entitles her to a pension of 7,500 drams a month (\$15). She receives a children's allowance of 6,000 drams a month (\$12). She earns about 600 drams (\$1.20) a day selling seeds.

Her flat consists of two sparsely furnished, cold rooms with a cement floor. One room has only a couch; the other has a cabinet, table, and chairs. One room has a light bulb. The only heating element is a hotplate that is used for heat and cooking. The apartment is about a 40-minute car ride from the boarding school.

The mother placed the child in the boarding school because she cannot work and also care for the child at

*Source:* World Bank mission to Armenia, November 1997.

home. In addition, the child was teased at the regular school because of her disfigurement. The mother would like to take her daughter home every night but she works until 11:00 p.m. and there is no one to take care of the child. The mother does not have enough money to pay for the bus twice a day for herself and her daughter and to buy food for her daughter. In addition, she has a two-month debt for electricity.

The mother was affectionate and caring during her interaction with the child. The mother expressed a desire for the child to live with her but felt financially unable to do so.

*Family 2: The child resides at home.* The family consists of a single mother and two children. The younger daughter has epilepsy and attends a boarding school during the day and comes home at night. She is the only child in the boarding school who goes home every night. The family members are refugees from Azerbaijan.

The mother and her two daughters live in a one-room apartment, about 8 feet by 15 feet plus a small alcove for cooking. The three share one bed. The apartment is in a building within a few hundred yards of the school, allowing the child to walk to and from school by herself every day.

The mother works as a cleaning woman in a local hospital and earns 4,000 drams a month (\$8). The mother was affectionate during her interaction with the child.

*Summary.* The income and housing of the two families are similar. A primary difference between the child who lives at home and attends the boarding school during the day and many other children in the school does not involve poverty, housing conditions or parental availability or involvement, but the family's proximity to the school. The simple lack of money or transportation has contributed to many children residing in boarding schools in Armenia.

ing in long-term facilities throughout Central and Eastern Europe and the former Soviet Union today than 10 years ago (UNICEF 1997, p. 66). As for the elderly, roughly the same number are residing in residential institutions as 10 years ago, though the situation varies by country. In Lithuania that number has increased substantially with the creation of new, smaller facilities and the conversion of former hos-

pitals to long-term residences for the elderly. In Central Asia the number of institutionalized elderly has decreased because of lack of resources to care for additional people.

At least 820,000 poor, vulnerable, or children with disabilities in the 27 countries of Central and Eastern Europe and the former Soviet Union live the early years of their lives isolated in 5,500 large,

regimented residential institutions. Excluded from these figures are many children who live in boarding schools or sanatoria, but are in the custody of their parents. Included in this number of institutionalized children are about 495,000 children with disabilities or labeled with disabilities (table 2.1). Roughly 365,000 elderly and elderly with disabilities lived in social care homes in the former Soviet Union in 1990 (see table 1.2); no aggregate data are available for the institutionalized elderly today in the former Soviet Union or in Central and Eastern Europe.

At least 0.7 percent of the region's children, 4 percent of people with disabilities, and 0.8 percent of the elderly live in residential institutions. The highest percentage of institutionalized children in the region is in Romania (1.8 percent); the lowest is in Albania (0.05 percent). Nearly one-third of all children in residential institutions are in Russia.

Although it is difficult to compare rates of institutional placement among countries in different regions, some broad comparisons are possible. In the United States, for example, 0.7 percent of children are in out-of-home care (500,000 of 69,000,000 children under age 18)—roughly the same percentage who are in residential institutions in Central and Eastern Europe and the former Soviet Union (Casey 1998). But, only 4 percent of the U.S. children are in institutions, 13 percent are in group homes, and 81 percent are in foster care (USDHHS 1997).<sup>3</sup>

Roughly 10 years after the fall of the Berlin Wall, in most countries throughout Central and Eastern Europe and the former Soviet Union more children and people with disabilities live in residential institutions than before the transition. In several countries children in institutions are disproportionately from ethnic minorities, particularly Roma. In Lithuania the number of residents in infant and children's homes increased 32 percent between 1990 and 1995. In Armenia the number of children in boarding schools rose 20 percent between 1995 and 1997. In the Kyrgyz Republic the number of young children under residential care jumped 69 percent between 1991 and 1994 (Armenia Ministry of Education and Science 1998a; Lithuania Ministry of Social Security and Labor 1996; Bauer and others

1998, p. 110). Hungary is the only country in the region where the drop in the number of children in public care is an unequivocally positive sign (UNICEF 1997, p. 66).

In 10 of the 14 countries of Central and Eastern Europe surveyed by UNICEF, the rates of infants and toddlers living in institutional care have risen since 1989. In Latvia, Romania, and Russia the number of children under 3 placed in infant homes has risen 35–45 percent (UNICEF 1997, p. viii). The number of children abandoned in maternity wards and the number of parents seeking placement for their children in infant and children's homes also increased.

The number of children in homes for people with disabilities has increased in countries such as Poland and Romania but decreased in Bulgaria, Moldova, and Russia. But in poor countries such as Armenia, poverty leads many parents to place their healthy children in special boarding schools for people with disabilities (UNICEF 1997, p. 67).

Children generally remain in residential institutions from the time of placement until they reach the institution's age limit of 14 to 18, although some return home or are adopted. Lithuania has one of the highest return rates—40 percent of the children placed in infant homes return to their families (Karcauskiene 1994).

Many factors contribute to the excessive and harmfully long lengths of residential care for children. First, staff believe that vulnerable children, people with disabilities, and the elderly are better off in residential institutions than in the community, especially because community-based social services are rarely available.

Second, many institutions—particularly those for children with disabilities, children with medical conditions, some boarding schools, and children's homes—accept children country- and regionwide, increasing the distance between them and their families. In addition, staff in institutions discourage contact between children and their families because such contacts disrupt the daily routine. Moreover, many staff believe that families have a harmful influence on children in residential care.

A third factor that contributes to the excessive length of care is the lack of responsibility and over-

**TABLE 2.1**  
**Number of Children in Residential Institutions in Central and Eastern Europe and the Former Soviet Union, 1995**

Country	Total number of children under 18	Children in residential institutions			Share of total children in institutions (percent)	Share of children with disabilities in institutions (percent) <sup>b</sup>
		Without disabilities	With disabilities	Total <sup>a</sup>		
Albania	1,246,000	—	—	585 <sup>c</sup>	0.05	—
Armenia	1,213,000	—	—	10,131	0.80	—
Azerbaijan	2,828,000	1,148 <sup>c</sup>	695	1,843	0.20	0.07
Belarus	2,655,000	5,587	1,841	7,428	0.30	0.70
Bosnia and Herzegovina	933,000	—	—	—	—	—
Bulgaria	1,903,000	12,718	8,246	20,964	1.10	4.0
Croatia	1,034,000	—	—	—	—	—
Czech Republic	2,400,000	8,684 <sup>d</sup>	11,583	20,267	0.80	5.0
Estonia	358,000	1,470	404	1,874	.50	1.0
Georgia	1,529,000	723	1,634	2,357	0.20	1.0
Hungary	2,250,000	9,708	738	10,446	0.50	0.3
Kazakhstan	5,890,000	—	—	—	—	—
Kyrgyz Republic	1,904,000	—	—	—	—	—
Latvia	609,000	1,751 <sup>e</sup>	420	2,171	0.40	0.7
Lithuania	957,000	5,037	1,790	6,827	0.70	0.2
Macedonia, FYR	636,000	—	—	—	—	—
Moldova	1,382,000	1,084	600	1,684	0.10	0.4
Poland	10,589,000	30,265 <sup>d</sup>	37,700	67,965	0.60	4.0
Romania	5,646,000	39,622 <sup>d</sup>	62,230	101,852	1.80	11.0
Russia	37,115,000	106,094	231,433	337,527	0.90	6.0
Slovak Republic	1,468,000	6,815	4,386	11,201	0.80	3.0
Slovenia	426,000	—	—	—	—	—
Tajikistan	2,842,000	—	—	—	—	—
Turkmenistan	1,887,000	—	—	—	—	—
Ukraine	12,377,000	16,433	8,525	24,958	0.20	0.7
Uzbekistan	10,614,000	—	—	—	—	—
Yugoslavia	2,678,000	—	—	—	—	—
Total for countries with data available	115,369,000	247,139	372,225	630,080	0.70	4.0
Total estimate for countries with no data available	28,844,000	79,188 <sup>f</sup>	122,720	201,908	0.70	4.0
Total	115,369,000	326,327	494,945	821,272	0.70	4.0

— Not available.

*Note:* This table understates the total number of children who reside in residential institutions. It is based primarily on data gathered by UNICEF on children in public care. According to UNICEF (1997) children in residential institutions include “children in permanent and temporary residential care (various types of infant and children’s homes, including boarding schools for children without a parental guardian); [and] children with severe disabilities in health facilities, although in some countries this includes children with less severe disabilities in full or part-time care ... Children in punitive institutions are excluded in most instances.” These data also generally exclude children who attend boarding schools or sanatoria and are in the custody of their parents.

a. It is difficult to determine a precise total because no database covers all countries of the region, there is no standard methodology for counting institutions and children, country classifications of children by level of disability are increasingly arbitrary, and some residential institutions have inflated the number of children on their rosters to increase government funding for those institutions.

b. According to WHO (1978), about 10 percent of the population in each country has disabilities.

c. Data are for 1998.

d. Data are for 1994.

e. Data are for 1992.

f. The aggregate number of institutionalized people with disabilities in countries for which data are unavailable was estimated using the same percentage (60.8 percent) of people with disabilities among all institutionalized children in countries for which data are available.

*Source:* UNICEF 1997, 1998b; Albania General Administration of Social Services 1998; Armenia Ministry of Education and Science 1998b.



sight outside the institution for a child. In Romania, for example, any movement of a child from an institution—whether to another institution or back to the community—must be approved by the commission for the protection of minors that placed the child. The commission, however, has no ongoing responsibility for the child, and rarely receives information about any child it has placed.

A fourth factor is that a disproportionately large percentage of children placed into residential facilities are ethnic minorities, particularly children of Roma. In Romania as many as 40 percent of institutionalized children are Roma, though less than 10 percent of the population is Roma. In Bulgaria the disproportion is reported to be more extreme. Prejudice toward ethnic minorities has led staff in residential institutions to discourage contact between parents and their institutionalized children and has reduced the options for foster care and adoptive placements in community-based service programs.

Finally, housing and employment are scarce for children who leave residential care. Children are now unofficially allowed to remain in many institutions beyond the institution's age limit to avoid the homelessness, unemployment, and social isolation that afflicts many deinstitutionalized children.

In the 12 republics of the former Soviet Union the number of elderly and adults with disabilities in institutions increased by almost 8 percent between 1980 and 1990, rising from 338,940 to 364,500 (ISCCIS 1997). Among seven countries of the for-

mer Soviet Union for which 1996 data are available—Azerbaijan, Belarus, Kazakhstan, the Kyrgyz Republic (1995 data), Moldova, Tajikistan, and Uzbekistan—the number of elderly in residential institutions dropped by 16 percent between 1990 and 1996 (table 2.2), though the number of institutions for the elderly increased by 4 percent. These countries, however, account for only 16 percent of all the institutions for the elderly in the former Soviet Union and may not reflect the overall situation in the region.

### The Effects of Humanitarian Aid

As the international community became aware of the conditions of children in residential institutions, emergency assistance and humanitarian aid poured in to assist specific institutions. International donors, NGOs, and religious organizations provided assistance by training staff, renovating the appearance of institutions, and providing fuel, food, books, toys, clothes, and recreational opportunities. This assistance reached a large number of institutions throughout the region.

Organizations also redesigned a few large institutions to make them more homelike. Large dormitories were divided into smaller units. Children reside in multiage groups, with each group having its own eating and, on occasion, its own cooking facilities. Although these residences are intended to be more

**TABLE 2.2**  
**Number of People in Residential Institutions for the Elderly and Adults with Disabilities in Countries of the Former Soviet Union, 1990–96**

Country	1990	1995	1996	Change in number of people, 1990–96	Percentage change, 1990–96
Azerbaijan	1,190	980	900	-290	-24
Belarus	17,580	15,340	14,900	-2,680	-15
Kazakhstan	18,090	15,970	16,000	-2,090	-12
Kyrgyz Republic	3,100	2,780	—	-320 <sup>a</sup>	-10 <sup>a</sup>
Moldova	3,410	2,200	2,200	-1,210	-35
Tajikistan	1,110	760	1,100	0	0
Uzbekistan	9,410	—	7,200	-2,210	-23
Total	53,890	38,030	42,300	-8,800	-16

Note: These figures exclude individuals in sanatoriums, rest homes, and boarding houses with medical facilities.

a. 1990–95 difference.

