This paper forms part of the background documentation resulting from the ongoing research project "Public Policies and Social Conditions: Monitoring the Transition to the Market Economy in Central and Eastern Europe" (MONEE), coordinated by Giovanni Andrea Cornia and Gáspár Fajth.

* Status of Women, Ottawa.

The views expressed in this paper are those of the author. They do not necessarily represent the views of the UNICEF International Child Development Centre.

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EXECUTIVE SUMMARY

When the needs of children cannot be met by those responsible for their care, the state recognizes its responsibility to intervene and assure their safety and development. Under the totalitarian regimes governing in Central and Eastern Europe prior to 1989, many children were removed from their families only to meet with a fate which was not much better than the conditions from which they were being saved. This was largely due to the underlying state ideology which contributed to the adoption of a "medical model" of care. As a result, many children were subjected to treatment which unnecessarily inhibited their normal growth and development. Rather than trying to understand the root causes of the child's problems and deal with these, the child's symptoms were classified according to various criteria and the "treatment" followed, devoid of the sensitive attention which children require in order to thrive.

In Poland, Hungary and the former Czechoslovakia, a few enlightened paediatricians and child psychologists led a reform movement away from the medical model. Their efforts improved the quality of institutional care to the extent that in these countries there evolved a model of care distinct from that in Albania, Bulgaria, Romania and the other countries of the Communist bloc.

This paper describes the child protective care systems, the types of care, the number of children and the conditions of institutions. The desperate conditions under which children found themselves and the violation of their rights are documented. Where possible, changes since 1989 have been tracked.

Under the socialist regime many risk factors prevailed that led to the removal of children from their homes. The paper outlines the structural causes underpinning this situation, including deteriorating social and economic conditions and a value system which undermined family bonds, fostered dependency on the state and "disempowered" individuals. These root causes brought about a host of immediate causes ranging from poverty to poor nutrition, to dire living conditions, illness, failed abortions, stresses in the school system and environmental degradation. The socialist system's full employment policy proved detrimental to children's health for a number of reasons tied to occupational hazards for mothers and inordinate job stress for parents and extended families. The strains of everyday life under the Soviet system also brought about grave social dysfunctions such as alcoholism, delinquency, family breakdown and high numbers of school dropouts.

After 1989 the legacy of the pre-Soviet regimes remained a problem. The rapid transition brought about by the market economy further accelerated social unravelling, and children bore the brunt of society's disintegration.

The social, economic, political, moral and spiritual collapse which followed is without recent precedent. Children suffered and continue to suffer as the systems which were once set up to serve them have failed them again. Ever-widening cracks are appearing, and children and youths are falling through them in ever-growing numbers, as evidenced by rising rates of child poverty, youth unemployment, homelessness, alcohol and drug abuse, prostitution, crime, disability, disease and death. These are uncivil times in an uncivil world.

UNICEF's task is clear. It must deliver a firm message to the West that these problems and their solutions belong every bit as much to it as to Central and Eastern Europe. It must assure that no more babies and infants suffocate from deprivation on cold iron cots in sterile institutions. It must drive a firm wedge between civility and barbarism and allow no one to cross it.
I. INTRODUCTION

In most societies primary responsibility for the protection of children goes to parents. When the growth and development of the children cannot be assured in this way, the state recognizes its duty to step in. A wide range of options is available to authorities, including state-supervised parental care, adoption, foster care, institutional care and various combinations thereof (see the next page).

Examples of each of these types of care can be found in Central and Eastern Europe. However, in most countries institutional care prevailed under the totalitarian regimes which dominated until 1989. The underlying state ideology encouraged the adoption of a "medical model" of care. As a result, many children were removed from their families and subjected to treatment which unnecessarily inhibited normal growth and development. Efforts have been made since then to create a more humane and sensitive child protection system.

This paper attempts to:
- Describe protective care systems in Central and Eastern Europe.
- Document the number of children in Central and Eastern Europe in protective care by the type of care they receive.
- Explore the risk factors associated with children being placed in protective care.
- Analyse the way changes in public policies and social conditions since 1989 have affected these risk factors.
- Describe the policy responses in Central and Eastern Europe before 1989 toward children in need of protective care.
- Detail changes in protective care policies since 1989.
- Evaluate the effectiveness of the changes.
- Examine factors hindering the implementation of new policies.

The next section offers a description of the protective care systems in the region. The picture which emerges is a summary of the typical situation. It does not fully capture the many variations which exist among countries; however, it does permit a general understanding of the difficult circumstances facing many children.

The next section also attempts to document the numbers of children in the different types of care and ways in which this has changed since the beginning of the transition. Given the lack of consistency of the definitions among the countries and the large discrepancies in the data, it is often difficult to establish a clear accounting. For the most part, the numbers quoted are those reported to the UNICEF "MONEE" project by Ministries of Statistics.
TYPES OF PROTECTIVE CARE

Various models of protective care have evolved around the world to meet the needs of children. It is generally accepted that children ought to grow up within their "natural" families and that families in difficulty should be supported in the care of their own children within their own homes. In instances where it is not in the child’s best interests to remain in the natural family setting, efforts should be made to assist the family and child so that the child can return safely to the family as quickly as possible. When this cannot be accomplished, a permanent substitute family should be located.

In general, protective care models may be clustered under four main headings: state-supervised parental care, adoption, foster care and institutional care.

1. Through state-supervised parental care, parents maintain custodial rights over their children, but receive assistance in the provision of care.

2. Adoption is available for children whose custodial parents—normally the biological parents—have died, or relinquished their parental rights, or had their parental rights permanently revoked by the state. Adoption grants permanent custodial rights to the adoptive parents. In most cases, all ties are severed with the biological parents; however, there are exceptions. Adoption is considered the best option for children who cannot remain in their families due to unsolvable problems. It gives children the chance to form stable, lasting relationships. Adoption by families of the same or similar cultural heritage is considered best, and adoption within the child’s country is preferred to adoption by parents from another country and cultural background.

3. Foster care is available for any child who does not meet the criteria for adoption or is waiting to be adopted. Custodial rights are temporarily granted to the child’s guardian. Foster care may be of short duration, while a crisis situation in the child’s family is being resolved, or it may be of long duration, sometimes approximating an adoptive relationship. When a child has serious difficulties, therapeutic foster care in a family or a group setting can help. Foster care may take place in a family setting, among relatives of the child, friends of the family, or people unknown to the family, or in small family-like group homes or clusters of such homes. Siblings are often placed in the same foster home. In group homes children of different ages are gathered in family-like groups where sibling-like relationships are formed. Foster care is considered a "next best" option for children, because it allows children to grow up in a relatively normal situation, with adults who take on the role of parents, sometimes on a permanent basis. Most Western nations have closed large childcare institutions in favour of individual or group home foster care.

4. Institutional care should be considered a last resort. Many studies (Dunovský 1989, Kovařik n.d., Tobis and Vitello 1994) have documented the harmful effects of institutional life on the growth and development of children. Only children who cannot adapt to the family should be considered candidates for institutional care. Smaller institutions with long-term care-givers are preferable to large, anonymous institutions with high staff turnovers. Institutions which group children in sibling-like age ranges are preferable to those that segregate children into large groups of similar ages.
II. PROTECTIVE CARE SYSTEMS

The approach taken in the protective care systems of Central and Eastern Europe under socialism was essentially a medical one. Children identified as being in need of protection were removed from their families for assessment. Once a diagnosis had been made, a clinical decision followed, and children were placed, for the most part, in institutions deemed appropriate to their particular case.

Like any other social "problem", these children were treated as a blight to be removed, for under socialism no social problems could exist. It was also in keeping with the socialist principle of removing responsibility for children from families and giving it to the state and of devaluing anyone different from the norm. Rather than trying to understand the causes of a child's difficulties and deal with these, the child's symptoms were classified according to various criteria, and a "treatment" followed.

Thus, children suffering from malnutrition were diagnosed as sick children rather than children whose nutritional needs could not be met because the parents were too poor, were misinformed about child nutrition, or had used up the family food budget buying alcohol. On the basis of this diagnosis, malnourished children were placed in dystrophic hospitals.

The system did not allow social assistance to be given to the parents so that they could afford an adequate and balanced diet for the children, nor did it offer parenting classes on proper and nutritious diets for children, or substance-abuse counselling for the parents. The problem was the child's problem. The child was the problem.

In a similar fashion, children with physical, mental or learning disabilities, or with difficulties because of behaviour or delinquency, or those suffering from abuse, neglect, abandonment or orphanhood were placed in institutions fitting the diagnosis. This included an array of possible "homes": for the disabled or "unrecoverable", for the reeducation of problem or delinquent children, for "social" orphans, as those suffering from abuse, neglect or abandonment were termed, or for "real" orphans.

However, unlike homes which nurture, which allow children to grow and develop and blossom to their fullest potential, where love and warmth and caring envelop the children and meet their every need, these homes were cold, sterile medical buildings where a child had a number rather than a name and a problem rather than a complex set of basic and essential needs. In these environments children shrivelled and shrank, and some faded away. It seemed that no one cared.
A few enlightened paediatricians and child psychologists in the former Czechoslovakia, Poland and Hungary did care. They realized that children could not develop normally in these circumstances and certainly would not flourish. Under their guidance a reform movement slowly gathered momentum during the 1960s, successfully lobbying for an alternative system where children could grow within the warm embrace of their own families or substitute families.

As a result, in Hungary and Poland and to a lesser degree in Russia and the former Czechoslovakia, rather than removing children in difficulty from their families, the state monitored their condition and treatment. The state remained ready to step in and remove the children if the situation deteriorated to a point where the children were placed at great risk. Foster care also took hold, notably in Lithuania, Russia, Belarus, Poland and Hungary, but it never replaced the medical model of institutional care that prevails in many of the countries to this day.

Since the onset of the transition, the shift away from institutional care has continued, with an increasing share of children in the protective care system being monitored by the state, or cared for in foster homes. Adoption is a solution for only a very small proportion of children in protective care in all countries but Bulgaria. (However, the large and growing number of adoptions in Bulgaria may include children being cared for in foster homes.)

These developments may reflect positive policy changes, with a new emphasis on supporting families to care for their children in their own homes. On the other hand, they may also reflect the fact that the breakdown in the social infrastructure and the rising costs of running, maintaining and repairing state institutions have brought about the collapse of the system which once identified and removed children from their homes and the fact that now these children are being left in potentially abusive or otherwise harmful home situations.

In Bulgaria, for example, only 45.5 percent of the 40,000 children identified as being at risk are served by state institutions, and children, especially gypsy children, are being abandoned at railway stations and other public places (Vaitshev n.d., Tassev 1994). Mounting homelessness and vagrancy among children and youths have been reported in all countries. Reports from Albania indicate that the number of abandoned children is growing rapidly (Fajth 1994a).

It is alarming that despite the worsening social and economic conditions throughout the region the overall rate of protective care has gone up only in Bulgaria, Hungary and
Russia since the beginning of the transition. In all other countries it has remained relatively constant or declined.

These recent trends raise serious concerns about the situation of children, more and more of whom are facing increasing risks to their health, safety and well-being. Reports of rising hospital emergency admissions because of child beatings, soaring child and youth mortality rates due to accidents and violence, higher suicide rates among youths and growing numbers of murdered newborn babies testify to a system gone wrong (Fajth 1994b, UNICEF 1994, Romanowska 1992).

**Children in Protective Care**

While it is clear that the number and proportion of children in protective care in Central and Eastern Europe are high, it is difficult to arrive at accurate estimates. The reported numbers vary from source to source. Sometimes data refer to the "stock" of children in care and other times to the annual "flow" of children into the various types of care. The accounts are often incomplete; sometimes incarcerated children are included, other times not, and definitions vary. For example, the distinctions between foster care and adoptive care and between foster care and institutional care in group homes are often blurred, and "child monitoring" is not always synonymous with state-supervised parental care.

Among those countries with a relatively thorough reporting system, Hungary has the highest rate of protective care. In Hungary in 1993 approximately 13 percent of children under 18 were reported to be involved in some kind of protective care, up substantially from 6 percent in 1989. In the other countries of the region, between 1 and 2 percent of children were reported to be in protective care in 1993, basically unchanged since 1989.

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1. The *models of care* differ greatly among countries. For example, in Hungary most children in protective care are monitored by the state in the homes of families or guardians. In 1993 nearly 93 percent of children in protective care were being monitored, up from 82 percent in 1989. This reflected a 250-percent increase in the monitoring "rate" per 10,000 children—from 493 in 1989 to 1,235 in 1993—following the acute deterioration in the welfare of many families during the transition. Nonetheless, among children removed from their homes, institutional care predominates, so that Hungary has one of the highest rates of
institutionalization in the region, despite a drop in the rate from 74.6 in 1989 to 57.8 in 1993. Foster care is slowly gaining ground, with rates rising from 33.1 in 1989 to 34.3 in 1993.

