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Improving child care in India through the development of the Questionnaire to Assess Needs of Children in Care (QANCC)

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Abstract

India has around 20 million children living without families who need to be cared for through alternative forms of care. Udayan Care has an innovative group care model for children in need of care, utilising the indigenously developed LIFE (Living In Family Environment) strategy in its 13 UdayanGhars (Sunshine care homes). The model offers long-term permanent mentor parents to all children through the Carer team at its homes. Most often, children's direct input is not available to the management of care homes. To address this Udayan Care has developed the Questionnaire to Assess Needs of Children in Care (QANCC) to assess the needs of children under its care. The questionnaire is administered to children in a scientific manner every year to understand the basic/ fundamental, emotional, educational and interpersonal needs of the children aged 10-18 years under its care program with the goal of evaluating the extent to which these needs are being met from the perspectives of the children themselves. A census methodology is used on children aged between 10-18 years who have lived minimum of 6 months at the UdayanGhars. Over the years, we saw that on an average, 76.8% of the children feel that their needs are met; which is further stratified as follows: 92% of the children feel their basic fundamental needs are

met, 80 % of the children feel their educational needs are met, 77% of the children feel that their Interpersonal needs are met, and 70% children feel their emotional needs are met. Areas of unmet needs have been identified to provide additional support specifically towards addressing them. The study allows children's participation in provide opinions on issues that directly impact upon them and the management of UdayanGhars consider these opinions while making decisions that affect their care; ultimately leading to improved standards of care at UdayanGhars.

Keywords

Child participation, childcare, childcare institutions, India, UdayanGhars

Article history

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Introduction

Children under 18 years of age constitute 40% percent of India's 1.2 billion population (Government of India 2011) and this is significant not only for representing a large number, but also a population group affected by vulnerability to abuse, deprivation and abandonment. India is also home to approximately 25 million orphans and vulnerable children (UNICEF 2008), though a more recent study by SOS Children's Villages of India in 2011 pegged the number closer to 20 million (SOS Children's Villages 2011). These children need stable family care or alternative forms of care, yet, between 2014-2015, only 4,362 children were adopted — less than 0.2% of those in need (Central Adoption Resource Agency, 2014-2015). The recent shift towards de-institutionalisation has led to more focus on other forms of alternative care like adoption, foster care, guardianship, kinship care and sponsorship (UNICEF 2006), however these are in the nascent stages in India. With this in mind, and believing in the fact that institutionalisation is always the last resort, the idea for Udayan Care began.

"Udayan" in Sanskrit, means "Eternal Sunrise" and the first "Sunshine Care Home" or UdayanGhar was opened in 1996 with the goal of empowering vulnerable children and youths across India through an innovative group foster care model based on the indigenously developed L.I.F.E. — Living In Family Environment strategy (Modi, Nayar-Akhtar, Gupta & Karmakar 2014). The 13 UdayanGhars are set up in units of 12 children of the same sex and are located in the heart of middle class communities to maintain a sense of belonging to the community and to help reintegrate re-entry into mainstream society. The

backbone of the model consists of Mentor Parents — a group of socially committed, civil society members, who voluntarily commit themselves for a lifetime to raise the children like their own; Caregivers — who live with the children 24/7; Social workers and Supervisors. The Mentor Parents, Social workers and care staff form the core Carer team (Modi et al. 2014). A child psychiatrist, psychotherapist, and a team of counsellors and social workers affiliated with the organisation also share and foster healthy relationships with the children which helps with their emotional and psychological wellbeing. The units are kept small to ensure that each child gets adequate one-to-one care (Modi, Nayar-Akhtar, Ariely & Gupta 2016).

Children stay in the same care home until the age of 18 and then are required to move out but provisions have been made through The Juvenile Justice Act 2015, Section 46, which allows for the establishment of aftercare programs to help the integration of these youths into society. Accordingly, two aftercare homes have been set up for children older than 18, one for boys and one for girls, where they are supported through higher education or vocational training and are encouraged to take up part-time jobs. In the 21 years since the first home was set up, more than 783 children have been impacted. Presently, 174 children (113 girls, 61 boys) and 29 young adults live at the 13 UdayanGhars, two ftercare facilities and other scattered site housing across Delhi, Kurukshetra and Jaipur across northern India.