Source: ISCCIS 1997.

supportive of children, no formal research has demonstrated that they mitigate the harm caused by long-term residential living.

International donors, NGOs, and religious organizations have also built smaller group homes for vulnerable individuals. In Romania, for example, homes range in size from an agency-operated boarding home for 6 children in Cluj (funded by a European foundation) to group residences for 25 children with disabilities in Cluj (run by nuns and funded by Caritas) to several cottages for 100 children in Bacau (funded by the Romanian Orphanage Trust and run by *Pentru Copii Nostri*). Some international donors have built cottages on large campuses that are often isolated from the community, as SOS Kinderdorf has done in Romania and other countries.

This type of humanitarian aid has been a double-edged sword. On the one hand, the aid has improved conditions in many institutions, primarily through staff training, capital renovations, and the provision of books, toys, food, and supplies.<sup>4</sup> On the other hand, these changes created the false impression among policymakers, donors, and the public that large residential institutions were not so harmful to children and people with disabilities. In the worst facilities, such as institutions for the severely disabled in Romania, basic survival needs were met, but other problems of living in an institution continued. The changes at most of the residential institutions, however, were minor relative to the magnitude of the harm caused by life in these institutions. Humanitarian aid reinforced the belief in and reliance on the use of residential institutions, and it also strengthened the influence of individuals who promote and run the facilities.

A second negative consequence of humanitarian aid to residential institutions has been that it has reduced the financial strain on the public sector from operating these facilities. Whereas the high cost of residential institutions has been a primary reason for Western countries to phase out such facilities, humanitarian aid has allowed countries of Central and Eastern Europe and the former Soviet Union to avoid or delay reducing their reliance on these institutions.

Finally, humanitarian assistance has been provided only briefly and is now decreasing throughout the region. This reduction in financial assistance has

contributed to the development of national plans to reduce the reliance on residential care in Armenia, Bulgaria, and Romania. But the reduced humanitarian aid has also resulted in renewed deterioration of conditions in these institutions.

In Romania, for example, international public reaction to the terrible conditions in institutions for people with disabilities led to additional government funding and international emergency assistance to improve the conditions in many of them. But as public attention decreased, international humanitarian assistance and real government expenditures on children's institutions also began to decrease. A survey in late 1993 showed that central government expenditures on children's homes had not kept pace with inflation, causing large reductions in staff. Since then the conditions in the worst institutions have improved from the deplorable pretransition conditions, but the level of care provided in most residential institutions continues to be far below acceptable standards. As the director of one home for children under 3 in Romania said in 1995, "we do not have enough staff to care for the children. The infants arrive healthy and leave disabled" (Tobis 1994). After several years of improvement, the conditions in residential institutions again deteriorated in 1999 after the institutions were decentralized without transferring adequate funding from the national budget to the localities. International humanitarian assistance is again being sought to alleviate the recurring crisis.

As another example, the earthquake in 1988 and the war with Azerbaijan in 1992 brought international attention and resources to Armenia. The large and wealthy Armenian diaspora contributed to individual boarding schools. This aid perversely allowed the national government to abrogate its responsibility to provide adequate resources for children in public residential institutions. Government funding for food in boarding schools in Armenia fell to roughly one-third of the standard set during the Soviet period. As humanitarian assistance began to decrease toward the end of the 1990s, the government of Armenia has not proportionately increased its funding to replace the lost assistance. As a result the conditions in boarding schools continue to deteriorate.

## Financing Residential Institutions

The financing of residential institutions promotes reliance on them but increasingly will contribute to a reduction in their use. Residential institutions are a very expensive way to assist individuals who are experiencing difficulties and the pressure to reduce government expenditures during the transition has led to reductions in expenditures for residential institutions. These reductions may lead to the closing or conversion to day programs of some residential facilities. In 1998, for example, the Armenian Parliament cut funding for boarding schools by 30 percent. The Ministry of Education and Science is trying to use the reduction as an opportunity to convert 20 percent of boarding schools into general schools and to close some facilities.

### *Source of funding for residential institutions*

During the socialist era all residential institutions in Central and Eastern Europe and the former Soviet Union were financed exclusively by the state budget.<sup>5</sup> Funding for these institutions was channeled through the ministry responsible for each type of institution. Each institution received an annual budget allocation from the ministry of finance based on a projection from the previous year's actual expenditures and a projection of the number of children to be served.

Today residential institutions that remain subordinated to national ministries continue to be financed in the same way. Residential institutions that have been decentralized to regional or local governments are funded differently. These institutions

are financed by transfers from national budgets to regional budgets. Although the localities generally have the legal authority to raise taxes, the local tax base is limited. As a result local governments generally contribute little to the cost of financing residential institutions in their jurisdictions.

In Lithuania 25 percent of the budgets of residential institutions are financed by municipalities, ranging from 45 percent for institutions for children to 4 percent for institutions for people with disabilities (table 2.3). It seems likely that the municipal contributions are primarily transfers from the national budget and that the differences primarily reflect the degree to which different types of institutions have been decentralized.

Many residential institutions receive marginal, supplemental financial assistance from foreign donors, NGOs, and individuals over several years. In Armenia, for example, 46 of 48 residential institutions received support from foreign donors for food in 1997. The average amount received by each institution is about 10 percent of its annual budget (Armenia Ministry of Education and Science 1998a).

### *Public expenditures for residential institutions*

Reliable information on total public expenditures on children's institutions is limited. UNICEF estimates that between 0.1 and 0.3 percent of all public expenditures in Central and Eastern Europe and the former Soviet Union go for children in institutional care. But this estimate may be low. In Lithuania, for example, 1.75 percent of national public expenditures in 1996 was for residential institutions for children, people with disabilities,

**TABLE 2.3**  
**National and Local Expenditures on Residential Institutions in Lithuania, 1996**  
(thousands of litas; 4 litas=\$1)

<i>Type of residential institution</i>	<i>National</i>	<i>State</i>	<i>State share (percent)</i>	<i>Municipal</i>	<i>Municipal share (percent)</i>
Total <sup>a</sup>	131,749	98,336	75	33,413	25
Institutions for children	27,785	15,312	55	12,473	45
Institutions for the elderly	31,337	21,558	69	9,779	31
Institutions for people with disabilities	61,510	59,008	96	2,502	4

a. Also includes other institutions and institutions for home visiting and housekeeping.

Source: Larsson 1998, table 11.

and the elderly (Larsson 1998). The data seem to show, according to UNICEF, that the level of funding for residential care is associated more with changes in GDP than with changes in the assessment of children's needs (UNICEF 1997, p. 85).

In real terms fewer government resources are devoted to residential institutions for children now than when the transition began. This drop is due to

lower government budgets for residential institutions and decreases in government consumer subsidies that increase the cost of operating institutions. As a result the living standards of children in long-term residential institutions in most countries have worsened. Available data show that per child expenditures are often lowest or have declined the most in special institutions for children with disabilities. As

## Box 2.2

### Cost of Community-Based Social Service Projects: Lithuania and Romania

How much does it cost to create community-based social services? The experience of Lithuania in creating pilot projects and of Romania in creating the foundation for a national community-based social welfare system for children and families can provide some guidance on the order of magnitude of investment and recurrent costs.

*Pilot projects in Lithuania.* The government of Lithuania approached the World Bank to develop a project to support the introduction of community-based social services. The project included 14 service programs located in six municipalities. These programs include a social service reception center, home care for the elderly, a day center for the elderly and people with disabilities, a training center for youths with disabilities, four day centers for children with severe disabilities, a temporary children's home, a temporary shelter for battered women, and a short-term reintegration residence for former prisoners. The project provided investment funds (for renovation of buildings, equipment, and vehicles), technical assistance (to design and evaluate the program and to train and supervise staff), and recurrent costs. About 1,000 people are served by the projects (box table 1); 1,500 people will be served in a year, when the projects are fully operational.

*National child welfare reform in Romania.* This three and a half year project, begun in 1998, was developed by the Romanian government through the Department for Child Protection to reform the child care and child protection system by reducing the flow of children into institutions, improving the quality of care for institutionalized children, developing alternative care systems, and assisting older institutionalized children to adapt to life in the community. The project will build on small-scale initiatives of other donors and NGOs and implementation structures within each county (judet).

The goals of the project are to:

- Use 40 percent of the national budget allocated for child welfare services for community-based services.
- Decrease by 35 percent the number of children entering large, state-run institutions.
- Increase by 35 percent the number of children who leave state-run institutions.
- Ensure that the cost per child served in community-based care is not more than half the cost of care in state-run institutions.
- Increase by 60 percent the number of street children who secure shelter.
- Encourage the government and NGOs to incorporate lessons from the sub-projects into future community-based child welfare services.

**BOX TABLE 1**

#### Actual Costs of Selected Pilot Projects in Lithuania

(U.S. dollars)

<i>Expenditure category</i>	<i>Education center for children with disabilities (Anyksčiai)</i>	<i>Shelter for battered women (Vilnius)</i>	<i>Program for former prisoners (Svencionys)</i>	<i>Home care for the elderly (Svencionys)</i>	<i>Reception center (Svencionys)</i>
Number of clients served	30	44	8	365	400
Physical expenditures <sup>a</sup>	118,358	371,219	43,835	97,667	25,177
Technical assistance and training	160,833	92,000	64,290	64,290	64,290
Annual recurrent expenditures	54,966	121,475	18,250	93,225	21,325

a. Civil works, equipment, furniture, and vehicles.

Source: World Bank 1999.

**BOX 2.2 CONTINUED****Cost of Community-Based Social Service Projects: Lithuania and Romania****BOX TABLE 2****Projected Costs of the Child Welfare Reform Project in Romania**

(millions of U.S. dollars)

<i>Project component</i>	<i>Local</i>	<i>Foreign</i>	<i>Total</i>
Community-based child welfare services	21.9	5.1	27.0
Street children initiative	0.6	0.1	0.7
Institution building, monitoring, and evaluation	1.2	0.6	1.8
Total project cost	23.7	5.8	29.5

*Note:* Actual costs for all project components are not yet available because the project has only recently begun. Funding for the \$29.5 million program (box table 2) is coming from the government of Romania (\$3.3 million), Council of Europe Social Development Fund (\$10.9 million), government of Japan (\$0.5 million), U.S. Agency of International Development (\$5.5 million), European Children's Trust (\$2.7 million), PHARE (\$0.5 million), Spain (\$0.2 million), Switzerland (\$0.1 million), SERA (\$0.8 million), and World Bank (\$5.0 million).

*Source:* World Bank 1998.

UNICEF concludes, "consequently, many of those who are especially dependent upon the state receive less financial support today than they did under socialism" (UNICEF 1997, p. 85).

In Poland, for example, total public expenditures for children under 17 living in long-term care centers, smaller family homes, children's villages, and temporary centers had dropped by 20–39 percent in real terms by 1992 and remained at that level until 1995. In poorer countries of the region the deterioration in funding of residential institutions has been more severe. In Bulgaria expenditures on homes for infants and children and homes for children with disabilities have fallen relentlessly. In 1995 the real expenditure level per child reached only one-third of the 1989 level (UNICEF 1997, pp. 85, 86).

### *Relative cost of residential care*

Residential care is far more expensive than alternate forms of care such as foster family homes for children or community-based services for children, people with disabilities, or the elderly. Armenia's Ministry of Education and Science reports that it is 10 times more expensive to educate a child in residential boarding school than in a regular school. Under the command economy residential education in Russia was reported to cost four times the cost of regular schools (Harwin 1996, p. 29).

In Romania a study conducted by UNICEF and the National Committee for Child Protection (1996) showed that the cost for foster care in a program run by an NGO was no more expensive than the cost of institutional care and was far better for the children. In Lithuania community services to provide home visits, meals, medical care, and other assistance to the elderly are projected to be only 25 percent of the cost of residential care. The same analysis found that it is no more expensive to serve children with disabilities in an enriched day school program that provides education, two meals a day, job training, and transportation, than in long-term residential care (World Bank 1995).