While the majority of children in the child protection system in Poland are also monitored by the state, the rates are much lower than they are in Hungary. In 1992, 64 percent of children in care were being monitored, down from 67 percent in 1989. (In Poland, "monitoring" may include restrictions by the state on the authority of parents.) This reflects both a drop in the rate of children being monitored per 10,000 children—from 131 to 121 between 1989 and 1992—and an increase in the rate of foster care. In fact, Poland has shied away from institutional care in favour of foster care for children removed from their homes. In 1993 children were much more likely to be in foster care than in institutional care, a considerable shift from the situation in 1989. In 1993 the foster care rate was 36.7 per 10,000 children compared to 26.4 for institutional care. The relevant rates in 1989 were 33.8 and 28.6.

Russia has also moved away from institutional care and toward foster care and, to a lesser extent, state monitoring (which, in Russia, may encompass children being brought up by "tutors" or guardians). In 1993 nearly 40 percent of children in protective care were in foster homes, up from 36 percent in 1989. Children in institutions accounted for just 22 percent of children in protective care, down from 25 percent in 1989.

In Romania institutional care predominates, such that children are being institutionalized at a pace close to two times higher than they are in countries, like Hungary and Lithuania, with the next highest rates of institutionalization and around five times higher than they are in the countries, like Poland and Slovenia, with low rates of institutionalization (Table 1). No other form of protective care was reported in Romania, so it is difficult to understand clearly the change in the importance of foster care, adoption and state monitoring in the overall protective care system. Nonetheless, the rate of institutionalization per 10,000 children dropped from 130 to 119.4 in 1990-3, indicating that there has likely been a shift to other forms of care.

Other countries, such as Lithuania and the Czech Republic, also have a large but decreasing proportion of children in care living in institutions. In Lithuania the proportion of children in care living in institutions dropped from 62 to 53 percent between 1989 and 1993. In the Czech Republic between 1989 and 1992 the proportion fell from 47 to 43 percent. A rise in foster care in Lithuania and state monitoring and foster care in the Czech Republic contributed to these downward trends. Meanwhile, the rate of institutionalization per 10,000
Table 1: The Rate of Institutionalization of 0-to-17-Year-Olds*  
(Per 10,000 Children in the Age Group, Rounded, 1989-94)

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Source: MONEE Database.  
* The criteria may vary among countries. In Russia, for example, children in detention are not included.

children declined in Lithuania from 74 to 63.5 between 1989 and 1993, and in the Czech Republic from 56.2 to 50.3 between 1989 and 1992.

In Bulgaria the share of children in institutions among all children in care moved down from 78 to 70 percent between 1989 and 1993. Advances in adoptions and state monitoring affected this trend. The dip occurred despite a climb in the rate of institutionalization per 10,000 children from 58.4 to 62.8 in 1989-93. However, the figures are questionable to the extent that in Bulgaria "monitoring" rather than "institutionalization" appears to include children in homes for juvenile offenders and in other special schools. The "monitoring" rate per 10,000 children mounted from 11.2 to 15.7 between 1989 and 1993.

2. Private adoptions occurred in all countries before the transition. For the most part those adopted were true orphans whose grandparents or other relatives adopted them following the death of the parents. "Social" orphans (children abandoned by parents in institutions) accounted for around 95 percent of all children in institutions; they were rarely adopted.

This changed after 1989, when international adoptions began to soar, resulting in sharp increases in the rate of adoption in some countries, despite plunging fertility rates (Table 2). In Latvia, for example, the sudden jump in the rate of adoption of 0-to-17-year-olds...
Table 2: ANNUAL RATES OF ADOPTION OF 0-TO-17-YEAR-OLDS
(Per 10,000 Children In The Age Group, Rounded, 1989-94)

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Source: MONEE Database.
* Adoption figures likely also include children in foster care.

per 10,000 in the age group from 1.8 to 15.7 in 1991-2 was most likely due to a surge in international adoptions. The following year the rate returned to 2.8. Similarly, increases in the adoption rates in Bulgaria in 1992-3 likely also reflect more international adoptions; the adoption rate rose from 4.4 in 1991 to 10.1 in 1992 and 10.9 in 1993. Estimates of the number of international adoptions in Romania confirm these findings. An estimated 2,951 Romanian children were adopted internationally in 1990, while the corresponding figure in 1991 was 7,328 (Zugrăvescu 1992).

As a result of these trends, laws were quickly amended or enacted in most countries to stem the tide of children being taken out of the country in what amounted to wholesale trafficking (see later).

In general, the number of children adopted represents only a tiny proportion of the children in need of protective care. With few exceptions this proportion has been falling since the onset of the transition. For the most part, this is because the rate of adoption, apart from a few short-term surges likely due to international adoptions, has been stable or declining.

Only in Bulgaria and Slovakia has the number of children being adopted increased as a proportion of children in the protective care system (Table 3). In Bulgaria the share rose
Table 3: Adoptees as a Share of All Children in the Child Protection System  
(In Rounded Percentages, 1989 and 1993)

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<tr>
<td>Slovakia</td>
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Source: MONEE Database.  
* Adoption figures likely also include children in foster care.

from 6.9 to 12.2 percent between 1989 and 1993. This was due not just to a higher overall rate of adoption, but also to a drop in the incidence of institutionalization. (In Bulgaria foster children may be included in the figures, and this may account for the much higher incidence of "adoption").

In 1993, 5.6 percent of children in the child protection system in Slovakia were adopted, up from 1.7 percent in 1989. The increase in the importance of adoption was due more to a shifting of children among the various categories than to an upswing in the rate of adoption, which increased only marginally from 1.4 to 3 percent between 1989 and 1993.

3. Foster care in private families has a long history in many countries, with grandparents and other close relatives assuming the care of a child when the parents cannot. Prior to the transition the largest obstacle to this type of arrangement was economic: families simply could not afford to feed, clothe and educate additional children. Deteriorating economic conditions since the onset of the transition have exacerbated this situation, although some countries have attempted to provide better foster care allowances (see later). Nonetheless, foster care is becoming a more viable option in many countries. In fact, with few exceptions, foster care rates have been increasing gradually (Table 4).

Institutional Care Systems

Institutional care is fairly standardized in the region. Depending on the ages and the perceived problems of the children welcomed by them, institutions are the responsibility of
Table 4: The Rate of Foster Care of 0-to-17-Year-Olds
(Per 10,000 Children In The Age Group, Rounded, 1989-94)

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Source: MONEE Database.

Specific ministries (Table 5). Generally, the Ministry of Health is responsible for all institutions housing infants and children who are too young to go to school and who have been identified as ill or as "social" or true orphans. The Ministry of Education is usually responsible for institutions for orphans and disabled children of school age, though, as in the case of Romania, those deemed "irrecoverable" may be assigned to the Ministry of Labour. The Ministry of the Interior is commonly responsible for "reeducation" and detention homes, though homes for problem children are sometimes assigned to the Ministry of Education.

The Russian system is typical. In Russia in 1993 there were 184 special homes and 152 boarding schools for true orphans and "social" orphans, including children with disabilities; the corresponding figures for 1988 were 83 and 95. There were also 55 social rehabilitation centres for minors and 88 orphan asylums for children and teenagers (MSPR 1994).

Within the education system, there are 142 institutions serving the educational and health needs of 22,000 students with a variety of health problems. Most of these—102 schools with over 15,000 children and adolescents—educate and care for children with tuberculosis. Another 14 care for 3,500 children with scoliosis. There is also a number of general-purpose boarding schools which care for children from problem families, as well as special-education remedial schools for children with developmental deficiencies.

In 1993, 20 special-education schools were built, as were seven boarding schools for
Table 5: THE INSTITUTIONAL CARE MODEL IN CENTRAL AND EASTERN EUROPE
(According To The Ministries Responsible For Various Institutions)

<table>
<thead>
<tr>
<th>Ministry of Health</th>
<th>Ministry of Education</th>
<th>Ministry of Labour</th>
<th>Ministry of the Interior</th>
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<tbody>
<tr>
<td>Psychiatric hospitals for acute or chronic cases, Tuberculosis hospitals, Homes for the mentally handicapped, Dystrophic hospitals, Orphanages for under-3-year-olds.</td>
<td>Schools for the deaf and the blind, Nonboarding schools for mentally handicapped children.(^a) Homes for the severely physically disabled, Orphanages for 3-to-7-year-olds and for 7-to-15-year-olds.(^b)</td>
<td>Homes for &quot;irrecoverable&quot; children: children with mental handicaps or paralysis.(^c)</td>
<td>Homes for delinquents, young offenders and &quot;problem&quot; children.(^d)</td>
</tr>
</tbody>
</table>

Source: MONEE Database.
\(^a\) In Albania the majority of children with mental handicaps were kept at home and were supported by state allowances into adulthood. \(^b\) In some countries the latter age group was 7-to-18-year-olds. \(^c\) This was the approach adopted in Romania. In some other countries these children fell under the Ministry of Education. \(^d\) In some countries problem children and delinquents fell under the Ministry of Education.

mentally handicapped children, nine schools for "developmentally delayed" children and one boarding school for children with hearing problems. Likewise, more classes have been set up in regular schools to meet "special" needs of children. By 1994, 385,000 children with developmental problems were receiving special education.

However, the network of new establishments and remedial classes can still not keep up with the growing number of disabled children. As a result, only about one-half of the children who needed special education assistance received it (Avraamova 1994).

In the Czech Republic, Slovakia and Poland there is less homogeneity in the institutional care system. Responsibility for the various institutions is, for the most part, still divided among ministries.

In some instances institutions have been modified so that children can be cared for in family-like settings. In Poland, for example, groups of young siblings are cared for six to eight at a time in family homes by married couples who act as substitute parents. Older siblings live in "children's villages" consisting of up to 100 cottages, with a "foster mother" running each cottage as a separate family unit.

Emergency care centres are located in all large cities in Poland for the diagnostic assessment of the problems of children. The children are transferred from these centres to the institutions appropriate to the diagnoses.

In Poland there is a network of 290 orphanages for older children with 16,147 places, 54 orphanages for small children with 3,200 places, 152 "family homes" with 9,116 places, 50 emergency care centres with 2,724 places, and two children's villages with 200 places.
Under-3-year-olds are cared for in orphanages for small children under the Ministry of Health. These orphanages have an average of 50-60 children. Girls aged 4 to 18 and boys aged 4 to 21 move from these orphanages to "dormitories" and attend local kindergartens and schools under the Ministry of Education. These institutions are located in large towns and also average 50-60 children (Romanowska 1992).

In Hungary there is a network of 20 child and youth institutes—one in each county—to provide childcare. These institutes hold administrative responsibility for all children in public care. Staff-to-children ratios are high (2.1 staffmembers per child). There are also 129 "educational homes", with 0.6 staffmembers per child, a few "special-education homes", which provide services for children in trouble with the law and have a ratio of 1.3 staffmembers per child, and 31 "infant homes", which also house older children and newborns (Fajth 1994b). Children's villages which group children in family-like settings have replaced many of the larger institutions which once cared for children.

Problems with the Institutional Care Model

Under the prevailing institutional model, care is fragmented because children are placed according to age, "problem" and ministry. This has meant that, for the most part, siblings have not been kept together, furthering the rupture of family bonds. Continuity of care is broken as children move into an older age group, or as changes in the nature of their problems result in transfer to a new institution. This aggravates the child's insecurity and inability to form lasting relationships. It may also result in gaps in the care of the child if a full disclosure of the child's needs is not adequately communicated at each move.

Descriptions of institutions paint a rather grim picture of the conditions children have to endure. Physical conditions pose serious threats to the health of the children.

1. Buildings in need of repair. Buildings, plumbing and equipment are often in a very poor state. In Albania children have to stay wrapped in blankets during the winter because of the poor heating systems and lack of coal. The situation is worse in homes for children with mental handicaps and in hospitals where psychiatric patients over age 13 are sent for the rest of their lives. Conditions are so grim that every winter there is an expectation that some patients will not survive.
Likewise, in Bulgaria most homes are old and without central heating, indoor toilets and other "conveniences". Just seven of the 136 homes for children have been constructed for the purpose for which they are now being used (Valtshev n.d.).

With the help of foreign assistance, there has been improvement in Romania in some cases. However, the situation is still quite primitive. In 1990 the worst conditions were in the homes for children with severe disabilities operated by the Ministry of Labour (Helsinki Watch 1990). Unfortunately, given the shrinking budgets of many institutions, it is likely that many children are still housed in such homes.

In Russia 80 percent of schools for children with chronic illnesses are located in buildings in need of repair or reconstruction (MSPR 1994). Many institutions have no showers, and central heating systems are broken. Toilet facilities are wholly inadequate.