Table 1: Data showing the year of inception and current census of children (as on March 31st 2017)

Name of the Ghar	Year of Inception	Number of children
Home 1- Sant Nagar- Girls	1996	13
Home 2- MayurVihar- Boys	1999	13
Home 3- Mehrauli- Girls	1999	13
Home 4- Greater Noida- Girls	2003	24
Home 5- Gurgaon- Boys	2004	15
Home 6- Noida Boys Home	2007	11
Home 7- Noida Girls Home	2008	8
Home 8- MayurVihar- Boys	2008	10
Home 9- Kurukshetra- Girls	2008	10
Home 10- Jaipur- Girls	2009	20
Home 11- Ghaziabad- Girls	2009	12
Home 12- Mehrauli- Girls	2010	13
Home 13 – Sant Nagar – Boys	2013	12

Need for the development of an assessment tool

In the initial years after starting the group homes, Udayan Care had streamlined procedures for the training of staff and caregivers. Though children were doing well in school and responding with more trust subjectively, there was no objective way to assess if children were satisfied with the care they were receiving. The importance of meaningful participation by children has been

emphasised by the United Nations Convention on the Rights of the Child (UNCRC 1989) and child participation is one of the core principles of the UNCRC, Article 12. This asserts that there is an obligation to listen to children's views and to facilitate their participation in all matters affecting their lives. Section 3 (iii) of the Juvenile Justice Care and Protection of Children Act, 2015, clearly lays down the principle of participation as follows:

> Every child shall have a right to be heard and to participate in all processes and decisions affecting his interest and the child's views shall be taken into consideration with due regard to the age and maturity of the child (Juvenile Justice Act, 2015).

In periodic self-examination of care strategies, it was found that children and their mentors had quite varied ideas about care and control, which highlighted the importance of understanding the differences in caregiving perspectives from both the child and the adult, for appropriate development in childhood and successful transition into adulthood (Modi et al., 2016; Modi, Sachdev & Prasad, 2016). Most importantly, an internal process was required to promote routine collaborative input by children who were receiving care, which could be used as a measure to rate the quality of changes being implemented. There has not been a similar tool in India to assess this as far as is known currently and there is no standard for self-assessment in this setting. Using a previously validated questionnaire may have been useful. Although a broad literature search did not reveal a questionnaire which had been validated for use in a similar care home setting with the specific cultural contexts in mind, there have been several subjective wellbeing assessments promoted in other countries (Rees & Main,

2015) as well as research into positive indicators of wellbeing (Ben-Arieh 2000; Lippman, Moore & McIntosh 2011).

To address this, in 2011, Udayan Care initiated this census study with the aim of developing evidence to assess whether the needs of children under its care were being met from their own point of view. The survey is titled 'Questionnaire to Assess Needs of Children in Care' (QANCC), and it aims to understand four categories of needs — basic/ fundamental, emotional, educational and interpersonal — of children aged 10-18 years under its care from the perspective of the child.

Development of the questionnaire:

This tool was developed in consultationwith individuals with extensive experience in the field: child psychiatrist Dr Deepak Gupta, clinical psychologist Ms Hemanti Sikdar, social workers Ms Garima, Mr Rahul and Ms Nidhi, and Dr Kiran Modi who is the managing trustee and founder of Udayan Care. Input from professionals involved in different aspects of childcare ensured that a wide variety of concerns were represented, which helped with establishing the salience and credibility of the content.

The questionnaire comprises 29 questions and the parameters measured cover basic fundamental needs, emotional needs, interpersonal needs and the educational needs of the children on a four point rating scale with answers ranging from Never, Sometimes, Most of the time and Always. Questions were generated and vetted based on careful consideration of the various factors which were deemed to impact child development, based on the experiences of the

authors of the questionnaire in working with Udayan Care. Previous work in the domains and constructs relating to child wellbeing were also considered in the process (Lippman et.al. 2011). Specific questions were retained as they were deemed to represent the areas where children's subjective input would be most valuable in providing feedback for objective change.