In the early 1990s the monthly cost per child under residential care ranged between roughly one to three times the average wage in the region. The Czech Republic spent about 3.5 times the average monthly wage per institutionalized child, Poland spent almost 2.0 times the average wage, and Bulgaria spent the average wage per institutionalized child. Romania spends about 90 percent, and Moldova allocates only 70 percent of the average wage (UNICEF 1997, pp. 84, 87).

According to UNICEF, the per bed expenditure is highest in infant homes. Estonia allocates 1.9 times the average wage per child in infant homes, but only 1.3 times the average wage per child in homes for people with disabilities. In Romania in 1995 per child expenditures in infant homes (*leagan*) equaled the average wage and per child expenditures in

homes for people with disabilities equaled 74 percent of the average wage. In Lithuania in 1995 1.8 times the average wage was spent per child with disabilities in residential care. (UNICEF 1997, p. 88).

On the other hand, the operating costs per child for many of the new, small group homes being built by NGOs throughout the region may be more expensive than the cost per child in residential institutions. This is because of higher salaries and better supervision, food allotments, and programming in group homes.

The World Bank's Romania country team compared the costs of various types of care for children in Romania. Table 2.4 shows that state institutions are far more costly than community residential care, foster care, or family reintegration.

## The Current Situation of Residential Institutions

The use of residential institutions in Central and Eastern Europe and the former Soviet Union has shifted since the transition began almost a decade ago. Some changes—in attitudes and oversight—may have improved conditions of children in institutions. Other changes—such as deteriorating care and reduced funding—have had detrimental effects. An examination of these changes can inform the debate on social welfare policy in the region.

### *Attitudes have changed*

Throughout Central and Eastern Europe and the former Soviet Union the family is increasingly seen as

the most important social unit for raising children and fostering social values. The family is becoming a primary focus of social welfare policy, reflecting a return to the more traditional role of the family that was deemphasized during the command economy. At the same time, attitudes toward residential institutions are also changing, albeit slowly. Senior policymakers, newly trained social workers, some social welfare administrators, and staff in some residential institutions are beginning to recognize the limitations and harm of residential care and the high cost to government. They increasingly see residential care as a last resort, an orientation that began to develop before the end of the socialist era (UNICEF 1997, p. 64). The concerns raised by senior policymakers, however, often focus on the high cost of residential care. The importance of quality care, high standards, and the harm to clients caused by residential care are still secondary concerns.

### *Few residential institutions have closed*

Changes in attitudes have had little impact on the region's reliance on residential institutions. Few residential institutions have been closed throughout the region. Even in a country like Romania, which has hundreds of residential institutions for children and people with disabilities and new legislation to create a national system of social services, only a very few residential institutions have closed. War-torn Georgia and Moldova are two notable exceptions—severe government deficits drastically reduced the funding to institutions and caused their closings. But even in those two countries the numbers of closed institu-

**TABLE 2.4**  
**Recurrent Cost Analysis of Alternative Child Welfare Modalities, March 1998**  
(millions of lei per child per month)

<i>Cost category</i>	<i>State institutions</i>	<i>Community residential care</i>	<i>Professional foster care</i>	<i>Voluntary foster care</i>	<i>Adoption or family reintegration</i>
Operational costs per child	1.7 to 2.4	0.8 to 1.1	0	0	0
Foster parent salary	0	0	0.40	0	0
Foster allowance	0	0	0.15	0.15	0
Child allowance	0.07	0.07	0.07	0.07	0.07
Supervision costs	0	0	0.18	0.18	0.10
Total	1.77 to 2.47	0.87 to 1.17	0.80	0.40	0.17

Source: World Bank 1998.

tions are small. In Georgia between 1992 and 1996 the number of children's homes dropped from 12 to 9; the number of boarding schools for children with disabilities was also reduced (UNICEF 1997, p. 86).

*Some residential institutions have been redesigned for other purposes*

In Yerevan, Armenia, a wing of a boarding school is being used to house refugees of the war with Azerbaijan. In Budapest, Hungary, part of a long-term children's institution was converted to temporarily house and train teenage mothers and their children. In Bucharest, Romania, part of an infant home was converted into short-term apartments for mothers and their children. In Utena, Lithuania, plans are being developed to convert part of a temporary children's home into apartments for mothers and their children.

*Some children with disabilities have been reintegrated into general schools from special schools*

These children represent only a small fraction of the children living in residential facilities and are primarily well-functioning individuals. In the Czech Republic, where integration has been strongly promoted and national laws have been changed, the care and education of the majority of children with disabilities is still provided in special institutions, but the process of integration has begun. Between 1989 and 1995 about 25,000 children with disabilities were integrated into regular schools. Of this number, 9,000 students attended regular classes and 15,000 went to special classes in regular schools. However, about 70,000 students still attend one of the 1,370 special schools. Nevertheless, the Czech Republic, as well as other economically more developed countries of the region, are considering allocating funds to construct new residential institutions (Halova and Bottge 1999).

*Administrative responsibility for some institutions has been decentralized*

Some residential institutions have been decentralized, primarily to the regional level, through the shift

in administrative responsibility that has caused little change in authority or financial control. These changes appear to have had little effect on clients in the institutions.

The clients of decentralized institutions came from the regions where the institutions were located. Residential institutions that serve an entire country generally remained under the national government's authority. Armenia's boarding school for hearing-impaired children, for example, remains under the national government's control; boarding schools that serve socially vulnerable children from a particular region are transferred to the respective regional government's control. Since March 1998, 30 of 49 boarding schools, children's homes, and sanatoriums for children have been transferred to regional governments (Armenia Ministry of Education and Science 1998b).

Most decentralized institutions serve children, followed by social care homes for the elderly. Institutions for people with disabilities have rarely been transferred from state to local authority, primarily because they serve people who come from areas throughout each nation.

*Conditions in institutions have deteriorated*

Although the conditions in some of the worst institutions have improved and staff in many have received some training, the overall picture for residential care is worse today than it was 10 years ago. More people are cared for with fewer government resources. Although private donors have supplemented government revenues to the institutions, these funds have generally not fully compensated for the loss of public funding.

In addition to the general harm caused by residential care, research has begun to document abuse of children in facilities. In Armenia, for example, children report being exposed to frightening incidents, including harsh punishment by staff and attacks by other children at or outside the institutions (Bertmar 1999).

Abuse of people with disabilities is especially acute, particularly in southeastern Europe and the countries of the former Soviet Union. According to UNICEF, in Moldova 73 of 493 mentally disabled children in state residential facilities died in 1995. In

**Box 2.3****Community-Based Social Service Projects**

Many community-based social service projects have been established in Central and Eastern Europe and the former Soviet Union by local governments and NGOs. Few of these projects have been formally assessed, fewer still have had outcome evaluations, and none has been evaluated with a comparison group to assess its impact. Nevertheless, site visits to these programs, interviews with staff and clients, and reviews of program materials and limited assessments suggest that some of these programs provide important help to vulnerable individuals. The brief descriptions below reflect the range of new programs that have begun operating in the region, including social services, foster care, and small group homes.

*Family Support Center, Albania (Shkodra).* The center opened in 1996 to help needy families with children at risk of institutionalization. It was established by Save the Children (Denmark), which provided training, technical assistance, and funding until 1998, when the General Administration of Social Services began paying the program's recurrent costs. The center has two social workers who assist 10 families with children living at home, providing food, education, home visits, parent training, and help with school work for the children. The program also identifies children in local infant and children homes who could return to their families. In the first year and a half, four children returned home safely and six others were close to doing so.

*Bridge of Hope, Armenia (Yerevan).* The program was set up by *Oxfam* for children with severe disabilities who were not permitted to attend regular schools. About a dozen children attend daily classes provided by the program, including some on academic subjects such as literature, history, and English as a foreign language and some on developing skills for independent living. The program also created a theater company in which children with disabilities perform with children who do not have disabilities. A parent of one of the children in the school said, "I used to be afraid about my daughter's future. I'm not afraid now."

*Support for Families in Especially Difficult Circumstances, Romania.* The Commissions for the Protection of Minors in two counties in Romania (Cluj, Iasi) and three sectors of Bucharest set up programs with assistance from *UNICEF* to help families whose children were at risk of being placed in residential institutions. At each site, two to four government social assistants who investigate whether a child should be placed in an institution were trained to counsel families, conduct social work home visits, and place children who could not remain safely with their families in foster homes. Although the projects kept many children from entering residential institutions, some workers found that families needed more material assistance than was provided.

*Temporary Families for Children, Romania (Constans and Bucharest).* The program was created by Holt International in the mid-1990s to place children in temporary foster care until a permanent placement can be found, either by returning them to their families or by having them adopted. Social assistants received special training to recruit temporary foster homes, assess and train foster families, and place and supervise children in the foster homes. In 1995 the average placement lasted 4.5 months for the 32 children who were placed in temporary foster homes. Of these children, 21 were adopted (20 within Romania, 1 internationally), 5 were reintegrated with their birth families, 1 died of Sudden Infant Death Syndrome and 5 were awaiting a permanent placement.

*Group Home For Mentally Disabled Young Adults, Lithuania (Vilnius).* Twelve severely disabled adults live in a large house on the outskirts of Vilnius. During the day the young people go into Vilnius to an employment training center for people with disabilities. When they return to the center, they participate in regular household chores and other social activities. The program is funded by the municipality and administered jointly with *Viltis*, an NGO of parents of children with disabilities.

Ukraine about 30 percent of severely disabled children living in specialized homes die before they reach the age of 18 (UNICEF 1997, pp. 88, 89).

The worst conditions in the region exist in countries that have experienced war, natural disasters, or have severe poverty, such as Georgia and Moldova. According to UNICEF, children in those two countries "are now living in institutions beyond the point of

financial collapse" (UNICEF 1997, p. 86). In Armenia there has been a general deterioration in institutional conditions. More than 10 years after an earthquake struck northern Armenia, children still attend boarding schools in temporary trailers with minimal heat. Directors of residential institutions report that conditions are worse and resources are more scarce now than before the transition.



### *Life after discharge from an institution is more difficult*

Many children who grow up in residential institutions find it difficult to reintegrate into mainstream society and have fewer options available to them than before the transition. According to survey data from the Procuracy General of Russia, 1 in 3 children who leave residential care becomes homeless, 1 in 5 ends up with a criminal record, and as many as 1 in 10 commits suicide. In Romania many homeless street children fled residential institutions. One study reported that 1 of 10 young offenders in Russia was raised in public care (Harwin 1996, p. 147). In one case 25 young people who aged out of the children's home in Tirana, Albania, have been living as squatters in an abandoned vocational training center. After living most of their lives in institutions, these children received no assistance in finding a job or a home.

Few studies have been conducted on the effects of residential care on children who left institutions during the transition (except for children who were adopted), and no study with a control group has been undertaken. Without such studies it is difficult to differentiate the effects of poverty from the effects of residential care. In Albania, for example, the director of a children's home reported that in 1998 all the children who left the institution are now unemployed except those who pursued additional education. Their life in the institution as well as the current conditions in Albania could have contributed to this result.

### **The Current Situation of Community-Based Services**

Many community-based service modalities are being tried in various parts of the region, most notably in three areas—social services, foster care, and adoption.

#### *Social services*

Over the past 10 years community-based social services have developed very slowly in Central and Eastern Europe and the former Soviet Union. Small,

isolated programs have been established by multinational organizations, international donors, NGOs, and religious organizations. These projects often collaborate with national or local governments, operate mainly in large cities, and serve relatively small communities. Romania is one of the few countries that has passed legislation creating a national social service system for children and families, though implementation of the legislation has only recently begun. Lithuania has also passed national legislation authorizing localities to deliver community-based social services to vulnerable groups but has provided funding to cover only a limited number of programs in specific municipalities. In Hungary, one of the few countries with an extensive family support network, there are 150 family help centers and 20 advisory centers for parents, all funded by municipalities (Herczog 1997).