2. Care of the children. Children’s physical needs are not met in other ways as well. Blankets and clothes are often filthy, in need of replacement, in short supply, or nonexistent. Poor hygienic and sanitary conditions are reported in all homes in Albania. Diapers (nappies) and bedclothes are changed infrequently. Homes for children with mental handicaps are extremely dirty. Children in the institutions run by the Ministry of Labour are often filthy (Helsinki Watch 1990).

The nutritional needs of the children in these institutions are frequently not met. Bottle-feeding was introduced in dystrophic hospitals in Albania by foreign aid agencies to replace the spoon-feeding that had been taking place. However, because of the lack of sterilization equipment, dirty bottles are being used.

Infants in Romanian orphanages are still being fed by propping up bottles on piles of dirty rags. Those unable to keep the bottle from slipping away remain hungry (Burke 1994, Helsinki Watch 1990). At the same time, they are deprived of the warmth and contact of being held in someone's arms as they eat. The children in orphanages are ill fed. Food is of the poorest quality, often just a watery soup, and is sometimes served to the children directly on the floor (Helsinki Watch 1990).

Food intended for children is often diverted by staff who eat it themselves or steal it to sell on the street. This was the case in one-half the boarding schools in Moscow. Dishes, dairy products, meat and preserves were being sold by employees and, in one school, by the director (Leveille 1990a, 1990b).

Sometimes, even the medical needs of children are not taken care of because of negligence, lack of medical staff and other personnel and shortages of medicines and medical
equipment. Of grave concern for the health and safety of children is the practice of giving children microtransfusions of blood—sometimes regularly every two weeks—and injections of antibiotics. The lack of sterilization facilities, shortages of disposable needles, and ignorance and negligence on the part of staff resulted in an epidemic of AIDS and hepatitis-B infections among infants in dystrophic hospitals in Albania and Romania (Zaka n.d., Helsinki Watch 1990). The epidemic spread when the children were transferred from the hospitals to orphanages. In Romania the practice continues.

Toys, books, games and other objects required for stimulation and development are frequently lacking. Children are often tied to their beds for long hours, causing contracture and injuries to their wrists. In Romania children are sometimes tied back-to-back when outdoors to keep them from running away. Sedative injections are administered to children with behavioural problems in some institutions (Helsinki Watch 1990).

Equipment for treating children with medical problems or for remedial work with children with disabilities is in very short supply or in need of repair. In institutions in Russia the medical, diagnostic and physical-therapy equipment represents only 50-70 percent of what is required (MSPR 1994).

Staff are not always appropriately trained to deal with the developmental needs of children. Often they are women from local communities, with little education and no special training. They are poorly motivated and poorly paid. In all countries, as part of the Soviet legacy, training for the "helping professions" was halted sometime during the 1970s. As a result, there is an acute shortage of trained, qualified staff, including nurses, physical therapists, social workers and psychologists.

3. Many serious breaches of the rights of children have been documented, from the placement process itself to physical and emotional abuse suffered at the hands of those entrusted to protect and care for children on behalf of the state (International Children's Rights Monitor 4th Quarter 1993).

Youths in detention in Romania are held in adult penitentiary centres until their cases can be heard and processed. They must wear prison uniforms and have their heads shaved. At no point during the period of inquiry do they have access to their files, nor do they have a right to a lawyer. Often families are not immediately informed; thus, one mother looked for her son in vain for a month until she found out that he was in jail (Riazantsev, Sipos and Labetsky 1992, Zugarăvescu 1992). In rehabilitation centres teenagers are crammed together
in dark cells. They do not have access to toilets and are not allowed to keep personal items or have many contacts with the outside world (Riazantsev, Sipos and Labetsky 1992).

In Russia difficult children who have not broken the law are frequently sent to vocational and technical training centres which are little more than penitentiaries. Youths may be sent away without trial, investigation or legal defence. They often spend one to four years in detention. They work and follow a study programme which is supposed to correspond to their age group. Frequently the work amounts to little more than the exploitation of child labour. Youths suffer from serious problems of alcoholism and drug abuse and from sexual aggression (Leveille 1990a, 1990b).

III. RISK FACTORS AND PLACEMENT IN PROTECTIVE CARE

Under the socialist regime an extensive system of child and family policies provided support to families and eased the dichotomy between work and family responsibilities. This was often cited as an example of the humanity of socialist policies (Fajth 1994c). Nonetheless, the situation of many children in these countries was quite grim. This resulted in many children being unnecessarily taken away from their families and placed in state institutions, frequently in conditions detrimental to their development and well-being.

The root causes of this situation were structural. First, the public policies pursued under the socialist model aggravated the effects of rapidly deteriorating social and economic conditions (Cornia and Sipos 1991). Second, cultural and social values intrinsic to socialism (and reflected in public policies) contributed to the weakening of family bonds, the "dismemberment" of individuals and increased dependency on the state. Third, the ideology of state socialism actively promoted a "medical model" of institutional care for anyone deemed not "normal".

The immediate causes were the same as those facing children everywhere: abuse, neglect, abandonment and parental illness or death. However, under socialism—and because of the structural problems—children in Central and Eastern Europe were more likely than those in other developed regions to be at risk in their family situations and therefore to be in need of protection.

The majority of children in state care throughout the region were "social" orphans; just 4 to 5 percent were true orphans (Fajth 1994a, Romanowska 1992, Avraamova 1994). For the
most part, they came from families living in marginal situations and with a complex and interwoven set of social and economic problems (MOHR and UNICEF 1991). Their families were the most vulnerable subgroups in the population and suffered economic hardships: young, unmarried or single mothers, large families with three or more children, families with unemployed or student parents, dysfunctional families with a mentally or physically ill family member, parents who suffered from alcoholism, prostitutes and law breakers. Overrepresented in these groups and in the population of children in state care were gypsies, the most vulnerable of the vulnerable.

The Risk Factors before the Transition

The following are the major "risk factors" associated with the placement of a child in protective care before the transition.

1. **Financial hardship** was the most important contributing factor. Under the socialist system, every adult was expected to be employed. Incomes were relatively low, and income distribution was flat. Adequate family incomes depended on a two-earner family (the model under socialism), and benefits were tied to employment. Thus, families with just one or no wage-earner, or with many children, experienced hardship.

For instance, in the former Czechoslovakia in 1985 the incomes of single-parent families were 85 percent of those of two-earner families. As a result, single-parent families were more likely than two-parent families to fall below the subsistence minimum. In 1985, 55 percent of families headed by abandoned wives, 35 percent of families headed by unmarried women, 22 percent of families headed by divorced women, and 19 percent of families headed by widowed women had incomes below the subsistence minimum (Struk 1990a). The situation was similar in other countries.

The social safety net which should have protected these vulnerable families failed to do so for several reasons. First, originally designed as an integral system of financial and nonfinancial assistance, state aid for families with children was not adequately adjusted to keep up with the changing conditions and actual needs of families (Struk 1990b). Second, prior to the transition, benefits were firmly tied to employment rather than to demonstrated need. Thus, parents in difficult financial circumstances had few options. Often the only
possibility was for municipalities to institutionalize children in cases where parents had trouble providing support (Fajth 1994b).

2. Financial hardships and housing shortages contributed to *overcrowded housing*, especially among large families, or in situations where several families were forced to share accommodations. Families with three or more children suffered from very overcrowded conditions, an oft cited "risk factor" (Valtshev n.d., Avraamova 1994, Struk 1990a, 1990b). The size of the flat thus determined the size of the family, rather than the other way around (Struk 1990b).

Inadequate, overcrowded housing placed an enormous strain on families and contributed to the breakup of marriages and the abandonment of children. In Romania the average number of children was much higher among the families of institutionalized children (3.4) than it was in the general population (1.7). Some families had more than one child who had been institutionalized (MOHR and UNICEF 1991). In the former Czechoslovakia children were often born to parents living together or separately in provisional housing, with grandparents, or in dormitories. Only 20 percent of newly married couples had their own flats, and, though about three-quarters of young couples obtained flats within five years of marriage, a considerable portion of these flats were unsuitable (Struk 1990a).

3. If a parent was not able to work because of an *illness* or *disability*, the family's economic situation was threatened. Rather than helping a family in such circumstances with additional home care services and financial assistance, the state's solution was all too frequently to remove the children.

A child with a prolonged or chronic illness likewise placed a considerable financial burden on families. Family income was drastically reduced if a parent had to forgo wages to stay home with a sick child, and the quality of medical treatment often varied considerably depending on the ability of parents to pay, albeit "under the table".

Doctors were very quick to admit sick children to hospitals rather than helping parents to care for them at home. In Romania the death of a sick child triggered a formal investigation, and doctors could be penalized. Thus, children were quickly placed in medical institutions where doctors would not be held personally responsible (*Helsinki Watch* 1990). The admission of a child to hospital often ruptured family bonds. If hospital stay was prolonged, or if a child’s illness was too threatening for a parent, or if parents were unable to cope financially with a child’s return home, the child would be abandoned in hospital. In
many cases, once they had been declared medically fit, such children were transferred to childcare institutions.

Throughout the region dystrophic hospitals sprang up to treat children who were malnourished or "failed to thrive" for other reasons. Often parents would bring their children to these hospitals when they felt unable to provide for them. Many healthy children were thus admitted to hospital and either remained there, or were subsequently transferred to other institutions. Many unwanted babies in Romania were abandoned in this way (*Helsinki Watch* 1990). The tendency to treat social problems as medical ones facilitated this unjust solution (Struk 1990a).

In the case of a child with a physical or mental disability, the decision to place the child in an institution was often purely economic. Caring for the child at home meant the loss of one income. The allowances for children with disabilities were often too small to make up the difference. The lack of equipment to serve the needs of a disabled child exacerbated the situation (Struk 1990a).

Negative attitudes and practices contributed to the institutionalization of children who were "different" (Vitello 1992). The state's approach to people with disabilities hampered the integration of individuals into society (Kroupova n.d.). The belief that the state was responsible for everything resulted in the abandonment of deformed or severely disabled babies at birth.

As a result of the tendency to adopt a "medical" approach, children not requiring institutionalization, such as those with mild retardation, Down's syndrome, or epilepsy, were often placed together with severely retarded ones. An important factor in the adoption of this approach was the fact that most staff had medical backgrounds and no training in social work or child development, training which was no longer provided by the state as of the middle or late 1970s.

Not only were children with medical problems and disabilities more likely to be institutionalized in Central and Eastern European countries than they were in other developed regions, but there also tended to be a very high incidence of children with these types of problems. Environmental degradation, unhealthy lifestyles, poor nutrition, overcrowded living conditions, extensive use of abortion as a means to control fertility, high rates of birth to very young and unmarried mothers, and inadequate medical supplies and facilities all contributed to the risk of a child being born ill or with a disability, or becoming so shortly thereafter. At the root of these problems were public policies which advocated
economic growth and full employment ahead of sustainable environmental practices and the well-being of the people.

There was a high incidence of premature births, and many of the babies who survived were medically fragile or had disabilities. In Bulgaria, for example, premature births accounted for 5 percent of the crude birth rate. One-third of premature babies either died, or required special medical care due to health complications (Valtshev n.d.).

In instances where legal abortions were prohibited or access to them was difficult, illegal abortions were widely performed. Botched abortions resulted in the birth of babies with severe deformities and neurological problems. A high rate of repeat abortions also increased the risk involved in subsequent pregnancies. One study on Romania (Burke 1978) found that women coming in for an abortion had had on average four prior abortions.

4. Only very well-adapted children could cope with the rigorous demands of the regular school system. Children who had difficulty keeping up at school because of learning disabilities, hyperactivity, or other minor disorders were removed from regular classrooms and placed in special schools. In some cases, perfectly normal children who had difficulty keeping up because of hunger or a stressful home life were placed in institutions together with children with severe medical, psychological, physical, or mental problems (Leveille 1990a, 1990b). Overloaded school curriculums heightened the demand on these vulnerable children and added to their risk of institutionalization (Struk 1990b).

Special-education schools often created more problems than solutions. Teachers were inadequately trained to meet children's special needs, and these schools were often considered as a means to eliminate the "difficult" pupil from the normal educational process. Thus, once sent to special-education schools, children ran the risk of falling even further behind and remaining institutionalized (Struk 1990b, Helsinki Watch 1990, MOHR and UNICEF 1991, Avraamova 1994, Leveille 1990a, 1990b).

5. Decades of unsafe environmental practices have rendered the Central and Eastern European region one of the worst wastelands on earth. Some countries, notably the former Czechoslovakia, Poland, Hungary and Bulgaria, have sustained longer and more serious devastation than others. Belarus, Ukraine and neighbouring countries will feel the effects of the Chernobyl disaster well into the next millennium.