The questionnaire is designed as a self-assessment tool to be administered to children between the ages of 10-18. These age groups were chosen specifically in light of their language development being more advanced than younger children — the intent being that questions could be understood without much prompting, reducing the possibility of interviewer bias and proneness to suggestibility (Hritz, Royer, Helm, Burd, Ojeda & Ceci 2015; Moriguchi, Okanda & Itakura 2008). The questions were developed in English and were translated into the native language Hindi and independent translations from the native language were done to English to ensure accuracy in the creation of the materials. The level of understanding children had was also assessed for all the ages the same way.

The questions were not initially grouped under different needs criteria when the questionnaire was created but were categorised later when it was important for specific needs groups to be identified for targeting interventions. Patterns also started emerging when data collection was initiated, as to which needs are impacted when answers to some questions were Never or Sometimes

Methodology:

The methodology used to is a survey of all the children who have lived at UdayanGhar for a minimum of 6 months. A census of all the children was attempted due to the limited number of children and the desire to obtain individual input from all the children in the group home. Data was collected around October or November each year, which allowed for children to settle down after starting the school year in April and have a routine day-to-day schedule. A year was defined as the time period from April 1st of the current year to March 31st of the next year as it represents the administrative and financial year in India and at Udayan Care (Data from 2011-2012 implies that it was collected from April 1st 2011 to March 31st 2012). The surveys were administered by interns on a yearly basis for each of the homes starting from 2011. All the interns are Masters in Social Work students who have been trained in the administration of surveys and studies at the undergraduate level. They rotate through the care homes for small periods of time during the year based on the requirements of their schoolwork and a new batch of students come in each year. Care is taken to ensure that the intern who administers the questionnaire is previously unknown to the child to reduce any social desirability bias which could arise from the children being surveyed by individuals they are dependent on for their needs. All the children in a Ghar are surveyed in the course of a few days and were asked to complete the survey individually. Although the test is designed to be a self-administered tool, the questions were read to younger children and their answers were recorded, so interns are trained to follow a standard protocol at the initiation of their rotation through Udayan Care to minimise variations in administration. Younger children were asked to

repeat the questions — which were read to them in English — in their native language to ensure that they comprehended the questions adequately. Older children completed the questionnaire by themselves but interns were available to them if any questions arose. The implementation of the questionnaire was in strict accordance to the ethical standards for research established by Udayan Care and care is taken to ensure voluntary participation and obtain informed consent from the children. The aims of the survey were explained to the children and all the children in the homes completed the questionnaire, so the data represents a consistent sample, excepting for those children who turned 18 and graduated the program or those who had just turned 10 and were being included in the study. Mean scores were calculated for each home based on a numerical value assigned to each of the responses and the data was analysed. The results were not blinded, as the goal was to identify areas for change both centrally and for individual children.

Results:

The results indicate that, on average, 80% of the children residing at UdayanGhars feel that their needs are met (evidenced by answers of Always and Most of the time in the study) which is further stratified as follows: 92% of the children feel their basic fundamental needs are met, 76.8% of the children feel their educational needs are met, 77% of the children feel that their interpersonal needs are met, and 70% children feel their emotional needs are met.

The average mean score for all ages was 3.25, it varied from 3.32 for boys and 3.18 for girls which was not clinically significant, ($p = 0.2731$, Confidence

interval 0.115 - 0.355) (Table 3). There was no clinical difference in the average mean scores based on the different age groups (Table 4); but there was a difference in the means based on the year the study was conducted (Table 5). The difference was also clinically more evident in looking at the percentage of answers on the four point scale where there was a drop specifically in questions answered Always in Noida girls home, Mehrauli girls home, Mayur Vihar Boys home and Ghaziabad girls home in 2014-2015 (Table 6) but these scores increase the next year after measures were taken to improve areas of need there. More analysis may be needed to deduce statistical differences through the years.

For 2012-2013, the mean scores were 3.5 but there was a drop to 3.2 the next year and a low of 3.1 in 2014-2015. It is not clear if this drop was statistically significant, but it indicated some areas of concern especially on a deeper analysis of the categories of needs (Table 7). There was a universal drop in the scores of basic needs, interpersonal needs and educational needs across homes but the drop was greatest in the area of emotional needs where the mean score dropped from 3.3 in 2012-2013 to 2.8 in 2014-2015.