In contrast, many countries are developing individual programs. In Shkodra, Albania, a family support center provides counseling, parent training, home visits, and referrals. In Vilnius, Lithuania, youths with disabilities are taught work skills. Yerevan, Armenia, now has a theater company and a special education program for children with severe disabilities. In several cities in Armenia, as well as in many countries in the region, Special Olympics and sports and recreation programs for people with disabilities have been established.

Fewer programs have been set up for the elderly than for children or people with disabilities. Still, programs include home delivery of food, household chores, and senior citizen centers. In Svencionys, Lithuania, home care for the elderly provides assistance with meals, heating, household chores, and planting.

#### *Foster care*

Another community resource used in the region to care for vulnerable children is foster parents. Most children in foster placements in the region reside in the homes of relatives, primarily grandparents or aunts. Relatives, for example, account for about 80 percent of foster parents in Poland, Romania, and Russia (UNICEF 1997, p. 90).

Across the region there are marked differences in the use of foster care. Foster care was most common in the western former Soviet Union and Central Europe but is still rarely used in southeastern Europe. Despite the rise in children in public care, Bulgaria still has no formal foster care program. An attempt to introduce foster care there in 1993 was largely unsuccessful (UNICEF 1997, pp. 65, 73).

With few exceptions, the number and rates of children in foster care have increased across the region—reflecting both an increased use of foster rather than residential care and a larger number of children residing outside their homes. In Poland, for example, the number of children in foster homes increased from 38,000 in 1989 to more than 46,000 in 1997. Poland has the highest rate of foster children in Central Europe—433 per 10,000 people. Throughout the region, however, relatively few children in public care (less than 40 percent) are in foster homes (UNICEF 1997, pp. 72, 73).

Nonrelative foster homes are used infrequently throughout Central and Eastern Europe and the former Soviet Union. And when they are, few countries have programs to recruit, train, monitor, and assist foster families. When nonrelative foster care is used, it is often as a pre-adoptive placement or in place of adoption rather than as a short-term placement (as is the case in Western Europe). Few children from infant or children's homes are returned to the community through placement in a foster home, and almost no children with disabilities are placed in foster families.

Professional foster parents—though rare in the region—have been used in Hungary since 1986. Some 30 percent of the 8,500 children in foster care in Hungary live with professional foster families. These families are trained as educators and have raised children of their own. They receive 60 percent of the average national salary in addition to a foster-child allowance, and care for at least five children in addition to their own (UNICEF 1997, p. 90).

In the past few years NGOs, international schools of social work, and multinational agencies have promoted foster care as an alternative to the residential placement of children, with limited success. In Russia, for example, foster care is increasingly being

sidelined (Harwin 1996, p. 142). Several factors account for the difficulty of using foster care in the region. First, the financial and housing difficulties of many families make it hard to care for an additional person, particularly with the limited financial assistance provided by government. In Lithuania, for example, reimbursement to foster parents in 1994 was less than 20 percent of the average wage, and in Romania it was less than 10 percent (UNICEF 1997, p. 91).

Countries like Lithuania that have recently increased financial support to foster families have been able to increase the number of foster families. The rise in fostering rates in Poland has been influenced by the doubling of allowances to relatives since 1991—from 20 to 40 percent of the average wage for children over 2. Families that care for children younger than 2 or who have special needs receive 100 percent of the average wage (Stelmaszuk and Klominek 1997; UNICEF 1997, p. 90). Other factors also limit the use of foster care, including cultural prejudices toward children who have lived in residential institutions, limited public awareness about foster care, and the absence of a legal framework or cultural tradition to use nonrelative foster care.

### *Adoption*

Adoption is still an underdeveloped resource in Central and Eastern Europe and the former Soviet Union. Only a small percentage of children living in infant homes are adopted each year. Some countries, however, have relatively high adoption rates from infant homes—such as Hungary (21.8 percent) and Russia (36.5 percent) (Harwin 1996; UNICEF 1997, p. 74).

Since 1990 the number of children adopted each year has decreased in all parts of the region except Bulgaria, Slovak Republic, and the western CIS (UNICEF 1997, p. 74). This decrease partly reflects disruptions in old administrative systems for adoption without adequate replacements. In Armenia, for example, adoptions had been the responsibility of district committees on guardianship, foster care, and adoption. These committees no longer function but

have been replaced by municipal committees that do not yet operate. As a result adoption lacks formal criteria, referral, or decisionmaking procedures (Duncan and Vitillo 1998). Another factor contributing to the reduction in adoptions has been the decrease in the age cohort of children under 3, the main age group of adopted children.

International adoption has been a significant factor in the increasing adoption rates of southeastern Europe and the Baltics. Most countries of the region, with the exception of Poland and Hungary, had no experience with international adoption during the socialist period. As a result these adoptions initially were poorly controlled and monitored, resulting in many violations of the 1986 United Nations Declaration on Adoption. Albania, Georgia, Romania, Russia, and Ukraine imposed temporary moratoriums on intercountry adoptions until more appropriate standards and procedures could be established. Still, violations continue to be prevalent throughout the region, even with the adoption of standards. Nonetheless, international adoptions continue to account for a small percentage of adoptions in the region, though reaching relatively high percentages in Romania (42.8 percent), Lithuania (36.5 percent), and Latvia (45 percent) (UNICEF 1997, pp. 75–79).

The 1986 United Nations Declaration on Adoption and the 1993 Hague Convention on Intercountry Adoption view intercountry adoption as a last resort because of the problems it can cause. Although interests in intercountry adoption are often purely humanitarian, many complications can develop, including international child trafficking and unforeseen problems with the child leading to disrupted adoptions. As a result the Hague Convention specifies that intercountry adoption should be used only when appropriate care, including adoption, cannot be provided in the child's country of origin (UNICEF 1994).

Major work is needed to improve adoption practices throughout the region. Most countries lack a central adoption authority to provide high-level oversight of adoptions. Countries lack simple, clear, and transparent procedures for adoptions that are communicated to the general population. Eligibility

rules must be developed to make possible the adoption of a child by the most suitable person or persons. Currently, most adoptions are geared toward the needs of the adopting family rather than the needs of the child first.

## Conclusion

The continued reliance on residential institutions has created a vicious cycle in the region. The institutions absorb much of the limited governmental and nongovernmental resources that are desperately needed to assist vulnerable groups. The lack of alternatives has pushed donors and governments to increase the region's reliance on residential institutions. More vulnerable individuals are being placed into deteriorating residential institutions. As a result they experience more hardship and find it difficult to reintegrate into the community, further burdening the public sector.

The transition to a market economy has created opportunities as well as problems for people of the region. Political openness and democratization have given rise to new governmental and nongovernmental solutions for vulnerable groups. Decentralization and community participation have laid the groundwork for consumers to influence the types and quality of services that they receive. And the transition has created the opportunity for new community-based social service systems to reduce the region's reliance on residential institutions.

## Notes

1. Poland 1991–94.
2. Armenia 1990–93.
3. Amount does not total 100% due to rounding.
4. Not all of this humanitarian assistance was helpful.

For example, a large shipment of wood chips to heat boarding schools after the Armenian earthquake was unusable. As a result enormous boxes of wood chips litter the playground in front of Boarding School #5 in Gumri, Armenia (World Bank Mission to Armenia in November 1997). In addition, not all of the humanitarian assistance actually

reached the children for whom it was intended (Hunt 1998).

5. In rare instances NGOs or religious organizations provided funding for residential institutions. For example, in

Poland during the command economy nuns were permitted to administer a few residential institutions for children and people with disabilities. The state provided the operating budgets and staff salaries; the church provided supplemental funding.

## CHAPTER 3

# The Use of Residential Institutions in Other Industrial Nations

**R**eliance on residential institutions to care for about 1.3 million vulnerable individuals in Central and Eastern Europe and the former Soviet Union has created powerful barriers to change. In industrial nations similar barriers caused a slow transition from residential care to community-based services. Nevertheless, efforts to overcome these barriers were successful and offer valuable lessons for Central and Eastern Europe and the former Soviet Union.

### Children and Residential Institutions

In the past the countries of Western Europe and the United States relied on residential institutions to care for vulnerable individuals. Until the mid-20th century dependent, neglected, abused, and orphaned children were one of the primary groups to receive residential care. The recent trend in the industrialized world, however, has been away from institutional care. Institutions have been replaced with the increased use of community-based social services for families, kinship foster family homes, and nonkinship foster family homes for children who cannot remain safely with their own families, and small group homes for the most severely troubled children (Tolfree 1995, p. 11).

Many factors, primarily related to cost, contributed to the demise of large residential institutions as a primary resource for the care of children in the United States and Western Europe. Factors included the high cost of institutions relative to foster family homes, the professionalization of institutional staff (which further increased costs), and the increasing needs of the children who were placed in insti-

tutions, (which also increased costs; Jones 1993). More recently, the United Nations Convention on the Rights of the Child, which deemphasizes the use of residential institutions, has become a standard in Western European countries that has contributed to the move away from residential care (Madge and Attridge 1996, p. 145).

### *Impact of residential institutions on children*

One factor that contributed to the decline of residential institutions was the harm they caused to children. However, in the 19th century, criticism of orphanages—and their detrimental effects on children—did not limit the growth of residential institutions. The number of residential institutions, and the number of children residing in them, increased well into the 20th century.

More recent formal studies have documented the harm caused by residential institutions. Research conducted by John Bowlby in 1951 for the World Health Organization began the recent attack on residential institutions. Bowlby reviewed the literature on children deprived of maternal care who were separated from their families—whether in institutions, group homes, or foster homes. He concluded that “when deprived of maternal care, the child’s development is almost always retarded—physically, intellectually, and socially” (Bowlby, p.15). “Neither foster homes nor institutions,” he wrote, “can provide children with the security and affection which they need” (p. 112). He argued in favor of child care for brief periods by foster parents in the child’s neighborhood (p. 111). “Small group homes should always be avoided for children under six years, though it is a suitable alternative under special cir-

cumstances for older children, including the seriously maladjusted child and adolescents who do not readily accept strangers in a parenting role” (p. 137).

Bowlby concluded that as of the 1950s, “even in so-called advanced countries there is a tolerance for conditions of bad mental hygiene in nurseries, institutions, and hospitals to a degree which, if paralleled in the field of physical hygiene, would long since have led to public outcry” (p. 157).

Since then much research has documented the difficulties for children living in residential institutions. These difficulties include the inability to bond with a primary caregiver (close and continuous relationships with trusted adults), the lack of individualized attention, the regimentation of daily activities, the isolation from normal life, and the stigma of living in a facility for marginalized individuals. As a result institutional care has been found to limit children’s ability to bond and form lasting relationships, to delay or stunt their cognitive development, and to prepare them inadequately to live in the broader society (Rutter 1981; UNICEF 1997, p. 64; Tolfree 1995, p. 16; Kadushin 1980). Most studies of the effects of institutions on children indicate that the longer they stay in an institution, the greater is the likelihood of emotional or behavioral disturbance and cognitive impairment (Tolfree 1995, p. 23).

Some research, however, has found that institutions are not harmful to older children; the harm results from the conditions in the institutions. Tizard, Sinclair, and Clarke (1975) identified “child-oriented” and “institution-oriented” residential units that have very different effects on children with learning disabilities. The child-oriented units had more flexible systems of staff deployment, which allowed more continuous relationships for the children (Tolfree 1995, p. 64). Tizard and Rees (1975, p. 98) concluded that “as far as cognitive development is concerned, institutional life is clearly not inevitably depriving.” Thomas (1975, p. 206) studied 36 institutions for dependent and neglected children and found that competency levels of institutionalized children do not differ radically from those of noninstitutionalized children.

Among child advocate organizations there is also disagreement on the effects of institutions. Defense

for Children International concludes that “the use of institutional placements is in itself a form of violence on the child.” Save the Children, on the other hand, believes that “institutions are not intrinsically damaging to children, but the evidence suggests that certain features of institutional care are likely to have a detrimental effect on children’s development” (cited in Tolfree 1995, p. 29).

Kadushin (1980), author of an encyclopedic study of child welfare services, concludes that “for infants and young children, there is really no controversy. There is a general consensus that institutions are undesirable for infants and young children” (p. 133). But “it is difficult to find empirical support for the contention that alternative facilities are more advantageous for the development of children than well-run small institutions”(p. 136, emphasis added).