The health of populations has been seriously compromised. The incidence among children of respiratory illnesses, anaemia and other diseases related to environmental pollution is high (Valtshev n.d.). In the former Czechoslovakia, for example, one of the major
causes of deteriorating health status in 1956-85 was environmental degradation. The incidence of allergies, including dermo-respiratory syndromes, asthma and bronchial diseases, rose by more than 200 percent during the period, reaching 13,600 cases among children aged 0 to 5 and 43,600 cases among those aged 6 to 15 (Kovarik n.d.). The incidence of congenital anomalies and tumours also increased sharply (Struk 1990b).

6. Poor diets were all too common in Central and Eastern Europe. Diets were characterized by a high intake of fats and a low intake of fibres, essential vitamins and micronutrients. Families with low incomes—typically families with children—consumed greater quantities of bread and fats and lower quantities of more nutritious foods—fruits and vegetables in particular—than did higher income families (UNICEF 1994). The good nutrition of infants and small babies was also compromised by a generalized rise in bottle-feeding rather than breastfeeding (Valtshev n.d., Struk 1990b). This was aggravated by shortages in the production of breastmilk substitutes, commercial baby foods and the special dietary supplements needed to treat metabolic disorders such as phenylketonuria and galactosæmia (Valtshev n.d.).

As social conditions worsened during the 1970s and 80s, the admission of infants and children suffering from malnutrition and other related diseases to hospitals mounted. One of the more extreme cases was Romania. A Government decision to pay off the foreign debt resulted in a policy of exporting most of the country’s agricultural produce, leading to a total collapse of the economy by 1989. Under these conditions children increasingly suffered from malnutrition. Indeed, the dystrophic hospitals were established in the middle to late 1980s to deal with this situation (Helsinki Watch 1990).

7. Full employment policies had a detrimental effect on the health of children. Pregnant and nursing women were exposed to workplace hazards and strenuous jobs. This resulted in real risks to their health and that of their babies (Kroupova n.d.). Placement in nurseries and childcare centres further jeopardized the health of already vulnerable infants and children. Extended stays in nurseries and childcare centres in close proximity to many other children exposed children to the risk of contracting illnesses (Libanova and Paliy 1993). In many cases this resulted in chronic illnesses.

Nurseries and childcare centres did not always provide adequate care. They were often overcrowded, and staff were not trained to meet the needs of infants and young children. The development of children already at risk was further hampered under such circumstances, adding to the risk that these children would eventually be institutionalized.
8. **Family breakdown.** Central to the extreme hardships facing many families was the organization of socialist societies around the workplace, rather than around families and communities (Ranschburg n.d.)

Two wage-earners were required to achieve an adequate family income. Long, monotonous hours on the job, combined with lengthy queuing for household essentials and the shortage of paid services, sharply limited the time available for family life. Time was even more curtailed among families in which the parents worked a second job.

The forced relocation of families from villages and towns to tiny apartments close to workplaces ruptured family and community ties. Intergenerational links often broke because of the limited contact between children and grandparents due to separate housing and the time constraints of job and school. Socialist ideology, which "devalued" the nonproductive members of society, further reduced the bonds between retired grandparents and the rest of the family (Kroupova n.d.).

Under the socialist system, responsibility for children was expressly transferred from family to state. This policy led to a diminished sense of personal accountability for children. It also encouraged a propensity to raise children to be obedient and disciplined, rather than responsible, enterprising, independent and confident (Avraamova 1994).

A highly developed network of nurseries and childcare centres was created to accommodate the work schedules of parents, and many care options were made available, including 24-hour care. Parents with hectic schedules and few financial resources were therefore assured that their children could receive constant care and three meals a day. While this did ease the dichotomy between work and family and permitted both parents to work outside the home, it left very little time for family life and the building of parent-child bonds.

Children went from childcare centres to state-controlled schools. The school system was rigorous. To be successful, children were obliged to spend long hours doing homework, further cutting into the little time available for family life (Struk 1990b). Overcrowding created a need for split-shift schools; in some cases schools ran three shifts per day. For children attending the early morning or late afternoon and evening shifts, fatigue was a problem. In fact, sleep deprivation was common among all family members. Mothers with small children were especially vulnerable (Struk 1990b).

Limited time with their children created an ambivalence in the attitude of parents toward their children. State control over childcare led to the expectation among parents that
the state should and would assume responsibility whenever parents were in difficulty. Children, sensing the lack of values, distanced themselves from relationships (Kroupova n.d.).

In some cases this resulted in children and youth turning to delinquent or criminal activity and to their eventual institutionalization in "reeducation" homes, detention centres and prisons. Others sought solace in alcohol, following the example of their disillusioned parents. Indeed, extremely high rates of alcoholism have been cited as one of the major risk factors contributing to the neglect of children and the breakup of families (Avraamova 1994, Kolaczek 1994, Romanowska 1992, Valshev n.d., Vitello 1992, Struk 1990a).

Some youths sought refuge from their unhappy home situations in sexual activity. Taboos against discussing or dealing with sexuality, lack of information about contraception and, in the case of Romania, limited access to modern contraceptives resulted in high rates of pregnancy (Vitello 1992). As single motherhood was not accepted under the socialist system, this led to greater numbers of abortions and early marriages. In the former Czechoslovakia, for example, almost one-half of all children were born within eight months after the marriage of their parents.

The countries of Central and Eastern Europe had the highest rates of early marriage in Europe. This is viewed as a primary cause of the high frequency of child abandonment and institutionalization in the region (Riazantsev, Sipos and Labetsky 1992).

More than any other group of children, gypsy children were more likely to be in state care. While gypsies account for only 3 to 5 percent of the population in each of these countries, gypsy children account for almost one-half of the institutionalized child population. For example, in the former Czechoslovakia 50 percent of institutionalized children and 20 percent of hospitalized children were gypsies, as were 14 percent of children placed in foster care and 23 percent of those adopted (Costarelli 1992, Struk 1990b). In Hungary 45 percent of children in "education homes" were gypsies (Fajth 1994b). Fifty-three percent of all children in dystrophic hospitals in Romania were gypsies, as were 43 percent of all children in orphanages (MOHR and UNICEF 1991).

This reflects the very harsh conditions in which most gypsy children are raised, the professional prejudices on the part of physicians and legal professionals, the lack of ethnic-sensitive measures to deal with many of the problems facing gypsies, and the discrimination directed against dominated or marginalized cultures (Vitello 1992).

In the former Czechoslovakia in 1990, for example, 30 percent of gypsies were living in shanties, many of which had no sanitary facilities. Just 1 percent had showers; 36 percent
had toilets; 21 percent had town gas, and 61 percent had water (Costarelli 1992). Housing was overcrowded, especially as gypsy families tended to have many children (Struk 1990b).

This low standard of living was reflected in the nutritional and health status of the gypsy population. Infant mortality rates were high among gypsies in all countries. In the former Czechoslovakia in 1985, for example, the rate among gypsies was more than twice the rate among the overall population (30 per 1,000 live births and 13 per 1,000, respectively). Likewise in Czechoslovakia in 1989 the incidence of low birthweight was 200-500 percent higher among gypsies than it was among the rest of the population (Costarelli 1992). Gypsy children were more likely than other children to suffer from bronchitis, pneumonia, dermatological disorders, such as impetigo, skin parasites and eczema, and nutrition-related disorders, such as gastritis, colitis, enteritis and dental carries. This is reflected in high rates of hospital admissions among gypsy children.

Given the very grim conditions in which many gypsy children were living, they faced a higher risk than did other children of being removed by state authorities on the grounds of neglect. They were also more likely to be placed in institutions by their parents, particularly babies born during the cold winter months. In some cases a mother who was unaware of legislation defining parental abandonment after a certain period of stay in residential care returned to hospital for her child only to find that the child had been institutionalized (Costarelli 1992). Truant gypsy children were often picked up by authorities and placed in special educational institutions.

Housing policies disregarded the importance of the extended family among gypsies and contributed to the breakdown of gypsy families and their ability to care properly for their children. Campsite planning, for example, did not consider the number of people using the various facilities, nor did it consider kinship settlement patterns. This led to overcrowding and contributed to unsanitary conditions.

**Changes in Risk Factors since 1989**

The Central and Eastern Europe which emerged from the socialist experiment in 1989 was battered and bruised. Social and economic conditions had deteriorated significantly in the latter half of the 1970s and throughout the 80s. Decades of environmental abuse, coupled with ecological catastrophes such as the disaster at Chernobyl, had contaminated the soil. The cities, where large workforces had been concentrated, were cold, inhumane and unhealthy.
People were demoralized and dispirited and suffered from social, medical and economic ills. Industrial infrastructure was decaying. The vacuum created by the fall of the socialist system caused countries to split apart and new independent entities to appear.

Major reforms were necessary and urgent. The shock waves which passed through the countries as reforms were introduced had sudden and sometimes unintended consequences, exposing populations to new risks to their safety, health and well-being.

Children and other vulnerable groups have been the hardest hit. Rapidly falling birth rates have substantially pared the child population since the onset of the transition. Worsening conditions have on almost every count boosted the number and severity of the risks children face. Nonetheless, there has been a slight drop in the number of children actually being placed in protective care. In fact, this may signal an important new risk. The system designed to help those needing protection seems to have developed fresh weaknesses.

The root causes of the large number and proportion of children in need of protective care remain structural. They are grounded in the decaying legacy of the former Soviet model and in the problems associated with the transition to a market-oriented economy.

In almost every country social conditions have deteriorated since the beginning of the transition. While the situation may be improving in, for example, the Czech Republic, Poland, Hungary and Slovenia, it remains critical or is worsening in other countries. Suicide rates, lawlessness, civil strife, outright war and drastic demographic developments resulting in negative population growth have sharply increased.

1. *Deterioration in children's economic status.* Poverty rates have risen more quickly among children than they have among any other group (Zaka n.d., Avraamova 1994, MSPR 1994, UNICEF 1994). Child poverty rates have been going up in all countries, with the largest jumps occurring in Central Europe. Even in the Czech Republic, where economic recovery appears to be under way, more than 38 percent of all children were living in poverty in 1992. In most other countries the share of children in poverty was well over 50 percent in 1993 and in some cases closer to 65 percent. The massive erosion in child allowances was a major factor. Rising unemployment is expected to produce a further climb in child poverty rates in Hungary, Poland, Bulgaria and the countries of the former Soviet Union (UNICEF 1994).

Families with three or more children still experience the most difficulty, though most families with children are facing problems. In Latvia, for example, 88 percent of families with three or more children do not have enough money for food (CSOL 1995). The situation is
more serious in Russia, where young families with one or two children are in similar straits. Since 1992, 72 percent of young Russian families with children have fallen below the subsistence minimum income, and 40 percent can buy little more than food, which absorbs 80 percent of their incomes. In 1993, 40 percent of all Russian children were living below the poverty line. This reflected a twofold drop in real cash incomes in 1991-3 (MSPR 1994).

In Romania the transition and economic recovery have been very difficult because of the industrial backwardness of the country. International contributions have eased circumstances for some of the more vulnerable children, but there is concern that there will be a sharp deterioration when the delivery of foreign assistance slows down or stops (Helsinki Watch 1990).

Tumbling family incomes, flourishing unemployment and more intensely competitive labour markets have resulted in a plunge in the number of parents taking leave from their jobs to care for their sick children. According to some estimates, the number of days of leave taken has dropped by as much as one-half. In Russia the number of leaves taken accounts for just one-half of the number of cases of childhood diseases and a small fraction of the number of cases of chronic diseases among children. This disturbing new trend could lead to the development of more acute illnesses or more chronic conditions, thereby elevating the risk that more children will require protective care.

2. Housing shortages have become more acute, and the quality of housing has deteriorated considerably. Rising prices and industrial slowdowns have limited new housing starts and severely curtailed the maintenance of the existing housing stock. More children are now living in overcrowded conditions, and many are without adequate sanitary facilities or heating during the winter months. The number of the homeless, many of whom are children, has swollen. In Moscow alone, there are at least 100,000 homeless and possibly as many as 300,000, and the number is growing daily (UNDDSMS 1994). An estimated 6,000 to 10,000 12-to-18-year-olds are living on the streets and in parks, abandoned houses and railway and subway stations in Hungary (Kollman 1992).

Public expenditure cuts on water and sewage systems and garbage collection have exacerbated the problem. In Russia, for example, over 75,000 water mains break each year (UNICEF 1994). In Moldova the safety of the water supply is a very real issue (CSOM 1995). Rising prices and falling incomes have also affected the ability of families to pay for these services. In the winter months this is an especially critical situation; in numerous cases services have been severed for nonpayment.
Young families are in the most desperate need of housing, precisely those families most likely to have young children. In the Czech Republic, for instance, just 30 percent of newly married couples have their own housing (Kovarik n.d.). The elimination of price controls, the restricted supply of housing and the growth in incomes among those working in the emerging private sector have contributed to a jump in rents beyond the means of many families with children. Waiting lists for housing are long. In early 1993, 9.6 million Russian families were on waiting lists for improved housing (MSPR 1994).