Follow up of the mean scores after measures were implemented to improve emotional needs showed that the overall average scores went up from 3.1 to 3.3 in 2016-2017 and specifically in the emotional needs category where they went up from 2.8 to 3.1 respectively (Table 7).

Table 2: Breakdown of gender over the years of the survey

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of Boys	30	40	43	36	44

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of Girls	62	81	85	82	88

Table 3: Breakdown of mean scores by gender

	2012-13	2013-14	2014-15	2015-16	2016-17
Mean Scores-Boys	3.6	3.2	3.2	3.3	3.3
Mean Scores-Girls	3.4	3.2	3	3.1	3.2

Table 4: Breakdown of numbers of children surveyed by age groups

Age of child	2012-13	2013-14	2014-15	2015-16	2016-17
10yrs old	8	15	11	5	7
11yrs old	13	13	19	13	5
12yrs old	19	31	19	19	11
13yrs old	10	20	22	21	22
14yrs old	11	16	24	16	23
15yrs old	10	10	11	25	21
16yrs old	6	7	11	11	25
17yrs old	10	7	4	7	15
18yrs old	5	2	7	1	3

Table 5: Breakdown of mean scores by age groups

Age of child	2012-13	2013-14	2014-15	2015-16	2016-17
Mean Score-10yrs	3.4	3.3	3.0	3.3	3.3
Mean Score-11yrs	3.3	3.4	3.1	3.1	3.3
Mean Score-12yrs	3.4	3.3	3.0	3.1	3.3

Age of child	2012-13	2013-14	2014-15	2015-16	2016-17
Mean Score-13yrs	3.6	3.1	3.1	3.1	3.2
Mean Score-14yrs	3.5	3.1	3.0	3.2	3.3
Mean Score-15yrs	3.5	2.8	3.1	3.1	3.3
Mean Score-16yrs	3.6	3.4	3.1	3.1	3.1
Mean Score-17yrs	3.5	3.3	3.0	3.0	3.3
Mean Score-18yrs	3.5	3.1	3.3	3.0	3.3

Table 6: Breakdown of responses with answers indicating Most of the time + Always by homes

Responses with Most of the times+ Always	2012-13	2013-14	2014-15	2015-16	2016-17
Home 1-Sant Nagar	86%	64%	69%	59%	47%
Home 2-MayurVihar	61%	62%	58%	75%	79%
Home 3-Mehrauli	77%	82%	70%	81%	84%
Home 4-Greater Noida	91%	70%	71%	73%	78%
Home 5-Gurgaon	90%	73%	77%	82%	82%
Home 6-Noida Boys	88%	71%	83%	93%	76%

Responses with Most of the times+ Always	2012-13	2013-14	2014-15	2015-16	2016-17
Home 7- Noida Girls	81%	72%	65%	78%	84%
Home 8- MayurVihar	64%	73%	56%	85%	83%
Home 9- Kurukshetra	91%	89%	91%	90%	97%
Home 10- Jaipur	90%	79%	72%	59%	73%
Home 11- Ghaziabad	94%	93%	74%	74%	80%
Home 12- Mehrauli	56%	69%	62%	71%	77%
Home 13- Sant Nagar	-	83%	63%	66%	68%
Overall average	81%	74%	70%	82%	77%

Table 7: Breakdown of mean scores by needs

	2012-13	2013-14	2014-15	2015-16	2016-17
Basic/Fundamental needs	3.8	3.8	3.6	3.5	3.7
Emotional needs	3.3	3.0	2.8	3.0	3.1
Educational needs	3.4	3.2	3.2	3.2	3.3
Interpersonal needs	3.5	3.3	3.1	3.1	3.3

Strengths and Limitations:

When the questionnaire was created, the intent was to assess the perception the children in the care homes had of their needs over time. The survey has been successful in providing useful and workable information towards this and towards assessing a wide variety of concerns children have expressed through it

over the past 5 years, whether it be in their basic needs ("The food gets over fast"), emotional needs ("No one is here to listen"), interpersonal needs ("They don't like me") or educational needs ("I'm not able to understand most of the words"). The results studied are chiefly descriptive in nature owing to the lack of a control group being assigned at the time, which is a factor of the specific nature of this population. More detailed statistical measures of comparison, specifically variance analysis, may yield further information and provide statistical strength to the results and this is a work in progress. The questionnaire was also not assessed for test - retest reliability, as there was a concern for introduction of bias due to carry-over effect. Children being required to elaborate further when they answer Never or Sometimes could potentially introduce a response bias and this needs further consideration especially given the high level of reticence shown in the data. Analysing the same child's response over time is another area which could be explored to provide more information on reliability and to assess progress made individually.