### *Residential institutions for children in the United States*

The movement in the United States away from reliance on residential institutions for children is illustrative of the international trend. Residential institutions for children in the United States developed as a social phenomenon in the latter half of the 19th century, when the social turmoil and poverty caused by the industrial revolution, the Civil War, immigration, epidemics, and the diminishing role of the family as a unit of production created large numbers of homeless, vagrant, delinquent, orphaned, and neglected children. Residential institutions developed to care for these children at the same time that specialized institutions developed for other populations—the mentally ill, the blind and deaf, and criminals. In 1851 there were only 77 residential institutions for children in the United States. By 1910 there were 1,151, peaking at 1,613 in 1933 (Smith 1995, p. 118).

Residential institutions for children served several functions. First, they removed potentially disruptive children from the streets. Second, they educated and socialized immigrants or the children of immigrants into the mainstream values of the dominant culture. Finally, the institutions provided care and

assistance to vulnerable youngsters. Children's institutions were often run by private religious organizations that were established to care for children of their own denominations. Local, state, and, later, the national government provided an increasing share of the funding for residential institutions.

As the use of institutions spreads, criticism of them increased. Reformers reported widespread abuse of children and other harmful consequences of institutional life (Leiby 1978). Representatives of government and the philanthropic community found these large institutions to be far more costly than the foster homes. The 1909 White House Conference on the Care of Dependent Children marked a national consensus against residential care for children, concluding that children should be helped in their families before being placed in a foster family, and only in the most extreme situation should a child be placed in a large orphanage-type institution (Bremner 1971, p. 365).

Despite this consensus, after the White House conference the number of children in large residential institutions increased for the next quarter of a century, rising from 115,000 in 1910 to 144,000 in 1933. Subsequently the number of children in institutions slowly decreased, falling to 95,000 in 1951, 79,000 in 1962, and 20,000 in 1996. These 20,000 children in residential institutions represent about 4 percent of the 500,000 children in out-of-home placement (Wolins and Piliavin 1964, p. 37; U.S. Department of Health and Human Services 1997).

The decrease in the number of children in large residential institutions occurred on a large scale after the passage of the Social Security Act in 1937, which provided financial assistance to poor families with dependent children (Lerman 1982). Over more than 60 years the number of institutionalized children decreased at an average rate of only 1–2 percent a year. There was substantial institutional and political pressure to maintain these residences. Institutions serving as a source of employment, income, and patronage were most salient and greatly prolonged the reliance on residential institutions for the care of vulnerable children (Wolins and Piliavin 1964, p. 17).

### *Community alternatives to residential institutions for children*

The Convention on the Rights of the Child, adopted by the United Nations General Assembly in 1989 and ratified by almost all nations, established the international standard for the rights of children. Among other provisions, the convention states that families should be the primary caretakers of children and that the best interests of the child should be the primary consideration. The state is obliged to help families care for their children, but when a child must be temporarily or permanently deprived of his or her family environment, alternative forms of care—including foster placement and adoption—should be tried. Residential institutions should only be used, however, “if necessary ... for the care of children” (UNICEF 1991, p. 54, Article 19.3). The Convention on the Rights of the Child has been used by UNICEF, NGOs, and other development agencies as a guiding principle to encourage countries to reduce their reliance on large residential institutions.

Large residential institutions in the United States and in most industrial countries were replaced with four primary modalities of care. The first, and by far the largest in terms of expenditures and children served, particularly in the United States, is foster family care. In the United States in 1933, 58 percent of children in out-of-home care resided in institutions and 42 percent were in foster homes. In 1996, 4 percent were in institutions, 13 percent were in group homes, and 81 percent were in foster families (U.S. Department of Health and Human Services 1997).<sup>1</sup>

Although foster care is an improvement over large residential institutions for abused and neglected children, foster care can also be harmful to children. The placements are temporary, and children are often moved from one home to another, increasing the impermanence experienced by children. Potential foster parents too often are inadequately assessed and at times provide inadequate care or abuse their charges. Finally, children often spend an excessive number of years in these temporary placements. Optimally, children should remain in foster care for no more than a year; in New York City the average placement is for more than four years (*Child Welfare Watch* 1998, p. 15).

The second and preferred approach to creating a permanent home for children is to provide assistance to families so that children can remain safely in their homes. Types of assistance include so-called soft services such as parent training, counseling (family, individual, and group), respite care, drug and alcohol treatment, and in-home assistance. They also include so-called hard services that help with a family's material needs—housing, cash assistance, health maintenance, job training, or job placement.

The use of a third approach, group homes that house as many as 25 children, expanded greatly during the 1960s. Ideally, these facilities should be located in community settings and used as short-term placements for children with special needs—such as older children with behavior problems or physical or mental disabilities. Too often, however, younger children or children who do not have severe problems are housed in such institutions.

Adoption is the final approach used to provide a permanent placement for children who cannot be cared for in their own homes. About 1 in every 100 children born in the European Union will be adopted (Madge and Attridge 1996, p. 148). Adoptive parents may be related to the child, or they may be people who were total strangers to the child. Nonrelative adoptions make up about half of all adoptions and are generally by individuals who were foster parents of the child. Kadushin's (1980, pp. 565, 566) review of the literature on completed adoptions in the United States and other countries through the 1970s concludes that about 65 percent are unequivocally successful and that an additional 18 percent achieve some intermediate level of success; 17 percent are deemed unsuccessful.

### **People with Disabilities and Residential Institutions**

The World Health Organization estimates that the world prevalence rate for all levels of disabilities—mental, physical, or sensory impairments—is 10 percent (WHO 1978). In many industrial countries religious and philanthropic organizations originally established separate schools for people with disabili-

ties. These schools were created for the blind, the deaf, and the mentally disabled. This approach was then typically adopted and extended as part of national education arrangements. Although many of these segregated facilities provided humane care for people with disabilities, some had subhuman conditions, as in the notorious case of the Willowbrook Center for people with disabilities in New York City in the mid-1960s. In recent years, however, the idea of having a separate system for children with disabilities has been challenged—both from a human rights perspective and an effectiveness perspective—and given rise to the notion of “integration for people with disabilities.”

The term integration is sometimes used for all attempts to avoid a segregated and isolated education for children with disabilities. Integration is location- (being present), social (mixing with other pupils), and curricular (learning together with other pupils) (UNICEF 1998a, p. 51). The scope of integration can range from the actual integration of regular and special schools or classes to measures for reducing the outflow from general education to special education.

The principle of integration is contained in the Framework for Action on Special Needs Education, adopted by the World Conference on Special Needs Education and jointly arranged by the United Nations Educational, Scientific, and Cultural Organization and the Ministry of Education in Salamanca, Spain (1994) states:

Integrated education and community based rehabilitation represent complementary and mutually supportive approaches to serving those with special needs. Both are based upon the principles of inclusion, integration and participation and represent well tested and cost-effective approaches to promoting equality of access for those with special educational needs as part of a nationwide strategy aimed at achieving education for all.

In some industrial countries integration is still an unrealized goal. In Germany, for example, many children who are declared eligible for special education are placed in special schools. In the Netherlands almost 4 percent of students aged 4 to 18 attend full-



time, special schools, though recent policy is attempting to change this emphasis. Canada, Denmark, Italy, Norway, Spain, and parts of Australia have made considerable progress in implementing the integration principle.

The culmination of this line of thinking is the concept of *inclusive education*. Instead of emphasizing the integration of exceptional children within a system that remains largely unchanged, inclusive education seeks to restructure schools and classrooms to respond to the needs of all children. Indeed, children with special needs are the stimulus for a richer environment for learning (UNICEF 1998, pp. 51, 52). A primary component of this approach is *community-based education*, sometimes referred to as *community-based social services* or *community-based rehabilitation*. According to a joint position paper by the International Labour Organization (ILO), UNESCO, and WHO (1994), community-based rehabilitation:

Is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. It is implemented through the combined and coordinated efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services. Its goals are to bring about a change; to educate and involve governments and the public; to develop a system capable of reaching all people with disabilities in need; to empower people with disabilities and promote their human rights; and to build that system with resources that are both realistic and sustainable in the national context.

Through this approach it is estimated that up to 70 percent of people with disabilities can receive meaningful rehabilitation in their own communities. Conventional, institution-based rehabilitation services would still play an important role in assessing and referring severely disabled persons for assistance (Jonsson 1998).

Advances in the implementation of this new orientation is difficult, and evidence of progress is limited in most countries. In addition, some argue that

small, specialized units, well integrated into the standard school environment, are a better alternative to give the knowledge, equipment, and support to students for which mainstream classrooms and teachers can never be a full substitute.

Regardless of which approach is used, the trend is toward educating children with disabilities within the mainstream educational environment. In the short run substantial costs may be incurred in moving from a system of separate schools to integrated schools because of the requirements for new facilities and teaching and support staff (UNICEF 1998a, p. 51). In the longer term, however, this approach may lead to lower costs, the improved well-being of children with special needs, and more productive members of society (Simms 1986).

Evaluation is needed to document that the projected cost savings and desired changes in the school system have occurred—including in curriculums, teacher training, examinations, and child-centered methodologies. Unless these elements have changed, the reforms may only result in mainstream dumping.

## The Elderly and Residential Institutions

The elderly are the largest group of people receiving social care in Western Europe (table 3.1). Western European policy responses to the growing need for long-term care among the elderly have taken two main forms, according to a report prepared for the United Nations on lessons from the European Union for Central and Eastern Europe (Walker 1997). The first response has been an increased emphasis on community care that maximizes the use of both formal and informal resources as a cost-effective alternative to long-term institutions. This policy has support from the elderly and the general public in the countries of the European Union. However, recent limitations in the growth of long-stay facilities have not been matched by a comparable expansion in home care or other social services for the elderly. Similarly, social services for the elderly are failing to keep pace with the needs created by aging populations. As a result smaller families are expected to do more at a time when they are less able to care for the elderly.

**TABLE 3.1**  
**Elderly Western Europeans Living Alone, in Institutions, or Receiving Home Care, 1990**  
 (percent)

<i>Country</i>	<i>Living alone</i>	<i>In institutions</i>	<i>Receiving home care</i>
Austria	36.0	—	1.0
Belgium	38.0	6.6	6.0
Denmark	53.0	5.3	20.0
France	28.0	4.5	8.0
Germany	41.0	5.9	4.0
Greece	14.0	0.6	1.0
Italy	31.0	2.3	1.0
Ireland	20.0	5.0	3.0
Netherlands	31.0	9.7	12.0
Portugal	18.0	2.0	1.0
Spain	19.0	2.0	1.0
Sweden	41.0	10.0	16.0
United Kingdom	26.0	5.0	9.0

Source: Baldock and Ely 1996.

The second policy response in Western Europe has been the encouragement of pluralism in the supply of care services for the elderly. This involves assistance from various sources, including the public sector (national and local), NGOs, informal and volunteer support, and church groups. But there are risks associated with this approach. First, increasing welfare pluralism in social care may threaten the current universalism of service provision in some countries. This “piecemeal pluralism” may result in inconsistent care for the elderly based on different assumptions, providers, and eligibility requirements. Second, increasing pluralism could result in the replacement of rights with discretion—leaving the elderly with no voice in a pluralistic system without intervention by the state.

#### *Institutional care or community services?*

A cross-national survey conducted by the U.S. Health Care Financing Administration (HCFA) reviewed long-term care policies for the elderly in 18 industrial countries (as well as some middle-income countries; table 3.2). The findings of this study are relevant for the transition economies of Central and Eastern Europe and the former Soviet Union.

The HCFA survey reported that the most frequently cited long-term policy concern of governments was the high cost of institutional services. Most of the industrial countries surveyed considered their institutional long-term care use rates for the elderly to be higher than necessary. Most also reported pursuing policies to expand home- and community-based long-term care services as a means of reducing institutional use (Doty 1988).