The flood of immigrants, refugees, returning expatriates and returning or former military personnel has exacerbated this situation. For instance, in Ukraine 300 settlements had to be created for Crimean Tartars. Just 30 percent of these settlements have electricity, while only 8 percent have water. More than one-half of active participants in the labour force in these settlements had no jobs (Libanova and Palii 1995).

In Belarus and other countries affected by the Chernobyl disaster, the necessary relocation of populations has compounded these problems, especially in the large urban centres where many of the people are going. In Belarus more than 130,000 people have been relocated since the disaster; however, 41,200 living in the relocation zone have refused to move to cleaner areas due to declining socioeconomic conditions, thus increasing the danger to the health and safety of the children (UNICEF 1995a).

3. **Deteriorating nutritional status among children.** Plunging agricultural output, a crisis in food supply, the removal of price subsides on food and contracting family incomes have contributed to the greater risk of malnourishment among children. Both the level of food intake among children and the quality of food have declined (UNICEF 1994). Children in urban areas may be more affected by this trend. Staff of dystrophic hospitals in Albania, for instance, have noticed an increase in the number of admissions of urban children as food becomes unaffordable for the urban poor.

Data from Albania, Bulgaria, Romania, Slovakia and Russia point to a rise in malnutrition (UNICEF 1994). In some countries there has been a surge in food imports to deal with declining food production and shortages in food supplies, and, with the exception of the Czech Republic, Hungary and Slovakia, countries have required extensive food aid. In 1993 the region received more food aid than did sub-Saharan Africa (UNICEF 1994).

Deterioration in the nutritional status of pregnant and nursing women, growth in the percentage of babies born at low birthweight, declines in breastfeeding, shortages in the
supply of breastmilk substitutes and special baby foods, and poorer childcare and child feeding practices have raised the health risks (UNICEF 1994).

4. **Weakened health and social welfare infrastructures.** The shortage of financial and material resources has influenced preventive health care services and curative care in hospitals and clinics. Lack of foreign currency and restricted imports have rendered the supply of medicines and diagnostic and therapeutic devices inadequate. Equipment in health care and social service facilities is outdated and overworked (Veltshev n.d.).

The weakening of universal health care systems and the movement toward health insurance in some countries have amplified the vulnerability of some groups. In Bulgaria free health care and medicines have been restricted to the poorest since 1 April 1993. As a result many people cannot afford to pay for the care they need (Tassev 1994). In some countries the crisis has left the health system underfunded and unable to prevent or cure emerging health problems among young people (UNDDSMS 1994). The care of people with illnesses or disabilities has also been compromised. Many hospitals can no longer provide care for premature babies that requires special equipment and treatments (CSOL 1995).

5. **Disaffected youth.** The institutions which protect young people on the difficult path to adulthood have been dramatically weakened by the transition. The resources of youth organizations, the education system, the family and the community have been cut back. Adolescents and young people are being left to fend for themselves at a time when the traditional values and norms to which they could have once turned for guidance are disappearing (UNDDSMS 1994).

The transition has dramatically changed the needs in education. The type of skills and academic content needed for a market economy are not those being taught in higher education systems. Education expenditures have plummeted. Teacher salaries are low and not always paid regularly. Many young people are failing to enrol in, or are dropping out of, compulsory education and no longer attend university. In Russia compulsory schooling has been reduced to nine years, resulting in declining enrolments in higher grades and a reduction of the number of places in vocational schools. As a result, many adolescents, some as young as 14, cannot continue their education even if they wish to do so (Avraamova 1994).

6. **A further breakdown in family values.** The average age at first marriage has dropped even lower since the onset of the transition (UNICEF 1994, Kovarik n.d.). While the number of births has been sinking drastically among every other age cohort, it has been rising among

Higher rates of poverty, alcoholism, disease, unemployment and death are placing enormous strains on already fragile family ties. Higher rates of divorce and soaring death rates among the middle-aged have contributed to the larger proportion of children growing up in single-parent families or as orphans.

The expanding gap between rich and poor has led to greater anxiety among the poorer families and to a decline in social solidarity, as distorted perceptions of capitalism take hold, and people pursue economic success at any cost (Avraamova 1994, UNDDSMS 1994).

7. War and civil strife have also raised the risk to children. Children have suffered injuries resulting in disfigurement, dismemberment and death. Those surviving will require years of counselling and rehabilitation to deal with the psychological scars and crippling conditions given them by conflict. Many others have become homeless and orphaned.

In war-torn areas, the housing situation is very grim. Cuts in basic services and extended periods of habitation in bunkers and cellars threaten the health and safety of the children caught in the middle of war. For refugees, the arduous roads of escape and life in primitive camps add to the risk.

Disruptions in schooling will result in long-term problems for many children. The damage of war has caused many schools to be closed and created unsafe situations in many others. In Armenia, for instance, 20 percent of rural schools have no water supply; 50-60 percent of kindergartens need glass for windows; sewage systems are disrupted in every third school, and in most schools central heating systems do not work (CSOA 1995).

8. The health and well-being of children are under siege. The direct effects on children of soaring morbidity, disability and mortality rates have been compounded as their parents, grandparents and friends also fall victim. Many have been left with sick or disabled parents, or have been orphaned.

The incidence of certain pathologies has increased since the onset of the transition. In Moldova, for example, nervous disorders and depressions have risen. Suicide has become much more frequent throughout the region. In Moldova there was an average of two suicides per day in 1994 (CSOM 1995). In Latvia the number of suicides jumped nearly twofold between 1991 and 1993 (CSOL 1995). Tuberculosis rates have spiralled in the region (UNICEF 1994). In Russia between 1992 and 1993 the number of children with active lung tuberculosis climbed by 12.7 percent (MSPR 1994). In Moldova the incidence of pediculosis mounted from
12,000 to 48,000 cases between 1990 and 1993, and the incidence of digestive poisonings rose starkly (CSOM 1995). In Russia in 1993, 15-25 percent of preschoolers had one or more chronic pathologies, as did 30-5 percent of 6-to-7-year-olds and 40-5 percent of older school children. Health deficiencies among children increased by a factor of three during the year. Three times more children had neurological and sensory diseases; 1.2 times more had diseases of the digestive tract; five times more had urino-genital diseases, and three times more had clinical psychiatric deficiencies (MSPR 1994).

Breakdowns in immunization programmes in some countries have led to epidemics of childhood diseases, some of which can result in permanently disabling conditions and death. A diphtheria epidemic has swept Russia and Ukraine, and there is some evidence that the same is happening elsewhere as well (UNICEF 1994). In Russia between 1992 and 1993 the number of cases of diphtheria jumped by a factor of 3.9, whooping cough, by 1.5, and measles, by 4 (Avraamova 1994). The immunization programme developed for 1993-7 should be addressing this problem, but it is not likely ever to be implemented because of a lack of financing (MSPR 1994).

Among children living in ecologically unsafe areas the incidence of various types of diseases is higher than it is among other children. In Russia children living in environmentally hazardous areas suffered 3.5 times more blood and hematopoietic diseases, 2.8 times more urino-genital system diseases, 1.8 times more eye diseases, 1.3 times more skin and cellular tissue diseases and 1.4 to 1.8 times more respiratory diseases than did the average Russian (MSPR 1994).

The rise in the proportion of low birthweight babies in all countries but Hungary and Albania has resulted also from worsening nutritional conditions. This, coupled with the upswing in births to young and poorly educated mothers, environmental degradation and the breakdown in medical infrastructure, has led to higher rates of infant and maternal mortality and of congenital anomalies and developmental deficits (Avraamova 1994). Congenital anomalies in Russia increased from 270,000 new cases in 1990 to 347,300 in 1993 (SCSRF 1994). The number of babies born ill or becoming ill shortly after birth nearly doubled, from 14.8 percent of all births in 1990 to 23.5 percent in 1993. Only 40-5 percent of Russian women had deliveries without complications in 1993, when the maternal mortality rate was 51.6 per 100,000 live births, up from 47.4 in 1991 (MSPR 1994). The number of births complicated by anaemia more than doubled, from 65 to 148 per 1,000 births between 1990 and 1993 (SCSRF 1994).
The incidence of disability was also up in the region. In Russia in 1993, 342,700 under-16-year-olds suffered from disabilities, four times more than the figure in 1985. The immediate causes were psychoneurological diseases (60 percent), internal diseases (close to 20 percent), eyesight and ear troubles (nearly 17 percent), and locomotive apparatus diseases (close to 10 percent).

Many families have too few resources to cover the cost of caring for a child with a disability. On average, medical services cost three times more for a child with a disability than they do for a healthy child. A growing number of parents are unwilling to take leave from their jobs for fear that the jobs will not be available when they return. In Russia no more than 20 percent of mothers are able to stay home full time to care for children with disabilities; another 10 percent work part time and can thus provide some care (MSPR 1994). Exacerbating the situation is the tendency of fathers to desert their families when a child with a disability is born. In Russia 33 percent of such families have been abandoned by the fathers (MSPR 1994).

9. Drug, tobacco and alcohol abuse are becoming rampant among youth. In Ukraine official statistics show just 65 drug addicts per 100,000 population in 1993; however, data on drug-related crime, which grew by 249 percent between 1991 and 1993, present a much bleaker picture (Libanova and Paliy 1995). Information from Armenia indicate a rise in drug-related crime (CSOA 1995). In Russia, where 66 percent of drug addicts are teenagers and adults below 30, the number of drug-related crimes tripled and the quantity of drugs impounded shot up tenfold between 1985 and 1993 (UNDDSMS 1994). In Bulgaria in the 1970s drug use was most common among 15-to-18-year-olds; by the 1980s the average age had fallen to 13 or 14, and since the onset of the transition the average age has gone below 10 (Valtshev n.d.).

A similar decline in the age of young Bulgarian smokers is attributed to the lapse of antismoking controls even in schools, a phenomenon not uncommon in the region. Generally, tobacco consumption has been mounting, most markedly among adolescents and women (UNICEF 1994).

The evidence points to a dramatic surge in alcoholism, particularly among youth. In Russia the statistics on alcoholism are so dramatic that one tends to doubt their reliability: one-half of all adult males are said to have severe alcohol problems (UNDDSMS 1994). Youths are increasingly at risk of neglect and abuse at the hands of drunken adults. They are also at risk of becoming alcohol-abusers themselves. In Moscow the proportion of adolescents abstaining from alcohol dropped between 1989 and 1992 from 39.5 percent to 20.8 percent
among boys and from 35.2 percent to 25.5 percent among girls (UNICEF 1994). In 1993 in Ukraine, 853,000 people were arrested for being intoxicated in public, and 34 percent of all crimes were alcohol related (Libanova and Paliy 1995). In Hungary, the estimated rate of alcoholism nearly doubled and the alcohol-related death rate more than doubled between 1986 and 1992 (UNICEF 1994). More than two-thirds of crimes in Latvia in 1993 were committed by youth gangs, and one-quarter were committed under the influence of alcohol (CSOL 1995).

10. Sexual promiscuity and prostitution among youth also appear to be on the rise (Valshev n.d., UNICEF 1994). Few data exist, but the jump in teenage pregnancies lends support to this view (UNICEF 1994). Reports in the media in the West about teenage prostitutes from these countries offer more corroborative evidence. This is a very disturbing trend, especially in light of the risk to mother and child that is involved in a birth to a teenager, the very high abortion rates, the growing drug use and the spread of AIDS and other severe sexually transmitted diseases (UNDDSMS 1994).


Young people who have become involved in crime through adults account for much of the crime among youths (MSPR 1994).

A growing number of crimes are being committed by youths who are not attending school and are out of work. In Russia the number of youths not going to school but unable to find work doubled from 20,500 to 40,200 between 1989 and 1993.

Youths are becoming involved in more violent crimes, many of which are drug related (UNDDSMS 1994, CSOA 1995). In Latvia 71.4 percent of juvenile crimes in 1993 were serious crimes (CSOL 1995). In Russia the number of murders committed by 10-to-14-year-olds doubled between 1990 and 1993, as did the rate of aggravated assaults (MSPR 1994).

Growing juvenile delinquency has contributed to an upturn in the institutionalization of youths. Conviction rates among youths have risen in almost all countries. Bulgaria and the Czech Republic are the exceptions. The proportion of youths convicted was halved in Bulgaria between 1992 and 1993 and in the Czech Republic between 1991 and 1992. This
likely represents a breakdown in the criminal justice system, given that youth crime has mounted steadily. Youth conviction rates in 1992-3 ranged from 8 per 100,000 population in Bulgaria to 91 per 100,000 in Russia; the rate in 1989 had been 23.9 per 100,000 in Bulgaria and 63 per 100,000 in Russia (UNICEF 1994).