Discussion:

Although data was collected from 2011, only the results from 2012-2017 were used in the analysis, as the procedures for data collection had not been standardised in 2011. The number of children in the homes who were surveyed increased over the years from 92 in 2012 to 132 in 2016 out of whom a third on average were boys and the rest were girls. In 2016-2017 there were 44 boys and 88 girls across 13 homes who were surveyed (Table 2). The participation each year was expanded to include the individual children who turned 10 years old; those who turned, moved on and were excluded. On an average, 110

children have been a part of the research each year, of which 58 children have been surveyed every year starting 2011-2017, and if home 13 (which was started in 2013) is taken into account, 70 children have participated consistently in the survey from 2013-2017.

To rectify areas of concern expressed in the drop in scores on QANCC, regular counselling and therapy were initiated for children requiring help. Although a social work team headed by Dr.Gupta, a child and adolescent psychiatrist had been in place since 2004, counsellors and psychologists were hired for the individual Ghars. This was started from 2013 as a pilot program to address concerns that children had brought up and to work with them on a one-to-one basis, and from 2014 in all homes. Workshops and life skills training were conducted with the children on a regular basis and the understanding of unmet emotional and interpersonal needs from these questionnaires was utilised to conduct workshops with the Carer team. Specific committees were also formed to address needs in education, health, aftercare and for alumni; these meet on a monthly basis to examine areas of inadequacy and targets for innovative change. Care plans for each child were also examined side-by-side and altered to include the input from responses in the questionnaire. These are revised on a regular basis and new care plans are adapted in accordance with the dynamic evolving needs of children in care.

The results of the study have been useful for internal feedback and progress has been noted with implementing changes. The information obtained is disseminated to the Carer teams during the annual meetings and areas for intervention are identified. With the changes in the needs scores observed over the first few years of the QANCC study, the need to have a psychologist on site

in addition to the mentor mothers, social workers and the care staff, with a child and adolescent psychiatrist became evident. In the past two years, a psychologist has been employed in most of the homes for at least six hours a week in each home. The psychologist spends one to two hours with the care staff, and the rest of the time either with individual children or conducting groups with the kids. Group therapy work with the children consists of life skill modules teaching and other targeted interventions identified from weekly meetings between the Carer team members and the psychologists.

In looking at specific responses to unmet needs (as evidenced by answers of Never or Sometimes), some of the common concerns expressed were “I am unable to share feelings openly with other housemates”, “The feeling of living in a family environment is missing”, “I am ashamed of living as an orphan”, “I have a lack of confidence in facing the outside world”. For 2016-2017, an astounding 87% of children reported Never or Sometimes to the question “I share my concerns with others”, 69% answered Never or sometimes to “I share my concerns with supervisor/care giver/social worker/mental health professional”. The high level of reticence expressed by children in the survey is an area where care needs to be focused urgently as it is evident that more needs to be done. As it is now, to address this, individual counselling and care, workshops focusing on trauma and attachment, trust building; life skills and leadership have been implemented.

As a result of the changes implemented between 2014 and 2015, there have been changes noticed in the percentage scores, and the mean scores which have gone up from 3.1 to 3.3 in 2016-2017 and specifically in the emotional needs category where they have gone up from 2.8 to 3.1 respectively (Table 7).

Though not at the levels seen initially in 2012 (3.5), there appears to be a response to measures set in place and more importantly, the information from the QANCC is a continuing source of valuable information to inform ongoing care planning. The reason for the drop in the emotional needs scoresis still unclear and needs further research. The increase in concerns was also noted to be more universal in the home when there was a specific child in the home who was struggling, presumably due to bandwagon effects from sharing beliefs and friendships among the children. One possibility could be that previous scores were conflated owing to reporter bias, which reduced over the years following adhering to strict standards of privacy and confidentiality. Overall there did not appear to be any Ghars, which consistently exhibited lower scores attesting to the quality and strength of staff in the homes.