The reported institutional rates in industrial countries varied considerably for elderly individuals—from a low of 3.6 to 4.5 percent in the Federal Republic of Germany to more than twice that rate in Sweden and the Netherlands (see table 3.2).<sup>2</sup> Institutional rates tend to be lower in countries with less generous (that is, means-tested) government financing, representing about half of the countries surveyed. Medical facilities tend to house a larger percentage of the elderly than nonmedical facilities.<sup>3</sup>

**TABLE 3.2**  
**Cross-National Institutional Use Rates for the Elderly, 1980**  
 (percent)

<i>Country</i>	<i>Total</i>	<i>Medical facility</i>	<i>Nonmedical facility</i>
Argentina	<0.1	—	—
Australia	6.4	4.9	1.5
Belgium	6.3	2.6	3.7
Canada	8.7	2.6	3.7
Costa Rica	1.5–2.0	n.a.	1.5–2.0
Denmark	7.0	n.a.	n.a.
France	6.3	5.3	1.0
Germany, Federal Republic of	3.6–4.5	1.2–3.6	0.9–2.4
Greece	0.5	n.a.	n.a.
Israel	4.0	1.4	2.6
Japan	3.9	3.1	0.8
Netherlands	10.9	2.9	8.0
New Zealand	6.3–6.7	2.4–2.8	3.9
Spain	2.0	n.a.	2.0
Sweden	8.7–10.5	4.6	4.1–5.9
Switzerland	7.8–9.0	2.8	5.0–7.2
Turkey	<0.2	n.a.	n.a.
United States	5.7	4.5	1.2

— Not available.

n.a. Not applicable.

Note: Data vary between 1980 and 1984.

Source: Doty 1988.

The use of alternatives to institutional care for the elderly varies greatly among the countries surveyed. The use rates of home nursing services ranged from 30–40 home nursing service users per 1,000 elderly people in Israel, Sweden, and the United States to 164 users per 1,000 elderly in the Netherlands. Home-delivered nursing is a more recent phenomenon in France—included in national health insurance coverage only since 1981. Professional home nursing care in most European countries and the United States is primarily a short-term service for individuals recovering from an acute illness that required hospitalization.

In most European countries nonmedical home and community-based long-term care services are generally characterized as social services. They are administered locally and are likely to be paid for by a combination of central and local government financing. Although eligibility for these services is not means-tested in Scandinavia, income-related co-payments are required. Sliding-scale cost sharing is also required from home-help clients in France, where close to 5 percent of elderly people living in the community received such care (Dotty 1988, p. 152).

According to the HCFA survey, policy initiatives to promote noninstitutional alternatives to institutional long-term care have had limited success. There is evidence from Sweden and other Scandinavian countries that home-delivered services, especially those provided in sheltered housing environments (such as service flats) can reduce use rates of nonmedical homes for the elderly. In Britain there has been an historic association between funding home help and low institutionalization rates (4–5 percent). However, political decisions that limit the availability of beds seem to keep institutional use rates low more than the availability of home and community-based alternatives. As the author of the HCFA survey concluded (Dotty 1988, p.153):

The data suggest—albeit in most cases more by inference than by direct measures—that community-based services complement, rather than substitute for, institutional-level care. Thus, greater availability of public funding for noninstitutional services is not systematically associated with

lower cross-national use rates of institutional care. Indeed, use rates of these noninstitutional services tend to be especially high in those countries that also have above-average institutional use rates (e.g. Sweden and The Netherlands). It is therefore inferred that the populations typically served by home-care programs tend to be more moderately disabled than those in institutions, and most such clients are probably not at imminent risk of institutionalization.

Two factors contribute to the limited success of home and community-based care as a successful alternative to institutionalization for the elderly. One is the insufficiency of the services offered. The kind of intensive (20 hours or more a week, including nights if needed), nonprofessional nursing or personal care required by persons with severe impairments in their ability to perform activities of daily living—bathing, dressing, eating—are typically not widely available in any of the countries surveyed. The second factor is the lack of coordination among providers and payers of medical services and social services. Fragmentation of long-term care services organization and financing is a perceived problem in nearly all countries (Dotty 1988, p. 153).

The lesson for the countries of Central and Eastern Europe and the former Soviet Union, therefore, is that it is not sufficient to create community-based alternatives to institutional care for the elderly. To reduce the number of elderly residing in long-term institutions, it is necessary to provide intensive community-based support and to limit the number of institutional beds.

## Notes

1. Amount does not total 100% due to rounding.
2. When age and sex differences between countries were held constant, the institutional placement rates among countries were found to be less extreme.
3. The data on residential care for the elderly presented for Central and Eastern Europe and the former Soviet Union elsewhere in this study correspond to placements in non-medical facilities.



## CHAPTER 4

# Finding a Solution

As this study has documented, the countries of Central and Eastern Europe and the former Soviet Union increasingly rely on residential institutions as the primary form of care for a growing number of vulnerable children, people with disabilities, and the elderly. This approach is harmful for the individuals who reside in the institutions, undermines family bonds, and is financially costly for government.

The experience in other industrial nations and increasingly in Central and Eastern Europe and the former Soviet Union is that community-based social services are a preferred way to care for and ensure the social protection of these vulnerable groups. Community services are better for the individuals who are served and in many situations may be less expensive for government.

- How can the countries of Central and Eastern Europe and the former Soviet Union make a transition from relying on residential institutions to developing community-based social services? Three interrelated parts are essential to a solution:
- Principles of community-based social services appropriate for Central and Eastern Europe and the former Soviet Union.
- Service modalities in a continuum of community-based care.
- Strategies to implement community-based social services.

### Core Principles of Effective Community-Based Social Services

Community-based services are provided where people live, close to friends and relatives. Ideally, a range

of assistance would be provided at one location in a community.

Community-based services provide individuals with assistance in a comfortable, familiar environment. The people who assist them know the neighborhood, the needs of the community, the services that are available, and how to get them for their clients. Individuals who are assisted in their neighborhoods maintain close bonds with their friends and families, which is important for normal child development and maintenance of healthy adults.

One goal of community-based social services in the region should be to assist individuals and families in periods of difficulty and ensure their safety. These services should also be used to promote independence, not merely to care for those who are temporarily dependent. In the longer term however, when additional resources are available within the region, community-based social services should try to maximize an individual's chances of reaching his or her full potential and be available before an individual's problems become severe.

The principles on which community-based social services are based are key to their effectiveness in achieving these goals. One widely accepted set of principles for highly effective social services was identified by Lizbeth Schorr in the book, *Within Our Reach* (1988). The following attributes of outstanding community-based social service programs are based on her review of exemplary programs for families in the United States:

- Programs that are successful in helping the most disadvantaged children and families typically offer a *broad spectrum of services*. They recognize that social, emotional, and material support may

have to be provided before a family can make use of other interventions such as antibiotics or parenting advice.

- Successful programs provide *services that are coherent and easy to use*. Relying on too many referrals to other agencies interferes with the development of a good working relationship with the client and impedes the delivery of needed services to the individual or family.
- Successful *agencies provide a continuum of services to meet a range of needs to individuals and families*. A continuum of care enables some kind of help to be provided no matter how severe the problem or what type of problem the child or family confronts.
- Interventions cannot be routinized or applied uniformly, *staff members and program structures must be flexible*, able to exercise discretion about meeting individual needs allowing families to choose the services they use and how they want to participate.
- *The child should be seen in the context of the family and the family in the context of its surroundings*. Successful programs mobilize parents in a collaborative effort to help the child, to strengthen the family, and to build the community. These programs offer services and support to parents who need help with their lives so that they can make good use of services for their children.
- Successful programs have skilled and highly committed staff. Staff have the training, support, and time to establish trust and personal relationships with clients.
- Successful programs also *adapt or circumvent traditional professional and bureaucratic limitations as necessary to meet the needs of clients*. Professionals sometimes provide services in nontraditional settings, including homes, and often at nontraditional hours.
- Programs should be *inclusive for individuals with disabilities*.<sup>1</sup> Instead of emphasizing integration, inclusive programming should seek to restructure schools, work settings, and other environments to respond to the needs of all individuals. Individuals with special needs should be regarded as the stimulus of a much richer environment.

### *Service modalities in a continuum of community-based services*

People experiencing difficulties such as unemployment, poverty, and hardships created by the transition to a market economy, require material help—such as cash assistance, food, wood, or clothes. Financial assistance, however, is often necessary but insufficient to meet the wide range of needs that people have. Problems such as alcoholism, child or wife abuse, teenage pregnancy, or juvenile delinquency cannot be solved by financial assistance alone. Other kinds of support are needed.

Poverty is often the context in which these problems surface—and once they appear, poverty makes coping with them much more difficult. Financial assistance to meet the minimum subsistence level of an individual or family is the prerequisite to addressing all other problems (Maslow 1970). Both cash assistance and noncash assistance must be provided to avoid the placement of vulnerable individuals in residential institutions.

Preferably, these services are provided free of charge, because services exclusively for the poor tend to be poor services, and the absence of these services could lead to residential care and much greater expenses for government. For some nonessential services, a sliding-fee scale can be used.

The list of service modalities presented below is not meant to be comprehensive or prescriptive. Rather, it is meant to illustrate the range of community-based social services that could eventually be available as part of a continuum of care to individuals and families and to prevent institutionalization of vulnerable groups. These services can provide some help regardless of the severity of the problems.

Social services can be provided before problems develop, when problems begin to surface or become severe, when problems are overwhelming and one or more individuals must be removed from the home, and as reintegration services to reunite individuals with their families or communities after they have been removed from their homes. Countries of Central and Eastern Europe and the former Soviet Union will likely focus on service modalities for individuals and families after problems begin to surface.

### *Services when problems begin to develop or become severe*

Social service programs should provide services that are tailored to individual needs rather than based on an arbitrary categorization of all recipients. They should provide a wide range of assistance—ideally, a continuum of care—to help individuals regardless of how severe their problems are. All individuals need to have their physical, emotional, and financial situation assessed and served by a case manager to ensure proper assistance.

Children and families may need several types of services, including housing, counseling, child care, respite care, health care, family planning, material assistance, parent training, crisis intervention, alcohol treatment and prevention, job training, and job placement.

Assistance for people with disabilities includes trained teachers, vocational training centers, special equipment, day treatment centers and community schools for children with disabilities, visiting nurses to provide home care, and specially designed, small, and semi-independent living facilities in the community.

The elderly can receive assistance at senior citizen centers where they eat, socialize, receive medical or other help, and work or volunteer. For the frail or homebound elderly, visiting nurses, social workers, and volunteers can help with household chores, cooking, medical visits, and errands.

### *Services when problems are overwhelming and an individual must be removed from the home*

Some community-based services are designed to provide help when problems have become so severe that an individual must be removed from his or her home. Ideally, all of the relevant services above have been offered and tried before an individual is removed from the home. It is obviously preferable to remove the source of the risk in a family—such as a physically abusive father or a dangerous apartment—than to remove a child. Removal of a child or a person with disabilities or elderly person should be the last option considered

#### **Box 4.1**

#### **Types of Community-Based Services**

##### *General (for all individuals)*

- Assessment (of an individual's or family's social, economic, physical, and psychological situation)
- Service plan
- Case management
- Advocacy
- Hot lines, early warning systems
- Transportation

##### *Family support*

- Respite care
- Child care
- Parent training
- Counseling
- Peer support groups
- Homemaker services
- Home visiting (crisis intervention, risk management)
- Domestic violence counseling
- Alcohol treatment and rehabilitation
- Family planning
- Day treatment for troubled children and youth

##### *People with disabilities*

- Inclusive education
- Special education classes
- Sheltered workshops, job training and placement
- Special day schools for children with disabilities
- Rehabilitation (to promote self-care and self-reliance)
- Technical aids

##### *Elderly*

- Senior citizens centers (meals, social activity)
- Home visiting (food, health, household chores)
- Respite care (for caregivers)
- Small-scale enterprises and cooperatives

##### *Out-of-home placement*

- Kinship foster care
- Nonkinship foster care
- Temporary shelter (for battered women and their children)
- Supportive apartments (semi-independent living for children and the elderly)
- Small group homes
- Relocation homes for a family (with supervised, therapeutic treatment)
- Adoption

or tried. Even then, it should be used for a brief period, until the individual can be reunited with his or her family. If reunification is not possible, a permanent solution, such as adoption for children, should be found.

Out-of-home services for children include neighborhood foster care (preferably with relatives), adoption, temporary shelters for battered women and their children, and small group homes in the community. For people with disabilities, semi-independent living programs or small group homes may be helpful. Assisted-living programs or other community-based social care facilities, including skilled nursing care, for the elderly are also options.

There are, of course, limited circumstances in which residential care is the appropriate service modality. Such circumstances include placement for the severely disabled (such as a person in a vegeta-

tive state), the very frail elderly, or adolescents with extreme behavior disorders.