The profile of juvenile offenders appears to be consistent with that of other institutionalized children. In Russia 10 percent of all juvenile offenders were young people already in institutions, while 40 percent were from single-parent families, most of which were headed by women (Riazantsev, Sipos and Labetsky 1992).

One Polish study (Kolaczek 1994) has documented a boost in the number of crimes committed against families and youths and points very clearly to a rise in the incidence of these crimes since the onset of the transition. It also shows an increase in the default rate of alimony and child-support payments.

12. There has very clearly been a jump in child labour. Rapidly falling school enrolment rates offer some evidence of the numbers of children who may be involved (UNICEF 1993).

In most countries privatization is now well under way. As the number of small family businesses grows, children are being called on to help their parents in the shop or on the farm and thereby supplement family incomes, especially in the case of single-parent families. More and more children are working on the streets. In Russia, for example, many of the street vendors are children (UNDDSMS 1994). As many as 1,400 children, most of whom were between 14 and 16 years of age, were living and working in the streets of Bucharest (International Children’s Rights Monitor 1st and 2nd Quarters 1993).

In Russia 45 percent of the two-parent families and 47 percent of the single-parent families responding to a survey were relying on income from child labour (Avraamova 1994). In most cases the families stated that they were forced to resort to child labour, but that they disapprove of the practice in principle.

Childhood is under siege in Central and Eastern Europe. Rapidly falling birth rates and soaring mortality rates have reduced the number of children in the region. Environmental pollution continues unchecked. The health and nutritional status of mothers is poor. Children are exposed to high rates of illness and disability. Murder, suicide, violent crime and premature death are rampant. Children are being abandoned, forced to live on the street, or orphaned. Public policies are increasing the burden on families, contributing to high
rates of poverty and unemployment. The whole social infrastructure is unravelling. Now more than ever children are in need of protective care.

Yet, since the beginning of the transition, the number of children in state care has declined. This may reflect the inability of child protection systems to cope with demand, rather than a decrease in demand. In Hungary, for example, there are indications that local governments are replacing, not augmenting, family protection activities with social assistance money. In 1993 alone the number of children registered with local child-protection entities dropped by 42 percent and the number of children removed from lists of children "at risk" grew by 96 percent. This reflects a change in public policy, not a change in social conditions.

In Poland, despite worsening social conditions and increasing risks to children, the number of court cases involving the deprivation, suspension or limitation of the custodial rights of parents over their children has not changed substantially during the transition (Kolaczek 1994).

Other changes in public policies may also be adding to the risks which children are facing. In countries where social welfare allowances are no longer tied to employment, but rather to the presence of children, parents have an incentive to have children early—a growing phenomenon throughout the region—and to keep them at home. While this is certainly beneficial for some families, it is not in the children's best interests if the parents are using the children to exploit the system.

In Hungary there is fairly clear evidence that many children are suffering abuse as a result of policy changes. Hospital records show a climb in child beatings, and the number of children abandoned to the street has been rising. Because of the breakdown in the registration of alcoholics, more children are probably being left with alcoholic parents.

The danger is growing that more children are now being exploited as labour in households and in family income-generating activities, including begging and prostitution. In some countries this situation is exacerbated by the absence of laws to protect children in these circumstance (MSPR 1994).

Obviously, the scheduled reforms in child protection systems must address these very real problems. Children, especially those who are already socially, medically, morally or emotionally very fragile, must be protected and allowed to develop to their fullest potential.
IV. PROTECTIVE CARE POLICIES

Pre-transition Policies

One of the principles of the Communist regimes was that the state would provide care "from the cradle to the grave" rather than supporting individuals to care for themselves and their families. This principle was reflected in state policies governing family and child support, and it contributed to the high rates of child institutionalization throughout the region.

The economies of these countries were organized around high employment rates, relatively flat income distribution, and savings and investments kept in public hands for use by the state to advance the economy. Social policies were structured to facilitate this by offering employment and childcare assistance to families. In particular, an extensive system of childcare and education facilities and generous maternity and parental leaves to care for sick children were made available. This included crèches and nurseries, some of which offered 24-hour care, for under-3-year-olds, kindergartens for 3-to-6-year-olds, and schools and recreational and summer camps for older children (Fajth 1994c).

Family support measures included comprehensive social security systems which involved monthly family allowances ranging from 3 to 20 percent of the average wage, free or low-rate public services, additional benefits from employers, a centralized tax and pricing system, cash and in-kind benefits, and indirect transfers such as public subsidies for housing and most consumer goods (Fajth 1994c).

While most of these measures were very generous by Western standards, they were essential in order to level the incomes of families with children—especially families with three or more children, families with just one parent and families in special circumstances, such as those including a parent with a disability—with those of families without children. This was necessary because wages were kept low, and two wage-earners were required to provide adequate subsistence incomes even for families with one or two children.

Nonetheless, families with children were at a disadvantage. Even in the more well off countries such as Hungary, family benefits never offset more than 30 or 40 percent of child-related expenditures (Fajth 1994c). As a result, children were overrepresented among the poor, and many families had difficulty in providing for their children.

Rather than supporting families which could not cope with their child-rearing responsibilities, the policy of the state was to remove the children from their homes. There
were no other options for families in most countries, although in the former Czechoslovakia reforms dating back to 1980 established a network of free advisory and consulting services, the focus of which was the prevention of and therapy for problems associated with marriage and the family. However, the lack of trained staff limited the effectiveness of these services. Indeed, training schools for social workers, nurses and family and child therapists had been closed in all countries during the 1960s, and there was an acute shortage of all types of social workers throughout the region.

Legislation was in place in all countries to deal with children who could not be maintained by their families for economic or other reasons. Other legislation specified who had responsibility for placing children in institutions selected according to the perceived problems of the children.

Children entered the system of protective care following a referral from parents, relatives, dispensary staff, or police or other local officials. Although there were variations, children were usually put into institutions for assessment before a final placement decision was made (see earlier). In most cases the assessment period was four to six months. Final placement decisions were normally the responsibility of medical doctors (in the case of medically "fragile" children), local authorities or the courts.

After the assessment period, children were adopted, placed in foster care, or sent to an institution to await adoption, receive treatment, or be "reeducated". Children awaiting adoption or foster care could languish in institutions for months or even years while their cases were being processed. Some children were deemed to be "irrecoverable" and remained in institutions for life.

Review and follow-up of an individual child's placement occurred infrequently in most countries: once a year, or in some cases never. Once placed in institutions, very few children were ever reunited with their families. Children with severe disabilities, belonging to an ethnic minority (gypsies in particular), or older children were rarely adopted. For the most part, these children spent the rest of their childhood, and in many instances adulthood as well, shut away from society.

Parental visits to children in institutions were restricted. Prolonged separation, especially in the case of a young child, led to situations where children no longer recognized their parents. A large number of parents failed to stay in touch with their children. In some instances, this led to the removal of parental rights and the declaration that the child was
available for adoption; in others the child’s legal status remained unclear, and so adoption was not possible.

Post-transition Policies

Since 1989 there has been a shift throughout Central and Eastern Europe toward a more child-centred approach to the care and protection of children. Ratification of the UN Convention on the Rights of the Child by many of the countries in the region has added some impetus to the movement to reform laws dealing with children. The shift is apparent in the attitudes of professionals working in protective care systems. Policies in line with these principles have begun to be adopted in most countries.

1. Training programmes for social workers, psychologists, physical therapists, childcare workers and child development specialists are being implemented in many countries. Expert foreign consultants are being used to set up training curriculums and institutions in countries where no indigenous expertise exists.

2. Following the focus of international attention on the horrific conditions of institutionalized children in the region, there was a flood of adoption requests from people abroad. In some countries international adoptions were already permitted; in others, such as Romania, laws were changed in 1989 to facilitate these adoptions.

There followed what amounted to international trafficking in children. In Romania, for example, 2,951 international adoptions took place in 1990, and 7,328 in 1991 (Zugrăvescu 1992). In many cases there were concerns that the rights of the children and their parents were being violated. An investigation into one child trafficking network revealed that pregnant Polish women, who for social or economic reasons felt they could not keep their babies, were being paid approximately $900 each for the children (International Children’s Rights Monitor 3rd Quarter 1993). Other pregnant women were being paid to travel to Scandinavian countries or elsewhere in Europe to give birth and subsequently put their babies up for adoption according to a previously agreed contract. Adoptive parents covered travel costs, medical expenses and a fee for the "purchase" of the child (International Children’s Rights Monitor 1st and 2nd Quarters 1993).

As a result, some countries imposed a ban on international adoptions until new laws could be passed to protect the rights of the children and their parents and until adoption
committees could be established (Zaka n.d., MOHR and UNICEF 1991, Zogrâvescu 1992, *International Children's Rights Monitor* 1992, 2nd Quarter 1993). In other countries, such as Poland, laws regulating international adoptions have still not been passed.

As most children in institutions are "social" orphans rather than true orphans (see earlier), the identification of the children eligible for adoption has been a problem. Recent legislation in some countries has attempted to deal with this. In Albania parents placing children in an institution must consent to relinquish custody, though for up to one year they retain the right to retract their consent. In Bulgaria the adoption of institutionalized children without the consent of the biological parents is possible if the parents have shown no interest in their child for one year, or if they have been declared unfit parents. In both cases, the parents have the right of appeal before a judge. In Romania institutionalized children whose parents have shown no interest in them for more than six months are declared legally abandoned and eligible for adoption.

Legislation in Albania and Romania requires that international adoptions be handled through an approved adoption agency. Families wishing to adopt may not directly approach the biological parents or childcare institutions. Penalties exist for the infringement of these regulations. In both countries children must be on an adoption list for at least six months, and proof must be offered that no adoptive parents could be found locally.

In Bulgaria adoptive parents may have direct contact with the biological parents or with childcare institutions. The biological parents must provide a certificate to the relevant authorities stating that it has not been possible to arrange the adoption of their child within the country and that there are no other solutions. In the case of the adoption of a child from an institution, the institution must produce declarations from three Bulgarian families stating that they have refused to adopt the child. Although children do not have to be on an adoption list for a specified period of time before adoption can take place, families usually have to wait two years to adopt a child.

While these recent legal changes may help to identify children eligible for adoption and cut down on the incidence of baby-trafficking, a 6-to-12-month waiting period is not in the best interests of the child. Infants who lie in institutions unattended on iron cots, without stimulation and without the opportunity to develop close, loving relationships, can suffer irreparable damage. Most infants have been traumatized by the end of their six-month wait.

3. *Foster care* is being advocated as a more viable alternative to the institutionalization of children. However, policy change is slow in some countries where there is no tradition of
foster care. In Romania, for example, no statutes have yet been passed on foster care. In Albania there is no foster care system. Each child in care is housed in one of 15 institutions. Nonetheless, there are plans to turn the institutions into "children's villages" providing "group" foster care (Fajth 1994a).

Other countries have pursued legal changes more actively. Under a 1993 ordinance in Poland, for instance, childcare and adoption centres have been assigned responsibility for the identification of the children to be cared for in foster homes and, preferably, in adoptive homes, for finding foster and adoptive homes for these children, and for providing advice to the substitute parents. In principle, priority in the selection of foster families is given to blood relatives, relatives through marriage and families chosen by the biological parents; an attempt is made to see that siblings are placed in the same foster family and that there is an appropriate age gap between the foster parents and the children (Kolaczek 1994). In Russia foster parents must be between 25 and 40 years of age and have no more than three children already living in the household.

To spur parents to foster children, foster care allowances have been raised in many countries. In Slovakia payments to foster parents were boosted in October 1993. They include lump-sum payments for the purchase of clothing for each child and monthly benefits which are based on the subsistence minimum and the number and ages of the children in care and which are aimed at supporting the purchase of food and other essentials (Wolekova 1995).

In Poland legislators have taken a further step, requiring the biological parents to contribute to the costs of foster care. Defaults in these payments are common, and foster parents receive some financial assistance from the state that partially offsets the costs they incur (Kolaczek 1994). In Hungary payments to foster parents were extended in 1993 to help young people between 18 and 24 remain in their foster homes, given the slim prospects in employment and housing (Fajth 1994b).

4. Supervised home care. In keeping with the general move to a more child-centred approach to the care and protection of children, many countries are attempting to set up service networks to support families so that they can care for their own children. While these are still fledgling initiatives, they are indicators of the positive and creative forces at work throughout the region on behalf of families and children.

One of the main strategies of child welfare policy in the Czech Republic and Slovakia has involved new initiatives aimed at assisting families to care for their own children (Kroupova n.d.). In Hungary, municipalities have been able to offer financial assistance to
families in economic difficulty so that children who once might have been institutionalized are able to remain at home (Fajth 1994b). Likewise, authorities in Hungary have stepped up a programme of home monitoring of children identified as being at risk rather than sending them to institutions. In 1993, 303,814 Hungarian children were monitored in their homes, up from 129,977 in 1989 (UNICEF 1994).