For meaningful participation of children and young people, both girls and boys have the right to say what they think should happen and have their opinions taken into account. UNICEF's Sustainable Development Goals made it a point to mention

sustainable development must be inclusive and people-centred, benefiting and involving all people, including youth and children in decision-making processes and the need to promote intergenerational dialogue and solidarity by recognizing their views (Goal 17, SDGs)

The study establishes that children and young adults know more about their lives and has opened a forum for expression of their views. It has helped initiate a dynamic childcare practice, which can review and adapts itself to changes with input directly from children. The questionnaire as it stands right now falls into a

consultative participation model. The results can be utilized to inform care and bring about more collaborative and child-led participation (Landsdown 2011).

An option for the future would be to do side by side comparisons of the QANCC with versions of other similar measures, perhaps adapted versions of the Child Health and Illness Profile — Child Edition or CHIP-CE (Riley, Forrest, Rebok, Starfield, Green, Robertson & Friello 2004) or comparisons with studies such as the Children's worlds survey (Rees & Main 2015), or the British household survey from the UK Millennium cohort study (Patalay & Fitzsimons 2016) or other health related quality of outcome measures and patient outcome measures. Another innovative challenge to take on would be in working on improving child participation in the evolution of the questionnaire itself. There has been some success in this as seen by the development of Child Led indicators by the Transcultural Psychosocial Organization in Nepal (Robinson, Metzler & Ager 2014). This program involved obtaining information from children by having them draw pictures depicting their positive and negative feelings, chose the most pressing psychosocial issues they face, mapping the cause to the effect, and identifying a target for intervention, thus developing a self-determined indicator in the process.

Preliminary data from the study from 2013-2015 has been presented at the 2nd Biennial conference on "Improving Standards of Care for Alternative Child and Youth Care: Systems, Policies and Practices" to providers and researchers from the South Asian region (Gupta, Modi, Shroff & Bhattasharjee 2016), organised and instituted as Biennials by Udayan Care, and the hope is to continue this practice at the next conference in 2018. Future directions include continued advocacy at the governmental level in policy making to make child derived

feedback a standard of practice and in making the QANCC more available to non-governmental organizations and care homes, regionally and nationally.

Conclusions

The QANCC survey has provided an opportunity for children in care homes to offer opinions on matters relating to their lives and these opinions are seriously considered by the management while decisions are made for the running of UdayanGhars, hence directly impacting the lives of such children and has enabled us to measure the status of child and adolescent wellbeing at individual and local level. At the same time it has enhanced children's ability to impact their own lives through a process of feedback and transparency. This however is only the tip of the iceberg — promoting the representation of children in every aspect of their care is the ultimate intent.

The majority of children who enter the care system of UdayanGhars have undergone grave loss, and other traumatic experiences, which affect their attachment and growth. There have been various interventions identified towards this (Silverman, Ortiz, Viswesvaran, Burns, Kolko, Putnam & Amaya-Jackson 2008) which are utilised in individual and group sessions but its effect on the results of children's perception in survey outcomes is an area which is a future focus of research. More work will be needed to streamline the process of interpretation of data and identifying correlations of targets for intervention.

This model has been used for this setting and the hope is that this approach will find a larger audience in India and abroad to embrace and incorporate child feedback into the daily care planning process. Ongoing goals aim to utilise

expert guidance in applying the findings nationally in policy-making and practice so that a larger number of children in institutions living in alternative care can benefit from improved care across India.

About the author

Dr. Kiran Modi is the Founder Managing Trustee of Udayan Care. Udayan Care is an Indian NGO with its head office in New Delhi and has been providing nurturing family homes to orphaned and abandoned children; higher education to underprivileged girls; and the dignity of self reliance by livelihood trainings and employment opportunities to youth, and inculcates in them the desire to give back to society for the last 24 yeas.

A doctorate in American Literature from IIT Delhi, Dr. Modi is also the liason editor and founder of an academic journal “Instituionalised Children: Explorations and Beyond”, a journal focused on alternative care of children out of home care. Recipient of many prestigious awards, Dr. Modi continues to strive towards ensuring the rights of the underprivileged with the same zeal and passion as she started out four decades back.

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