### *Reintegration services*

It is much harder to reintegrate a child with his or her family or community than to prevent the child's removal from the family in the first place. The sooner the child can be reunited with the family, the greater is the likelihood that a permanent, safe, and nurturing environment can be established.

As soon as a child has been removed from his or her home, efforts should be made to ensure regular and frequent contact between the child and the child's family in a safe setting. A range of services should be available after a child is removed and reintegrated into his or her family to assist with the difficult task of reintegrating a child into the family.

#### **Box 4.2**

#### **Lithuania's Community-Based Social Service Pilot Projects**

During the Soviet period the Lithuanian Republic relied on an extensive network of residential institutions—infant homes, boarding schools for vulnerable and gifted children, institutions for mildly and severely disabled children, and residences for adults who were incapable of caring for themselves. Almost 8,000 children, people with disabilities, and elderly lived in such institutions in 1995.

As the transition progressed, new ideas for the care of children with disabilities, as well as neglected children and the elderly, began to appear in cities throughout Lithuania. These new ideas were nurtured by contact with state of the art social work practice and training from Sweden and other countries. Several fledgling nongovernmental organizations, particularly Viltis, an organization of parents of children with disabilities, championed these reforms and lobbied for legislation granting equal rights to people with disabilities. The Ministry of Social Security and Labor, which set policy for residential institutions that housed people with disabilities and the elderly began to implement these reforms.

Even as the new ideas were taking root, the country's GDP dropped by 55 percent between 1990 and 1993, drastically reducing the country's ability to support the growing number of individuals placed in large residential institutions. Although the government began pro-

viding a small cash allotment to poor families, cash alone could not meet many of the social, emotional, or other service needs of at-risk individuals or families.

The government approached the World Bank to develop a project to support the introduction of community-based social services to meet the needs of various groups at risk of placement in long-term residential institutions. A four-part partnership was created to develop and implement the project: the Ministry of Social Security and Labor, the University of Stockholm School of Social Work (supported by the Swedish government), six Lithuanian municipalities, and the World Bank.

The Ministry of Social Security and Labor, through its Department of Social Care, oversees institutions for the elderly and people with disabilities and social services. The ministry was the primary counterpart for the project. The University of Stockholm's School of Social Work (funded by a grant from Sida, the Swedish International Development Agency) organized study tours to Sweden, worked with social welfare staff in the municipalities to design each pilot project, and worked with the Department of Psychology at Vilnius University to train staff for the new programs, to conduct a baseline study, and eventually to evaluate the project.

Each municipality where a pilot project was located agreed to provide a building for its project and to cover



**BOX 4.2 CONTINUED****Lithuania's Community-Based Social Service Pilot Projects**

all recurrent costs (including staff salaries, building maintenance, heat, and transportation) throughout the five years of the project.

The World Bank developed the plan and provided funding to renovate all buildings in the project and to purchase furniture, vans, office equipment, and specialized equipment for people with disabilities. The project cost \$8.5 million—\$3.75 million from the World Bank (loan), up to \$3.2 million from Sida (grant), and \$2.5 million from the municipalities. A \$400,000 grant from the Japanese government funded project development.

During project preparation a competitive tendering process for the community pilots was developed and implemented with foreign technical assistance. Among Lithuania's 56 municipalities, 6 were selected from 16 responses to the tender offer. This was the first tender offer ever conducted for social services in Lithuania.

The selected municipalities submitted 14 pilot projects that became the community-based social services initiative. Each project was designed to be a feasible, cost-effective approach to social service delivery that is community-based and responsive to local needs. Each project was designed to result in fewer individuals placed in institutional care, and thus lower the cost per client served.

The following illustrate some of the 11 pilot projects operating at the beginning of 1999.

*Education centers for children with disabilities in four municipalities (Anyksciai, Moletai, Svencionys, and Utena).* Before these projects began, many of the severely disabled children in the region resided in their own homes, received no education or training, and had very little social contact. They were at risk of being placed in long-term institutions because of the strain on their parents. These four schools now provide daily, individualized education classes to almost 100 children. Vans pick up the children from their homes, take them to school, and return them home at the end of the day. Seven of the children in these centers had been living in large, long-term residential institutions for the severely disabled but are now living at home. Children from the schools in Anyksciai and Svencionys attend classes and share meals and special events with children in the neighboring regular schools. The Utena school has plans for similar integration.

*Shelter for battered women (Vilnius).* A former children's nursery in Vilnius has been converted into a tem-

porary residence for 50 mothers and their children. All the mothers have been physically abused; some are teenagers and others have grown up in a children's home and have children of their own. The project provides social services and helps these mothers find permanent and safe living accommodations and employment. In the first six months of the program, seven mothers and their children found work and a safe living situation. Without such a program, mothers might become homeless and their children might have to be placed in a long-term institution.

*Program for former prisoners (Svencionys).* Individuals who have returned from prison have caused serious problems in Svencionys. This program provides a short-term residence, services, and assistance to find work to eight former prisoners. Without this assistance, former prisoners returning to Svencionys would be more likely to commit new crimes and return to prison.

*Home care for the elderly (Svencionys).* Many elderly in this rural community are frail or homebound. The pilot project provides daily and weekly in-home services for 365 elderly, including counseling, food delivery, home chores, wood cutting, and transportation to medical care. Several years ago the municipality converted a hospital to a long-term residence to care for the rapidly growing number of frail elderly. There was a 35-person waiting list for the residence until the home care program began. Now there is no longer a waiting list.

The different groups served by these programs—the parents of people with disabilities children, the homebound elderly, former prisoners, abused and neglected children, and battered women—have been enthusiastic about the care they have received. The Ministry of Social Security and Labor has been so encouraged by the projects that in 1998, even before the mid-term evaluation began, the government passed legislation providing \$1.25 million for the creation of additional community-based social service projects. Municipalities submitted 143 project proposals; 40 were selected for funding. The government and the European Social Development Fund made additional funding available in 1999. More than 230 proposals have been submitted by municipalities and NGOs to establish additional pilot projects. The Ministry of Social Security and Labor has begun discussions to pursue a follow-on project with the World Bank that would focus on creating elements of a national system of community-based social services to reduce the country's reliance on residential institutions.

Source: World Bank 1997.

## Strategies to Implement Community-Based Services

Many approaches for making the transition from residential institutions to community-based social services have been developed and tried in Central and Eastern Europe and the former Soviet Union. These approaches and others used in other Western nations could be used effectively on a far broader scale throughout the region.

The transition from residential care to community-based services is a long and complex process. It requires careful planning, adequate resources, and an involved constituency. The lives and well-being of many individuals—children, people with disabilities, the elderly and their families, as well as the staff of residential institutions and of the new service programs—are at stake.

Six elements are part of a strategy to reduce the region's dependence on residential institutions. They are not separate strategies but are part of an integrated, comprehensive approach to restructure the noncash social assistance systems of transition economies:

- Changing public opinion and mobilizing community support.
- Strengthening or creating a social welfare infrastructure.
- Establishing community-based social service pilot projects.
- Creating pilot projects to reduce the flow of individuals entering residential institutions and reintegrate individuals into the community.
- Redesigning, converting, or closing individual facilities.
- Creating a national system of community-based social services.

The sequence in which these activities occur is important. Should reform begin with pilot projects that test various approaches, demonstrate their efficacy, and provide the rationale for national legislative reform? Or should legislative reform be implemented first to create the conditions for revising entire systems? Although no one rule applies in all situations, the experience in Central and Eastern Europe and the former Soviet Union appears to be

that formal changes in legislation rarely lead to meaningful change in practice, unless there is broad preexisting administrative support and funding for reform. Those two conditions are rarely met without considerable education of policymakers and administrators, pilot testing of service models, formal and informal evaluation, and changes in public opinion.

Although countries may be at different stages in their willingness to support and fund large-scale national reform, the development of community-based social services should proceed in roughly the following order.

### *Changing public opinion and mobilizing community support*

A multipronged public information campaign should be developed to change the attitudes of the public, policymakers, administrators, and line staff toward residential institutions. The campaign could build and nurture the region's reliance on families and local communities—an approach that was deemphasized under command economies.

Such a campaign might begin with a national or local survey to assess the reasons people support the use of boarding schools, infant and children's homes, social care homes for the elderly, and institutions for people with disabilities. A series of messages for the campaign might emphasize that:

- Children, people with disabilities, and the elderly can thrive and grow with the support of family and the community.
- Children, people with disabilities, and the elderly are often harmed by living in residential institutions.
- Most children in such institutions are not orphans but have families who would care for them if assistance were available. Many of the elderly could also remain in their homes with assistance.
- Alternative ways to help children, families, people with disabilities, and the elderly are available and may soon be created within the country.

A public opinion campaign could be conducted as a collaboration among national and local governments, NGOs in the field, and donors. Ideally a grassroots effort in Central and Eastern Europe and the

former Soviet Union would rely on local constituencies such as women's organizations, organizations of parents of children with disabilities, and NGOs involved in community development. Such a campaign will not only begin to change attitudes but will mobilize these groups as allies in efforts to develop community-based social services for vulnerable groups.

In Armenia, for example, a public information campaign has begun on a national level that describes the harm of residential care and the benefits of community services. In Hungary a public awareness campaign was developed in Debrecen and Pecs at the community level that emphasizes the value of community integration for children with disabilities. One important vehicle for such a campaign is the United Nations Convention on the Rights of the Child as well as other human rights conventions, which have been signed by all countries of the region. In Romania, for example, the Convention on the Rights of the Child has contributed to changing public opinion and the attitude of policymakers on children's rights, the rights of people with disabilities, and the role of residential institutions. Advocacy and promotion of human rights, including children's rights and the rights of people with disabilities, will help move the social consensus toward more effective ways to help vulnerable groups.

### *Strengthening or creating a social welfare infrastructure*

Social work schools are needed to train staff in residential institutions, local social assistance offices, new community-based social service programs, and the bureaucracies that oversee all these programs. In recent years basic social work programs have been created in several transition economies, with some success. These programs are often in departments of psychology, sociology, or social pedagogy, while staff training centers continue to be located in departments of defectology within schools of pedagogy.

Many programs could benefit, however, from additional study tours, technical assistance, and training in basic social work skills and specific service modalities. They could also benefit from collab-

orating to provide training or research to create new social service programs, as is being done in Lithuania. Personnel from local universities could work in collaboration with advisers from external schools of social work, child development, special education, or other disciplines. The participation of these nascent departments of social work could both strengthen their capacities as well as enhance the quality of social work in the community. Some countries, however, still require initial investments and local capacity building in social work education. NGOs, working in close cooperation with the public sector, should also be a vital component in a new, effective social welfare infrastructure. The development of these organizations needs to be nurtured, and their cooperation with and support by government need to be encouraged.

### *Establishing community-based social service pilot projects*

There are many advantages to using pilot projects to develop a network of community-based social services:

- The flexibility to test a wide range of approaches—service modalities, organizational auspices, geographic locations).
- Opportunities to identify and correct inappropriate approaches and mistakes made on a small scale.
- Time and data to gain popular support to carry out the project on a larger scale.
- Limited investment and risk by donors.
- The opportunity to initiate a policy dialogue.

Pilot testing can lead to the development of the most cost-effective service models for a country. The main disadvantages to pilot projects are that they reach only a small portion of the population in need of assistance, and the policy environment is not necessarily changed as a result of the projects.

A community-based pilot project can be created that provides a specific service to a specific group of clients (such as home delivery of food to the elderly) or that provides a range of services to different groups of clients (such as a multiservice center). Programs that provide a range of assistance are preferable

because they serve many individual needs and can be located in a variety of settings—in a free-standing service center (such as a multi-service center or a family service center) or in a larger organization (such as a government social assistance office, a general school, or a polyclinic). Community-based social service programs should be operated by municipal or regional government agencies or NGOs, preferably close to the point of service delivery. The most effective and sustainable service programs are based on citizen participation, including family members, direct consumers of service, and professionals.

Many strategies could be used to identify the municipalities or regions where community-based social service pilot projects should be located. One approach is a national tender offer, as in Lithuania, for which a ministry might establish broad guidelines for municipalities to develop service programs. Each project could operate as a collaborative, cost-sharing effort by the government, municipalities, donors, and NGOs.