In some countries family support centres, similar to those already functioning to a certain degree in the Czech Republic and Slovakia, have been established. Thus, in Russia in August 1993, for the first time centres were opened to provide assistance for disabled children and their families. Other legislation enacted in September 1993 implemented a special programme of legal, educational, health and other measures aimed at preventing delinquency among children and youths (MSPR 1994).

In Bulgaria "home patronage" centres have been instituted in municipalities to supply services such as the delivery of free food, goods acquired through foreign aid, free lunch programmes for the needy, periodic medical checkups and hygienic services, and free transport services on public vehicles. The number of people taking advantage of these centres increased from 19,139 in 1988 to 33,280 in 1992 (Tassev 1994).

The mayor and municipal government in Košice, Slovakia, in collaboration with gypsy leaders, have proposed two programmes to assist gypsy families, who comprise approximately 10 percent of the city's population. The programmes are geared to supporting the gypsy population in its dealings with the district-level government in a self-help housing and home-improvement programme and in a culture-sensitive education programme to boost primary school retention rates and to guide gypsy children in the transition from preschool to primary education.

5. Institutional reforms. Since the onset of the transition, conditions in many childcare institutions have improved with the assistance of European and North American organizations and private citizens and new policies based on a more enlightened approach to the development needs of the children. Reforms have been introduced in many countries to facilitate new models of institutional care, consolidate or change administrative responsibility for the various childcare institutions, enhance the training and pay of institutional staff, halt unsafe medical practices within institutions, involve families more with the care of their institutionalized children, and improve placement and follow-up procedures, including the identification of children eligible for adoption.
6. *New models of care.* In some countries the age groupings in institutions have been modified to allow siblings to be kept together and long-term care relationships to be formed. Steps are being taken in Romania, for example, to eliminate age restrictions in protective care institutions and reduce the size of the various institutions (*Helsinki Watch* 1990). Pilot projects have been set up to allow older children to remain in orphanages for small children rather than moving them out at age 6 (Burke 1994). Similarly, Hungary has introduced measures to ease the transition of older youths to noninstitutional life. Since 1993, Hungarian youths between 18 and 24 have been permitted to remain in institutional care until they are able to obtain employment and housing (Fajth 1994b).

Work has also been carried out to restructure the care in large institutions so that children can remain in small family-like groupings. More children are being cared for in "children's villages" in the Czech Republic, Slovakia and Poland. Bulgaria is moving in this direction as well (Tassev 1994).

Other reforms have been introduced to improve the care provided to children in institutions. In Romania attempts are being made to attenuate the social isolation of children in institutions. In some instances children from surrounding neighbourhoods have been integrated into kindergartens in orphanages and children from orphanages have been integrated into neighbourhood schools (Burke 1994).

In Slovakia in 1993 the system of education and special education was altered to improve the services provided to children with physical, mental, learning or developmental disabilities, help them become integrated into regular classrooms, and offer support to their families. A centre was also created to coordinate preventive care measures and secure the involvement of professionals (Papaj 1994).

Similar legislation in Russia passed in August 1993 established new local institutions providing training, medical care and rehabilitation in order to serve the needs of children with disabilities.

New schools were set up in Poland in 1991 for children in correctional institutions. These schools help "resocialize" delinquent children by assisting them in catching up with their schoolwork and guiding their care and upbringing (Kolaczek 1994).

7. *Administrative responsibility.* Steps are being taken to build a comprehensive, tightly controlled, community-based system of protective care for children to improve accountability and work with families as closely as possible. In many countries, reforms have been applied or are being considered to consolidate and decentralize the responsibility for institutional
care. In Albania, for instance, plans are under way to decentralize staff and the responsibility for decisions regarding the admission of children to institutions. Currently, however, all decisions are made at the state level; no systems exist at the municipal level (Fajth 1994a).

New legislation in 1991 and 1993 brought the administration of all institutional homes for children in Poland under the direction of the Ministry of Education. Homes for small children were transferred from the Ministry of Health. Public childcare and adoption centres, under the jurisdiction of the Ministry of Education, are now responsible for carrying out the search for and selection of adoptive and foster parents in family or group homes, selecting children for adoptive or foster care, providing advice to adoptive and foster families and parents in group homes, running adoption agencies, and supplying advisory services and legal assistance to families on the education and care of children. Private childcare and adoption centres have also been set up by churches and the Society of Friends of Children. The Warsaw centre of the Society runs a national database on the children available for adoption or foster care (Kolaczek 1994).

Nonetheless, the movement toward family-based alternatives to institutionalization in Poland is mostly theoretical, as there is no effective, well-organized social service system. The lack of coordination and cooperation among the Ministries of Health, Justice, Social Welfare, and Education, as well as the Church, all of which offer various child welfare services, has prevented the formation of a solid, homogeneous system of social service interventions to assist those in urgent need (Romanowska 1992).

The consolidation of responsibility for protective care institutions has begun in Romania, but similar problems exist there. Steps are being taken to transfer institutions for children with disabilities from the Ministry of Labour to the Ministry of Health. Within institutions administered by the Ministry of Health, measures are being put into place to create a more humane system. Abandoned children from dystrophic hospitals, for example, are being transferred to orphanages, where they can be made available for adoption or foster care (Helsinki Watch 1990).

In Russia the Ministry of Social Protection has been created to coordinate child protection services. The reorganization of protective care services for adolescents has also begun, but much remains to be done. A national "youth plan" with detailed programmes geared to preventing delinquency and other problems facing adolescents has been adopted, but not yet implemented. It is to be supported by an advisory committee on youth matters and a national youth fund, neither of which is yet in operation (UNDDSMS 1994).
8. **Staffing in institutions.** A more child-centred approach to the institutional care of children depends ultimately on those working most closely with the children. Programmes have been put in place to sensitize staff to the developmental, health, physical, social and other needs of children and to provide them with the skills and knowledge to offer the care best suited to the individual requirements of each child. Often, this training has been carried out within the institutions by experts from North America and Western Europe (Burke 1994). In some instances staff pay has been increased, reflecting a new recognition of the importance of this type of work. Programmes have also been re instituted at universities to train professionals, including child development experts.

9. **Safer health practices.** AIDS epidemics in childcare institutions in some countries, most notably Romania, have silhouetted the need for safer health care practices. The Ministry of Health in Romania has issued directives banning the use of microtransfusions and the administration of vitamins and antibiotics by injection, given the risk of children contracting hepatitis, AIDS and other sexually transmitted diseases from unsterilized syringes. It is unclear if similar directives have been issued in other countries, such as Bulgaria and Albania, where these practices have also been commonplace.

10. **The involvement of families.** Policies on many different levels attest to the growing recognition that families do and should play a central role in the care of children. Parents are becoming more involved in the planning and delivery of services to their children. Since 1990 parents in Slovakia have been making the decision on the most appropriate service or institution for their child. Specialists may comment on the appropriateness of the choices of the parents, but they are no longer responsible for the placement decision. Parents are also expected to contribute to the costs of caring for an institutionalized child (Papaj 1994).

    Institutions are now becoming more open to the public. Parents are being welcomed so that they can spend time with their children and participate in their care. This new policy has affected not just hospitalized children, but also those being cared for in orphanages. In some orphanages in Romania, for example, rooms have been set aside for family visits, so that relatives may spend time alone with the children away from the "judgmental" view of staff. In these institutions staff have noted a rise in the frequency of family visits since the special rooms were opened (Burke 1994).

    Parents dealing with unruly or delinquent children are now also entitled to more support. In Poland a law passed in 1993 obligates public officials such as the police and prosecutors to help parents whose children are delinquent (Kolaczek 1994).
11. **Placement follow-up procedures.** Prior to the transition, the review of a child's placement occurred infrequently or never in most countries. Since 1989, attempts have been made to gear the review process to the best interests of the child. In Romania measures are being taken to set up mechanisms to maintain close contact with the families of institutionalized children and to make systematic efforts to reevaluate periodically the status of children vis-à-vis their families (MOHR and UNICEF 1991).

Progress has been made in building a new model of protective care for children in Central and Eastern Europe. Official ideology no longer advocates institutionalization as the solution for children in need of protective care. Instead, there is a recognition that the family is the best environment for a child. In many countries legal changes have been made to move to a more child-centred system of protective care. However, much more work is required to construct an integrated child welfare system which responds to the individual needs of children and which works in their best interests. Unfortunately, these changes will likely come too late for today's children (*Helsinki Watch* 1990).

V. PROBLEMS IN POLICY IMPLEMENTATION

The reform of child protection systems in Central and Eastern Europe has been fraught with difficulty. The transition to the market-oriented economy has resulted in unprecedented political, social and economic upheaval and the collapse of organizations which had framed people's lives for more than 50 years. As a result, many needed reforms have still not been introduced. Those reforms which have been undertaken have been difficult to implement, are inadequate and have not always led to the most efficient use of available resources. The situation of many children has worsened.

**Feeble Legislation**

As the countries of Central and Eastern Europe undertook the transition to the market economy, it became evident that child protection systems were in need of a complete overhaul. Pressing problems, such as trafficking in children for international adoption, generated new legislation. The ratification of the UN Convention on the Rights of the Child
also boosted the pressure for legal changes. However, modifications were introduced in a
piecemeal fashion. This has resulted in a set of measures that has considerable gaps and relies
on obsolete standards which seriously limit the effectiveness of the legislation. Nowhere has
a comprehensive system of child protection policies been introduced.

The problems have been similar in most countries. The major shortcomings in Russia,
for example, are not much different from those in almost any country in the region. These
include the following.

- Child protection laws which are full of well-meaning declarations, but which are
difficult to apply. Many laws lack guidelines or do not include specific measures. Thus,
additional instructions, provisions and rules have to be issued. These in turn are hard to
carry out.

- Standards on child rights issues that do not meet the general level of the standards
set by the constitutional protection offered for individuals in the Russian Federation, nor
human rights standards in general.

- Information on new regulations is not widely distributed through the media, and
parents, educators, social workers and children themselves remain ill informed about legal
changes (MSPR 1994).

Child protection laws in line with the UN Convention on the Rights of the Child
ought to be enacted in all countries so that families and institutions can meet not just the
medical, but also the social, emotional and development needs of the child (MSPR 1994,
Konopasek 1991). This would involve legislation designed to strengthen parent-child bonds,
thereby preventing children from falling into situations requiring protective care. Such laws
would enhance care and require breastfeeding in maternity hospitals, modify regulations in
paediatric hospitals to permit parents to stay with their children and be involved in their care,
and minimize hospital referrals and the length of stays. Additional measures would reinforce
health promotion programmes and disease prevention initiatives for women and young
children and institute the monitoring of child abuse and neglect (MSPR 1994).

Other legal provisions would offer protection for pregnant women and mothers of
young families. They would include measures to improve the nutritional status of women,
supplementary feeding and prenatal vitamin-supplement programmes for pregnant and
lactating women, measures to assure adequate rest toward the end of pregnancy, basic
prenatal care and pregnancy monitoring, counselling on alcohol and drug abuse, and
measures to promote breastfeeding for the first four to six months of the life of infants (Kroupova n.d., MOHR and UNICEF 1991).

**Budgetary Restraints**

Fiscal restraints have led to a decline in funding for child protection institutions, the construction of new facilities and the purchase of special equipment, medical supplies and even basic medicines. They have also limited the scope of the training of professionals to work in the protective care system and of training and allowances for foster parents.

In some instances budget cuts have diminished the share of the child population being served. Part of the decrease in the child population in institutions has been due to dwindling budgets. Government expenditures on residential institutions in Slovakia, for example, fell from 1,707 crowns in 1992 to 1,290 crowns in 1994 (Wolekova 1994).

In many instances legislation cannot be implemented due to fiscal constraints. In Russia the youth fund has not been endowed; the advisory committee on youth matters has not met, and the resources needed to carry out the programmes contained in the youth plan have not been made available. The Federal programme "Children of Russia", which was adopted by the Council of Ministers and which includes numerous programmes aimed at women, families and children, cannot be implemented due to lack of financing. The amendments required to bring all Russian laws on the legal and social protection of children into line with the UN Convention on the Rights of the Child likewise cannot be carried out for the same reason (UNDDSMS 1994).

Budget restraints and the new philosophy which encourages individuals to take care of themselves rather than depend on the state have generated cutbacks in family support programmes in all countries. There have been sharp drops in real family incomes, the coverage of most employment and childcare support programmes, and the relative size of government expenditures on childcare and education. This has resulted, for example, in declining preschool enrolment rates in all countries but Hungary (Fajth 1994c).

These changes in child and family support policies and programmes have exacerbated the financial difficulties facing families with children and have increased the likelihood that children will be living in poverty and other especially difficult circumstances.
Social and Political Instability

Worsening conditions since the beginning of the transition have led to social unrest, civil strife and war in some parts of the region. Regime after regime has been toppled in most countries as voters search for a magical solution to lift them out of their woes. Governments have been reluctant to introduce reforms which might prove their undoing, or reforms have been halted as governments have been swept from power.

Social instability has reduced the capacity of governments to implement reforms which have been successfully enacted. For example, measures were taken in Russia to implement the UN Convention on the Rights of the Child, but growing social and economic problems have aggravated the situation of a great number of children and reduced the possibility of many families and of the state to assure the subsistence, development and socialization of children (MSPR 1994). In such a climate it is unlikely that comprehensive reforms in the child protection system can be carried out.

Inertia

The consolidation of child protection services under a single ministry or under an umbrella organization has met with resistance in some countries because ministries are reluctant to lose part of their budgets. In an environment of escalating unemployment, institutional staff have also been reluctant to introduce changes which could result in the loss of their jobs. In the Czech Republic such concerns have led to a lack of coordination and cooperation among workers in child and family protection.

Ignorance of child development needs has also perpetuated the resistance of staff to sensitive approaches to the children entrusted to their care. Medical specialists in Albania, for example, continue to diagnose and refer cases of malnourishment and disability to institutions rather than seeking alternatives more suited to the best interests of the children.

Communication breakdowns have added to the gravity of the situation. In Romania many paediatricians seemed unaware that the Ministry of Health had ordered that abandoned children in dystrophic hospitals were to be transferred to neighbouring orphanages immediately, rather than waiting the usual two years for formal certification of abandonment. Most disturbing was the fact that microtransfusions and the injection of vitamins and antibiotics continued, despite the directives of the Ministry and the awareness of doctors of

The sudden rupture of all things familiar and the moral vacuum left by the collapse of the socialist system have led to a sense of inertia among people. One survey in Russia (Avraamova 1994) found that many people are disoriented. A sizeable group of people are either doing nothing as they wait for social assistance, or have given up all hope of adapting. This is obviously a major obstacle to reform.

To become more self-reliant, self-sufficient and accepting of their primary responsibility for the health and welfare of their children, families will need help from skilled and knowledgeable health care and social workers.

**Weaknesses in Organizational and Institutional Infrastructure**

The collapse of the socialist system also involved the collapse of many of the institutions which had served families, children and youth for decades. In many instances new ones have not been formed to take their place; those which continue to exist are in need of urgent reform. Decentralization has begun even though the local and regional infrastructures are not yet in place. Organizational change is slow. In some cases legislation is required; in others, administrative inertia has set in. Without cooperation and coordination, comprehensive child protection systems will remain more theoretical than operational.

The Czech Republic and Slovakia have begun to transfer decisionmaking from state to local authorities, civic groups, churches and political parties, as well as to families (Kroupova n.d.). Nonetheless, the needs of children and families cannot be served until social welfare offices are established and able to pay out social support benefits to families with children and offer social assistance services.

In Bulgaria difficulties in organizing fully functional regional health care units have limited the extent to which prenatal and child screening can be carried out to determine the impact of environmentally caused disorders (Tassev 1994).

The implementation of new policies in Russia is impeded by a top-down approach. Decisions are made by top Federal bodies and then confirmed in provinces by the republic and regional administrations.

To support new child protection systems, work is urgently needed in the following areas.
1. **Nongovernmental organizations.** Private not-for-profit organizations and volunteer activity could efficiently and cost-effectively mobilize services for families, children and youth. Growth in the voluntary sector has been limited since the onset of the transition for many reasons. Few voluntary organizations existed under socialism, and the tradition of voluntarism has never become developed. Institutional structures to support NGO activity must still be put in place. Legislation does not yet favour voluntarism; positive tax support measures still have to be developed in most countries. Training programmes must be designed and implemented to facilitate efficient management structures and accounting and evaluation techniques.

2. **Family support centres.** A comprehensive network of centres to service the needs of children and their families is required to assist in the application of child and family policies geared to the best interests of children. Such a network would fill the current void and would provide parents with assistance so that they can become self-sufficient in caring for their children. Without support centres of this type, reforms aimed at "deinstitutionalizing" disabled children and reducing the number of "social" orphans will be greatly hindered. The centres could play a "preventive" role by supplying parental training, parenting skill-building, and social, physical and psychological health care. They could also be focal points for various other services for children and families, such as legal services and emergency services. Policy research and advocacy could also flow out of such a network.

3. **Youth service centres.** Reforms geared to meeting the needs of youth are blocked by the void in services for adolescents. The institution of a network of youth service centres would fill the vacuum created by the collapse of Communist youth organizations and other services which existed before the transition. These centres could perform the following functions.

- Advocate for legislative changes in youth policies, including tighter minimum working age laws, educational reforms which help young people bridge the gap from school to work, and social assistance reforms to enable youths to move from a life on the street, preferably back to their families.
- Carry out research on policy issues affecting young people.
- Provide emergency care and after school care for adolescents with working parents.
- Operate as referral centres for education, vocational training and employment.
- Act as hostels for youths otherwise living on the street.
- Help rehabilitate young people with drug, alcohol and related problems.
- Furnish hot lines, counselling services and legal assistance services.
More and more children and adolescents are living in very difficult circumstances and are in need of urgent help. These include street children, youths engaged in delinquent or criminal activities, young prostitutes, and drug and alcohol abusers. Without services for these young people, the demands on the protective care system will continue to grow.

4. **Adoption and foster care services.** Moving children out of institutions and into adoptive or foster care homes has been difficult due to a shortage of people willing and able to take on the task of parenting. This is especially so since many of the children necessitating this type of care have very urgent and demanding needs. The shortage in suitable family care opportunities is especially acute for severely handicapped children, teenagers and troubled youths who require short- and long-term therapeutical foster care.

The absence of training courses for prospective and current adoptive and foster parents, adequate income support measures, and services for foster parents, such as weekend relief services and therapeutic, emergency and crisis counselling services, aggravate the situation. Without such assistance, adoption and foster care will remain peripheral in the child protection system.

5. **Other capacity-building mechanisms.** There is currently no information network in most countries to track the progress of individual children. Without such a network, it is not possible to identify trouble spots in the system, such as those regions or municipalities where children are more likely to be placed in long-term institutional care.

In most countries there is also no mechanism offering children, parents, or other adults in guardian roles the possibility to initiate a review of a particular situation by a disinterested party acting in the best interests of the children. Without an ombudsman or similar mechanism in place to advocate on behalf of children, the abuses which characterized child protection systems in the past will continue.

6. **Shortages of facilities, equipment and supplies.** Reforms aimed at improving the conditions of children in institutions and at offering alternative care for children with disabilities and other children needing special care have been seriously compromised by acute shortages of basic supplies. In Bulgaria, for instance, foreign assistance is required for the importation of medicines and food for infants and children.

Reforms in the care of high-risk newborns and of infants and children with disabilities are also seriously frustrated by shortages in special equipment such as prosthesis, orthopaedic shoes, equipment and material for the intensive care of women, newborns, infants and children at risk, equipment for genetic centres and ultrasound devices for early discovery of
hip dislocations in newborns, and laboratories for foot and other orthopaedic examinations (Valtshev n.d.).

7. **Lack of qualified staff and staff training.** Staff who are not skilled in child development needs continue practices harmful to the health, safety and proper development of children. Many are unaware of changes in legislation and policies. Inadequate training programmes and shortages of basic items such as books and writing materials impede the training of qualified workers. Emigration, war and soaring death rates have depleted the ranks of qualified professionals.

In the absence of well-trained staff to work with children in protective care systems, many of the reforms simply cannot be implemented. In the Czech Republic, for example, an estimated 250 additional child and youth social workers and 1,000 family social workers would be required before the end of 1996 to serve the needs of children and families. The lack of qualified social workers with the knowledge to carry out casework has prevented the implementation of a less superficial approach to childcare. It has also meant that there is no one to serve children and youths at risk in places where these young people are gathering.

Prior to the transition, physically disabled and mentally handicapped children were among the most neglected groups in protective care systems. While there is a growing recognition that the needs of these children have not been met, shortages of trained staff have prevented the implementation of reforms in the care practices of the relevant institutions. Shortages of staff trained in early child development, psychiatric nursing and the care of the disabled have been identified in Albania (Tassev 1994). In Russia this problem is particularly acute. Just 73 percent of the staff doctor vacancies and 80 to 87 percent of the other medical staff positions have been filled in homes for disabled children (Leveille 1990a, 1990b). Similarly, the shift from institutional care to foster care has been thwarted by the lack of trained foster parents.

The infrastructure is not available to develop training programmes. This seriously influences the effectiveness of legislated changes. In Romania, for instance, professionals are now being trained, but the conditions for learning are still deficient. There is an acute shortage of up-to-date textbooks; supplies as basic as pens, pencils and paper are expensive and not readily available (MOHR and UNICEF 1991).

In many instances professional training is not possible, and those wishing to acquire the skills have to take courses in other countries. The costs involved are often prohibitive, especially given the reduced economic resources of most people. In Bulgaria the training of
staff for children and adolescent homes and boarding schools depends on foreign experts because of a shortage of Bulgarian educators. Since this involves sending Bulgarian students abroad or bringing in foreign advisors to develop programmes within the country, the process is costly (Valtshev n.d.). It will likely take many years before there is a capacity to provide training by Bulgarians within the country and before enough trained professionals are available to implement the needed reforms.

The Sustainability of Policies

The sustainability of reforms in child protection systems will depend on the creativity with which existing financial and human resources are used to meet the changing needs of children, as well as on the flow of aid from the West. Clearly, no fresh local resources can be injected into the system. Indeed, inflation and hyperinflation are sharply reducing the available resources.

In many instances reforms have been implemented only because of the financial, technical and professional assistance from child welfare and other humanitarian organizations in the West. Should this aid be cut off, or should conditions for children deteriorate further, the already desperate situation of many children will most certainly pass the crisis point.

Sustainability will also depend on the degree of commitment to reform at the political, legislative and administrative levels and on the political and social stability of the region. The shifts in governments that have characterized almost every country in the region over the past six years are not conducive to any kind of sustained policy initiative. For countries immersed in or hovering on the edge of war and civil conflict, reform has taken a backseat to more pressing concerns.

The demands on the reform process have risen dramatically as the unprecedented drop in welfare has taken its toll. Worsening conditions have resulted in a rising stream of children into situations of extreme risk. The needs of these children cannot be left unattended, but require immediate action. The human cost of inaction alone is unendurable.

The willingness and ability of parents to accept responsibility for the care of their children and the degree of support they receive will also influence the sustainability of reform. Providing parents with the economic means to support their families and the availability of family and community resources, of the skills of professionals and other individuals involved in the care of children, and of the parenting skills necessary to meet the
many needs of children will, over the long term, be the best investment for assuring sustainable child protection systems.

For over 50 years the socialist regimes battered away at families, attempting to rupture family and community bonds, destroy family and community values and reduce families to helpless dependency on the state. That families endured at all and that many children did grow up to become productive, loving individuals is testimony to the sustainability of families.

Indeed, according to a recent survey (cited in Avraamova 1994), children and the family represent the most important "value" for people in Russia. Of those surveyed, 90 percent believe that the most important thing in life is to raise children and assure their future, while 86 percent of the respondents said that "forging a strong family" was their primary "value". This is a ray of hope for children.

VI. CONCLUSION: UNICEF'S TASK

Poverty, unemployment, homelessness, malnutrition, disease, death, drug and alcohol abuse, sexual promiscuity, prostitution, crime, war: these are the everyday realities of a growing number of children and youth in the transitional economies in Central and Eastern Europe. Not just a few, but thousands and tens of thousands of children and youths are being denied their basic rights (UN 1989).

The road ahead is daunting. The child protection infrastructure is foundering; buildings and facilities are deteriorating, and even the most basic goods—food, clothing and medicine—are in short supply. Staff are ill equipped to meet the needs of the most vulnerable. Preventive measures are all but impossible because devastating socioeconomic conditions are daily adding more children in desperate straits to the system, and the system is unravelling. Laws cannot be enacted quickly enough to introduce the required reforms.

UNICEF's task is evident. It must state to the world in a loud, clear voice that the exploitation of the most vulnerable is not tolerable. It must deliver the message to the West that it is morally obliged to see that no more children are killed by mortars, hunger, cold and neglect, that no more children suffocate from deprivation on hard iron cots in sterile, unloving orphanages. It must move the debate away from the social contract of market liberalism toward the social covenant of a sustainable society (O'Neill 1994).
Swings in employment rates, wages and government transfer payments constantly erode the thin line between civility and barbarism for large segments of the population. On the international level, the vocabulary of "basic human needs" is fraught with the market fantasy of material survival in a world without any commitment to stop the destruction of children. Nothing is said about a world in which UNICEF never goes out of business.

That is UNICEF's ultimate task. It must take every step possible to put itself out of business.
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