A second approach is to establish pilot projects in municipalities where residential institutions are located. This approach may increase the likelihood that a social service program will be targeted to individuals who are more at risk of institutionalization or who are already living in a residential institution. Pilot projects should also be developed in municipalities without residential institutions, because these municipalities place residents into institutions in other localities.

An essential element to creating successful projects is frequent, ongoing training and supervision. In Lithuania, for example, in addition to study tours and formal classroom training, a team of social work experts visited the project sites every two to three weeks during the two years the pilot projects were being established.

*Creating pilot projects to reduce the flow of individuals entering residential institutions, protect the rights of individuals in institutions, and reintegrate individuals into the community*

The protection of the rights of individuals who are already institutionalized should be one of the first

areas of focus of a reintegration program. One of the rights ensured by international human rights law is a right to community integration for children with and without disabilities. As social service projects begin to provide alternatives for individuals at risk, pilot projects should be established that reduce the number of individuals entering residential facilities and increase the number returning to the community. This approach was used by UNICEF and others in collaboration with local governments in Romania. This can be done by developing new standards for placement and working with the local referral agency to use those standards as prerequisites to placement. Additional approaches include developing a system to assess individuals' strengths and needs, using individualized service plans, and retraining staff to work on reintegrating children or people with disabilities into the community. As noted however, it is far more difficult to reunite a person with his or her family once those bonds have been broken and the individual has been placed in residential care. For this reason the reintegration programs in the region have had only limited success.

*Redesigning, converting, or closing individual facilities*

Most staff in residential institutions are untrained in social work, child development, child psychology, or special education. Staff and oversight personnel in residential institutions should be trained in the value of family upbringing and the limitations of residential care. Such staff are often eager to receive training that may both improve the way they care for children and give them additional marketable skills. A local university can provide training with consultation from external advisers who have experience in social work and in reducing reliance on residential institutions in their own countries.

Alternative employment can be found for staff in residential institutions. One option is to redeploy educators and child care personnel who work in boarding schools. As community services are created and the population of residential institutions decreases, staff could be reassigned (on a voluntary basis) to work in a community service program that

reintegrates children from boarding schools into the community.

In addition, residential institutions can be redesigned to allow staff to focus on reintegrating children into the community. Sites can be redesigned to create smaller, semi-independent units housing for no more than 15–25 children. These group homes should be used only for children over 6 and only in cases of severe disability or behavioral problems.

Finally, alternate uses for institutions can be found. In Hungary part of a children's home has been converted to apartments for young mothers and their infants. In Armenia part of a boarding school has been converted to apartments for refugees. In Romania part of an infant's home was converted into apartments for mothers and their children. In Lithuania plans are being developed to convert part of a children's home to rooms for mothers and their children to stay during a family crisis. Many groups of vulnerable individuals—single mothers and their infants, battered women and their children, refugees, former prisoners—in the region could benefit from short-term stays in redesigned residential institutions. The risk, however, is that short-term facilities have a tendency to become long-term residences if people are not reintegrated into their homes and communities.

### *Creating a national system of community-based social services*

After pilot projects have been tested and redesigned to best address community needs, programs can be implemented nationwide. National legislation and public policy should focus on:

- *Restricting the use of residential institutions.* In few situations some individuals—disturbed older children, severely disabled children, or frail elderly persons—will require placement in residential care. Prerequisites and standards should be created to ensure that only severely and permanently vulnerable individuals are placed in residential institutions—and only after community-based alternative services are offered, provided, and unable to remedy the individual's risk of harm. These criteria should also be used to determine

who, with assistance, could be reunited with their families.

- *Improving the care in residential facilities.* The quality of care in residential institutions could be improved by developing individual service and treatment plans, focusing on reintegrating individuals into their families and communities, and creating smaller residential units. International human rights laws provide a primary framework for these changes.
- *Creating alternative ways to assist vulnerable groups in the community.* Legislation should authorize and fund localities to provide the range of essential services—including social work, material assistance, special education, home care, foster care, and adoption. In most cases a national ministry will need to initiate efforts to create community-based social services, such as a ministry of social security that establishes national policies and guidelines for social services. Ideally, an inter-ministerial working group, including NGOs and advocates of children, people with disabilities, and the elderly, should lead the effort to create community-based social services. The reform efforts should also be integrated and coordinated across sectors, including education, health, employment, and social services sectors.
- *Ensuring quality and specialized services.* A broad continuum of high quality services should be available as a human right. Specialized, qualified human resources at all levels need to be developed to staff and sustain these programs. Such services would include, for example, staff in schools or assessment centers that make the decisions to refer children or others to community services or residential care.
- *Ensuring sustainability through long-term funding for recurrent costs.* Donors generally provide investment funds for civil works, equipment, furniture, technical assistance, training, and perhaps short-term salaries for specific projects. Recurrent costs for salaries, utilities, supplies, and other ongoing expenses must be provided locally—generally by a level of government. Without a secure source of funds for recurrent costs, projects will end when donor participation ends. In Central and Eastern Europe and the former Soviet Union many excel-

lent community-based social service projects have been suspended because long-term funding was not secured.

Recurrent costs can be provided in a variety of ways. A municipal government may agree to fund recurrent costs (either initially or after the cost-effectiveness of the pilot project has been demonstrated) in exchange for the creation of a pilot project in its city. The national government may agree to allocate additional resources so that a series of pilot projects can be created. Staff lines and other expenses might be reallocated from residential facilities (as the number of staff needed decreases). Armenia is considering such an approach. In some situations a sliding-fee scale for services may provide a portion of the funds needed for recurrent costs.

- *Eliminating the financial incentive to use residential institutions.* Current funding streams create a financial incentive for local governments to reduce their expenses by placing vulnerable individuals in residential institutions that are funded by a higher level of government. Shifting the financial incentive from residential institutions to community-based social services can be achieved by having “money follow the client.” In this approach, which may be tried in Latvia, localities receive one allocation from the national budget to be used for social services or residential care on a per client basis. Localities must pay all or part of the cost for each individual placed in a residential institution or receiving social services. Because community-based social services are less expensive than residential care, this approach creates an incentive for community care.
- *Making evaluation a central component of a national social safety net.* Pilot projects and systemwide reforms must be evaluated to identify strengths and weaknesses, improve program designs, and provide documentation to assess whether a program should be expanded, replicated, or established systemwide. Project evaluation is also a necessary component to ensure that the service system is accountable to the people who are served, the public and donors who fund it, and the staff who work in it.

Project evaluation should begin with a baseline study to examine the composition and needs of vulnerable groups and assist policymakers. A baseline study can also use socioeconomic and social service conditions as a basis for comparison with other evaluations at important stages of intervention. Multiple pilot projects in Lithuania are being assessed in this way.

There are, however, many ways in which a program may achieve positive results that are not easily measured through program evaluation. For example, the quality of life of a person with a disability may improve through increased social contact, but this subtle improvement is difficult to measure. Case studies that illustrate such changes should be gathered in areas that are not easily quantifiable.

### **Increased Demand and Additional Resources**

One key element that should be evaluated is the cost-effectiveness of community-based social services relative to residential care. Community services are likely to be less expensive on a per client basis than residential care. A simple cost-benefit analysis to compare the recurrent cost of residential care with the recurrent cost of community social services can demonstrate the relative cost of the two approaches.

Several factors, however, limit the actual savings that government will accrue by using community social services. First, creating alternative social services requires an initial investment in capital, staffing, training, and other resources. Second, government savings from the use of community-based social services are likely to accrue only after the number of individuals in a residential institution decreases. Savings may not be substantial until a residential facility is closed or an alternative use is found.

Finally, and most important, new services generally increase the number of individuals who receive assistance. Residential institutions serve only a small portion of vulnerable individuals. Community social service would assist not only current recipients (the institutionalized) but also many others who previously received no assistance.

Thus the target population for community-based services would be significantly larger than those individuals who receive residential care. The increase in the number of recipients provides much-needed assistance to previously unserved people but will require additional resources beyond the money saved by closing residential institutions. Ultimately the focus of assistance should be to prevent the underlying causes of institutionalization—unemployment, poverty, and social exclusion of ethnic minorities, people with disabilities, the elderly, and other vulnerable groups.

### *Risks*

There are three salient risks to reducing the region's reliance on residential institutions. The first is that vulnerable individuals could be forced out of residential institutions before community services are available to assist them. The United States failed to provide alternate housing when the mentally ill were deinstitutionalized in the third quarter of the 20th century, contributing substantially to the homelessness of the mentally ill.

A second risk is creating inadequate community services. Staff may not be well trained, and services may not fully address an individual's problems or material needs. This risk can surface when successful, carefully nurtured, small-scale pilot projects are replicated or expanded.

A third risk is that projects may not be sustainable. Governments change, priorities shift, resources decrease, or a different level of government becomes responsible for the project and may not treat it as a priority. These changes can profoundly affect financial sustainability, programmatic integrity, and staff continuity.

Risks can be mitigated with careful, continuous planning, adequate funding, and, most important, with an active constituency that is involved in the decisionmaking for these services.

### **Note**

1. This principle is not included in the list developed by Schorr (1988) but reflects views in ILO, UNESCO, and WHO (1994).





## CHAPTER 5

# Conclusion

Ten years have passed since the Berlin Wall fell and the conditions in residential institutions in Central and Eastern Europe and the former Soviet Union became known to the world. The most vivid images from this period were the shocking pictures of children with disabilities in residential institutions in Romania. The worst of these institutions were improved to provide for basic material needs, yet roughly 100,000 children still live in residential facilities in that country—similar to the number soon after the transition began.

During the transition a more extensive and intractable problem of residential care has appeared. Residential institutions are the main type of assistance for vulnerable children, people with disabilities, and the elderly who experience severe difficulties. Many of these children remain in institutions throughout their childhood, people with disabilities remain throughout their lives, and the elderly remain until they die. Residential institutions are costly for governments and destructive to the individuals who live in them. As the director of one infant home said, “The infants arrive healthy and leave disabled.”

As the economic and social conditions in Central and Eastern Europe and the former Soviet Union deteriorated, more people were placed in these institutions. Today at least 1.3 million people live in 7,400 institutions in Central and Eastern Europe and the former Soviet Union. The conditions in most of these facilities are worse today than they were 10 years ago. Unfortunately, the well-intentioned work of donors to improve conditions in residential institutions reinforced the reliance on them. Community-based social services that are cost-effective in industrial nations are still uncommon in the region.

A few seeds for such a change have been planted. Multinational donors (the World Bank, the European Union, UNICEF), and individual nations (Sweden, Denmark, the United States), and NGOs (Save the Children, Caritas, International Social Service) have worked with the governments of the region to create community-based social service programs. These efforts build on global best practices to prevent institutionalization and to reintegrate individuals into the community. The preliminary results of these programs are encouraging—people are able to remain safely with their families at a cost similar to or less than that for institutional care.

These programs, however, operate on a small scale, generally covering only parts of a few large cities. Hungary, Lithuania, Poland, and Romania are among the few countries in the region that are developing or planning for national systems of community-based services as a primary way to prevent institutional placement. Existing pilot programs need to become the first steps of a longer process of creating national systems of high quality community care for vulnerable individuals.

Donors, governments, and NGOs should further reduce the region’s reliance on residential institutions and increase the use of community-based services. This study presents a six-part strategy to make that transition. The strategy begins with public information and pilot projects and concludes with the transformation of national laws, funding, and uses of institutions. In the short term it is a costly strategy. Although on a per client basis community services are far less expensive than residential care, such services should be provided to the much larger group of vulnerable people who have

the same problems as those living in institutions but who receive little or no help. Whereas just 1–4 percent of vulnerable children, people with disabilities, and elderly individuals in the region live in residential institutions, far more live in poverty, are neglected or abused, and receive little or no help.

A paradigm shift that focuses on the larger group of people in poverty and prevents the causes of institutionalization is needed. A prevention strategy needs to attack the causes of poverty and provide

assistance to individuals and families before problems develop or become overwhelming.

The strategy also carries the risk that deinstitutionalization will occur without preestablished community-based services or long-term support. But if national systems are not created to care for individuals housed in residential institutions, the medium- and long-term costs and risks are likely to be even greater. More children will become homeless when they leave institutions, more healthy children will become disabled by institutions, and vast human resources will be wasted.

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